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Cheryl A. King, Ph.D.

Department of Psychology

Associate Professor

Testimony

Statement of Cheryl A. King, Ph.D. Associate Professor of Psychology University of Michigan Before the Subcommittee on Substance Abuse and Mental Health Services U.S. Senate Committee on Health, Education, Labor and Pensions Hearing on "Suicide Prevention and Youth: Saving Lives" March 2, 2004 Good morning, Chairman DeWine, and members of the Subcommittee, and thank you for inviting me here today. The number of children and adolescents who commit suicide in our country is alarming, and I applaud you for taking the lead in addressing this tragedy with today's hearing. I am Dr. Cheryl King, a licensed clinical psychologist and Associate Professor of Psychology at the University of Michigan. I also serve as director of the Child and Adolescent Program at the University's Depression Center and as Chief Psychologist in the Department of Psychiatry at the University of Michigan Medical School. Over the past 15 years, my work has focused on both the clinical and research aspects of youth suicide. Regrettably, youth suicide is a continuing national tragedy. According to the Centers for Disease Control and Prevention (CDC), suicide is the third leading cause of death among children and adolescents. In 1998, 2,054 young people between the ages of 10 and 19 ended their lives. More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic disease, combined. A series of highly visible legislative, public policy, advocacy, and organizational events have created a historic juncture for suicide prevention efforts. The report of the President's New Freedom Commission on Mental Health released last year stressed the urgent need for action on suicide prevention. The Commission encourages public education efforts to be targeted to distinct and often neglected populations, such as ethnic and racial minorities and adolescents. In 2002, the Institute of Medicine underscored suicide prevention as a significant public health problem with the publication, *Reducing Suicide: A National Imperative*. The report urged the implementation and enhancement of the National Strategy for Suicide Prevention, which lays out a suicide prevention framework for action and guides development of an array of services and programs. In 1999, *The Surgeon General's Call to Action to Prevent Suicide* also stressed the need for effective suicide prevention and intervention strategies. *Methods of Suicidal Deaths* Firearms are the most common method of suicide among adolescents in the United States. In one study, firearms were present in the homes of 74.1 percent of completers and 33.9 percent of suicidal inpatients. Several more recent control studies also demonstrate a strong link between completed suicide and the availability of firearms in the home. In 1996, firearms were used by 66.4 percent of male suicide victims and by 48.3 percent of female victims (aged 15 to 19). After firearms, the most common methods for adolescent males were hanging (including instances of strangulation and suffocation, 22.7 percent), gas poisoning (3.4 percent), and poisoning that involved solid or liquid substances (2.3 percent). Methods of suicides for female victims included

hanging (29.3 percent), solid or liquid poisoning (12.1 percent), jumping from heights (3.1 percent), and gas poisoning (2.5 percent). Suicide Rates Across Gender and Race/Ethnicity The suicide rate for youth ages 15 to 19 is 8.2 per 100,000, and the rate for youth between the ages of 5 and 14 is 0.8 per 100,000. The suicide rate for males in the 15- to 19- year age group is markedly higher than that for females. From 1980 to 1997, 83.8 percent of all suicides among this age group were committed by males. There is a gender difference in completed suicides, although it is the reverse of what is seen with ideation and attempts. Approximately 4 to 10 percent of boys versus 10 to 20 percent of girls report a history of suicide attempt. Thus, two to three times as many girls as boys report having made at least one suicide attempt. At no other time in the human life span is the prevalence of suicide attempts as high as that documented during adolescence. Suicide rates also differ by racial and ethnic group. American Indian/Alaska Native adolescents are more than twice as likely to commit suicide as any other racial/ethnic group. With 52.9 deaths per 100,000, adolescent American Indian/Alaska Native males are at four times the risk for suicide than are males of any other racial/ethnic group. Among high school students, 10.7 percent of all Hispanics and 14.9 percent of Hispanic females reported attempting suicide in the past 12 months. In addition, 30.3 percent of Hispanic female high school students reported seriously considering suicide, the highest rate of any racial or ethnic group in the country. This compares to 26.1 percent of Caucasian females and 22 percent of African American females. During 1981 to 1998, the suicide rate for African American youths aged 10 to 19 years increased from 2.9 to 6.1 per 100,000. As of 1995, suicide was the third leading cause of death among blacks aged 15 to 19. However, African American youth have lower suicide rates than Caucasian youth, and African American females have the lowest adolescent suicide rate. Suicidal Ideation Among Youth It is not uncommon for adolescents to think about suicide. The 1999 Youth Risk Behavior Surveillance (YRBS, 2000) found that, in the previous year, 19.3 percent of high school students nationwide had seriously considered attempting suicide, and 14.5 percent had made a specific plan to attempt suicide. Every year, two million children and adolescents attempt suicide, and two-thirds of them are females. Among high school students in 1997, 27.1 percent of females seriously considered suicide, compared to 15.1 percent of males. Suicide ideation includes a broad continuum of suicidal thoughts, ranging from thoughts that others (such as parents) might be better off if the adolescent were dead to the careful consideration of a specific plan for completing suicide. Such thoughts may be expressed behaviorally, either in writing or in speech. Suicidal actions include the broad domain of self-injurious behavior with some degree of suicidal intent. One of the most striking aspects of adolescent suicidal behavior is the high prevalence rate for non-lethal suicide attempts. The 1999 Youth Risk Behavior Surveillance data showed that suicidal thoughts tended to peak in the 10th grade. Twenty two percent of 10th graders had seriously considered suicide in the previous 12 months, and 17.7 percent had made suicide plans. Although many youth who report suicidal thoughts or attempt suicide do not become suicide victims, these categories overlap substantially. For instance, having frequent thoughts of suicide is the best predictor of suicide attempts, and most youth who attempt suicide report a history of suicidal ideation. Furthermore, greater severity of reported suicidal thoughts increases the likelihood of a suicide attempt within the next year. Approximately 35 to 45 percent of adolescents who complete suicide have a history of

suicide attempt. And while research tools and opportunities currently exist to address the problem of suicide, there continues to be a dramatic mismatch in terms of federal dollars devoted to the understanding and prevention of suicide contrasted with other diseases of less public health impact.

**Risk Factors for Suicidal Behavior** Risk factors for completed suicide and suicidal behavior are similar in most respects. There are a few exceptions, however, such as the more specific relationship between availability of firearms and completed suicide.

**Prior Suicide Attempt.** A history of prior suicidal behavior is the strongest predictor of future suicidal gestures or self-inflicted harm. While these acts are sometimes thought to be manipulative or attention-seeking, they should not be taken lightly. Youth can be poor judges of lethality, and what is believed to be a gesture may be accompanied by significant suicidal intent. It also may result in substantial physical harm or even suicide because of an error in knowledge or judgment.

**Mental Disorder.** Approximately 80 percent of youth who attempt suicide and 90 percent of youth suicide victims have histories of identifiable mental disorders. The most common types are depressive disorders, alcohol or substance abuse, conduct disorder or patterns of aggressive behavior, and anxiety disorders. Depressive disorders are linked with increased risk for suicide ideation, suicide attempts, and completed suicides. Eighty percent of depressed youth report significant suicidal ideation, and 32 percent of depressed youth report one or more suicide attempts prior to adulthood.

**Psychosocial Factors.** Environmental or family stress, especially a history of neglect or physical, emotional, or sexual abuse, are considered significant risk factors for suicidal behavior. Interpersonal conflict and loss (i.e., break-ups, deaths) also are risk factors. Additionally, hopelessness, impulsivity, aggressive behavior, and agitation are psychological characteristics associated with increased risk for suicidal behavior. Gay, lesbian, and bisexual adolescents are at increased risk for suicidal behavior. Recent general population surveys indicate that approximately 42 percent of these youth experience suicidal ideation, and 28 percent have made one or more suicide attempts during the past year. Many of the risk factors in these youth are the same as those for heterosexual youth. Problems such as comorbid substance abuse and depression, however, are more common among youth who have a homosexual orientation. In addition, risk factors such as stigmatization and discrimination are specific to those who face negative attitudes within society.

**Contagion.** The risk for depression, anxiety, and suicide increases when a youth knows someone who commits suicide. In these situations, intervention aimed at promoting grief and mourning and decreasing guilt, trauma, and social isolation, as well as providing psychoeducational counseling aimed at decreasing identification with the suicidal behavior, are recommended. Media coverage of suicide may spark suicide contagion.

**Availability of the Means.** The importance of restricting suicidal youth's access to firearms is highlighted by documented associations between more restrictive gun control laws and decreases in suicide rates. Similarly, potentially lethal drugs (such as prescription or over-the-counter sedative drugs) either should be removed from the homes of potentially suicidal youth or monitored closely by parents and guardians.

**Substance abuse.** Research demonstrates a clear connection between increased severity of suicidal behavior and the presence of alcohol abuse and major depression among adolescent inpatients. Retrospective studies have found that about 50 percent of adolescent suicides involve the consumption of alcohol, which increases impulsivity, impaired judgment, and mood changes. Research also documents a threefold increase in

suicide attempts among depressed youths with comorbid conduct and/or substance use disorders. Family and Interpersonal Difficulties. A growing number of empirical studies indicate that family and interpersonal difficulties are associated with suicidal behavior. An examination of acculturation issues among immigrants deserves our attention. Research suggests that some acculturating Hispanic adolescents experience high levels of acculturative stress. These adolescents are also at risk for experiencing critical levels of depression and suicidal ideation. In fact, a study revealed that approximately one quarter of the Hispanic American adolescents experienced critical levels of suicidal ideation. The study highlights the importance of assessing and treating the depressed and potentially suicidal acculturating adolescent within a cultural context. Since the Hispanic culture is not entirely homogenous, further research should examine variables within more specific Latino subgroups. Pathways to Prevention Much still needs to be done to prevent youth suicide. Few randomized controlled intervention trials have been conducted with youth, evaluated interventions have shown limited impact on suicidal ideation and behavior, and suicidal adolescents' follow-through with treatment recommendations has generally been poor. Preventing the onset of some types of mental disorders, however, may be feasible. Alcohol and substance abuse is an example of one such risk factor that has been related to a significant portion of suicides across the life span. A comprehensive, strategic plan for suicide prevention should include multiple points for prevention, maximizing the likelihood of reaching people in need. A goal of suicide prevention strategies is to alter developmental trajectories, moving individuals onto healthier pathways fraught with less suicide risk. Effective suicide prevention strategies need not be specific to suicide, and, they need not be implemented only in close temporal proximity to imminent suicide risk. However, the less specific and proximal they are, the more likely it is that a successful prevention effort will require the efforts of prevention specialists and advocates in diverse fields. These might include violence prevention (firearm availability), general mental health (access to services), prevention of alcohol-related traffic accidents (stricter legal enforcement and penalties), or prevention of teen pregnancy (alcohol/substance abuse education programs). The list of possible collaborators for prevention efforts is lengthy. Many of the prevention strategies that would feasibly result from unified efforts would include societal, public policy, and educational efforts. "Universal" preventive interventions directed at the entire population, including health promotion and educational efforts, would be examples of efforts to prevent the onset of a risk factor. These might include educational public service announcements, restrictions on advertising for alcoholic beverages, school-based health classes emphasizing mental health and substance abuse problems or health promotion activities. "Selective" interventions, directed at subgroups with some increased level of risk, might include school-based mental health programs for identified "high risk" children. School-based prevention programs are critical in helping children at risk for suicide. Because the school is the community institution that has the primary responsibility for the education and socialization of youth, the school context has the potential to moderate the occurrence of risk behaviors and to identify and secure help for at-risk children. The Centers for Disease Control and Prevention has demonstrated great commitment to reduce youth suicide rates through an array of initiatives. These include the expansion of a state public health youth suicide prevention program; funding an evaluation of telephone crisis services for adolescents; and funding a program to provide information on the prevalence

of Internet use by teenagers in their attempt to seek help for emotional problems. The National Institute of Mental Health continues to develop and test various interventions to prevent suicide in children and adolescents through early diagnosis and treatment of depression and other mental disorders and is working to find effective methods to evaluate suicidal thinking and behaviors. The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration continues to provide critically needed mental health promotion and youth suicide prevention services primarily through its Children's Mental Health Services Program, Community Mental Health Block Grants, Children's State Incentive Grants, School-Based Violence Prevention Program, and National Child Traumatic Stress Initiative. Taking a developmental perspective on the problem of youth suicide, it is evident that we must consider multiple pathways to prevention, place renewed emphasis on prevention strategies that have their impact earlier in the life course or earlier in the course of mental disorder, and collaborate more effectively with colleagues and advocates in other prevention fields. Meeting our suicide prevention objectives will require the unified effort of prevention specialists and advocates in the broader mental health, substance abuse prevention, and health promotion fields. The development and implementation of an overarching strategic plan for suicide prevention, including a lifespan continuum of accessible prevention options, can be achieved with the shared vision, commitment and resources of disciplines and government working with individuals and communities. Thank you, again, for the opportunity to present this testimony. I would be pleased to answer any questions.