An Update on the Latest Treatment Strategies for Suicidal Adolescents and Parents/Caregivers

Wednesday, August 11, 2021

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Transcriber: Holly Fox-Schauffner

Linda Dimeff: Many of us were eager to participate. We're at the top of the hour. I want to welcome everyone as you're joining and logging on. I'm Linda Dimeff, one of the cofounders of Jaspr Health and the director of the institute.

In addition to saying thank you to everyone for being part of this event today, if you wish to have CEs, you'll receive an email immediately after the talk from Jaspr Health that includes two links: One for an evaluation and another for CEs called an attestation. You'll be required to do both of those. You may recognize that when you go to complete those forms, they'll be from Portland DBT, the organization providing today's credits.

The way we'll handle questions is, at the end of today's presentations, about 10-15 minutes before the conclusion, we'll move to Q&A. If you have any questions along the way, please don't hesitate to write them in the chat. I'm sure by now you're all super familiar with how to use the chat. At the bottom of your screen, in the center, you'll see a chat button. Click that and write your question to the host. Those will be pulled together by my colleague and Jaspr Health CEO, Kelly Kerner [sp?] who will lead us in the Q&A session with Tony at the talk's end.

Having said all the housekeeping, I want to say thank you for caring about this topic, about treating suicidal youth, and supporting their families. I want to thank Anthony Spirito for joining us and sharing his wisdom today.

Dr. Spirito is a professor of Psychiatry at Brown University and is one of the handful of folks who does not only research in the area of youth suicide and strategies to help parents and caregivers, but he brings a particular emphasis in also thinking about how to address alcohol and drug problems among suicidal youth.

You'll learn from Dr. Spirito that having drugs or alcohol on board for suicidal youth exponentially increases the risk of death by suicide. This focus is incredibly important.

Dr. Spirito is viewed as an expert in this area internationally and has published over 250 peer-reviewed articles. He's been awarded grants from all National Institutes of Health, including institutes on mental health, drug abuse, alcohol abuse, alcoholism, and the American Foundation on Suicide Prevention. He's won numerous awards for his groundbreaking work in this area.

Dr. Spirito, we're grateful to have you today with us and leading the way in helping us address this important problem of youth suicide in our country.

With that, we'll turn it over to you. Thank you, Tony.

Anthony Spirito: Thank you for that introduction and the invitation to do this talk. I was at my nephew's wedding this weekend, which inspired the title.

I don't have any disclosures. The advertised title of the talk doesn't exactly match the content of the talk. This is a clinical talk. I'll have references of our own work and chapters that are primarily clinical that people can look up. It's not a purely research talk. It's more on the clinical side of things.

I'll go over some slides quickly with the idea that they will be posted after. I have more details slides so people can have those in the future.

In terms of overview of today's talk, I'll talk about something new and old. That's the SAMHSA evidence-based guide specifically on teen suicide. I'll mention that a bit.

I'll talk about some of the old, tried, and true treatment techniques.

I'll mention some newest things happening with respect to adolescent depression and treatment of suicidal ideation and behavior in adolescents. Those include the beginnings of the work in ketamine and psychedelics, transcranial magnetic stimulation, and more ecological momentary interventions being piloted right now.

I'll focus more on something old, which is often neglected in grants and interventions with adolescents, which is the work with the parents around the time of the suicidal crisis. I've done a lot of work in the emergency room where we did some initial interventions. Kids came to the emergency department who were suicidal. I've done a lot of work with patients being discharged from inpatient psychiatric care following a suicide attempt.

The work I talk about with parents is less about dealing with them throughout the course of therapy and more how to manage their adolescents when discharged from the ER or inpatient care and preparing them to work with their adolescents. We tend to neglect that area.

I'll talk a little about working with teens who are using substances and are suicidal. How do you integrate that into the protocol and your work with adolescents?

It strikes me that people say, "I'm a mental health person. I don't deal with substance abuse" and vice versa. We have a paper that surveyed substance abuse and mental health counselors in the community. The mental health people shied away from dealing with substance abuse in adolescent patients. Substance abuse counselors were more willing to deal with mental health issues, which is interesting. It's important that people talk about integrating the work with the psychiatric symptoms and substance abuse into their individual work with adolescents.

This slide points out that SAMHSA has an evidence-based resource guide series. One of them was treating suicidal attempts among youth. These are the 5 major areas

discussed in this publication. It's free. You can Google it right now and download the PDF. It has a lot of interesting material that can be used clinically. It includes examples of programs and how they've developed clinics or programs to deal with suicidal youth.

It's worthwhile clinicians looking at it. It summarizes things pretty well.

The something old with respect to the SAMHSA guide is that these are the treatment protocols that have some evidence with respect to working with suicidal adolescents.

DBT has the best evidence at this point in time.

[Chime]

Hold on one second.

This is interesting. I'm in my office. My battery says it's low.

Sorry about that.

Let me go back and open my other computer just in case. I don't know why it's low. This is par for the course for Zoom.

I'll talk while opening my other computer so you don't lose me totally.

DBT has the best evidence at this point.

Sorry. I don't understand. I'm plugged in. It's not working.

[Dr. Spirito troubleshooting]

It says I'm plugged in. We'll hope that I don't leave you in the middle of this.

DBT has the best evidence.

Sorry. That threw me a little bit.

It still doesn't have a lot of great evidence in that it's short-term evidence about the effects of working with suicidal adolescents.

The other programs here have less evidence but some beginning evidence to suggest that they're effective with suicidal adolescents.

I'll let you look those up.

The integrated cognitive behavioral therapy is what we've used to address suicidal behavior and substance abuse in the same protocol.

Here's the something old, the cognitive techniques most commonly used with adolescents and suicidal adults, too. I won't go through these details, but I think these are something to refer back to in terms of looking at these slides.

These are the most common cognitive approaches used with adolescents. The first one is re-attribution, to say, "it's in out all your fault." Say an adolescent's boyfriend breaks up with them, and they say it's their fault. In therapy, even in short-term crisis intervention, you're getting them close to discharge and re-attribute their role in modifying their cognitions with respect to the triggering event.

The pros and cons and de-catastrophizing are common.

The examination of options and alternatives are important to do. You include suicide attempts or suicidal behaviors as options. In other words, do you say, "no, absolutely you can't do that," or do you say, "is it something to consider?" A lot of therapists don't like to say that we can include suicide in making another attempt as another option if things get really bad.

On the other hand, if you include it in a way that says, "I recognize that you're so distressed that this could be an option, and you feel that way, but let's discuss the other options so we can rank the other options in terms of least to most onerous." That way, a discussion moves beyond suicidal behavior as the only option to the variety of options that are possible.

These are the other types of cognitive strategies. The reasons to live -- there are measures for reasons to live that you can look up. Those are freely available and can be useful. Otherwise, the rest are techniques you'll integrate right into treatment.

The affect regulation techniques are well-known. Some come from DBT, like mindfulness and distress tolerance.

Emotion regulation is a typical strategy regulated in CBT protocols as well as the feelings thermometer. I won't go through them in detail.

We have a paper that just came up on the latest treatment approaches with suicidal adolescents that covers this material and things I'll talk about later. If you're interested in following up on some of these details, that is a paper you might want to look into. It covers some things I'm talking about today.

Something new -- we talk about latest treatment strategies. IMH is interested in experimental medicine and target medicines. An example is the neuropathway indicated in the disordered. They want investigators to move on to assess the mechanisms. We can refer to the effective mechanism we've engaged or not engaged. Then we can have a better idea of what's getting people better with respect to suicidal behavior.

Finding the circuit is no mean feat. This is from Rebecca Price at the University of Pittsburgh. It addresses the circuitry in the brain, which makes the notion of looking for a circuit implicated in suicidal behavior appealing, but it also makes it quite a difficult task.

Even though this experimental medicine approach is new (I want to at least give some overview of something new), it's not as easy as we think. It isn't that new. Freud started there as a neurologist. He was interested in mapping the brain with respect to psychiatric conditions. Given the primitive technology of the time, he moved from that to psychoanalysis. I don't think you want to throw away the mind for the brain. The Wizard of Oz thought that anybody could have a brain. Maybe we should be thinking about the mind.

I think you'll see more studies about TMS and latest adaptions of it to address depression. Most of the work so far has been with adults. There are a lot of studies on that, especially with treatment to resist depression.

Carl Cloaken [sp?] at the Mayo Clinic has studies about adolescents and depression. I'm sure you'll see people working on the applications of TMS for adolescent suicidal ideation and behavior.

Again, you have to address the circuit and what circuit you're hitting with respect to circuitry and using TMS.

I should pause to say I hope my computer doesn't die. I think it's okay.

This talk is a lot better in-person when I can address the audience. It seems weird to have a talk on bad brains. I don't know how many people know what bad brains are.

There are other ways to engage the circuits. It's important to remember we don't have to have fancy techniques to engage circuitry. There's a book about how music engages various brain circuits. We've known this in the past. There are various ways to get at the circuits.

Whether we can get at the circuits in the next decade or two to really have an impact on suicidal behavior is an open question given the various given the various stimuli in the world that can affect circuitry.

Psychedelics is being discussed at John Hopkins. With adolescents, we have ecologically valid -- I don't know if it's valid -- but a lot of ecological data. These are slides from Woodstock. Psychedelics have been used for years.

At my age, people talk about "bad trips" as opposed to helping people therapeutically with psychedelics. If you don't know the history, Timothy Leary was a Harvard professor, and that's what he was working on, the effect of psychedelics on the mind

over 70 years ago.

What was it? "Tune in, turn on, drop out"? That was his research at Harvard in the '60s.

I looked up recently, we have three new ketamine clinics in Rhode Island. Ketamine is showing promise for suicidal behavior, especially with adults. Yale is doing studies with adolescents. I'm sure they are doing studies elsewhere, too.

For most cases, treating with ketamine makes sense to me. We have to be careful of what we wish for once ketamine is out into the general public. With the three clinics in Rhode Island, are they treating patients with severe depression or suicidality? That's the level of indication of treating with ketamine, either IV or nasal. As we expand and think of the financial implications of treating persons, will there be so much off-label use that what has a specific, valid, and important treatment application is expanded in a way that causes societal problems. The perfect example of that is opioids, which are extremely important in treatment of cancer pain, especially end-of-life and terminal disease. Those treatments have been expanded societally to cause so many other problems. Those are some of the newest things people are working on that we'll see in the next decade.

How do we work with parents of adolescents? Is it equally important, regardless of what treatment you do with the adolescents (whether newer, DBT, CBT, etc.) that we really work with parents and not neglect them in that work?

This has been interesting to me. I've done a lot of training with community mental health clinics in the local area. We've run studies to train licensed mental health counselors to deliver some of our CBT protocols. It's clear, in general and not just with the MHCs, that clinicians' preferences are to work with the adolescents and parents. Given their choice, they spend more time with adolescents in individual therapy than working with parents. I think that's a mistake. We have to spend more time working with parents to be the most effective with suicidal adolescents. I'll talk more about that later.

How are these parents affecting work with teens who are suicidal? I think it's under-emphasized. I'll discuss working with parents at the time of attempt or discharge from the hospital or ER. What can we do in that moment to be most helpful to make the transition of going to therapy receiving outpatient care?

You want to know if the parents are providing protective environments for the teenager? I can say that I've seen parents in the emergency room where there's been an attempt being extremely upset and angry at the child. The worst I've seen is when I was interviewing a teen who made a suicide attempt by overdose, and the parent wasn't there yet. It was halfway through the interview. The parent showed up (in the old days when there were curtains between the beds), and the parent pulled the curtain back, which surprised me and the teenager. They walked in and punched the adolescent.

That's the extreme example of a stressful, toxic environment that the adolescent might return to.

In this case, the teenager made multiple attempts. The parents' anger was why they were doing this to them and their family.

This points out the need to work with parents at the time of discharge. In some ways, it's more important to ferret that out in more subtle situations. You don't need computer adapted testing or EMA every day for two weeks. We don't have to look at how the brain responds with the parent with stressful tasks. We have to do the basic, clinical interviewing that mental health professionals have been trained to do to work with parents in the most effective way.

My father was a urologist. At our family dinner table, there was a phone against the wall (before beepers). My father answered, and he was a great guy, but he'd get mad if patients weren't being treated well. I remember him saying he was talking to a resident on the phone. He said, "You gave me results of all the tests. Why did you order all the tests? Did you talk to the patients about their symptoms and make assumptions based on the interview, or did you not bother to interview the patient? Doesn't anybody teach you in medical school to interview the patient anymore?" This was 60 years ago.

When we talk about something old and something new, we can't neglect the importance of interviewing the patients and doing a good interview.

With respect to parents, did they play a role in triggering a teen's suicidal ideation or attempt? Studies have shown that parents are a trigger for the child and sometimes exacerbates the suicidal behavior.

We can have serious and obvious background problems like abuse and neglect. These are easy ones, but there are more subtle things that you can discern, even on a brief diagnostic interview at the hospital or in the emergency room to try and understand how to make the best discharge plan.

Recently, Jackie Nesi, who works with me, took the lead on a paper. She is probably under review now. There were 200 kids. This is a contemporary study. We asked what are the social media reasons for psychiatric hospitalization? The highest was about a quarter of adolescents reported it was their phone being taken away as the reason for their attempt.

Of course, there could be reasonable and important reasons why parents would take a phone from a teen. We don't want to take that at face value. It's also important to look at the implications of taking a phone away from an at-risk adolescent. How do you deal with that as a parent? That's an example of an important clinical question to ask parents on discharge. How will they handle the phone situation? We have admissions to the hospital triggered by parents taking the phone away.

It points out the important needs of assessing the role of parents as a trigger. It also points out my anecdote about the father punching the adolescent in the ER. It talks about the parents' feelings or behaviors towards the adolescent following the ED visit, attempt, or hospitalization.

You really have to talk to parents and ask them things about how they reacted when they found out about the attempt and their thoughts about it now. How are you dealing with the distress of your experience? So, you can approach it in a positive way even when the parents are a trigger. You can try to get them aligned with you in terms of working out a plan to maximize chances of the adolescent being safe upon discharge from an ED after a session, even an outpatient treatment, where they're acutely suicidal, but you're not sending them to the hospital.

We need to know if parents and caretakers can provide a safe environment. That's not always the case. We have to know if they're available to the teen and able to monitor upon discharge and during treatment? That's not always the case. Sometimes there are practical reasons like the parent has more than one job.

You can get initial impressions of the quality of the relationship in the interview, often, when you bring the parent and teen together to better understand how to make sure the teen and parent can work together, and the parent can keep the adolescent safe.

The willingness to remove and lock up lethal means is important. I've had multiple discussions (usually not around firearms) about medications in the kitchen and locking them up. A lot of parents are unwilling to do that. You have to talk to them about the importance of being overly protectionistic in the short-term when kids have made an attempt because of the impulsive nature of suicidal behavior in teens. It may interrupt the household routines of others but taking knives away may be really important.

That's not necessarily a universal recommendation, but it's a common recommendation. Fight I say it as the doctor, don't assume they'll do it. Work with parents about the importance of doing this. It often takes persuading and work with them.

It's important if parents have the energy and ability to provide the monitoring and support. Their living situations may make it difficult.

If a parent's stressed out, it's important to talk about backup plans in discharge. Who can help you out? If you're really having trouble, can the teenager go to their aunt or uncle for a couple days to get respite? Can you make a plan like that?

It's important to talk about these things right after hospitalization or sending people home after the ED.

I cover our Psych emergency department on Wednesdays for years. I also did it in a time when captative care came into existence. We worked clinically on how to send kids home from the ER or sent to the hospital.

Depending on where you are and availability of psychiatric beds, the go-to is if the kid makes an attempt, will you admit them psychiatrically?

It's manageable and possible -- a lot of it hinges on the work with the parents at the time. That's why I point this out. In many cases, you may be hospitalizing an adolescent.

Here are things we talk about when discharging adolescents, especially from an ED.

It's important to take all suicidal statements and behaviors seriously. It's important to react supportively and seek help from others if you need to and are concerned about your adolescent.

Sometimes teens attempt suicide to prove their parents wrong or show their pain when they think parents don't believe them. You can tailor that to the circumstances of the case you're dealing with. It's important for parents to show that concern.

Do you think this is something you can do week to week with the teens? This is something to work with the parent alone before you bring them together. If you don't prepare the teen and parents separately prior to discharge, you may not know the level of volatility or emotion in the room. You want to have a handle on that and prepare them for the session together.

Again, we tend to put most of our energy into work with the adolescents, but it's important to do an equal amount with the parents, in my opinion.

These are more examples of some language we use when talking to parents about meeting with their teen prior to discharge. You ask them questions. If they don't want to answer, don't push them. That's a common situation where parents ask why they did it and have to know why before they take the adolescent home. In those situations where you're the evaluator in a psychiatric crisis, it's important to think as a therapist on how to work with the parent about handling the distress over this attempt to make it safe for the kid to be home. Even 5 days in the hospital, same thing. There's still trepidation after taking a kid home after an attempt.

We will talk about communicating with teens when you get in the room, and we'll also review the teen safety or coping plan.

I won't talk about safety plans today. There's a lot of information about that. That's something that would work in any emergency room. You will have done that with a teen. You have to go over that with the parent in the meeting, but I won't go through that because it's so well talked about in the field now.

In the end, it's important to make sure the parents are on board with the teen safety plan. There are times when the parents disagree with some strategies that teens talk

about in their safety plan. You have to go over various aspects. If they disagree, you have to come to some resolution and change the safety plan in a way that parents work collaboratively with the teen to ensure the highest level of safety following discharge.

Parents monitoring the teens' safety is important. Another important thing is the something borrowed that we've done. It's to talk about how to respond to your teen's emotion.

Emotion coaching isn't much discussed under these circumstances. You'll see it in some protocols. Even under crisis situations, it's important to try to educate the parent about emotions of the teen.

The goal of emotion coaching is for parents to give the teens the message that they understand how their teen is feeling. This is an important therapy technique that's used across various therapies we've talked about that have been used for suicidal adolescents, but even in crisis circumstances. Emotion coaching is really important in those situations.

Validating the teen's emotion sets the stage to coping with the emotion and working productively with parents. Some parents will say they don't want to say any emotion is fine. If you accept the emotion and can recognize a teen's emotion, it can include feedback about aspects of behavior related to the emotions that aren't appropriate.

For example, it's okay to feel mad, but it's not okay to punch a hole in the wall. Making that discrimination for the parents is important. A lot of parents don't make that discrimination. It's important to cue them in to the importance of validating their teen's emotions.

It's important to understand that if they can respond to the teen's emotion, they'll probably have a better chance of working with the teen and engaging them about problem solving and how to move forward and understanding that the teen can't just shut off their emotion. It's obvious to this mental health audience, but it's not with many parents.

This is more for the slides that will be available afterwards. How do we talk when we bring the parents together and conclude the interview by going over the safety plan with the parents? Review the plan in the short-term and steps to take after they leave the hospital.

What's unknown is how much supervision is enough after a suicidal episode? There's no right answer. There's no data as far as I know to fall back upon.

A lot of it is how is it done? You'll know that suicidal patients will come into a therapy session after a hospitalization and say, "My parents are all over me. I can't get a minute to breathe." That's probably too much. A child has to have some autonomy and move back to the ability to function, but this makes it difficult to do.

How should they monitor, including monitoring the teen's phone use, and how long to monitor are all important questions. It depends on the individual situation. At this point, I think it's clinicians who work with parents who are discharging them from the hospital who probably have the best advice to do that and think of major approaches.

Like anything, probably the extremes are bad. Striking the middle is important.

To conclude, we're talking about how to keep the environment safe like removing medications, etc.

People don't talk about removing alcohol from the house. This is my poor attempt at a segue to talking about moving from parents to teens and talking about alcohol.

The reason I'm talking about two disparate aspects of management of teens is because when Linda and I initially talked, this was a particular interest to Jaspr. If you're figuring out why I'm talking about these two different things, that's part of the reason.

When working with adolescents who use alcohol, in particular, there's a relationship between suicide and alcohol. It seems to be that they're positively and statistically significant. The higher levels of alcohol in a suicidal kid, the more at risk they tend to be. It's important to work with parents about the monitoring of substance abuse and alcohol in suicidal patients.

How might alcohol affect suicidality? What are the acute effects of intoxication that are kind of obvious?

One example is it may heighten psychological distress. If they're drinking, it may bring those feelings to the surface, and they're less able to monitor their thoughts and behaviors and emotions. They may come to the surface more, and it will be more difficult for the teen to manage them.

There's increased aggressiveness under high levels of alcohol. Aggressive behavior interacts with internalizing systems to increase risk for suicide attempts. That's another way that we see alcohol affecting suicidal behavior in adolescents.

If an adolescent has planning, or they're planning an attempt and thinking if they get drunk, they'll get the courage to kill themselves, that's something you do see in planned attempts. That's something that can occur. It's not that frequent, but it can certainly happen. It's something to inquire about when talking with adolescents about their use of alcohol and drugs at the time of suicidal behavior.

Of course, the higher level of alcohol use and symptoms, the more difficult it will be to inhabit the generation and implementation of adaptive coping strategies. Strategies they might have used or learned about in therapy will be less effective. They may not be able to be called on by the adolescents if they're inebriated. It's something that's

important to talk about with the adolescents.

There are also distal effects, which puts an adolescent more at risk. If there's a history of alcohol use, this may lead to substance-related, social, academic, and legal problems, which increase and worsen psychiatric symptoms. It may lead to more severe depression and suicidal thoughts or behaviors. So, there's an accumulative effect of the alcohol because it causes other related problems.

Those are ways to think about alcohol and why it's important to address it.

I'll talk briefly about marijuana. There's a modest association between heavy and problematic use of marijuana, cannabis, and depression.

In cross-sectional studies, there's some longitudinal data -- this isn't a data-oriented talk -- but infrequent use isn't highly related to suicidal ideation. It's trickier dealing with an adolescent who is smoking marijuana and is also depressed and suicidal, not from a clinical point of view. It's not that we want them to continue to smoke during treatment, but it's to make the direct case to the adolescents of their risk of smoking. It's much harder.

I'll talk about how THC can be related to the regulation of their emotions. That mechanism may affect depressed motor suicidal thinking. You can try to make inroads with the adolescent when talking about marijuana and put it in the context of the range of emotions you've experienced when you smoke marijuana typically or over the course of your smoking history? What are the emotions you've experienced? Does that include some negative emotions? If so, can you see how those negative emotions were to arise given your current state of having just attempted suicide or high levels of ideation? Can you see where that might be a problem?

That's the way to try to get at it with adolescents. I can say in our studies and clinically, it's much easier to get a kid to recognize the potential difficulties that alcohol will cause them as opposed to marijuana. It's more of a therapeutic issue. It's harder for a therapist to get a handle on marijuana. I don't know who's in the audience. All I can see is myself. I'm sure you're working with adolescents who say the only time they feel good is when they're smoking marijuana, so they ask why quit. It takes more therapeutic talent and work with the adolescent to get them to see the potential problems.

This study was part of Tordia [sp?], which showed that the major depression response after 12 weeks of treatment was greatest with teens with low 12-week substance related impairment regardless of whether they had high or low baseline substance-related impairment. If you used substances while being treated for depression, your response to depression wasn't as robust to the depression treatment.

I'll mention the study to teens to try to say that to them. It was significantly lower among teens with high 12-week substance-related impairments. You want to point out that it's

a problem. Despite how it makes you feel in the moment, it does affect you and your depressed mood.

This substance-related impairment in the study didn't mean such severe impairment that you had to go to day treatment programs or anything. There was a whole range of impairment. It's important to think about that when dealing with patients who are just using some alcohol and marijuana, even if just on the weekends. It can impair their response to depression treatment, which in turn, is highly related to suicidality. It's important to talk about that.

With respect to the assessment of adolescent depression, there are a million measures out there you could use routinely in your practice, which is fine. I'm just going to talk about how you want to know what substance abuse history is. How long have they been smoking or drinking? That's the most basic level.

I say that because if you're newly working with an adolescent and ask them a lot of questions about their substance abuse, it's common to get a response that they hardly ever use. It's only throughout therapy that a kid will reveal how much smoking they're actually doing. It doesn't help much to get a real structured or intense or comprehensive assessment of substance abuse at intake for therapy because your understanding of use evolves as the teen gains me ore trust in you typically.

That's not always the case. Some teens are willing to talk about it, and they don't feel it's a problem. When that's the case, they're not concerned about their parents' response to it, which comes back to how the parents are managing their kid's substance abuse and what are their attitudes about it that may play a role in not only their use, but the prolongation of their suicidal ideation and depressed mood?

It's important to ask about substance abuse and suicidal ideation at the time of the attempt to see if they can make that connection. If you can get them to see that connection early on, whether it's through worsening of mood, decreasing inhibition, etc., you can get a better handle on a way to work with the adolescent during the course of therapy.

It's also important to talk about future intent, so you have some idea about how it may impair your treatment of their presenting psychiatric problems. At least have some idea of how it evolves for the teen, which is important. So, you'll have better notion.

I mentioned you may not get those truths at first. It's important to have that evolve throughout therapy.

Linda alluded to the protocols we've used. Early on, we did we project called TRYADS (treatment of youth alcohol abuse and suicidality, funded by NIAAA because they had an interest in the topic. I won't go into the protocol details, but it compares an integrated outpatient CBT protocol for adolescents who had to have a cooccurring substance abuse disorder, major depression, and suicidality. They were all recruited right after a

psychiatric hospitalization. They weren't an easy population to work with.

This describes it. Seven out of 10 made a suicide attempt or had high levels of suicidal ideation. They could use multiple substances. You can see the rates of substance use in the population.

[On screen]

They had to have alcohol or marijuana use to be in the study.

Everyone in both conditions received medication, typically antidepressants, case management following hospitalization, comprehensive baseline assessment, and integrated treatment delivered by our staff.

This CBT protocol was different than most. It goes back to my initial focus in this talk about parents. We were funded by the American Foundation of Suicide Prevention. I am using the royal "we." Christy Esposito is the PI at the AISP and AIAAA grant.

We started with the AISP grant. I had experience doing treatment studies of suicidal adolescents. We just published a paper on our first randomized controlled trial, CBT, with suicidal adolescents. When we changed the criteria to include alcohol-abusing adolescents, and we used our CBT protocol with them in addition to integrated substance abuse protocol (which I'll talk about in a minute), we got nowhere when working with adolescents alone and just checking in with the parent.

Based on that pilot work with AFSP -- AFSP funded that pilot study. It showed us we were missing the boat and had to spend much more time working with parents.

In the NIAAA study, we worked with the parents and teens separately. The parents had their own therapists. A lot of work with the parents was on parental management of adolescent behavior, especially the substance abuse behavior.

If you're working in the substance abuse field, the importance of working with parents with adolescents is well-known. When we talk about integrated protocols, people were tending less to do that. Historically, when people talk about suicidal adolescents, they want to work with the adolescent. This protocol differed because we had parents come in, bring the teen, and the teen and parents each had their own therapists.

I won't go into the details, but here's the important part. We had no suicide attempts in the experimental group where we worked with parents. They put as much effort and energy as we did when working with the adolescents.

We did have an effect on substance abuse. This graph has a baseline. There's much more alcohol use in the experimental group at baseline. Regression to the mean is playing a role in this. The green bars go down significantly. Part of that is certainly due to regression to the mean.

But if you compare it to the gray bars, treatment as usual, that's pretty stable. There's no change, and a little increase, at the 12 month follow-up in that group.

We felt that the mechanism we were proposing when these kids were comorbid, working it out with substance abuse did bear out. We did have a positive effect on alcohol.

Marijuana isn't as strong of an effect, but we see the same pattern. The green bars are decreasing significantly in the experimental group. We were reducing percentage of marijuana use.

You can see from the gray bars, in the treatment as usual group, there's no change across the entire year period.

We didn't get many kids to quit smoking marijuana, but we got them to reduce their marijuana use significantly.

I'll talk about cessation and moderation with respect to marijuana in a minute.

I point this data out to show that in that integrated protocol where we worked with parents, we did seem to have a positive effect on both the substance abuse and suicidal behaviors. That underscores the importance of working with parents.

We didn't make this up. This wasn't new. This is borrowed from our substance abuse protocols. I have a separate line of research where we do substance abuse use intervention with teenagers. Some of this came from my experience doing that.

We talk about alcohol and drug refusal skills. We work with the teen about how to enter situations where drugs and alcohol are available and skills they can use to try to not use or moderate use.

Part of the session in the CBT protocol was to role play alcohol refusal skills and dispute getting in the way of using alcohol and drug skills. "If I don't drink, no one will ask me to things on weekends."

This is behavior rehearsal and cognitive restructuring around substance abuse, which are classic treatment approaches you use with adolescents for mental health problems and psychiatric disorders.

When people say they don't treat kids who use substances, and they don't know how to do it, the idea behind our protocol is that we were just using the exact same CBT approach with the symptoms as they occurred. In this case, it was alcohol.

We talked to the kids about why they should learn alcohol and drug refusal skills and the fact that being offered alcohol or being pressured to use it is a common situation.

You had more leverage in this case because you could say that it put them more at risk to doing something to making another suicide attempt. Hopefully, you're working with a kid who doesn't want to make another suicide attempt again. We tend to do cessation and not moderation. We say it doesn't mean you can never do it in your life, but how do you protect yourself from the distress that led to the suicide attempt?

It's best to avoid these situations, but it's not always possible. You can say the more quickly you can refuse alcohol, the less likely you are to use.

These are typical alcohol refusal skills. I had them in the slide for people to refer back to.

[Reading alcohol and drug refusal skills on screen.]

Try to get them to see the positive aspects of it.

Then have a coping plan that they use. "My high risk situations are going to my best friend's house who has an older sibling who sneaks beer into the bedroom." Then have their responses about their drug and refusal skills. That's standard substance abuse treatment CBT types of treatment protocols you can find pretty much anywhere.

We talk about coping with cravings some. It's a relatively small percent of adolescents who have cravings. It usually takes a longer period of use to get cravings, but some do. We do talk about coping with craving, identification of triggers for urges and how to cope with them. Again, standard CBT approaches are like self-talk, distraction, relaxation, etc.

Then have a plan to cope with the high risk situations. That's part of the action plan I just described.

Riding the wave is a perfect example of taking something from the DBT world and applying it to substance abuse. They do that in DBT. We talk about that with adolescents.

20 minutes is a long time. It's less common with teens.

Again, we have a plan to take home. Now we take pictures of it and put it on the phone, that kind of thing. We're giving them planning strategies.

One motivational interviewing technique we use -- you don't have to know MI to do these things, but you can use MI approaches. You can use MI style to help with some of this rather than being dogmatic.

You can try to use MI style strategies to cope with questions.

You can work with them on their drinking habits. That's within the context of the

treatment of alcohol, even with CBT protocol. You can use MI style.

In our substance abuse treatment protocol, we use a program from San Diego State. E-CHUG is for alcohol. We usually asked people at San Diego State to make an adolescent version, so we have an adolescent version that's commonly used in colleges. e-TOKE is for drugs.

We give them normative feedback. That's good with respect to alcohol and drugs.

In this example, I'm taking it from e-CHUG. We input the Rhode Island norms for drinking. They input their drinking behavior, and it spits out normative feedback.

Even in a one-on-one interview, you don't necessarily need that. If you knew the rates of drinking in your community in general, and you gathered that information from the teen, you can give them normative feedback. It's almost always that they say, "That can't be true. All kids in my school drink." Then you get to how it may have to do with the peer group they're around.

You can use normative feedback on marijuana, but I'm giving you alcohol as an example here. You can use that to see how they might have a distorted picture of the norms regarding that.

Another thing you can do is work on situational confidence. Ask them how confident they feel. There's a measure you can use that's quick and easy. You can use that measure. I'm 90% sure it's freely available.

It talks about situations where you're most likely to use. Is it pleasant emotions, unpleasant emotions, physical discomfort, etc.? They rate each situation.

If you know that, it looks like they're equally likely to use when feeling good or bad. What are things you can do when feeling good as an effective replacement? How about when you're feeling bad? You can focus on those situations with the teens when things are most difficult to handle and deal with substance abuse.

With respect to suicide, we talk about how alcohol affects you. What's the effect of alcohol? The So, from e-CHUG. They give a number of options. The teen reported forgetting things, feeling less motivated, and reacting slower. We give other ways it can affect you like masking emotional problems, making you feel your problems go away, etc. When the buzz wears off, teens often feel more depressed than before, which can lead to suicidal thoughts and even attempts. Intoxication is associated with suicide attempts.

One reason to cut down use is its relation to mood and distress.

Here's another example of the kinds of feedback we give. These are the kinds of things you can use the principles of therapy. You don't necessarily need an electronic program

to do this.

I do talk about cessation and moderation. We talk about cessation with drinking and moderation with marijuana, but it's on a case by case basis.

Some of you will disagree that it should always be cessation. If cessation hits a brick wall and gets nowhere, you're better off talking about moderation and having *some* effect than going for cessation and getting nowhere.

Here are examples of things you can do, coping plans we'd devise, for a kid who wanted to stop drinking.

[Reading cessation examples on screen]

Other things you can do:

[Reading options for stopping drinking/drug use on screen]

If you're cutting down, they'll be similar.

[Reading options for cutting down]

Here are more examples.

[Continues reading]

You can read those.

Again, more strategies that we go over to try to create an individualized plan for teens when in places.

[On screen]

I'm trying to leave time for questions. I will conclude there.

I talked about something old. Old doesn't necessarily mean worse.

Throughout the talk, I tried to talk to you as a clinician would talk to another clinician. We shouldn't abandon tried and true approaches or a general importance of engaging clients in the therapeutic process. We can't get distracted by the something new and think that will cure our problems. It gets back to how it's important to fall back on our most basic and important skills that are most specific and relevant to our profession than to other professions.

New isn't always better. The jury is out on most new approaches.

It would be surprising if we found a new approach that would be the magic bullet. Medications are often talked about as the magic bullet, but we have enough history with medications over the last 50-70 years to see that there's hardly anything that's a magic bullet. It's unlikely the case that any new approaches will be magic bullets or could be used so widely that it would have a population-wide effect. We always have to fall back on other approaches.

My last point is the something borrowed. We can integrate treatment approaches from other specialties like I talked about with substance abuse. We don't necessarily have to be experts in the treatment of substance abuse. I tried to give examples of how the approaches we use are integrated and used in the framework of CBT protocols, in particular. You can do that. You don't have to go get a lot of additional training. You get some training, but you don't have to feel if you don't have training on addressing substance abuse, you'll never be able to treat a kid who uses substances.

These are from our clinical chapters. The last one is on substance abuse.

A lot of people have helped with this. I've only named a few people here who helped with the treatment protocols that have been the focus of this talk. If there's one, there's 100 people who worked on my studies throughout the years. We've had a lot of funding and support from these foundations.

I'll stop there. I know you want time for questions. I hope I can answer them.

Kelly Koerner: Thank you. A number of great questions came in.

To follow-up, when educating parents, especially in the period of discharge, how do you talk about the return of suicidal urges and risk for repeat attempts? Can you say more about that?

Anthony Spirito: Yeah. There are probably others watching this who are better at this or have different approaches. There's no one right way. Of course, it's always tailored to the parent.

I'd try to say that this has been a stressful situation. We hope if a teen makes a suicide attempt, that this won't happen again, but we know from following kids at our hospital in particular, that there's a group of kids who will stay low. They will have little ideation after this. There is also a group of kids who will have a chronically high level. With some, there will be moderation, and you'll see a more inconsistent pattern.

We want parents to be aware that there could be continued periods where your child will be suicidal despite that we've worked with them in the hospital, that they've cooled down in the hospital, and they're starting new meds. It's not something to be alarmed about. It's happened. We have a plan to deal with it, but you should be aware of it and monitoring in a way that shows the teen that you're concerned, but you're not intrusive in a way that makes your teen angry and creates more stress, which exacerbates the

suicidal ideation. Something along those lines is what I try to say to parents in those situations.

Kelly Koerner: That's helpful. I think there were a couple others along those same lines.

Your blend of research plus having done the work -- your off the cuff is helpful modeling. Let me look through others in the same vein.

If your kid is at home, and you're balancing the staying in the room versus pushing for family engage -- allowing the video game, holing up, versus pushing for change -- will you talk about that, as well?

Anthony Spirito: Yeah. It's almost like the moderation principle. You can tell your teen you're concerned about them, and you know they're doing better, but that was a scary episode for me and you. You felt so bad that you took pills and wanted to die. "When you isolate yourself in the room, it concerns me that those feelings could come up again. I understand it's important to have contact with friends, texting, or be on video games, and you enjoy doing that. I'd ask that you spend some time with the family and some time with others, so we feel more comfortable and give you more space. Then you can spend some time in the room. All I'm asking you to do is come out and spend some time with me, even if it's a 10 minute break on the hour. Come out. See what we're watching on TV. See if mom can get you some ice cream." That's sexist. [Laughing.] "See if I can get you some ice cream or something to drink. I'd really appreciate that. That would make me feel better. If I feel better, I won't be on your back so much." You'll find that works to your advantage, something on those lines. I'm making that up.

Kelly Koerner: Yeah. It's great modeling. Being able to model this moderated this position, extreme, is super helpful.

A number of folks appreciated the reasons kids end up re-triggered, the slide about phones being taken away as a common thing that would end up with a readmission to the hospital. Do you have thoughts there about ways in which it could be an increased trigger for the kid, so you'd be tempted to take it away, but taking it away could be a prompt.

Anthony Spirito: I don't work in the inpatient unit. I did in the past, but I work with other people on the unit. Some of my ideas come from Jen Woolford [sp?] who's worked with me for 10 years and works in the unit right now. Other clinical psychologists and she talk about this a lot.

It's back to moderation probably. We say 25% of the kids reported that phones being taken away was the reason for their attempt. We have to assume that at least half of those cases, there was a legitimate reason that the parent did that, and you or I would is the same thing. It's not just a parent acting inappropriately. The child demonstrated

behaviors that made them so concerned that they took the phone away.

We have to go back and talk to parents about the initial reasons they did that. You have to walk through with the parents why they're doing that. If they are being bullied on the phone, they don't want them near the phone because of the bullying.

Then, if that's also how they're connecting to others and getting social support, you have to talk to the parent about the balance there. What's the amount of distress caused by being bullied by one individual versus the amount of support they gain by feeling connected to their friends through social media?

We tend to give talks like this about teens and suicide. We tend to think that social media is all negative. Jackie Nesi who works with me and knows 100 times more about this than me and has published multiple papers on this -- it's clear that there are positive and supportive reasons for social media, even with kids who are having psychiatric problems. There's a balance of both.

You can lay out rules on discharge for the teen right away to say, "Here's when I think you need a break from the phone. It's not about your behavior on the phone. It's about how the phone and social media are affecting you and why we have to sometimes take a break from it."

It's no different than any punishment. Think of it that way. If you feel the need to take the phone away, don't do it as punishment when a kid is relying on it following a suicidal event. Think of it therapeutically. "At this point, I won't take away the phone for punishment, but I'll take it away for a short period of time if I think it's causing you distress and making you more upset." At the time, you say, "I won't take your phone away for a week. I may take it away for a couple hours or overnight. I'll return your phone when. You can demonstrate that you've calmed down, and your emotions are more under control." You can use as phone to help engage the teen to talk about feelings. Go back to the emotion coping idea.

If you take away the phone for a month, that's the worst thing you can do. You have to give them a way to get their privileges back regardless of what it is.

Kelly Koerner: That's so helpful. This last question is maybe from the provider side.

In gray zones where it's not clear how a kid will do when they return home -- there's a lack of data -- can you say some about how you think about that and in the context of there being so little outpatient resources? Will you talk about that hard situation we're all up against?

Anthony Spirito: I'll only pontificate. First, I'd say that there is a large percentage of kids who don't benefit form psychiatric hospitalizations. It can make it worse. I should take that back.

The negatives outweigh the positives in psychiatric hospitalization. Kids who cut after being exposed to it in another unit is an example.

There can definitely be negative effects with psychiatric hospitalization.

I recall within the last 5 years on a Friday night at 6:00 talking to parents for an hour about why I felt they could take the kid home and manage them. In the long run, that's more therapeutic. At a certain point, when parents don't feel comfortable, then you, as a clinician, wonder if you force them to take the kid home if they're not comfortable? What if something happens? They've lost trust in me. The leverage I have working with them is gone. Even worse, the kid kills themselves. You can become anxious about making that decision.

When I covered the ER, it was hard to get kids in the hospital. I was used to sending suicidal kids home.

We don't have enough mobile crisis psychiatric units. That's what we should be investing money in.

It's hard to establish a mobile psychiatric crisis team. If you pay full-time for them, then you're not getting your money back. You only get sporadic use of it. Theoretically, you can pay them to work all weekend, the most high-risk team, but it's almost impossible from an administrative and financial point of view to make a crisis team that can be financially viable and operate at the necessary hours unless you have philanthropy helping with that. That seems like a good place to think about engaging private donors about helping that situation.

Theoretically, you wouldn't have so much exposure to the iatrogenic parts of the psychiatric hospitalization.

It's a tough problem. Over this winter, our psych emergency room, I had weekends with 24 boarders. I'd come to meetings with the ED physicians and say I had nothing to do last night. There were 12 psych admissions and only two medical. I sat there because psych handled it.

Kelly Koerner: It's the same across the country. I think Titian's where that question was coming from. It's helpful. I didn't feel like pontificating. It's like your whole talk. It seems you're in it with us. The way in which you blend research with clinical acumen, share credit to colleagues, and give us 40 years of work in an hour was really valuable. Thank you so much for joining us. We really appreciate it.

Anthony Spirito: I hope everyone found some part of it useful.

Linda Dimeff: I took copious notes. This was super helpful. I feel such gratitude to you for today's talk and the work you and your colleagues have done over the decades.

A reminder to everyone -- Thank you very much for being part of today's talk. You'll receive an email from Jaspr Health that will include two links. If you want CE credit, make sure to fill out both the evaluation from today's talk as well as the attestation saying you were here, so Portland DBT can issue your CEs.

A special thanks to Portland DBT, our cohost for today's talk, and their kindness for offering the CE credits for us. We appreciate that.

Kelly, anything you want to say to bring us home?

Kelly Koerner: No. Just thank you again, Tony. We appreciate it.

Linda Dimeff: Thank you, Tony.

Anthony Spirito: Alright, bye.

[End of meeting]