Chapter 1

INTRODUCTION TO SUICIDE AND THE YOUNG

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ABSTRACT

Suicide is a leading cause of death in adolescence. Studies indicate that the best way to prevent suicide is through early detection and treatment of depression and other psychiatric illnesses that increase suicide risk. Prevention of suicide may often depend upon front-line professionals who see suicidal youth. These professionals will likely not be mental health professionals, so primary care physicians and others who have substantial contact with youth need to be aware of and screen for suicidal ideation. A number of studies show that deliberate self-harm patients who presented to emergency rooms and left without a psychosocial and/or psychiatric assessment were more likely to engage in subsequent self-harm. Prevention of suicide must include intervention regarding the precursors of the ideation, intention, and behavior as well as continued assessment and treatment subsequent to a suicide attempt.

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INTRODUCTION

Suicidal behavior in youth ages 18-25 years is not uncommon and currently suicide is one of the leading causes of death within this age group.

There are several risk factors for suicidal thinking and behavior in young adults. Psychiatric disorders have been shown to play a major role in youthful suicidal behavior (1) and up to 90% of completed suicides have at least one disorder at the time of death (2). Further, those with multiple or comorbid mental disorders have a elevated risk of suicidal behavior compared to those with no disorder. Beautrais (3) estimated that young people with a single disorder were eight times and those with two or more disorders were 15 times more likely than those with no disorder to attempt suicide.

Mood disorders, i.e., major depression and bipolar disorder, have been shown to produce significantly elevated risks of suicidal behavior in college students and depression is the most common diagnosis among young adults who have attempted or completed suicide (4). Substance abuse has also been associated with suicidal behavior. Externalizing disorders, i.e., conduct disorder, oppositional defiant disorder, antisocial personality disorder, have significant correlations with suicidal behavior in young people. Anxiety disorders have also been shown to have a small, but significant association with suicidal behavior in youth (1) and those with psychotic disorders are at high-risk for suicidal behaviors. However, since these disorders affect relatively few young people, they make a small contribution to overall rates of suicidal behavior in this population (1).

A number of studies have looked at personality characteristics associated with suicidality in young adults. Among the characteristics found to be associated are dependency and self-criticism, high scores on measures of neuroticism and hopelessness and positive attitudes toward suicide. A strong predictor of suicidal behavior in young people is the presence of a family history of suicidal behavior (5), suggesting a genetic component to suicide. Twin studies have shown moderate levels of heritability in which up to 45% of variance in suicidal behavior may be genetic.

Being male places one at much higher risk for a completed suicide. While females attempt suicide much more frequently, among 20-24-year-olds, the ratio of male to female completed suicide is greater than 6:1 (6). Method of suicide also varies between genders, with ingestions accounting for approximately 16% of 15-24-year-old female suicides, but for only 2% of suicides in males; males are much more likely to use firearms.

Research has shown that young people who identify as gay, lesbian, or bisexual (GLB) are twice as likely to have a history of suicidal behavior than their heterosexual peers (7). Stressors associated with suicidal behavior in this population include interpersonal turmoil associated with publicly acknowledging one’s sexual identity, especially to parents and discrimination and victimization related to sexual orientation.

Previous suicide attempts predict higher probability of future suicide attempts. Estimates have ranged from 18-50% for those completed suicides with a past attempt, indicating wide variability in studies regarding numbers of attempters completing. Parental psychopathology, depression, and substance abuse all contribute as risk factors for youth suicide. Parental or family discord and/or parental separation or divorce have an impact as well.

Negative life events have been shown to be related to suicidality in youth (8). A history of physical and/or sexual abuse during childhood has also been associated, with sexual abuse
being more significant. Environmental factors that influence suicidality in youth include media-generated contagion.

Whether youth 18-25 years old are college students or members of the general population, this developmental stage of life presents multiple challenges, including the need to accomplish independence and individuation while maintaining connectedness to family, the development of intimate relationships, and the pursuit of personal and career goals. These tasks may provide a level of stress that will precipitate suicidal thinking and behavior. Additional stressful tasks for college students include the pressure of academic endeavors, and their noncollege peers must establish a work ethic upon which to build their lives.

**PREVENTION**

Studies indicate that the best way to prevent suicide is through early detection and treatment of depression and other psychiatric illnesses that increase suicide risk. For college students, campus mental health services must be enhanced and adequately staffed to ensure the best outcome for those with mental health problems. Past-year prevalence of mental illness is highest (39%) for youth ages 15-21 years, suggesting that college students have a high level of psychological distress that may lead to suicide. Post-attempt interventions are also necessary and may include cognitive therapy, dialectical behavior therapy, and pharmacological approaches.

Prevention of suicide may often depend upon front-line professionals who see suicidal youth. These professionals will likely not be mental health professionals, so primary care physicians and others who have substantial contact with youth need to be aware of and screen for suicidal ideation; such assessment needs to occur before a suicide attempt as well as after an unsuccessful one. A number of studies show that deliberate self-harm patients who presented to emergency rooms and left without a psychosocial and/or psychiatric assessment were more likely to engage in subsequent self-harm. Thus, prevention of suicide must include intervention regarding the precursors of the ideation, intention, and behavior as well as continued assessment and treatment subsequent to a suicide attempt.

**THIS BOOK PROJECT**

This book is based upon experiences from the “Stop Youth Suicide Campaign” (SYS), a community-based youth suicide prevention program, led by the Division of Adolescent Medicine at University of Kentucky Children’s Hospital. This program raises awareness and educates government agencies, teachers, parents, and students about the high risk behaviors that can lead to youth suicide. It provides education for medical care agencies to recognize and screen for adolescent depression and suicide, connects youth, parents, citizens, caregivers, and professionals with appropriate support services.

The “Stop Youth Suicide Campaign” is a holistic suicide awareness campaign. In other words, the programme seeks to provide appropriate information and assist all stakeholders, e.g., individuals, communities and governments/policy makers to make informed decisions. In Kentucky, the Campaign has been successful in changing some laws, introduce suicide
education and training at schools and provide interventional services as well as prevention strategies throughout Kentucky. A measure of success is a sustained drop in suicide rates over time correlated to when the “Stop Youth Suicide Campaign” started.

REFERENCES