UNC School of Social Work's
Clinical Lecture Series

Depression and Suicide in Children and Adolescents

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Jodi Flick, ACSW, LCSW
Family and Children's Resource Program
Jordan Institute for Families
UNC-Chapel Hill School of Social Work
919-962-4988
joflick@email.unc.edu

Suicide in the Young

Tripled in the last 35 years;
10 -14 year olds, rates up 120%

- **Decreasing onset of puberty**
- **Increased alcohol use / gun access**
- **Environmental pollutants**
- **Increased rate at all ages**
- **Anticipation**

Third leading cause of death

- 1st – accidents
- 2nd – homicide (15-24), malignancy (10-14)

Demographics

- Late spring / early summer: highest rates
- Rates rise with age: highest among white males in their 70's and 80's
- More people use guns than drugs
  - Kids – 58%
  - Teens – 74%
  - NC – higher than U.S. rate
  - Availability = increased risk

Demographics

- Females attempt more, males succeed more
- Most do not leave notes
- More rural than urban
- More common than homicide
  - suicide - 10.7 per 100,000
  - homicide - 6.2 per 100,000
- Increase after natural disasters

Parents and professionals seriously underestimate depression in children / teens

- Under 10, rate low, but not impossible
- 90% attempt at home
- 70% with parents at home
- 1 in 5 high school students has seriously considered
- 1% occur before age 15
- 25% occur between ages 15-25
- 50-300 attempts for every completion

Efforts in Prevention

- Limit access to methods
- Mass media coverage
- Religious proscriptions
- Desecration of corpse
- Crime against the state
- Telephone / internet crisis lines
- Primary medical care assessment
- School prevention programs
- Gatekeeper programs

School Suicide Prevention Programs

- Stress model
  - Normalizes the behavior
  - Overemphasizes frequency
  - Ignores contagion effect
  - "Could happen to anybody" model
- Biological model
  - 90-95% of suicides have identifiable mental illness
  - Computerized screening; interview high risk kids
  - Effective at getting kids treatment

School Prevention Programs

SOS - Signs of Suicide

Educate teens that depression is a treatable illness and equip them to respond

- Cost-effective
- Evidence-based
- Easily implemented
- www.mentalhealthscreening.org (781-239-0071)

Gatekeeper Programs

ASIST: Applied Suicide Intervention Skills Training

- Two-day
- Injury Prevention: (919)715-6452, dhhs.state.nc.us
- info@livingworks.net

QPR: Question, Persuade, Refer

- 2-4 hour
- qprinstitute.com

Suicide: Causes

- Most explanations are too simplistic
- Never the result of single factor or event.
- No single CAUSE of suicide; only CAUSES.
- Highly complex interaction of biological, psychological, cultural, sociological factors.

Multiple risk factors:

- Mental disorders
- Substance abuse
- History of trauma
- Traits: impulsiveness
- Relationship loss
- Economic hardship
- Isolation

90 - 95% of suicides have clearly identifiable mental illness

- Depression
- Bipolar disorder
- Schizophrenia
- Substance abuse
- Borderline personality

Risk: number of times expected rate

Prior attempt	38x	Personality d/o	8x
Depression	20x	Anxiety d/o	7x
Bipolar d/o	15x	Incarceration	9x
Schizophrenia	8x	AIDS	8x
Sub. abuse	6-14x	Cancer	2x
Exposure as child	9x	Pregnancy	(-)5x
GLBT	2-14x		

Increased Suicide Risk in Children and Adolescents

- Bipolar Disorder
- Depression
- ADHD
- Disorders of child maltreatment:
  - Conduct Disorder
  - Borderline Personality Disorder
  - PTSD
- Anxiety Disorder
- Substance abuse

Illness in Adults vs. Children

- **Early childhood disorders more likely:**
  - **hereditary**
  - **chronic**
  - **severe**
- Symptoms differ in same disease
- At different ages, symptoms may vary

- Don't want to die; want to end intolerable pain.
- Most suicidal crises last very brief time: minutes, hours, days
- Half of all attempts occur with 5 minutes premeditation
- Although act itself may be impulsive, going downhill a long time
- 70% give some warning

Depression and unhappiness are not the same.

Unhappiness: normal grief, bereavement, situational depression, reactive depression
exogenous – originating from outside

Depression: biochemical, clinical, biological
endogenous – originating from inside

Depression in Young People

Usually first diagnosed in early 20s

3% of children (5-6% with mild / moderate)
- Rates the same for boys and girls

3 – 8% of adolescents
- After puberty, girls twice the rate of boys
- One in 11 kids before age 14

Bipolar disorder: depressive episode
- 1% of population

Pediatric Depression Symptoms - Physical

- Change in appetite
- Change in sleep
- Change in libido (teens)
- Fatigue not relieved by rest
- Slowed responses
  - movement, speech
- Physical complaints
  - headaches, stomachaches, pains

Pediatric Depression Symptoms: Emotional

- Increased irritability / aggression
- Frequent sadness (empty, numb)
- Persistent boredom / apathy
- Low self-esteem (unworthy, guilty)

Pediatric Depression: Symptoms: Cognition

- Poor concentration
- Difficulty problem solving
- Difficulty decision making
- Sensitive to rejection
- Negative thought patterns
  - pessimism, catastrophizing, critical
  - hopeless, helpless, self-defeating

Pediatric Depression Symptoms: Behavioral

School problems
- attitude, performance, absence, worry

Isolation

Difficulty in relationships

Suicidal communication / acts
- Running away
- Preoccupation with death - drawings, music

Pediatric Depression

- More likely recurrent
- Subsequent episodes more severe and shorter time between episodes
- Depression vs. dysthymia
- Onset insidious or gradual
- Untreated, usually lasts 5-6 months to 2 years

How to help:

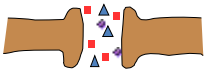
- Educate person and family
  - Causes of illness
  - Realistic expectations
  - Course of illness and recovery
  - Responsibility for treatment
  - Role of stress and thinking
- Encourage – treatment takes time

Depression: Causes

- Biology:
  - changes in brain structure and chemistry
  - hereditary vulnerability
- Environment:
  - stresses can trigger and/or worsen episodes
- Cognition:
  - thoughts / beliefs

Serotonin

- Central in regulating:
  - mood
  - sleep
  - addictive behaviors
  - impulsivity / aggression
  - perception of pain



Depression: Changes in the brain

- Low levels of neurotransmitters
- Loss of brain cells (glia)
- Lack of nerve growth factor
- Over-activity of limbic system; area 25
- Decreased blood flow / metabolism
- High levels of cortisol
- Blunted TSH

Hereditary Risk

- In general population: one in 10
- Close relative: 2 - 3 times greater
- Both parents: 7 times greater
- Gene for decreased serotonergic functioning
- Family, twin and adoption studies show influence beyond heredity

Childhood trauma

- Elevates risk of suicide / mental disorder
- Greater number = greater risk
  - greatest risk is 5 or more
- Greater severity -> greater risk
  - Sexual abuse: duration, relationship, force, penetration
- Disrupts development by:
  - lasting changes in anatomy and physiology
  - stress response dysregulation
  - vulnerability to subsequent traumas
  - deficits in normal social learning

Childhood trauma

Sexual abuse - highest risk of suicide of all types of child maltreatment

- Increases risk independent of psychopathology
- 25 times those without
- Puts males at greater risk:
  4 – 11 times vs. 2 – 4 times
- Effective treatments available, but most kids don't get treatment

Environmental Influence

Influences:

- **stigma vs. acceptability:** society and family 2-3 times more likely to have family member with history of suicide
- **stressors / risk factors:**
  - economic hardship
  - available methods
  - use of alcohol
- **protective factors:**
  - support: migration, religion, population density
  - access to treatment

Cognitive Distortions

Thoughts / beliefs common to depressed kids:

- I'm not as good as others, I'm worthless.
- Mistakes prove I'm no good.
- No one will ever like me. My parents don't love me.
- Nothing will ever change. My life is ruined.
- Suicide is a way out of this pain. I can't take it.
- I can't live without this person.

(Riley 2000; Hockey 2003; Goldstein 1994)

Explanatory Style

Tend to interpret

- bad events as:
  - permanent (will last forever)
  - pervasive (will affect other parts of life)
  - personal (has something to do with them)
- good events as:
  - random / accidental
  - external (caused by something outside them)

(Seligman)

Feedback Loop

- Chemistry interacts with thinking
- Thinking interacts with stress
- Stress interacts with chemistry

(Riley, 2000)

Possible Consequences

- Underachievement / failure in school
- Social failure = poor support
- Increased punishment
- Low self-esteem
- Drug use / abuse
- Kindling effect: relapse / worsening

Balance risk of meds vs. risk of not being treated

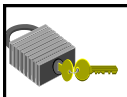
Depression results in:

Lowered immune system functioning

- Four times higher rates of illness / death
  - Heart attack
  - Bone loss
  - Nursing home admission
  - Premature delivery

Death

- One in 6 with depression
- One in 5 with bipolar disorder



Treatment / Intervention

Medication

- Treats the chemical imbalances

Cognitive Behavioral Therapy

- Changes the negative thought patterns that reinforce and worsen feelings

Environmental changes

- Reduce stress: abuse, conflict, sleep
- Increase protective factors: skills
- Hospitalization: safety/intensive treatment

Treatment in children and adolescents

Medications
- TCAs – ineffective or harmful
- No use: ECT / MAOIs / St John's Wort
- SSRIs – effective
- Placebos – some effectiveness

Meds combined with CBT
- Increases response rate
- Reduces relapse risk

Youth and Antidepressants

- 2004 FDA black-box warning
  - Prescriptions for ages 5-18 fell more than 50%
  - Teen suicides jumped a record 18%
- Treatment puts **2 – 3%** people at temporary risk, but untreated depression is far more lethal. (10%+)
- Antidepressants save lives; **untreated depression kills**.

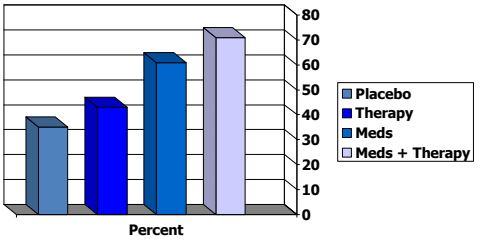
(JAmPsy, 2007)

Cognitive Behavioral Therapy

- Identify automatic thoughts and learn to modify
- Dispute:
  - require proof that thought is true
  - if no proof exists…replace with alternate, realistic explanation
    - 100s of studies proving its efficacy
    - Those who have attempted suicide and are treated with CBT are 50% less likely to try again.

(Brown & Beck, 2005)

Percentage of patients (12-17 y.o.) showing improvement



(March, JS et al, JAMA, 2004)

Unfortunately,

- **Two-thirds** of children **do not** see a doctor or therapist within a month of beginning drug treatment
- More than **half** have still not had a mental health visit by three months.

(Medco study, 2001-2003 data)

Environmental Changes

Reduce stress
- child abuse / neglect / sexual abuse
- conflict: family, bully, teacher
- sleep / exercise / nutrition
- social concerns / hygiene
- unmet spiritual needs
- extracurricular over-commitment

Environmental Changes

Increase protective factors:

- Social skills
  - making friends
  - assertiveness
  - empathy
  - reading social situations
  - negotiating / setting limits
- Optimism
- Coping skills: managing stress / emotions

(Goldsmith, 2002; Hockey, 2003)

Protective Factors

- Perception that important adult cared about them
- School connectedness (teachers care, treat fairly)
- School safety
- Parental presence before and after school
- Parent / family connectedness / caring
- GPA
- Religious identity
- Counseling services offered by school
- Number of parent / child activities

Three or more reduced risk of suicide in adolescents by **70-85%.**

(Goldsmith, 2002)

New research / resources

- School-based programs
  - 5th- 6th graders taught prevention class: half as likely to develop depression (Beardslee)
- Authentic Happiness: Seligman
  - Book and website
  - The Optimistic Child
- Beyondblue
  - Beyondblue.org
- Penn Resiliency Project
  - Adaptivlearning.com

Hospitalization considered if:

- Episode accompanied by:
  - severe weight loss
  - agitation
  - psychotic features
- Intent to harm self or others
- Unable to do self-care / follow instructions

Signs of elevated risk

- hopelessness
- helplessness
- insomnia
- anxiety
- ambivalence

Childhood Bipolar Disorder

- Inherited
- Illness of brain biochemistry; dysfunction of the limbic / paralimbic system
- **Life stressors worsen the illness**
- Recognized in children since 1995
- Onset in early childhood = more severe

Bipolar: risk of suicide

- Lifetime rate is 20% during depressive episode (1 in 5)
- Highest first few years after diagnosis
- High rate of non-compliance among teenagers
- High rate of substance abuse
- High comorbidity

Childhood Bipolar Disorder
Treatment / Interventions

- Medication
  - relief of symptoms
- Family focused treatment
  - prevent damage to relationships
- Education / Therapy
  - prevent relapse
  - reduce stress

Comorbidity

More than one illness is the norm

- ODD - almost never seen alone
- **CBD before age ten - 90% have coexisting illness**
- **65% of maltreated children have three or more coexisting illnesses**
- **Depression, ODD and ADHD coexist most commonly**
- Substance abuse often coexists in adolescence
- Learning disabilities

Prevention

- Skills training: coping, hopelessness
- Gatekeepers training: identify and get treatment for kids at risk
- **Reduce access to methods, especially to guns**
- **Target special populations (children in foster care)**
- **Reduce barriers to treatment**

Common beliefs that are not true…

- Talking about it will give them the idea.
- Suicide occurs with little or no warning.
- If act was not fatal, it means it was only an attention-seeking behavior.
- Suicide occurs because of a stressful event.
- If they want to die, they will just keep trying until they succeed.
- Intervening takes away a person's right to individual choice.

If you recognize some of those beliefs are part of your thinking, it will likely impair your ability to help a person at risk of suicide.

How to help: What to say

- Don't accuse of faking or attention seeking; take comments seriously
- Don't use "logic" or "bluff"
- Don't appear too afraid – you may be, but if you look too much so, they may not tell you more
- Say, "have times you're depressed" rather than "depressed" kid

Estimating Risk

- Age
- Gender
- Stress → Subjective: Their view, not yours!
- Symptoms →
- **Current suicide plan**
- **Prior suicidal behavior**
- **Resources**

(ASIST, 2001)

How to help: What to do

- Decrease physical distance: sit close, touch, put arm around
- Reduce pain in every possible way
- Limit access to easy, lethal methods
- Increase support and protection
- Expect difficult behavior: uncooperative, ungrateful, angry
- Recognize lack of evidence supporting use of no-harm contracts

Aftermath

- Loss of child most devastating bereavement
- Support groups need to be specific to suicide survivors and have change-oriented guidance
- Redefine as "incurably ill"
- Few professionals address survivor needs: often treat family as dysfunctional

Aftermath

- Tell children the truth
- Display concern for survivors
- Legal action rare, based on failure to protect
- Debriefing for those involved
- Confidentiality does not end at death
- Consultation and review for self
- Expect intrusive stress
- Help define as severe illness

Aftermath support

- Parents of Suicide – POS
  - angelfire.com/mi2/parentsofsuicide
- Friends and Family of Suicide – FFOS
  - angelfire.com/ga4/ffos/support
- Compassionate Friends
  - compassionatefriends.org
- Survivors of Suicide Loss Support groups (SOS) in Raleigh and Chapel Hill

Remember, this is a child with a handicap. The child cannot always help behaving in the ways a child with that illness does.

But, the parent can.

Paraphrased from: Dr. Russell Barkley