

YOUTH SUICIDE

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Introduction

Suicide and suicide attempts by children and adolescents constitute a major public health problem in the United States. Each year in the United States, thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15-to-24-year-olds, and the sixth leading cause of death for 5-to-14-year-olds (American Academy of Child and Adolescent Psychiatry [AACAP], 2004). Moreover, the middle teenage years are the period in the life cycle where the incidence of suicide attempts is the greatest (Fritz, 2001). The National Alliance for the Mentally Ill [NAMI], (2004) reports the following statistics for youth suicide in 2003:

- 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.

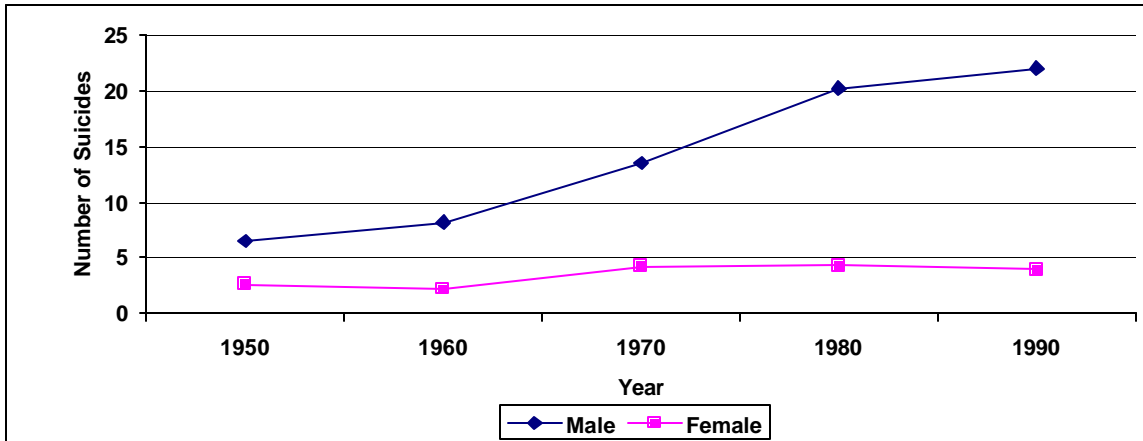
Over the last thirty years, there has been a sharp proliferation at the national level in the rates for both completed suicide and suicide attempts among adolescents and young adults. According to Garland and Zigler and cited by the Virginia Commission on Youth (2001), the adolescent suicide rate increased 200 percent over the last three decades, compared with a 17 percent increase in the general population. According to the National Center for Health Statistics (Virginia Commission on Youth), in 1998, an average of one young person every two hours took his or her own life. Furthermore, the actual number of deaths caused by suicide is likely to be higher due to the fact that some of the deaths may have been classified as accidental. Chart 1 shows the suicide rates for persons in the U.S. ages 15 to 24.

There has been increasing attention paid to the issue of suicide and suicide prevention and, in 1999, the U.S. Surgeon General issued a "Call to Action" emphasizing the need for greater awareness on this national problem (Vetter, 2002). Shortly thereafter, the National Strategy for Suicide Prevention was published by the U.S. Department of Health and Human Services,

addressing issues such as collaboration with agencies and stakeholders (Vetter). Table 1 sets forth Virginia's suicide statistics.

Chart 1

U.S. Suicide Rates* for Persons 15-24 Years of Age



* Per 100,000 persons.

Source: American Association of Suicidology, 2000, as cited by the Virginia Commission on Youth, 2001.

Table 1

Virginia Suicide Statistics

In Virginia, suicide is:

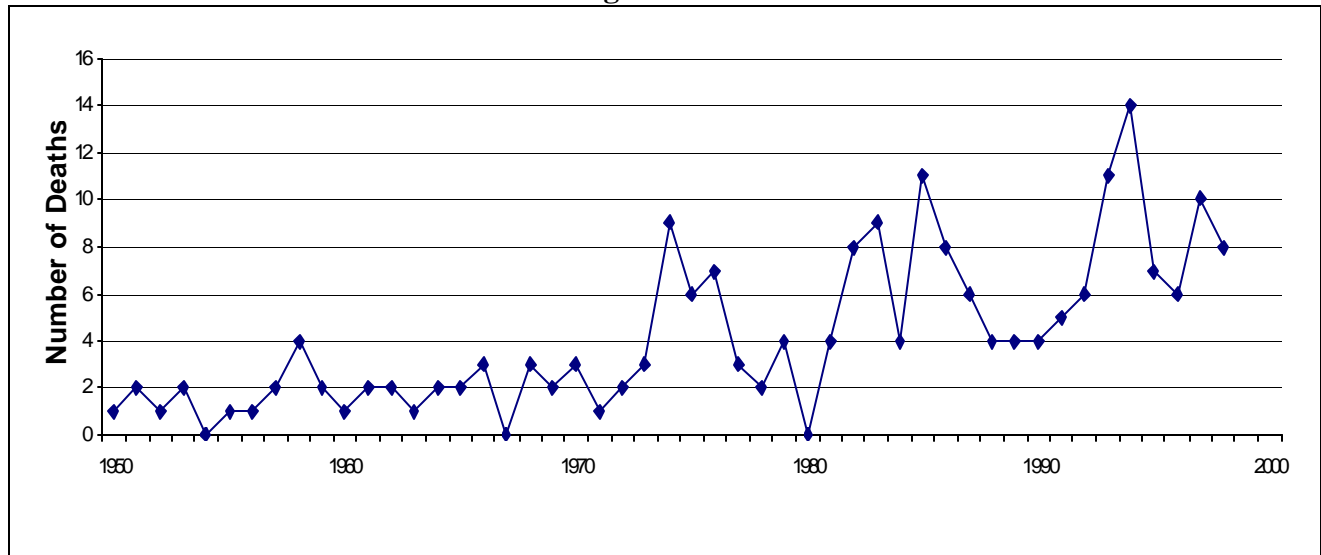
- the third leading cause of death for ages 10-24,
- the second leading cause of death for ages 25-34, and
- the fourth leading cause of death for ages 35-54.
- In almost all age groups, Virginia's suicide rates are slightly higher than the national average.
- One teenager a week, two adults each day, and one older adult every 3 days are lost to suicide.
- There are an estimated 25 suicide attempts for every death by suicide.
- In 2000, the total cost for hospitalizations due to suicide attempts in Virginia was over \$25 million.

Source: Vetter, 2002.

The Virginia Department of Health conducted a study on Suicide in the Commonwealth of Virginia and the findings are discussed in the following paragraphs. The study revealed that the suicide rate for young Virginians, aged 10 to 19, had increased an alarming 32 percent since 1975. In 1998, seven Virginia children, aged 5-14, were reported to have died from suicide.

Another 50 children, aged 15-19 ended their lives. Chart 2 shows Virginia deaths for children and adolescents from 1950 to 1998.

Chart 2
Virginia Deaths from Suicides 1950-1998
Ages 5-14



Source: Virginia Center for Health Statistics, 2000, as cited by the Virginia Commission on Youth

Contributing Factors in the Rise of Youth Suicide

According to NAMI, suicide is the result of many complex factors (2004). More than 90 percent of youth suicide victims have at least one major psychiatric disorder (Gould et al., as cited by NAMI, 2004). Hopelessness appears to be an important mediating variable between depression and suicide (Gould et al., 2004). Anxiety, particularly when it co-occurs with depression, also increases the risk of suicide (Gould et al.).

Several factors contribute to a child or adolescent attempting or completing suicide. The American Academy of Pediatrics, as cited by the Virginia Commission on Youth (2001), identifies a number of factors which may explain the dramatic increase in youth suicide in recent years:

- It's easier to get the tools for suicide. (Males often use firearms to kill themselves; females usually use pills.)
- The pressures of modern life are greater.
- Competition for good grades and college admission is stiff.
- More violence is seen in the media.
- Parents may be less involved in their children's lives.

Warning signs for suicide are shown through changes in a person's normal behavior and may include: loss of interest in activities once thought of as pleasurable, giving away possessions of personal value, substance abuse, change in weight, apathy about appearance, personality changes

and an increase in self-harming behaviors (Better Health Channel, 2000). Other important risk factors for suicide and suicidal behavior, according to NAMI (2004), 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 (shown only 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")

If adolescents are currently receiving psychiatric treatment for a mental health disorder, these risk factors can be discussed with the family and the treatment team so that the adolescent can be appropriately monitored.

Table 2 presents statistics addressing risk factors for youth suicide.

Table 2

Risk Factors for Youth Suicide

- | |
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| <ul style="list-style-type: none">• Suicide is much more common in adolescent and young adult males than females.• The ratio for male to female suicides is 3:1 in the rare prepubescent suicides to approximately 5.5:1 in 15- to 24-year-olds.• Mood disorders, poor parent communication, and a previous suicide attempt are risk factors for suicide in both boys and girls.• Previous suicide attempts are more predictive in male.• Substance and/or alcohol abuse significantly increases the risk of suicide in teenagers aged 16 and older.• Family pathology and a history of family suicidal behavior may also increase risk and should be investigated. |
|--|

Source: American Academy of Pediatrics, as cited by the Virginia Commission on Youth, 2001.

Research reveals that youth suicide is neither random nor inevitable. The Virginia Commission on Youth (2001) discussed in its summary of findings that—in order to address youth suicide and the problem—one must also be made aware of the dynamics surrounding this issue. In its report, *Suicide Fatalities among Children and Adolescents in Virginia 1994-95*, the Virginia State Child Fatality Review Team found that more than 40 percent of the children who took their lives had told someone about their intent to die (Virginia Commission on Youth). Unfortunately, for various reasons, the opportunity to intercede was lost. Also discussed in the report were the significant findings that the warning signs for youth suicide were not recognized, the extent of the problem was not understood, the means for conducting the act were not

removed, and families often thought they could handle the problems themselves. Contributing to the problem was that families may not have known where or how to get help, or that help in fact was not available.

A recent study has shown that many adolescents who report having suicidal thoughts or behaviors are not known by school officials to be at risk (Moyer, 2004). Identifying these students would help to diagnose potential mood disorders and treat symptoms sooner, before any serious suicide attempts (Moyer).

There has been considerable debate about the use of antidepressants in treating youth and whether their use increases the risk of suicidal behaviors. A further description of the use of antidepressants is included in the “Antidepressants and the Risk of Suicidal Behavior” section of the *Collection*.

Mental Health Disorders and Youth Suicide

The factors that predispose children and adolescents to complete suicide are numerous.

The AACAP’s *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior* (2000) discusses the importance of understanding the various risk factors for potential suicidal behavior. The following elements are discussed in this practice parameter:

Awareness and acknowledgment of the various risk factors that can trigger both suicide and suicide attempts are crucial in assessing and potentially preventing suicide. Such factors include preexisting psychiatric disorders, which are considered to be both biological and social-psychological facilitating factors. More than 90 percent of adolescents who commit suicide suffered from an associated psychiatric disorder at the time of their deaths. More than half had suffered from a psychiatric disorder for at least two years preceding the event.

Disruptive disorders increase the risk of suicidal thoughts in children 12 years old and younger. Moreover, substance use or separation anxiety may incite adolescents to attempt suicide. Mood and anxiety disorders increase the risk of suicidal ideation in children and adolescents. Panic attacks are a risk factor for both ideation and attempts in females, while aggressiveness increases the risk of suicidal ideation or attempt in males.

As stated in a Joint Statement by the American Academy of Child & Adolescent Psychiatry & American Psychiatric Association (2001), some of the psychiatric illnesses in adolescents which include suicidal thoughts or behaviors include depression, ADHD, and bipolar disorder. Depression has been identified as the top risk factor in youth suicide with estimates of five percent of children and adolescents in the general population being depressed at any point in time. Children at a higher risk for depression are those under stress, those experiencing loss, and those with attention, learning, conduct or anxiety disorders. Also, studies conducted disclose that teenagers with bipolar disorder may have an ongoing combination of moods which may make the child at risk.

Stress events often precede adolescents' suicides; however, it is difficult to discern whether the stress is a result of the mental disorder or is related to events with which the child or adolescent having a mental disorder may not be able to cope (AACAP, 2000). Furthermore, an adolescent with a mental disorder may be faced with a greater number of stressful events and may perceive the events that occur as more stressful than an adolescent who does not have a diagnosed mental disorder (AACAP).

Even the most capably trained clinician can find it difficult to differentiate between those youth who have thoughts of engaging in suicide and those youth intending to commit the act of suicide. Many adolescents who have made a medically serious attempt will never do so again, while others who have made what seemed like only a mild attempt may eventually commit suicide (AACAP, 2001). However, research has provided some broad indicators about risk factors and means for assessing the risk.

Virginia's Suicide Prevention Plan

Senate Joint Resolution 148, introduced in the 2000 General Assembly, directed the Commission on Youth, with the assistance of the Departments of Health, Education, and Mental Health, Mental Retardation and Substance Abuse Services, to develop a comprehensive youth suicide prevention plan. With the support of the departments identified above and significant input from survivors, service providers, and other stakeholders, the Commission undertook development of the plan.

The goals of the Virginia Youth Suicide Prevention Plan, as presented by the Virginia Commission on Youth (2001), were:

- To prevent suicidal behavior among youth in Virginia;
- To reduce the impact of suicide and suicidal behavior on individuals, families, and communities; and
- To improve access to and availability of appropriate prevention services for vulnerable individuals and groups.

The Commission on Youth conducted an extensive review of the research and, in the Suicide Prevention Plan, discussed the evidence for effectiveness of various youth suicide prevention strategies in place around the country. General recommendations were made, based on research compiled by the Centers for Disease Control and Prevention (1992):

- Ensure that new and existing suicide prevention programs are linked as closely as possible with professional mental health resources in the community.
- Avoid reliance on one prevention strategy.
- Incorporate promising but underused strategies into current programs where possible.
- Expand prevention efforts for young adults, aged 20-24 years of age.
- Incorporate evaluation efforts into all new and existing suicide prevention programs.

Universal prevention strategies were recommended as part of Virginia's Youth Suicide Prevention Plan. The Commission on Youth model for Virginia's Youth Suicide Prevention Plan was adapted from the model developed by the Institute of Medicine and the National Institutes of Health. The prevention scheme included three levels of prevention strategies:

universal, selective, and indicated. This three-tier approach targeted prevention at varying degrees and to different audiences.

Universal prevention is the provision of needed interventions to keep communities healthy. These programs provide general awareness information and education. The mission of selective prevention is to prevent the onset of suicidal behavior in targeted risk groups. These strategies include screening and assessment, training of “gatekeepers,” and community-based mental health treatment. Finally, indicated prevention strategies target individual youth known to be at high risk for suicide in order to provide skill building and supportive services and treatment.

Upon the recommendation of the Virginia Commission on Youth, the 2001 General Assembly enacted legislation which designated the Virginia Department of Health as the lead agency for directing youth suicide prevention activities across the Commonwealth. The Department of Health was charged with coordinating the activities of agencies pertaining to youth suicide prevention to address various preventive and support issues. Currently, the Department of Health and the Virginia Department of Mental Health Mental Retardation and Substance Abuse Services actively participate in the Virginia Suicide Prevention Council, a public-private partnership designed to concentrate on suicide prevention in the Commonwealth. These activities assist with education and the implementation of prevention practices found to be crucial in reducing youth suicide.

Evidence-based Practices in Youth Suicide Prevention

As interventions for preventing suicide are developed and implemented, several key factors must be considered. It is critical that youth with psychiatric disorders or otherwise at increased suicidal risk receive adequate assessment, treatment, and follow-up care (U.S. Department of Health and Human Services, 2001).

The following finding emerged from information reported by the U.S. Department of Health and Human Services (2001):

Clinical studies have shown the efficacy of training emergency department staff to treat suicide attempts with gravity and to emphasize to family members the dangers of ignoring suicide attempts. Furthermore, the benefits of follow-up treatment to reduce the recurrence of attempted suicide should be emphasized. Such training has been linked to greater completion of treatment on the part of persons having sought care in emergency departments.

According to the AACAP and the American Psychiatric Association (APA) (2001), clinicians should be prepared to admit suicide attempters who express a persistent wish to die or are exhibiting symptoms of severe mental disorders. Discharging the youth should occur only after the following three issues have been addressed. These include: making certain adequate supervision is available; ensuring that the level of suicidality has stabilized; and gaining assurance that the youth’s environment will be rid of all potentially-lethal items such as guns or medications. Following up with appropriate psychotherapy is vital in order to appropriately treat the mental disorders associated with suicidal behavior. Additionally, psychotherapy must be tailored to meet the needs of the youth appropriately and to treat any diagnosed mental disorders effectively.

Coping behaviors developed during adolescence may be precursors of patterns of coping through adulthood so it is imperative that service providers and researchers understand the range and associated coping behaviors that adolescents may establish (Gould et al., 2004). Thus, cognitive behavioral approaches may provide a method to assess coping strategies and beliefs that may be associated with maladaptive beliefs (Gould et al.) This is based on study findings that indicate that adolescents who are at risk of suicidal behavior are less likely to employ appropriate coping strategies (Gould et al.). Gould asserts that high-risk adolescents may possess beliefs that support the use of maladaptive coping strategies (such as substance use) to deal with depression and suicidal thoughts and behaviors.

Pharmacological Treatment

U.S. Department of Health and Human Services (2001) has outlined pharmacological interventions thought to be effective in reducing suicide. However, it must be emphasized that any medications prescribed to the suicidal child or adolescent must be carefully monitored by a third party and any change of behavior or side effects immediately reported. New interventions are being developed and tested for the treatment of disorders associated with suicidal behaviors. Because few studies of treatments for mental disorders have included suicidal individuals, treatments need to be assessed for their potential to reduce suicide and suicidal behaviors. Furthermore, the youth must be thoroughly assessed for any mental disorders and psychopharmacological interventions must be tailored to address any diagnosed disorders.

To date, there are only two psychopharmacological treatments that have been associated with reduced suicide—lithium and clozapine (Baldessarini et al., as cited by the U.S. Department of Health and Human Services, 1999). Research into lithium, which is shown to have a significant impact on the reduction in the suicide rate, is extensive.

According to the AACAP and the APA (2001), 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 children and adolescents on SSRIs to insure that no new suicidal ideations are noted.

Antidepressants and the Risk of Suicidal Behavior

The information discussed below is attributed Gould et al. (2004). There has been considerable debate about the use of antidepressants in treating children and adolescents with depression and whether SSRIs increase the risk of suicidal behaviors in these youth. Some researchers assert that increased prescriptions of SSRIs have resulted in decreased suicide rates. However, findings from randomized controlled trials reveal that certain medications are contraindicated for youth under 18 years of age. As directed by the Food and Drug Administration in September of 2004, manufacturers in the United States are now required to place a “black box” warning label on these medications.

A more detailed discussion regarding the use of antidepressants in treating children and adolescents is included in the “Antidepressants and the Risk of Suicidal Behavior” section of the *Collection*.

Contraindicated Treatments

As noted by the AACAP and the APA (2001), tricyclic antidepressants should not be prescribed for the suicidal youth as a first line of treatment because the potential for toxic effect outweighs the therapeutic effects. Studies have not found these drugs to be effective in reducing suicide in children or adolescents. Furthermore, other medications that may increase disinhibition or impulsivity, such as the benzodiazepines and Phenobarbital, should be prescribed with caution.

Cultural Considerations

The following is taken from a synopsis of proceedings for a NIMH conference held in 2004 at the Annenberg School for Communications and Inn at the University of Pennsylvania.

According to the Centers for Disease Control and Prevention, valid measurement of suicidality for many cultures remains a critical need. Research with culturally and linguistically diverse populations raises a number of issues including variation in concepts and language for suicide, measurement correspondence, and communication of internal processes related to suicide concepts. This includes how emotional and cognitive states are communicated and addresses the variations that exist in language usage. Cultural relevance must be addressed in both concept and intervention (e.g., the role of family, religious traditions, and values or rituals).

According to *Health, United States, 2004*, as reported by the Technical Assistance Partnership for Child and Family Mental Health, adolescent Hispanic females are significantly more likely than adolescent Hispanic males to consider suicide, attempt suicide, and injure themselves in attempting suicide. The rate of suicide attempts among female Hispanic youth also exceeds that for their African-American and Caucasian female counterparts. This disparity has been attributed to sex role socialization, acculturation, social and linguistic isolation, and depression.

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Additional Resources/Organizations

American Association for Suicidology

1-800-273-TALK (8255)

<http://www.suicidology.org>

American Foundation for Suicide Prevention

<http://www.afsp.org>

The Children's Safety Network

<http://www.childrenssafetynetwork.org>

Florida Initiative for Suicide Prevention

<http://www.fisponline.org>

Jason Foundation

<http://www.jasonfoundation.com>

The Link's National Resource Center for Suicide Prevention

<http://www.thelink.org>

National Hopeline Network and the Kristin Brooks Hope Center

800-SUICIDE 784-2433

<http://www.hopeline.com>

National Suicide Prevention Resource Center

1-800-273-TALK (8255)

<http://www.sprc.org>

National Youth Violence Prevention Resource Center

<http://www.safeyouth.org>

Organization of Attempters and Survivors of Suicide in Interfaith Service (OASSIS)

<http://www.oassis.org>

Prevent Suicide Now

800-SUICIDE 784-2433 (Prevent Suicide Virginia)

<http://www.preventsuicidenow.com/virginia-suicide-hotlines.html>

Suicide Awareness Voices of Education

<http://www.save.org/symptoms.html>

Suicide Prevention Advocacy Network USA, Inc. (SPAN)

<http://www.spanusa.org>

National Alliance for the Mentally Ill (NAMI)

<http://www.nami.org>

U.S. Department of Health and Human Services

National Strategy for Suicide Prevention

<http://www.mentalhealth.org/suicideprevention/strategy.asp>

Virginia Department of Health Center for Injury and Violence Prevention

Calvin Nunnally, Suicide and Youth Violence Prevention Consultant

P.O. Box 2448, 1500 E. Main St., Room 105 - Richmond, VA 23218-2448

804-864-7736

<http://www.vahealth.org/civp/preventsuicideva/index.asp>

Youth Suicide Prevention Program (YSPP)

<http://www.yspp.org>

Crisis Centers in Virginia Localities

*Information is provided by the Virginia Department of Health's
Suicide and Youth Violence Prevention Program and local providers.*

<p><u>Arlington</u> CrisisLink 703-527-4077 (TTD Accessible)</p> <p><u>Blacksburg</u> Access Emergency and Emergency Services 540-961-8400</p> <p><u>Bristol</u> 540-628-7731 540-466-2312</p> <p><u>Charles City County</u> 804-966-2496</p> <p><u>Charlottesville</u> 804-295-8255</p> <p><u>Chesterfield County</u> 804-748-6356</p> <p><u>Danville/Pittsylvania County</u> 804-792-4357</p> <p><u>Dumfries</u> 703-368-4141 Teen line 703-368-8069 Spanish 703-368-6544</p> <p><u>Goochland County</u> 804-556-3716</p> <p><u>Hampton</u> 757-245-0217</p> <p><u>Hanover County</u> 804-752-4200</p>	<p><u>Martinsville</u> Contact for Martinsville/Henry County 540-632-7295 540-489-5490 - Franklin 540-694-2962 – Patrick & TeenLine</p> <p><u>Middle Peninsula</u> 804-758-9398</p> <p><u>New Kent County</u> 804-966-2496</p> <p><u>Newport News</u> 757-245-0217</p> <p><u>Norfolk</u> 757-622-1126</p> <p><u>Northern Neck</u> 804-758-9398</p> <p><u>Page County</u> 540-743-3733</p> <p><u>Powhatan County</u> 804-598-2697</p> <p><u>Richmond</u> 804-819-4100</p> <p><u>Roanoke</u> 540-344-1948 Teen line: 540-982-8336</p> <p><u>Shenandoah County</u> 540-459-4742</p>
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<p>Henrico Mental Health 804-261-8484</p> <p><u>Lynchburg</u> Crisis Line of Central VA 888-947-9747 or 804-947-4357 Teen talk 888-299-7277</p>	<p><u>Warren County</u> 540-635-4357</p> <p><u>Winchester</u> 540-667-0145</p>
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National Suicide Hotlines

Toll-Free / 24 hours / 7 days a week

<p>National Hopeline Network <i>1-800-SUICIDE</i> <i>1-800-784-2433</i></p>	<p>National Suicide Prevention Lifeline <i>1-800-273-TALK</i> <i>1-800-273-8255</i></p>
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<http://suicidehotlines.com/national.html>

TTY: 1-800-799-4TTY (4889)