YOUTH SUICIDE

OVERVIEW

Most teenagers experience stress while growing up. Stressors can include societal pressures to adhere to cultural norms, pressure to succeed, divorce within a family, and financial difficulty. Youth may view suicide as the answer to these stressors if proper treatment is not rendered in time.

Suicide is a leading cause of death for 10- to 24-year-olds. However, deaths from suicide are only part of the problem. Each year, approximately 157,000 youth between the ages of 10 and 24 receive medical care for self-inflicted injuries at emergency departments across the U.S.

KEY POINTS

- **Suicide is the leading cause of death for 10- to 24-year-olds.**
- **90 percent of adolescents who commit suicide suffer from at least one psychiatric disorder at the time of death.**
- **No evidence-based interventions have been identified. Cognitive behavioral therapy and dialectical behavior therapy, in conjunction with appropriate medication therapy, are promising interventions.**
- **Early intervention is critical. Families should be alert to warning signs.**

Nationwide, firearms are the most common method of suicide for youth, followed by suffocation and poisoning.

It is important to note that, although non-suicidal self-injury (NSSI) is very serious, the individual's intention and ambivalence about the outcome distinguish it from suicidal behavior. A more detailed discussion of this disorder is included in the "Non-Suicidal Self-Injury" section of the *Collection*.

RISK FACTORS

While there are important risk factors to note, the presence of risk factors does not necessarily mean a youth will commit suicide. It is important to have a communication system in place that allows the youth to express his or her feelings. Talking about suicide is difficult, but with more open communication and less stigmatization, it could be an easier subject to broach.

Families and friends should be aware of the warning signs of suicide and should seek help immediately if they believe a family member or friend is contemplating suicide. Table 1 outlines risk factors that may increase the likelihood of a suicide attempt.

Table 1
Factors that Put Youth at Risk of Suicide

Risk Factors	Description
General risk factors	• Past suicide attempts, especially with methods other than ingestion or superficial cutting • Being diagnosed with a mood or conduct disorder • Substance use, especially among males • Aggression or fighting • Living alone or in a violent community • Currently depressed, manic, hypomanic, and/or severely anxious • Irritable, agitated, delusional, or hallucinating • Experiencing physical and/or sexual abuse • Family history of suicide and suicide attempts
Mental health disorders	Studies have shown that as many as 90 percent of adolescents who committed suicide suffered from at least one psychiatric disorder at the time of death, and that more than half suffered from a psychiatric disorder for at least two years preceding the event. The most common disorders include major depressive disorder, bipolar disorder, substance abuse, and conduct disorder.
Environmental stressors	Stress has been identified as a precipitator for suicide. One national study reported that 35 percent of youth suicides occurred the same day those youth experienced a crisis, such as a relationship breakup or an argument with a parent. Another study found that non-intimate-partner relationship problems, such as issues with parents or friends, preceded over 51 percent of suicides in the study, and a crisis that occurred in the past two weeks preceded 42.4 percent of suicides.
Bullying	Being the victim of school bullying or cyberbullying is associated with substantial distress, and researchers have found a clear relationship between bullying (victimization and perpetration) and suicidal ideation.
Sexual orientation	Among lesbian, gay, bisexual, and transgender (LGBT) adolescents, a history of attempted suicide, impulsivity, prospective LGBT victimization, and limited social supports were linked to increased risk for suicidal ideation.
Exposure to suicide	Sometimes the suicide rate among adolescents rises following a highly publicized suicide. This likelihood of co-occurring suicide is also referred to as “contagion” or “clustering.” Co-occurring suicide may occur when a classmate or someone with whom the youth has a personal relationship commits suicide. The associations between both ideation and attempts remained for at least two years after the initial exposure, suggesting that intervention and therapy should extend past the first few months following a suicide.
Sleep disturbance	Sleep disturbance has been associated with an elevated risk of suicide in youth. Assessing sleeping patterns may assist in assessing the presence of suicidal ideation and depression.
Access to firearms	Having firearms in the home is associated with both suicide attempts and suicide completion.

INTERVENTIONS

Currently there are no interventions that have been deemed evidence-based. Despite limitations in the literature, there is research to support the use of some techniques over others. A summary of interventions is included in Table 2.

Table 2
Interventions for Youth Suicide

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Selective serotonin reuptake inhibitors (SSRIs)	These antidepressants may help reduce suicidal ideation; however, in some individuals they may cause suicidal ideation. Youth taking SSRIs must be closely monitored.
Cognitive behavioral therapy (CBT) Dialectical behavior therapy (DBT)	These psychotherapies have both shown promise in reducing suicidal ideation in some youth when paired with appropriate medication therapy. Other psychotherapies, such as interpersonal therapy for adolescents, psychodynamic therapy, and family therapy, may also be effective.
SOS (signs of suicide) prevention program	A school-based education and screening program that teaches students to recognize warning signs of depression and suicidality in themselves or their peers.
Not Adequately Tested	
Gatekeeper training	Involves educating youth, parents, and caregivers in warning signs of suicide to encourage early intervention.
What Does Not Work	
Tricyclic antidepressants	Not recommended; effectiveness has not been demonstrated, and older tricyclic antidepressants are lethal in overdose quantities.
No-suicide contracts	Designed as an assessment tool, not a prevention tool. Studies on effectiveness in reducing suicide are inconclusive and their use is discouraged, as they may be interpreted as being coercive or may encourage suicide in some individuals.

Selective serotonin reuptake inhibitors (SSRIs) may be successful in reducing suicidal ideation and suicide attempts in non-depressed adults with certain personality disorders. However, it is necessary to closely monitor youth taking SSRIs, as there is some evidence that suggests that SSRIs can increase suicidality in youth and young adults under age 24. A more detailed discussion of the use of antidepressants in treating children and adolescents is included in the "Antidepressants and the Risk of Suicidal Behavior" section of the *Collection*.

Psychotherapy, although not in itself an evidence-based practice, is an important component to the treatment of suicidality in youth. Cognitive behavioral therapy (CBT) has seen promising results in recent years. When paired with the appropriate pharmacological treatments, CBT can be effective in reducing suicidal ideation. In addition, dialectical behavior therapy (DBT) has promise for youth with borderline personality disorder and recurrent suicidal ideation and behaviors.

The SOS Signs of Suicide Prevention Program (ages 11-13 and 13-17) is a universal, school-based education and screening program that teaches students to recognize warning signs of depression and suicidality in themselves or their peers and to seek help from a trusted adult. The screenings within the SOS Program are informational, not diagnostic. The goal of the screening is to identify students with symptoms consistent with depression and/or suicidality and to recommend a complete professional evaluation.

RESOURCES AND ORGANIZATIONS

American Association of Suicidology
http://www.suicidology.org/

American Foundation for Suicide Prevention (AFSP)
https://www.afsp.org/

Anxiety and Depression Association of America (ADAA)
https://adaa.org/

Association for Behavioral and Cognitive Therapies (ABCT)
http://www.abct.org

Children's Safety Network (CSN)
http://www.childrenssafetynetwork.org

Jason Foundation
http://jasonfoundation.com/

National Action Alliance for Suicide Prevention
http://actionallianceforsuicideprevention.org

National Alliance on Mental Illness (NAMI)
http://www.nami.org

National Center for Injury Prevention and Control
Suicide Prevention
1-800-CDC-INFO (232-4636)
http://www.cdc.gov/violenceprevention/suicide/index.html

National Institute of Mental Health (NIMH)
https://www.nimh.nih.gov

National Organization for People of Color Against Suicide (NOPCAS)
http://nopcas.org

National Suicide Prevention Lifeline
1-800-273-TALK (8255)
https://suicidepreventionlifeline.org

Society of Clinical Child and Adolescent Psychology
https://sccap53.org/

Society for the Prevention of Teen Suicide
http://www.sptsusa.org

Suicide Awareness/Voices of Education (SA/VE)
http://www.save.org

Suicide Prevention Resource Center (SPRC)
http://www.sprc.org

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov

The Trevor Project
1-866-488-7386
http://thetrevorproject.org

VIRGINIA RESOURCES AND ORGANIZATIONS

Virginia Department of Health
Suicide Prevention Program
http://www.vdh.virginia.gov/suicide-prevention/

Virginia Suicide Prevention Resource Directory
https://www.vdh.virginia.gov/suicide-prevention/resources/

National Crisis Hotlines

National Suicide Prevention Lifeline

3-digit dial: 988 – Launching in July 2022

1-800-273-TALK (8255)

TTY: Dial 711 then 1-800-273-8255

Veterans: Press 1

Spanish: Press 2

National Youth Crisis Hotline

1-800-442-HOPE (4673)

Military One Source

24-hour resource for military members, spouses and families

1-800-342-9647

LGBT Youth Suicide Hotline

Trevor Project

1-866-488-7386

Girls and Boys Town Home National Hotline

Crisis and resource referral services for adolescents age 11-17

1-800-448-3000

Virginia Crisis Centers and Hotlines

ACTS Helpline

Serving Dumfries, Manassas City and Manassas Park

Hotline: 703-368-4141

https://www.actspwc.org/

Concern Hotline

Clarke Hotline: 540-667-0145

Frederick Hotline: 540-667-0145

Page Hotline: 540-743-3733

Shenandoah Hotline: 540-459-4742

Warren Hotline: 540-635-4357

Winchester Hotline: 540-667-0145

https://www.concernhotline.org/

CrisisLink

Serving Arlington and the Washington Metropolitan area

Hotline: 703-527-4077

https://prsinc.org/crisislink/

HELP Line

Serving Albemarle County, City of Charlottesville, and UVA Students

Hotline: 434-924-TALK

https://www.helplineuva.com/

New River Valley Community Services

Serving counties of Floyd, Giles, Montgomery, Pulaski and the City of Radford

Hotline: 540-961-8400

http://www.nrvcs.org/

Regional Education Assessment Crisis Services Habilitation (REACH)

Region 1 (Charlottesville and Surrounding Areas): 888-908-0486

Region 2 (Northern VA): 855-897-8278

Region 3 (Southwest VA): 855-887-8278

Region 4 (Richmond and Surrounding Areas): 833-968-1800

Region 5 (Southeast VA/Tidewater): 888-255-2989

Richmond Behavioral Health Authority (RBHA)

Hotline: 804-819-4100

The Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs, 8th Edition

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