Risk and Protective Factors for Depression and Suicide in Children and Adolescents

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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 increases risk

- Mental (brain) disorders
- Substance abuse
- History of trauma
- Traits: impulsiveness
- Relationship loss
- Economic hardship
- Isolation
Efforts in Prevention

- Religious prohibitions
- Desecration of the corpse
- Crime against the state
- Mass media coverage
- Limit access to easy, lethal methods
- Telephone and internet crisis lines
- Primary 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

1. 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)

2. Prevention class for 5th-6th graders: half as likely to develop depression (Gillham)
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
- Mental Health Association of Central Carolinas 704-365-3454; mha@mhacentralcarolinas.org
Annual suicide rates among persons aged 15-19 years, by year and method - NC, 1992-2002
90 - 95% of suicides have clearly identifiable mental illness

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

1 episode: **60%** chance will have second
2 episodes: **70%** chance will have third
3 or more: **90%** chance will have another

Subsequent episodes more severe and shorter time between episodes

APA, 2000; Marano, 1999; Marsh, 2002
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

APA, 2000; Murano, 1999
Depression: Causes / Influences

- **Biology:**
  - changes in brain structure and chemistry
  - hereditary vulnerability

- **Environment:**
  - stresses can trigger and/or worsen episodes

- **Cognition:**
  - thoughts / beliefs
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
Childhood trauma

- Elevates risk of suicide / mental disorder
- Greater number = greater risk
  - greatest risk is 5 or more
- Greater severity = greater risk
- 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
Feedback Loop

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

Riley, 2000
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
Cognitive Behavioral Therapy

- Used alone in mild / moderate depression
- Identify automatic thoughts and learn to modify
- Evidenced based
  - Hundreds 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 to reduce risk:

**Reduce stress in child’s life**
- 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
Signs of elevated risk

- hopelessness
- helplessness
- insomnia
- anxiety
- ambivalence
- psychosis
Prevention

- Provide skills training: coping, hopelessness
- Gatekeepers training: people who work with kids - identify and get treatment for kids at risk
  - **ASIST** and **QPR**
- Reduce access to lethal methods, especially to guns
- Target special populations (children in foster care)
- Reduce barriers to treatment
Internet resources for teens

Tween and Teen Resources

LGBT teen resources
CYBERBULLYING & SUICIDE: What Schools Must Do to Protect Students and Districts

MARCH 31, 2011

TOOLS YOU CAN USE

FROM

Well Aware™

YOU’VE WEIGHED IN!

Check out how attendees at our March 29th webinar are putting the information to use:

- FEEDBACK FROM DR. AGATSTON
- TIPS AND TOOLS FROM YOUR COLLEAGUES
- NEXT STEPS YOU CAN TAKE
Since every man is part of a community, he injures that community by killing himself.

St. Thomas Aquinas
Postvention is prevention.

Schneidman, 1972
School’s Response

sprc.org/afterasuicideforschools
School response after a suicide

Lifeline Postvention Manual:

School Response

2. Communicate with students

- Small groups – no assemblies, no announcement
- Tell the truth, but no details
- Focus on living and coping skills (we’re here to help you/each other, help prevent other deaths)
- Don’t glorify / vilify victim: Emphasize likelihood that person struggling with serious mental issue
- Emphasize that help is available
- Screen students for potential risk (those who were close to victim, kept the secret, facilitated, didn’t recognize, or have mh problems)
Aftermath: family / community

- Use “died by suicide”
- Tell children the truth
- Confidentiality does not end
- Display concern for survivors
- Educate about what to expect, fears, follow-up
- Attend to contagion effect / limit public memorials
- Focus on “living” memorials