



University of Kentucky  
UKnowledge

---

Pediatrics Faculty Publications

Pediatrics

---

3-1-2013

# The Young and Suicide

Hatim A. Omar

*University of Kentucky*, [hatim.omar@uky.edu](mailto:hatim.omar@uky.edu)

Joav Merrick

*Ministry of Social Affairs and Social Services, Israel*

**Right click to open a feedback form in a new tab to let us know how this document benefits you.**

Follow this and additional works at: [https://uknowledge.uky.edu/pediatrics\\_facpub](https://uknowledge.uky.edu/pediatrics_facpub)

 Part of the [Mental and Social Health Commons](#), [Pediatrics Commons](#), and the [Preventive Medicine Commons](#)

---

## Repository Citation

Omar, Hatim A. and Merrick, Joav, "The Young and Suicide" (2013). *Pediatrics Faculty Publications*. 250.

[https://uknowledge.uky.edu/pediatrics\\_facpub/250](https://uknowledge.uky.edu/pediatrics_facpub/250)

This Editorial is brought to you for free and open access by the Pediatrics at UKnowledge. It has been accepted for inclusion in Pediatrics Faculty Publications by an authorized administrator of UKnowledge. For more information, please contact [UKnowledge@lsv.uky.edu](mailto:UKnowledge@lsv.uky.edu).

---

**The Young and Suicide**

**Notes/Citation Information**

Published in *International Journal of Adolescent Medicine and Health*, v. 25, issue. 1, p. 1-2.

© 2013 by Walter de Gruyter Berlin Boston

The copyright holders have granted the permission for posting the article here.

**Digital Object Identifier (DOI)**

<https://doi.org/10.1515/ijamh-2013-0001>

## Editorial

Hatim A. Omar and Joav Merrick

# The young and suicide

Suicidal behavior in youth ages 18–25 years is not uncommon, and it is currently 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). Moreover, 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 an elevated risk of suicidal behavior compared with those with no disorder. Beautrais (3) estimated that young people with a single disorder were eight times more likely 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 and 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, 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), thereby 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 a 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 >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 themselves 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, as well as discrimination and victimization related to sexual orientation.

Previous suicide attempts predict higher probability of future suicide attempts. Estimates have ranged from 18% to 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 suicidal behaviors 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 who are part of the 18–25-year-old age group 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 could precipitate suicidal thinking and behavior. Additional stressful tasks for college students include the pressure of academic endeavors, and the fact that their noncollege peers must establish a work ethic upon which to build their lives.

## Prevention and intervention

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 must take place before a suicide attempt as well as after an unsuccessful one. A number of studies show that deliberate self-harm patients 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.

## References

1. Beautrais AL. Life course factors associated with suicidal behaviors in young people. *Am Behav Scientist* 2003;46:1137–56.
2. Houston K, Hawton K, Sheppard R. Suicide in young people 15–24: a psychological autopsy study. *J Affect Disord* 2001;63:159–70.
3. Beautrais AL. Serious suicide attempts in young people: a case control study. Doctoral dissertation. Dunedin, New Zealand: University Otago, 1996.
4. Langhinrichsen-Rohling J, Arata C, Bowers D, O'Brien N, Morgan A. Suicidal behavior, negative affect, and self-reported delinquency in college students. *Suicide Life Threat Behav* 2004;34:255–66.
5. Mann JJ, Brent DA, Arango V. The neurobiology and genetics of suicide and attempted suicide: a focus on the serotonergic system. *Neuropsychopharmacol* 2001;24:467–77.
6. National Center for Health Statistics (Centers for Disease Control and Prevention). Death rates for 113 selected causes, by 5-year age groups, race, and sex: United States, 1999–2003. Worktable GMWK291R, 2006; pages 373–376. Accessed 2012 Apr 15. URL: [http://www.cdc.gov/nchs/dataawh/statab/Mortfinal2003\\_worktable291r.pdf](http://www.cdc.gov/nchs/dataawh/statab/Mortfinal2003_worktable291r.pdf).
7. Russell ST, Joyner K. Adolescent sexual orientation and suicide risk: evidence from a nation study. *Am J Public Health* 2001;91:1276–81.
8. Joiner TE, Rudd MD. Intensity and duration of suicidal crises vary as a function of previous suicide attempts and negative life events. *J Consult Clin Psychol* 2000;68:909–16.

### Hatim A. Omar

Chief, Division of Adolescent Medicine and Young Parents Program (J422), Department of Pediatrics, Kentucky Children's Hospital, UK Healthcare, University of Kentucky College of Medicine, Lexington, KY 40536, USA,  
E-mail: haomar2@uky.edu

### Joav Merrick

Medical Director, Health Services,  
Division for Intellectual and Developmental Disabilities,  
Ministry of Social Affairs and Social Services,  
POBox 1260, IL-91012, Jerusalem, Israel,  
E-mail: jmerrick@zahav.net.il

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.