Crisis Intervention with Youth at Risk for Suicide

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Current Statistics

• In the United States, suicide is 3rd leading cause of death among 10-14 year-olds and the 2nd leading cause of death among 15-24 year olds (CDC, 2017).

• 17.2% of adolescents in the U.S. report seriously considering suicide and 7.4% report a suicide attempt in the past year (Kann, 2018).

• The prevalence of both suicidal ideation (SI) and suicide attempts (SA) increases dramatically during adolescence (Nock et al., 2013).

• Suicide rates have continued to rise across age groups in the United States over the last 15 years, with females aged 10–14 showing the greatest increase (200%) across groups (Curtin et al., 2016).

• Recent data has also shown that Emergency Room and hospital visits among youth for SI and SA nearly doubled from 2008 – 2015 (Plemmons et al., 2018).

• Rates of non-suicidal self-injury in the United States high school students are high (Total = 17.6%; 24% among girls; 11% boys).
Definitions

- **Suicide attempt**: A potentially self-injurious behavior, associated with *some evidence of intent to die*

- **Non-suicidal self-injury behavior**: Self-injurious behavior not associated with intent to die (intent may be to relieve distress or communicate with another person), often called “self-mutilation,” “suicide gesture.”
Assessment of Suicidal Behavior

- **Suicidal Ideation:** thoughts about wanting to be dead (passive) or killing oneself (active)
- **Plan:** a method of suicide has been identified and preparations have been made
- **Intent:** intent to actually attempt suicide
- Ability to commit to safety/a safety plan
- Existing risk factors
- Current prompting events/triggers (suicide attempts are generally the result of underlying risk factors combined with a prompting event)
- Safety of home environment/ability of parents to monitor safety
- Access to lethal means
Suicide Assessment Tips

- Be careful about asking, “if you were going to kill yourself, how would you do it?”
- Ask about willingness to seek help if feeling suicidal versus promise not to be suicidal.
- If the teen says “I don’t know” if they will attempt suicide because they don’t know what mood they will be in the future, get willingness to ask for help if that happens in the future. Technically, this not imminent danger.
- If teen says, “I won’t kill myself unless my boyfriend breaks up with me,” then it is not imminent danger, increase parental monitoring and visits, etc.
Risk Factors

- Past suicide attempt
- Non-suicidal self-injury
- Access to weapons/lethal means
- Psychopathology: Depression, substance abuse, conduct disorder (males)
- Severe emotion dysregulation
- The tendency to be aggressive and violent, and to engage in dangerous, illegal, or risky activities
- Impulsivity
- Alcohol and drug use/abuse
- History of child sexual abuse
- Family conflict
- Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, conflict with peers, family members – real or anticipated)
- Hopelessness, the belief that problems cannot be solved, poor problem solving ability
- Family history of suicide
- Severe insomnia and agitation
- Acute psychosis
- Bullying
- LGBT
- Contagion
Risk Factors cont.

- Severity of prior attempts
  - Method/Lethality
  - Intent to die (Beck Suicide Intent Scale)
    - Precautions taken against discovery/intervention
      - Alone
      - Nobody likely to be home/discover him/her
      - Did not seek help after attempt
  - Planning/Preparations for death
    - Getting affairs in order
    - Suicide note
    - Time spent planning in advance v. impulsive attempt
  - Expectation of likelihood of death
    - Thought that death was probable or certain
    - Equaled or exceed what he/she thought would be lethal
  - Reaction to attempt
    - Regrets failure of attempt v. glad to be alive
Protective Factors

- Reasons for living
- Hope for the future
- Responsibility to friends, family, pets, etc. that client would not abandon
- Attached to therapy/therapist
- Embedded in protective social network/family
- Fear of suicide, death, dying
- Religious beliefs that do not allow suicide
- Has plans for the future


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Non-suicidal self-injury behavior

- Common methods: cutting, burning, scratching, head banging
- No intent to die
- Risk factor for suicide attempts
- Not “suicide gestures”
- Treatment involves determining function of the behavior and helping client attain function in alternative ways
- Generally does not require hospitalization
- Remove means of self-harm
- Estimated 10% prevalence rate in general population; 35% hospitalized adolescents (Grandclerc et al., 2016)
Common reasons for NSSI

- Affect regulation/avoidance
- To reduce dissociation
- Interpersonal communication
- Self-punishment

Relationship between Suicidal Behavior and NSSI

- NSSI is a predictor of subsequent suicide attempts among depressed youth (Asarnow et al., 2011; Wilkinson et al., 2011).

- Adolescents often engage in both NSSI and suicidal behavior concurrently (Whitlock et al., 2012).

- NSSI increases the risk of engaging in suicidal behavior and may serve as a “gateway” to attempting suicide (Whitlock et al., 2012).
Safety Procedures

- Safety plan
- Removal of lethal means
- Parental monitoring
- Increased frequency of contact with therapist (or linkage to outpatient treatment if the teen is not currently in treatment)
- Hospitalization
- Confidentiality: share information about safety with parents unless there is a compelling reason not to.
Removal of Lethal Means

- Decreases possibility of impulsive attempts
- Dieting metaphor
- Review with both adolescent and parent
- Continue to assess access to lethal means throughout treatment
- Remove guns, sharps, pills (both over the counter and prescription), alcohol, household poisons, and additional means as needed.
Youth Safety Plan (adapted from Stanley & Brown, 2012)

Step 1: Warning signs (situations, thoughts, feelings, body sensations, behaviors) that a crisis may be developing:

Step 2: Internal coping strategies - Things I can do by myself to take my mind off my problems (such as distracting myself, a relaxation technique, physical activity, etc.):

Step 3: People and social settings that provide distraction:

Step 4: People whom I can ask for help:

Step 5: Professionals or agencies I can contact during a crisis:

If you are in immediate danger of hurting yourself, CALL 911 OR TAKE GO TO THE NEAREST EMERGENCY ROOM.
You may also call one of the 24/7 hotlines listed below.

- Santa Clara County Child and Adolescent Mobile Crisis Program (EMQ):
  - 1-877-41-CRISIS (for residents of Santa Clara County)
- San Mateo County Crisis Intervention and Suicide Prevention Center:
  - (650) 579-0350 (for residents of San Mateo County)
- California Youth Crisis Line: 1-800-843-5200
- National Suicide Prevention Lifeline: 1-800-273-TALK
- Crisis Text Line: Text START to 741-741

Step 6: Making the environment safe:

The one thing that is most important to me and worth living for is:
Youth Safety Plan Template

Step 1: Warning signs (situations, thoughts, feelings, body sensations, behaviors) that a crisis may be developing:
1. 
2. 
3. 

Step 2: Internal coping strategies - Things I can do by myself to take my mind off my problems (such as distracting myself, a relaxation technique, physical activity, etc.):
1. 
2. 
3. 

Step 3: People and social settings that provide distraction:
1. Name Phone
2. Name Phone
3. Name Phone

Step 4: People whom I can ask for help:
1. Name Phone
2. Name Phone
3. Name Phone

Step 5: Professionals or agencies I can contact during a crisis:
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Step 6: Making the environment safe:

The one thing that is most important to me and worth living for is:

Safety plan template adapted from Stanley & Brown, 2012
Feel the Worst

Feel the Best

Feeling Thermometer
Safety Plan Role Play
Hope Box

- In a suicidal crisis, it is often difficult for youth to identify coping skills and reasons to live.
- To combat this problem, the youth should be asked to create a “hope box” for use during suicidal crises.
- The hope box is a box or other type of container in which the youth places items and mementos that elicit positive feelings, cue them to use coping skills (such as distraction and self-soothing), and serve as reminders of reasons to live.
- Examples: photographs of favorite people and places, postcards, paper and colored pencils, letters, gifts, a scented candle, etc.
- The youth is instructed to put the hope box in a place where they can easily access it when feeling suicidal.
Hope Box Example

https://myjourneywithdepression.wordpress.com/2014/02/02/how-to-create-a-self-harm-safety-box
Factors to consider regarding hospitalization

- Removal of lethal means
- Ability of the parent to provide close monitoring
- Client’s commitment to treatment/relationship with the therapist
- Willingness of patient and parent to follow outpatient treatment plan
- Willingness of patient to commit to asking for help instead of engaging in self-harm
- Are there symptoms that can be better treated in the hospital (e.g., acute psychosis, mania, medication changes)?
- Consider possible negative consequences of hospitalization
Potential Problems with Hospitalization

- Reinforcement of suicidal behavior
- Contagion/Interaction with problematic peers
- Expensive
- Disruptions in daily life (e.g., school, relationship with peers)
- Stigma
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Specific Steps to be Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restriction of Access to Lethal Means</td>
<td>Discussed importance of removal of firearms from the home.</td>
</tr>
<tr>
<td></td>
<td>Reviewed removal of lethal means with parent.</td>
</tr>
<tr>
<td></td>
<td>Reviewed access to lethal means with teen.</td>
</tr>
<tr>
<td></td>
<td>Asked teen if he/she has any lethal means hidden “just in case” he/she wants to use them in the future.</td>
</tr>
<tr>
<td>Parental Monitoring</td>
<td>Reviewed need for close monitoring and discussed amount of close monitoring currently needed.</td>
</tr>
<tr>
<td></td>
<td>If 24/7 monitoring is needed, a plan has been set-up to re-assess safety within the next one to two days.</td>
</tr>
<tr>
<td>Creation of a Written Safety Plan</td>
<td>Written Safety Plan Completed with Teen.</td>
</tr>
<tr>
<td></td>
<td>Written Safety Plan Reviewed with Parent.</td>
</tr>
<tr>
<td>Creation of a Hope Box</td>
<td>Hope Box Completed.</td>
</tr>
<tr>
<td>Providing Emergency Contact Information</td>
<td>Parent and teen were provided with emergency cards with 24/7 emergency hotline numbers/911.</td>
</tr>
<tr>
<td>Discussion of the Importance of Reducing Family Conflict</td>
<td>Parents were informed of the importance of reducing family conflict until the teen is no longer suicidal.</td>
</tr>
<tr>
<td>Educating Parents to Take Communications of Suicidality Seriously</td>
<td>Parents were informed to take all communications about suicidal thoughts or urges seriously and to implement appropriate safety interventions as needed.</td>
</tr>
<tr>
<td>Reducing Contamination</td>
<td>A plan was discussed with parent and teen for limiting access to internet content related to suicide</td>
</tr>
</tbody>
</table>
Documentation

- Need to document your safety assessment, safety plan, and your rationale for treatment decisions (e.g., hospitalization or not).

- Things to document:
  - Parent was informed of any reports of suicidality or urges to self-harm.
  - Parent was told and agreed to removal all lethal means/means of self-harm from the home.
  - Parent was told to increase monitoring of youth, and in cases where the degree of risk is high, told not let the youth be alone at all until the patient is re-assessed and it is determined to be to safe to decrease monitoring).
  - A safety plan was discussed with the parent and teen, including being told to call 911, Uplift or go to the nearest ER if pt. is in danger of harming herself.
  - Other clinicians treating the patient (e.g., the psychiatrist or therapist) were informed.
  - If the degree of risk is high, a plan was made for increased therapy sessions and telephone check-ins.
  - Explanation of your choice of hospitalization or outpatient treatment
What can a mental health professional do to prevent suicides?

- We do not have the power to completely prevent suicides from occurring.
- Currently, there is no way to accurately predict who will attempt or complete suicide.
- Mental health professionals can only lower the risk.
- It is important to learn how you can lower risk.
Consult with colleagues!!!!
Treatment Approaches
Treatment Approaches

• There is limited research on treatment approaches
• Only a small number of treatments have been shown to reduce suicidal and/or self-harm behavior in adolescents
• Dialectical Behavior Therapy (DBT) is the only treatment meeting criteria (replication) for a “well-established” empirically supported treatment.
• Lack of research may be related to anxiety, liability concerns, lack of expertise, and large sample sizes needed.
7 Treatments With Demonstrated Effectiveness

1. **Multi-systemic therapy** was shown to be more effective than hospitalization at decreasing rates of youth-reported suicide attempts (Huey et al., 2004).

2. **Developmental group therapy** was shown to be more effective than routine care at decreasing deliberate self-harm (Wood et al., 2001).

3. **Mentalization-based treatment** was shown to be more effective than TAU at decreasing self-harm (Rossouw & Fonagy, 2012).

4. **Integrated CBT** for co-morbid suicidality and substance abuse was shown to be more effective than TAU at decreasing suicide attempts (Esposito-Smythers et al., 2011).

5. **Resourceful Adolescent Parent Program (RAP-P)** was shown to be more effective than usual care at decreasing self-harm behaviors (Pineda & Dadds, 2013).

6. **Safe Alternatives for Teens and Youth (SAFETY) Program** was shown to have a significantly lower likelihood of a suicide attempt by the 3-month follow-up point as compared to E-TAU youths (Asarnow et al. 2017).

7. **Dialectical Behavior Therapy** was shown to be more effective than enhanced usual care at decreasing self-harm behaviors (Mehlum et al., 2014) and more effective than supportive therapy at reducing suicide attempts and self-harm (McCauley et al., 2018).
DBT is the only “well-established” empirically-supported treatment for adolescents at risk for suicide

- DBT is the only treatment that has been replicated across two separate RCTs, conducted by different groups of investigators.
- Mehlum et al., 2014, DBT was shown to be more effective than enhanced usual care at decreasing self-harm behaviors at end of treatment and 1-year follow-up.
- McCauley et al., 2018, DBT was shown to be more effective than individual and group supportive therapy at reducing suicide attempts and self-harm (McCauley et al., 2018) at end of treatment.
What is DBT?

- Cognitive-behavioral treatment approach developed by Marsha Linehan, Ph.D. for treating chronically suicidal and self-harming patients.
- Targets emotion dysregulation as the primary cause of suicidal and self-harm behaviors.
- Is a multi-component treatment, including individual therapy, skills group therapy, availability of telephone coaching and a consultation team for therapists.
Video: What is DBT for Adolescents?
Theory of Borderline Personality Disorder in DBT
Biosocial Theory of BPD

Biological Dysfunction in the Emotion Regulation System

Invalidating Environment

Pervasive Emotion Dysregulation
Emotional Vulnerability

- **High Sensitivity**
  - Immediate Reactions
  - Low threshold for emotional reaction

- **High reactivity**
  - Extreme Reactions
  - High Arousal dysregulates cognitive processing

- **Slow return to baseline**
  - Long-lasting reactions
  - Contributes to high sensitivity to next emotional stimulus
Invalidating Environment

- The caregiver responds to the child’s expression of emotion in ways that are “inconsistent, inappropriate to the emotion expressed, and/or trivializing of the emotional experience (Linehan, 1993).”
- “You shouldn’t be so upset.”
- “Get over it.”
- “You are over-reacting.”
- “Snap out of it.”
Effects of the Invalidating Environment

- Individuals do not learn to accurately label emotions
- Individuals do not learn how to tolerate distress
- Individuals learn to self-invaliditate
- Individuals learn that only escalated expressions of negative affect are taken seriously
Summary of DBT Theory

- Suicidal/self-injurious individuals with BPD traits are biologically predisposed to experiencing very strong emotions.
- These emotions were invalidated by caregivers.
- Hence, these individuals experience very strong negative emotions but know few skills to manage them.
- Suicidal/self-injurious behavior is used as a maladaptive means of coping with negative emotions.
- DBT reduces suicidal/self-injurious behaviors by teaching skills for coping with emotion dysregulation safely and effectively.
Standard Adolescent DBT Components

- Outpatient Individual Psychotherapy
  - Behaviorally-oriented
  - "validation and change"
- Outpatient Multi-family Group Skills Training
- Therapists’ Consultation Meeting (DBT Team)
- Telephone Consultation
- Family therapy and parent sessions as needed
Modifications of DBT for Adolescents

- Very few changes from adult version
- Biosocial theory rooted in developmental psychopathology
- Inclusion of families in skills training/family therapy
- Direct intervention in the invalidating environment
- Adding new skills relevant to families (Middle Path; Miller, Rathus & Linehan, 2007)
- Abbreviating treatment length (from 1 year to 4 to 6 months)
- Including skills examples that are relevant to teens
DBT is a treatment package

- Research data supports standard DBT
- No research data to support using components of DBT separately for suicide and self-harm outcomes
- “DBT-informed” treatment
- Adopt versus adapt?
DBT with adolescents should only be implemented as a complete treatment package, as supported by research (Mehlum et al., 2014; McCauley et al., 2018).

Basic DBT principles, such as reducing emotion dysregulation, balancing acceptance and change and helping suicidal individuals "build a life worth living" (Linehan, 1993), as well as DBT skills, may be considered for use in everyday practice, but are not presently supported by research apart from the comprehensive treatment model.

If you are adapting DBT, consider ways to address the functions and modes of DBT (e.g., generalization of skills to the natural environment, if you are not doing phone coaching; Koerner, Dimeff & Swenson, 2007)
Overarching DBT Goal
“Building A Life Worth Living”
DBT Skills Modules

- 3 Skills Modules
  - Distress Tolerance
  - Emotion Regulation
  - Interpersonal Effectiveness

- At the beginning of each module, Mindfulness and Middle Path skills are taught (dialectics, validation, behaviorism)
Mindfulness

“Mindfulness means paying attention in a particular way; on purpose, in the present moment, and non judgmentally.” - Jon Kabat-Zinn

- Meditation practice derived from Buddhism
- Attention training
- Awareness of the present moment
- Awareness of thought processes leads to greater control over behavior
- Acceptance
Adolescent Mindfulness Practices
(see Miller et al., 2007)

- Observing mindfully: (eating a food using all 5 senses, like an orange; “What’s different about me?” exercise)
- Mindfulness of resisting urges (e.g., being mindful of a piece of chocolate that youth is not allowed to eat)
- Mindfulness of judgments (e.g., drawing a picture with your non-dominant hand)
- Attention training (e.g., “Snap, Crackle, Pop,” “Last letter/first letter,”)
Middle Path Skills

- Originally designed by Alec Miller and Jill Rathus to focus on issues specific to adolescents and families
- Included in Linehan’s revised (2015) DBT skills manual in IE module
- 3 Skills Taught
  - Dialectics/Middle Path
  - Validation
  - Behaviorism/Contingency Management
Acknowledging that there is truth in both people’s viewpoints and working toward a solution that honors both viewpoints.

Example: parent does not approve of the teen’s clothing because it is too revealing and the teen feels that she needs to wear these clothes to be popular.

Middle path: finding clothing that the parent does not find too revealing and that the teen feels is acceptable to peers.
Adolescent Dialectical Dilemmas

- Too loose ↔ Too strict
- Forcing independence ↔ fostering dependence
- Making light of problem behaviors ↔ Making too much of typical adolescent behavior
Definition of Validation

- Validation communicates to another person that his/her feelings, thoughts, and actions make sense and understandable to you.

- Validation does not mean that you AGREE with the other person’s perspective. It just means that you UNDERSTAND how THEY might feel that way.

- Balancing validation and change is central dialectic for DBT therapist.

- Can also apply this to parent/child interactions.
Validation

- “I understand that you feel ____________________.”

- “It makes sense to me that you feel ____________________.”
Behaviorism

- Positive Reinforcement
- Negative Reinforcement
- Extinction
- Shaping
- Punishment
Practicing Behaviorism in Group

- Make a list of behaviors you would like your parent/teen to do more of.
- Exchange lists and have parent/teen circle behaviors they are willing to change.
- Parent and Teen each make their own list of 10 things that are reinforcers for them.
- Exchange lists and select reinforcers parent/teen are each willing to give each other.
- Have them pick 3 behaviors they will focus on for the week as homework.
DBT Distress Tolerance Skills

- “Crisis Survival” Skills
- STOP
- TIP
- Distraction
- Self-soothing with the five senses
  - Sight
  - Sound
  - Smell
  - Taste
  - Touch
- Improve the moment
- Radical Acceptance
Emotion Regulation Skills Module

- Goal is to reduce emotional suffering
  - Understanding and Naming Emotions
  - Changing Emotional Responses
  - Reducing Vulnerability to Emotion Mind
  - Managing Really Difficult Emotions
Interpersonal Effectiveness

- Assertiveness training
- Balancing getting interpersonal goals met with maintaining relationships and self-respect
  - Objectives Effectiveness
  - Relationship Effectiveness
  - Self-Respect Effectiveness

- DEARMAN
- GIVE
- FAST
DBT and PTSD Symptoms

- Treats comorbid suicidality/self-harm in stages.
- Stage 1 focuses on stabilization of suicidality/self-harm.
- Exposure treatments are not recommended until the patient is stable and non-suicidal, and has mastered the coping skills needed to tolerate exposure (Stage 2).
Case Description: Anna

- 14 year old Latina female
- Presents to clinic after hospitalization for a suicide attempt (overdose on pills)
- Lives with biological mother
- History of NSSI for the past year
- History of sexual abuse by male relative, from ages 12-14.
- PTSD Symptoms:
  - Intrusive thoughts
  - Nightmares
  - Difficulty separating from mother
- Depressive symptoms:
  - Depressed mood
  - Insomnia
  - SI
  - Hopelessness and guilt
- Anxiety
  - Social anxiety, frequently worries about making mistakes, people judging her, being embarrassed.
  - Anxiety interferes with meeting new people and expressing herself
- School functioning: Average to low grades, frequently misses school due to headaches and stomach aches
- Peers: Has a small group of friends
- Family: Mother is frequently unavailable due to work schedule. No contact with father.

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DBT Case Conceptualization and Treatment Plan for Anna

- Initial sessions:
  - Orientation to DBT and commitment to treatment
    - Teen commits to working on reducing self-harm behaviors and to participating in all components of DBT for 6 months.
    - Parent agrees to participate in treatment (multifamily group, family/parent sessions; facilitate teen’s participation in treatment).
  - Safety planning
    - Restriction of lethal means (particularly pills and sharps)
    - Parental monitoring of teen
    - Creation of a safety plan
  - Phone coaching
  - Diary card
Primary goal of Stage 1 DBT is stabilization/reducing suicidal and self-harm behaviors

Life-threatening behaviors
- Therapist conducts a chain analysis of the most recent suicide attempt/self-harm in initial sessions and in every subsequent session where self-harm has occurred.
- Anna reports that primary trigger for suicide attempt was an intrusive thought about her abuse, therapist introduces DBT Distress Tolerance (e.g., distraction, self-soothing) skills to help Anna manage intrusive thoughts in the future. Encourages Anna to use phone coaching if she has intrusive thoughts in the future.

Therapy-interfering behaviors
- Anna’s social anxiety makes it difficult for her to engage in therapy.
- Mother is frequently unavailable due to work schedule, Anna is afraid to be alone and will not attend individual or multifamily group sessions without her mother present.
- Therapist works with mother to problem solve barriers to attendance, works with Anna on DBT Distress Tolerance (e.g., distraction, self-soothing, TIPP) and Emotion Regulation (e.g., opposite action, check the facts, cope ahead) skills to reduce anxiety when she is alone.
DBT Case Conceptualization and Treatment Plan for Anna cont.

- Quality of life interfering behaviors
  - Ordered in terms of priority/closest link to suicidal and self-harm behavior
  - Building a “life worth living”
    - PTSD symptoms
    - Depressive symptoms
    - Anxiety symptoms
    - School problems

- Parent/family intervention
  - Worked with mother on reducing invalidation, particularly related to abuse

- Anna completed 6 months of standard DBT and achieved significant reductions in suicidal and self-harm behaviors. She terminated treatment with her DBT therapist and began trauma-focused CBT (TF-CBT) at the same clinic, with a different therapist.