National Institute of Mental Health

Frequently Asked Questions about Suicide

What should you do if someone tells you they are thinking about suicide?

If someone tells you they are thinking about suicide, you should take their distress seriously, listen nonjudgmentally, and help them get to a professional for evaluation and treatment. People consider suicide when they are hopeless and unable to see alternative solutions to problems. Suicidal behavior is most often related to a mental disorder (depression) or to alcohol or other substance abuse. Suicidal behavior is also more likely to occur when people experience stressful events (major losses, incarceration). If someone is in imminent danger of harming himself or herself, do not leave the person alone. You may need to take emergency steps to get help, such as calling 911. When someone is in a suicidal crisis, it is important to limit access to firearms or other lethal means of committing suicide.

What are the most common methods of suicide?

Firearms are the most commonly used method of suicide for men and women, accounting for 60 percent of all suicides. Nearly 80 percent of all firearm suicides are committed by white males. The second most common method for men is hanging; for women, the second most common method is self-poisoning including drug overdose. The presence of a firearm in the home has been found to be an independent, additional risk factor for suicide. Thus, when a family member or health care provider is faced with an individual at risk for suicide, they should make sure that firearms are removed from the home.

Why do men commit suicide more often than women do?

More than four times as many men as women die by suicide; but women attempt suicide more often during their lives than do men, and women report higher rates of depression. Several explanations have been offered: a) Completed suicide is associated with aggressive behavior that is more common in men, and which may in turn be related to some of the biological differences identified in suicidality. b) Men and women use different suicide methods. Women in all countries are more likely to ingest poisons than men. In countries where the poisons are highly lethal and/or where treatment resources scarce, rescue is rare and hence female suicides outnumber males. More research is needed on the social-cultural factors that may protect women from completing suicide, and how to encourage men to recognize and seek treatment for their distress, instead of resorting to suicide.

Who is at highest risk for suicide in the U.S.?

There is a common perception that suicide rates are highest among the young. However, it is the elderly, particularly older white males that have the highest rates. And among white males 65 and older, risk goes up with age. White men 85 and older have a suicide rate that is six times that of the overall national rate. Why are rates so high for this group? White males are more deliberate in their suicide intentions; they use more lethal methods (firearms), and are less likely to talk about their plans. It may also be that older persons are less likely to survive attempts because they are less likely to recuperate. Over 70 percent of older suicide victims have been to their primary care physician within the month of their death, many with a depressive illness that was not detected. This has led to research efforts to determine how to best improve physicians' abilities to detect and treat depression in older adults.

Do school-based suicide awareness programs prevent youth suicide?

Despite good intentions and extensive efforts to develop suicide awareness and prevention programs for youth in schools, few programs have been evaluated to see if they work. Many of these programs are designed to reduce the stigma of talking about suicide and encourage distressed youth to seek help. Of the programs that were evaluated, none has proven to be effective. In fact, some programs have had unintended negative effects by making at-risk youth more distressed and less likely to seek help. By describing suicide and its risk factors, some curricula may have the unintended effect of suggesting that suicide is an option for many young people who have some of the risk factors and in that sense "normalize" it—just the opposite message intended. Prevention efforts must be carefully planned, implemented and scientifically tested. Because of the tremendous effort and cost involved in starting and maintaining programs, we should be certain that they are safe and effective before they are further used or promoted. There are number of prevention approaches that are less likely to have negative effects, and have broader positive outcomes in addition to reducing suicide. One approach is to promote overall mental health among school-aged children by reducing early risk factors for depression, substance abuse and aggressive behaviors. In addition to the potential for saving lives, many more youth benefit from overall enhancement of academic performance and reduction in peer and family conflict. A second approach is to detect youth most likely to be suicidal by confidentially screening for depression, substance abuse, and suicidal ideation. If a youth reports any of these, further evaluation of the youth takes place by professionals, followed by referral for treatment as needed. Adequate treatment of mental disorder among youth, whether they are suicidal or not, has important academic, peer and family relationship benefits.

Are gay and lesbian youth at high risk for suicide?

With regard to **completed suicide**, there are no national statistics for suicide rates among gay, lesbian or bisexual (GLB) persons. Sexual orientation is not a question on the death certificate, and to determine whether rates are higher for GLB persons, we would need to know the proportion of the U.S. population that considers themselves gay, lesbian or bisexual. Sexual orientation is a personal characteristic that people can, and often do choose to hide, so that in psychological autopsy studies of suicide victims where risk factors are examined, it is difficult to know for certain the victim's sexual orientation. This is particularly a problem when considering GLB youth who may be less certain of their sexual orientation and less open. In the few studies examining risk factors for suicide where sexual orientation was assessed, the risk for gay or lesbian persons did not appear any greater than among heterosexuals, once mental and substance abuse disorders were taken into account.

With regard to **suicide attempts**, several state and national studies have reported that high school students who report to be homosexually and bisexually active have higher rates of suicide thoughts and attempts in the past year compared to youth with heterosexual experience. Experts have not been in complete agreement about the best way to measure reports of adolescent suicide attempts, or sexual orientation, so the data are subject to question. But they do agree that efforts should focus on how to help GLB youth grow up to be healthy and successful despite the obstacles that they face. Because school based suicide awareness programs have not proven effective for youth in general, and in some cases have caused increased distress in vulnerable youth, they are not likely to be helpful for GLB youth either. Because young people should not be exposed to programs that do not work, and certainly not to programs that increase risk, more research is needed to develop safe and effective programs.

Are African American youth at great risk for suicide?

Historically, African Americans have had much lower rates of suicides compared to white Americans. However, beginning in the 1980s, the rates for African American male youth began to rise at a much faster rate than their white counterparts. The most recent trends suggest a decrease in suicide across all gender and racial groups, but health policy experts remain concerned about the increase in suicide by firearms for all young males. Whether African American male youth are more likely to engage in "victim-precipitated homicide" by deliberately getting in the line of fire of either gang or law enforcement activity, remains an important research question, as such deaths are not typically classified as suicides.

Is suicide related to impulsiveness?

Impulsiveness is the tendency to act without thinking through a plan or its consequences. It is a symptom of a number of mental disorders, and therefore, it has been linked to suicidal behavior usually through its association with mental disorders and/or substance abuse. The mental disorders with impulsiveness most linked to suicide include borderline personality disorder among young females, conduct disorder among young males and antisocial behavior in adult males, and alcohol and substance abuse among young and middle-aged males. Impulsiveness appears to have a lesser role in older adult suicides. Attention deficit hyperactivity disorder that has impulsiveness as a characteristic is not a strong risk factor for suicide by itself. Impulsiveness has been linked with aggressive and violent behaviors including homicide and suicide. However, impulsiveness without aggression or violence present has also been found to contribute to risk for suicide.

Is there such a thing as "rational" suicide?

Some right-to-die advocacy groups promote the idea that suicide, including assisted suicide, can be a rational decision. Others have argued that suicide is never a rational decision and that it is the result of depression, anxiety and fear of being dependent or a burden. Surveys of terminally ill persons indicate that very few consider taking their own life, and when they do, it is in the context of depression. Attitude surveys suggest that assisted suicide is more acceptable by the public and health providers for the old who are ill or disabled, compared to the young who are ill or disabled. At this time, there is limited research on the frequency with which persons with terminal illness have depression and suicidal ideation, whether they would consider assisted suicide, the characteristics of such persons, and the context of their depression and suicidal thoughts, such as family stress, or availability of palliative care. Neither is it yet clear what effect other factors such as the availability of social support, access to care, and pain relief may have on end-of-life preferences. This public debate will be better informed after such research is conducted.

What biological factors increase risk for suicide?

Researchers believe that both depression and suicidal behavior can be linked to decreased serotonin in the brain. Low levels of a serotonin metabolite, 5-HIAA, have been detected in cerebral spinal fluid in persons who have attempted suicide, as well as by postmortem studies examining certain brain regions of suicide victims. One of the goals of understanding the biology of suicidal behavior is to improve treatments. Scientists have learned that serotonin receptors in the brain increase their activity in persons with major depression and suicidality, which explains why medications that desensitize or down-regulate these receptors (such as the serotonin reuptake inhibitors, or SSRIs) have been found effective in treating depression. Currently, studies are underway to examine to what extent medications like SSRIs can reduce suicidal behavior.

Can the risk for suicide be inherited?

There is growing evidence that familial and genetic factors contribute to the risk for suicidal behavior. Major psychiatric illnesses, including bipolar disorder, major depression, schizophrenia, alcoholism and substance abuse, and certain personality disorders, which run in families, increase the risk for suicidal behavior. This does not mean that suicidal behavior is inevitable for individuals with this family history; it simply means that such persons may be more vulnerable and should take steps to reduce their risk, such as getting evaluation and treatment at the first sign of mental illness.

Does depression increase the risk for suicide?

Although the majority of people who have depression do not die by suicide, having major depression does increase suicide risk compared to people without depression. The risk of death by suicide may, in part, be

related to the severity of the depression. New data on depression that has followed people over long periods of time suggests that about 2% of those people ever treated for depression in an outpatient setting will die by suicide. Among those ever treated for depression in an inpatient hospital setting, the rate of death by suicide is twice as high (4%). Those treated for depression as inpatients following suicide ideation or suicide attempts are about three times as likely to die by suicide (6%) as those who were only treated as outpatients. There are also dramatic gender differences in lifetime risk of suicide in depression. Whereas about 7% of men with a lifetime history of depression will die by suicide, only 1% of women with a lifetime history of depression will die by suicide.
Another way about thinking of suicide risk and depression is to examine the lives of people who have died by suicide and see what proportion of them were depressed. From that perspective, it is estimated that about 60% of people who commit suicide have had a mood disorder (e.g., major depression, bipolar disorder, dysthymia). Younger persons who kill themselves often have a substance abuse disorder in addition to being depressed.

Does alcohol and other drug abuse increase the risk for suicide?

A number of recent national surveys have helped shed light on the relationship between alcohol and other drug use and suicidal behavior. A review of minum-age drinking laws and suicides among youths age 18 to 20 found that lower minimum-age drinking laws was associated with higher youth suicide rates. In a large study following adults who drink alcohol, suicide ideation was reported among persons with depression. In another survey, persons who reported that they had made a suicide attempt during their lifetime were more likely to have had a depressive disorder, and many also had an alcohol and/or substance abuse disorder. In a study of all nontraffic injury deaths associated with alcohol intoxication, over 20 percent were suicides.
In studies that examine risk factors among people who have completed suicide, substance use and abuse occurs more frequently among youth and adults, compared to older persons. For particular groups at risk, such as American Indians and Alaskan Natives, depression and alcohol use and abuse are the most common risk factors for completed suicide. Alcohol and substance abuse problems contribute to suicidal behavior in several ways. Persons who are dependent on substances often have a number of other risk factors for suicide. In addition to being depressed, they are also likely to have social and financial problems. Substance use and abuse can be common among persons prone to be impulsive, and among persons who engage in many types of high risk behaviors that result in self-harm. Fortunately, there are a number of effective prevention efforts that reduce risk for substance abuse in youth, and there are effective treatments for alcohol and substance use problems. Researchers are currently testing treatments specifically for persons with substance abuse problems who are also suicidal, or have attempted suicide in the past.

What does "suicide contagion" mean, and what can be done to prevent it?

Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors. Direct and indirect exposure to suicidal behavior has been shown to precede an increase in suicidal behavior in persons at risk for suicide, especially in adolescents and young adults.
The risk for suicide contagion as a result of media reporting can be minimized by factual and concise media reports of suicide. Reports of suicide should not be repetitive, as prolonged exposure can increase the likelihood of suicide contagion. Suicide is the result of many complex factors; therefore media coverage should not report oversimplified explanations such as recent negative life events or acute stressors. Reports should not divulge detailed descriptions of the method used to avoid possible duplication. Reports should not glorify the victim and should not imply that suicide was effective in achieving a personal goal such as gaining media attention. In addition, information such as hotlines or emergency contacts should be provided for those at risk for suicide.
Following exposure to suicide or suicidal behaviors within one's family or peer group, suicide risk can be minimized by having family members, friends, peers, and colleagues of the victim evaluated by a mental

health professional. Persons deemed at risk for suicide should then be referred for additional mental health services.

Is it possible to predict suicide?

At the current time there is no definitive measure to predict suicide or suicidal behavior. Researchers have identified factors that place individuals at higher risk for suicide, but very few persons with these risk factors will actually commit suicide. Risk factors include mental illness, substance abuse, previous suicide attempts, family history of suicide, history of being sexually abused, and impulsive or aggressive tendencies. Suicide is a relatively rare event and it is therefore difficult to predict which persons with these risk factors will ultimately commit suicide.

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