

Suicide in Youth



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How many young people make serious suicide attempts or commit suicide?

Each year in the U.S., approximately 2 million U.S. adolescents attempt suicide, and almost 700,000 receive medical attention for their attempt (AACAP, 2001). According to the Youth Risk Behavior Surveillance System, in 2001, 2.6% of students reported making a suicide attempt that had to be treated by a doctor or nurse. With respect to suicide, it is estimated that each year in the U.S., approximately 2,000 youth aged 10 – 19 complete suicide. In 2000, suicide was the 3rd leading cause of death among young people aged 15 to 24 years of age, following unintentional injuries and homicide (CDC Wonder).

- The suicide rate among children aged 10-14 was 1.5/100,000, or 300 deaths among 19,895,072 children in this age group.
- The suicide rate among adolescents aged 15-19 was 8.2/100,000, or 1,621 deaths among 19,882,596 adolescents in this age group.
- The suicide rate among young people aged 20-24 was 12.8/100,000, or 2,373 deaths among 18,484,615 people in this age group.

What leads to suicide in children and adolescents?

Suicide is the result of many complex factors. More than 90% of youth suicide victims have at least one major psychiatric disorder, although younger adolescent suicide victims have lower rates of psychopathology (Gould et al., 2003). It is important to note that while the majority of suicide victims have a history of psychiatric disorder, especially mood disorders, very few adolescents with psychiatric disorder will go on to complete suicide.

Other important risk factors for suicide and suicidal behavior include:

- Prior suicide attempt
- Co-occurring mental and alcohol or substance abuse disorders
- Family history of suicide
- Parental psychopathology
- Hopelessness
- Impulsive and/or aggressive tendencies
- Easy access to lethal methods, especially guns
- Exposure to the suicide of a family member, friend, or other significant person
- History of physical or sexual abuse
- Same-sex sexual orientation (only been shown for suicidal behavior, not suicide)
- Impaired parent-child relationships
- Life stressors, especially interpersonal losses and legal or disciplinary problems
- Lack of involvement in school and/or work ("drifting")

Is there some way that family or other adults can identify a young person at risk?

Yes, people can be educated about the warning signs of suicidal behavior. Some of the key risk factors to look for are listed above. The single biggest risk factor is serious current suicidality, either suicidal ideation with intent to commit suicide, or a recent attempt. Other warning signs include (abstracted from AACAP Teen Suicide Fact Sheet):

- Change in eating and sleeping habits
- Withdrawal from friends, family, and regular activities
- Violent actions, rebellious behavior, or running away
- Drug and alcohol use

- Unusual neglect of personal appearance
- Marked personality change
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Loss of interest in pleasurable activities
- Not tolerating praise or rewards

For adolescents who are already receiving psychiatric treatment, family psychoeducation may be an effective approach to help parents and family members to understand better the problems of their adolescent. The goals of such education are to increase compliance with treatment, promote a partnership with the parents so that they can monitor the patient with regard to recurrences, and to help the family learn how to cope with a child with a psychiatric illness.

Is there some way that suicide can be prevented in young people?

Yes, suicide can be prevented. As noted above, most suicides occur with at least some outward warning. One of the most effective suicide prevention strategies is educating people about how to identify and effectively respond to the warning signs of suicidal behavior, thus increasing the referral of at-risk youth. Screening for psychopathology among adolescents may be one way to detect youths at risk for suicide. However, because suicidal tendencies tend to wax and wane, screenings may have to be repeated. Treatment of parental psychopathology may also attenuate risk in psychiatrically ill youths.

One of the primary goals of effective suicide prevention strategies among young people is to reduce suicide risk factors. Psychopathology, particularly mood disorders, conduct/antisocial disorders, and substance abuse, is strongly associated with youth suicide. Importantly, these mental disorders are all treatable. Therefore, it is imperative that psychiatric disorders in young people be accurately recognized and effectively treated.

According to one recent case-control study (Brent et al., 1999) the effective targeting of a handful of risk factors, namely past suicide attempt, psychopathology in the adolescent, parental psychopathology, and gun in the home, is likely to result in a substantial reduction in the suicide rate among youth.

If a youngster attempts suicide, what interventions should be sought?

Unfortunately, very little is known about the treatment of suicidal youth. However, in the majority of adolescent suicide attempters have a depressive disorder, and we do know that SSRIs, cognitive therapy, and interpersonal therapy are all efficacious treatments for depressive disorders. However, since seriously suicidal adolescents have been excluded from the clinical trials that these conclusions are based upon, we do not know the efficacy of these treatments in seriously suicidal patients.

A number of approaches have been taken to the treatment of suicide attempting adolescents. It is important to note that none of the treatments have demonstrated documented efficacy in reducing the reattempt rate of treated patients. However, each treatment modality has provided some benefit to youthful attempters relative to treatment as usual. For instance, case management has been shown to improve treatment adherence and reduce emergency room visits (Deykin et al., 1986). Treatment compliance and endpoint measures of suicidal ideation and depression have been shown to be superior in a family intervention plus an educational intervention at intake in the emergency room, relative to the family intervention alone for adolescent Latina suicide attempters (Rotheram-Borus et al., 1996). A home based 4-session family therapy intervention was not more efficacious than treatment as usual for adolescent suicide attempters, except in the subgroup of attempters were not depressed. Since this subgroup was the least suicidal, this was considered a negative study. (Harrington et al. 1998). In a study of adolescents who made repeat suicide attempts, subjects randomized to a group treatment that involved elements of interpersonal therapy, cognitive therapy, and DBT showed a trend toward decreasing reattempt and a significant decrease in the number of subjects who made more than one attempt upon follow-up (Wood et al., 2001). Studies in adults using dialectic behavior therapy (DBT), CBT, and short-term IPT have all been shown to be more efficacious than treatment as usual in reducing repeat suicidal behavior, but these treatments have not yet been studied in suicidal adolescents (Beck, find ref from TASA; Linehan et al., 1991, 1993; Dutch study).

Currently, no psychopharmacological studies have been undertaken that have specifically targeted suicidal adolescents. However, the British Committee on Safety of Medicines (CSM) recently ruled that paroxetine, a member of the same class of drug as Prozac, is an ineffective treatment for children or adolescents who are suffering from major depressive disorder and the drug could possibly increase suicidal tendencies. This highlights the importance of carefully evaluating the safety of SSRIs and also of testing their efficacy in suicidal individuals.

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