YOUTH SUICIDE

KEY POINTS

- **46 percent of adolescents who die by suicide suffer from at least one psychiatric disorder at the time of death.**
- **No evidence-based interventions have been identified. Cognitive behavioral therapy, dialectical behavior therapy, and possible appropriate medication therapy are promising interventions.**
- **Early intervention is critical. Families should be alert to warning signs.**

OVERVIEW

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

Suicide is one of the leading causes of death for 10-24 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.

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 NSSI is included in the "Non-Suicidal Self-Injury" section of the *Collection*.

If you are experiencing emotional distress or a suicidal crisis, dial "988" for the Suicide and Crisis Lifeline.

RISK FACTORS

While there are important risk factors to note, the presence of risk factors does not necessarily mean a youth will die by suicide. It is important to have a communication system in place that allows the youth to express their feelings. Talking about suicide is difficult, but with more open communication and less stigmatization, it could be an easier subject to broach. Talking about those feelings can be the first step in encouraging an individual to live. 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 indicate the possibility of a suicide attempt; however, risk factors cannot be used to predict whether a suicide will occur. Table 2 lists warning signs an individual may be suicidal. Four out of every five individuals considering suicide give some sign of their intentions, either verbally or behaviorally.

Table 1
Factors that Put Youth at Risk of Suicide

Risk Factors	Description
General risk factors	• Past suicide attempts • 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, emotional, and/or sexual abuse • Family history of suicide and suicide attempts • Serious illness • Chronic pain • Legal problems • Current or prior history of adverse childhood experiences • Sense of hopelessness
Mental health disorders	Studies have shown that as many as 90 percent of adolescents who died by 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, anxiety disorder, bipolar disorder, substance abuse, and conduct disorder. If suicidal ideation is not present, this does not mean that there will not be a suicide attempt.
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 (thoughts/plans about suicide).
Gender identity and 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.” Co-occurring suicide may occur when a classmate or someone with whom the youth has a personal relationship dies by 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 sleep patterns may assist in assessing the presence of suicidal ideation and depression.

Access to lethal substances (firearms, pills)	Having firearms in the home is associated with both suicide attempts and suicide completion. 9 out of 10 child and adolescent suicides by gun involve firearms from the victim's own home or that of a relative. Gun safety practices such as keeping firearms unloaded, locking firearms, and storing ammunition separately helps decrease this risk.

Table 2
Warning Signs Someone May Be Suicidal

A child or youth may be suicidal if you notice one or more the following…
• Talking about suicide/wanting to die • Talking about being hopeless or having no reason to live • Sudden increase/decrease in appetite • Sudden changes in appearance (different style of dress than normal, lack of personal hygiene) • Dwindling academic performance • Preoccupation with death and suicide • Final arrangements (giving away prized/favorite possessions, saying goodbye, talking about funeral) • Increasing use of alcohol or drugs • Extreme mood swings

INTERVENTIONS

Currently there are no interventions that have been deemed conclusively evidence-based; however, SAMHSA's "Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth" highlights promising treatments. 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 3. There is no one-size-fits all approach to treatment, but each path should include ongoing safety planning, coping skills training, continuity of care, and family involvement. Continual intervention trainings are necessary to remain competent.

Table 3
Interventions for Youth Suicide

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Cognitive behavioral therapy (CBT) Dialectical behavior therapy (DBT)	Both of these psychotherapies have 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. Suicide focused treatment can be effective without medication therapy in some cases.
Selective serotonin reuptake inhibitors (SSRIs)	These antidepressants may help reduce suicidal ideation in teens with diagnosed depression; however, in some individuals they

	may cause suicidal ideation. Youth taking SSRIs must be closely monitored. Limitations: SSRIs must be taken consistently, require a therapeutic dose per individual, and can take up to 3 months to show effectiveness.
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. Includes a screening component.
Safety Planning	Clinicians help patients identify effective coping techniques to use during crisis events (American Academy of Pediatrics).
Sources of Strength	Peer leaders model and encourage friends to name and engage trusted adults; reinforce and create an expectancy that friends ask adults for help for suicidal friends; and identify and use interpersonal and formal coping resources.
Attachment-Based Family Therapy	Most effective for youth aged 12-24; based on the idea that the quality of familial relationships has the potential to exacerbate or mitigate depression, suicide, and suicidal ideation; the only treatment adapted specifically for LGBTQ+ youth.
Not Adequately Tested	
Collaborative Assessment and Management of Suicidality (CAMS)	Centered on building a relationship between the physician and individual that allows the individual to identify and manage suicidal thoughts, feelings, and behaviors.
Gatekeeper training	Involves educating youth, parents, and caregivers about warning signs of suicide to encourage early intervention.
What Does Not Work	
Group counseling	Multiple randomized control trials fail to demonstrate efficacy.
Tricyclic antidepressants	Not recommended; effectiveness has not been demonstrated. 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.

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 included as an evidence-based practice in this document due to limitations surrounding randomized controlled trials, is an important component to the treatment of suicidality in youth.

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, 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

988 Suicide & Crisis Lifeline
https://988lifeline.org/

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)
https://www.abct.org/

Center for Disease Control and Prevention
Suicide Prevention
https://www.cdc.gov/suicide/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fsuicide%2Findex.html

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 Child Traumatic Stress Network
https://www.nctsn.org/

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

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

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

The Trevor Project
http://thetrevorproject.org

Youth Suicide Warning Signs
https://www.youthsuicidewarningsigns.org/youth

VIRGINIA RESOURCES AND ORGANIZATIONS

Virginia Department of Health
vdh.virginia.gov/suicide-prevention/

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

National Crisis Hotlines

988 Suicide & Crisis Lifeline
3-digit dial: 988
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)

Crisis Text Line
Text HOME to 741741,
http://crisistextline.org

Military One Source
24-hour resource for military members, spouses and families
1-800-342-9647

LGBTQ Youth Suicide Hotline
Trevor Project
Call: 1-866-488-7386
Text: 678-678

Trans Lifeline
1-(877)-565-8860

Girls and Boys Town Home National Hotline
Crisis and resource referral services for adolescents age 11-17
1-800-448-3000

Coping with Grief and Finding Treatment

The Dougy Center for Grieving Children and Families
503-775-5683
dougy.org

The Compassionate Friends
630-990-0010
compassionatefriends.org

Mental Health America
703-684-7722
mentalhealthamerica.net

MentalHelp
888-993-3112
mentalhelp.net

Theravive
360-350-8627
theravive.com

Mental Health, Suicide Prevention, and Community Resources

Teen Line – Youth Crisis
310-855-4673
Text TEEN to 839863
teenlineonline.org

Depression and Bipolar Support Alliance
800-826-3632
dbsalliance.org

Virginia Crisis Centers and Hotlines

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

Text CONNECT to 85511

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: 540-961-8300

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, 9th Edition

Virginia Commission on Youth, 2023

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