Suicide Prevention for Adolescents

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Suicide Trends

- 3rd leading cause of death in youth.
  - Prior suicide attempts = 7%
  - Serious suicidal thoughts = 15%
- Among youth (15-24), there is one suicide for every 100-200 attempts
- 60% of us will know someone who commits suicide
  - Up to 20% will know someone in their family

Rates of Suicide

- National Suicide rates = 10.42*
  - Homicide = 6.97
- Geographic Differences:
  - Northeast = 7.57
  - South = 11.53
  - Midwest = 10.02
  - West = 11.82

* Mortality rate (per 100,000 deaths)
Annual Suicide Rates for Males and Females Aged 10 to 19 Years in the United States, 1996 Through 2005

Teachers: The First Line of Defense
- Identification is a critical first step!
- 99% of teachers have known a student at risk for suicide
- Yet knowledge of risk factors/screening is limited:
  - Able to identify a specific behavioral warning sign = 47%
  - Lack of awareness of key risk factors = 80%
  - Misinformation about risk factors = 73%

Myths vs. Facts

Scouller and Smith (2002)
Myths versus facts...

MYTH:
People who talk about suicide don't complete suicide.

FACT:
Many people who die by suicide have given definite warnings to family and friends of their intentions.

Always take any comment about suicide seriously.

American Foundation for Suicide Prevention

Myths versus facts...

MYTH:
Suicide happens without warning.

FACT:
Most suicidal people give many clues and warning signs regarding their suicidal intention.

American Foundation for Suicide Prevention

Myths versus facts...

MYTH:
Males are more likely to be suicidal.

FACT:
Men COMPLETE suicide more often than women.
Women ATTEMPT suicide three times more often than men.

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Myths versus facts...

**MYTH:** Asking a depressed person about suicide will push him/her to complete suicide.

**FACT:** Studies have shown that patients with depression have these ideas and talking about them does not increase the risk of them taking their own life.

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Myths versus facts...

**MYTH:** Improvement following a suicide attempt or crisis means that the risk is over.

**FACT:** Most suicides occur within days or weeks of "improvement" when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts.

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Myths versus facts...

**MYTH:** Once a person attempts suicide the pain and shame will keep them from trying again.

**FACT:** The most common psychiatric illness that ends in suicide is Major Depression, a recurring illness. Every time a patient gets depressed, the risk of suicide returns.
Myths versus facts...

**MYTH:**
Sometimes a bad event can push a person to complete suicide.

**FACT:**
Suicide results from serious psychiatric disorders not just a single event.

American Foundation for Suicide Prevention

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Myths versus facts...

**MYTH:**
Suicide occurs in great numbers around holidays in November and December.

**FACT:**
Highest rates of suicide are in April while the lowest rates are in December.

American Foundation for Suicide Prevention

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Risk Factors for Suicide

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Risk Factors

- Static
- Psychiatric
- Social/Environmental
- Acute

Risk Factors: Static

- Family history of suicide or suicide attempts
- Male gender
- Parental mental health problems
- Gay or bisexual orientation
- History of physical or sexual abuse
- Previous suicide attempt

Risk Factors: Psychiatric

- Most common psychiatric risk factor resulting in suicide:
  - Depression*
    - Major Depression
    - Bipolar Depression
    - Alcohol & Drug Abuse
    - Schizophrenia
  - Other psychiatric risk factors
    - Post Traumatic Stress Disorder (PTSD)
    - Eating disorders
    - Non-Suicidal Self-Injury
Suicide and Non-Suicidal Self-Injury

- NSSI is different from suicide
  - Intent/function
  - Lethality & Method
- Yet, NSSI is a major risk factor for suicide
  - Second only to suicidal ideation!
- Understand, manage, and treat differentially
- Carefully monitor
  - assess interdependently

Risk Factors: Social/Environmental

- Access to firearms or other lethal means
- Impaired parent-child relationship
- Living outside of the home
  - Homeless
  - Corrections facility
  - Group home
- Difficulties in school, falling grades, not attending school
- Social isolation
- Recent interpersonal loss
- Stressful life events (legal, romantic difficulties, parent conflict)
- Recent suicides/attempts in school or social group
- Summer unemployment

Risk Factors: Acute

- Agitation
- Intoxication
- Recent stressful life event
  - Family & Relationship
- Recent suicide/attempts
- Recent improvement!

What is my role in Suicide Prevention?

• Screening & Early Identification
• Initial Assessment
• Assess & Address Lethality
• Referral
  ▪ Crisis Services
  ▪ Treatment
• Active monitoring
Universal Screening

- Teen Screen
  - Comprehonsive approach
  - Screens all students to identify at-risk students
  - Few false negatives
- But...
  - May require parental consent
  - A lot of work!
  - Need to follow-up (many false positives)
  - Must have effective referral sources for evaluation and treatment
  - Screening is only one point in time; need multiple, ongoing screenings

Targeted Screening

- General depression/mania scales:
  - Strengths & Difficulties Questionnaire
  - http://www.sdqinfo.com/
  - Child Mania Rating Scale
  - Reynolds Adolescent Depression Scale
  - Child Behavior Checklist (CBCL/TCL)
  - Behavior Assessment Scale for Children (BASC)
- Suicide-Specific Scales:
  - Suicide Probability Scale
  - Scale for Suicide Ideation
  - Suicidal Ideation Questionnaire

Suicide Scales are Not Enough

“Self-administered suicide scales are useful for screening normal, high-risk, and patient populations. They cannot substitute for a clinical assessment, and their tendency is to be oversensitive and underspecific. At this point, suicide scales alone do not have a predictive value. A child or adolescent who is positive on a suicide scale should always be assessed clinically.” (p. 38)

AACAP Practice Parameter
Asking about Suicide

- Separate from parents
  - Discuss limits of confidentiality
- Set the mood
  - Open-ended, non-threatening, general questions:
    - “Aside from XYZ, how have you been doing?”
    - “What kind of things have been stressing you out lately?”
    - “How have things been going with [school, friends, parents, sports]?”
  - Follow-up with more detailed questions

Asking about Suicide

Depression Symptoms

- “Everyone feels sad, angry, or irritable at times. How about you?”

Suicide

- “Have you ever thought about killing yourself or wished you were dead?”
  - If Yes: nature of past and present thoughts and behaviors, time frame, intent, who knows and how did they find out
- “Have you ever done anything on purpose to hurt or kill yourself?”
- “If you were to kill yourself, how would you do it?”
- Find out if firearms are in the house

She Said “Yes!” Now What??

Remain calm
  - Empathetic expression & voice tone
  - Acknowledge the deep despair
    - “You’ve come really close to killing yourself.”
    - “Sounds like things have been really difficult.”

Provide reassurance
  - You’ve heard them
  - You will help

Immediately arrange crisis care
Assess for Depression

Diagnostic Criteria

DSM-IV Major depression episode

- Persistent depressed mood or irritability for at least 2 weeks and:
  - Motivation, sleep, appetite, concentration, and energy disturbances
  - Guilt, suicidal thoughts or behaviors
  - Impairment in psychosocial functioning
- Not only due to other psychiatric and medical conditions

SPACE DRAGS

S - Sleep disturbance
P - Pleasure/interest (lack of)
A - Agitation
C - Concentration problems
E - Energy (lack of) or fatigue
D - Depressed mood
R - Retardation movement
A - Appetite disturbance
G - Guilt, worthless, useless
S - Suicidal thought

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Signs & Symptoms in Youth

<table>
<thead>
<tr>
<th>Symptom of Major Depression</th>
<th>Manifestation in Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritable or cranky mood;</td>
<td>Predisposition with using语气 that suggest life is meaningless</td>
</tr>
<tr>
<td>Depressed mood most of the day</td>
<td>Failure to gain weight as normally expected</td>
</tr>
<tr>
<td>Preoccupation with song lyrics that suggest life is meaningless</td>
<td>Frequent complaints of physical pain</td>
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<tr>
<td>Loss of interest in once-favorite activities</td>
<td>Excessive late-night TV or video games</td>
</tr>
<tr>
<td>Decreased interest/enjoyment in once-favorite activities</td>
<td>Refusal to wake for school in the morning</td>
</tr>
<tr>
<td>Loss of interest in sports, video games, and activities with friends</td>
<td>Psychomotor agitation/retardation</td>
</tr>
<tr>
<td>Failure to gain weight as normally expected</td>
<td>Frequent complaints of physical pain</td>
</tr>
<tr>
<td>Anorexia/bulimia</td>
<td>Frequent complaints of physical pain</td>
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<td>Refusal to wake for school in the morning</td>
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</tr>
<tr>
<td>Psychomotor agitation/retardation</td>
<td>Frequent complaints of physical pain</td>
</tr>
<tr>
<td>Insomnia or hypersomnia</td>
<td>Refusal to wake for school in the morning</td>
</tr>
<tr>
<td>Fatigue or loss of energy</td>
<td>Frequent complaints of physical pain</td>
</tr>
<tr>
<td>Loss of appetite; feelings of guilt</td>
<td>Frequent complaints of physical pain</td>
</tr>
<tr>
<td>Decreased ability to concentrate; inversion</td>
<td>Frequent complaints of physical pain</td>
</tr>
<tr>
<td>Recurrent suicidal ideation or behavior</td>
<td>Frequent complaints of physical pain</td>
</tr>
</tbody>
</table>

Depression Measures

- Columbia DISC Depression Scale
  - Youth & Parent
- Kutcher Adolescent Depression Scale
  - Youth
- Patient Health Questionnaire – 9
  - Youth
- Kiddie SADS Semi-Structured Interview, Major Depression Module
  - Clinician

Assess for Mania
Diagnostic Criteria

DSM-IV Manic episode
- Persistent elevated, expansive, or irritable mood for at least one week and:
  - Inflated self-esteem; decreased need for sleep; talkativeness; racing thoughts; distractibility; increased activity; and daring behaviors
  - Impairment in psychosocial functioning
- Not only due to other psychiatric and medical conditions

DSM-IV Hypomanic episode: less intensity than mania, at least 4 days

Signs & Symptoms of Mania
- Increased energy, activity, and restlessness
- Excessively "high," overly good, euphoric mood
- Extreme irritability
- Racing thoughts and talking very fast, jumping from one idea to another
- Distractibility, can't concentrate well
- Little sleep needed
- Unrealistic beliefs in one's abilities and powers
- Poor judgment
- Spending sprees
- A lasting period of behavior that is different from usual
- Increased sexual drive
- Abuse of drugs, particularly cocaine, alcohol, and sleeping medications
- Provocative, intrusive, or aggressive behavior
- Denial that anything is wrong

GRAPES
- Grandiosity
- Racing Thoughts
- Activity is goal directed, hypersexual
- Pressured Speech
- Elation/ elevated or expansive mood
- Sleep need is decreased

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Assess for Alcohol/Drugs

Alcohol/Drugs: CAGE

Do you ever drink alcohol? If yes then . . .
- Have you ever felt the need to Cut down on your drinking?
- Have people ever Annoyed you by criticism of your drinking?
- Have you ever felt Guilty about your drinking?
- Have you ever taken a morning Eye opener to steady your nerves or get rid of a hangover?

Alcohol/Drugs: CRAFFT

- Have you ever ridden in a Car driven by someone (including yourself) who was high or had been using alcohol or drugs?
- Do you ever use alcohol or drugs to Relax, feel better about yourself, or fit in?
- Do you ever use alcohol or drugs while you are by yourself Alone?
- Do you ever Forget things you did while using alcohol or drugs?
- Do your Family or Friends ever tell you that you should cut down on your drinking or drug use?
- Have you ever gotten into Trouble while you were using alcohol or drugs?
Assess & Address Lethality

- **Firearms** most lethal suicide method
  - 55% of all suicides
  - 54% of rural & 18% of innercity families have firearms
  - Only 1/3 safely store firearms
- Assess other methods (drugs, poisons, etc…)
- Brief intervention with parents:
  - Ask about firearm ownership/storage
  - Help parent assess positives/negatives of current storage method (motivational interviewing)
  - Discuss safe storage
  - Provide trigger locks


The limits of evaluation

“We may know the risk factors, but knowledge of the risk factors will not permit the psychiatrist to predict when or if a specific patient will die by suicide.”


Interventions for Suicide Risk

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Suicide Awareness Curriculum

- Presentations, statistics, and videotapes about the consequences of failing to help suicidal peers
  - Signs of Suicide program
- Rationale: At-risk youth turn to other youth, not adults
- Relatively effective
  - Modest increases in knowledge, attitude, help-seeking
  - Decreases attempts up to 40%
- Concern about social contagion

Aseltine and DeMartino, 2004; 2007

Skill Development Curriculum

- Focus on problem-solving, coping, and cognitive skills; increasing positive social support
  - Reconnecting Youth Program
- Universal or targeted
- Pros:
  - Less social contagion
  - Easily implemented
  - Reduces suicidal thoughts and hopelessness
  - Increases coping knowledge and ability
- Con: Unclear if it helps the high-risk students

Active Monitoring

- Schedule frequent visits
  - 40% of suicidal events occur in first 4 weeks of treatment
- Prescribe regular exercise and leisure activities
- Recommend a peer support group
- Review self-management goals
- Follow-up with students via telephone
- Provide students and families with educational materials

Brent, JAAJCAP.2009;48:987-996;
South Elgin High School Suicide Prevention Program

Primary Goals:

- Education:
  - Challenge incorrect/undesirable attitudes about suicide
  - Educate about major depression
  - Reduce stigma and fear associated with seeking help
- Screen for at-risk students
- Intervene with at-risk students

Jerry Ciffone: http://www.u-46.org/sehs/spp/

South Elgin High School Suicide Prevention Program: Components

- Written intervention policies for all staff
- Freshman orientation presentations
- Reduce access barriers and stimulate self and peer referrals
- Assessment, intervention, and referral with on-site social workers
- Structured classroom discussions on mental health, mental illness, and suicide to all 10th-grade students in health class
- Prevention information materials for distribution to all 10th-grade students
- Formal and informal evaluations of prevention message effectiveness
- Follow-up screening mechanism for pro-suicide attitudes
- Intervention with at-risk students
- Postvention component to be used following any student death

Jerry Ciffone: http://www.u-46.org/sehs/spp/

More Than Sad
No-Suicide Contracts

- History:
  - Began as a “No-suicide decision” questionnaire
  - Developed for daily assessment & monitoring
  - Morphed into a “no-suicide contract”
  - Now a pseudo-legal agreement
- Are they helpful?
  - Limited evidence
  - Most data = suggest no effect
  - Some data = dangerous
- Recommendation:
  - Do not use “Contracts”
  - Instead, develop a suicide prevention plan

Peers

- Training influential teen peer leaders
  - Identification and referral
  - Focus on coping strategies (Sources of Strength program)

Anti-Bullying Strategies

- Bullying Child
- Henchmen
- Supporter
- Passive Supporter
- Victim
- Defender
- Passive Defender
- Passive Defender
- Disengaged Onlookers

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Psychotherapy

Cognitive Behavioral Therapy
- Identify and change negative or distorted thoughts
- Increase prosocial behavior & problem solving

Interpersonal Therapy
- Focuses on how depression relates to relationships
- Modify interpersonal relationships via skills and therapeutic relationship

Medication

SSRIs: medication of choice
- Refer for non-responders, comorbid conditions

Efficacy
- Mixed evidence (ES from .26 to .68)
- Some evidence for CBT and medication

Monitor medication response weekly
- Symptoms (e.g., PHQ-9)
- Suicidal ideation/behavior

Side-effects

Antidepressants

Selective serotonin reuptake inhibitors:
- Fluoxetine (Prozac), Sertraline (Zoloft), Paroxetine (Paxil), Fluvoxamine (Luvox), Venlafaxine (Effexor), Citalopram (Celexa) and Escitalopram (Lexapro).

Atypical antidepressants:
- Bupropion (Wellbutrin), Nefazodone (Serzone), Trazodone (Desyrel), and Mirtazapine (Remeron).

Tricyclic antidepressants
- Amitriptyline (Elavil), Clomipramine (Anafranil), Imipramine (Tofranil), and Nortriptyline (Pamelor).

Monoamine oxidase inhibitors
- Phenelzine (Nardil), and Tranylcypromine (Parnate).
BlackBox Warning

SSRI = “activating effect”
- Increased energy comes before mood improvement

FDA
- 1991 = Not enough evidence
- 2004 = Increased risk for youth & young adults
  - Relative risk for suicidality = 1.95 for RX
  - 4% in RX vs. 2% in Placebo
- Later adult data = No increased risk

Odds of suicidality (ideation or worse) for active drug relative to placebo by age in adults with psychiatric disorders

<table>
<thead>
<tr>
<th>Age range</th>
<th>Odds ratio (95% CI)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0-24</td>
<td>1.62 (0.97 to 2.71)</td>
<td>0.76 (0.53 to 1.08)</td>
</tr>
<tr>
<td>25-34</td>
<td>0.78 (0.53 to 1.14)</td>
<td>0.93 (0.66 to 1.34)</td>
</tr>
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<td>35-44</td>
<td>0.78 (0.53 to 1.34)</td>
<td>0.93 (0.66 to 1.34)</td>
</tr>
<tr>
<td>45-54</td>
<td>0.76 (0.53 to 1.10)</td>
<td>0.93 (0.66 to 1.34)</td>
</tr>
<tr>
<td>55-64</td>
<td>0.63 (0.40 to 1.01)</td>
<td>0.76 (0.49 to 1.10)</td>
</tr>
<tr>
<td>65-74</td>
<td>0.53 (0.22 to 1.33)</td>
<td>0.76 (0.49 to 1.10)</td>
</tr>
<tr>
<td>75-84</td>
<td>0.74 (0.68 to 0.98)</td>
<td>0.83 (0.69 to 1.00)</td>
</tr>
<tr>
<td>All ages overall</td>
<td>0.83 (0.69 to 1.00)</td>
<td>0.83 (0.69 to 1.00)</td>
</tr>
</tbody>
</table>

Effect of Warning

- 20% decrease in antidepressant medications
- Yet no increase in psychotherapy
- 70% drop in diagnosis of depressive disorders
- Increased rate of suicide among youth
  - United States = 8-14%
  - Largest 1-year increase in 15 years
  - Canada = mortality rate increase from 4 to 15
  - Netherlands = 49%

Bridge, Gibbons, Lineberry, Libby, 2007
Population rates of major depressive disorder (actual and predicted) by age group (male and female individuals combined).
Therapy & Medications?

Rates of Response in the Treatment for Adolescents with Depression Study (TADS)

Depression:
- Fluoxetine may help in the early stage

Suicidal Ideation:
- Decreased for all groups, but more so with CBT

Treatment of Adolescent Suicide Attempters (TASA) Study

- 124 Adolescents with depression (MDD)
- 90-day history of suicide attempt
- 6-month treatment study:
  - Antidepressant medication
  - CBT focused on suicide prevention
  - Combination treatment
- Combination treatment decreased suicidality/depression similar to non-suicidal focused CBT

Policy Recommendations

- Know the risk level of your school
  - Anonymous surveys, screenings
- Assess what faculty/staff know about suicide
  - Correct misinformation
- Provide staff training & development
  - Make sure ALL employees know the risk factors
  - Make sure ALL employees know what to do in response to acute risk factors
- Review suicide prevention policies annually
  - Recommendations change!
- Collaborate with community agencies, universities

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Thank you!

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