University of Pittsburgh
Office of Child Development

Children, Youth & Family

background

Report # 5 **Adolescent Suicide** **Winter 1998**

Adolescent Suicide

From psychiatric disorders to firearms at home, a complex mix of factors place young people at risk of committing tragic acts of self harm

Adolescent suicide is a tragedy that an increasing number of American families must endure. Each death brings intense heartbreak, a devastating sense of loss, and a greater likelihood that friends and classmates of the victim will attempt suicide themselves.

Suicide ranks second only to accidents among the causes of death of American adolescents. The suicide rate has risen from 2.7 suicides per 100,000 adolescents in 1950 to 11.1 in 1990. Attempted suicide is among the most common adolescent psychiatric emergencies; annual estimates range between 2% and 10% of the U.S. adolescent population.[1]

Many factors can draw adolescents toward suicidal behavior. Mental disorders and drug and alcohol abuse are the most frequent risks. Other factors are found within the family and the home, such as the presence of a mentally ill parent and easy access to guns.

The complex nature of suicidal behavior poses a challenge to treatment and prevention. Effective treatment involves both the adolescent and family in addressing factors that put a child at risk. Prevention strategies can be as simple as parents knowing the warning signs of suicide and depression or as involved as a school-wide suicide intervention plan.

A pre-existing psychological disorder places more adolescents at risk of suicidal behavior than any other factor. While most adolescents do not have a psychiatric disorder, as many as 90% of young suicide victims had at least one major psychiatric disorder.

Psychiatric Disorders

Affective disorders, or mood disorders, are the most common. These include depression and bipolar disorder (manic depression), in which periods of mania and depression may alternate with abrupt onsets and recoveries.

In studies, as many as 76% of the adolescent suicide victims had been diagnosed with a mood disorder. Mood disorders are also more common among female suicide victims than males.

Adolescents who've made repeated attempts at suicide often suffer from more than one psychiatric disorder – combinations of mood disorders and anxiety disorders, for example. *Anxiety disorders* include obsessive/compulsive disorder, general anxiety, and post-traumatic stress disorder.

Aggressive behavior and hostility also increase the risk that an adolescent will attempt suicide. A history of aggression, and hostility suggests an inability to control intensive moods and aggressive feelings.

Several other factors increase the risk of an adolescent suicide.

Other Possible Risks

- **Drug and alcohol abuse** is a problem that many adolescent suicide victims struggle with before taking their own lives. Researchers report drug and alcohol abuse to be a factor in one-third to two-thirds of the suicide cases studied.
- Several **family factors** increase the risk of suicidal behavior, including having parents who suffer from depression, parents who abuse drugs or alcohol, and a history of family violence.
- **Physical abuse** and **sexual abuse** contribute to suicidal behavior. One study reports finding that nearly all of the adult women who attempted suicide reported a history of sexual abuse.[2]
- **Stressful events**, such as the loss of a sibling or a boyfriend or girlfriend, also increase the risk that an adolescent will attempt suicide.
- **Firearms** accessible in the home give adolescents the means to commit suicide. Several studies report that firearms were more likely to be found in the homes of suicide victims.

*For more on school-based intervention see the **background** report, **Responding to Suicide** (Report # 6, Winter* 1998)

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Warning Signs Of Suicide

These signs may indicate an adolescent is harboring suicidal feelings, especially if they persist and are severe

- Change in eating and sleeping habits.
- Withdrawal from friends, and 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 stomach aches, headaches, fatigue, etc.
- Loss of interest in pleasurable activities.
- Not tolerating praise or rewards.

A teenager who is planning to commit suicide may also:

- Complain of being "rotten inside."
- Give verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," "I won't see you again."
- Put his or her affairs in order--for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- Become suddenly cheerful after a period of depression.

Source: Teen suicide, *Facts for Families, Fact 10*, November 1995, American Academy of Child and Adolescent Psychiatry. Internet: www.aacap.org.

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Treatment & Prevention

Treatment focuses on preventing adolescents who've attempted suicide from trying attempting again. Effective treatment begins with a "no-suicide" contract, based on the individual factors that put an adolescent at risk, and involves both adolescent and family.

In a no-suicide contract, an adolescent promises not to attempt suicide again and to notify a clinician, a parent, or another adult when a suicidal urge arises. It can help alert parents to an oncoming crisis. It can also give clinicians insight into a youth's level of risk, coping skills and home support.

Adolescents who attempt suicide often do so as a way to express hostility, induce guilt, or gain attention. They may have trouble with being direct and assertive and with sizing up a problem and finding appropriate solutions. Effective treatment teaches problem-solving skills, how to listen to others, and how to communicate directly.

Doing well in therapy doesn't guarantee success. Some impulsive adolescents attempt suicide after appearing to respond to treatment. One reason is that some are unable to be dispassionate and rational when tension builds in their lives. The use of a "feeling thermometer" sometimes helps them avoid high stress by having them chart their emotions on a scale of 0 to 100 with 0 representing a state of total control and calm and 100 representing no control and maximum agitation. These can help adolescents and parents recognize an approaching crisis.

Keeping guns out of the hands of troubled adolescents is also important. Suicide rates tend to drop when more restrictive gun control laws are enacted. Studies also suggest that legal restrictions on prescription sedatives and hypnotic drugs contribute to lower suicide rates.

Unfortunately, getting adolescents to comply with treatment has been a challenge. Those who balk at treatment are often among the most seriously troubled and are more likely to attempt suicide again.

References

Brent, D.A. (1997). Practitioner review: The aftercare of adolescent with deliberate self-harm. *Journal of Child Psychology and Psychiatry, 38,* 3, 277-286.

Brent, D.A. (1995). Risk factors for adolescent suicide and suicidal behavior: Mental and substance abuse disorders, family environmental factors, and life stress. *Suicide and Life-Threatening Behavior, 25* (supplement).

[1] Shafii, M. Whittinghill, R., & Healy, M.H. (1985). The pediatric-psychiatric model for emergencies in child psychiatry: A study of 994 cases. *American Journal of Psychiatry, 136,* 1600-1601.

[2] Romans, S.E., Martin, J.L., Anderson, J.C., Herbison, G.P., & Mullen, P.E. (1995). Sexual abuse in childhood and deliberate self-harm. *American Journal of Psychiatry, 152,* 1336-1342.

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