EDITORIAL

Check for updates

Suicidal Thoughts and Behaviors Increased Among Young Adults. Why?

Joseph C. Blader, PhD

The normal physiologic mechanisms of life unify toward one purpose: not to die. However, people overwhelmed with anguish and hopelessness defy that imperative and, with alarming frequency, strongly consider or enact suicidal behavior. In the United States, the most perilous time of life for suicide-related thought, behavior, and fatality is young adulthood, roughly 18 to 25 years of age.

The study by Han *et al.*[1] in this issue of the *Journal* on trends in suicidal thought and behavior from 2009 through 2015 among US 18- to 25-year-olds is significant for several reasons. First, the most recent survey year is less than 2 years old. This efficiency in data gathering, processing, and analysis reflects the strong infrastructure and quality of the National Surveys on Drug Use and Health, a large-scale annual undertaking mandated by Congress. Second, we learn that suicidality in this age group has increased recently. Third, its analysis of demographic and clinical covariates of these trends provides important new information.

Han *et al.* report that the overall prevalence increased for 3 nonfatal suicide-related phenomena. Suicidal ideation ("At any time in the past 12 months …, did you seriously think about trying to kill yourself?") increased from 6.1% to 8.3%. Planning for suicide ("… did you make any plans to kill yourself?") increased from 2.0% to 2.7%. The rate of attempted suicide ("… did you try to kill yourself?") increased from 1.1% to 1.6%.

Some professionals might think, "Yes, this is very bad, but not unexpected if the prevalence of major depression also grew." They would be partly right. National Surveys on Drug Use and Health data indicate that among 18- to 25-year-olds in 2015, 10.3% reported they experienced a major depressive episode (MDE) in the previous year.[2] This is a significant increase from 2005 through 2013, when rates ranged around 8% to 9%, and higher than the uptick in 2014 to 9.3%. Other adult age groups did not show a significant increase during this period. In each year, 18- to 25-year-olds had the highest rate of prior-year MDE, consistent with other research.[3,4] Suicidal ideation, planning, and attempts occurred for approximately 35% to 40% of those with MDE. More people with depression would increase the prevalence of these events.

However, Han *et al.*'s findings show that the increasing prevalence of depression is at best only part of the picture. The largest gains in the rates of these events were among those without major depression. Although suicidal ideation among young adults with prior-year MDE increased during the survey years by 11% (from 34.2% to 38.1%), the increase in this age group for those without prior-year MDE was 33% (from 3.6% to 4.8%). Suicide attempt rates remained the same or decreased in MDE-affected groups but increased 150% (0.4% to 1.0%) in nonaffected groups. Were those without full MDE less likely to receive or adhere to treatment and therefore at higher risk for escalating to an attempt? A diagnosis-by-treatment-by-time interaction would have been an interesting test of that possibility.

The increase in suicide attempts in the non-MDE group from 0.4% to 1.0% might come across as meager in absolute terms, but look at it this way: in 2015, there were approximately 35 million 18- to 25-year-olds in the United States. Approximately 3.5 million had prior-year MDE, and 31.5 million did not. One percent of 31.5 million reporting suicide attempts amounts to 310,000 people. Had the attempt rate stayed level at even 0.5%, the average from 2009 through 2010, there would have been 155,000 fewer suicide attempts that year.

Risk factors for suicidal thoughts and behaviors have included low income, low education, and female gender[3,5] (although death by suicide is 4 times more frequent among men[6]). It is striking that the largest increases in suicidal thoughts in this young adult cohort occurred among those who were employed full time (versus unemployed), had household incomes higher than $75,000 (versus $20,000–$75,000), had private health insurance (versus Medicaid or no insurance), and were enrolled full time in college (versus their non-enrolled and nongraduated peers). Trends for attempts were similar but increased most for those in high school and non-college attendees. In other words, the protective effects of some factors show possible early signs of erosion.

We often wonder about the role of changes in broader social, cultural, or economic factors that might explain such trends. Another somewhat different possibility is a cohort effect, that is, a group of people today might exhibit change from a historical norm not because of what is happening now, but because of their collective exposure to some previous event. The 18- to 25-year-olds who provided data in 2009 were born from 1984 through 1991. Survey respondents in 2015 were born from 1990 through 1997. Are there "sensitive periods" for exposure to social disruptions or changes such as those that occurred in the United States from 2001 through 2010, such as fatal terrorist attacks, extended military campaigns, economic upheavals, and the transition of social interaction toward electronic and highly public communication? Is psychological vulnerability different if a person viewing destruction in September 2001 had been 7 years old or 17? Hard to know, but epidemiologic due diligence requires that we at least consider cohort effects as ongoing health surveillance programs continue.

For more contemporaneous influences on mental health, one suicidal factor often mentioned is social connectedness, especially the possibility that a society might have more or less of it over time. Circumstances that undermine "social cohesion"—one's sense of community, belonging, and integration—have long been invoked as contributors to suicide. Emile Durkheim's late 19th-century writings popularized this idea. Durkheim was probably too dismissive of psychopathology's role, and he was wrong about some things (e.g., that women had lower suicidal inclination). However, his contention that

social fractionation produces a society's suicide rate still affects how social scientists interpret data on, for instance, suicide's relations to economic disadvantage, loneliness, and social capital.

The trends that Han *et al.* identify bring to mind a more neglected aspect of this work that might have heightened relevance today. These are the unfavorable consequences of being, in a sense, overly integrated and susceptible to the harsh application of communal standards and expectations to oneself and seeing only shortcomings. Certainly, many people with suicidal thoughts are isolated, lonely, feel rejected, and are depressed. On the other hand, how many young adults experience the pain of feeling worthless, guilty, or disappointed in themselves, that they are disappointments to others, that they cannot ever fulfill some idealized version of who they should be, or that some humiliation or interpersonal conflict makes this life forever ruined? In fact, these experiences underlie many cognitive distortions that psychotherapy with suicide attempters addresses. Impulsivity, anxiety, and vulnerability to intense negative affect can catapult one toward drastic thoughts and acts about putting an end to it all, but despair kindled by beliefs that one falls short, in the eyes of others or oneself, seems more strongly rooted in social compression than in lonely detachment. One might say that worries about becoming socially marginalized are the bedrock of these concerns, consistent with the strong role of anxiety in suicidal thoughts and behaviors.[3,7]

Intervention trials for suicidal phenomena are notoriously hard to implement,[8] but well-done observational research indicates the value of readily accessible 24-hour crisis services and specialized treatment tracks for those with substance abuse.[9] Children and adolescents with suicidal thoughts and behaviors have a higher likelihood for them in adulthood, but they account for a small portion of total adult risk.[7] Therefore, greater interest in the transition to adulthood as a pivotal and risk-laden life stage is a timely development in which child and adolescent experts have a crucial role.

Han *et al.* show that only a minority of suicide ideators and attempters received mental health care. However, many suicidal young adults will have had some mental health encounters as youngsters. Curiously, we do not know whether those experiences facilitate or deter seeking help in later life. Even care that might seem to us and to parents as exemplary and helpful might not always be remembered so fondly by patients later in life, which could hinder their seeking treatment. It might be worthwhile to learn from their recollections so that our care processes instill an enduring readiness to take advantage of treatment when needed and ensure that we do not iatrogenically create an aversion to getting help when it is most desperately needed.

Accepted November 14, 2017.

Dr. Blader is with the University of Texas Health Science Center at San Antonio.

Disclosure: Dr. Blader has received consultant's honoraria from Arbor Pharmaceuticals.

Correspondence to Joseph C. Blader, PhD, Division of Child and Adolescent Psychiatry, Department of Psychiatry, Joe R. and Teresa Lozano Long School of Medicine, The University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, Mail Code 7719 (Clarity CGC), San Antonio, TX 78229; e-mail: blader@uthscsa.edu

https://doi.org/10.1016/j.jaac.2017.11.005

REFERENCES

1. Han B, Compton WM, Blanco C, Colpe L, Huang L, McKeon R. National trends in the prevalence of suicidal ideation and behavior among young adults and receipt of mental health care among suicidal young adults. J Am Acad Child Adolesc Psychiatry. 2018; 57:20-27.
2. Center for Behavioral Health Statistics and Quality. Key Substance Use and Mental Health Indicators in the United States: Results From the 2015 National Survey on Drug Use and Health. HHS Publication No SMA 16-4984, NSDUH Series H-51. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf. Accessed November 6, 2017.
3. Nock MK, Borges G, Bromet EJ, *et al.* Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. Br J Psychiatry. 2008;192:98-105.
4. Brezo J, Paris J, Barker ED, *et al.* Natural history of suicidal behaviors in a population-based sample of young adults. Psychol Med. 2007;37:1563-1574.
5. Turecki G, Brent DA. Suicide and suicidal behaviour. Lancet. 2016;387:1227-1239.
6. Curtin SC, Warner M, Hedegaard H. Increase in Suicide in the United States, 1999-2014. NCHS Data Brief (No 241). Hyattsville, MD: National Center for Health Statistics; 2016. https://www.cdc.gov/nchs/data/databriefs/db241.pdf. Accessed November 7, 2017.
7. Copeland WE, Goldston DB, Costello EJ. Adult associations of childhood suicidal thoughts and behaviors: a prospective, longitudinal analysis. J Am Acad Child Adolesc Psychiatry. 2017;56:958-965.e4.
8. Brent DA, Greenhill LL, Compton S, *et al.* The Treatment of Adolescent Suicide Attempters Study (TASA): predictors of suicidal events in an open treatment trial. J Am Acad Child Adolesc Psychiatry. 2009;48:987-996.
9. While D, Bickley H, Roscoe A, *et al.* Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. Lancet. 2012;379:1005-1012.