Suicidal ideation and attempts in children and adolescents:

Key assessment and treatment aspects
Outline of presentation

1. Key assessment factors
2. Key psychosocial treatment factors
3. Key biological treatment factors
4. A clinical screening model
5. Population-based strategies
1. ‘At risk’ groups of young people

- completed suicide risk factors are not specific for a given individual, that is, they have a limited predictive validity, but they do alert clinicians to a clinical group that are at risk for completed suicide and that therefore need specific preventative strategies to be put in place

-Brent et al. (1993):

1. mood disorder
2. alcohol/substance abuse/dependence disorder
3. conduct disorder
4. past history of suicidal behaviour
5. family history of suicidal behaviour
6. schizophrenia
7. personality disorder
1. **Key assessment factors**

- check to see the child/adolescent’s expectations of death from suicide – some believe they will come back, there is life after death or that after punishing others by their suicide they can come back

- **warning signs:**
  - marked decline in school performance and levels achieved
  - skipping classes and opting out of school activities generally
  - poor concentration, sleepiness, inattentiveness
  - unusually disruptive or rebellious behaviour
  - death or suicide themes dominate written, artistic or creative work
  - loss of interest in previously pleasurable activities
  - inability to tolerate praise or rewards
1. Key assessment factors

- **warning signs:**
  - interpersonal behaviour
  - giving away prized possessions
  - sudden changes in relationships, for example, exhibiting disruptive behaviour
  - withdrawing from friends and social involvements
  - not wanting to be touched by others
  - previous suicide attempts
  - communication difficulties
  - apathy about dress and appearance
  - sudden change in weight, mood, sense of humour, personality style
1. Key assessment factors

- warning signs:
  - running away from home
  - accident proneness
  - sleeping pattern changes
  - self-mutilation behaviours
  - noticeable increase in compulsive behaviour
  - sudden happiness after prolonged period of depression
  - unrealistic expectations held of self
  - reckless thrill seeking behaviour (hanging out of trains; provoking fights; promiscuous sexual behaviour; alcohol and drug use)
1. Key assessment factors

- **warning signs:**
  - verbal expression of suicidal intent or ‘depression’
    - Direct statements – “I wish I were dead” “I’m going to end it all”
    - Indirect statements – “No one cares if I live or die” “Does it hurt to die?”
1. Key assessment factors

- adolescent suicidal behaviour:
  - motivated by revenge
  - an act of anger or irritation
  - impulsive
  - romantically and idealistically driven
  - related to low self-esteem
1. Key assessment factors

- adolescent suicidal behaviour:
  - adolescents don’t necessarily look or seem sad
  - they engage in certain activities to escape from their sad thoughts
  - antisocial behaviour (start to drink, take drugs, fight, commit acts of vandalism, run away from home, or become sexually promiscuous)
  - may emphasise profound boredom; feeling unloved; lonely
  - may in response to favourable events describe brief windows of normal mood which may belie underlying ‘depression’
1. Key assessment factors

- warning signs:
  Episodic stressful precipitants
  - in trouble with school authorities or police
  - breaking up with boyfriend or girlfriend
  - feared pregnancy
  - major family dysfunction
  - refusal by significant other to provide anticipated help, support or love
1. Key assessment factors

- **warning signs:**
  Chronic stressful life situations – in home life and interpersonal relationships
  - chronic depression or mental illness in parents
  - incest or child abuse
  - severe parental conflict
  - family involvement with drug or alcohol abuse
  - poor communication with parents
  - pressures for high achievement to gain parental approval or acceptance
  - inability to relate well to peers
  - sexual promiscuity
  - feelings of worthlessness, being a burden or having let parents or others down
  - feelings of guilt, failure, having no control over their lives
2. Key psychosocial treatment strategies for adolescent suicide attempters

Most adolescent suicide attempts occur outside normal office hours
  – 24 hour community based response teams
  – flexible working arrangements
  – youth friendly emergency departments
  – 24 hour help lines

Community training programs (warning signs, referral sources and procedures) that target members who may have frequent contact with youth (clergy, doctors, police etc.)

Means restriction

Postvention and cluster prevention – screen for at risk youth (survivor groups)
2. Key psychosocial treatment strategies for adolescent suicide attempters

Primary intervention
- reducing the likelihood of antecedent conditions (eg mental disorders, comorbidity)
- strengthening protective factors (eg family cohesion, help seeking behaviour etc)
- skill based training in schools (depression management skills training; anger and aggression management skills; loneliness prevention; interpersonal problem solving skills; competency enhancement skills; critical viewing skills; help seeking behaviour skills)

Secondary intervention
- early detection and treatment of risk factors

Tertiary prevention
- reduce long-term psychiatric disability
- thorough and effective rehabilitation programming
- community support for chronically suicidal young people
2. Key psychosocial treatment strategies for adolescent suicide attempters

Individual psychotherapy:
- a competent assessment of the risk of further suicidal behaviour, the precipitants and context of the suicide attempt, the presence of coexisting psychopathology, and the availability of supports
- a decision whether to hospitalize
- cognitive therapy
- problem solving therapy
- affect management
- family work – communication, conflict resolution and affect regulation within the family
2. Key psychosocial treatment strategies for adolescent suicide attempters

Individual psychotherapy

- Focus on the erroneous assumptions and beliefs that occur in the suicidal adolescent
- A typical false logic that can arise in an egocentric teenager is “he argued with me, therefore he does not love me, therefore nobody must love me, therefore I am unloveable”
- Gently challenge these assumptions and assist them to recognize that s/he is overgeneralizing from a specific incident
- Drawing conclusions from minimal or even absent evidence
- Over or underestimating the significance of events
- Dichotomous thinking (seeing things as ‘black or white’)
- Catastrophising
- Some adolescents project all the blame for an event on to others
- Or take personal responsibility for events that have multiple causes
- - therefore reattribution of blame
- Invite them to generate a list of alternative actions – suicide may be included as an option
- Problem solving therapy
- Social skills training – teach how to communicate more effectively
- Recognition and regulation of anger before it escalates to suicidal behaviour – recognise tension (feeling thermometer)
2. Key psychosocial treatment strategies for adolescent suicide attempters

Family treatment
  – psychoeducational approach
  – communication skills
  – conflict resolution
  – orientate the parents toward limit setting in a non-coercive way (sensitive to the developmental needs of the adolescent but still provides containment)
2. Key psychosocial treatment strategies for adolescent suicide attempters

- continue to monitor safety
- there is no consensus concerning the optimum length of treatment and follow up
- a sensible approach involves a period of intense intervention followed by intermittent low-intensity contract.
- do not let the adolescent decide whether or not it is necessary to continue appointments – it is likely they will interpret this to mean “you don’t need to come” and some could feel that they are being rejected by the clinician
2. Key psychosocial treatment strategies for adolescent suicide attempters

- School based interventions
  - In-service training of teachers to improve knowledge of mental illness, its early detection and management of disruptive behavioural disorders
  - Secondary consultation on how to deal with behavioural problems
  - Tertiary consultation on dealing with particular students with behavioural problems
  - School based assessment and counselling services
  - Support to children experiencing grief, trauma, loss, parental discord or mental illness
  - Programs that aim to reduce school violence, bullying and racism to promote healthy relationships
  - Develop policy and programs to reduce drug use by young people (including teacher professional development, parent involvement and strategies for identifying and monitoring at risk students)
  - Developing programs that teach pro-social behaviours to adolescents
  - Classroom Peer psychoeducation regarding what to do if your friend is talking of suicide (primary prevention and a secondary prevention)- discussion of relevant facts, statistics, myths, warning signs, available community resources (and how to use them) help-seeking and problem solving skills and development in the areas of stress management, communications and social coping
  - Screening programs – questionnaires
  - School drop out prevention / school enhancement programs
  - Provide staff and students with information about mental health resources
2. Key psychosocial treatment strategies for adolescent self harmers

- mental state exam (presence of psychotic symptoms, intoxication, dissociative states, and cognitive functioning)
- frequency, duration, and onset of the self-harming behaviour as well as the antecedents and consequences. Ask about the first, last, most severe, and most typical incidents
- assess for suicidal ideation, plan and intent as well as risk factors of suicide
- enquire about medical complications
- drug and alcohol
2. Key psychosocial treatment strategies for adolescent self harmers

Learn to understand
- explore the meaning of the self harm including triggers, thought feelings etc
- may be possible for the young person to develop an understanding of the self-harm in context of life events and relational interactions
- if possible address the function of the self harm eg to feel in control = other effective methods of gaining control
2. Key psychosocial treatment strategies for adolescent self harmers

Validation
- allow emotional ventilation
- offer reflective statements
- communicate that their responses make sense and are understandable within their current life context
- validation of their emotions – assist them to observe and identify feelings

Emotional regulation skills
- identifying emotions
- obstacles to changing emotions
- reducing vulnerability to stress
- increasing positive emotional events
- applying distress tolerance techniques

Problem solve
- identify current problem
- generate, evaluate and implement alternative solutions that might have been used or could be used in the future

Use of relationship
- strengthen coping behaviour by praise and positive regard
- find alternative behaviour to their problem behaviour that can be reinforced
2. Key psychosocial treatment strategies for adolescent suicide attempters and/or self harmers

Survivor groups:
- to meet with others who have had a similar traumatic experience
- to normalise their experience by discovering that others have had similar experiences and reactions
- to learn more about suicide/self harm and share information
- to give and receive help
- giving help is one way to create something positive out of a traumatic event
- to break the isolation and alienation these individuals feel
- provide an environment where positive changes will be supported
- to dispel the myths of suicide/self harm, and be active in education sessions
3. **Key biological treatment factors**

Linked to comorbid disorders:

Depressive (and anxiety) disorders: dysthymic disorder and/or major depressive disorder

Disruptive behaviour disorders: oppositional defiant disorder through to conduct disorder ADHD – inattentive type, combined type

Alcohol and substance abuse/dependence disorders: Cannabis; metamphetamine; cocaine
3. Key biological treatment factors

- SSRI medication
- TCA medication
- Stimulant medication
- Neuroleptic medication
3. Key biological treatment factors

- **SSRI medication**
  - primary treatment for anxiety and depressive disorders
  - slow titration to optimal level
  - adverse effect profile includes increased suicidal potential BUT this is rare
3. Key biological treatment factors

- **TCA medication**
  - potentially very helpful for anxiety symptoms
  - adverse effects profile includes cardiotoxic effects that require monitoring at changes of dosing
3. Key biological treatment factors

- **Stimulant medication**
  - Primary treatment for ADHD symptoms
  - Potent mood regulation effects as well
  - Optimal effect when emotionally salient cues present
3. Key biological treatment factors

- Neuroleptic medication
  - Primarily risperidone
  - Positive mood regulation, cognitive and behavioural effects
  - Longer term motor adverse effects require monitoring
4. Clinical screening: an approach

NHMRC Guidelines - Depression in young people - 1997

SJ Edwards 4Rs:

**recognising the signs** - numerous accidents; dangerous risky behaviours; discussing death/morbid themes; giving away favourite possessions

**raising the issue** - ask directly; talk alone; discuss limits confidentiality; allow time for empathic and reflective responses; ask permission to broach sensitive areas and/or obtain collaborative history; be aware of practitioner responses - denial of suicide risk possibility; anger towards self harming patients; anxiety about misdiagnosis and/or feeling unprepared
4. Clinical screening: an approach

risk assessment-

How prominent are the suicidal thoughts?
How hopeless, helpless, futile is the person?
How clear and lethal are the plans?
How available is the method?
How developed is the plan?
How confiding, trusting and available are the person’s interpersonal links?
How dangerous have prior suicide attempts been and what triggers have been associated with them?

A visual analogue scale as well as verbal indicators can be used to assess severity
4. **Clinical screening: an approach**

**responding-**

- arrange close supervision/family support  
- remove all sources of danger  
- establish contact and develop rapport  
- maintain contact  
- consider a ‘no-suicide’ contract  
- referral to a community assessment and treatment team; mental health clinician; consultant psychiatrist; hospital emergency department and/or adolescent inpatient unit  

- reasons for referral include the following:  
  severe depression; manic symptoms; psychotic symptoms; treatment non-responsive; community treatment not available; basic care not available; uncontained serious threat
4. Management of the individual young person

- establish ideas of self harm

- establish a change in one or more life domains
  - person’s thinking pattern and/or thinking content
    confusion or unusual clarity and resolve
  - person’s emotional state either extreme of
    (dis)inhibition flat, unresponsive or overly
    ‘friendly’ and solicitous
  - person’s behaviour in particular settings or
    in all settings: risky behaviour, self care,
    drug and/or alcohol use, school/work performance,
    withdrawal versus ‘gifts’ of parting
4. Management of the individual young person

- empathic engagement with the young person; ability to tolerate silence
- establish the boundaries of confidentiality; ‘what is and what is not’
- detailed assessment of meaningful links—confiding, trusting interpersonal relationships; family and peer
- establish a working alliance that involves close contact, supervision, and monitoring of the young person’s emotional life, behaviour, and cognitions
5. Population strategies to decrease the incidence of Youth Suicide

Data collection:
- Coroner’s working party on youth suicide
- Adolescent cohort studies: deliberate self-harm, depression, substance abuse

Service provision:
- Register of crisis counselling services in the telephone directory
- Same sex attracted services
- Homeless services (for example, Homeless Agencies Resource Project)
- Rural services: specific high risk groups, professorial research/evaluation units
- Drug and Alcohol services linked in with mental health services, schools, and community agencies
5. Population strategies to decrease the incidence of Youth Suicide

Service provision:
- National training programme: Suicide Prevention Australia Training Package
- School-based programmes: in service training of teachers; school-based assessment and counselling services; specific care for children experiencing parental discord and/or mental disorder, grief, trauma

Key future direction:
- improved links between services and public and private sectors