Suicide in Children and Adolescents

Risks, Ideations, Behaviors

AMY A. CANUSO, D.O.

PHYSICIAN, BOARD CERTIFIED IN PSYCHIATRIC MEDICINE

DIPLOMAT, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

FOR CHILD ADOLESCENT AND ADULT PSYCHIATRY

There is no conflict of interest pertaining to this presentation, materials, and/or content

Objectives

1.) Discuss risk factors associated with suicide in children and adolescents

2) Name at least one screening tool that is used by professionals to evaluate suicide risk in children and adolescents

3) Discuss research findings regarding the relationship between psychotropic medications and suicide in children and adolescents

4) Understand what other behaviors need to be considered with a child is evaluated for suicide risk

Suicidality

Second leading cause of death in age 10-24 Approximately 2K suicides each year in adolescents

Third leading cause of death, all children all age groups

In 2007 -14.5 % grades 9-12 reported ideation and 6.9% reported at least one suicide attempt

Completed suicide rare prior to puberty but risk increases in teen years

Overwhelming (90%) have a psychiatric disorder, and more than half have had the disorder for 2 years

Other medical/psychological/ social factors are all important

Usually Stress Events Preceded Suicides

Loss of romantic relationship

Problems in school or problems with authority

Family difficulties

Newly recognized stressors

Bullying

Sexual orientation not supported by parents

Victims of abuse

Risk Factors

Older adolescents and male

Mood disorders

Previous attempt more predictive in males

Substance use

Family pathology and family suicidal behavior

African American have lowest suicide rate in adolescents

Native American highest suicide rate

Hispanic rate greater than Caucasian

Suicidal Ideation

Very common in children and adolescents and is not always associated with other psychopathology

Ideation more common in children with Disruptive Disorders, Mood Disorder, and Panic Disorders

Suicide Attempt

Attempts are more common in girls than boys (1.6: 1)

Estimated that 2 million adolescents have a suicide attempt yearl and almost 700K are seen for medical evaluation

Attempt usually occur in context of brief adjustment reaction

Impulsivity is largest clinical factor of concern (followed by substance use)

An actual attempt increases boys risk of eventually completing suicide

Suicide Attempt

Many adolescent who have serious attempt never will attempt again

And only half of all completed suicides have made a known suicide attempt before completed suicide
AACAP warns against using “gesture” as it minimizes potential risk

We can not predict future suicidal behavior! We do have and risk factors

Risk Factors

family history of suicide attempts

exposure to violence

impulsivity

aggressive or disruptive behavior

access to firearms

bullying

feelings of hopelessness or helplessness

acute loss or rejection

Risk for males

Previous suicide attempts

Age 16 or older

Associated mood disorder

Associated substance abuse

Females

Mood Disorders

Previous suicide attempts

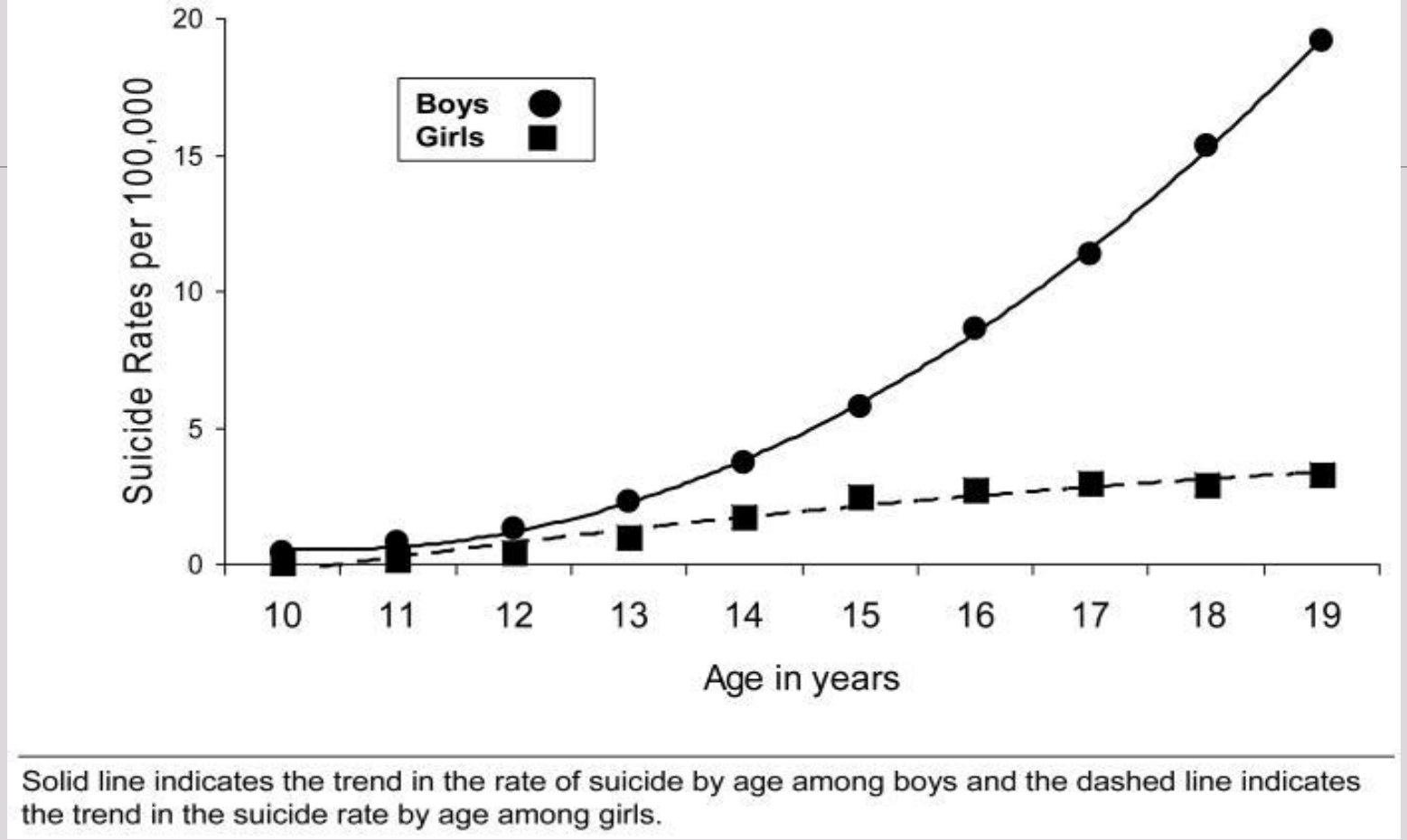
History of abuse

Completed Suicide Methods

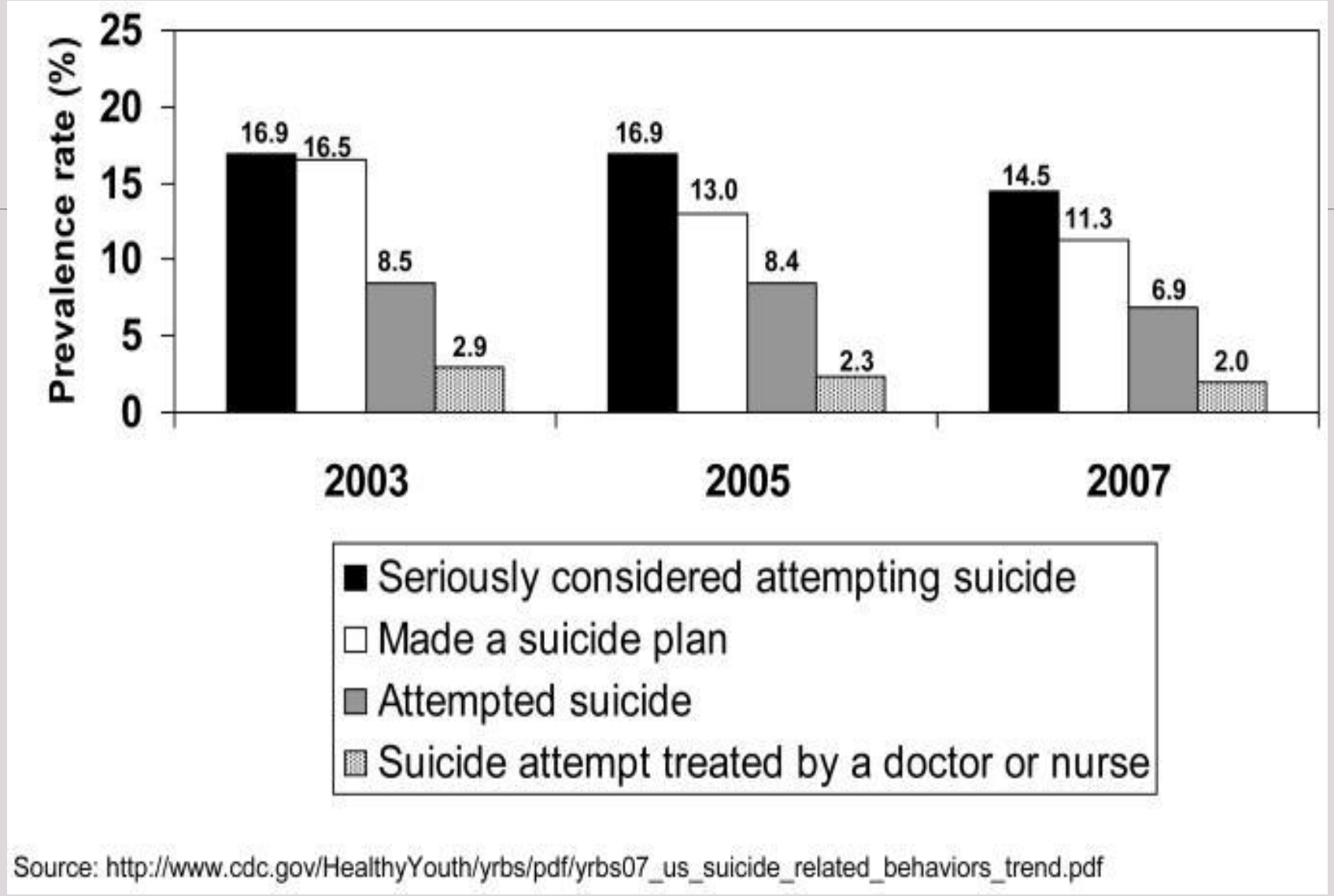
Firearms

Hanging Suffocation

Poisoning/toxic ingestion



Solid line indicates the trend in the rate of suicide by age among boys and the dashed line indicates the trend in the suicide rate by age among girls.



Source: http://www.cdc.gov/HealthyYouth/yrbs/pdf/yrbs07_us_suicide_related_behaviors_trend.pdf

Assessment

Recommend CSSRS or SAD PERSONAS for adolescents

If found to be low risk, a safety plan should still be established parents notified, reduce means

“No Suicide Contracts” – No data to support using

Suicide resources- 1800 273 TALK

High risk patients may warrant inpatient or more acute treatment

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT VERSION

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Suicidal and Self-injurious Behavior (Past week)			**Clinical Status (Recent)**
☐	Actual suicide attempt ☐ Lifetime	☐	Hopelessness
☐	Interrupted attempt ☐ Lifetime	☐	Major depressive episode
☐	Aborted or Self-Interrupted attempt ☐ Lifetime	☐	Mixed affective episode
☐	Other preparatory acts to kill self ☐ Lifetime	☐	Command hallucinations to hurt self
☐	Self-injurious behavior without suicidal intent ☐ Lifetime	☐	Highly impulsive behavior
Suicidal Ideation (Most Severe in Past Week)		☐	Substance abuse or dependence
☐	Wish to be dead	☐	Agitation or severe anxiety
☐	Suicidal thoughts	☐	Perceived burden on family or others
☐	Suicidal thoughts with method (but without specific plan or intent to act)	☐	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
☐	Suicidal intent (without specific plan)	☐	Homicidal ideation
☐	Suicidal intent with specific plan	☐	Aggressive behavior towards others
Activating Events (Recent)		☐	Method for suicide available (gun, pills, etc.)
☐	Recent loss or other significant negative event	☐	Refuses or feels unable to agree to safety plan
	Describe:	☐	Sexual abuse (lifetime)
		☐	Family history of suicide (lifetime)
☐	Pending incarceration or homelessness	**Protective Factors (Recent)**	
☐	Current or pending isolation or feeling alone	☐	Identifies reasons for living
Treatment History		☐	Responsibility to family or others; living with family
☐	Previous psychiatric diagnoses and treatments	☐	Supportive social network or family
☐	Hopeless or dissatisfied with treatment	☐	Fear of death or dying due to pain and suffering
☐	Noncompliant with treatment	☐	Belief that suicide is immoral; high spirituality
☐	Not receiving treatment	☐	Engaged in work or school
Other Risk Factors:		**Other Protective Factors:**	
☐		☐	

Describe any suicidal, self-injurious or aggressive behavior (include dates):

ADDRESSING Mental Health CONCERNS IN PRIMARY CARE A CLINICIAN'S TOOLKIT

ADAPTED SAD PERSONS

Assessment of Suicide Risk*
The patient and family need to partner with the provider to monitor safety in the depressed adolescent. When doing a risk assessment on a suicidal teen, there are several risk factors which should be taken into consideration. A mnemonic that can help with this assessment is "**SAD PERSONS**." Risk factors are ranked with stars, ranging from 0-2, with 2 stars representing increased risk.

Adapted-SAD PERSONS Scale for Children and Youth

Sex (males are considered at increased risk)

Age (adolescents aged 15 and older are at greater risk than younger children)

Depression or affective disorder

Previous suicide attempt

Ethanol or drug abuse

Rational thinking loss (from physical or psychological disorder)

Social supports lacking

Organized plan

Negligent parenting, significant family stressors, or suicidal modeling by parents or siblings

School problems (aggressive behaviors or experiencing humiliation)

References:

1. Patterson W, Dohn H, Bird J, Patterson G. Psychsomatics, 1983, 24, 343-349
2. Juhnke, G.E. "SAD PERSONS scale review." Measurement & Evaluation in Counseling & Development, 1994, 27, 325-328
3. Juhnke, G.E. ("The adapted SAD PERSONS: As assessment scale designed for use with children" Elementary School Guidance & Counseling, 1996, 252-258

doi:10.1542/peds.2010-0788T

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Children’s Service Center Suicide Risk Assessment “Sad Persons” ITEM YES NO

Sex (male) Age (15 and older) Depression or affective disorder Previous suicide attempt or psychiatric care Ethanol or drug abuse Rational thinking loss (psychosis) Social support lacking Organized plan or attempt
Negligent parenting, significant stressors, suicidal modeling by parents
School problems (aggressive behaviors or experiencing humiliation)

1-2 Low Risk Not serious threat, keep watch

3-6 Moderate Risk +/-supervision at home/psychiatric consult

7-10 High Risk Supervision/psychiatric consult/hospitalization

Signs of clinical depression

Depressed mood most of the time

Loss of interest or pleasure in usual activities

Weight loss or gain

Can't sleep or sleeps too much

Restless or slowed-down

Fatigue, loss of energy

Feels worthless or guilty

Low self-esteem, disappointed with self

Feels hopeless about future

Can't concentrate, indecisive

Recurring thoughts of death

Irritable, upset by little things

Signs of Mania

Depressed mood most of the time

Elated, expansive, or irritable mood

Inflated self-esteem, grandiosity

Decreased need for sleep

More talkative than usual, pressured speech

Racing thoughts

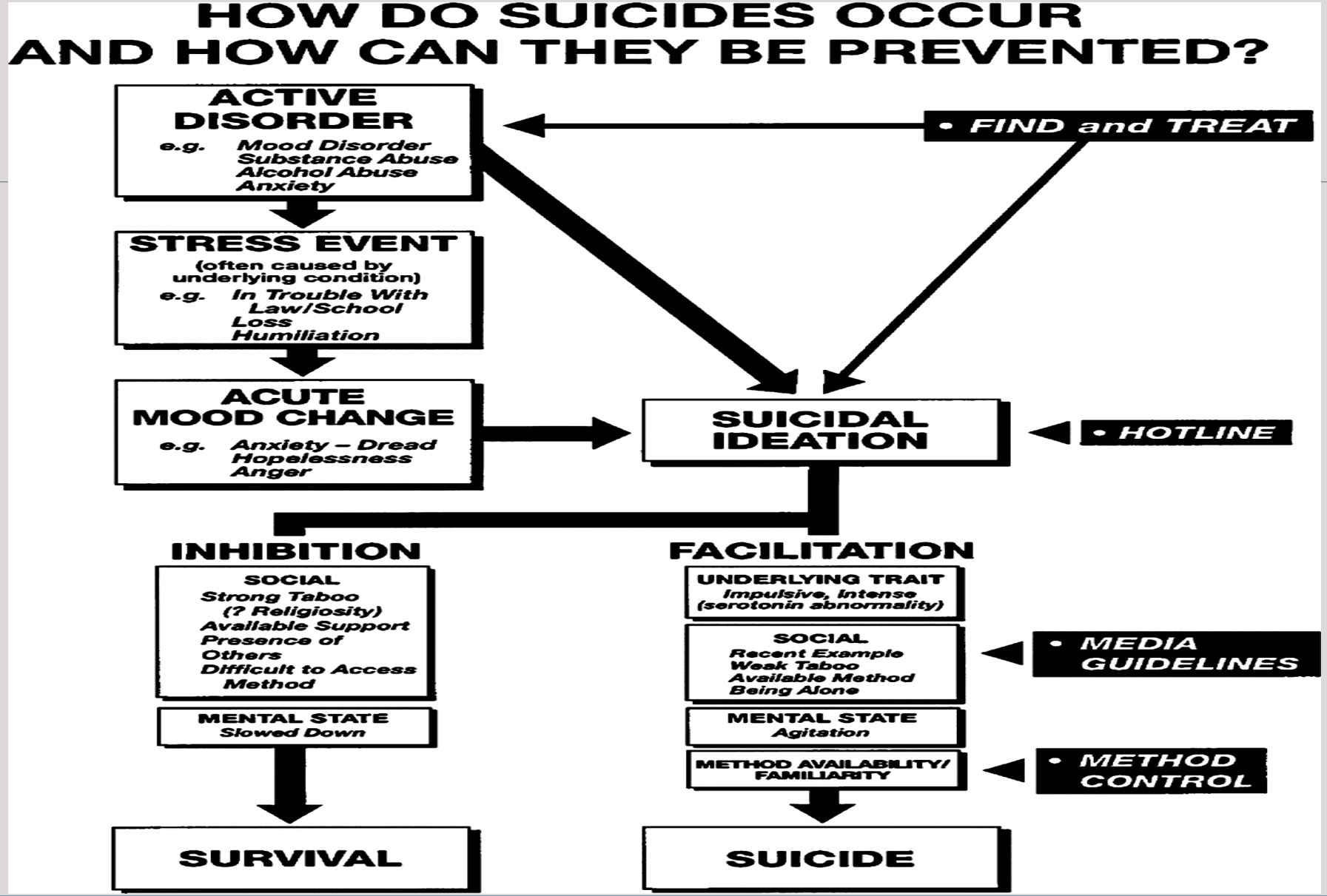
Abrupt topic changes when talking

Distractible

Excessive participation in multiple activities

Agitated or restless

Hypersexual, spends foolishly, uninhibited remarks


HOW DO SUICIDES OCCUR
AND HOW CAN THEY BE PREVENTED?
ACTIVE DISORDER
e.g. Mood Disorder
Substance Abuse
Alcohol Abuse
Anxiety
• FIND and TREAT
STRESS EVENT
(often caused by underlying condition)
e.g. In Trouble With Law/School
Loss
Humiliation
ACUTE MOOD CHANGE
e.g. Anxiety – Dread
Hopelessness
Anger
SUICIDAL IDEATION
• HOTLINE
INHIBITION
SOCIAL
Strong Taboo
(? Religiosity)
Available Support
Presence of Others
Difficult to Access Method
MENTAL STATE
Slowed Down
SURVIVAL
FACILITATION
UNDERLYING TRAIT
Impulsive, Intense
(serotonin abnormality)
SOCIAL
Recent Example
Weak Taboo
Available Method
Being Alone
• MEDIA GUIDELINES
MENTAL STATE
Agitation
METHOD AVAILABILITY/ FAMILIARITY
• METHOD CONTROL
SUICIDE

Black Box Warning

In June 2003 MHRA, FDA in UK, warned about possible increased risk of suicidal ideation in children and adolescent taking SSRI based on one study and recommendation for further studies.

2004 Black Box Warning was issued, but also established a classification project to improve the study of “range of suicidal behaviors” and other behaviors “not directly related to suicidal behavior.”

Black Box Warning

Warning was established after 3 RCT: 1 of three studies showed a difference between drug and placebo in “possibly suicide related behavior” but another study showed increased behaviors in placebo. Not one of the 4000 children or adolescents participating in theses studies actually committed suicide.

Multiple Hypothesizes

Feeling better?

Precipitated manic episodes?

SSRI Paradoxical response- Activation agitation disinhibition leading to more cutting behavior and parasuicidal behavior

Black Box Warning

More studies support the decrease in suicide rates. Suicide rates have been declining since 1987 , through the mid-n90s for children and adolescents (only recently started to increase again in 2001),

Landmark study, Treatment of Adolescent Depression Study (TADS) 2004 – Fluoxetine + CBT most effective and Fluoxetine alone still more effective than placebo.

TADS also showed that there may be an increase in “harm-related events” but not suicide.

TADS and other studies indicate that SSRI does effectively treat depression, which is prominent feature in completed suicides

Increase in Suicide 2004- 2009 by 18% in U.S.

"…..influence of internet social networks increases in suicide among young U.S. troops and higher rates of untreated depression in the wake of recent "black box" warnings on antidepressants—a possible unintended consequence of the medication warnings, required by the FDA in 2004."

Cash, S. J., & Bridge, J. A. (2009). Epidemiology of youth suicide and suicidal behavior. *Current opinion in pediatrics*, *21*(5), 613.

Other Para-Suicidal Behaviors- Self Injury- NSSI

Cutting or self mutilation – a complex behavior and symptom results from variety of factors

Release tension

Boredom

Release of endorphins

Rebel or get reaction from others (unconscious dynamic vs conscious)

Bonding activity

A way to show hopelessness feelings of worthlessness or emotional numbing

Other Para-Suicidal Behaviors- Self Injury- NSSI

Prevalence- as much as 10% of children engage in self injurious behaviors up to 35 % of patients with eating disorders. Meta analysis indicates 17% Adolescents, 10% college students and a 5% life time prevalence

NSSI in western counties highest in white adolescent males

Research indicates half of patients with NSSI may not meet criteria for a major psychiatric disorder.

Increased “contagion’ factor

However, considered to have an increase risk to attempted but not completed suicide

Other Dangerous Behaviors

Autoerotic asphyxiation

“Challenges”- Online challenges that target suggestible children and adolescents, particularly targeted to low intelligence, low self esteem, and impulsive children

What To Do?

Manage one's own anxiety

Evaluate for suicidal vs NSSI

Safety stratification

Refer to professional as indicated

What Do You Think Physicians/Professionals Do?

Prevention

Crisis hotlines 1 800 273- TALK

Restricting access to firearms

Suicide awareness programs minimize the role psychiatric illness and have not been shown to be effective in reducing suicidal behavior or increasing self help

Suicide awareness programs may disturb high risk students

AACAP recommend focus on clinical characteristics of depression or other mental illness.

References

AACAP References for suicide
https://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Suicide_Resource_Center/Home.aspx

Centers for Disease Control and Prevention. 2007 Youth Risk Behavior Survey. [6/19/2009]. Available at: http://www.cdc.yrbss. [Ref list]

Grandclerc, S., De Labrouhe, D., Spodenkiewicz, M., Lachal, J., & Moro, M. R. (2016). Relations between nonsuicidal self-injury and suicidal behavior in adolescence: a systematic review. *PLoS One*, *11*(4), e0153760.

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and adolescent psychiatry and mental health*, *6*(1), 10.

Peterson, J., Freedenthal, S., Sheldon, C., & Andersen, R. (2008). Nonsuicidal self injury in adolescents. *Psychiatry (Edgmont)*, *5*(11), 20.

Review Adolescent suicide and suicidal behavior.Bridge JA, Goldstein TR, Brent DA

J Child Psychol Psychiatry. 2006 Mar-Apr; 47(3-4):372-94.

Shaffer, D., & Pfeffer, C. R. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *Journal of the American Academy of Child & Adolescent Psychiatry*, *40*(7), 24S-51S.