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Original Research

Emerging Adults’ Attitudes and Beliefs About Suicide and Technology/Social Media

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Abstract

Suicide in emerging adults (18-29 years) is increasing in the United States, especially amidst coronavirus disease 2019. How the use of technology/social media affects suicidal behaviors is unclear. The purpose of this study was to examine attitudes and beliefs of emerging adults about suicide and identify whether relationships exist with technology/social media use. A total of 297 participants completed an online survey examining attitudes about suicide and technology use. Results indicate a normalization of suicide. Significant relationships were found with technology/social media, including a positive relationship between YouTube and glorification/normalization of suicide. Recommendations for primary and secondary suicide prevention are made for nurse practitioners in various settings.

Background and Significance

A leading public health concern in the United States is the increasing rate of suicide and suicide attempts. Suicide is associated with high morbidity and mortality for survivors and family and friends of those who complete suicide. Suicide has become not only a psychologic burden but also a social and financial one, costing the US an estimated $70 billion annually. The impact of suicide is so great that Healthy People identified reduction of the suicide rate as a leading health indicator for the 2020 campaign. Despite recognition and campaigns to decrease suicide, the overall rate has risen steadily since 1999. In 2018, there were 48,344 completed suicides, 1.4 million attempted suicides, and 12.0 million individuals who reported having suicidal thoughts. Although clinical depression and substance abuse have been identified as risk factors for suicide, a recent study identified that more than half of people who died from suicide did not have a known mental health condition. Instead, circumstances such as substance misuse, money, work, housing, and/or legal problems were found to raise the risk for suicide.

One population at increased risk for suicide is the emerging adult. Emerging adulthood is a developmental stage that includes people aged 18 to 29 years. Events that characterize this stage may be linked to the higher rates of suicide during these years. Moving out of family homes, living independently, seeking full-time employment, becoming legal drinking age, seeking financial independence, and marriage are all changes that may occur during emerging adulthood. These transitions in life circumstances and increasing independence of emerging adulthood increase the risk for suicide behaviors.

This increased risk is supported by recent suicide-related statistics. Although suicide is the 10th leading cause of death overall in the US, it is the second leading cause of death for people aged 15 to 34 years, and the rates are consistently rising. In 2019, the prevalence of suicide attempt in 18- to 25-year-old individuals was 1.8%; the highest among all age groups. Similarly, the prevalence of serious suicidal thoughts was highest among emerging adults at 11.8%. Given recent worldwide events, health care providers need to have heightened suspicion for individuals experiencing suicidal thoughts and/or behaviors.

Throughout 2020, as the world has faced the coronavirus pandemic, anxiety, depression and stress have increased as well as isolation and loneliness resulting from stay-at-home orders, social distancing, and quarantines. Emerging adults are being disproportionately affected and reporting an increase in suicidal thoughts. Results of recent surveys show that a quarter of 18- to 24-year-old respondents reported having seriously considered suicide in the previous 30 days. This is a disturbing increase from the 11.8% with serious suicidal thoughts reported in 2019 and warrants immediate concern.

One factor that may influence suicidal thoughts and behaviors in emerging adults is their heavy use of technology and social media. Emerging adults, as part of the Millennial generation, use technology as a means of communication, entertainment, shopping, and acquiring information. Among people aged 18 to 29, reports regularly using at least 1 social media site in 2019. Higher rates of social media usage by emerging adults have been associated with increased rates of anxiety, substance use, and antisocial behavior, which are all risk factors for suicide behaviors.
Research has also shown that technology and social media influence interest, attitudes, and behaviors related to suicide. The impact of technology/social media use on the attitudes and behaviors related to suicide is mixed. There is concern that technology/social media may lead to a normalization, contagion, and clustering of suicides. Conversely, some have reported technology and social media may provide a way to ask for help for those considering suicide.

The current status of suicidality among emerging adults is distressing. The importance of identifying beliefs about suicide is great, because previous suicidal attempts and thoughts are a leading risk factor for suicide completion. Identifying attitudes and beliefs of emerging adults about suicide, and whether their technology and social media use is related to those attitudes and beliefs, is key to understanding the increasing suicide rates and developing interventions to decrease the trend.

**Purpose**

The purpose of this study was to examine emerging adult’s attitudes and beliefs about suicide and to identify whether a relationship exists between technology and social media use and those attitudes and beliefs.

**Methods**

**Participants and Recruitment**

Individuals were considered eligible for the study if they were between 18 and 29 years old, able to read and write English, and could access the study survey via the internet. A recruitment email, with the study description and link to the survey, was sent to students at the University of Massachusetts Dartmouth. In addition, posters and flyers with a link to the survey were posted. Participants were encouraged to share study information with friends to increase recruitment by word of mouth. Study participants were entered into a raffle for a $25 e-gift.

**Power Analysis**

Scant prior research about attitudes and beliefs of suicide and technology/social media usage has been done with the emerging adult population. Therefore, an estimated medium effect value of .50 was used. The necessary sample size was found to be 84 individuals.

**Protocol**

The University Institutional Review Board approved the study. An online survey was established for interested individuals to access directly from the recruitment email or flyer. Individuals who linked into the survey were asked to enter their age to establish eligibility. If determined to be eligible, participants were directed to informed consent. Those who consented were directed to the study questionnaires. Participants completed a demographic questionnaire, the Stigma of Suicide Scale-Short Form (SOSS-SF), and Technology Use Questionnaire (TUQ). All data were collected and securely stored using Qualtrics LLC.

**Measures**

**Demographics.** Demographic information collected included age in years, sex, race, student status, and previous exposure to suicide.

**SOSS-SF.** The SOSS-SF questionnaire measures the respondent’s attitudes and beliefs about suicide. The 16-item, 5-point Likert style scale rates 3 factors found to be related to suicide: Stigma, Isolation/Depression, and Normalization/Glorification. Each factor is rated by a separate subscale that consists of related items. The Stigma subscale queries 8 items associated with stigma of suicide. The Isolation/Depression subscale queries 4 items associated with perception of isolation and depression associated with suicide. The Glorification/Normalization subscale queries 4 items associated with a glorification and normalization about suicide. The Cronbach $\alpha$ for the subscales was 0.88 for Stigma, 0.80 for Isolation/Depression, and 0.78 for Glorification/Normalization. For purposes of this study, the SOSS-SF was used to measure emerging adult’s attitudes about suicide and to find whether a relationship exists between those attitudes and technology/social media usage.

**TUQ.** The TUQ assesses the typical amount of time an individual uses technology, specifically social media, on an average day. Popular platforms defined by the Pew Research Center as social media sites are assessed by the TUQ. These platforms include Facebook, Twitter, Instagram, Snapchat, Vine, Tumblr, YouTube, and Google+. The 18-item questionnaire uses Likert-style responses to determine the average number of hours spent using technology and social media daily, ranging from 0 to $\geq$4 hours. The total social media use score is calculated by adding the time spent using each individual platform. The internal consistency of the total social media use score is good (Cronbach $\alpha = 0.86$), and the item-total correlations indicate that individual items are strongly and positively associated with the total social media use ($r = 0.60–0.80, P < .001$).

**Statistical Analysis**

Descriptive analysis was used to measure and report sample characteristics and results of the SOSS-SF scale and TUQ. Correlation was used to determine whether a relationship exists between attitudes and beliefs about suicide and technology/social media use. All data were analyzed using SPSS 26.0 software (IBM Corp).

**Results**

**Demographics**

The invitation to participate resulted in 423 responses. Of these, 55 were ineligible by age, and 71 did not provide consent or did not complete the entire survey. The remaining 297 respondents were included in final data analysis. The study participants were predominantly women (63.3%) and White (74.1%), and 97.0% were college students. A preponderance of participants (81.1%) reported knowing someone who committed or attempted suicide. Further sample characteristics are described in Table 1.

**Attitudes and Beliefs About Suicide**

The SOSS-SF assesses individual items using a 5-point Likert-style scale, with a possible score of 1 to 5 for each item. Each item is a component of 1 of the 3 subscales, and item scores are totaled for a score of the respective scale. The Stigma subscale inquiries about 8 items for a potential total score range of 8 to 40, with higher scores indicating higher stigma associated with suicide. Scores of the Stigma subscale in this study ranged from 8 to 38 with a mean of 15.5. The Isolation/Depression subscale inquiries about 4 items for a potential total score range of 4 to 20, with higher scores indicating higher perception of Isolation/Depression associated with suicide. Scores of the Isolation/Depression subscale in this study ranged from 4 to 20 with a mean of 16.1. The
Glorification/Normalization subscale inquiries about 4 items for a potential total score range of 4 to 20, with higher scores indicating higher perception of Glorification/Normalization of suicide. Scores of the Glorification/Normalization subscale in this study ranged from 4 to 20, with a mean of 13.2. Mean scores of individual items and subscale totals are presented in Table 2.

The relationship between the SOSS-SF subscales was investigated using a Pearson product-moment correlation coefficient. A significant negative correlation was found between the scores of the Stigma and Glorification/Normalization subscales. There was also a significant negative correlation between the Isolation/Depression and Glorification/Normalization subscales. Descriptive statistics and correlations for SOSS-SF subscales are presented in Table 3.

### Technology/Social Media Use

The 5 most widely reported forms of technology used were listening to music, texting, streaming movies, YouTube, and Snapchat. Descriptive statistics for technology/social media use are given in Table 4.

The relationship between the SOSS subscales and items on the TUQ was explored. There was a significant correlation between watching television and Isolation/Depression ($N = 297; r = 0.13, P < .05$), with greater number of hours watching television associated with a higher score for Isolation/Depression. A significant negative correlation existed between Tumblr and Stigma ($N = 297; r = -0.17, P < .01$), with use of Tumblr associated with a lower score for Stigma. There was also a significant negative correlation between e-reader and Glorification/Normalization ($n = 295; r = -0.15, P < .01$), with use of an e-reader associated with lower Glorification/Normalization scores. Lastly, a significant positive correlation existed between YouTube and Glorification/Normalization ($N = 297; r = 0.14, P < .05$), with more time spent on YouTube associated with higher scores of Glorification/Normalization.

### Discussion

This descriptive correlational study provides valuable information about emerging adults’ attitudes and beliefs regarding suicide and the relationship between technology/social media use and those attitudes and beliefs.

### Demographics

Participants were predominantly full-time college students, all between the ages of 18 and 29 years, and 81.1% knew someone who had attempted or committed suicide. This is higher than the number of approximately 50% previously reported in the literature. This result is particularly concerning, because according to

### Table 1 Demographic Characteristics of Participants

| Characteristic                        | No. | %    |
|---------------------------------------|-----|------|
| Gender                                |     |      |
| Male                                  |    93 | 31.3 |
| Female                                |   188 | 63.3 |
| Transgender male                      |    2 |  .7  |
| Transgender female                    |     | 1.3  |
| Gender variant/nonconforming          |   10 |  3.4 |
| Race                                  |     |      |
| White                                 |  220 | 74.1 |
| Black/African American                |    27 |  9.1 |
| Hispanic or Latino                    |    18 |  6.1 |
| Asian                                 |    19 |  6.4 |
| Not sure                              |     |  7.7 |
| Other                                 |     | 1.7  |
| No response given                     |     |  1.9 |
| Student status                        |     |      |
| Yes                                   |  288 | 97.0 |
| No                                    |      |  3.0 |
| Known contact who committed or attempted suicide |       |      |
| Yes                                   |  241 | 81.1 |
| No                                    |     | 18.9 |

### Table 2 Mean Scores of Individual Items and Subscale Scores of Stigma of Suicide Scale-Short Form (N = 297)

| Item                              | Mean | SD  |
|-----------------------------------|------|-----|
| Glorification/Normalization subscale |      |     |
| Brave                             | 3.5  | 1.1 |
| Dedicated                         | 3.3  | 1.0 |
| Noble                             | 2.9  | 0.9 |
| Strong                            | 3.5  | 1.0 |
| Total                             | 13.2 | 3.2 |
| Isolation/Depression Subscale     |      |     |
| Disconnected                      | 3.9  | 0.9 |
| Isolated                          | 3.9  | 0.9 |
| Lonely                            | 4.1  | 0.9 |
| Lost                              | 4.2  | 0.8 |
| Total                             | 16.1 | 2.8 |
| Stigma subscale                   |      |     |
| Cowardly                          | 2.3  | 1.2 |
| An embarrassment                  | 1.6  | 0.8 |
| Immoral                           | 1.9  | 1.0 |
| Irresponsible                     | 2.2  | 1.1 |
| Pathetic                          | 1.7  | 0.9 |
| Shallow                           | 1.9  | 1.0 |
| Stupid                            | 2.0  | 1.1 |
| Vengeful                          | 2.0  | 0.9 |
| Total                             | 15.5 | 6.0 |

### Table 3 Descriptive Statistics and Correlations for Stigma of Suicide Scale-Short Form Subscales (N = 297)

| Subscale                     | Mean | SD  | 1 (r) | 2 (r) | 3 (r) |
|------------------------------|------|-----|-------|-------|-------|
| 1. Stigma                    | 15.5 | 6.0 | 0.10  | -0.34 |       |
| 2. Isolation/Depression      | 16.1 | 2.8 | 0.10  | -0.26 |       |
| 3. Glorification/Normalization | 13.2 | 3.2 | -0.34 | -0.26 |       |

SD = standard deviation

### Table 4 Mean Time per Day of Technology and Social Media Use (N = 297)

| Variable                      | Mean (hours and minutes a day) | SD  |
|-------------------------------|--------------------------------|-----|
| Listen to music on iPod/online station | 2 h 14 min | 1 h 18 min |
| Text                          | 1 h 54 min | 1 h 24 min |
| Stream movies                 | 1 h 30 min | 1 h 12 min |
| YouTube                       | 1 h 18 min | 1 h 18 min |
| Snapchat                      | 1 h       | 1 h 6 min |
| Instagram                     | 55 min    | 1 h     |
| E-mail or instant messaging   | 54 min    | 1 h     |
| Watch television              | 54 min    | 1 h     |
| Play video games              | 48 min    | 1 h 12 min |
| Talk on phone                 | 42 min    | 54 min |
| Facebook                      | 42 min    | 54 min |
| Twitter                       | 30 min    | 48 min |
| Facetime                      | 24 min    | 48 min |
| Read with e-reader            | 12 min    | 42 min |
| Tumblr                        | 12 min    | 36 min |
| Google+                       | 6 min     | 30 min |
| Skype                         | 6 min     | 24 min |
| Vine                          | 2 min     | 18 min |

SD = standard deviation.
the National Institute of Mental Health (NIMH), 2 of the main risk factors for suicide are being between the ages of 15 and 24 years and being exposed to others’ suicidal behavior.25

Prior exposure to suicide is known to play a factor in suicide contagion by producing an increase in suicide and suicidal behaviors in the person exposed, especially adolescents and emerging adults.26 Contagion occurs when exposure to suicidal behaviors increases another person’s probability of suicidal behaviors.27,28 The high number of participants who reported previous exposure to suicide may indicate a willingness within this population to discuss suicide. This willingness to talk about previous exposure may lead to an excellent opportunity for health care providers to screen emerging adults for suicidal thoughts and intervene appropriately.

SOSS-SF

The scores of the SOSS-SF provide valuable insight into the attitudes and beliefs of emerging adults regarding suicide. The mean score for the Glorification/Normalization subscale was approximately the midpoint of possible scores. There has been concern that frequent social media use20 and exposure to suicidal content in media can glorify and normalize suicide.29-32 In addition, studies have shown that glorified and repeated exposure to suicide from the media can lead to suicide contagion.31 The score found on the Glorification/Normalization subscale in this study further increases alarm over the acceptance and normalization of suicide among emerging adults.

The score for the Isolation/Depression subscale was higher than the midpoint on the continuum, revealing a greater attribution of suicide to isolation/depression. This is not surprising, because feelings of isolation and loneliness are known risk factors for suicide, whereas feelings of connectedness with family and community are known to be protective.5

The score for the Stigma subscale was below the midpoint. Stigma consists of the negative and flamed attitudes about a group of people such as those who commit suicide.22 The most frequently endorsed Stigma item on the scale was “cowardly,” with 49 participants selecting agree or strongly agree. Although this was the most frequent stigmatizing item chosen, less than half the participants agreed. The lower-end scores found on the Stigma subscale in this study indicate that emerging adults are less likely to view people who attempt/commit suicide in a flawed and negative manner. This finding is in accordance with other studies that have supported that suicide is not stigmatized among emerging adults.18

TUQ

The top 5 forms of technology/social media used were listening to music, texting, streaming movies, YouTube, and Snapchat. These results are in line with previous research into these venues. Emerging adults are the age group who text message, stream music,34 and watch movies35,36 most frequently. YouTube and Snapchat are 2 of the social media platforms most widely used by those aged 18 to 29 years.13

Correlations

We found some statistically significant correlations between technology/social media use and the suicide subscales. Most concerning is the positive relationship found between use of YouTube and increased scores for Glorification/Normalization. Content available on YouTube related to suicide and self-injury are mixed. Some posts offer tips to commit suicide, whereas others promote suicide prevention.17,20,37-39 There are thousands of videos on YouTube that focus on suicide; many with graphic, visual representations. There are also thousands of comments and responses to these videos. Many of these posts do not comply with the Suicide Prevention Resource Center safe messaging guidelines.40 There is concern that the sheer volume, ease of availability, and visual representations may lead to a normalization of suicide.38,39 YouTube use is prevalent among emerging adults; therefore, it is concerning but not necessarily surprising to find increased glorification/normalization of suicide in this population. Another concerning finding was the positive relationship between watching television and higher scores on the Isolation/Depression subscale. This finding is concurrent with the literature, which indicates that increased screen time has been linked to an increased risk for depression.41,42

Increased use of Tumblr and an e-reader were associated with decreased scores for Stigma and Glorification/Normalization, respectively. Why these specific associations were noted is unclear. There may be personality and/or lifestyle traits common to these users that cause them to score lower on the suicide subscales. Further investigation into these relationships is warranted and may help identify factors protective against suicidal thoughts and behaviors.

Implications

The results of this study have practical implications for clinical practice. Given the increased risk for suicidality among emerging adults, especially amid the coronavirus disease 2019 pandemic, it may be wise to consider increasing secondary prevention efforts with this population. Despite the increased rates of suicide and the development of suicide screening tools, there is no standard recommendation for screening of suicidal risk in primary care.43 In a 2013 statement, the US Preventive Services Task Force (USPSTF) found insufficient evidence to recommend screening for suicide in adolescents, adults, and older adults in primary care. The USPSTF was unable to determine the diagnostic accuracy of screening tests for suicide risk and also could not determine the balance of benefits vs harms derived from screening.43 The USPSTF does recommend routine screening for depression in primary care44; however, a recent study of suicide trends found more than half of people who died as a result of suicide did not have a diagnosed mental health condition.45 Of those with no known mental health condition who committed suicide, 14.4% were age 10 to 24 years and 31% were aged 25 to 44 years.6 The study found no differentiation of rates in those who received primary care and those who did not.6

However, previous studies have shown that most individuals who attempt or commit suicide made at least 1 health care visit within the 12 months prior, with most of those visits occurring in the primary care setting.15,46 This was true of all age groups, including those in the age range of emerging adulthood. This supports that primary care can be an essential setting for secondary suicide prevention, even in patients with no known mental health condition.

Secondary suicide prevention is directed toward identifying those at risk for suicide and decreasing the likelihood of attempts by those considered at risk.47,48 Asking about things that are known risk factors could initiate the screening process. For example, simply asking if an emerging adult knows someone who committed or attempted suicide would identify a key risk factor for suicide.25,26 Screening tools such as the Ask Suicide-Screening Questions (ASQ)49 are available for use in emergency departments, inpatient hospital units, and primary care practices to aid in secondary prevention. The ASQ Suicide Risk Screening Toolkit is part of a step-by-step resource program from the NIMH for providers to screen and assess for suicidality, and if necessary, intervene appropriately.
The first step is to screen with the ASQ, a 4 to 5 question screening tool for nonpsychiatric clinicians to use with children, adolescents, and young adults, and takes less than 2 minutes to complete. Patients who screen positive on the ASQ are then moved to a brief suicide safety assessment (BSSA) to determine whether a further mental health evaluation is needed.49 The steps of the BSSA follow a prescribed path and help guide care decisions for individuals at different risk levels for suicide.49 The toolkit is available for use from the NIMH and includes the ASQ, BSSA, scripts to use with patients, videos, mental health resources, and information sheets.49 The ASQ is a widely supported, secondary prevention strategy that nurse practitioners (NPs) can use in various settings, including primary care, to incorporate into practice. In addition to the ASQ program, clinical pathways for suicide screening have been implemented in some settings,48,50,51 and evidence-based standardized screening and care recommendations have been developed for use in various settings.52,53

Primary care practitioners have reported time constraints, stigma, discomfort asking about suicide, and not knowing how to manage those who screen positive as barriers to suicide screening.47,54 Step-by-step, prescribed tools such as the ASQ and clinical pathways may standardize screening and treatment decisions, eliminating some of the noted barriers and improving secondary suicide prevention by NPs and other health care providers. Many of these tools were not available when the USPSTF found insufficient support to recommend screening for suicide in 2013. Of note, the USPSTF is currently working on an update to the recommendation statement on screening for suicide risk in adolescents, adults, and older adults.55

NPs in primary care practices may be especially well equipped for screening and treatment initiation. They often have an established relationship with patients and may know of any past exposure to suicide, current life circumstances, and past medical/psychiatric history.56 In addition, they can use their primary care role to provide primary suicide prevention and teaching during sports physicals and other annual wellness examinations. They could also offer group educational programs within their own practice setting or in their local community. Within the primary care setting NPs can work to increase awareness and teach individuals and communities about the risk and protective factors for suicide and about suicide prevention resources.5

Another setting that NPs can be instrumental in primary and secondary prevention of suicide in emerging adults is in college health. Suicide screening has been shown to be feasible and effective in college health settings57 and led to staff education, electronic medical record safety alerts, mental health referrals, and follow-up appointments for at-risk patients.57 Resources are available from the Suicide Prevention Resource Center58 for colleges and universities to implement suicide prevention. NPs in these settings can use the resources to increase awareness and offer educational and prevention programs for students, faculty, and staff.

Another important factor to screen for is technology and social media use. Asking about what types of platforms are being accessed, with what frequency, and specific suicide–related content may help identify those at greatest risk. Past research and the results of this study show mixed effects of technology and social media use on beliefs about suicide among emerging adults.

One concerning finding from this study is the significant correlation between YouTube use and glorification/normalization of suicide. YouTube was regularly used by 77% of emerging adults in early 2020.59 The amount of YouTube use is expected to have increased since March 2020, while during the COVID-19 pandemic, as 64% of adults reported they would use YouTube more if confined to home.60 The high YouTube use in emerging adults, especially during the pandemic, is concerning in light of the correlation with glorification/normalization of suicide. NPs should screen for social media use and ask emerging adults specifically about YouTube use. Educating users of potential risk for normalization, glorification, and contagion may help alleviate the increased risk. NPs should teach social media and YouTube users to be aware of suicide-related content on social media, how it is being presented, and to be aware of their own feelings and reactions to such content.

Limitations

Although the results are informative, this current study has some limitations. The sample may not be representative of emerging adults who are not college students. The study results are susceptible to response bias due to the self-select nature of the survey. It is possible the high number of participants who reported a previous exposure to suicide participated in the study due to the previous exposure and personal interest.

Another limitation is the datedness of the TUQ. The TUQ includes some of the most popular technology/social media sites that emerging adults use, including Snapchat, Facebook, Instagram, and YouTube. However, some of the platforms included on the TUQ, such as Vine, and Google+ are no longer widely used, and some that are currently more popular, such as TikTok, Pinterest, and Reddit, are not included.13,61

Future Research

Further investigation into the relationship between technology/social media use and suicidality is warranted. Results of past studies have been conflicting about whether social media promotes suicidal behavior or protects against it. There are likely ways in which it does both. Results from this study are particularly concerning for those who regularly use YouTube because a significant association between YouTube and glorification/normalization was found. In addition, looking for common characteristics among those users of venues with protective relationships against suicide may help identify possibilities for intervention. Any future research should be conducted with a technology/social media use questionnaire that is inclusive of all current social media sites.

Conclusion

This study aimed to examine attitudes and beliefs of emerging adults related to suicide and to identify whether a relationship exists between technology and social media use and those attitudes and beliefs. Results reveal concerning risk factors among this age group, including a high rate of exposure to suicidal behaviors and patterns of technology/social media use. Study findings are in accordance with current literature that identifies the unknown, overall effect of technology and social media use on attitudes and beliefs about suicide among emerging adults. Recommendations include increased suicide screening in clinical practice and further research into the relationship between social media use and attitudes about suicide.

References

1. Centers for Disease Control and Prevention. Suicide Prevention. 2020; Accessed October 12, 2020, https://www.cdc.gov/violenceprevention/suicide/factsheet.html.
2. U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Mental Health and Mental Disorders. October 8, 2020; Accessed October 12, 2020, https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives#4804.
3. Hedegård H, Curtain SC, Warner M. Increase in Suicide Mortality in the United States, 1999–2018. NCHS Data Brief No. 362, April 20, 2020. National Center
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