Suicide and Suicidal Behaviors Among Minoritized Youth

Tami D. Benton, MD[a,b]

KEYWORDS

• Suicidality • Asian American/Pacific Islander • Hispanic • Black • Pediatric
• Adolescent • Disparities

KEY POINTS

- Suicide is among the leading causes of death for American Indian/Alaskan Native, Asian American/Pacific Islanders, black, Hispanic, and multiracial youth. Although recent data suggest increasing trends in suicide and suicidal behaviors among minoritized populations, limited research is available to understand these trends. Emerging data regarding suicidal ideation, attempts, and suicide deaths suggest increasing trends among minoritized populations. Youth who identify as racial/ethnic minorities and sexual minorities appear to be at even greater risk. Existing data suggest a disparity in recognition and interventions for these vulnerable populations.
- Trends in suicidal ideation and behaviors for minoritized youth populations show some variations in age of onset, gender disparities, and outcomes when compared with white youth.
- Interventions targeting suicide and suicidal behaviors among diverse youth are lacking, calling for increased research support for understanding this growing population of youth.

INTRODUCTION

Suicide and suicidal behaviors continue to be a significant public health problem.[1–4] It remains the second leading cause of death for youth aged 10 to 24 years, taking more young lives than all medical disorders of childhood combined.[1] Emerging data further suggest worsening trends in suicidal behaviors since the onset of COVID-19. During February 21 to March 20, 2021, emergency department visits for suspected suicide attempts were 50.6% higher among girls aged 12 to 17 years than during the same time period in the prior year, whereas for boys, suspected suicide attempts increased by 3.7%. In some states and jurisdictions, suicide has become the leading cause of death.[5]

[a] Department of Child and Adolescent Psychiatry and Behavioral Sciences, Children's Hospital of Philadelphia, 3440 Market Street, Suite 400, Philadelphia, PA 19104, USA; [b] Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA, USA
E-mail address: BENTONT@chop.edu

Child Adolesc Psychiatric Clin N Am 31 (2022) 211–221
https://doi.org/10.1016/j.chc.2022.01.002 **childpsych.theclinics.com**
1056-4993/22/Published by Elsevier Inc.

Suicide and suicidal behaviors are complex phenomena without a single cause, complicating efforts to predict who will make a suicide attempt or die by suicide. Although rates of completed suicide among children and adolescents are very low, 2.57/100,000 adolescents aged 10 to 14 years and 10.5/100,000 adolescents aged 15 to 19 years,[1] suicide attempts occur at a much higher rate and are associated with significant morbidity.[1,6,7]

Most recent data examining suicide and suicidal behaviors among youth have been obtained through the Youth Risk Behavior Surveillance System, a school-based survey for ninth through twelfth graders that is collected every 2 years by the Centers for Disease Control and Prevention asking adolescents about health behaviors they have experienced in the 12 months before the survey. The data collected represent a national sample of youth from US states, territorial, and tribal governments. Approximately 30 years of cross-sectional data have been collected reflecting trends in suicide and suicidal behaviors for 1991 to 2019. Findings from the most recent nationwide Youth Risk Behavior Survey completed in 2019 found that 16% of all high school students (grades 9–12) reported suicidal thoughts with a plan in the past year; 9% had made a suicide attempt, and 3% of attempters required medical intervention. These most recent data also found significant differences in rates of these behaviors among ethnic/racial minorities and lesbian, gay, bisexual, transgender, and queer (LGBTQ)+ youth.

Historically, rates of suicide and suicidal behaviors have been reported to be low among minoritized youth, which includes African American (AA)/black, American Indian/Alaskan Native (AI/AN), Asian American/Pacific Island/Native Hawaiians (AAPI), Hispanic, and multiracial youth, with the exception of Native American/Alaskan Native youth.[1] Consequently, little research has focused on minoritized youth, with the assumption that suicide was most relevant in white youth. However, recent research has challenged these assumptions and is beginning to identify trends in suicide and suicidal behaviors among minoritized populations, noting variations in suicidal behaviors that appear to be specific to these groups. For example, trends in suicidal ideation and behaviors increase with age across childhood and adolescence; however, variations in age of onset of suicidality have been noted in Native American and black youth with earlier age of onset found for Native American and black boys.[8] Disparities in suicide rates have also been found among black boys with rates of suicide increasing for 5- to 11-year-olds while at the same time declining for same-aged white boys.

This review focuses on trends in suicide and suicidal behavior observed among AA/black, AI/AN, Asian American/Pacific Island Hispanic, and multiracial youth, recent evidence-based and promising interventions for suicidal ideation, and behaviors for children and adolescents, emerging studies of culturally adapted suicide interventions for minoritized youth and directions for future research.

AFRICAN AMERICAN/BLACK YOUTH

Published studies of youth suicide research in the United States have reported lower rates of suicide and suicidal behavior (suicidal ideation and behaviors [SIB]) for black youth compared with other racial and ethnic groups. Emerging research, however, raises questions about prior research reporting lower rates and concerns about racial disparities.[2] For AA/black youth, rates of suicide have been increasing over the last 10 years.[8–10]

In 2019, suicide was the third leading cause of death for AA/black youth aged 5 to 19 years (3.12/100,000), a significant increase compared with rates reported in 2009 (1.98/100,000). Overall, a 58% increase in suicide rates for AA/black youth was

observed between 2009 and 2019. For black youth aged 10 to 14 years of age, a 131.5% increase was observed between 1999 and 2019. The gender disparities noted in other populations were not the same as those observed in AA/black youth. Boys and girls aged 5 to 17 years experienced increased suicide rates between 2003 and 2017, with suicide rates for black girls showing twice the annual percentage change compared with black boys.[3] Across age groups, suicide rates were highest for girls and boys aged 15 through 17 years.[3]

Several studies examining suicidal ideation and attempts for black youth have reported similar findings.[2] Youth Risk Behavior Survey (YRBS) data from 1991 to 2017 found that black adolescents experienced not only a significant increase in suicide attempts but also suicide attempts that required medical attention. Price and Khubchandani reviewed suicide trends among AA/black adolescents from 2001 to 2017, finding a significant increase in suicidal ideation, plans, and attempts requiring medical treatment.[11] Interestingly, the data also showed that black youth were more likely to make suicide attempts, but were less likely to report suicidal ideation or plans.[12] YRBS data analyzed from 2009 through 2019 confirmed a significant increase in rates of attempted suicide among black youth.[10] Bridge and colleagues, in a study of suicide rates using psychological autopsy data of 5- to 12-year-old black children, found that black children were 2 times more likely to die than same-aged white youth, suggesting an age disparity for black youth, with suicide for black youth occurring at earlier ages.[8]

Recent reports of increasing rates of black youth suicide prompted Representative Bonnie Coleman-Watson to convene a multidisciplinary task force of the congressional black caucus to study black youth suicide with the goal of improved identification, intervention, and prevention, prompting increased research focus to understand risks, resilience, and protective factors for suicide in the black youth population.[13]

AMERICAN INDIAN/ALASKAN NATIVE YOUTH

Suicide is the leading cause of death for AI/AN youth aged 15 to 19 years of age and the second leading cause of death among youth aged 10 to 14 years. Rates of completed suicide are notably high among AI/AN youth with suicide death 3 times higher than overall rates of suicide deaths among children and adolescents in the United States.

AI/AN youth aged 10 to 19 years have the highest rates of completed suicide across all racial and ethnic populations for boys (18.83/100,000) and girls (8.79/100,000). Gender differences have been observed for AI/AN girls having increased prevalence of suicidal ideation compared with other racial/ethnic groups with AI/AN boys showing higher rates of suicide attempts. The most recent YRBS surveys found that AI/AN youth were more likely to endorse suicidal ideation (1.43 times more) and to report a suicide attempt (1.46 times) in the 12 months before the survey compared with white youth.[14]

Other studies examining suicidal ideation and behaviors among AI/AN youth have sought to understand factors influencing rates of SIB. Manzo and colleagues reviewed YRBS data covering 2005 to 2011 for AI/AN students attending urban schools compared with those attending tribal schools.[15] Rates of suicidal ideation (SI) were higher for youth attending urban schools compared with those attending tribal schools. Similar findings were identified for suicide attempts among AI/AN youth. Gender differences were noted, however, with AI/AN girls attending urban schools reporting similar prevalence of suicide attempts compared with tribal schools, whereas boys in urban schools reported higher prevalence of suicide attempt (SA) compared with tribal schools, suggesting that a culturally concordant environment may play some role as a protective factor for boys.[15]

ASIAN AMERICAN, PACIFIC ISLANDER, AND NATIVE HAWAIIAN YOUTH

Suicide is the leading cause of death for AAPI youth aged 10 to 19 years of age. It is the number one cause of death for 10- to 19-year-olds and 15- to 19-year-olds, and the third leading cause of death for 10- to 14-year-olds.[16]

Despite an increase in suicide deaths by 131.8% occurring between 2009 and 2019 for AAPI youth, very little data exist examining these trends, risk factors, or circumstances influencing these high suicide rates. Several analyses of YRBS data have shed little light on suicide and suicidal behaviors among AAPI youth. For example, one analysis of data from 1991 to 2017 found decreased suicidal ideation and behaviors.[2] Another study examining suicidality among AAPI youth found significant decreases in suicide plans and behavior but no decrease in suicidal ideation or attempts.[17] In some studies, gender differences were studied and have been noted among AAPI youth; however, the observed differences reflected differing temporal trends with declines in suicidal ideation for girls observed between 1991 and 2019 and decreasing SI noted for boys between 1991 and 2006, making comparisons difficult.

Other studies attempting to understand trends and risks for SIB for AAPI youth have examined suicide attempts by racial/ethnic group status. One study used the Native Hawaiian High School Health Survey for this purpose. The study's findings were that Native Hawaiians reported significantly higher rates of suicide attempts compared with white, Filipino, and Japanese adolescents.[18] Another school-based study found that adolescents exposed to violence at school were more likely to have suicidal plans and a history of attempts.[19] Currently, the limited data available focused on suicide and suicidal behaviors in the AAPI population prevent formulations about suicide trends among AAPI youth, calling for increased support for studying suicide in AAPI populations.

HISPANIC YOUTH

Suicide is the second leading cause of death for Hispanic youth aged 15 to 19 years, and the third leading cause of death among 10- to 14-year-olds.[16] Suicide continues to trend upwards significantly for Hispanic adolescents, with notable increases observed for early adolescents. Between 2015 and 2019, suicide deaths increased by 89% among boys aged 10 to 14 years and by 79% for girls. Among youth aged 15 to 19 years, suicide-related death rates increased by 29% among boys but remained stable among girls. From 2007 to 2016, the ratio of male-to-female suicide deaths for youth aged 10 to 19 years decreased, driven by the increased numbers of suicide deaths for Hispanic girls.[20] Between 1991 and 2019, rates of suicidal ideation were relatively stable for Hispanic girls and boys, whereas suicide attempts showed a downward trend. Although downward trends were noted for suicide attempts among Hispanic girls from 1991 to 2009, rates began to increase from 2009 to 2019. Rates for Hispanic boys did not change across this time period.[20]

Recently, studies have increasingly focused on contextual factors, systemic and structural, impacting Hispanic youth that might contribute to SIB. One structural factor significantly impacting these youth are current immigration policies, with one recent study finding that 25% of Hispanic adolescents surveyed had a family member who had been detained or deported in the past year. This finding was associated with 2.63 greater odds of SI compared with nonimmigrant peers. Contextual factors must be considered when examining suicide risks for minoritized and vulnerable youth.[21]

MULTIRACIAL YOUTH

Even more limited data exist regarding suicide deaths and suicidal behaviors for multiracial youth. Several factors contribute to the limited knowledge of this group. Early data collection efforts were hampered by low numbers of self-identified multiracial individuals. Furthermore, heterogeneity in group composition makes it difficult to identify a "target group." However, the existing data reflecting trends in suicidality among multiracial youth raise cause for concern. Recent data from the YRBS found higher prevalence of suicidal ideation (26.2%), suicide plans (20.7%), and suicide attempts (13%) in comparison to rates for white youths (18.9%, 14.4%, and 6.7%). The study also found an association between alcohol and tobacco use and suicidal ideation, plans, and attempts for multiracial groups.[14]

Multiracial youth are one of the fastest growing populations of youth in the United States, yet little is known about suicide risks for this population. A recent published study examining trends in suicidal behaviors from 1991 to 2017 using the YRBS data found no significant changes in suicide attempts, suicidal ideation, or plans for multiracial high school students. However, the limited research available does not allow for conclusions, calling for increased focus on this population of youth. Given the rapid growth of this population, increased focus is imperative.[22]

Across ethnic and racial groups, higher rates of suicide and suicidal behaviors have been reported for LGBTQ+ youth of color compared with white LGBTQ+ youth. This growing population of youth identifying as sexual and racial/ethnic minorities is an at-risk group requiring significant research focus.[17,23–25]

ASSESSMENT OF SUICIDE FOR YOUTH: RACISM AND RACIAL TRAUMA

As previously noted, suicide is influenced by multiple interacting factors. The biopsychosocial model posits that genetic, experiential, psychological, clinical, sociologic, and environmental factors contribute to an individual's suicide risk. A comprehensive review of suicide assessment can be found in an excellent review by Turecki and colleagues[6]. Any or all of these factors may interact at a given time to precipitate suicidality for an individual; however, their relative contributions to risk for suicide will be mediated by factors unique to that individual. For example, depression is commonly present among those who have attempted and died by suicide; however, the presence of depression among those with suicidal ideation does not inevitably lead to a suicide attempt or death. Depression and its proximal association with a suicide attempt is mediated by other factors that make suicide a more likely outcome. The elevated rates of SIB identified among minoritized youth populations must be considered within the context of racism, racial trauma, and xenophobia and should be assessed as an integral component of the conceptual framework when evaluating youth. The negative impact of racial stress and trauma, identified as an adverse childhood experience, has been well documented.[26] These factors, racism and discrimination, must be considered in the mental health assessments of minoritized youth when assessing causes for suicidal behaviors, developing treatment plans, and interventions. For example, some studies suggest improved treatment outcomes with cultural adapted interventions or racially concordant therapists.[27–31] A recent meta-analysis found that therapy with a majority of black youth had lower effect sizes when youth lived in states with greater anti-black racism compared with states with less anti-black racism, demonstrating the effects of racism on treatment outcomes for minoritized youth.[32]

TREATMENTS FOR SUICIDAL YOUTH OF COLOR

As with all suicidal youth, a comprehensive assessment for underlying psychiatric conditions should inform selected interventions. Depression, substance use, or other psychiatric disorders should be identified and treated with evidence-supported interventions, including pharmacotherapy and psychotherapy when indicated. Fortunately, increased focus on suicide prevention for adolescents and young adults has produced effective psychotherapeutic interventions. Some of the intervention trials have included minoritized youth populations in their studies, with most reporting limited representation; thus, these interventions are not well studied for minoritized youth populations. Interventions available for suicidal youth consist of individually focused interventions, family-focused interventions, and multicomponent interventions, which are discussed later. Recent reviews report that dialectical behavior therapy for adolescents (DBT-A) is the only intervention meeting criteria as a well-established treatment for reducing suicidal ideation and behavior in adolescents, but others are promising.[33]

INDIVIDUALLY FOCUSED INTERVENTIONS

Dialectical Behavior Therapy for Adolescents

DBT-A is a multicomponent cognitive-behavioral treatment that targets emotional, interpersonal, and behavioral dysregulation that leads to self-injurious thoughts and behaviors.[34] DBT-A has been found to be an effective clinical intervention for adolescents presenting with self-injurious thoughts and behaviors.[35] In an randomized controlled trial (RCT), adolescents with a history of deliberate self-harm and borderline personality disordered features receiving a shortened form of DBT-A (19 weeks vs typical 6-month package) showed significantly greater reductions in deliberate self-harm and suicidal ideation over the course of treatment and at the end of the 19 weeks than adolescents in enhanced usual care (weekly psychodynamic or cognitive-behavioral therapy, plus medication as usual).[36] A second RCT compared DBT-A with individual and group supportive therapy in a sample of adolescents with a history of suicide attempts and found that the adolescents receiving DBT-A reported significantly fewer instances of deliberate self-harm, nonsuicidal self-injury, and suicidal behavior as well as reductions in suicidal ideation from baseline to 6 months.[33]

DBT-A itself consists of multiple components: individual therapy, skills training group, phone coaching, and ancillary treatment. The skills training group is primarily focused on teaching skills for enhancing emotion regulation in addition to other constructs, such as distress tolerance and interpersonal effectiveness. In addition, keeping in mind the research demonstrating the efficacy of family components in interventions targeting adolescent suicidality, the skills training group adapted for DBT-A is multifamily, consisting of a group of adolescents and their parents. According to DBT theory, the behaviors of suicidal and self-injurious individuals stem from a combination of a biological sensitivity and environmental factors.[34]

Cognitive behavioral therapy (CBT) for suicide prevention (CBT-SP)[35] developed from a recognition that traditional CBT for depression does not adequately address suicidality. CBT-SP as designed for adolescents integrates traditional components of CBT for depression, such as cognitive restructuring and behavioral activation, with elements of DBT-A. In addition, there is an emphasis on family engagement and collaboration, an important addition given the role of family factors in the development of suicidality. CBT-SP aims to target suicidal feelings through teaching several different emotion regulation skills, including relaxation, mindfulness, emotion identification, and hope building. The overall goal of this treatment is to reduce the risk of suicidal behaviors in adolescents.

Interpersonal psychotherapy for adolescents (IPT-A) is another individually focused therapeutic intervention that has shown promise in the treatment of youth presenting with self-injurious thoughts and behaviors. School-based IPT-A significantly reduced suicidal ideation compared with treatment as usual (ie, psychoeducation and supportive counseling).[37,38] Although IPT-A focuses on the impact of adolescents' interpersonal relationships on psychiatric symptoms and overall functioning, there is also an emphasis on emotion education and awareness, mood monitoring, and feeling expression.

FAMILY-FOCUSED INTERVENTIONS FOR SUICIDE

It is not surprising that several psychosocial interventions for suicide target family context factors directly or include a component focused on family relationships.[39] For example, Attachment-Based Family Therapy (ABFT), which is rooted in attachment theory, teaches interpersonal and affect regulation skills with the goal of improving the quality of parent-adolescent relationships and fostering a sense of relational security in which the adolescent can confront and manage difficult issues.[40] In an RCT, adolescents in ABFT showed significantly greater improvements in suicidal ideation than adolescents in enhanced usual care.[41] In a follow-up RCT comparing ABFT with family-enhanced nondirective supportive therapy (FE-NST), adolescents in ABFT showed significant reductions in suicidal ideation, but this change was not significantly different from the FE-NST comparison group.[42] ABFT is one of the few studies to include a racially diverse population.

Another example of a family-focused intervention is Safe Alternatives for Teens and Youths (SAFETY), a cognitive-behavioral family treatment that is informed by DBT and designed to prevent suicide attempts. SAFETY aims to bolster protective interpersonal supports within the family and teach skills that promote safer behaviors and reactions in the face of stressors. SAFETY has been shown to reduce suicidal ideation and prevent suicide attempts among high-risk youth.[43,44] Across studies, reviews of interventions for youth suicidal behaviors, investigators have concluded that those interventions that include a family component show the strongest evidence of efficacy in the treatment of suicidality and self-harm.[35,45,46] Thus, the evidence strongly suggests that a consideration of family context is an essential feature of interventions aimed at treatment of youth suicidality.

Although many more studies are focusing on suicide prevention for adolescents, few interventions have focused specifically on minoritized youth. However, burgeoning research has focused on AA, AAPI, NA/AI, and Hispanic youth. Three recent studies of culturally focused interventions are promising. A sociocognitive behavioral intervention was developed for SIB in Puerto Rican adolescents.[47] A school-based prevention program, including a cultural adapted-coping with stress course (A-CWS), has been developed for black youth at risk for suicide.[48] Another prevention program focused on AI/AN was implemented by community elders in junior high schools using a curricula focused on cultural values.[49] Much more research is needed to gain understanding of risk, resilience, and protective factors that will be needed to develop effective interventions that will be culturally acceptable.

SUMMARY

Suicide and suicidal behaviors are increasingly prevalent across all racial and ethnic groups, especially for youth identifying as racial/ethnic and sexual minorities. Currently, existing suicide research does not address prevention, identification, or interventions for these vulnerable populations. The tools that are used for screening, intervention, and prevention have demonstrated effectiveness for white youth, but

have not been well studied for minoritized youth populations. It is unclear which factors contribute to the increasing rates of suicide and suicidal behaviors observed for youth of color. Although there are likely to be many similarities, there are also likely to be many differences within groups, such as multiracial groups, and between groups with different ethnic histories. However, there is one pressing need that is similar for all groups: there is a need for culturally appropriate interventions integrating contextual factors, including racism, racial trauma, xenophobia, and biases impacting minoritized youth. Increasing research that will support developing culturally appropriate, evidence-based interventions, and training the workforce to use them, will be required to stem the rising tide of suicide that we are observing among minoritized youth.

DISCLOSURE

Youth Suicide Prevention, Intervention and Research Center Deneen-Coyle fund is the source of funding.

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