



# Facts About Suicide and Mental Disorders in Adolescents

from *After a Suicide: A Toolkit for Schools*

Suicide is not inexplicable and is not simply the result of stress or difficult life circumstances. The key suicide risk factor is an undiagnosed, untreated, or ineffectively treated mental disorder. Research shows that over 90 percent of people who die by suicide have a mental disorder at the time of their death.

In teens, the mental disorders most closely linked to suicide risk are major depressive disorder, bipolar disorder, generalized anxiety disorder, conduct disorder, substance use disorder, and eating disorders. While in some cases these disorders may be precipitated by environmental stressors, they can also occur as a result of changes in brain chemistry, even in the absence of an identifiable or obvious “reason.”

Suicide is almost always complicated. In addition to the underlying disorders listed above, suicide risk can be affected by personality factors such as impulsivity, aggression, and hopelessness. Moreover, suicide risk can also be exacerbated by stressful life circumstances such as a history of childhood physical and/or sexual abuse; death, divorce, or other trauma in the family; persistent serious family conflict; traumatic breakups of romantic relationships; trouble with the law; school failures and other major disappointments; and bullying, harassment, or victimization by peers.

It is important to remember that the vast majority of teens who experience even very stressful life events do *not* become suicidal. In some cases, such experiences can be a catalyst for suicidal behavior in teens who are already struggling with depression or other mental health problems. In others, traumatic experiences (such as prolonged bullying) can precipitate depression, anxiety, abuse of alcohol or drugs, or another mental disorder, which can increase suicide risk. Conversely, existing mental disorders may also lead to stressful life experiences such as family conflict, social isolation, relationship breakups, or school failures, which may exacerbate the underlying illness and in turn increase suicide risk.

## Warning Signs of Suicide

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has recently increased in frequency or intensity, and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or kill oneself
- Looking for ways to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated, or behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

## What to Do in a Crisis

Take any threat or talk about suicide seriously. Start by telling the person that you are concerned. Don't be afraid to ask whether she or he is considering suicide or has a plan or method in mind. Resist the temptation to argue the person out of suicide by saying, "You have so much to live for" or "Your suicide will hurt your family and friends." Instead, seek professional help.

In an acute crisis:

- Call 911.
- Do not leave the person alone.
- If safe to do so, remove any firearms, alcohol, drugs, or sharp objects that could be used.
- Call the National Suicide Prevention Lifeline: 1-800-273-TALK (8255).
- Take the person to an emergency room or walk-in clinic at a psychiatric hospital.

## Symptoms of Mental Disorders Associated with Suicide Risk

Most adults are not trained to recognize signs of serious mental disorders in teens, and symptoms are therefore often misinterpreted or attributed to normal adolescent mood swings, laziness, poor attitude, or immaturity. Diagnosis of a mental disorder should always be made by a qualified mental health professional.

The key symptoms of *major depressive disorder* in teens are sad, depressed, angry, or irritable mood and lack of interest or pleasure in activities the teen used to enjoy, lasting at least two weeks. Symptoms represent a clear change from the person's normal behavior and may include changes in appetite or sleep, feelings of worthlessness/guilt, inability to concentrate, slowed or agitated movement, recurrent thoughts of death or suicide, fatigue/loss of energy, and self-harm behavior.

Sometimes referred to as manic depression, *bipolar disorder* includes alternating episodes of depression and mania. Symptoms of mania last at least one week, cause clear social or academic problems, and include extreme distractibility, lack of need for sleep, unusually rapid speech or motor activity, excessive talking, and involvement in risky activities such as gambling or irresponsible sexual behavior.

The key characteristic of *generalized anxiety disorder* is excessive, uncontrolled worry (for example, persistent worry about tests or speaking in class) occurring on most days for a period of six months. Symptoms may include restlessness or feeling keyed up, irritability, being easily fatigued, muscle tension, difficulty concentrating, and sleep disturbances.

Teens with *substance use disorder* show a problematic pattern of drug or alcohol use over 12 months or more, leading to significant impairment or distress. Symptoms include taking larger amounts, over a longer period, than intended; continued use despite knowing that it is causing problems; increased irritability and anger; sleep disturbances; and family conflict over substance use.

*Conduct disorder* is a repetitive, persistent pattern in children or adolescents of violating the rights of others, rules, or social norms, occurring over 12 months. Symptoms include bullying or threatening others, physical fights, fire-setting, destroying property, breaking into houses/cars, physical cruelty to people or animals, lying, shoplifting, running away from home, and frequent truancy.

Anorexia nervosa and bulimia are *eating disorders* that are strongly linked to other mental disorders, especially depression and anxiety. Symptoms of anorexia nervosa include refusal to maintain body

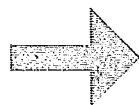
weight at a minimally normal level for age and height, intense fear of gaining weight, and a denial of low body weight. Symptoms of bulimia include repeated episodes of binge eating (at least twice a week for three months) combined with recurrent inappropriate behaviors to avoid gaining weight such as vomiting, misuse of laxatives, or excessive exercise.

## Help Is Available

If there are concerns about a student's emotional or mental health, a referral should be made to an appropriate mental health professional for assessment, diagnosis, and possible treatment. Mental health resources that may be available include school counselors, community mental health agencies, emergency psychiatric screening centers, and children's mobile response programs. Pediatricians and primary care providers can also be a source of mental health referrals.

Some depressed teens show improvement in just four to six weeks with talk therapy alone. Most others experience a significant reduction of depressive symptoms with antidepressant medication. Medication is usually essential in treating severe depression and other serious mental disorders, such as bipolar disorder and schizophrenia. Since 2004, an FDA warning has recommended close monitoring of youth taking antidepressants for worsening of symptoms, suicidal thoughts or behavior, and other changes. Risks of medication must be weighed against the risks of not effectively treating depression or other serious mental disorders.

(Adapted with permission from *More Than Sad: Preventing Teen Suicide*, American Foundation for Suicide Prevention, <http://www.morethansad.org>.)



## Additional Information

Center for School Mental Health Assistance. Crisis intervention: A guide for school-based clinicians. (2002). [http://csmh.umaryland.edu/resources/CSMH/resourcepackets/files/crisis\\_intervention\\_2002.pdf](http://csmh.umaryland.edu/resources/CSMH/resourcepackets/files/crisis_intervention_2002.pdf)

Maine Department of Health and Human Services. Media guidelines for school administrators who may interact with reporters about youth suicide. (2006). <http://www.maine.gov/suicide/professionals/program/mediaschool.htm>

National Association of School Psychologists. Culturally competent crisis response: Information for school psychologists and crisis teams. (2004). [http://www.schoolcounselor.org/files/cc\\_crisis.pdf](http://www.schoolcounselor.org/files/cc_crisis.pdf)

National Suicide Prevention Lifeline. <http://www.suicidepreventionlifeline.org>  
800-273-TALK (8255)

Reeves, M. A., Brock, S. E., and Cowan, K. C. Managing school crises: More than just response. (2008). <http://www.nasponline.org/resources/principals/School%20Crisis%20NASSP%20May%202008.pdf>

Suicide Prevention Resource Center (SPRC). Customized information for school health and mental health care providers. (2008). [http://www.sprc.org/featured\\_resources/customized/school\\_mentalhealth.asp](http://www.sprc.org/featured_resources/customized/school_mentalhealth.asp)

U.S. Department of Education, Office of Safe and Drug-Free Schools. Practical information on crisis planning: A guide for schools and communities (2007). <http://www2.ed.gov/adms/lead/safety/emergencyplan/crisisplanning.pdf>

Weekley, N., and Brock, S. E. Suicide: Postvention strategies for school personnel. (2004). [http://www.nasponline.org/resources/intonline/HCHS2\\_weekley.pdf](http://www.nasponline.org/resources/intonline/HCHS2_weekley.pdf)