

Risk Factors

Risk and Protective Factors, and Warning Signs

Suicide is the result of an extremely complex interaction involving a number of factors that all contribute to the expression of suicidal behaviors. This Issue Brief discusses how knowledge of risk factors, protective factors, and warning signs plays a key role in youth suicide prevention. Risk factors are characteristics that make it more likely that someone will consider, attempt, or die by suicide. Protective factors are those that make it less likely that someone will consider, attempt, or die by suicide. Warning signs are behaviors and characteristics that someone may harm him or herself in the near future.

There are numerous risk factors for suicide, any one of which may be present or absent in an adolescent at-risk for suicide. Researchers have identified a number of factors associated with a higher risk for youth suicide, as well as protective factors that may reduce the likelihood of youth suicidal behavior. Given the amount of time children and adolescents spend in school, it is imperative that school faculty and staff are educated about youth suicide risk factors, warning signs, and protective factors of suicidal behavior (3, 15).

Suicide does not lend itself easily to an identifiable period of symptoms that occur before the disease; however, research does show that suicidal youth tend to give evidence about their distress both verbally and through changing behavior (5, 14). Being able to recognize these clues and knowing the risk factors associated with adolescent suicide may help school staff prevent a student at-risk for suicide from attempting and/or dying by suicide. The importance of risk and protective factors can vary by age, gender, and ethnicity (13).

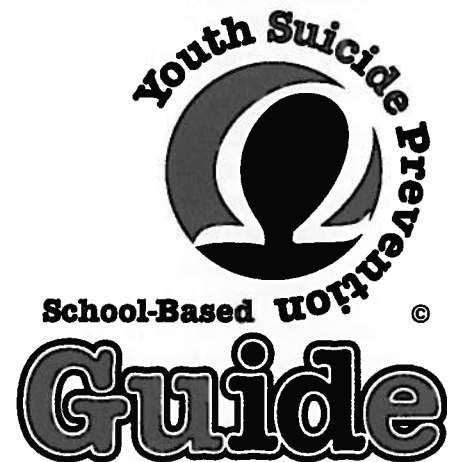
There is no tangible, all encompassing method for determining if an adolescent will attempt or die by suicide. Many students will present some of the factors mentioned in the list of risk factors that follow, however, not all will feel, act, or have ideas about suicide. By using this list, school administrators, faculty, and staff may be able to recognize a student at-risk for suicide and who may need help. By recognizing a teen that is potentially at-risk for suicide, faculty, staff, and administration take the first and the most important step for alleviating and reducing the risk for suicide. After a student has been identified as at risk, he or she can get help and intervention, which is of paramount importance for preventing a student from attempting or dying by suicide.

Risk Factors (for non-fatal suicide attempts and deaths by Suicide)

Risk factors are characteristics that increase the possibility that an individual will attempt to end his or her life, although it is important to note that risk factors are not necessarily causes of self-injury or death (17). Risk factors can be thought of as indicators to a child's potential for self-harm, and much research has gone into identifying specific risk factors for youth (4, 15, 17, 18). Research has shown that the following are risk factors for suicide attempts and death by suicide in adolescents: previous suicide attempt (2, 4, 6, 7, 9, 10, 15, 20); mood disorder (particularly depression) or psychopathology (2, 4, 7, 8, 9, 10, 15, 20, 35); substance abuse disorder (2, 4, 7, 8, 9, 10, 20, 35); family history of

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suicidal behavior or mental illness (2, 4, 8, 10, 20); relationship, social, work, or financial loss (3, 4, 8, 10, 20); access to lethal agents (such as firearms or medications) (3, 4, 8, 10, 20, 33); contagion or exposure to individuals who have attempted or died by suicide with exposure through media, television, and direct contact (8, 10, 11); history of physical or sexual abuse (6, 7, 10, 23); conduct disorder (7, 10, 20, 35); juvenile delinquency (7, 10); gay, lesbian, or bisexual sexual orientation, or identification as transgendered (2, 4, 8, 10, 16, 24); stressful life events (7, 10); chronic physical illness (2, 4, 8, 20); impulsive or aggressive tendencies (3, 4, 20); being homeless/runaway (7, 10, 20); and school problems (2).

The impact of some risk factors can be reduced by interventions such as providing treatment for depression or substance abuse, and removing access to firearms (3, 20, 33). Those risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder, or following a significant stressful life event (11). The following list of risk factors that have been found to be associated with adolescent suicide is intended for use by school staff in order to help identify a student who may be at-risk for attempting or dying by suicide.

Protective Factors

Measures that enhance resilience or protective factors are as essential for preventing suicide as reducing the factors that increase risk for suicide. Resilience refers to the process by which individuals build their coping skills, gain competencies, and increase their resistance to stress (36).

Protective factors are characteristics believed to reduce the likelihood that someone will harm or kill him/herself by counterbalancing risk factors, and vary according to age, gender, ethnicity, and religion (11, 17). Leading researchers in the field of youth suicide have noted that much research still needs to be conducted regarding specific protective factors for children and teens (4) although the following have shown to be protective factors for preventing youth suicide: parental/family support and connectedness (2, 4, 7, 11, 12, 20, 34), good social/coping skills (11, 12), religious/cultural beliefs (2, 4, 11, 12), good relationships with other school youth/best friends (7, 12), reduced access to means (10, 11), support from relevant adults/teachers/professionals (7, 11, 12), help-seeking behavior/advice seeking (12), impulse control (7), adaptive problem solving/conflict resolution abilities (11), social integration/opportunities to participate (7, 12), positive sense of worth/confidence (7, 12), stable living environment (7), access to and care for mental/physical/substance disorders (11), responsibility for others/pets (7), and their perceived connectedness to school (2). Additionally, involvement on sports teams (high school and community teams) is associated with reduced suicide ideation and non-fatal suicide attempts (27, 29, 30), reduced hopelessness and self-reported

Risk Factors

- Previous suicide attempt
- Physical abuse
- Sexual abuse
- Feelings of hopelessness or isolation
- Psychopathology (especially mood disorders)
- Parental psychopathology
- Substance abuse disorder (especially with comorbid mental health disorder)
- Conduct disorders or disruptive behaviors
- Juvenile delinquency
- School problems
- Exposure to suicidal behavior of friends or acquaintances, or in the media
- Chronic physical illness
- Being homeless/or having run away from home
- Aggressive-impulsive behaviors
- Life stressors such as interpersonal losses (relationship, social, work) and legal or disciplinary problems
- Access to firearms or other means

Demographic Risk Factors

- Being male (for death by suicide)
- Being female (for suicide attempt)
- Homosexual or bisexual orientation, or trans-gendered identity
- Family history of suicidal behavior

Protective Factors

- Family cohesion (family with mutual involvement, shared interests, and emotional support)
- Good coping skills
- Support from teachers and other relevant adults
- Perceived connectedness to the school
- Positive relationships with other school youth
- Reduced access to means for suicidal behavior
- Help-seeking behavior/advice seeking
- Impulse control
- Problem solving/conflict resolution abilities
- Social integration/opportunities to participate
- Sense of worth/confidence
- Stable living environment
- Access to and delivery of effective care for mental/physical/substance disorders
- Responsibilities for others/pets
- Religious or cultural beliefs that discourage self-harm
- Sports team participation

plans of suicide (28), and decreased risks for depression (30). Higher involvement (usually 3 or more teams per year) often showed more pronounced protection (28, 30, 32). However, one study revealed male high school athletes who made non-fatal suicide attempts reported serious injury more often than non-athlete counterparts (31, 32). The following checklist presents these protective factors in an easy-to-read format.

Warning Signs

While risk factors suggest long-term risk (i.e., a year to lifetime), warning signs are the earliest detectable signals that someone may harm themselves in the near-term (i.e., within minutes, hours, days, or months) (19). If risk factors can be compared to "clues," then warning signs might be thought of as "red flags." Emotional ups and downs are inherent in adolescence, and it can be hard to determine what behavior is normal and what may be harmful, therefore research has been done on suicide warning signs specifically for youth (1, 19). Again, it must be noted that these factors and warning signs do not provide a definitive method for determining if a student is or is not suicidal, but rather present a method to help identify potentially suicidal adolescents.

In 1997 the American Academy of Child & Adolescent Psychiatry adopted a list of symptoms and warning signs specifically for adolescents who may try to kill themselves, which was updated in May 2008 (14). The Suicide Prevention Resource Center [SPRC] has also compiled a list of youth-specific suicide warning signs (26). Three state suicide prevention program guideline manuals also offer youth suicide warning signs: Maine Youth Suicide Prevention Program (7), Washington State's Youth Suicide Prevention Program (YSPP) (21), and the Virginia Guidelines for Suicide Prevention manual (22). Additionally, researchers in Utah conducted 49 psychological autopsies of adolescents and young adults who died by suicide in the mid-1990s in an effort to examine risk factors and warning signs of the descendents (25). Warning signs for youth suicidal behavior from these resources are combined and appear in this section.

One key to preventing suicide in children and teens is to know these warning signs and know what to do when faced with a student who presents them so that they may get the help they need. Some of these signs are similar to those for depression, a risk factor for suicidal behavior (15, 20). The following lists present warning signs that have been found to be associated with adolescent suicide.

Warning Signs

- **Actually talking about suicide or a plan***
- **Seeking out ways to harm or kill oneself***
- **Saying other things like: "I'm going to kill myself," "I wish I were dead," or "I shouldn't have been born"***
- Withdrawal from friends and family
- Change in eating and sleeping habits
- Loss of interest in pleasurable activities
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Loss of interest in things one cares about
- Preoccupation with death
- Exhibiting impulsivity such as violent actions, rebellious behavior, or running away
- Complaining of being a bad person or feeling "rotten inside"
- Making statements about hopelessness, helplessness, worthlessness, or being "beyond help"
- Marked personality change and serious mood changes
- Giving verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," and "I won't see you again"
- Becoming suddenly cheerful after a period of depression-this may mean that the student has already made the decision to escape all problems by ending his/her life
- Giving away favorite possessions
- Difficulty concentrating and a decline in quality of school work

* **These signs and behaviors indicate an individual needs immediate professional attention or 9-1-1 should be called (19).**

References

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Myths and Current Facts About Adolescent Suicide

Myths	Evidence-Based Facts
Youth suicide is an increasing problem in the United States.	For youth age 10 to 24, the suicide rate declined from 9.48/100,000 in 1990 to 6.78/100,000 in 2003. This was a decrease of 28.5% in the rate of youth suicide over 14 years (22). The youth suicide rate for 10-24 year olds rose 8% from 2003 to 2004, then showed a general decline through 2007 (6.3%). The rate has increased again from 2007 to 2009 by 7.2%, the most current year data is available as of this publication (2). The 2009 suicide rate for 15-19 year olds stands at 7.75 per 100,000 and the 2009 suicide rate for 10-14 year olds is 1.30 per 100,000 (2).
Most teenagers will not reveal that they are suicidal or have emotional problems for which they would like emotional help.	Most teens will reveal that they are suicidal. Although studies have shown that they are more willing to discuss suicidal thoughts with a peer than a school staff member (3), this disposition that most teens have towards expressing suicidal ideations could be used for screening adolescents through questionnaires and/or interviews (4).
African-American teens do not die by suicide.	African-Americans do die by suicide. The Center for Disease Control and Prevention reports a 114% increase in suicides among black males aged 10-19 from 1980 to 1995, a rate higher than that of any other group. Among black males aged 10-14 during the same period, the suicide increase was 233%, compared with 120% for white males in the same age group (5). For black males aged 15-19, the suicide rate rose 146%, compared with 22% for white males (5). More recently, the rate of youth suicide among Black youth 10 - 24 years of age declined from nearly 5.5/100,000 in 1999 to 4.4/100,000 in 2007 (2).
Adolescents who talk about suicide do not attempt or die by suicide.	One of the most ominous warning signs of adolescent suicide is talking repeatedly about one's own death (3). Adolescents who make threats of suicide should be taken seriously and provided the help that they need (6).
Educating teens about suicide leads to increased suicide attempts, since it provides them with ideas and methods about killing themselves.	When issues concerning suicide are taught in a sensitive educational context they do not lead to, or cause, further suicidal behaviors (7). Since three-fourths (77%) of teenage students state that if they were contemplating suicide they would first turn to a friend for help, peer assistance programs have been implemented throughout the nation (1). These educational programs help students to identify peers at risk and help them receive the help they need. Such programs have been associated with increased student knowledge about suicide warning signs and how to contact a hotline or crisis center, as well as increased likelihood to refer other students at risk to school counselors and mental health professionals (8, 9, 14). Directly asking an adolescent if he or she is thinking about suicide displays care and concern and may aid in clearly determining whether or not an adolescent is considering suicide. Research shows that when issues concerning suicide are taught in a sensitive and educational manner, students demonstrate significant gains in knowledge about the warning signs of suicide and develop more positive attitudes toward help-seeking behaviors with troubled teens (8, 11). Additionally, recent research indicated that asking about suicidal behavioral does not plant the idea of suicide. Researchers found that students who were asked about suicidal ideation or behavior in a screening survey were no more likely to report thinking about suicide than students not exposed to these questions. The research results seem to indicate that asking about suicidal ideation or behavior may have been helpful for at-risk students (i.e., those with depression symptoms or previous suicide attempts) (25).
Talking about suicide in the classroom will promote suicidal ideas and suicidal behavior.	Talking about suicide in the classroom provides adolescents with an avenue to talk about their feelings, thereby enabling them to be more comfortable with expressing suicidal thoughts and increasing their chances of seeking help from a friend or school staff member (3).
Parents are often aware of their child's suicidal behavior.	Studies have shown that as much as 86% of parents were unaware of their child's suicidal behavior (3). When compared to control subjects, adolescents who died by suicide were found to have had significantly less frequent and less satisfying communication with their parents (1).

Myths and Current Facts About Adolescent Suicide

continued

Myths	Evidence-Based Facts
Most adolescents who attempt suicide fully intend to die.	Most suicidal adolescents do not want suicide to happen (10). Rather, they are torn between wanting to end their psychological pain through death and wanting to continue living, though only in a more hopeful environment. Such ambivalence is communicated to others through verbal statements and behavior changes in 80% of suicidal youths (1).
There is not a significant difference between male and female adolescents regarding suicidal behavior.	Adolescent females are significantly more likely than adolescent males to have thought about suicide and to have attempted suicide (1, 3, 4, 7). More specifically, adolescent females are 1.5 to 2 times more likely than adolescent males to report experiencing suicidal ideation and 3 to 4 times more likely to attempt suicide (1). Adolescent males are 4 to 5.5 times more likely than adolescent females to die by suicide (12). While adolescent females die by suicide in one out of 25 suicide attempts, adolescent males kill themselves in one out of every three attempts (1).
The most common method for adolescent death by suicide is drug overdose.	Guns are the most frequently used method for deaths by suicide among adolescents (3, 12, 13). In 1994, guns accounted for 67% of all adolescent deaths by suicide while strangulation (via hanging), the second most frequently used method for adolescent suicides, accounted for 18% of all adolescent deaths by suicide (1). A shift has taken place in the methods used to attempt suicide. In 1990, firearms were the most common method for both girls and boys. In 2004, hanging/suffocation was the most common method of suicide among adolescent girls, accounting for over two-thirds of suicides among 10- to-14-year-old girls (71.4%) and nearly half among 15-to-19 year-old girls (49%). From 2003 to 2004, there was a 119 percent increase in hanging/suffocation suicides among 10-to-14-year-old girls. For boys and young men, firearms are still the most common method (22). Having a gun in the house increases an adolescent's risk of suicide (15, 23, 24). Regardless of whether a gun is locked up or not, its presence in the home is associated with a higher risk for adolescent suicide. This is true even after controlling for most psychiatric variables. Homes with guns are 4.8 times more likely to experience a suicide of a resident than homes without guns (1). In lieu of these findings, it should not be surprising that restricting access to handguns has been found to significantly decrease suicide rates among 15–24 year olds (1, 15).
Because female adolescents die by suicide at a lower rate than male adolescents, their attempts should not be taken seriously.	One of the most powerful predictors of death by suicide is a prior suicide attempt (1, 3, 4, 12, 15, 16-21). Adolescents who have attempted suicide are 8 times more likely than adolescents who have not attempted suicide to attempt suicide again (1). One-third to one-half of adolescents who kill themselves have a history of a previous suicide attempt. Therefore, all suicide attempts should be treated seriously, regardless of sex of the attempter.
Suicidal behavior is inherited.	There is no specific suicide gene that has ever been identified in determining or contributing to the expression of suicide (1, 12, 20, 21).
Adolescent suicide occurs only among poor adolescents.	Adolescent suicide occurs in all socioeconomic groups (15, 16, 21). Socioeconomic variables have not been found to be reliable predictors of adolescent suicidal behavior (1, 3, 15, 16, 21). Instead of assessing adolescents' socioeconomic backgrounds, school professionals should assess their social and emotional characteristics (i.e., affect, mood, social involvement, etc.) to determine if they are at increased risk.
The only one who can help a suicidal adolescent is a counselor or a mental health professional.	Most adolescents who are contemplating suicide are not presently seeing a mental health professional (7). Rather, most are likely to approach a peer, family member, or school professional for help. Displaying concern and care as well as ensuring that the adolescent is referred to a mental health professional are ways paraprofessionals can help.