

Suicide Prevention with Children and Adolescents

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Disclosures

Nothing to disclose.



Data on Child and Adolescent Suicide

- Suicide is the second leading cause of death for children, adolescents, and young adults age 5-to-24-year-olds.
- The majority of children and adolescents who attempt suicide have a significant mental health disorder, usually depression.
- Among younger children, suicide attempts are often impulsive. They may be associated with feelings of sadness, confusion, anger, or problems with attention and hyperactivity.

Data on Child and Adolescent Suicide

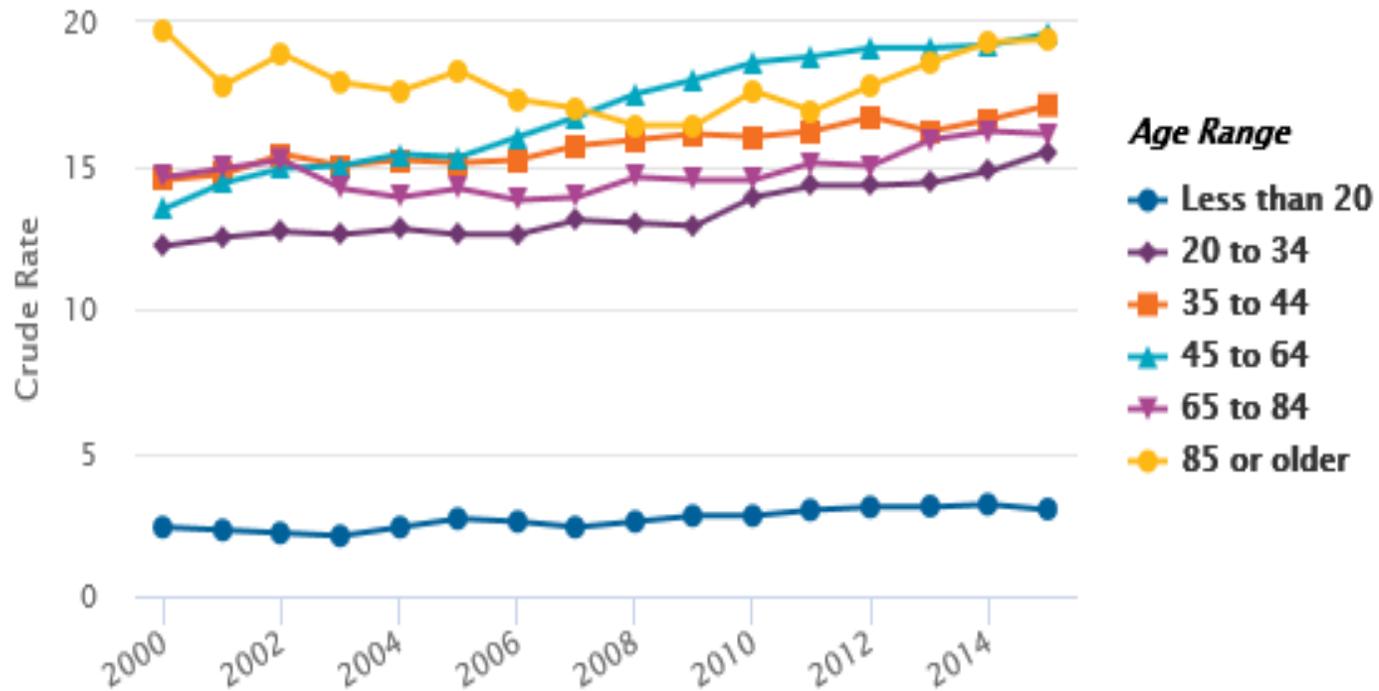
- Among teenagers, suicide attempts may be associated with feelings of stress, self-doubt, pressure to succeed, financial uncertainty, disappointment, and loss. For some teens, suicide may appear to be the **only** solution to their problems.
- Thoughts about suicide and suicide attempts are often associated with depression.

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

Prevalence

Suicide Rates by Age from 2000 to 2015



Highcharts.com

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.
- Actuarial methods, clinical judgement and self-report methods are inherently flawed and will not capture everyone who is at **imminent** risk.
- **Clinical judgment is the key factor to prevention.** What can and cannot be modified at this moment.
- Most people who inherently have risk factors for suicide will **not** engage in suicidal behaviors.

Risk and Protective Factors

- **Risk factors** – Increase likelihood that a young person will engage in suicidal behavior (Mostly distal factors)
Intrapersonal, Social/situational, cultural environmental
- **Protective factors** – Mitigate or eliminate risk
Intrapersonal, Social/situational, cultural, environmental
- **These are the reasons for living that the child gives to you**
i.e. “Why I haven’t or won’t take my life.”

Risk Factors: Intrapersonal

- Mental disorders (particularly depression)
- Hopelessness, helplessness, guilt, worthlessness
- Previous suicide attempt
- Alcohol and other substance use disorders
- Disciplinary problems
- High risk behaviors
- Sexual orientation confusion
- Male gender (Girls have higher rate of attempts)

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 and non-belongingness
- Victim of bullying or being a bully

Risk Factors: Cultural/Environmental

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

Protective Factors aka “Reasons for Living”

- 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 - Continued

- 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
- **MAKE NO ASSUMPTIONS. VERIFY THAT PATIENT DOES REALLY SEE IT AS A PROTECTIVE FACTOR.**



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!
- Children and adolescents thinking about suicide may make openly suicidal statements or comments such as, "I wish I was dead," or "I won't be a problem for you much longer."

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 contemplating 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)

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 that are in bold and underlined. | YES | NO |
| 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? <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u> | | |
| 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." <u>Have you had any actual thoughts of killing yourself?</u> | | |
| 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 a 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." <u>Have you been thinking about how you might do this?</u> | | |
| 4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as oppose to "I have the thoughts but I definitely will not do anything about them." <u>Have you had these thoughts and had some intention of acting on them?</u> | | |
| 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. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u> | | |
| 6) Suicide Behavior Question <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> 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: <u>Was this within the past 3 months?</u> | Lifetime | |
| | 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
- Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

- If already using the PHQ-9, pay close attention to question #9.
- If patient endorses 1, 2, or 3, inquire further.

#9. **Thoughts** that you would be better off dead or of hurting yourself in some way. 0 1 2 3

Communicating with Suicidal Patients

not talking about suicide
won't make it go away



1-800-273-Talk

“Are you suicidal?”

- The patient may not identify their experience as being “suicidal”
- They are hopeless and in pain and just want the pain to stop.
- “Suicidal” may carry stigma in mind of patient (crazy, mentally ill, etc.)
- Patient may think you and others would view them as being weak, with no resilience
- Patient fears you may over-react
- Individuals who are genuinely intent on taking their lives do not want you or anyone else to thwart or prevent their efforts.

“How are you feeling?” (Too Broad)

- Likely to be met with a rote, socially acceptable reply: “*fine.*”
- Commits patient to “being well” and patient loses face if they have to amend their answer later in the interview.

Avoid Using Psychological Jargon or Evasive Questions

“Are you having thoughts of hurting yourself or others?”

“Do you feel you are a danger to yourself or others?”

- Affront to self-esteem:

- Patient considers self a decent person who does not wish to “hurt” others, and does not want to be considered dangerous or a menace to society

- Implies a Taboo:

- They know, at a certain level that we are referring to suicide, but because we side-stepping a direct question, we give subtle message that the subject is shameful or taboo.

- Impersonal:

- It distances the questioner from a sincere inquiry; we are trying to check-off a box on a form and move on, rather than listen to what the patient is actually experiencing

Asking the Negative

“You’re not having any thoughts of suicide, are you?”

- Implies you do not want to hear an affirmative answer

DO ASK Open-ended Questions

- “In what situations do you think it’s okay to take your own life?”
- “If you were dead, who do you think would miss you?”
- “What do you hope will soon be different?”
- “ You said that you thought about killing yourself last week. What stopped you?”

Asking questions in this manner will get the patient to tell you the reasons that they want to live.

➤ Remember: Patient ambivalence buys you and them time to come to another way of thinking.

Validate and Normalize

Overcoming a client's anxiety or hesitancy by letting them know that others have experienced the same thoughts, feelings, or behaviors.

Underlying Principles:

- Clients are more apt to give valid details if they think their experience is “normal.”

➤ Example:

- *“Many of my patients tell me that, at times, the pain of their depression can be so great that they have thoughts of wanting to kill themselves. Have you ever had any thoughts like that?”*

Avoid correcting their thinking as it will only shut them down more. Validate their pain and experience.

Involving Parents/Guardians

- Does the patient's family know about their suicidal thoughts? If not, what is the patient's hesitation?
- How do they think their family would react?
- Let the patient know why you think it is in their interest to enlist their family's aid.
- Let consumer decide how much they are comfortable sharing

“How would you like your family to ask if you are feeling like things are getting really bad?”

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
- Do whatever possible to eliminating the means for suicidal behavior in the home.
- 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

When to Call Mobile Crisis/Police

- The child endorses a realistic and organized method to kill themselves, reports having access to means for suicide and verbalizes positive intent to execute same.
- Recent “acts of furtherance.” (Child already began the process)
- Parents report feeling that they are unable to keep the suicidal child safe at home without placement in an acute psychiatric unit where they are directly observed 24 hours per day.
- Suicidal child presents as very agitated in office and you believe there is a strong possibility of violent behaviors.
- If parents insist on transporting child to closest ED, contact local police to have them provide escort and ensure that child gets there.

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



Suicide Hotlines

Available 24/7:

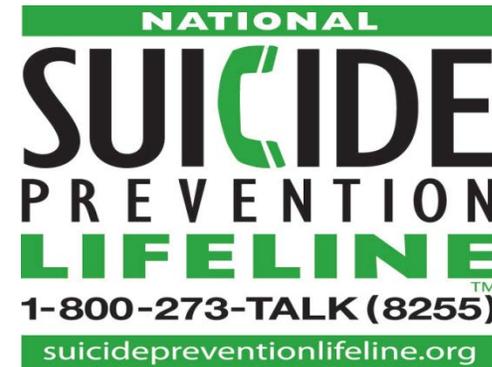
National Suicide Prevention Lifeline:
<http://www.suicidepreventionlifeline.org>

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/>

1-866-488-7386



THE **TREVOR** Lifeline
866.488.7386

**YOU ARE
NEVER
ALONE**

TheTrevorProject.org

Online Prevention Resources

- National Association of School Psychologists: http://www.nasponline.org/resources/crisis_safety/suicideprevention.aspx/
- American Association of Suicidology: <http://www.suicidology.org/>
- American Foundation for Suicide Prevention: <http://www.afsp.org/>
- Society for the Prevention of Teen Suicide: <http://www.sptsusa.org/>
- Youth Suicide Prevention Program (YSPP): <http://www.yspp.org/>

Aftermath of Suicide

- American Association of Suicidology: Suicide Loss Survivors – Books and Resources.

<http://www.suicidology.org/suicide-survivors/suicide-loss-survivors>

Take Action!

For more information on suicide in children and adolescents:

- American Psychological Association
<http://www.apa.org/topics/suicide>
- American Association of Suicidology
<http://www.suicidology.org/>
- Frequently Asked Questions (FAQ) about Teen Suicide Prevention:
<http://marinschools.org/SafeSchools/Documents/SMH/SuicidePreventionFAQs.pdf>

