Suicide Prevention with Children and Adolescents

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Disclosures

Nothing to disclose.
Continuum of Suicidal Behavior

- **Suicide**: Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
- **Note**: Terms “committed” suicide, “completed suicide” and “successful suicide” are no longer considered acceptable; preferred terms are “death by suicide” or "died by suicide".
- **Suicide attempt**: A non-fatal self-directed potentially injurious behavior (may or may not result in injury) with any intent to die as result of the behavior.
- **Suicidal ideation**: Thoughts of suicide that can range in severity from a vague wish to be dead to active suicidal ideation with a specific plan and intent.
Child Suicide is a Serious Problem

- Third leading cause of death for young people ages 10-24 and accounts for 20% of all deaths annually
- Top methods used - firearms, suffocation, poisoning
- Boys are more likely than girls to die from suicide
- Of the reported suicides in the 10-24 age group, 81% were males
Suicidal Behavior: A Serious Problem

- Rates of other suicidal behavior are high according to a nationally-representative sample of high school students
- 15.8% seriously considered attempting suicide
- 12.8% made a plan about how they would attempt suicide
- 7.8% attempted suicide one or more times
- 2.4% made a suicide attempt that resulted in an injury, poisoning, or an overdose that required medical attention
Suicidal Behavior: A Serious Problem

- In 2015, adolescents and young adults aged 15 to 24 had a suicide rate of 12.5. (CDC)
- More than one in every 10 high school students reported having attempted suicide; nearly 1 in 6 students between the ages of 12-17 have seriously considered it.
- More than 30% of LGBTQ youth report at least one suicide attempt within the last year.*
- Almost 50% of transgender youth have seriously thought about suicide, and 25% reported that they have made a suicide attempt.*
- Youth suicides outnumber youth homicides.
Prevalence

Suicide Rates by Age from 2000 to 2015

Age Range
- Less than 20
- 20 to 34
- 35 to 44
- 45 to 64
- 65 to 84
- 85 or older

Crude Rate

Suicide in Children under 12

- Between 1993 and 2012 a total of 657 children between the ages of 5 to 11 died by suicide. (CDC)
- About 84 percent of the deaths occurred among boys.
- Hanging and suffocation were the most common methods employed.
- The suicide rate nearly doubled among African-American children during those years while it fell among white children.
Cultural Considerations

- Suicide rates are also on the rise for African-American adolescents, particularly among males.
- Many factors – including increased exposure to violence and traumatic stress; early onset of puberty; and lower likelihood to seek help for depression, suicidal thoughts, and suicide attempts may come to explain this.
- Girls attempt suicide more than boys, a particular problem for girls from Hispanic backgrounds.
Emphasis is on Prevention not Prediction

- There is no way to predict who will and who will not go on to attempt suicide and overall, it is a low base-rate behavior.
- Actuarial methods, clinical judgement and self-report methods are inherently flawed and will not capture everyone who is at imminent risk.
- Not everyone who has the risk factors for suicide will engage in suicidal behaviors.
Common Myths Re: Suicide

- MYTH: Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.
- MYTH: Young people who talk about suicide never attempt or complete suicide.
- MYTH: A promise to keep a note unopened and unread should always be kept. (Need to break confidentiality)
- MYTH: Attempted or completed suicides happen without warning.
Common Myths Re: Suicide

- MYTH: If a person attempts suicide and survives, they will never make a further attempt.
- MYTH: Once a person is intent on suicide, there is no way of stopping them.
- MYTH: People who threaten suicide are just seeking attention. (Always take it seriously)
- MYTH: Suicide is hereditary.
- MYTH: Only certain types of people become suicidal.
- MYTH: Suicide is painless.
Common Myths Re: Suicide

- MYTH: All suicidal young people are depressed.
- MYTH: Marked and sudden improvement in the mental state of an attempter following a suicidal crisis or depressive period signifies that the suicide risk is over. (3-month refractory period)
- MYTH: Once a young person is suicidal, they will be suicidal forever.
- MYTH: Suicidal young people cannot help themselves.
- MYTH: The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.
Common Myths Re: Suicide

- MYTH: Most suicidal young people never seek or ask for help with their problems. (Non-verbal gestures)
- MYTH: Suicidal young people are always angry when someone intervenes and they will resent that person afterwards.
- MYTH: Break-ups in relationships happen so frequently, they do not cause suicide.
- MYTH: Most suicides occur in winter months when the weather is poor. (Spring & Summer most common)
Common Myths Re: Suicide

- MYTH: Some people are always suicidal.
- MYTH: Every death is preventable.
Risk and Protective Factors

- **Risk factors** – Increase likelihood that a young person will engage in suicidal behavior
  - Intrapersonal, Social/situational, cultural, environmental
- **Protective factors** – Mitigate or eliminate risk
  - Intrapersonal, Social/situational, cultural, environmental
- Consider the balance between the two
Risk Factors: Intrapersonal

- Recent or serious loss
- Mental disorders (particularly mood disorders)
- Hopelessness, helplessness, guilt, worthlessness
- Previous suicide attempt
- Alcohol and other substance use disorders
- Disciplinary problems
- High risk behaviors
- Sexual orientation confusion
Risk Factors: Social/Situational

- Recent or serious loss (e.g., death, divorce, separation, broken relationship; self-esteem; loss of interest in friends, hobbies, or activities previously enjoyed)
- Family history of suicide
- Witnessing family violence
- Child abuse or neglect
- Lack of social support
- Sense of isolation
- Victim of bullying or being a bully
Risk Factors: Cultural/Environmental

- Access to lethal means (i.e. firearms, pills)
- Stigma associated with asking for help
- Barriers to accessing services
- Lack of bilingual service providers
- Unreliable transportation
- Financial costs of services
- Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
Bullying

- Bullying has three elements: aggressive or deliberately harmful behavior:
  1) between peers
  2) is repeated and over time and
  3) involves an imbalance of power, for example, related to physical strength or popularity, making it difficult for the victim to defend himself or herself.

- Suicidal ideation and behavior are greater in those bullied, controlling for age, gender, race/ethnicity and depressive symptomology. Suicidal ideation and behavior are increased in victims as well as bullies and are highest in those who have been both victims and bullies.
Bullying

- Girls who are victims or perpetrators of bullying are at higher risk for suicidal thoughts or attempts regardless of how common or rare the bullying is, whereas boys had an increased risk only when the bullying was frequent.
- Bullying as early as age 8 years was associated with attempted and completed suicides in adolescence, according to one study.
- Cyberbullying occurs among 21% of the girls and 9% of the boys.
Internet Use

- **Pathological internet use.** Self-reported daily use of video games and internet exceeding five hours is strongly associated with higher levels of depression and suicidality (ideation and attempts) in adolescents.

- **Searches for suicide-related topics.** Suicide-related searches are associated with completed suicides among young adults. Pro-suicide websites and online suicide pacts facilitate suicidal behavior, with adolescents and young adults at particular risk.
Internet Use

- **Learning of another’s suicide online.** Such information is available through online news sites (44%), social networking sites (25%), online discussion forums (15%) and video websites (15%). Social networking sites, in particular, may reveal information on others’ suicidality that would not otherwise be available.

- **Participation in online forums, however, is associated with increases in suicidal ideation.** Discussions in these forums may be anonymous and not particularly supportive, at times even encouraging suicide attempts by susceptible individuals.
Protective Factors

- Skills in problem solving, conflict resolution and handling problems in a non-violent way
- Strong connections to family, friends, and community support
- Restricted access to highly lethal means of suicide
- Cultural and religious beliefs that discourage suicide and support self-preservation
Protective Factors

- Easy access to a variety of clinical interventions
- Effective clinical care for mental, physical, and substance use disorders
- Support through ongoing medical and mental health care relationships
Warning Signs

- A warning sign does not mean automatically that a person is going to attempt suicide, but it should be responded to in a serious & thoughtful manner.
- Do not dismiss a threat as a cry for attention!

What kinds of warning signs are cause for concern?
Specific Warning Signs

- change in eating and sleeping habits
- withdrawal from friends, family, and regular activities
- violent actions, rebellious behavior, or running away
- drug and alcohol use
- unusual neglect of personal appearance
- marked personality change
- persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- loss of interest in pleasurable activities
- not tolerating praise or rewards
A teenager who is planning to commit suicide may also:

- complain of being a bad person or feeling rotten inside
- give verbal hints with statements such as: I won't be a problem for you much longer, Nothing matters, It's no use, and I won't see you again
- put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- become suddenly cheerful after a period of depression
- have signs of psychosis (hallucinations or bizarre thoughts)
Use of Antidepressants & Suicide

- The FDA calls on clinicians to balance increased risk of suicidality with clinical need and to monitor closely “for clinical worsening, suicidality or unusual changes in behavior.” The need for close monitoring during the first few months of treatment and after dose changes was particularly stressed.

- Studies suggest that, for appropriate youths, the risk of not prescribing antidepressant medication is significantly higher than the risk of prescribing: The 2% increased risk of suicidality cited by the FDA may be an overestimate; there is a negative correlation between antidepressant prescribing and completed adolescent suicide; very few adolescent suicide victims were found to have recent exposure to antidepressant medications; and the increase in adolescent suicides following the warning appears to correlate to a documented reduction of antidepressant prescribing.
Guidance for Pediatricians

- Ask adolescents about mood disorders, use of drugs and alcohol, suicidal thoughts, bullying, sexual orientation and other risk factors associated with suicide via routine history-taking. Consider using a depression screening instrument at 11- to 21-year-old health maintenance visits and as needed.
- Educate yourself and your patients about the benefits and risks of antidepressants.
- Recognize the medical and psychiatric needs of the suicidal teen, and work closely with families and other health care professionals in the management and follow-up of those who are at risk or have attempted suicide. Develop working relationships with colleagues in the community. Ensure good communication, continuity and follow-up through the medical home.
Guidance for Pediatricians

- Become familiar with local, state and national resources related to suicide prevention in youths.
- Consider additional training in diagnosing and managing adolescent mood disorders, especially if practicing in an area underserved by mental health professionals.
- During routine evaluations, ask whether firearms are kept in the home and discuss with parents the increased risk of adolescent suicide with the presence of firearms. For teens at risk of suicide, advise parents to remove guns and ammunition from the house, and secure supplies of prescription and over-the-counter medications.
Screening in Primary Care Setting

Columbia-Suicide Severity Rating Scale (C-SSRS)  http://cssrs.columbia.edu/

- **Simple.** Ask all the questions in a few moments or minutes — with no mental health training required to ask them. Anyone can use it, including counselors, nurses, teachers, students, coaches, resident assistants, and social workers.

- **Efficient.** Use of the C-SSRS redirects resources to where they’re needed most. It reduces unnecessary referrals and interventions by more accurately identifying who needs help — and it makes it easier to correctly identify the level of support a person needs, such as patient safety monitoring procedures, counseling, or emergency room care.

- **Effective.** Real-world experience and data show that the scale has helped prevent suicide.

- **Free.** The scale and the training on how to use it are available free of charge for use in community and healthcare settings, as well as in federally funded or nonprofit research.

- **Universal.** The C-SSRS is suitable for all ages and special populations in different settings and is available in more than 100 country-specific languages. The scale was originally created for use with children and is available in versions specifically for younger children, as well as for those with autism or other developmental or intellectual disabilities.

- **Evidence-supported.** An unprecedented amount of research has validated the relevance and effectiveness of the questions used in the C-SSRS to assess suicide risk, making it the most evidence-based tool of its kind.
## Suicide Ideation Definitions and Prompts:

**Past month**

### Ask Questions 1 and 2

#### 1) Wish to be Dead:
Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?

*Have you wished you were dead or wished you could go to sleep and not wake up?*

#### 2) Suicidal Thoughts:
General non-specific thoughts of wanting to end one's life/commit suicide, “I've thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.

*Have you had any actual thoughts of killing yourself?*

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

### 3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):

Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it… and I would never go through with it.”

*Have you been thinking about how you might do this?*

### 4) Suicidal Intent (without Specific Plan):
Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to “I have the thoughts but I definitely will not do anything about them.”

*Have you had these thoughts and had some intention of acting on them?*

### 5) Suicide Intent with Specific Plan:
Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

*Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*

### 6) Suicide Behavior Question

*Have you ever done anything, started to do anything, or prepared to do anything to end your life?*

Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

If YES, ask: *Was this within the past 3 months?*

### Response Protocol to C-SSRS Screening (Linked to last item marked “YES”)

**Item 1** Behavioral Health Referral
**Item 2** Behavioral Health Referral
**Item 3** Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
**Item 4** Behavioral Health Consultation and Patient Safety Precautions
**Item 5** Behavioral Health Consultation and Patient Safety Precautions
**Item 6** Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

**Past 3 months ago or less:** Behavioral Health Consultation and Patient Safety Precautions
Suicide Safety Planning


- Prioritized written list of coping strategies and resources for use during a suicidal crisis
- Helps provide a sense of control
- Uses a brief, easy-to-read format that uses the individual’s own words
- Can be used as a single-session intervention or incorporated into ongoing treatment
- Usually takes 20 to 40 minutes
Suicide Safety Planning

- Identify the Warning Signs “How do I know when to use the Safety Plan?”
- Internal coping strategies that could be employed without the assistance of another person
- People or social settings that could serve as a distraction
- Information for reaching out to friends or family members for help Information for contacting professionals and agencies
- Making the environment safe (i.e., limiting access to lethal means)
Tips for Parents

- Prioritize interacting with them in positive ways
- Increase their involvement in positive, life-affirming experiences
- Monitor *appropriately* child’s whereabouts and communications (i.e., texting, Facebook, Twitter) with the goal of keeping them safe
Tips for Parents

- Get involved and be aware of child's friends
- Communicate regularly with other parents in the community
- Limit child’s access to guns, knives, alcohol, prescription pills, and illegal drugs
- Communicate regularly with the child’s school to ensure optimal safety and care for the child in the school setting
Tips for Parents

- Talk with your child about your concerns and ask directly about suicidal thoughts
- Explain value of therapy and potential for medication management of symptoms
- Address your concerns with other important adults in your child’s life
- Discuss concerns with your child’s doctor to get appropriate mental health referrals
- Talk with people in the school who can provide support and guidance
Seek Professional Help

- Be safe, not sorry!
- Take appropriate action when needed to protect your child
- Feel that something is not right
- Notice warning signs in your child (including worsening signs)
- Recognize if your child has a lot of risk factors for suicide and few protective factors
Seek Professional Help

- Find a mental health provider that has experience with suicidal youth
- Choose a mental health provider with whom you and your child feel comfortable
- Participate actively in therapy with your child
- Call 911, local crisis response (if available) or take your child to a hospital in case of an emergency
- Suicidal thoughts or behaviors are a mental health emergency
Intervention Programs

- Psychotherapy is an important component in the management of suicidal ideation and behaviors.
- There are two documented effective psychotherapies for treating those who attempt suicide:
  - Cognitive behavior therapy (CBT)
  - Dialectical behavioral therapy (DBT) for youth diagnosed with borderline personality disorder and recurrent suicidal ideation.
Intervention Programs

- There are other promising interventions!
- Family therapy
- Medications
Partner with Schools & Community

To prevent suicide:

- Work with schools to ensure that educational suicide prevention programs are offered
- Collaborate with schools on the development of peer gatekeeper programs related to identifying at-risk peers and encouraging them to seek help
- Work with local sections of national suicide prevention organizations to have optimal suicide prevention programming available in your community
Immediate Prevention Help

- Available 24/7:
  - National Suicide Prevention Lifeline: [http://www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)
    1-800-273-TALK (8255)
  - The Trevor Project, a national organization providing crisis intervention and suicide prevention services to LGBTQ youth:
    - [http://www.thetrevorproject.org/](http://www.thetrevorproject.org/)
      1-866-488-7386
Online Prevention Resources

Take Action!

- For more information on suicide in children and adolescents,
  - Frequently Asked Questions (FAQ) about Teen Suicide Prevention: [http://marinschools.org/SafeSchools/Documents/SMH/SuicidePreventionFAQs.pdf](http://marinschools.org/SafeSchools/Documents/SMH/SuicidePreventionFAQs.pdf)
Questions?