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Youth Suicide

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Youth Suicide in the United States

- Suicide is the 10th leading cause of death in the U.S., claiming more than 38,000 lives annually
- In youth aged 10-25 years, suicide is the third leading cause of death, accounting for 7.34 deaths per 100,000 people
- In 2009, 76% of suicide deaths in the age group of 12 to 18 were boys, most likely due to using a more lethal means
- Suicide is a leading cause of death on college campuses

Statistics for Suicide Attempts

Statistics for Suicide Attempts

- An estimated 10 to 15% of nonfatal suicide attempters go on to die by suicide in the years following their attempt
- Suicide attempts peak between the ages of 16 and 18, after which there is a steady decline in frequency
- Adolescent girls experience suicidal ideation and attempt suicide at a rate of 4 to 1 compared to boys
- Adolescent girls are more likely than boys to seriously consider attempting suicide and to make specific plans for suicide

Suicide Prevention

Suicide Prevention

- The U.S. Centers for Disease Control and Prevention (CDC) states that suicide prevention efforts must occur at all levels of influence: individual, relationship, community, and societal
- Preventing suicide and suicide behaviors is a public health imperative
- Only 29 to 41% of formal educational programs in mental health disciplines offer training in suicide risk assessment and intervention
- Most clinicians will treat individuals who are suicidal in some capacity during their careers
- Many will interact unknowingly with suicidal individuals due to insufficient knowledge about key risk factors and assessment strategies
- The goal of suicide prevention is to reduce factors that increase risk and increase factors that promote resilience
- Resilience, or the capacity to recover from difficulties, includes optimism and the ability to regulate emotions

Suicide Prevention

- Resilience in youth is facilitated by strong relationships with supportive adults, such as caregivers and healthcare providers
- You can support adolescents' capacity for resilience by being present in a caring way, validating their experience, engaging in authentic conversation, and working with youth to map out realistic action steps
- Asking youth about suicidal thoughts and behaviors is appropriate and saves lives
- Suicide prevention organizations and experts recommend screening, risk assessment, safety planning intervention, means reduction, and follow up and monitoring, including caring contacts
- Caring contacts are timely supportive contacts, such as calls, texts, letters, and visits, that should be standard for people with significant suicide risk after acute care episodes or when ongoing services are interrupted, like missing a counseling session
- Healthcare providers can make caring contacts and help patients build other supportive connections

Myths of Suicide

Myths of Suicide

I'm going to cover 10 myths about suicide and young people

1. **Suicides happen without warning.** Many signs of suicide risk are often present. Most teens who attempt or die by suicide have communicated their distress or plans to at least one other person. These communications are not always direct, so it is important to know some of the key warning signs of suicide
2. **Suicide is solely genetic.** There is little evidence linking an individual's genes to their predisposition to suicide. Refuting this myth is an essential part of psychoeducation for clients who have a history of suicide in their family
3. **Only certain types of people die by suicide.** No clear, specific traits separate people who are suicidal from people who are nonsuicidal
    - Individuals from all cultures, upbringings, and socioeconomic statuses kill themselves. Clinicians must pay attention to what a person actually says and does, rather than what a person has or looks like

Myths of Suicide

4. **Suicide is an act of aggression, anger, or revenge.** Most people who kill themselves do so because they feel they do not belong or are a burden on others. They think that their death will free their loved ones of this burden
5. **Talking to teens about suicide makes them more likely to kill themselves.** Fear of talking about suicide makes many situations worse. Talking about suicide with teens gives them an opportunity to express thoughts and feelings about something they may have been keeping a secret
    - Research clearly demonstrates that asking about suicide does not bring about new suicidal thoughts. In fact, discussion brings it into the open and allows an opportunity for intervention
6. **People who talk about suicide are not serious about killing themselves.** Many teens talk to others about their suicidal thoughts. However, many people become uncomfortable with the mention of suicide and may not take the person seriously

Myths of Suicide

7. **Suicidal thoughts and behaviors are ways to get attention.** It is important that any mention of suicide or suicidal behavior be taken seriously
    - Teens who express suicidal ideation need help to identify more effective ways to seek having their needs met, without dismissing the severity of their expressed thoughts, concerns, and/or behaviors
8. **Teens who are suicidal overreact to life events.** Problems that may not seem significant or important to one person may cause a great deal of distress for the teen who is suicidal. It is important to remember that a perceived crisis is just as concerning and predictive of suicidal behavior as an actual crisis
9. **Teens are at less risk for suicide as soon as they start to feel better.** Suicide reattempts in teens often occur in the first 6 months following a previous attempt. Some research suggests that the window for a reattempt may actually be within the first month after an attempt

Myths of Suicide

- Family and friends begin to return to their normal routines, but it may take longer for the teen to return to normal and they may feel abandoned by their support systems
- The teen may start to face the same problems they had prior to the attempt and may begin to think once again that suicide is the only solution. Teens who seem to recover very quickly are at heightened risk because it could indicate that they are planning their next attempt

10. **Suicide cannot be prevented.** Most teens who are suicidal exhibit symptoms weeks prior to an attempt and even those at the highest risk are suicidal for approximately 24 to 72 hours before a suicidal act
    - During the weeks and hours prior to suicidal behavior, it is possible to stop someone from committing suicide by showing them how and where to get help

Myths of Suicide

- This intervention also makes it less likely that they will make another attempt. A caring, concerned individual can help someone in distress. Listening and taking another individual's feelings seriously can truly save a life

Suicidal Youth

Suicidal Youth

- Youth who have suicidal thoughts may feel at their lowest and may be experiencing a great deal of physical, emotional, and psychological pain
- Their thinking may be influenced by circumstances over which they feel they have no control
- They may have depression or other mental, emotional, and behavioral disorders
- Reaching out for help may seem difficult, useless, or impossible

Risk Factors for Suicide

Risk Factors

- Healthcare providers play a crucial role in recognizing suicidal thoughts, expressions, and behaviors
- Healthcare providers with an understanding of risk factors and warning signs for suicide are better equipped when providing evidence-based screenings and interventions
- The challenge of youth suicide is difficult and healthcare providers are on the front lines
- Healthcare providers need to interpret risk factors carefully because risk factors are common, whereas suicide is infrequent
- The lack of most risk factors does not make an adolescent safe from suicide
- This lack of most risk factors and the frequency of suicidal ideation and attempts further emphasize the importance of universal screening
- Most people who have risk factors do not kill themselves, but someone who exhibits warning signs may be in more danger and need immediate help

Risk Factors

- Suicidal thoughts and actions are signs of extreme distress
- Threatening suicide is an alert that the person needs help
- Do not ignore any warning sign or symptom of suicide
- Take seriously all talk of suicide and give it the required attention it needs
- Threatening to die by suicide is not a normal response to stress and should not be dismissed
- Demographic factors – age, gender, race, and ethnicity
- Psychiatric diagnoses and symptoms
- Family and social factors
- Sexual minority status
- Bullying

Risk Factors

Demographic factors:

- Most suicides occur in older adolescent boys
- A spike in suicide deaths occurs in white males around the age of 14 and continues to increase rapidly until the early 20s

Race and Ethnicity:

- Suicide rates tend to be highest among American Indian/Alaskan Native youth – which experience greater social disconnect, increased access to firearms, and alcohol and drug abuse
- Suicide rates among white youth are higher than Black youth

Psychiatric diagnoses:

- The risk factor most highly correlated with suicidal behavior is psychiatric illness

Risk Factors

- Most psychiatric disorders, including major depressive disorder, dysthymic disorder, generalized anxiety disorder, panic disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders, are related to an increase in risk of a suicide attempt
- The strength of these relationships increases as adolescents get older

Psychiatric diagnosis:

- There is a lifetime suicidal ideation associated with all types of eating disorders
- Bulimia and subthreshold anorexia (less than 5 symptoms) are associated with suicide plans
- Bulimia and binge eating disorders are associated with suicide attempts
- More than half of all adolescents with bulimia reported suicidal ideation and nearly one third reported a suicide attempt

Risk Factors

Family and social factors:

- Poor family communication and problem solving hinder youth from communicating distress to their families and working on effective strategies of emotion regulation
- Parental psychopathology may lead to harsh, neglectful, or inconsistent parenting. It may also result in the modeling of disturbed behavior
- Family conflict and stress increase risk for suicidal ideation and behaviors
- A history of abuse is related to youth attempting suicide. Nonviolent verbal abuse has been linked to suicidal ideation, violent abuse (physical abuse, sexual abuse, and rape), and has been more strongly linked to suicide attempts
- A combination of family structure changes (loss due to death, separation/divorce of parents, or child placement out of the home) may place a child at increased risk for suicide attempts
- Children and adolescents whose parents died by suicide are at a threefold greater risk for suicide

Risk Factors

- Parental death by suicide is associated with an increased risk in their children of depressive, psychotic, and personality disorders
- Children of mothers who die from suicide have increased risk for suicide attempt hospitalizations
- Children of fathers who die from suicide have an increased risk for suicide attempt hospitalizations, but also increased risk of hospitalizations due to depressive and anxiety disorders
- Risk of attempt hospitalizations is higher in children of mothers that commit suicide than those whose fathers commit suicide
- Youth who are suicidal are more likely to experience stress in interpersonal peer relationships
- They may have large social networks, yet still feel alone
- The severity of suicidal symptoms has been linked to the degree of problems in peer relationships

Risk Factors

- Youth who are suicidal are more likely to have friends who are suicidal, which may promote suicidal thinking and behavior
- Exposure to a schoolmate's suicide has been found to predict subsequent suicide attempts

Sexual minority youth:

- Individuals self-identified as lesbian, gay, bisexual, or transgender (LGBT) are at increased risk for suicide
- Sexual minority youth have been found to have more elevated rates of suicidal ideation than heterosexual teens
- Youth who engage in same-sex sexual behaviors were found to be at higher risk for suicidal behavior than youth who did not engage in same-sex sexual behaviors
- Self-reported homosexual identity was more highly associated with elevated risk for suicide than same-sex attraction and behavior

Risk Factors

- Suicide attempts may be two to seven times more likely in high school students identifying as LGBT compared to those students identifying as heterosexual
- Suicide attempts in LGBT youth are associated with significantly higher rates of depression, generalized anxiety disorder, and conduct disorder compared to heterosexual youth
- Feelings of hopelessness
- Isolation, a feeling of being cut off from others
- Impulsive or aggressive tendencies
- Loss (relational, social, work, or financial)
- Easy access to lethal means, such as a firearm
- An unwillingness to seek help because of the stigma attached to mental health disorders, substance use disorders, and suicidal thoughts and behaviors

Risk Factors

- Cultural and religious beliefs
- Barriers to accessing mental health treatment
- Local clusters of suicide

Bullying:

- In one study, it was found that 32% of all middle and high school students reported being bullied in the U.S.
- There is no direct, empirical link between bullying and suicide deaths
- However, both victims and bullies are at higher risk for suicide
- Frequent victimization from bullying is associated with suicide and suicide attempts and deaths
- With the spike in utilization of online social networks, bullying has taken a new form, called cyberbullying

Risk Factors

- There are individual personal characteristics that increase the likelihood of a child being bullied, such as:
  - Internalizing problems (depression, anxiety, and withdrawal)
  - Low self-esteem
  - Low assertiveness
  - Early childhood aggressiveness
- These characteristics alone do not cause a child to be bullied, but having these characteristics along with problems in the family or problems in school can lead to bullying
- Those at the highest risk for suicide may also be those at the highest risk for being bullied
- Bullying can worsen experiences of suicidal ideation in sexual minority youth

Risk Factors

Other factors:

- Having a gun in the home
- Living in an economically deprived community
- Having deficits in problem-solving skills
- Challenges in understanding and responding to emotions
- Problems regulating impulsive behaviors
- Those with borderline personality disorder traits
- Those with less submissive and conforming traits

Acute Risk Factors

Acute risk factors are those associated with suicidal behavior in the hours or days before it occurs, including:

- Agitation
- Social withdrawal
- Severe weight loss
- Marked irritability
- Severe affective states
- Sleep disturbances
- Talking or writing about suicide
- Making plans or preparations for a suicide attempt

Warning Signs

Warning Signs

- Cognitive warning signs include having suicidal or morbid thoughts
- Behavioral warning signs include suicidal acts, self-destructive behaviors, and substance abuse
- Situational warning signs include medical problems, loss, trauma, and legal problems
- Other warning signs may include psychological, interpersonal, and family problems
- Talking about feeling trapped or being in unbearable pain
- Talking about being a burden to others
- Experiencing anxiety
- Showing rage or talking about seeking revenge

Warning Signs

When to get immediate help:

- Someone is threatening to hurt or kill themselves
- Someone is looking for ways to kill themselves – seeking access to pills, weapons, or other means
- Someone is talking or writing about death, dying, or suicide

Warning Signs

Is Path Warm?

- **I** – ideation: threats or talk of a wish to hurt or kill self
- **S** – substance abuse: increasing alcohol or drug use
- **P** – purposelessness: expressing that there are no reasons for living
- **A** – anxiety: symptoms of anxiety include agitation, restlessness, and an inability to sleep
- **T** – trapped: feeling that there is no way out
- **H** – hopelessness: feeling a lack of value, feels that no one cares, and that the future is set
- **W** – withdrawal: from friends, family members, or sleeping all of the time
- **A** – anger: having uncontrolled and excessive expressions of anger
- **R** – recklessness: acting recklessly, and involvement in high-risk behaviors
- **M** – mood changes: dramatic shifts from their typical mood state

Warning Signs

- ***IS PATH WARM***
- ***I***deation, ***s***ubstance abuse, ***p***urposelessness, ***a***nxiety, ***t***rapped, ***h***opelessness, ***w***ithdrawal, ***a***nger, ***r***ecklessness, and ***m***ood changes

Potential Risk Factors: Bullying and Internet Use

Potential Risk Factors: Bullying and Internet Use

1. Between peers
2. Repeated over time
3. It involves an imbalance of power, for example, related to physical strength or popularity, making it difficult for victims to defend themselves

Bullying

Bullying

Four categories of bullying are:

1. Direct-physical, such as assault or theft
2. Direct-verbal, such as threats, insults, or name-calling
3. Indirect-relational, such as social exclusion or spreading rumors
4. Cyberbullying

Bullying and Suicide

Bullying and Suicide

- There is a clear relationship between both bullying victimization and perpetration and suicidal ideation and behavior in children and adolescents
- Screening for bullying, whether as perpetrator or victim, should be part of the assessment for youth who have psychopathology, other emotional distress, or unusual chronic complaints

Internet Use and Suicide

Internet Use and Suicide

- Internet use that is pathologic, including self-reported use of video games for more than five hours per day, correlates with suicidal ideation, nonsuicidal self-injury, and higher levels of depression in adolescents
- Youth with suicidal ideation can find pro-suicide websites and can make online suicide pacts
- Those suicide-related searches were found to be associated with suicide deaths among young adults
- Learning of another's suicide through online news or discussion forums can also be a risk factor for suicidal thoughts and behaviors

Nonsuicidal Self-Injury

Nonsuicidal Self-Injury

- Self-injury often starts in the preteen or early teen years, when emotions are volatile and teens face increasing peer pressure, loneliness, and conflicts with parents or other authority figures
- Nonsuicidal self-injury includes cutting, burning, and self-hitting with no intent to die and can be evident in scarring and bruising
- Depression is a risk factor for self-injury, as are other mental health issues, as well as having friends who self-injure, adverse childhood experiences, and alcohol/substance use

Suicide Attempters and Those Who Die by Suicide

Suicide Attempters and Those Who Die by Suicide

- Among younger children, suicide attempts are often:
  - Impulsive
  - Associated with feelings of sadness, confusion, or anger
  - Associated with problems connected to attention and hyperactivity
- For adolescents, suicide may look like a solution to their problems and an option to stop overwhelming emotional pain
- Suicide attempts and completions are associated with feelings of depression, stress, self-doubt, pressure to succeed, financial uncertainty, disappointment, and loss
- Adolescents who attempt suicide may react to events, think, and make decisions differently than those who do not attempt suicide
- Those differences are associated with conditions such as depression, substance abuse disorder, anxiety disorders, borderline personality disorder, and psychosis

Suicide Attempters and Those Who Die by Suicide

- According to research, more than 90% of adolescent suicide victims met criteria for a psychiatric disorder before their death
- Immediate risk factors included agitation, intoxication, and a recent stressful life event

Suicide and Firearms

Suicide and Firearms

- Of all common methods used for attempting suicide, firearms are the most lethal, with approximately a 90% mortality rate
- In 2017, 6 out of 10 firearm deaths in the U.S. were suicides

Suicide and Firearms

- There are several ways to reduce death by suicide from firearms among children and adults:
  - Address firearms safety as part of your routine anticipatory guidance with youth of all ages
  - Ask about the presence of firearms in the home and counsel parents who do keep firearms to store them unloaded and locked, in a locked case with the ammunition locked separately

Firearm Safety

Firearm Safety

- Advise families to remove firearms from the home of any youth who is depressed
- Educate families that suicide attempts with a firearm are very likely to be fatal
- Alert families that the presence of a firearm in the home is associated with increased risk of suicide among children and adolescents
- Screen for mental health concerns and substance use at preventive medical checkups and have mental health resource materials available in the medical office
- Talk with parents and youth who come into your office to assess how they are feeling after any national tragedy, such as a school shooting
- As a routine, include discussion of “media diets” with parents and youth of all ages. Screen time, exposure to violence, and use of social media can all impact the mental and physical health of children and adolescents

Protective Factors

Protective Factors

- Internal locus of control
- High self-esteem
- Positive self-image
- Good problem-solving skills
- Good social support and social networks
- A good relationship with at least one person in the adolescent's family
- Positive experiences in school
- Spirituality
- A sense of purpose in life
- Satisfaction in life
- Positive emotions
- Stability of family routine and activities

Protective Factors

- Parental connectedness
- Perceived caring by friends
- Restricted access to highly lethal means during a suicidal crisis
- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support for seeking help
- Support from ongoing medical and mental healthcare relationships
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
- One study found that team sports protect against feelings of hopelessness and suicidality, and organized sports participation is associated with a lower likelihood of suicidal behavior

Basic Suicide Assessment

Basic Suicide Assessment

- Ask questions, such as:
  - How is life going? How have things been going lately?
  - How are things at home? How are things at work or school?
  - How have you been getting along with your family and friends?
  - How has your mood been?
  - How often do you drink alcohol or use other drugs?
  - Have things been going so badly that you think it will never get any better?
  - In the past week, including today, have you felt like life is not worth living?
  - In the past week, including today, have you wanted to kill yourself?
  - Have you done anything to prepare for your death?
  - Have you practiced how you might do it, or gotten things ready to kill yourself?
  - Have you ever previously tried to kill yourself? How many times?
  - What keeps you alive right now? What are your reasons for living?

Suicide Risk Assessment Interview

Suicide Risk Assessment Interview

Assess ideation and desire:

1. Have you been having thoughts of suicide or killing yourself? Have you been having thoughts of wanting to be dead? Please tell me about them. (If they answer no, ask, have you ever had thoughts of suicide or wanting to be dead?)
   - How often are you having these thoughts?
   - How long do they last?
2. Tell me about previous suicide attempts. How many times have you hurt yourself with some desire to die? How did you do it (means)? What were the results?

Now, assess resolved plans and preparations:

3. On a scale of 0 to 10, rate the strength of your intention to kill yourself right now (or tomorrow, or next week), with 0 being no intention at all and 10 being definite intention
   - What was the strength of your intention last week? What do you imagine your intention will be in the near future?

Suicide Risk Assessment Interview

4. Do you have any plans for how you would kill yourself? What are they?

(If client answers no to question 4, ask, have you ever made a plan to kill yourself? What was it? Have you researched methods of killing yourself?)

5. Have you made preparations for a suicide attempt (stockpiling pills, obtaining a gun or a rope)? Have you written a suicide note?
6. Do you have the pills, rope, or a gun?
7. When and where do you think you will implement your plan? Will there be an opportunity to implement your plan? When?
8. Are you afraid to die? (Scale of 0 to 10, with 0 = not at all afraid; 10 = very afraid) Are you confident that you could attempt suicide?

Now assess perceived burdensomeness and belongingness:

9. People sometimes think things such as: My friends or family would be better off without me. Do you ever have thoughts like that?

Suicide Risk Assessment Interview

10. Are you connected to others? Tell me about who you live with
11. When you feel bad, is there someone you can call? Who are they? Is there anyone you feel close to?
12. How hopeless do you feel? Is there more you can say about it?

Now assess important factors (other significant findings):

13. Have you ever harmed yourself by cutting, burning, or causing any other injury without the intention of dying?
14. Is there something stressful occurring currently? Has there been something stressful recently?
15. What do you do when you feel bad? People sometimes do impulsive things to help themselves feel better like self-harming, drinking alcohol, binge eating, having sex, or destroying things. What do you do to try to feel better?

Suicide Risk Assessment Interview

16. Interview should assess for the presence of psychopathology
17. Interviewer should assess for agitation, social withdrawal, rage, insomnia, guilt, nightmares, impulsivity, frequent exposure or participation in physical violence, and marked irritability

Safety Plans

Safety Plans

- We should treat suicide prevention as we treat heart attack prevention, with an emphasis on targeted preventive interventions for individuals with elevated risk
- Most individuals with high cholesterol get a statin, most individuals with suicide risk should get brief interventions like safety planning and caring contacts
- Safety planning is a brief intervention designed to assist individuals who are suicidal if a suicidal crisis emerges
- It is different from a no-suicide contract in that the safety plan provides information and instruction for people who are suicidal about what to do during a crisis
- Safety plans should be conducted following a comprehensive suicide risk assessment, utilizing data focused on warning signs, triggers, and protective factors
- The clinician and patient should sit side-by-side to complete the plan

Safety Plans

- All responses should be written in the patient's own words and be clearly legible
- The patient can fill out a safety plan template in their own writing
- The brief instructions of what to do during a crisis can then be adapted to a format that can be carried at all times
- The patient may store the written safety plan in a wallet or purse, or keep a photo of the completed safety plan on his/her cell phone

The safety planning intervention contains six steps:

- **Step 1:** focused on making the home environment safe. This includes discarding any unused medications, securing firearms, and identifying other potential methods for suicide and reducing access
  - This step can be conducted with both the adolescent and his or her parents
- **Step 2:** focuses on triggers of suicidal crises. This should be a list of thoughts, feelings, behaviors, or images that may trigger suicidal behaviors

Safety Plans

- **Step 3:** includes internal coping strategies that may have been effective previously in reducing thoughts of depression, loneliness, or suicide. This may include alternatives such as going for walks, listening to music, or playing an instrument. Patient should have realistic alternatives to suicidal behavior
- **Step 4:** identify distractions to get an individual who is suicidal through a crisis. Strategies for this step can include situations that can be distracting or individuals whom someone could spend time with
  - The goal is to put the person who is suicidal in the presence of others, with the hope that a sense of connection will trigger lifesaving cognitions
- **Step 5:** have a list of individuals whom an adolescent could speak to when feeling down, depressed, or suicidal. Step 5 should also include adults. Individuals listed should be upbeat and able to help foster a sense of hope

Safety Plans

- **Step 6:** includes professional agencies and resources that are available to the youth who is suicidal at any hour of the day. This may include the treating clinician, his/her answering services number, local crisis centers, the National Suicide Prevention Lifeline, emergency departments, or 911

Depression and Suicide

Depression and Suicide

- The majority of children and adolescents who attempt suicide have a significant mental health disorder, usually depression
- Depression and suicidal feelings are treatable mental disorders
- The child or adolescent must have the illness recognized and diagnosed
- The youth must be appropriately treated with a comprehensive treatment plan

Psychotherapies and Suicidal Youth

Psychotherapies and Suicidal Youth

Refer a youth for counseling when a youth experiences:

- An emotional or behavioral problem that threatens the safety of the youth or those around him/her
- A significant change in emotional or behavioral functioning with no recognized cause
- Emotional or behavioral problems, regardless of severity, who also has a primary caregiver with serious emotional impairment or a serious substance use problem
- Behavior that seriously interferes with the treatment of a chronic medical condition
- No meaningful improvement in behavioral or emotional problems after a course of treatment intervention for six to eight weeks
- Complex diagnostic issues involving cognitive, psychological, and emotional components that may be related to an organic origin, complex mental health condition, or legal problem
- Only a partial response to a course of psychotropic medication or treatment with more than two psychotropic medications

Psychotherapies and Suicidal Youth

- Emotional or behavioral disturbances, at age 4 years or younger, that are sufficiently severe or prolonged to merit a recommendation or the ongoing use of a psychotropic medication
- Hospitalization for the treatment of a psychiatric illness
- Families in chaos or parents with their own mental health issues and unable to supervise or provide consistency for their children
- A history of abuse, neglect, or removal from home, with current significant symptoms because of those circumstances

Dialectical Behavior Therapy (DBT)

- Involves balancing problem solving and validation
- There is a pretreatment stage and four additional stages
  - The pretreatment stage centers on orientation and commitment to treatment, as well as agreement on goals

Psychotherapies for Suicidal Youth

- Stage 1 focuses on decreasing behaviors that are life-threatening, interfere with therapy, and diminish quality of life, and increasing behavioral skills
- Stage 2 of DBT addresses decreasing post-traumatic stress
- Stage 3 focused on increasing respect for self and achieving individual goals
- Stage 4 focuses on resolving a sense of incompleteness and finding freedom and joy. DBT skills are divided into several modules, including core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance, and walking the middle path

Cognitive Behavioral Therapy

- Cognitive behavioral therapy (CBT) is a type of psychotherapeutic treatment that helps people learn how to identify and change destructive or disturbing thought patterns that have a negative influence on their behavior and emotions

Psychotherapies for Suicidal Youth

- CBT focuses on changing the automatic negative thoughts that can contribute to and worsen emotional difficulties, depression, and anxiety. These spontaneous negative thoughts have a detrimental influence on mood
- Through CBT, these thoughts are identified, challenged, and replaced with more objective, realistic thoughts
- CBT employs several strategies to reduce suicide risk including behavioral activation, emotion regulation, cognitive restructuring, enhancing problem-solving skills, and improving interpersonal effectiveness
- Clinicians help individuals who are suicidal elicit social support from others and discuss the significance of reducing periods of isolation when feeling depressed or suicidal
- CBT clinicians use commitment-to-treatment statements and crisis cards
- Crisis cards highlight mood regulation techniques, pleasant activities, and emergency numbers in the event that other techniques fail to reduce suicidal symptoms

Psychotherapies for Suicidal Youth

- Clinicians assist patients to match protective behaviors with feelings, thoughts, or non-protective behaviors that might activate a suicidal crisis
- For example, agitation may be met with relaxation and/or exercise. Loneliness might be addressed with behavioral activation with an interpersonal focus, such as calling a friend
- Mood graphing can also be a useful strategy
- Having youth record their mood at several points throughout the day can provide them and clinicians with information for their ongoing assessment and about the outcomes of various interventions
- A hope kit can be used to facilitate reasons for living when patients are feeling suicidal
  - Patients fill a small box with items that lead to positive feelings, instill hope, and take the edge off of a suicidal crisis. Items can be letters from friends, pictures of loved ones, or awards from school

Pharmacology for Suicidal Youth

Pharmacology for Suicidal Youth

- Per research, the selective serotonin reuptake inhibitor (SSRI) fluoxetine was effective in treating adolescents with moderate to severe depression
- Fluoxetine is sold under the brand names Prozac® and Sarafem®
- Combining fluoxetine with counseling is more effective than either therapy alone
- It is important to monitor youth for adherence to the medication
- Like adults, children treated with psychotropic drugs often do not remain on their medications long enough to obtain therapeutic benefit
- In the fall of 2004, the FDA issued a black box warning on the use of six selective serotonin reuptake inhibitors for individuals less than 18 years old
- Since that time, the warning has expanded to all antidepressant and antiepileptic medications and the age range has expanded through the age of 24
- As of 2010, 64 medications contained the black box warning

Pharmacology for Suicidal Youth

- The black box warning does not discourage providers from prescribing the medications, but it does encourage increased monitoring when beginning the medication or changing the dose
- Less than 5% of prescribers actually follow the FDA recommendation of weekly visits for the first month, bi-weekly visits for the second month, with a three-month follow-up
- After the black box warning and FDA recommendations, the number of diagnoses for depression and antidepressant prescriptions decreased among primary care providers, who had previously been prescribing over 75% of all antidepressants
- Since the warning label was released, child and adolescent suicide rates have increased in several countries around the world
- It is important to note that the use of antidepressants by youth is not associated with increased risk for death by suicide, but rather a small increased risk in suicidal behavior

Pharmacology for Suicidal Youth

- All clinicians working with youth that are taking antidepressants should be aware of signs of clinical worsening that may be related to antidepressant use
- These signs include anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (or psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation

Losing a Patient to Suicide

Losing a Patient to Suicide

- Approximately 80% of youth who are suicidal receive some form of mental health treatment
- The odds are good that you will lose a patient to suicide at some point in your career
- When this happens, the clinician may have symptoms similar to family survivors, such as shock, numbness, confusion, and disbelief, often followed by depression, sadness, and rejection
- Anger may be directed towards self, family, or police
- The clinician may also feel guilt and shame when a patient dies by suicide
- They may question their sense of professional judgment or competence to work with patients effectively
- They may have feelings of failure, responsibility, and fear of being blamed for the death

Losing a Patient to Suicide

- The clinician may also experience anxiety associated with managing the concerns of surviving family members
- In one study, 71 family survivors were interviewed about their feelings towards the treating clinician
- 78% reported having some contact with the clinician
- Of those, 42% felt the clinician had not answered all of their questions
- 48% felt that the clinician was withholding information
- 72% felt that the clinician made mistakes during the course of treating their family member
- 34% of family members interviewed had considered legal action against the clinician
- 17% had spoken to attorneys
- 7% had actually brought a lawsuit

Losing a Patient to Suicide

- The study found that most cases of litigation came from family members who felt the treating clinicians were unresponsive to their needs
- This unresponsiveness was perhaps prompted by the clinician's own concerns about responsibility and/or potential litigation
- It is critical for personal and professional reasons for clinicians to manage their experiences related to the loss
- Clinicians in individual or private practice should seek supervision from a professional knowledgeable about suicide to help them sort through their personal and professional feelings
- These consultations may need to occur for an extended period until feelings of shame, guilt, and loss of competence are resolved

Resources for Suicidal Youth

Resources for Suicidal Youth

- The National Suicide Prevention Lifeline serves as a triage service for a number of crisis call centers throughout the U.S. that have received specialized training offered by the American Association of Suicidology
- By dialing 1-800-273-TALK, callers are routed to the nearest of more than 160 certified call centers
- Youth can chat on Lifeline Chat at https://suicidepreventionlifeline.org/chat/
- Research findings suggest that national call centers reduce suicidal crises
- Clinicians should include the lifeline in their treatment and safety plans
- Call the Trevor Project© for LGBT youth at 1-866-488-7386 or chat online through TrevorChat© at https://www.thetrevorproject.org/get-help-now/
- Can also use TrevorText© by texting START to 678678
- https://www.bark.us
  - Allows parents to monitor text messages, emails, and social activity for signs of harmful interactions and content on 30+ platforms

Resources for Suicidal Youth

  - Sends parents alerts for issues such as cyberbullying, online predators, and suicidal ideation

Resources

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Youth Suicide

If you have any questions about the program you have just watched, you may call us at: (800) 424-4888 or fax (806) 743-2233. Direct your inquiries to Customer Service. Be sure to include the program number, title and speaker.

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