



# ANTIDEPRESSANTS AND THE RISK OF SUICIDAL BEHAVIOR

## OVERVIEW

Research indicates that as many as 18-20 percent of high school students have experienced depression or anxiety between 2021-2023.<sup>1</sup> Because depression substantially increases the risk of suicide, much focus has been placed on measuring the effectiveness of treatments. This is particularly true for adolescents because depression in that age group is a strong indicator of suicidal behavior.

Currently, only one pharmacological treatment has been approved for use in youth with depressive disorders by the Food and Drug Administration (FDA). This medication, fluoxetine (a selective serotonin reuptake inhibitor [SSRI]), has been approved by the FDA for treating children eight years of age or older. More research has been completed on fluoxetine than any other SSRI. For older youth (ages 12 and up), The FDA has approved the use of another SSRI, escitalopram, for depression.

However, research has also revealed a possible relationship between suicidal thoughts or actions and the use of SSRIs in children and adolescents with depression. This section outlines the benefits and risks associated with fluoxetine use in children and adolescents with depression.

## FOOD AND DRUG ADMINISTRATION ADVISORY STATEMENT

In response to findings that antidepressant use in pediatric patients had the potential to increase suicidal thinking and behavior, the FDA directed manufacturers to add a black-box warning to the health professional label on antidepressants. A summary of key points in this labelling is outlined in Figure 1.

The FDA also recommended that clinicians should screen for bipolar disorder, because symptoms of depression may be part of bipolar disorder. Antidepressants used alone may trigger a mixed/manic episode in these at-risk patients, which may contribute to suicidal thinking or behavior.

### KEY POINTS

- Research has revealed a link between suicidal thoughts and use of SSRI medications in children.
- Fluoxetine (SSRI) is currently the only medication approved for children suffering from depression.
- Children taking SSRIs must be carefully monitored by caregivers and professionals for suicidal thinking and behavior.

<sup>1</sup> Centers for Disease Control and Prevention. (2025, June 5). Data and statistics on children's mental health. Retrieved from <https://www.cdc.gov/children-mental-health/data-research/index.html>.

In addition, dosage appears to be a contributing factor. One study found that younger patients who began treatment with higher-than-recommended doses of antidepressants were more than twice as likely to try to harm themselves as those who were initially treated with the same drugs at lower, recommended doses. The risk of suicide attempts seemed to be highest in the first 90 days on the medications.

In response to the black-box warning, practitioners such as pediatricians and family practitioners have ceased prescribing antidepressants to children and have begun to refer patients to child and adolescent psychiatrists.

### Figure 1 Key Points of FDA Black-Box Warning Label For Suicidality and Anti-Depressant Drugs

- Antidepressants increase the risk of suicidal thinking and behavior in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders.
- Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance the risk of increased suicidality with the clinical need.
- Taper dosage to prevent risks of discontinuation syndrome if stopping SSRI treatment.
- Patients who are started on antidepressant therapy should be observed closely for agitation, irritability, clinical worsening, suicidality, or unusual changes in behavior.
- Families and caregivers should be advised to closely observe the patient and communicate with the prescriber.
- A statement regarding whether the particular drug is approved for any pediatric indication(s), and if so, which one(s), should be present.

## EFFECTIVENESS OF SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs) VERSUS THE RISK OF SUICIDALITY

When making decisions about the risks associated with antidepressants, particularly SSRIs, it is important to understand the limitations of the research. Suicidality can be very difficult to measure, as these events are rare, and the statistical method used to evaluate the risk associated with treating children and adolescents with antidepressants can only be used in studies where a minimum of one adverse event has taken place. Conversely, a study that fails to detect a significant increase in suicidal risk associated with antidepressant medication does not necessarily indicate that there is not a risk.

A full review of the current literature on the benefits and risks associated with antidepressant use in children and adolescents with depression is provided in the *Collection, 6th Edition*.

In summary, an evaluation of the risk-benefit ratio of using fluoxetine with children and adolescents diagnosed with depression has revealed that the benefits associated with treating moderately to severely depressed youth with this SSRI can outweigh the risks. Outcomes can be improved and risks of suicidal thinking and behavior can be reduced by combining cognitive-based therapy with fluoxetine. It is imperative, however, that when antidepressants are prescribed, youth should be closely monitored by both parents and clinicians. Additional

information about effective treatments for youth with depression is located in the “Depressive Disorders” section of the *Collection*.

About 40 percent of adolescents with depression do not adequately respond to a first treatment course. Persistence in finding the right medication, or combination of medications, may be necessary for successful treatment.

## RESOURCES AND ORGANIZATIONS

**Anxiety & Depression Association of America (ADAA)**

<https://adaa.org/>

**Association for Behavioral and Cognitive Therapies (ABCT)**

<http://www.abct.org/Home/>

**Child Welfare League of America (CWLA)**

<http://www.cwla.org>

**Georgetown University Center for Child and Human Development**

Trauma Informed Care

<https://gucchd.georgetown.edu/TraumaInformedCare/>

**International Society for Traumatic Stress Studies (ISTSS)**

<https://istss.org/home>

**National Child Traumatic Stress Network**

<https://www.nctsn.org>

**Prevent Child Abuse America**

800-CHILDREN (244-5373) or (312) 663-3520

<http://preventchildabuse.org/>

**Society of Clinical Child and Adolescent Psychology**

<https://sccap53.org/>

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

<https://www.samhsa.gov/>

## VIRGINIA RESOURCES AND ORGANIZATIONS

**Child Savers Guidance Clinic & Trauma Response**  
(804) 644-9590

<https://childsavers.org/>

**Families Forward**

<https://www.familiesforwardva.org/>

**University of Virginia Children’s Hospital**

<https://childrens.uvahealth.com/>

**University of Virginia, Department of Psychology**

<https://psychology.as.virginia.edu/ainsworth>

**VCU Health – Children’s Hospital of Richmond**  
Cameron K. Gallagher Mental Health Resource Center

<https://www.chrichmond.org/services/mental-health/cameron-k-gallagher-mental-health-resource-center>

**Virginia Treatment Center for Children (VTCC)**

<https://www.chrichmond.org/services/mental-health/virginia-treatment-center-for-children>

**Virginia Child & Family Attachment Center**

Phone number: (434)-242-2521

Email: [info@seureshild.center](mailto:info@seureshild.center)

<https://securechild.center/for-caregivers/>

**Virginia Department of Behavioral Health and Developmental Services**

<http://www.dbhds.virginia.gov/>

**List of TF-CBT Certified Providers**

<https://dbhds.virginia.gov/developmental-services/children-and-families/trauma-informed-care/>

***The Collection of Evidenced-Based Practices for Children and Adolescents with Mental Health Treatment Needs, 10<sup>th</sup> Collection***  
*Virginia Commission on Youth, 2025*

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