Understanding Suicide

Fact Sheet *2015*

Suicide is when people direct violence at themselves with the intent to end their lives, and they die as a result of their actions. Suicide is a leading cause of death in the United States.

A suicide attempt is when people harm themselves with the intent to end their lives, but they do not die as a result of their actions. Many more people survive suicide attempts than die, but they often have serious injuries. However, a suicide attempt does not always result in a physical injury.

To learn more about suicide and other self-directed violence, please visit: http://www.cdc.gov/ViolencePrevention/suicide.html

Why is suicide a public health problem?

Suicide is a significant problem in the United States:

- 41,149 people killed themselves in 2013.[1]
- Over 494,169 people with self-inflicted injuries were treated in U.S. emergency departments in 2013.[1]
- Suicides result in an estimated $44.6 billion in combined medical and work loss costs.[1]

These numbers underestimate this problem. Many people who have suicidal thoughts or make suicide attempts never seek services.[2]

How does suicide affect health?

Suicide, by definition, is fatal and is a problem throughout the life span. In 2013, suicide was the second leading cause of death among persons aged 15-24 years, the second among persons aged 25-34 years, the fourth among person aged 35-54 years, the eighth among persons aged 55-64 years, the seventeenth among persons 65 years and older, and the tenth leading cause of death across all ages.[1]

People who attempt suicide and survive may experience serious injuries, such as broken bones, brain damage, or organ failure. These injuries may have long-term effects on their health. People who survive suicide attempts may also have depression and other mental health problems.

Suicide also affects the health of others and the community. When people die by suicide, their family and friends often experience shock, anger, guilt, and depression. The medical costs and lost wages associated with suicide also take their toll on the community.

Who is at risk for suicide?

There is no single cause of suicide. Several factors can increase a person's risk for attempting or dying by suicide. However, having these risk factors does not always mean that suicide will occur.

Risk factors for suicide include:

- Previous suicide attempt(s)
- History of depression or other mental illness
- Alcohol or drug abuse
- Family history of suicide or violence
- Physical illness
- Feeling alone

Suicide affects everyone, but some groups are at higher risk than others. Men are about four times more likely than women to die from suicide.[1] However, women are more likely to express suicidal thoughts and to make nonfatal attempts than men.[3] The prevalence of suicidal thoughts, suicide planning, and suicide attempts is significantly higher among young adults aged 18-29 years than it is among adults aged ≥30 years.[3] Other groups with higher rates of suicidal behavior include American Indian and Alaska Natives, rural populations, and active or retired military personnel.[4]

Note: This is only some information about risk. To learn more, go to http://www.cdc.gov/violenceprevention/suicide.html.

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How can we prevent suicide?

Suicide is a significant public health problem, and there is a lot to learn about how to prevent it. One strategy is to learn about the warning signs of suicide, which can include individuals talking about wanting to hurt themselves, increasing substance use, and having changes in their mood, diet, or sleeping patterns. When these warning signs appear, quickly connecting the person to supportive services is critical. Promoting opportunities and settings that strengthen connections among people, families, and communities is another suicide prevention goal.

For more information about suicide prevention and connectedness, see Preventing Suicide: Program Activities Guide *(www.cdc.gov/violenceprevention/suicide/index.html) and* Promoting Individual, Family, and Community Connectedness to Prevent Suicide Behavior *(www.cdc.gov/ViolencePrevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf).*

How does CDC approach prevention?

CDC uses a four-step approach to address public health problems like suicide.

Step 1: Define the problem

Before we can prevent suicide, we need to know how big the problem is, where it occurs, and who it affects. CDC learns about a problem by gathering and studying data. These data are critical because they help us know where prevention is most needed.

Step 2: Identify risk and protective factors

It is not enough to know that suicide affects certain people in certain areas. We also need to know why. CDC conducts and supports research to answer this question. We can then develop programs to reduce or get rid of risk factors and to increase protective factors.

Step 3: Develop and test prevention strategies

Using information gathered in research, CDC develops and evaluates strategies to prevent suicide.

Step 4: Ensure widespread adoption

In this final step, CDC shares the best prevention strategies. CDC may also provide funding or technical help so communities can adopt these strategies.

For more information on suicide prevention activities at CDC, please visit http://www.cdc.gov/violenceprevention/suicide.

Where can I learn more?

If you or someone you know is thinking about suicide, contact the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255).

Centers for Disease Control and Prevention
www.cdc.gov/violenceprevention

CDC Facebook Page on Violence Prevention
www.facebook.com/vetoviolence

National Institute for Mental Health
www.nimh.nih.gov

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide Prevention Resource Center
www.sprc.org

Preventing Suicide: A Global Imperative
www.who.int/mental_health/suicide-prevention/world_report_2014/en/

References

1. Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013) National Center for Injury Prevention and Control, CDC (producer). Available from URL www.cdc.gov/injury/wisqars/index.html.
2. Diekstra RFW. Epidemiology of attempted suicide in the EEC. In: Wilmott J, Mendlewicz J, editors. New Trends in Suicide Prevention. New York: Karger; 1982.
3. Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services.
4. Kann L, Kinchen S, Shanklin SL, et al. Youth Risk Behavior Surveillance — United States, 2013. MMWR 2014; 63(ss04): 1-168.
5. Preventing Suicide: A Global Imperative, World Health Organization. 2014. Available from: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

Suicide

Facts at a Glance 2015

Suicide

- Suicide was the tenth leading cause of death for all ages in 2013.[1]
- There were 41,149 suicides in 2013 in the United States—a rate of 12.6 per 100,000 is equal to 113 suicides each day or one every 13 minutes.[1]
- Based on data about suicides in 16 National Violent Death Reporting System states in 2010, 33.4% of suicide decedents tested positive for alcohol, 23.8% for antidepressants, and 20.0% for opiates, including heroin and prescription pain killers.[2]
- Suicide results in an estimated $51 billion in combined medical and work loss costs.[1]

Nonfatal Suicidal Thoughts and Behavior

- Among adults aged ≥18 years in the United States during 2013:[3]
  - An estimated 9.3 million adults (3.9% of the adult U.S. population) reported having suicidal thoughts in the past year.
  - The percentage of adults having serious thoughts about suicide was highest among adults aged 18 to 25 (7.4%), followed by adults aged 26 to 49 (4.0%), then by adults aged 50 or older (2.7%).
  - An estimated 2.7 million people (1.1%) made a plan about how they would attempt suicide in the past year.
  - The percentage of adults who made a suicide plan in the past year was higher among adults aged 18 to 25 (2.5%) than among adults aged 26 to 49 (1.35%) and those aged 50 or older (0.6%).
  - An estimated 1.3 million adults aged 18 or older (0.6%) attempted suicide in the past year. Among these adults who attempted suicide, 1.1 million also reported making suicide plans (0.2 million did not make suicide plans).
- Among students in grades 9-12 in the U.S. during 2013:[4]
  - 17.0% of students seriously considered attempting suicide in the previous 12 months (22.4% of females and 11.6% of males).
  - 13.6% of students made a plan about how they would attempt suicide in the previous 12 months (16.9% of females and 10.3% of males).
  - 8.0% of students attempted suicide one or more times in the previous 12 months (10.6% of females and 5.4% of males).
  - 2.7% of students made a suicide attempt that resulted in an injury, poisoning, or an overdose that required medical attention (3.6% of females and 1.8% of males).

Gender Disparities

- Males take their own lives at nearly four times the rate of females and represent 77.9% of all suicides.[1]
- Females are more likely than males to have suicidal thoughts.[3]
- Suicide is the seventh leading cause of death for males and the fourteenth leading cause for females.[1]
- Firearms are the most commonly used method of suicide among males (56.9%).[1]
- Poisoning is the most common method of suicide for females (34.8%).[1]

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Suicide Facts at a Glance 2015

Racial and Ethnic Disparities

- Suicide is the eighth leading cause of death among American Indians/Alaska Natives across all ages.[1]
- Among American Indians/Alaska Natives aged 10 to 34 years, suicide is the second leading cause of death.[1]
- The suicide rate among American Indian/Alaska Native adolescents and young adults ages 15 to 34 (19.5 per 100,000) is 1.5 times higher than the national average for that age group (12.9 per 100,000).[1]
- The percentages of adults aged 18 or older having suicidal thoughts in the previous 12 months were 2.9% among blacks, 3.3% among Asians, 3.6% among Hispanics, 4.1% among whites, 4.6% among Native Hawaiians /Other Pacific Islanders, 4.8% among American Indians/Alaska Natives, and 7.9% among adults reporting two or more races.[3]
- Among Hispanic students in grades 9-12, the prevalence of having seriously considered attempting suicide (18.9%), having made a plan about how they would attempt suicide (15.7%), having attempted suicide (11.3%), and having made a suicide attempt that resulted in an injury, poisoning, or overdose that required medical attention (4.1%) was consistently higher than white and black students.[4]

Age Group Differences

- Suicide is the third leading cause of death among persons aged 10-14, the second among persons aged 15-34 years, the fourth among persons aged 35-44 years, the fifth among persons aged 45-54 years, the eighth among person 55-64 years, and the seventeenth among persons 65 years and older.[1]
- In 2011, middle-aged adults accounted for the largest proportion of suicides (56%)1, and from 1999-2010, the suicide rate among this group increased by nearly 30%.[5]
- Among adults aged 18-22 years, similar percentages of full-time college students and other adults in this age group had suicidal thoughts (8.0 and 8.7%, respectively) or made suicide plans (2.4 and 3.1%).[3]
- Full-time college students aged 18-22 years were less likely to attempt suicide (0.9 vs. 1.9 percent) or receive medical attention as a result of a suicide attempt in the previous 12 months (0.3 vs. 0.7%).[3]

Nonfatal, Self-Inflicted Injuries*

- In 2013, 494,169 people were treated in emergency departments for self-inflicted injuries.[1]
- Nonfatal, self-inflicted injuries (including hospitalized and emergency department treated and released) resulted in an estimated $10.4 billion in combined medical and work loss costs.[1]

References

1. Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from http://www.cdc.gov/injury/wisqars/index.html.
2. Parks SE, Johnson LL, McDaniel DD, Gladden M. Surveillance for Violent Deaths– National Violent Death Reporting System, 16 states, 2010. MMWR 2014; 63(ss01): 1-33. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6301a1.htm.
3. Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services, 2014. Available at http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf.
4. Kann L, Kinchen S, Shanklin SL, et al. Youth Risk Behavior Surveillance — United States, 2013. MMWR 2014; 63(ss04): 1-168. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6304a1.htm.
5. Sullivan EM, Annest JL, Luo F, Simon TR, Dahlberg LL. Suicide Among Adults Aged 35-36 Years – United States, 1999-2010. MMWR 2013; 62(17): 321-325. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6217a1.htm.

**The term "self-inflicted injuries" refers to suicidal and non-suicidal behaviors such as self-mutilation.*