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Youth suicide prevention needs added awareness

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Recently, Astor Services for Children & Families experienced more suicide attempts by youth than it had seen in its long history of providing services. This increase is mirrored nationwide, and punctuates the fact that youth suicide is a very real and tragic phenomenon in our communities. How can we prevent youth from becoming so disheartened as to consider ending their lives?


Suzanne Button

Thinking about or planning to kill oneself in youth is more widespread than is commonly understood. A 2009 Centers for Disease Control and Prevention (CDC) survey revealed that 14 percent of U.S. youth in grades nine through 12 had seriously considered suicide, while 11 percent had actually created a specific plan to commit suicide. Because youth who complete suicide tend to be more impulsive and engage in less planning than their adult counterparts, both numbers are grave indicators of the prevalence of suicide risk among our nation's youth.

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Contextual factors, including family stressors commonly associated with economic hardship, may exacerbate suicidality. Youth who have experienced stressful life events or loss, have lived with different caregivers and attended different schools, or whose family members have completed or attempted suicide are at increased risk. Youth who experience family or interpersonal conflict, or bullying are particularly vulnerable.

To prevent youth suicide, family and community members must be aware of risk factors: previous suicide attempts, a diagnosed psychiatric disorder, substance abuse, family or peer conflict, or bullying, and warning signs: any communication that hints of suicidal thinking or feeling trapped, withdrawal from relationships, drastic mood changes, risky behaviors, or excessive anger and agitation. A youth who already is struggling and is exposed to a crisis (the loss of a loved one, family crisis, the suicide of a peer), is more likely to experience the deep hopelessness and despair that lead to suicidal behavior. Youth who exhibit risk factors or

warning signs should be promptly assessed and treated. Preventing youth access to lethal methods (over-the-counter or prescription medication and weapons), is the single-most effective measure that can be taken to prevent suicide.

At the community level, preventative approaches that address the complexity behind youth suicide must be prioritized. Protective factors — strong connections to a caring adult and a sense of connectedness and belonging to community — are fostered by resourced schools, supported communities and stable families. Accurate diagnosis and effective treatment of psychiatric disorders that increase risk must be readily available to youth.

In the current economic climate, the possibility of the exacerbation of some risk factors for youth suicide is likely. Struggling families are forced to move, unemployed caregivers are at risk for depression, and access to high-quality treatment and preventive factors is reduced or eliminated. Funding cuts can inadvertently eliminate the kinds of family support and community resource programs that allow for the caring adult-youth relationships and community interconnectedness that dramatically reduce the risk of suicide.

Fiscal compromises must prioritize funding strategies that support youth well-being and reduce risk associated with psychiatric disturbance, poverty and family stress. Parents, teachers, religious figures and community leaders must work together to create a supportive community for each child, and all adults involved with youth must learn to recognize and respond to warning signs. Adults should know that asking a youth directly about suicidal feelings or intentions is far more likely to prevent harm than to cause suicidal thinking, and should reach out to youth who exhibit warning signs. Finally, communities must work to reduce the stigma associated with depression and other psychiatric illnesses, so that all families feel confident in seeking screening, assessment and treatment services when their children are at risk.

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