

# CBT For Suicidal, Depressed Adolescents

Anthony Spirito, PhD, ABPP

Alpert Medical School of Brown University

# DISCLOSURES

None

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- Jeffrey Hunt, M.D.
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I Conceptual Model

II CBT for Adolescent Depression-  
Effects on Suicidality

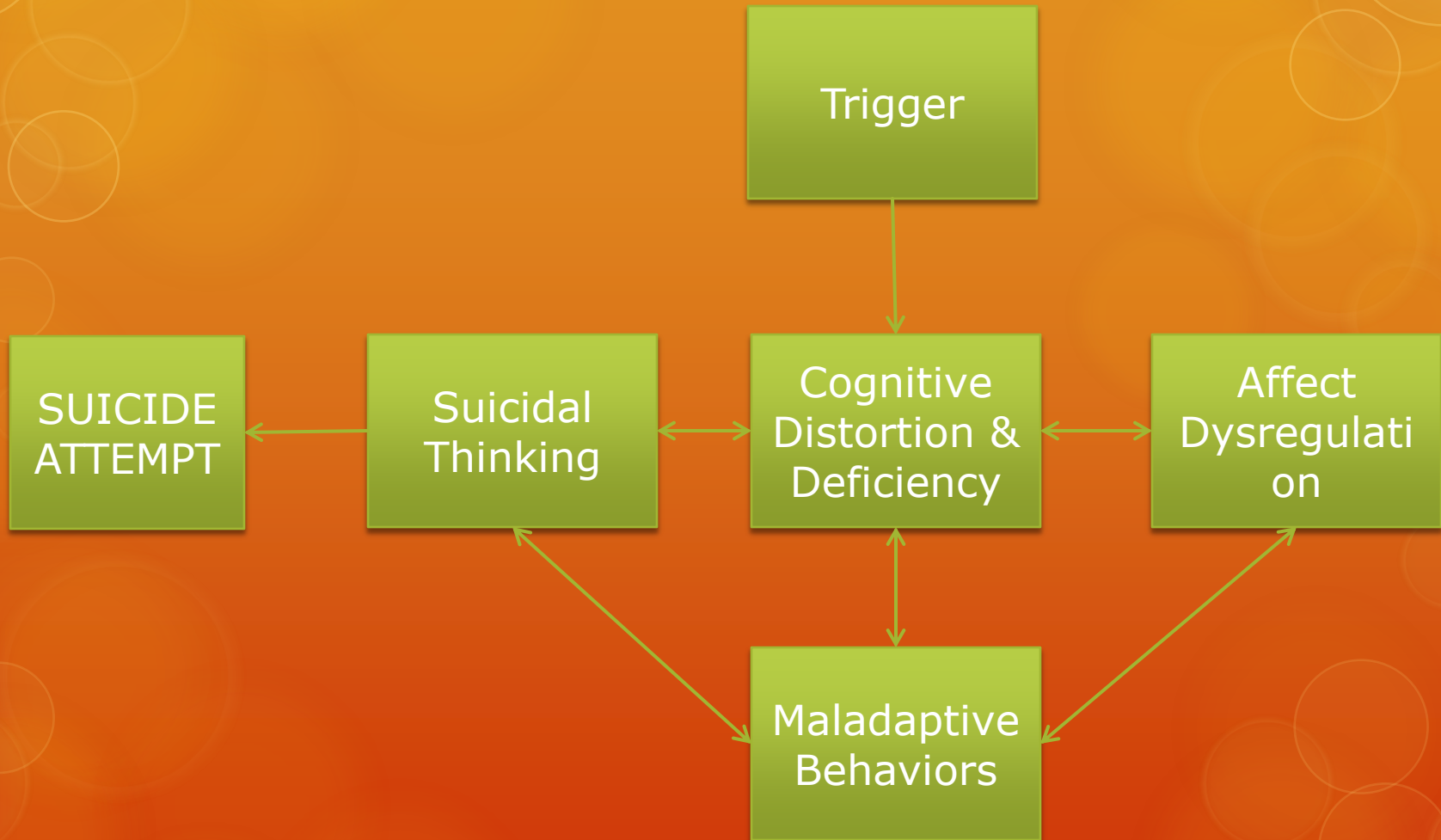
III Managing Suicidality in  
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IV Working with Parents during  
Suicidal Crises

V CBT Techniques for Suicidality

VI Special Circumstances –  
Alcohol Abuse and Suicidality

# CBT MODEL OF ADOLESCENT SUICIDAL BEHAVIOR



# Predisposing Vulnerabilities

This model posits that there is a predisposing vulnerability among youth who attempt suicide including:

Significant genetic predisposition toward psychopathology (Brent et al, 2008)

Exposure to significant negative life events, such as a history of abuse or neglect (King & Merchant,2008)

# Predisposing Vulnerabilities

Adverse parenting resulting from parental psychopathology (Melhem et al, 2007)

Peer victimization and bullying  
(Kim & Leventhal, 2008)

Vulnerabilities make it more likely that they will experience maladaptive cognitive, behavioral, and emotional responses to acute stressors



# STRESSORS

Stress, typically from an interpersonal conflict, may initially trigger a depressive episode and/or suicidal crisis in predisposed adolescents.

Higher catastrophizing, selective abstraction, overgeneralization, personalization and total cognitive errors have been found in suicidal compared to non-suicidal adolescent inpatients with a mood disorder (Brent et al, 1990)



# PROBLEM-SOLVING DEFICITS

Predisposed youth may also experience difficulties generating and/or selecting solutions to a stressor.

Suicidal adolescents report greater difficulty generating and implementing effective alternative solutions to problems compared to non-suicidal adolescents (Adams & Adams, 1996)

Suicidal youth are also more likely to view problems as irresolvable (Orbach et al, 1999)

# AFFECT DYSREGULATION

This difficulty in cognitive processing and problem-solving, which is also characteristic of depressed adolescents, can result in negative affect including anger and a worsening of the current mood state (Daniel et al, 2009)

Suicidal adolescents report greater difficulty regulating their internal states and using affect regulation skills compared to non-symptomatic adolescents (Fritsch et al, 2000)

# MALADAPTIVE COPING

Self-medication may also be used as a means to reduce negative affect via Alcohol or drugs

(Esposito-Smythers & Spirito, 2004)

Non-suicidal self-injury - cutting or burning oneself- has also been described as an emotional release (Guertin et al, 2000)

The maladaptive behavior chosen may have been modeled by parents, peers, or other important figures

# REPETITIVE CYCLE

Adolescents may cycle through this cognitive, affective, and behavioral process numerous times, with each cycle leading to greater depressed mood.

This cycle may take place over a few days, weeks, or even months. Either way, the end result of this cycle, if not interrupted, is intolerable affect and the perception that the situation is hopeless.

Adolescents may then begin to experience passive suicidal thoughts, such as “I would be better off dead” which over time may become active suicidal thoughts, and a suicide attempt, with or without prior planning, may result.

# SUICIDE ATTEMPTS

Suicidal behavior can be the outcome of this :

Distorted cognitive processing

Lack of perceived adaptive solutions

Heightened affective arousal related to the stressor

# SENSITIZATION INCREASES RISK

Once suicidal behavior occurs, it may sensitize adolescents to future suicide-related thoughts and behavior (Joiner, 2005)

Suicidal behavior makes the suicidal cognitive schema more easily accessible in future stressful situations (Beck et al, 1996)



# SENSITIZATION

Joiner (2005) suggests that suicide attempts habituate individuals to the experience of engaging in dangerous self-injurious behavior.

When combined with interpersonally-related cognitive distortions, this habituation increases the possibility of future suicidal behavior

Once the taboo against suicide has been broken, it becomes easier to view suicide as a viable solution to life's problems

## **II - CBT for Adolescent Depression – Does it affect Suicidality?**

- Do we need to specifically treat suicidality or is treatment of depression enough?
- Large studies conducted in the last decade have shown that CBT for depression in adolescents does result in reducing suicidality.
- TADS AND TORDIA

# TADS – Slight protective effect

- At 12 weeks, reductions in SI were greater for youth randomized to combination therapy than fluoxetine therapy, CBT only, or placebo, though SI was lower than baseline in all conditions.
- At 36 weeks, suicidal events were more common in patients treated with fluoxetine alone (14.7%), compared to 8.4% for combination and 6.3% for CBT alone

(March et al, 2004; 2007)

# TORDIA

- 58.5% of participants reported clinically significant SI and 23.7% reported a prior suicide attempt.
- SI decreased from baseline to post-treatment for participants across all conditions.
- 5% of participants attempted suicide and 20% experienced a self-harm related event (SI, suicide attempt, self-injurious behavior) during treatment, with no differences across conditions.

(Brent et al, 2008)

# RCTs with Adolescent Suicide Attempters

- Day Treatment (Rudd et al, 1994)
- Family (Harrington et al, 1998)
- MST (Huey et al, 2004)
- Individual CBT ( Donaldson et al, 2005)
- Group (Wood et al, 2001; Hazell et al, 2009; Green et al, 2011)
- TASA (Brent et al,2009)
- Intensive Individual CBT and Parent Training (Esposito-Smythers, Spirito, et al, 2011)

# RCTs with Adolescent Suicidality

Diamond et al (2010)- SI;attachment based family therapy

- Rossouw et al (2011);SIB – mentalization therapy
- Tang et al (2009) SI – IPT-A
- Ougrin et al (2011,2013) SIB - Therapeutic Assessment
- Asarnow et al (2011) SI/SA – ED intervention – improved adherence
- Pineda & Dadds (2013) SI/SA – Resourceful Adolescent Parent Program – Postive effect on composite score of suicidality



## Issue: Why so few studies?

- High risk period is 1-4 weeks post discharge
- Difficult-to-treat high risk sample
- Affect arousal high
- Impulse control low
- Emotional regulation poor
- Comorbidity common
- Families often dysfunctional

# Treatments of Choice?

- Most likely CBT and DBT – plus family/parent training– will be primary psychotherapies tested in future trials
- Why? Directive which is important when addressing suicidal behavior
- They have flexibility to address varying presentation and risk factors
- For example, most but not all adolescents who attempt suicide are depressed so need flexibility to address other factors than just depression

# Treatment of Choice?

- Brent et al. (1997) study on depressed adolescents indicated that nondirective, CBT, and family therapy had similar effects on depression.
- Re-analyses indicated that suicidal depressed adolescents fared less well in terms of depressive outcomes in the supportive, nondirective condition than in the CBT condition (Barbe et al., 2004)

# III – Managing Suicidality in the Course of Treatment

- Passive death wish
- Suicidal thoughts without plan or intent
- Suicidal thoughts with plan or intent
- Suicidal threat
- Interrupted attempt (by self)
- Aborted attempt (by another)
- Suicide attempt – with explicit or inferred intent to die

# CASES

○ DOES ANYONE HAVE CASES THEY WOULD LIKE TO DISCUSS AS WE GO THROUGH THESE MANAGEMENT TECHNIQUES?

# ASSESSMENT OF SI - Intensity, Frequency, Duration

- Proportion of day with suicidal thoughts.
- In a given hour, how much do you think about suicide?
- How well can you push away suicidal thoughts and think about something else (scale 1-10)
- To what extent do you think you can resist suicidal urges (scale 1- 10)
- If a teen does not report current SI, it does not mean that he/she is not at suicide risk



# PLANNING

- Do you have a preferred plan or method for committing suicide?
- What have you done to prepare for suicide?
- Have you made any plans for committing suicide?
- If you were to commit suicide, how would you attempt it?
- Have you written a goodbye letter, a suicide note or a letter of explanation?
- Have you thought about what you might say in such a note?

# Reasons For Living - Ideators

- Do you think things can improve and your future will be happier?
- Are there things you want to do that you haven't done yet?
- Do you have future plans that you want to carry out?
- Are there friends and family who will support you and want to see you do well?
- How would your friends/parents/siblings/pets feel if you committed suicide?

# ASSESSMENT AFTER A SUICIDE ATTEMPT - PRECIPITANTS

- Conflict with parents
- Conflict with peers
- Bullied
- Interpersonal loss – break-up
- School difficulties
- Legal or disciplinary crises
- Concerns about sexual orientation – primarily males

# INTENT

## ○ Motivation?

- To die or other reason for attempt
- Escape intolerable situation
- Communicate feelings
- Get help
- Make someone feel sorry
- Get revenge

# METHOD

- *What did you do? Why did you choose this method?*
- Availability of method at home, relatives, friends
- Attempts other than by overdose or superficial cutting may be predictive of higher likelihood of repeat suicide attempts and ultimately completed suicide
- Attempts of high lethality (such as attempts by hanging and firearms) are associated with completed suicide, and need to be considered very seriously

# Expected Outcome

- Expectations regarding fatality
  - *Did you think you would die after you took the pills?*
  - Lethality tends to be overestimated by adolescents
- Reversibility
  - *Did you think you could do something to undo the attempt, such as vomit, drink milk, etc.?*
- Ambivalence about living
  - *Did you care whether you lived or died after you made the attempt?*



# Planning

- Duration of planning
  - *How long did you think about it before you made the attempt?*
- Potential for discovery
  - *Did you tell anyone you were intending to kill yourself?*
  - *Did you take any precautions against being discovered by your parents, concerned adults, or friends after the attempt?*
- Preparation for death
  - *Did you make any preparations in anticipation of dying, such as leaving a suicide note?*

# Planned versus Impulsive Attempts

- Planned attempters were significantly more depressed and hopeless than the impulsive attempters
- No relation to age, sex or method of attempt
- Internalized anger and hopelessness were strongly related but only in the planned attempter group

# Intoxication

- Alcohol and drug history
- Intoxicated at the time of the attempt
  - Worsening of mood
  - Decrease inhibitions and self control
- Future intent to use and availability

# Reasons For Living- Attempters

- Do you think things can improve and your future will be happier?
- Are there things you want to do that you haven't done yet?
- Do you have future plans that you want to carry out?
- Are there friends and family who will support you and want to see you do well?
- How would your friends/parents/siblings/pets feel if you committed suicide?

# Environmental Response (Teen) & Safety Plan

- Did the adolescent achieve the goal which was underlying the reason for attempt?
  - Did someone respond to them differently?
  - Did their peers/parents change?
- Can teen commit to safety plan?

# AUDIOTAPE WITH SAFETY PLAN

- SAFETY PLAN CHECKLIST ON NEXT SLIDE



# Brent et al, 2011

<b>Make the Environment Safe: Remove Access</b>	<b>Warning Signs and Vulnerabilities</b>	<b>Things I Can Do on my Own</b>	<b>People who Can Help Distract Me</b>	<b>Adults I Can Ask for Help</b>
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
3.	3.	3.	3.	3.

# PLANNING FOR EMERGENCIES

- Unanticipated Trigger
- Loss of a loved one
- Social Separation
- School Problem
- Adjustment to a New Situation
- New Responsibilities

# In an emergency, this is how I will cope:

- Cool down by (list relaxation strategies) \_\_\_\_\_
- Use calming self-talk (list statements) \_\_\_\_\_
- Dispute negative beliefs with \_\_\_\_\_
- Generate more options with \_\_\_\_\_
- If thinking about suicide I will DEFINITELY tell an adult including \_\_\_\_\_
- I can also call my therapist, a suicide hotline, 911, or go the nearest emergency room.

# MY PERSONAL EMERGENCY PLAN

**I WON'T :**

- **Drink alcohol or use drugs**
- **Act without thinking**
- **Get overemotional**
- **Isolate myself or stay away from people who care about me**
- **STAY IN A HIGH RISK SITUATION**
- *If a relapse occurs I won't lose hope. I can and will get through it.*

# As part of my therapy I agree to:

- Work on problems to help myself feel better.
- Keep myself safe and not end my life.
- If I feel unable to keep myself safe, I will immediately tell one of the following adults and call my therapist\*.

○ *List names and numbers*

- If I can't reach an adult immediately, I will call a suicide hotline (*list numbers*), 911 for help, or go to an ER.

- I will use the following coping techniques to help calm myself as needed.

○ *List coping techniques*

# Relief Link available for free on iTunes

- The ReliefLink app won the \$50,000 first prize in an App Challenge sponsored by SAMHSA
- Mood and behavior monitoring and tracking, safety planning, medications and appointment reminders, a help center map locator, built-in coping tools (e.g., relaxation and mindfulness exercise, relaxing radio music), an emergency button to connect patients to helplines, providers, 911, and friends/family.

[http://news.emory.edu/stories/2013/09/kaslow\\_relieflink\\_app/campus.html](http://news.emory.edu/stories/2013/09/kaslow_relieflink_app/campus.html)



# Environmental Response (Parent)

- Assess parental feelings / behavior toward the adolescent following the attempt

- Best to do with parents alone

*"How did you react when you found out about the attempt? What are your thoughts about it? I know that these types of situations can be just as tough on parents, how are you managing?"*

# Environmental Response (Parent)

- Can parents/primary caregiver provide safe keeping?
  - Availability to teen & ability to monitor
  - Quality of relationship
  - Abuse or neglect
  - Parental mental illness or substance abuse
  - Volatility in the home
  - Willingness to removal/lock up lethal means (firearms, medications, substances, razors, etc.)

# Environmental Response (Parent)

- Taking suicidal behavior seriously

*“It is very important to take all suicidal statements and behaviors seriously. Even if you think there are reasons other than wanting to die behind it, it is VERY important to react in a support manner and immediately seek help. Sometimes teens attempt suicide to prove their parents wrong or show their pain when they think their parents do not believe them. So it will be very important to show concern and support to your son/daughter. Is this something that you think that you can do when we meet together? What do you think that you will say?”*

# Parent – Teen Meeting

- *Example: Okay, so let's go ahead and meet with (teen's name). You will get a chance to ask him/her questions. If he/she does not want to answer, please do not push him/her at this time. We will work on communication around the suicidal thoughts/behavior in therapy. We will also review (teen's name) coping plan as well as ways that you can support (teen's name) during this high risk time. Any questions?*

# Teen and Parent(s) Together To Discuss Suicidal Episode

- *Example: . Often, it is not easy for teenagers to share their suicidal thoughts (and/or attempt). It took a lot of courage. Now that we are aware of it, we can start working on it in treatment. (Teen's name) has come up with a coping plan to help him/her manage his/her suicidal thoughts.*



# Conclude Interview (Teen & Parent)

- Review teen safety plan with parents
- Review importance of supervision
- Review how to keep home safe
  - *Remove/lock up all means of attempt (medications, firearms, razors, knives, toxic substances, car keys)*
  - PARENTS must give teen all medications.
  - Temporary changes to address impulsiveness of suicidality
- Review steps for the family to take in the event of increased suicide risk
- Set up next appointment within a day or two



# Primary Sources

- Rudd, M.D. (2006). *The assessment and management of suicidality*. Sarasota, FL: Professional Resource Press.
- Shaffer, D. & Pfeffer, C. (2001). Practice parameters for the assessment and treatment of children and adolescents with suicidal behavior. *J Am Acad Child Adolesc Psychiatry*, 40(Suppl 7): 245-515.

- Spirito, A., Esposito-Smythers, C. et al. (2012). Adolescent suicidal behavior. In Kendal (ed.), *Child and Adolescent Therapy: Cognitive-Behavioral Procedures*. New York: Guilford.
- Spirito, A. & Overholser, J. (2003). *Evaluating and treating adolescent suicide attempters: From research to practice*. New York: Academic Press.
- Brent, D., Poling, K., & Goldstein, T. (2011). *Treating depressed and suicidal adolescents: A clinician's guide*. New York: Guilford Press.

## IV Working with Parents

Important to make sure that parents are on board with the safety plan

Parents need to be available to monitor their teen's safety

Parents need to be aware of teen's emotions

# SAFETY PLANNING

The parent is often the trigger for the child and sometimes exacerbates the situation

Parent may not have the energy or ability to provide support

Backup plans sometimes need to be used to identify another adult that the parent and teen could access in emergency situations

# Obstacles in Treatment

- NEGATIVITY, HOSTILITY AND BLAME
- Commonly encountered even when just setting a family agenda
- Start each family session with a focus on the positive – with the parent/teen giving each other some positive feedback, a compliment, or saying thank you. This helps to adjust the tone of sessions.

# DON'TS

- Mock, make light of, or criticize your child's emotions.
- Push your parental agenda at this point in time. Problem solving will come next.
- Side with the enemy (e.g., the teacher or other authority figure)
- Be defensive if you are the source of your child's negative emotions; it is still possible to be empathic even in these situations



# Emotion Coaching - Rationale

- The way that people respond to each others' emotions has a lot to do with how they get along with each other and how well they function in the world.
- Parents who are able to empathize with and validate their children's emotions have a stronger base of power from which to set limits on their children's misbehavior than parents whose base of power comes from threats, humiliation, or physical discipline.

# Emotion Coaching - Rationale

- Parents who can balance validation with limit setting also have a stronger base of power compared to parents who set no limits at all.
- Parent-child relationships are NOT a democracy; parents get to decide what BEHAVIOR is and is not permissible, but ALL OF THE CHILD'S FEELINGS ARE PERMISSIBLE.

# Emotion Coaching - Rationale

- The goal of emotion coaching is for parents to give the message that they understand how the child is feeling.
- This validation of emotion then sets the stage for guidance around adaptive methods for coping with the emotion and may include feedback about unacceptable parts of the child's behavioral response to emotion (e.g., it is okay to feel mad, but it is not okay to punch a hole in the wall.)

# DOs and DON'Ts for EMPATHIC LISTENING AND VALIDATION

- Talk in a slow, calm manner
- Offer praise when you see your child label one of their emotions or when they adopt an emotion word that you have offered them in your re-cap of their feelings
- To help you get with your child's emotions, think about how they are feeling in terms of similar adult situations (e.g., replace school peers with co-workers; siblings with spouse, etc).

# Empathic Listening

- Be patient with the process. This may be a new way of interacting for you and your child.
- Allow enough time for your child to express his/her feelings.
- Remind yourself that the goal of this is to explore and understand your child's emotions NOT to solve them at this moment in time.

# Steps for Empathic Listening and Validating your Child's Emotions

- Notice signs that your child is having an emotional reaction to a situation:
  - Posture. Facial expression
  - Content of their words
- Try to put yourself in his/her shoes and understand what your child is feeling in this situation.
- Notice subtle signs of their emotions that come before their reaction becomes more overpowering for them and you.



# Emotion Validation

- State in words to your child what you think their perspective looks like in a non-critical way (“So what I hear you saying is...”; give them labels for the emotions you think they feel experiencing (“Sounds to me like you are feeling...”).

# Emotion Validation

- Check in with your child about whether your view was on target (“How did I do? Do I get how you’re feeling?”).
- If they add to what you said, to show that you listened, make adjustments to your statements from above as necessary (“Oh, ok, so in addition to feeling x, you are also feeling y.” or “(Oh, so it wasn’t so much that you were feeling x; you were more feeling y.”).

# Emotion Validation

- DON'T attempt to change their perspective at this point or explain to them why it does or does not make sense
- Restate to them what you observe and feel about what they are feeling. (I hear you; I feel x (sad, upset, helpless) that you feel that way."

# Emotion Validation

- Once your child feels like you understand where s/he is coming from emotionally, s/he will be more ready to engage with you to solve the problem that caused the negative emotions in the first place.
- It is important for children to understand that their feelings are not the problem, their misbehavior is.
- Children cannot turn off their feelings just because a parent tells them to stop (e.g., "Stop that crying."), but they can learn better ways to express their feelings.

# IV Cognitive and Behavioral Techniques for Suicidal Risk

- CBT sessions follow a standard format.
- Medication adherence check, if applicable, followed by an assessment of suicidal thoughts or behavior as well as any alcohol or drug use since the last session.
- If the adolescent is at significant risk for suicidal behavior, conduct an assessment of current suicidality, and either review or negotiate a safety plan.
- Coping plan put into phone whenever possible

# Reframe Attempt as Failure in Problem-Solving

- *What would happen if you only had one option listed and you tried that and it didn't help your problem?*
- *Yes, you would be stuck. That may be what happened when you attempted suicide. You did not feel like you had any other options to deal with the bullying, you felt pretty stuck, so you picked the only option you thought you had.*
- *The more you practice coming up with a list of Options, the more Options you have to choose from when you have a problem, and the less likely you will feel stuck and end up making a poor decision.*



# Problem-Solving (SOLVE)

S = Select a Problem

O = Options

L = Likely Outcome

V = Very Best One

E = Evaluate

# SHOULD SUICIDE BE AN OPTION?

Allowing suicide as an option may facilitate the problem-solving discussion.

Some fear that a cognitively restricted suicidal individual will not be able to generate other options beside kill oneself.

Schneidman has suicidal patients rank order the options from the least to most onerous.

Once a patient no longer ranks suicide as a first or second option, suicidal ideation no longer needs to take precedence.

# AUDIOTAPE - TRIGGERS WORKHEET

- Fight with my boyfriend
- School and friends
- Loneliness or being alone
- Worrying about the future or past
- Trying to please my family

# AUDIOTAPE – SOLVE

- Cut
- Suicide
- Talk to my friends
- Call him and yell
- Talk to my mom
- Listen to music
- Watch TV
- Write in my journal

# AUDIOTAPE - Pros and Cons of Suicide

## PROS

- Wouldn't feel sad
- He'd feel bad
- I wouldn't hurt/be in pain
- I wouldn't see him w/ new girl
- I wouldn't have to think
- No more pressure

## Cons

- He'd be alive and I wouldn't
- My mom would miss me/feel bad
- I would miss my mom
- No college/no job
- No hanging out with friends
- XXX would be sad and lonely
- My sisters would be sad

# Cognitive Restructuring (ABCDE)

A = Activating Event

B = Beliefs

C = Consequences/Feelings

D = **Disputes**

E = Effect/Change



# HELP WITH DISPUTING BELIEFS

- **1. Is it true?**
- Am I making a thinking mistake?
- What evidence do I have that it is true/false?
- What would my friend say if he/she heard this belief?
- **2. Is this belief helpful?**
- Does this belief help get me what I want?
- Does this belief help me feel the way I want?
- Does this belief help me avoid conflicts?
- **3. Is there another explanation?**

# ABCDE Worksheet

Activating Event: Being bullied at school

Beliefs:

1. I am a loser
2. This will never stop
3. No one cares about me
4. They are making me go to school though I don't want to

# Review importance of disputing

- *Now, what would happen if you only came up with negative beliefs and did not dispute any of them?*
- *That's right, you would only have negative thoughts running through your head. Having all of these untrue and unhelpful thoughts may leave you feeling depressed or suicidal. That may be what happened when you attempted suicide. Now, the more you practice disputing negative beliefs, the more true and helpful beliefs you will have running through your head. This will help you to feel better and make better decisions.*

# ABCDE

Consequences/feelings: sad, angry

Disputes:

1. They are the ones with the problem
2. I can work with my therapist to help it stop
3. My family and teachers care about me
4. They are only making me go b/c they care about me

Effect/Change: Feel better & make better decisions

# Cognitive restructuring

- ***BLACK/WHITE THINKING:***

- You view a situation or person as all good or all bad, without noticing any points in between.

- ***PREDICTING THE WORST:***

- You predict the future negatively without considering other more likely outcomes.

- ***JUMPING TO CONCLUSIONS:***

- You decide that things are bad without any definite evidence.

# DISPUTES - DECATASTROPHIZING

- "What would be the worst thing that will arise if \_\_\_\_\_ occurs?" "If \_\_\_\_\_ does occur, how will it affect your life in 3 months? 6 months?" "What is the most likely thing to happen here?" "How will you handle it?"



# RE-ATTRIBUTION

- A technique that can be used to help the adolescent change the self-statement, "It's all my fault" to a new statement in which responsibility is attributed more appropriately, perhaps to friends or parents, or chance.
- The therapist may initially support the adolescent's view that it is his/her fault but then asks the adolescent to break down what he/she contributes to the situation and what other people contribute.

# SCALING THE SEVERITY OF THE EVENT

- In this technique, the therapist asks the adolescent to scale the suicidal precipitant or anticipated future stressful event on a scale from 0 to 100.
- Scaling the severity of an event provides a way for adolescents to view situations along a continuum rather than in a dichotomous fashion.

# Pros and Cons of Suicide - Bullying as Trigger

## PROS

- Never get picked on again
- No more pain
- Those kids will feel bad for what they did
- Bullies will never hurt me again

## Cons

- My family will miss me
- My little sister will not understand
- I will not be around to help my sister as she grows up
- My dog will be lost without me
- I will never get to make my own video games
- I won't be able to go to any more concerts

# More Cons of Suicide – Bullying as Trigger

- I will never get to do anything again
- I can work with my therapist and teachers to make the teasing stop
- Therapy could help me feel better
- Those kids will feel bad if they get expelled from school and punished by their parents

# Stay Cool Plan- Bullying as Trigger

- Self-Soothing Behaviors
  - Walk away
  - Talk to someone (guidance counselor, teacher, friend)
  - Go to library and read my favorite book
  - Listen to my favorite music
  - Deep breathing
- Positive Self-Statements / Disputes
  - They are the ones with the problem
  - I can work with my therapist to help it stop
  - My family and teachers care about me

# Pros and Cons of Suicide – Fight with parent trigger

## PROS

- Wouldn't have to deal with Mom being upset
- Won't be a burden to my family or friends
- No more emotional pain

## Cons

- I will never get to do anything again / I'll miss out on the good times
- Mom and family would be devastated (like when grandma died)
- Friends would miss me
- Bad example for my cousin
- Won't get to go to college and be a doctor



# Stay Cool Plan – Fight with Parent

- Behaviors that Can Help
  - Walk away
  - Go downstairs and see my cousin
  - Call a friend or therapist
  - Listen to my favorite music
- Positive Self-Statements / Disputes
  - Even though Mom is mad right now, I know we're close and she loves me
  - My friends fight with their parents too. This is normal.
  - I've been through worse than this.

# Take Home Tips

- Evaluate the pros list and help the teenager generate other ways to get their needs met
- Use your knowledge of teenager (values, supports, goals, etc.) to help identify cons of suicide and re-evaluate pros
- Ask questions to help the teenager generate cons rather than provide them

# CBT Techniques for Affect/Anger Regulation

- Helps teens to understand that intense emotions can lead to suicide attempts and get in the way of making good decisions or using skills
- Help teen identify physiological symptoms, behavior, and thoughts associated with anger dyscontrol

# Anger

- Adolescent attempters who expressed a desire to die reported higher levels of anger than those who expressed other motivations for a suicide attempt (Boergers et al,1998).
- Aggression was a significant predictor of suicidal events in suicidal adolescent inpatients 6-months after discharge, even after controlling for covariates such as PTSD, borderline features and childhood sexual abuse (Yen et al, 2013).

# Impulsive aggression (IA)

- Offspring of suicide attempters with siblings concordant for suicidal behavior showed a higher risk of suicide attempts and impulsive aggression than did offspring of nonsuicidal probands (Brent et al, 2003).
- Heritability of suicide is independent of a specific psychiatric disorder, suggesting that efforts to disentangle genetic and environmental influences on suicide must characterize phenotypes that cut across diagnoses (Baud, 2005)

# Attributional Style

- Studies have documented an association between adolescent aggression and an array of negative cognitive processing biases, particularly within interpersonal contexts.
- Bennett and Bates (1995) found that self-rated and mother-rated aggressive behaviors were positively correlated with aggression and maladaptive cognitive attributional style in a clinical sample of adolescents.



# Four Steps of Affect Regulation

1. Identify primary **emotion** associated with problem behavior
2. Identify and rank **“body talk,”** behaviors, and thoughts associated with primary emotion
3. Identify the teen’s **“boiling point”**
4. Create a **“Stay Cool Plan”**

# “Body Talk”

## Physiological

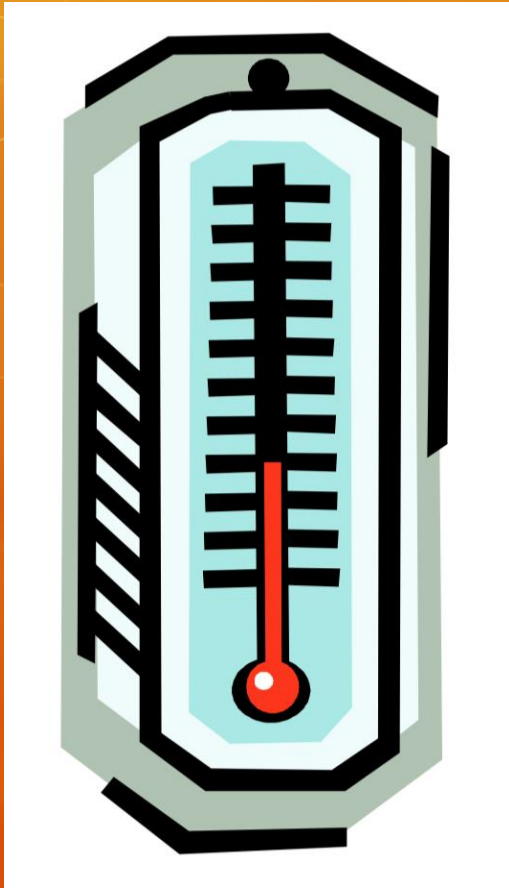
- **Tension** in any part of body
- Fast heart beat
- Sweating
- Shortness of breath
- **Breathe quickly**
- Hot flashes
- Rash
- **Lump in throat**
- **Headache** or stomachache

## Behavioral

- Fold arms
- **Cry**
- Slam door
- Throw or kick things
- Hit or punch
- Yell or swear
- Pull your hair
- **Isolate self**
- Silent treatment

# Feelings Thermometer & Danger Zone

Extremely SAD



Calm and Cool

10 "I am such a loser, no one care about me"

9 Isolate

8 "This is never going to end"

7 Cry

6 Headache

5 Chest tense/hurts

4 "Why won't they just leave me alone"

3 Breathe quickly

2 Lump in throat

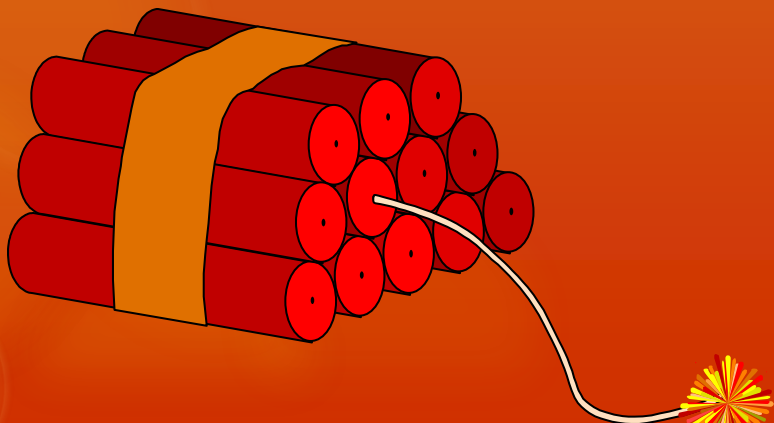
1 "Not again"

# Anger control approaches:

Physiologic – teach relaxation

Cognitive – teach self-control strategies

Behavioral – teach assertiveness technique



(Feindler & Ecton, 1986)



# Aggression reducing self-talk

- **Don't assume the worst - maybe it's just an accident, or I took it the wrong way.**
- **I'll try to stay calm and listen - maybe there's something I should hear in what he's been saying.**
- **Chill out. I'm not going to get riled up. Time for a few deep breaths.**
- **My muscles are starting to feel tight. Time to relax and slow things down.**
- **Think ahead, don't lose your head.**

(From Gibbs et al., 1995)

# Opposite action

- Identify the Emotion
  - “I’m mad!” “I feel hot and my fists are clenching.”
- Identify the Urge that goes along with it
  - To punch something
- Act opposite to the emotion
  - Choose behaviors and/or thoughts that are not compatible with anger
- Act opposite to the emotion **ALL THE WAY**
  - Unclench fists; take deep breaths; smile; Think about something nice that person has done for you; Actually do something nice for that person



# V Complicating Co-occurring Factors: Substance Use

- Depressive symptoms prospectively predict greater levels of marijuana use in adolescents (Repetto et al, 2008)
- Modest association between cannabis use and MDD and a strong association with suicidal ideation and attempts in 14-15 year olds (Fergusson et al, 2002)
- Followed 1600 Australian adolescents starting at age 14/15 for 7 years. Daily use in females resulted in 5-fold increase in the odds of reporting a syndrome of depression and anxiety at 21 years of age. Weekly use doubled the risk (Patton et al, 2002)

# Degenhardt et al (2003) Review

- Conclusions: Modest association between heavy or problematic use of cannabis and depression in cohort and well-defined cross-sectional studies in the GENERAL population
- Little evidence of this link with infrequent cannabis use
- Modest association of early-onset , regular cannabis use and later depression

# Why would this association exist?

THC appears to be related to regulation of emotional experience including depression, i.e a neurobiological effect of cannabinoids..

Alternatively, or more likely concurrently, the association is linked to common shared social, personality and environmental risk factors

# Alcohol and Suicidal Behavior

- The relation between suicidality and SUDs appears to strengthen as each problem increases in severity (Esposito-Smythers & Spirito, 2004)
- Substance abuse/dependence appears to be a factor in escalation from suicidal thoughts to behavior
- If diagnosed with SUD and Mood Disorder by age 14, 17 times greater chance of attempting suicide later in adolescence (Reinherz et al., 1995)
- Adolescents with SUD and Mood Disorder at greater risk for suicide (OR: 17.0) than those with SUD alone (OR: 3.3) (Brent et al., 1993)

# How Might alcohol affect suicidality?

## Acute effects of intoxication :

- May heighten psychological distress
- Increase aggressiveness towards self or others
- Enhance suicide-specific expectancies, e.g. “alcohol will give me the courage to kill myself”
- Inhibit the generation and implementation of adaptive coping strategies

# How Might Alcohol Affect Depression/ suicidality?

Distal effects of alcohol use :

May lead to substance-related social, academic, and/or legal problems, which in turn lead to :

Development or worsening of psychiatric symptoms , which in turn might lead to :more severe depression and suicidal thoughts or behavior (Hufford,2001)



# How does substance use affect your treatment of depressed adolescents?

- Depressed adolescents in treatment frequently report mood improvement after smoking marijuana
- “The only time I feel good is when I smoke pot and you want me to stop? That makes no sense”.
- Heavy use is related to depression but these adolescents focus on the immediate gratification

# Goldstein et al (2009)

- MDD response at 12 weeks was greatest for teens with low 12 week substance-related impairment regardless of whether they had high or low baseline substance-related impairment
- MDD response was significantly lower among teens with high 12 week substance-related impairment
- Suggests that it is important to characterize substance-related impairment even among teens with MDD who do not have a SUD – i.e. your patients!

# Our Integrated Treatment protocol

- Project TRYADS: **T**reatment of **Y**outh **A**lcohol **A**buse and **S**uicidality
- Funded by NIAAA
- Randomized clinical trial
- Compares a year long integrated outpatient CBT protocol for adolescents with co-occurring SUD, depression and suicidality to enhanced standard care

# Patient characteristics

- Suicide
  - 100% suicidal ideation
  - 70% suicide attempt
- Alcohol/Substance Use Disorders
  - 37% alcohol abuse
  - 30% alcohol dependence
  - 4% diagnostic orphan
  - 30% marijuana abuse
  - 56% marijuana dependence

# Treatment Schedule

- Three treatment phases
  - Active: 6 months of weekly sessions
  - Maintenance: 3 months of bi-monthly sessions
  - Booster: 3 months of monthly sessions
- Two therapists assigned to each case
  - Adolescent therapist
  - Parent/family therapist

# Modular CBT: Stages of Treatment

- Acute Treatment
  - ❖ 3 months
  - ❖ Weekly sessions
  - ❖ Emphasize new skills
- Maintenance Treatment
  - ❖ 3 months
  - ❖ Bi-monthly to monthly sessions
  - ❖ Emphasize skill practice and integration
- Booster Treatment
  - ❖ Fade from monthly to termination
  - ❖ Emphasize relapse prevention



# Treatment Arms

- Experimental (EXP)

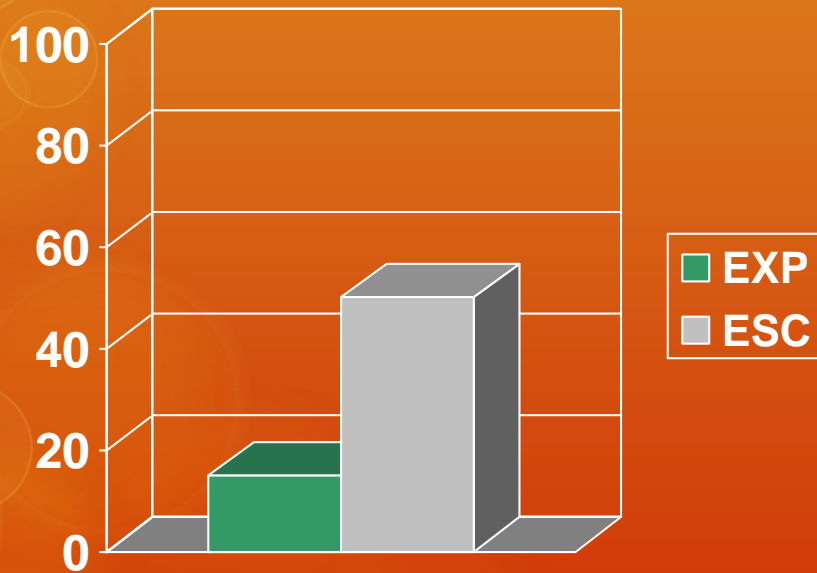
- Medication management
- Case management
- Comprehensive baseline assessment and follow-ups
- Integrated treatment delivered by study staff

- Enhanced SC (ESC)

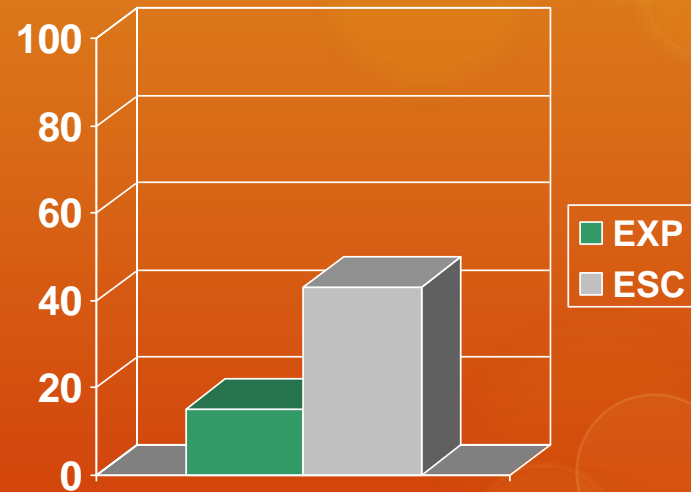
- Medication management
- Case management
- Comprehensive baseline assessment and follow-ups
- Treatment as usual in the community

# Other Service Utilization Outcomes

## Percentage Requiring ER Services

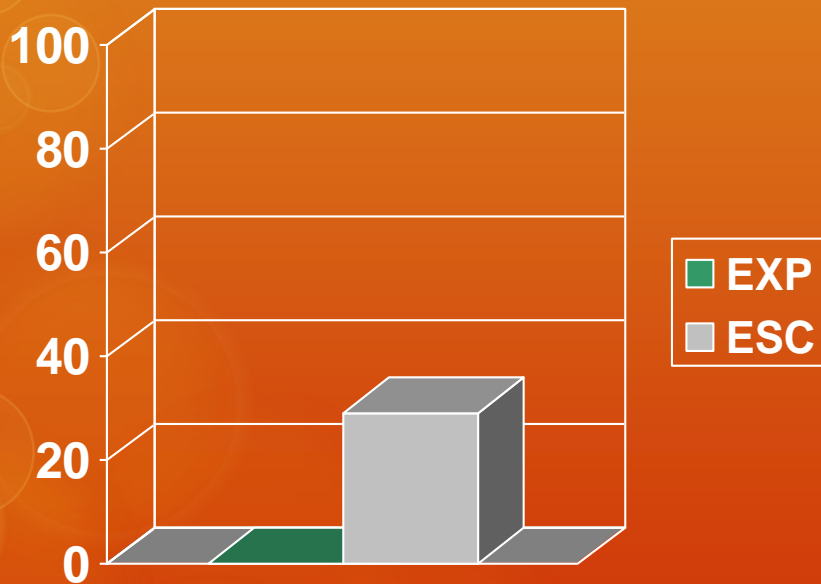


## Percentage Requiring Inpatient Services

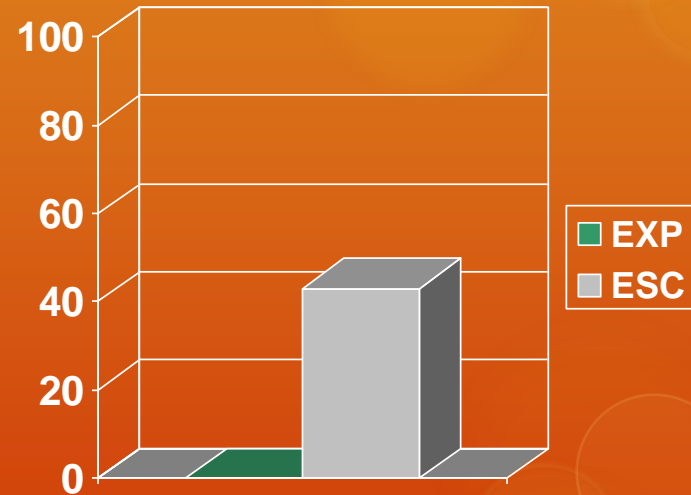


# Treatment Outcome

## Percentage Attempted Suicide

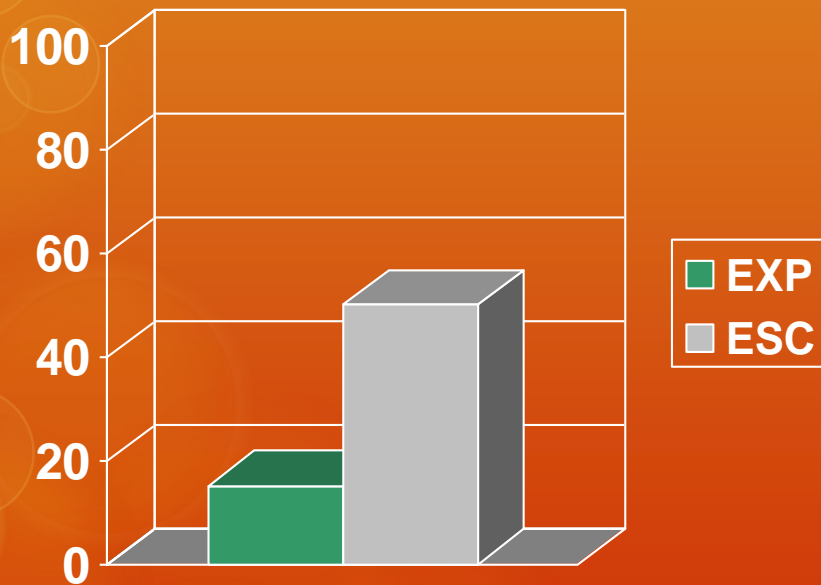


## Percentage Arrested

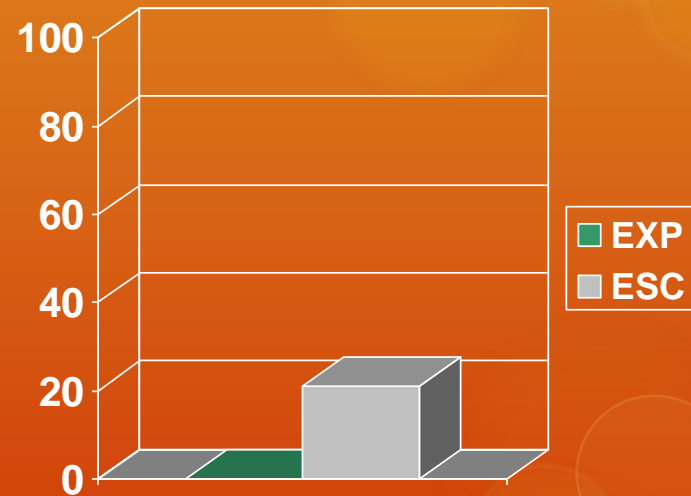


# Other Service Utilization Outcomes

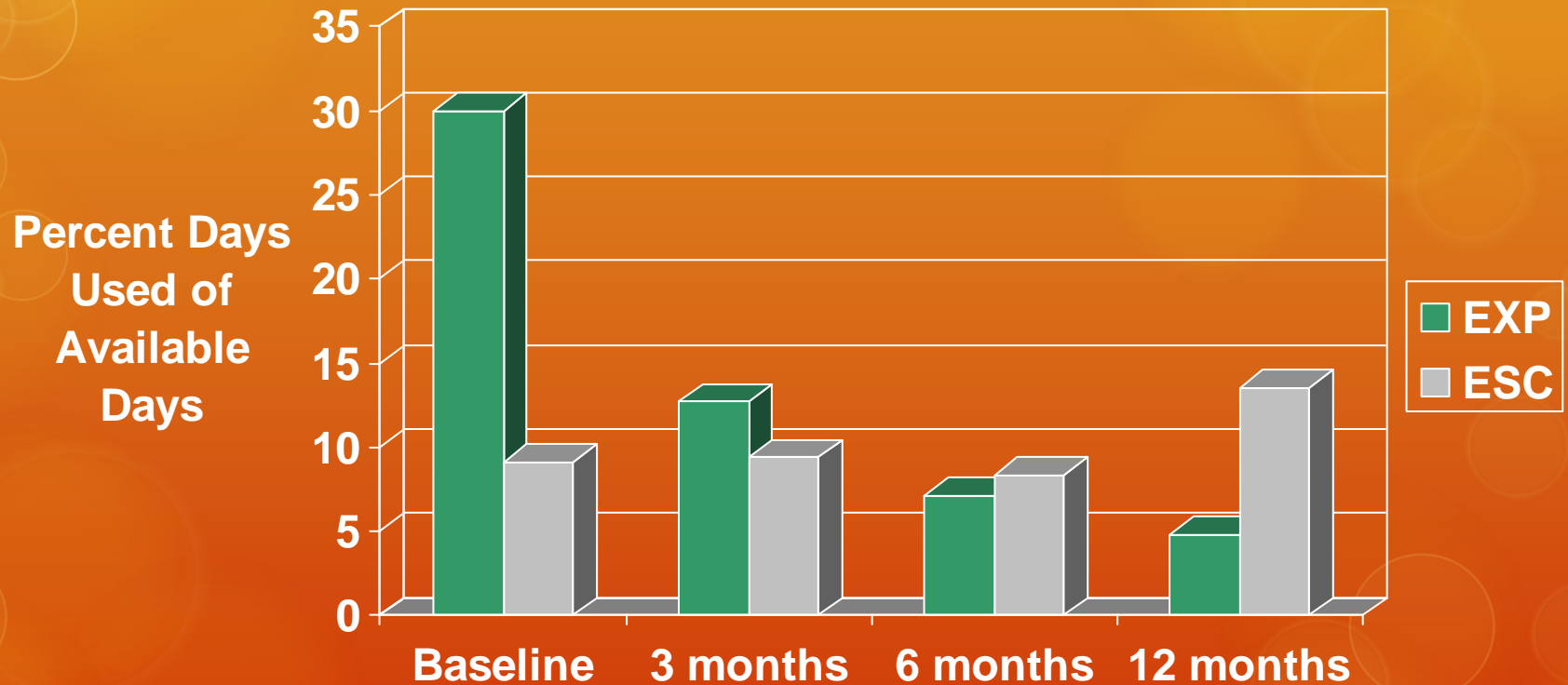
## Percentage In School Based Therapy



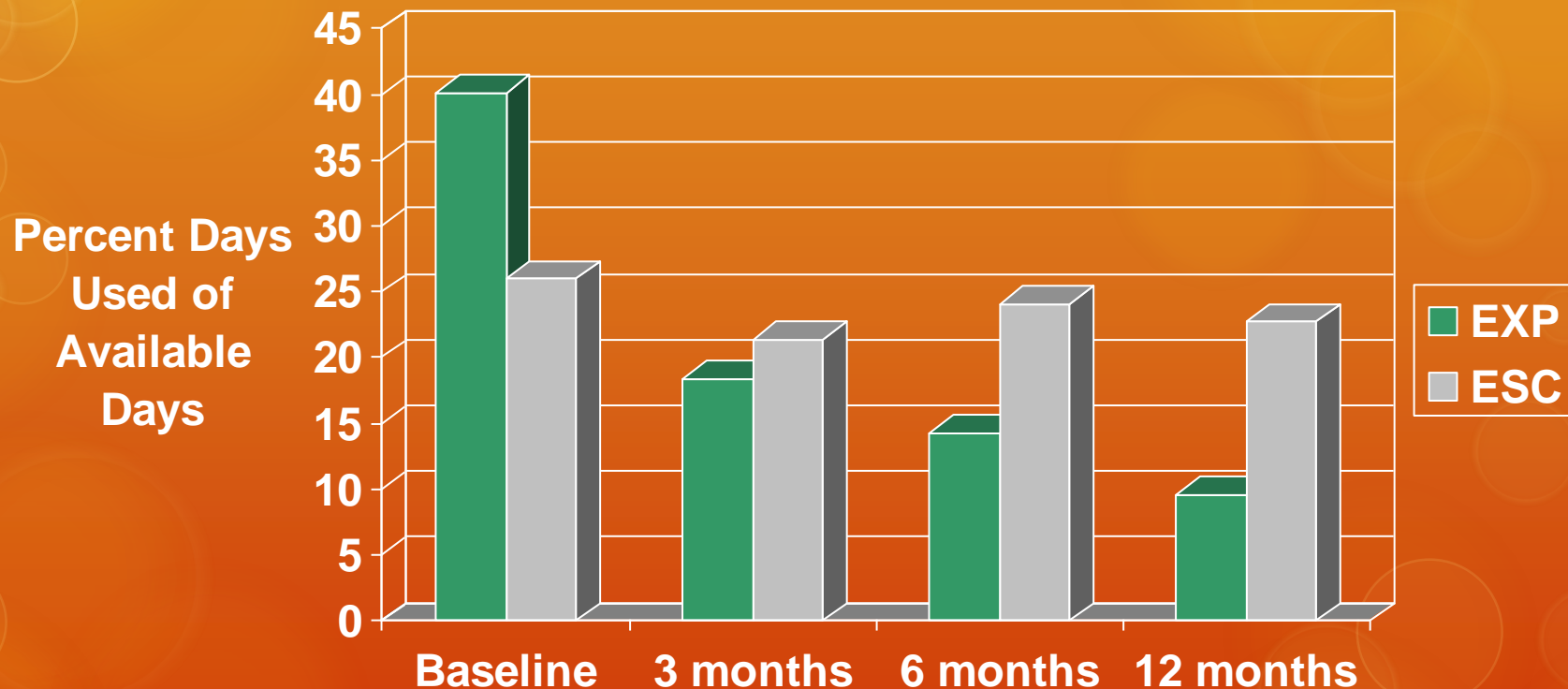
## Percentage In Residential Placement



# Average Alcohol Use by Treatment Condition



# Average Cannabis Use by Treatment Condition





# Alcohol/Drug refusal skills

- Provide rationale for improving alcohol/drug refusal skills
- Teach nonverbal alcohol/drug refusal skills
- Teach verbal alcohol/drug refusal skills
- Role play alcohol/refusal skills
- Dispute thoughts that get in the way of using alcohol/drug skills, e.g. “If I don’t drink, no one will ask me to do things on weekends”.

# Why learn alcohol/drug refusal skills ?

- Being offered AOD or being pressured to use them is a common high risk situation
- It is best to avoid these situations but it is not always possible or desirable
- The more quickly you can say “no” when offered AOD, the less likely you are to use

# Alcohol/drug refusal skills

- Make eye contact
- Don't feel guilty about refusing to drink
- Suggesting something fun and safe to do instead
- If pressured, ask him/her to stop asking you to drink/use drugs
- Change the subject

# Alcohol and Drug Refusal Tips

○

○ **Know your high risk situations, mine are:**

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○ **Things I can tell myself when I think about using alcohol/drugs, mine are:**

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# COPING WITH CRAVINGS

- Rationale - psychoeducation
- Identify triggers for urges to drink/use drugs using a drinking/drugs urges thermometer
- Identify alternative ways to cope with urges, e.g. self-talk, talking with friends and family, distraction, relaxation

# MY PLAN FOR COPING WITH URGES

- **The easiest thing to do is AVOID triggers,**

**but if that's not possible....**

- **Remember, urges are like waves.**

“They only last about 20 minutes. If I can make it

through the peak, I am home free.”



# My Plan for Coping with Urges

○ **I Can Use My Self- Talk**

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○ **I Can Talk With My Friends or Family**

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○ **I Can Distract Myself**

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○ **I Can Use My Relaxation Techniques**

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# Motivational Interviewing

## **Reasons to Stay the Same:**

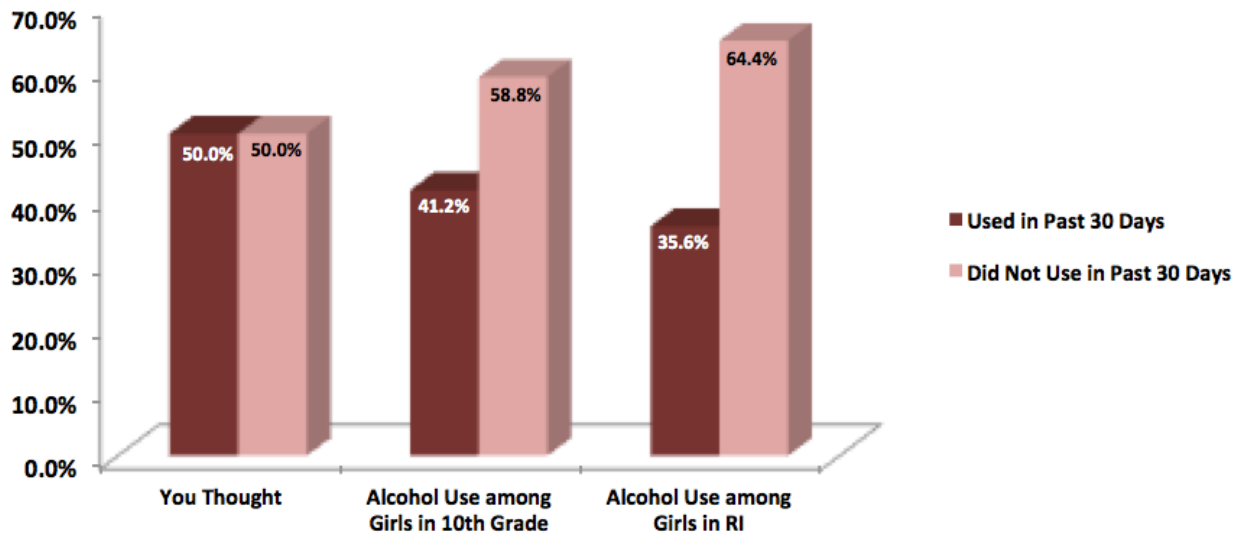
- **What do you like about drinking/using drugs**
- **What are the not-so-good things that might happen if you cut down or stopped drinking/using drugs?**

## **Reasons to Change:**

- **What do you not like so much about drinking/using drugs?**
- **What are the good things that might happen if you cut down or stopped drinking/using drugs:**

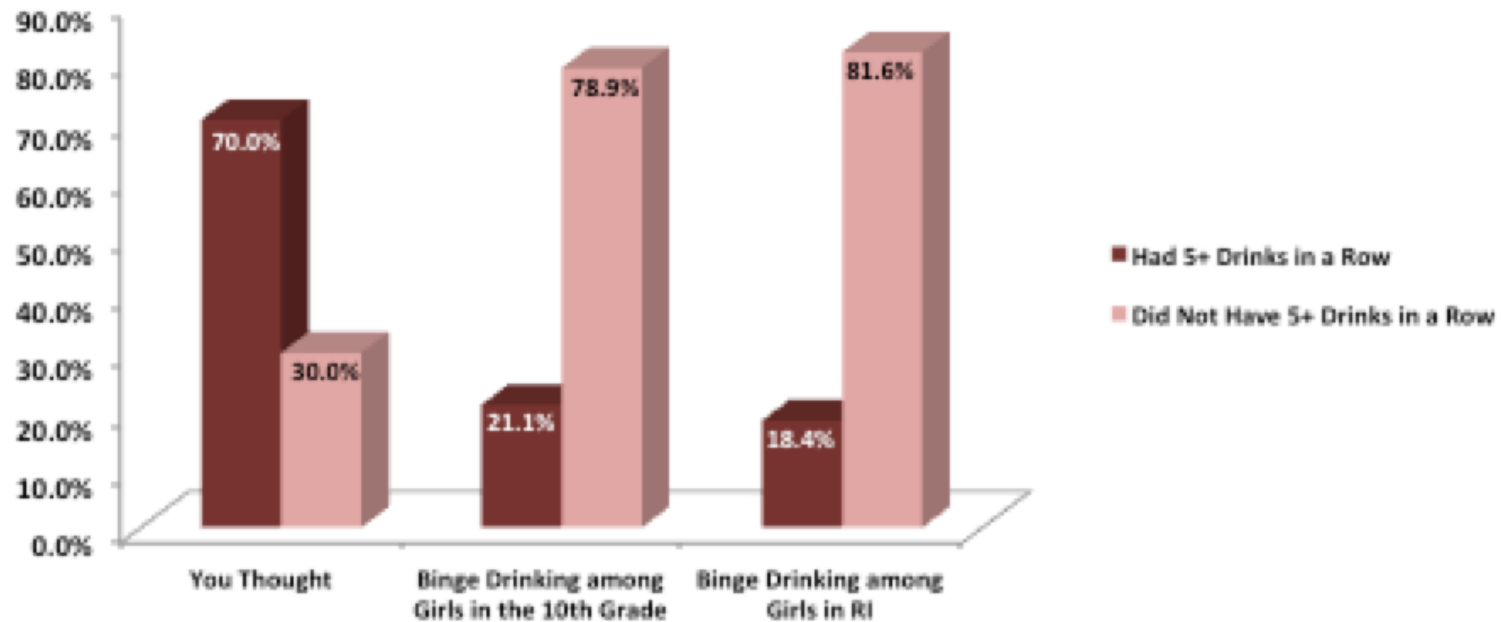
## How does your alcohol use compare to other females your age?

You used alcohol 8 times in the past 30 days and you thought 50% of people your age used alcohol at least once in the past 30 days.



This means that you used more than 58.8% of girls in the 10<sup>th</sup> grade, and more than 64.4% of girls in Rhode Island in the past month.

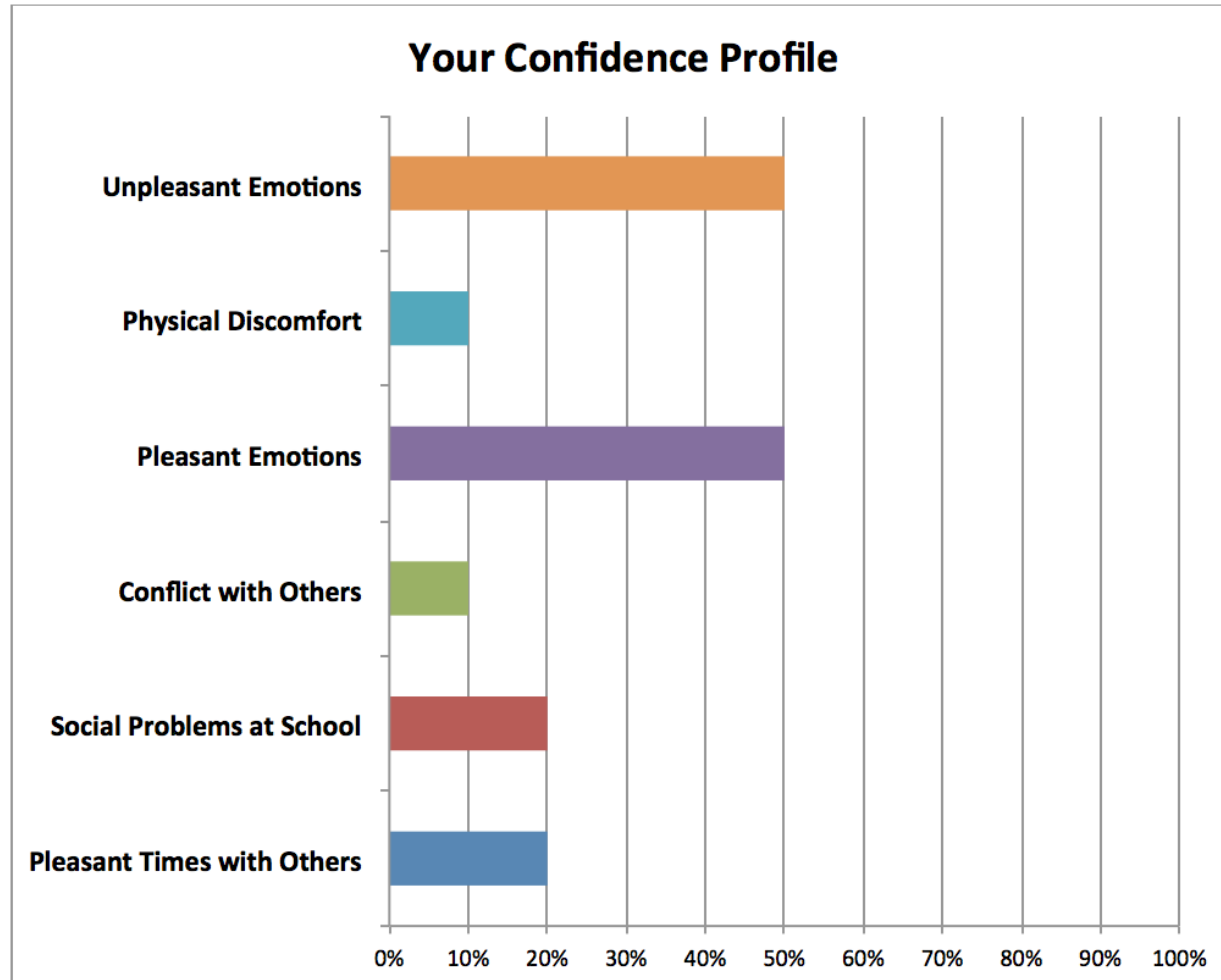
You had 6 occasions where you drank 4 or more drinks in a row in the past 30 days and thought that 70% of people your age engaged in binge drinking at least once a month.



This means that you engaged in binge drinking more often than 78.9% of girls in 10<sup>th</sup> grade and more than 81.6% of girls in Rhode Island in the past 30 days.

# How confident are you about resisting the urge to use alcohol in certain situations?

The following graph shows your confidence that you could resist using alcohol in different situations. Situations where you have low confidence are more likely to pose a risk for you. You may find it particularly helpful to think of ways to identify and plan for these situations in advance.



## How does alcohol affect you?

### You reported that alcohol makes you...

- ✓ Forget things.
- ✓ Feel less motivated.
- ✓ React slower.

### Here are some other ways alcohol can affect you...

- ✓ Excess alcohol use can cause or mask other emotional problems, like anxiety or depression.
- ✓ Many teens feel as though alcohol helps their problems go away, or they only feel “normal” when drinking alcohol. But when the “buzz” wears off, teens often feel even more depressed than they did before. These feelings can lead to suicidal thoughts, and even suicide attempts.
- ✓ Intoxication is associated with suicide attempts using more lethal methods, and positive blood alcohol levels are often found in people who complete suicide.



# How is your alcohol use putting you at risk for continued suicidal ideation and attempts?

## You thought...

- ✓ There is no relationship between your drinking and your suicidal ideation and attempts.

## Here are some statistics on alcohol and suicidal ideation and attempts among people your age:

- ✓ Teens who abuse alcohol or drugs are more likely to consider, attempt, or complete suicide than are non-abusers.
- ✓ Teens with an alcohol or other drug use disorder are one and a half times more likely to have a repeated suicide attempt.
- ✓ In teens, having an alcohol use disorder raises the likelihood of a suicide attempt by as much as 25 times.
- ✓ As many as 46% of teens who have attempted suicide reported being under the influence of alcohol at the time of the attempt.

# OPTIONS FOR ***STOPPING*** YOUR DRINKING/DRUG USE

- If You Drink/Use Drugs When Emotional, Create A Different Plan
- Plan Ahead Not To Drink/Use Drugs On A Night(s) When You Would Usually Use
- Plan Alternative Activities To Drinking/Using Drugs
- Avoid Places Where You Will Be Bored Or Uncomfortable If You Don't Drink/Use Drugs

# Options for *stopping* your drinking/drug use

- Spend More Time With People Who Don't Drink/Use Drugs
- Prepare An Excuse For Not Drinking/Using Drugs If Asked
- Hold A Non-Alcoholic Beverage In Your Hand
- Volunteer To Be The Designated Driver

# OPTIONS FOR ***CUTTING DOWN*** ON DRINKING/DRUG USE

## **Change How Much You Drink/Use Drugs**

- Keep Track of Number of Drinks/Hits
- Drink Fewer Drinks/Do Fewer Hits
- Drink/Smoke Fewer Days
- Set Number Of Drinks/Hits Ahead Of Time
- Set A Specific Time To Stop Drinking/Smoking

# OPTIONS FOR ***CUTTING DOWN*** ON DRINKING/DRUG USE

## **Change The Way You Drink/Use Drugs**

- Sip Rather Than Chug
- Empty Your Glass Before You Refill It
- Alternate Alcoholic Drinks With Water Or Soda
- Drink Beverages With Lower Alcohol Content
- Avoid Drinking Games
- Eat Before You Drink/Use Drugs
- Avoid Drinking/Using Drugs When Taking Medication

# OPTIONS FOR ***CUTTING DOWN*** ON DRINKING/DRUG USE

## **Recognize Triggers and Plan Ahead**

- Plan Ahead Not To Drink/Use Drugs On A Night When You Would Usually Use
- Plan Alternative Activities To Drinking/Using Drugs
- Avoid Places Where You Will Be Bored Or Uncomfortable If You Don't Drink/Use Drugs
- Spend More Time With People Who Don't Use
- Prepare An Excuse For Not Using, If Asked
- Volunteer To Be The Designated Driver



# Resources

- Brent, D., Poling, K., and Goldstein, T. (2011). Treating Depressed and Suicidal Adolescents : A Clinician's Guide. New York : Guilford.
- Spirito, A., & Esposito-Smythers, C. (2011). Addressing adolescent suicidal behavior: Cognitive-behavioral strategies. In P.C. Kendall, (Ed.), Child and Adolescent Therapy. New York: Oxford, 217-242.
- Spirito, A., Esposito-Smythers, C., Wolff, J., & Uhl, K. (2011). Cognitive-behavioral therapy for adolescent depression and suicidality. Child and Adolescent Psychiatric Clinics of North America, 20, 191-204

# APPENDICES

○ RCTs on adolescent  
suicide attempters

Rudd et al. (1996) – Two-week day treatment program with older adolescents with 3 components:

- Experiential affective group.
- Psychoeducational classes with homework
- Problem-solving and social competence group
- No differences between experimental programs and standard care on suicidality

# Harrington et al. (1998)

- Standard care versus standard care plus a 4 session home based family intervention. Very structured sessions on reviewing circumstances around the attempt, goal setting, communication, and problem-solving
- The additional home treatment resulted in reduced suicidal ideation, but only for adolescents without major depression.
- No differences in the rate of suicide re-attempts

# Wood et al. (2001) Developmental Group Therapy:

- Problem-solving
- Dialectical Behavior Therapy
- Psychodynamic approaches

# Acute Phase

6 group sessions on:

- Family & peer relationship
- School problems
- Anger management
- Depression
- Self-harm
- Hopelessness
- Long Term Phase – optional, focused on group process



# Wood et al. (2001)

- # sessions ranged from 0 to 25 (median = 8)
- Compared group therapy to standard care
- Adolescents in group therapy were less likely to make more than one repeat suicide attempt than those in standard care (Odds ratio 6.3/1)
- More sessions of group therapy were associated with better outcomes.
- Hazell et al (2009) Did not replicate

# DONALDSON ET AL

- In another trial,<sup>38</sup> individual CBT was compared to an individual problem-oriented supportive therapy with adolescents immediately following a suicide attempt. More than half of the sample reported at least one prior suicide attempt. Adolescents were randomized to either 10 sessions of CBT (N = 15) or the problem-oriented supportive treatment (N = 16). The CBT condition focused on teaching adolescents problem solving and affect management skills. Each session included an assessment of suicidality, instruction in a skill, and skill practice (both in-session and homework assignments). Participants were taught steps of effective problem solving and cognitive and behavioral strategies for affect management (e.g., cognitive restructuring, relaxation). Homework assignments were given to assist in skill acquisition and generalization. Participants in both conditions reported significant reductions in suicidal ideation and depression at 3 month follow-up but there were no between-groups differences. At 6 months, both groups retained improvement over baseline but levels of suicide ideation and depression were slightly higher (though not statistically significant) than at 3 month follow-up. Only 5% of adolescents re-attempted during the course of the study.

# Huey et al. (2004)

MST home-based treatment lasting 3 to 6 months

MST consists of:

- Increasing family structure and cohesion
- Provide parents with skills to monitor and discipline
- Increase activities with prosocial peers
- Assist parents in disengaging youths from gangs

## Huey et al. (2004)

- At one year follow-up the MST group had significantly lower rates of suicide attempts than those who had been psychiatrically hospitalized.
- No difference between the two groups on suicidal ideation

# Treatment of Adolescent Suicide Attempters

- Original study design: Recruit 320 adolescents with depression plus a suicide attempt in the prior 3 months
- Randomized to Medication Management (MM) vs. MM + CBT
- Switched to an open trial – Patient Choice Design
- 3 arms: MM (n = 15), CBT (n = 18), and MM + CBT ( n = 93)
- 84% chose their treatment condition – mostly combined treatment

# TASA

- CBT + DBT + Relapse Prevention Strategies
- Up to 22 sessions over 6 months
- Suicidal ideation decreased in all groups
- 12% reattempted
- No differences between groups

(Brent et al, 2009)



NOTE I NEED TO ADD SLIDES ON  
THESE STUDIES IF WANT TO BE  
COMNplete

Diamond et al (2010)  
Rossouw et al (2011)  
Tang et al (2009)  
Ougrin et al (2011,2013)  
Asarnow et al (2011)  
Pineda & Dadds (2013)