Understanding Trends and Preventative Factors in Teen Suicidality

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CE Webinar

Understanding Trends and Preventative Factors in Teen Suicidality

Featuring

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Brad Simpson, DSW, LCSW

Presented by

Evolve Adolescent Behavioral Health

Sunrise Residential Treatment Center

Questions

Please use the **Q&A** box to submit any questions that come up throughout the presentation.

Chat

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Objectives

1. Identify the prevalence of suicidality among adolescents in the United States
2. Understand developmental causes associated with suicidality
3. Identify three interventions to help reduce vulnerability to suicidality in adolescents
4. Identify three essential components in suicide intervention/prevention coaching.

The U.S. Youth Mental Health Crisis

Nationally representative sample of high school students (N = 17,232 in 2021)

The Percentage of High School Students Who:*	2011 Total	2013 Total	2015 Total	2017 Total	2019 Total	2021 Total	Trend
Experienced persistent feelings of sadness or hopelessness	28	30	30	31	37	42	
Experienced poor mental health†	–	–	–	–	–	29	–
Seriously considered attempting suicide	16	17	18	17	19	22	
Made a suicide plan	13	14	15	14	16	18	
Attempted suicide	8	8	9	7	9	10	
Were injured in a suicide attempt that had to be treated by a doctor or nurse	2	3	3	2	3	3	

Among U.S. high school students, nearly all indicators of poor mental health and suicidal thoughts and behaviors increased from 2011-2021 (CDC, 2023).

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Emergence of SITBs

Incidents of SITBs are rapidly increasing across adolescents into young adults—starting at approximately age 12.

Among adolescents from both inpatient and outpatient samples:

- The first onset of suicidal ideation was reported to begin 4-6 months before the first engagement of non-suicidal self-injury (NSSI)
- The first onset of NSSI preceded suicide planning by 3-6 months and suicide attempts by 1-2 years

NSSI and suicidal ideation may emerge at around the same time or suicidal ideation may emerge somewhat before NSSI.

Emergence *continued*

Most youth transitioned from suicidal ideation to suicide planning or attempting within the first year after the onset of their first suicidal thought.

63% of adolescents transition from suicidal ideation to suicide planning within 1 year

86% of adolescents transition from suicidal ideation to suicide attempt within 1 year

88% of adolescents transition from suicide planning to suicide attempt within 1 year

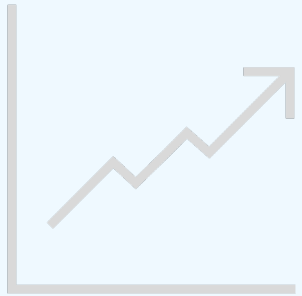
Research Gaps

Evidence suggests that an understanding of the concept of death first begins to form around age 5

- The transition from early to middle childhood may be another vulnerable period for the emergence of SITBs

Few studies exist focusing on child samples with youth between 9-12, with far fewer in the 3-8 age range.

Research gaps remain regarding when or how SITBs first emerge and progress across early childhood into adolescence



Research Gaps *continued*

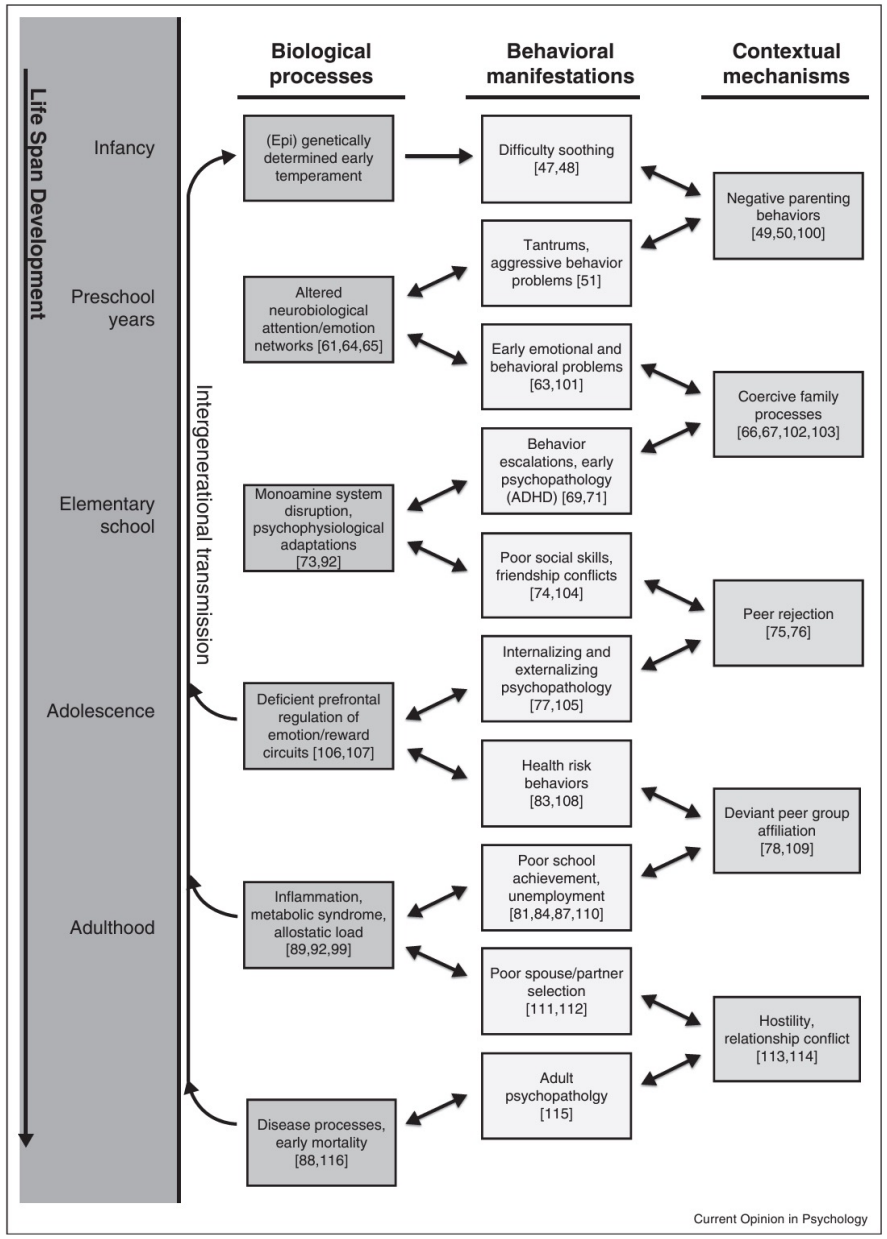
There is little known on the risk for SITBs from the first emergence to suicidal behavior, as well as the risk factors that predict transitions among SITBs.

There are still many questions that need to be researched, including:

- Understanding the risk for SITBs from the first emergence to suicidal behavior.
- What predicts and influences the transition between ideation and behavior?
- How do interactions among multiple risk factors predict the emergence and course of SITBs from childhood into adulthood?

Lifespan Development Model of Emotional Dysregulation

(Biological, Behavioral and Contextual Processes)



life span developmental model of emotion dysregulation across biological, behavioral, and contextual domains (See refs. [47–51•'3–78,81,83,84,87–89•,92,99–116]).

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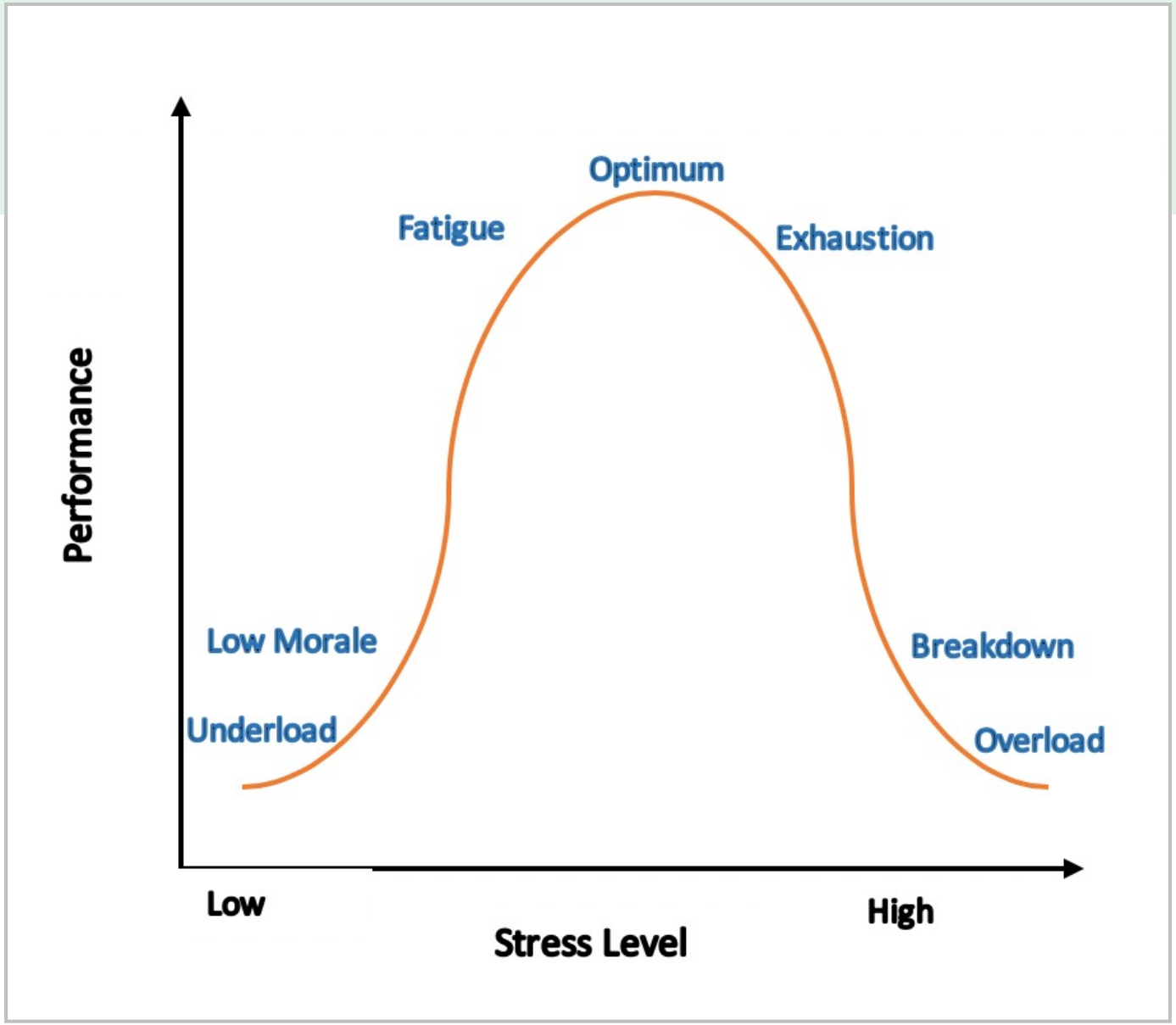
Allostatic Load



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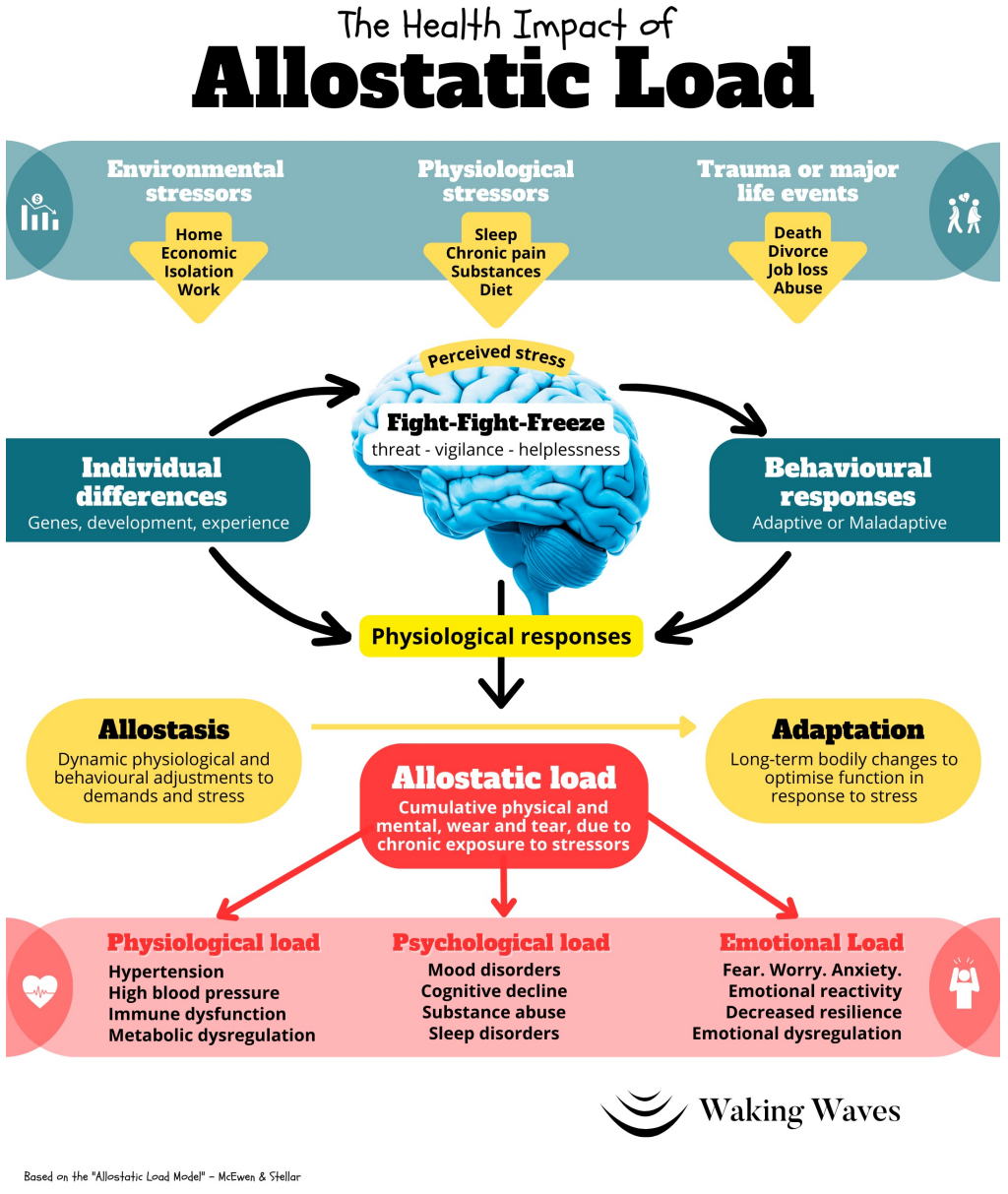
Allostatic Load



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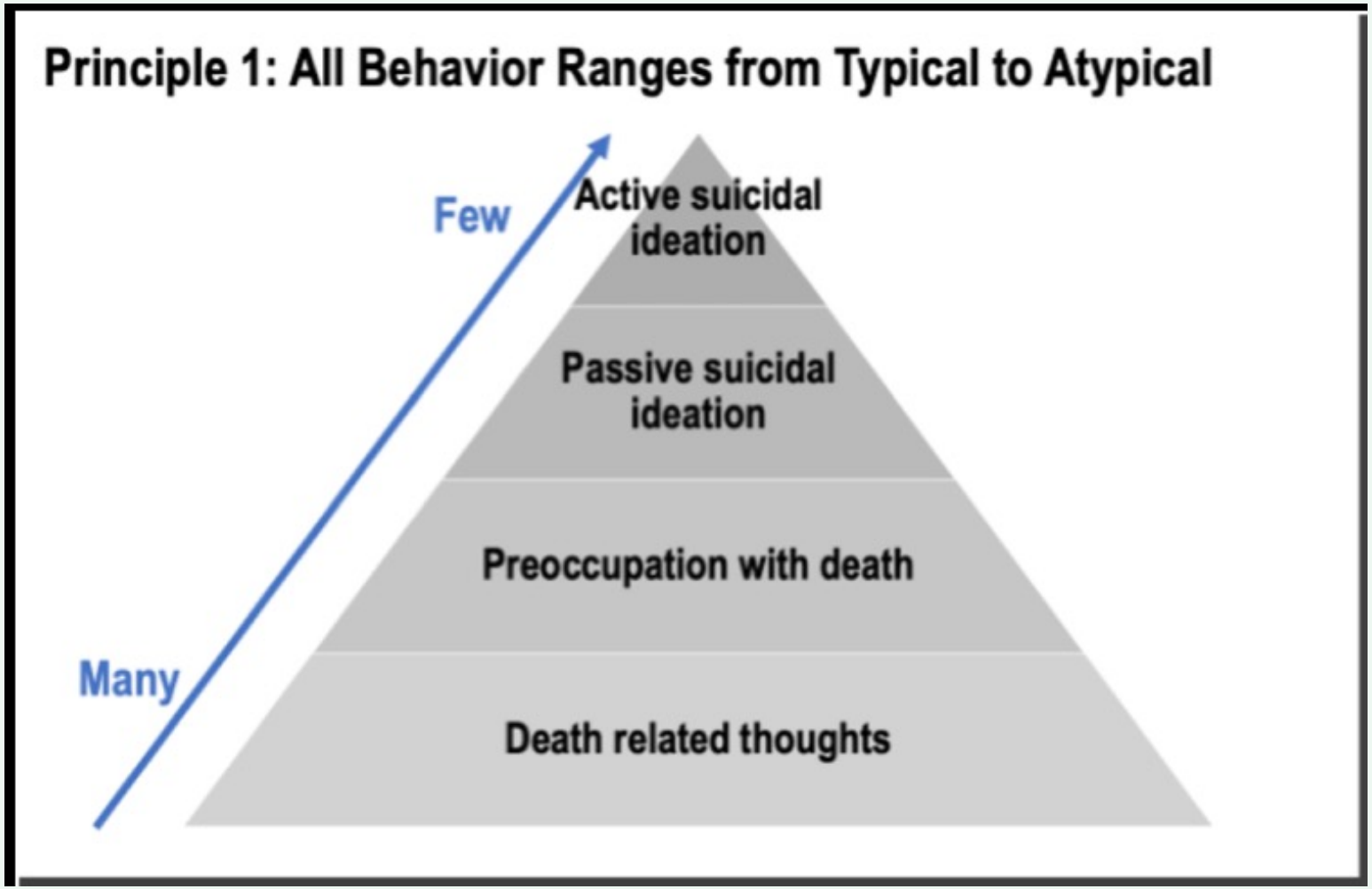
Principle 1



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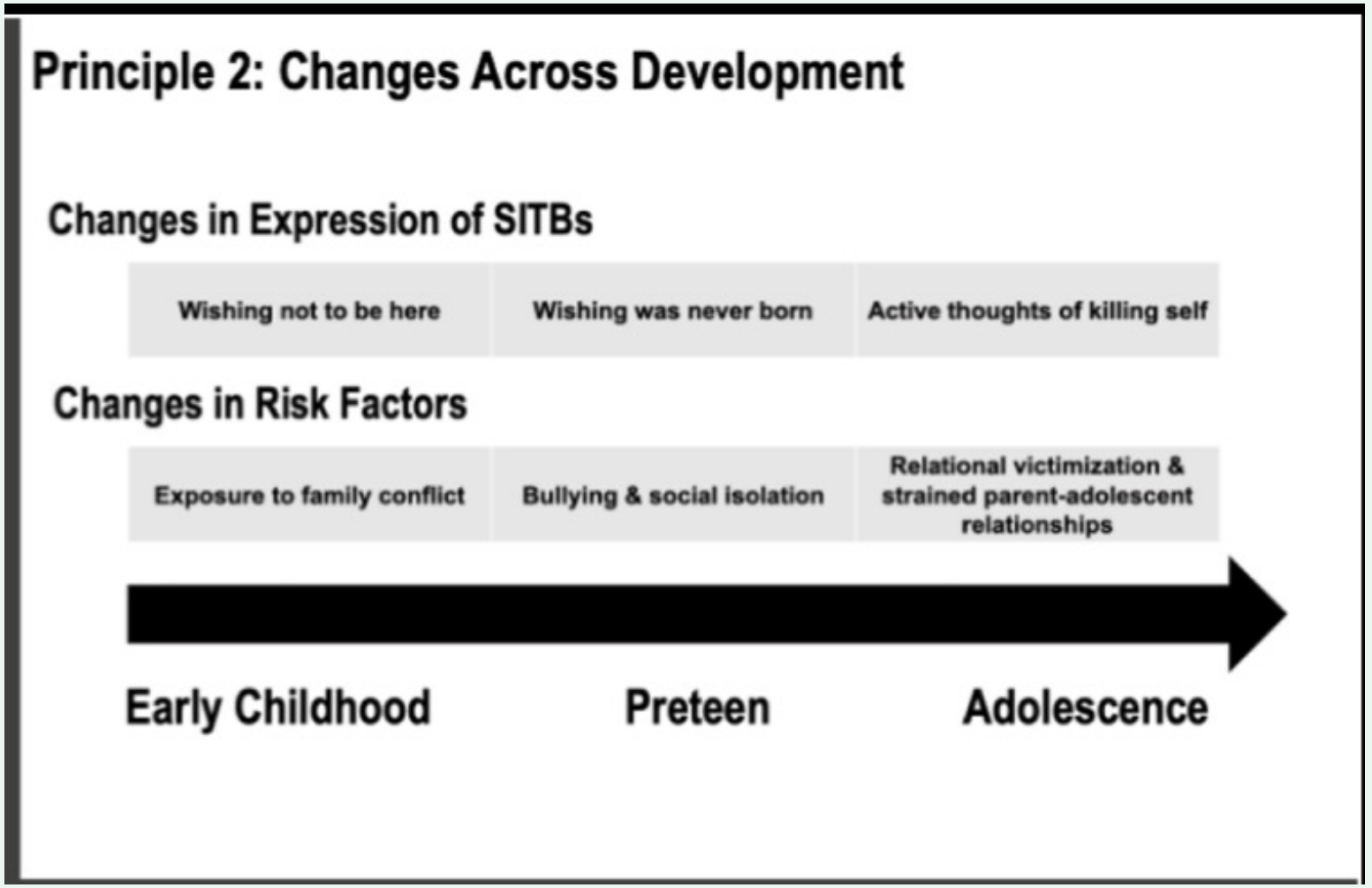
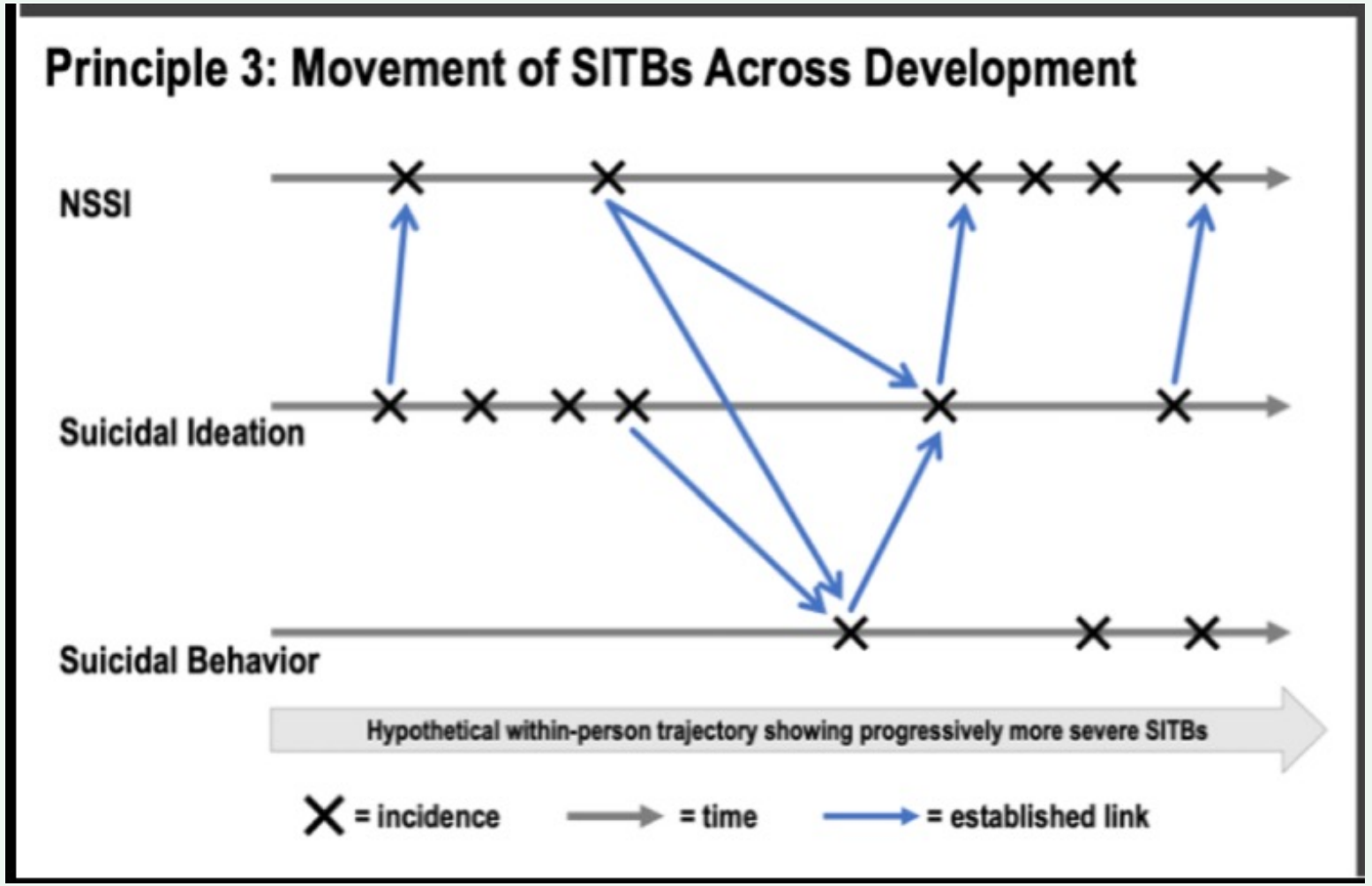
Principle 2


Principle 2: Changes Across Development
Changes in Expression of SITBs
Wishing not to be here
Wishing was never born
Active thoughts of killing self
Changes in Risk Factors
Exposure to family conflict
Bullying & social isolation
Relational victimization & strained parent-adolescent relationships
Early Childhood
Preteen
Adolescence

Principle 3



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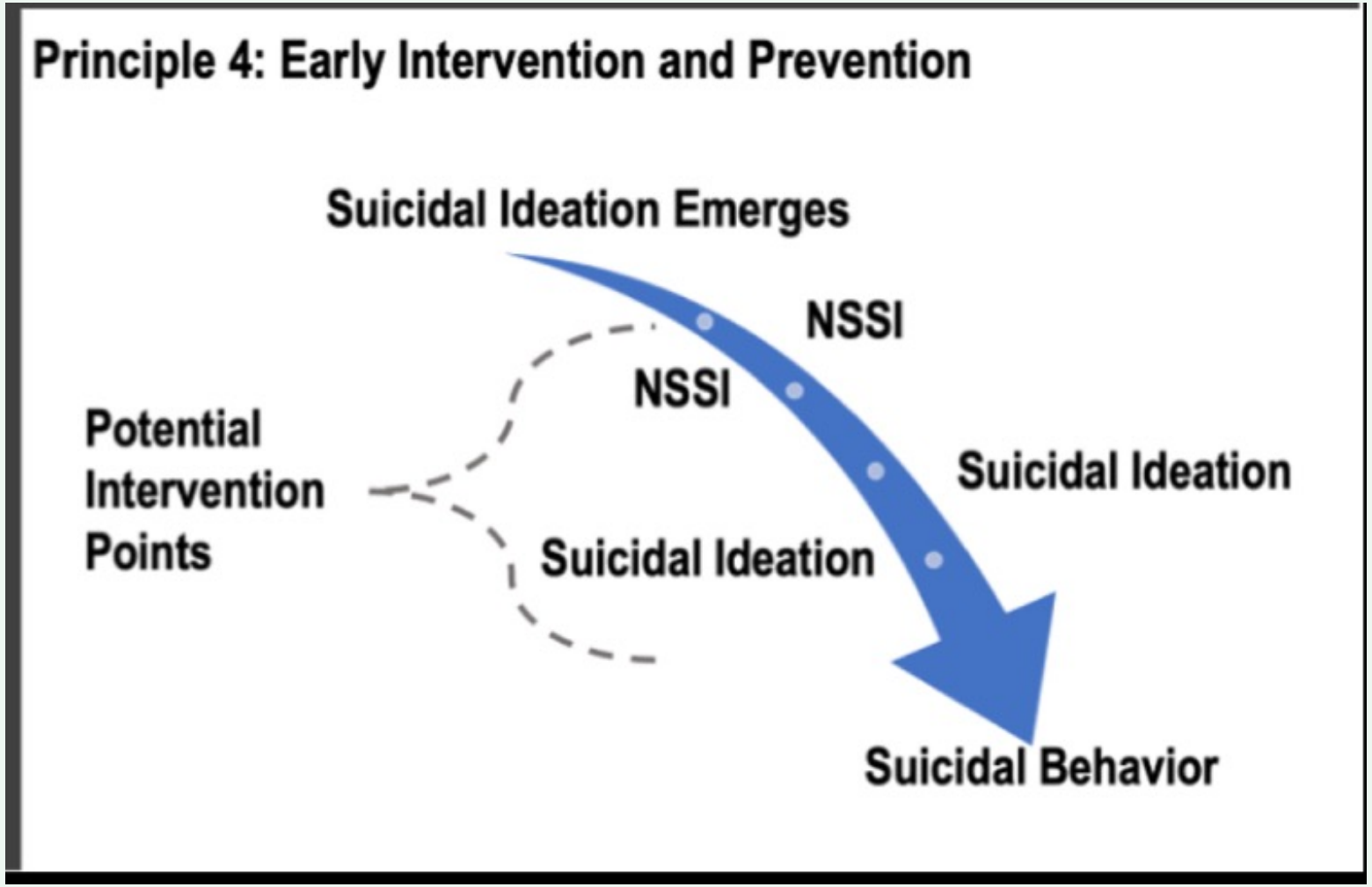
Principle 4



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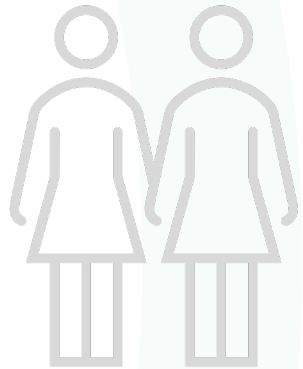
Mother Daughter Dyad

Examination of mother-daughter behavioral and psychophysiological reactivity during a conflict discussion using nonlinear dynamics to assess asymmetrical associations within time-series data.



Predictions:

1) Mothers/evocative behaviors would affect behavioral and psychophysiological reactivity among depressed and, especially, SII adolescents
2) Adolescents/behaviors would not evoke mothers' behavioral or physiological reactivity
3) Control teens and mothers would be less reactive, with no dynamic associations in either direction

Mother Daughter Dyad Findings

In dyads with a self-injuring teen, mother behavior drove the teen's physiological and behavioral responses

In dyads with a depressed teen, mother behavior drove teen behavioral response but not her physiology

In dyads with a typical control teen, mother behavior did not drive teen physiological or behavioral responses

Mother Daughter Dyad Findings

Across all groups, teens behavior did not have a driving effect on mother behavior or her physiology.

Findings support sensitivity theories on the development of self-injurious behaviors.

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Risk Versus Protection

Risk:

What makes someone vulnerable to suicidal ideation and behaviors

- Not definitive
- May be cumulative

Protection:

What keeps/prevents someone from acting on suicide urges

- May also be cumulative
- Should be highlighted during crisis intervention

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General Risk Factors

INDIVIDUAL

- Prior attempts
- Mental health dx
- Current substance use
- Serious illness
- Loss of job, property, money, home, etc.
- Impulsivity
- Hopelessness

RELATIONAL

- Isolation
- Loss due to divorce, death, etc.
- A loved one has died of suicide
- High conflict relationship

SOCIETAL

- Lack of treatment
- Suicides in the community
- Access to lethal means (i.e., firearms)
- Stigma
- Community violence

Additional Teen Risk Factors

INDIVIDUAL

- Recent loss of privileges
- Recent academic challenges or failures

RELATIONAL

- Being bullied
- Recent break-up
- Rejection from a social group
- Rumors and gossip
- School isolation

SOCIETAL

- More sources of contagion:
  - Suicide on social media
  - Celebrity suicides

Protective Factors

- Hope
- Supportive relationships
- Potential impact on others
  - Pets, romantic partner, friends
- Life goals – Life Worth Living Goals
- Fear of death
- Fear of accidental serious injury
- Religious and/or cultural condemnation of suicide

Risk Assessment & Management Tools

- **Columbia Suicide Severity Rating Scale (CSSRS)**
  - Thorough history of suicidal ideation, behavior, and lethality
  - Assesses recent and lifetime occurrences

- **P4 Screener**
  - “4 P’s”: past attempts, suicide plan, probability of completing suicide, and preventive factors

- **Linehan Risk Assessment and Management Protocol (LRAMP)**
  - Utilized in DBT
  - Focuses on risk assessment and management

LRAMP

- Created by Marsha Linehan, PhD, ABPP
- Includes Seven Sections:
    1. Reason for completion
       (new reports of SI, increased SI, suicide communication, recent attempt, etc.)
    2. Description of behavior that occurred
    3. Suicide risk assessment
    4. Acute suicide risk factors
    5. Suicide protective factors
    6. Suicide risk management
    7. Final disposition

Suicide Risk Management Steps

- **Provide emotional support through validation**

  This sounds really painful. It makes sense that you would not want to feel that way anymore.

- **Identify prompting events**
  - Helps with problem-solving and effective validation
  - *What sent you down the path to seriously contemplating suicide today?*

- **Summarize the situation**

  It sounds like the fight with your boyfriend left you feeling rejected and deeply sad. These feelings have been so intense that you started thinking about ways to end the pain, which led to thoughts of suicide. You then started planning how to get into your parent's gun safe. Does that sound right?

Suicide Risk Management Steps

- **Problem solving**
  - Can the situation creating distress be changed?

    I hear that you're feeling very lonely and that this is contributing to thoughts of suicide. Is there someone you can call or text to keep you company?
  - Can the prompting event be removed or avoided?

    I'm noticing that you tend to feel this way after spending time with certain friends. Is it possible to take a break from these friends?

- **Challenge maladaptive thoughts**
  - Wanting to escape intense emotional pain makes sense, and suicide is not an effective way to solve that problem. Suicide is a permanent solution to a temporary problem.

Suicide Risk Management Steps

- **Coach to utilize safe coping skills**
  - Distress tolerance
  - Emotion regulation

- **Reinforce safe and effective behavior**

  You kept yourself safe so far and came to me for help. Nice work! How were you able to do that?

- **Generate hope**
  - Highlight reasons for living (from protective factors)
  - Highlight ability to recover from past crises

Crisis Plan

- **Create a crisis plan** that includes safe and effective coping skills, use of support system, crisis phone lines, etc.
- **Gain commitment from the client** to abstain from suicidal behaviors and follow their crisis plan. Plan a time to check in.
- **Identify potential barriers**
  - What if the prompting event recurs?
  - What if your go-to skills aren't helping?
- **Create a backup plan**
  - Alternative problem solving
  - Alternative skills to use

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