



# YOUTH SUICIDE

## 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.

## 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.

**Table 1**  
**Factors that Put Youth at Risk of Suicide**

Risk Factors	Description
General risk factors	<ul style="list-style-type: none"> <li>• Past suicide attempts</li> <li>• Being diagnosed with a mood or conduct disorder</li> <li>• Substance use, especially among males</li> <li>• Aggression or fighting</li> <li>• Living alone or in a violent community</li> <li>• Currently depressed, manic, hypomanic, and/or severely anxious</li> <li>• Irritable, agitated, delusional, or hallucinating</li> <li>• Experiencing physical, emotional, and/or sexual abuse</li> <li>• Family history of suicide and suicide attempts</li> <li>• Serious illness</li> <li>• Chronic pain</li> <li>• Legal problems</li> <li>• Current or prior history of adverse childhood experiences</li> <li>• Sense of hopelessness</li> </ul>
Mental health disorders	<p>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.</p>
Environmental stressors	<p>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.</p>
Bullying	<p>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).</p>
Gender identity and sexual orientation	<p>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.</p>
Exposure to suicide	<p>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.</p>

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**

<b>A child or youth may be suicidal if you notice one or more the following...</b>	
<ul style="list-style-type: none"> <li>• Talking about suicide/wanting to die</li> <li>• Talking about being hopeless or having no reason to live</li> <li>• Sudden increase/decrease in appetite</li> <li>• Sudden changes in appearance (different style of dress than normal, lack of personal hygiene)</li> <li>• Dwindling academic performance</li> <li>• Preoccupation with death and suicide</li> <li>• Final arrangements (giving away prized/favorite possessions, saying goodbye, talking about funeral)</li> <li>• Increasing use of alcohol or drugs</li> <li>• Extreme mood swings</li> </ul>	

**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**

<b>What Works</b>	
There are no evidence-based practices at this time.	
<b>What Seems to Work</b>	
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.

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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.
<b>Not Adequately Tested</b>	
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.
<b>What Does Not Work</b>	
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%2Fsucide%2Findex.html](https://www.cdc.gov/suicide/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fsucide%2Findex.html)

### Children's Safety Network (CSN)

<http://www.childrensafetynetwork.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>

### 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>

## VIRGINIA RESOURCES AND ORGANIZATIONS

### Virginia Department of Health

[vdh.virginia.gov/suicide-prevention/](http://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](http://dougy.org)

### The Compassionate Friends

630-990-0010

[compassionatefriends.org](http://compassionatefriends.org)

### Mental Health America

703-684-7722

[mentalhealthamerica.net](http://mentalhealthamerica.net)

### MentalHelp

888-993-3112

[mentalhelp.net](http://mentalhelp.net)

### Theravive

360-350-8627

[theravive.com](http://theravive.com)

## Mental Health, Suicide Prevention, and Community Resources

### Teen Line – Youth Crisis

310-855-4673

Text TEEN to 839863

[teenlineonline.org](http://teenlineonline.org)

### Depression and Bipolar Support Alliance

800-826-3632

[dbsalliance.org](http://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 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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