DEPRESSION, SUICIDE & PTSD IN CHILDREN AND ADOLESCENTS

- Depression
- Symptoms of Depression
  - Co-occurring Disorders
  - Suicide
  - Suicide and Age: Children; Adolescents
- Treatment for Post-Suicide Attempts
- Prevention
- Stress Disorders
- Treatment for Adolescent Substance Abuse and Post-Traumatic Stress Disorder
LIFELONG RISK FACTORS AND INTERVENTIONS

Non-specific interventions: universal and targeted interventions in early childhood

- Benefits to child mental health have been shown from early childhood interventions including: early stimulation interventions; interventions to improve carer sensitivity and responsiveness, integrated nutrition, health, and stimulation programmes; attendance at a high-quality preschool; and conditional cash transfers to families. These early interventions benefit children exposed to various contextual and biomedical risks including poverty, institutionalization, low birthweight, stunning, and iron-deficiency anaemia.

- Nutritional interventions in early childhood have had mixed results. Prevention of iron-deficiency anaemia in Chilean infants improved behaviour and temperament at 12 months. However, no benefits were reported for iron supplementation, zinc supplementation, or both, for the behaviour of 6–7-year-old Mexican children, and nutritional supplementation of stunted Jamaican children in early childhood did not improve their behaviour at age 11–12 years or their mental health at age 17–18 years.

Interventions for behavioural disorders: universal

- School-based preventive interventions for children aged 3–8 years involving teacher training, teaching a class-wide social-emotional curriculum, or both, have shown concurrent improvements in child problem behaviors and child competencies. Furthermore, there is evidence that these interventions are well accepted by teachers. Integration of a brief behavioural parent training intervention into health services for 2–6-year-old children in Iran improved parent reported practices and child abuse. A community-based preventive programme targeting drug use in China successfully reduced drug use initiation in young men aged 15–19 years.

Interventions for behavioural disorders: selective

- Benefits from child training interventions for children aged 7–14 years with behaviour problems were reported for externalizing problems and social skills.

Interventions for emotional disorders: universal

- Interventions involving structured activities have shown benefits for children aged 7–14 years in war-affected communities. A school-based physical activity intervention for 15-year-old students in Chile showed benefits to anxiety and self-esteem but not to depression.

- A psychosocial intervention to prevent depression in 12–16-year-old adolescents in Mauritius showed short-term benefits to depression, hopelessness, coping skills, and self-esteem. Benefits to coping skills and self-esteem were sustained at follow-up after 6 months.

Interventions for emotional disorders: selective

- School-based and camp-based psychosocial group interventions have generally, although not consistently, shown benefits to child and adolescent mental health, including internalizing problems, behavioural difficulties, and competencies. Interventions have targeted children aged 7–18 years affected by conflict, 10–15-year-old children orphaned by AIDS, and 8–15-year-old children with substantial depressive symptoms. For 5–6-year-old children displaced by war, a combination of group psychosocial intervention and home visits for mothers improved maternal and child mental health.

Interventions for intellectual disorders: universal

- Effective interventions to prevent cognitive deficits in low-income and middle-income countries include maternal and child nutritional and micronutrient supplementation, immunisation programmes, reduction of exposure to environmental toxins, prenatal and perinatal maternal health interventions, malaria prevention, and early stimulation programmes. Other interventions with potential to prevent intellectual disorders include accident and injury prevention, child abuse prevention, and interventions to prevent prenatal alcohol exposure.

Interventions for intellectual disorders: selective

- Home-visit programmes to train mothers of 3–6-year-old disabled children in early stimulation activities have shown some benefits to child development.
SYMPTOMS OF DEPRESSION

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• M
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• B
What Are the Symptoms of Depression?

• Symptoms may vary from person to person
• Five main areas of functioning may be affected:
  • Emotional symptoms
    • Feeling “miserable,” “empty,” “humiliated”
    • Experiencing little pleasure
  • Motivational symptoms
    • Lacking drive, initiative, spontaneity
    • Between 6% and 15% of those with severe depression die by suicide
What Are the Symptoms of Depression?

- Five main areas of functioning may be affected (MMPTB):
  - Behavioral symptoms
    - Less active, less productive
  - Cognitive symptoms
    - Hold negative views of themselves
    - Blame themselves for unfortunate events
    - Pessimistic
  - Physical symptoms
    - Headaches, dizzy spells, general pain
Stress and Unipolar Depression

- Today’s clinicians usually concentrate on recognizing both the situational and the internal aspects of any given case
  - People with depression experience a greater number of stressful life events during the month just before the onset of their symptoms
  - Some clinicians distinguish reactive (exogenous) depression from endogenous depression, which seems to be a response to internal factors
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Major Depression (MD)

- Sad or irritable mood, changes in sleep, appetite, or body movement;
- Not interested in previous activities;
- Guilt or worthlessness, decreased energy;
- Frequent thoughts of death or suicide; difficulty concentrating;
- Rates of death by suicide, especially in early adolescence (ages 10-14) have increased in recent years.
- Lesbian and gay youth thought to be 2-6 times more likely to make a suicide attempt than other youth.
- Substance use may occur as an attempt to reduce or modify symptom experience or may be associated with peer group influences.
CO-OCCURRING SUBSTANCE ABUSE AND MENTAL DISORDER

Dysthymia

• General unhappiness, pessimism, negativity, hypersensitivity to criticism, dissatisfaction, may be hard to please, always remember feeling this way;

• Majority of children / adolescents with dysthymia (70%) go on to develop Major Depression (MD);

• Appears to interfere more with normal development than does MD.
Bipolar Disorder

- Cycling of manic and depressive episodes;

- Manic symptoms include irritability and agitation, sleep disturbance, distractibility/impaired concentration, grandiosity, reckless behavior, suicidal thoughts;

- Presentation in youth may be characterized by ‘very rapid, brief, recurrent episodes lasting hours to a few days; Early onset appears to have greater frequency in males;

- Stronger association with co-occurring SA, anxiety and CD than with unipolar depression
CO-OCCURRING SUBSTANCE ABUSE AND MENTAL DISORDER

Schizophrenia (Childhood Onset)

• Little range of emotion, few facial expressions;
• Poor eye contact, delays in language, unusual motor behaviors, odd speech, both in content and tone;
• May hear voices, ‘see’ things, problems with abstraction;
• May demonstrate confusion, suspicion, paranoia;
• unusual fears;
• May have few friends or be withdrawn from peers;
• Onset of full disorder before age 6-7;
• Difficulty in school functioning may be an early sign;
• Substance use may facilitate otherwise impaired peer group interactions.
5 A’s of Schizophrenia

• A
• A
• A
• A
• A
SEPARATING SUBSTANCE ABUSE AND MENTAL DISORDER

- TIME

- INTOXICATION
- WITHDRAWAL
- MENTAL DISORDER
When clients are actively abusing drugs, their symptom picture is apt to be that of intoxication or toxicity. Alcohol intoxication can occur, and severe intoxication can lead to stupor and even coma. With cocaine intoxication, a range of mental states can occur, from euphoria and hyperactivity to paranoia.

As blood levels of the abused drug drop, withdrawal symptoms begin to dominate the clinical presentation. With alcohol, these are minor or major (for instance, delirium tremens) withdrawal syndromes. There are similar problems with benzodiazepines and barbiturates. With cocaine, a crash and craving ensue. Acute withdrawal from chemicals of abuse can extend from days to weeks, depending on the agent(s) used. Severe and chronic abuse of potent psychoactive agents such as alcohol and cocaine may produce more subtle withdrawal problems that last for several months.

As recovery proceeds, and as toxic and withdrawal states abate, underlying Axis I and II disorders become more evident. Examples of this process include a manic illness that emerges as drug abuse symptoms wane and a panic disorder that expresses itself after all depressant drug abuse has ceased.
INTOXICATION
WITHDRAWAL
MENTAL DISORDER

SEPARATING SUBSTANCE ABUSE AND MENTAL DISORDER
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ICELAND ANTI-SUICIDE CAMPAIGN

• Suicide has in recent years been the biggest cause of death in Iceland among men aged 18-25. Each year sees 4-6 young men take their own life. A new campaign by the Red Cross has increased calls to the helpline 1717 and the internet chat-line 1717.is by 33 percent.

• The campaign is called, Útmeða (meaning ‘out with it’) and is a project aimed at combating and preventing suicide among young men in Iceland. The video accompanying the campaign has been shared over 10,000 times on social media. It shows a young man committing suicide at a deserted farm in Iceland.

• "We want people to speak out about emotional problems with respect and responsibility. We want to encourage young men to put their feelings into words and not to keep the sadness inside. People shouldn't be afraid to seek help for mental problems, just like they seek help for physical problems, it's nothing to be ashamed of," says Hjálmar Karlsson at the Red Cross.


• News | Iceland Monitor | Thu 24 Sep 2015 | 14.35 GMT
Suicide

• Suicide is one of the leading causes of death in the world
  • It has been estimated that 1 million people who die by it each year, with more than 36,000 suicides per year in the U.S. alone

• Many more (600,000 in the U.S.) make unsuccessful attempts
  • Such attempts are called “parasuicides”
Suicide

- People qualify for a diagnosis of *suicidal behavior disorder* if they have tried to kill themselves within the last two years, even if they changed their mind after initiating the attempt or if the attempt was interrupted.
  - It is not surprising that the majority of suicide attempters also display another psychological disorder, such as major depressive disorder, schizophrenia, or alcohol use disorder.
What Is Suicide?

• Shneidman defines suicide as an intentioned death – a self-inflicted death in which one makes an intentional, direct, and conscious effort to end one’s life

• He characterizes four kinds of suicide seekers...
What Is Suicide?

• Shneidman’s characterizations:
  • Death seekers – clearly intend to end their lives
  • Death initiators – intend to end their lives because they believe that the process of death is already underway (e.g. Hemmingway)
  • Death ignorers – do not believe that their self-inflicted death will mean the end of their existence (e.g. Heaven’s Gate, suicide bombers)
  • Death darers – have ambivalent feelings about death and show this in the act itself (e.g. Russian Roulette)
Patterns and Statistics

• Researchers have gathered statistics regarding the social contexts in which suicides take place
  • Suicide rates vary from country to country, with religious **devoutness** (not simply affiliation) helping to explain some of the difference
Patterns and Statistics

- The suicide rates of men and women also differ:
  - Women have a higher attempt rate (3x men)
  - Men have a higher completion rate (4x women)
    - Why? Different methods have differing lethality
      - Men tend to use more violent methods (shooting, stabbing, or hanging) than women (drug overdose)
    - Guns are used in nearly two-thirds of male suicides in the U.S., compared to 40% of female suicides
What Triggers a Suicide?

- Suicidal acts may be connected to recent events or current conditions in a person’s life
  - Although such factors may not be the basic motivation for the suicide, they can precipitate it
- Common triggers include stressful events, mood and thought changes, alcohol and other drug use, mental disorders, and modeling
Stressful Events and Situations

- Researchers have counted more stressful events in the lives of suicide attempters than in the lives non-attempters
  - One stressor that has been consistently linked to suicide is combat stress
- Both immediate and long-term stresses can be risk factors for suicide
  - Immediate stresses can include the loss of a loved one, the loss of a job, or natural disaster
Stressful Events and Situations

• Long-term stressors can include:
  • Social isolation – individuals without social support are particularly vulnerable
  • Serious illness – especially those which cause great pain or severe disability
  • Abusive environments – from which there is little or no hope of escape
  • Occupational stress
    • Psychiatrists and psychologists, physicians, nurses, dentists, lawyers, police officers, farmers, and unskilled laborers have particularly high suicide rates
Mood and Thought Changes

• People who attempt suicide fall victim to dichotomous thinking, viewing problems and solutions in rigid either/or terms
  • The “four-letter word” in suicide is “only,” as in “suicide was the only thing I could do”
Alcohol and Other Drug Use

• Studies indicate that as many as 70% of the people who attempt suicide drink alcohol just before the act
  • Autopsies reveal that about one-fourth of these people are legally intoxicated
• Research shows the use of other kinds of drugs may have similar ties to suicide, particularly in teens and young adults
Mental Disorders

• The majority of all suicide attempters display a psychological disorder beyond their suicidal inclinations
  • Those with depression, substance use disorders, and/or schizophrenia are at greatest risk
Is Suicide Linked to Age?

• The likelihood of committing suicide increases with age, although people of all ages may try to kill themselves.

• Although the general findings about suicide hold true across age groups, three age groups (children, adolescents, and the elderly) have been the focus of much study because of the unique issues that face them.
Although suicide is infrequent among children, rates have been increasing over the past several decades

- More than 6% of all deaths among children between the ages of 10 and 14 are caused by suicide
- Boys outnumber girls by as much as 5:1
Children

• Suicide attempts by the very young generally are preceded by such behavioral patterns as running away, accident-proneness, temper tantrums, self-criticism, social withdrawal, dark fantasies, and marked personality changes.

• Despite common misperceptions, many child suicides appear to be based on a clear understanding of death and on a clear wish to die.
Adolescents

• Suicidal actions become much more common after the age of 14 than at any earlier age
  • About 1500 teens commit suicide in the U.S. each year
    • As many as 10% make suicide attempts!!! and 1 in 6 may think about suicide each year!!!
Adolescents

- About half of teen suicides have been tied to clinical depression, low self-esteem, and feelings of hopelessness
  - Anger, impulsiveness, poor problem-solving skills, substance use, and stress also play a role
- Some theorists believe that the period of adolescence itself produces a stressful climate in which suicidal actions are more likely
Adolescents

• Far more teens attempt suicide than succeed
  • Ratio may be as high as 200:1
  • Several explanations, most pointing to societal factors, have been proposed for the high rate of attempts among teenagers
The Elderly

• In Western society the elderly are more likely to commit suicide than people in any other age group
  • There are many contributory factors:
    • Illness
    • Loss of close friends and relatives
    • Loss of control over one’s life
    • Loss of social status

• Elderly persons are typically more determined than younger persons in their decision to die, so their success rate is much higher
Treatment and Suicide

• Treatment of suicidal persons falls into two categories:
  • Treatment after suicide has been attempted
  • Suicide prevention
What Treatments Are Used After Suicide Attempts?

• After a suicide attempt, most victims need medical care
• Psychotherapy or drug therapy may begin once a person is medically stable
  • Unfortunately, even after trying to kill themselves, many suicidal people fail to receive systematic follow-up care
What Treatments Are Used After Suicide Attempts?

- Therapy goals:
  - Keep the patient alive
  - Reduce psychological pain
  - Help them achieve a non-suicidal state of mind and a sense of hope
  - Guide them to develop better ways of handling stress

- Various therapies and techniques have been employed
  - Cognitive and cognitive-behavioral therapies may be particularly helpful (e.g., DBT, Marsha Linehan)

[Image]

Expert on Mental Illness Reveals Her Own Fight (NYT, June 23, 2011)
What Is Suicide Prevention?

- During the past 50 years, emphasis worldwide has shifted from suicide treatment to suicide prevention
  - There are hundreds of suicide prevention programs in the U.S.
  - There are also hundreds of suicide hot lines (24-hour-a-day telephone services)
    - Hot lines are predominantly staffed by paraprofessionals – people trained in counseling but without formal degrees
What Is Suicide Prevention?

• Both suicide prevention programs and suicide hot lines provide crisis intervention

• The general approach includes:
  • Establishing a positive relationship
  • Understanding and clarifying the problem
  • Assessing suicide potential
  • Assessing and mobilizing the caller’s resources
  • Formulating a plan
What Is Suicide Prevention?

• Although crisis intervention may be sufficient treatment for some suicidal people, longer-term therapy is needed for most.

• Another way to prevent suicide may be to limit the public’s access to common means of suicide.
  • Examples: gun control, safer medications, better bridge barriers, and car emissions controls.
Do Suicide Prevention Programs Work?

• It is difficult to measure the effectiveness of suicide prevention programs
  • Prevention programs do seem to reduce the number of suicides among those high-risk people who do call (i.e, those who succeed, don’t call)

• Many theorists have argued for more effective public education about suicide, as education is the ultimate form of suicide prevention
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The Psychological Stress Disorders

• During and immediately after stressful situations, we may temporarily experience levels of arousal, anxiety, and depression
  • For some, symptoms persist well after the situation ends
    • These people may be suffering from:
      • Acute stress disorder
      • Posttraumatic stress disorder (PTSD)
  • The precipitating event usually involves actual or threatened serious injury to self or others
    • The situations that cause these disorders would be traumatic to anyone (unlike other anxiety disorders)
The Psychological Stress Disorders

• **Acute stress disorder**
  • Symptoms begin within four weeks of event and last for less than one month

• **Posttraumatic stress disorder (PTSD)**
  • Symptoms may begin either shortly after the event, or months or years afterward
  • Symptoms continue longer than one month
    • As many as 80% of all cases of acute stress disorder develop into PTSD
Symptoms of PTSD

- Re-experiencing the trauma
- Emotional numbing
- Avoidance
- Neurobiological changes
- Physical manifestations
  - Headaches
  - Stomach or digestive problems
  - Immune system problems
  - Asthma or breathing problems
  - Dizziness
  - Chest pain
  - Chronic pain or fibromyalgia
- Psychological outcomes
  - Depression, major or pervasive
  - Anxiety disorders such as phobias, panic, and social anxiety
  - Conduct disorders
  - Dissociation
  - Eating disorders
- Social manifestations
  - Interpersonal problems
  - Low self-esteem
  - Alcohol and substance use
  - Employment problems
  - Homelessness
  - Trouble with the law
- Self-destructive behaviors
  - Substance abuse
  - Suicidal attempts
  - Risky sexual behaviors
  - Reckless driving
  - Self-injury
The Psychological Stress Disorders

• Symptoms of Acute and Posttraumatic Stress Disorders:
  • Re-experiencing the traumatic event
  • Avoidance
  • Reduced responsiveness
  • Increased arousal, anxiety, and guilt
What Triggers a Psychological Stress Disorder?

• Can occur at any age and affect all aspects of life
• At least 3.5% of people in the U.S. are affected each year
• 7–9% of people in the U.S. are affected sometime during their lifetime
• Around two-thirds seek treatment at some point
• Ratio of women to men is 2:1
  • After serious trauma, around 20% of women and 8% of men develop disorders
• Some events – including combat, disasters, abuse, and victimization – are more likely to cause disorders than others
What Triggers a Psychological Stress Disorder?

• **Combat and stress disorders**
  • For years clinicians have recognized that soldiers develop severe anxiety and depression during combat
    • Called “shell shock” or “combat fatigue”
    • Post-Vietnam War clinicians discovered that soldiers also experienced psychological distress AFTER combat
  • As many as 29% of Vietnam veterans suffered acute or posttraumatic stress disorders
    • An additional 22% experienced at least some stress symptoms
    • 10% still experiencing problems
  • A similar pattern is currently unfolding among veterans of wars in Iraq, Afghanistan, and Syria
What Triggers a Psychological Stress Disorder?

• Disasters and stress disorders
  • Acute and posttraumatic stress disorders may also follow natural and accidental disasters
    • Types of disasters include earthquakes, floods, tornadoes, fires, airplane crashes, and serious car accidents
    • Because they occur more often, civilian traumas have been implicated in stress disorders at least 10 times as often as combat traumas
What Triggers a Psychological Stress Disorder?

• Victimization and stress disorders
  • People who have been abused or victimized often experience lingering stress symptoms
    • Research suggests that more than one-third of all victims of physical or sexual assault develop PTSD
  • A common form of victimization is sexual assault/rape
    • Around 1 in 6 women is raped at some time during her life
    • Psychological impact is immediate and may be long-lasting
    • One study found that 94% of rape survivors developed an acute stress disorder within 12 days after assault
What Triggers a Psychological Stress Disorder?

• Victimization and stress disorders
  • Ongoing victimization and abuse in the family may also lead to stress disorders
  • The experience of terrorism or the threat of terrorism often leads to posttraumatic stress symptoms, as does the experience of torture
Why Do People Develop a Psychological Stress Disorder?

• Clearly, extraordinary trauma can cause a stress disorder
  • However, the event alone may not be the entire explanation

• To understand the development of these disorders, researchers have looked to the:
  • Survivors’ biological processes
  • Personalities
  • Childhood experiences
  • Social support systems
  • Cultural backgrounds
  • Severity of the traumas
Why Do People Develop a Psychological Stress Disorder?

• Biological and genetic factors
  • Traumatic events trigger physical changes in the brain and body that may lead to severe stress reactions and, in some cases, to stress disorders
    • Some research suggests abnormal neurotransmitter and hormone activity (especially norepinephrine and cortisol)
    • Evidence suggests that other biological changes and damage may also occur (especially in the hippocampus and amygdala) as a stress disorder sets in
    • There may be a biological/genetic predisposition to such reactions
Why Do People Develop a Psychological Stress Disorder?

• Personality factors
  • Some studies suggest that people with certain personalities, attitudes, and coping styles are particularly likely to develop stress disorders
    • Risk factors include:
      • Preexisting high anxiety
      • Negative worldview
  • A set of positive attitudes (called resiliency or hardiness) is protective against developing stress disorders
    • Control
    • Commitment
    • Challenge
Why Do People Develop a Psychological Stress Disorder?

• **Childhood experiences**
  • Researchers have found that certain childhood experiences increase risk for later stress disorders
  • Risk factors include:
    • An impoverished childhood
    • Psychological disorders in the family
    • The experience of assault, abuse, or catastrophe at an early age
    • Being younger than 10 years old when parents separated or divorced
Why Do People Develop a Psychological Stress Disorder?

• Social support
  • People whose social and family support systems are weak are more likely to develop a stress disorder after a traumatic event
Why Do People Develop a Psychological Stress Disorder?

• **Severity of the trauma**
  
  • The more severe the trauma and the more direct one’s exposure to it, the greater the likelihood of developing a stress disorder
  
  • Especially risky: Mutilation and severe injury; witnessing the injury or death of others
How Do Clinicians Treat the Psychological Stress Disorders?

- About half of all cases of PTSD improve within 6 months; the remainder may persist for years.
- Treatment procedures vary depending on type of trauma.
- General goals:
  - End lingering stress reactions
  - Gain perspective on painful experiences
  - Return to constructive living
How Do Clinicians Treat the Psychological Stress Disorders?

• Psychological debriefing
  • A form of crisis intervention that has victims of trauma talk extensively about their feelings and reactions within days of the critical incident
    • Four-stage approach:
      • Normalize responses to the disaster
      • Encourage expressions of anxiety, anger, and frustration
      • Teach self-help skills
      • Provide referrals
  • Relief workers themselves may become overwhelmed
  • Research on this type of intervention continues to call into question its effectiveness
Recovery from traumatic events unfolds in three stages:

- **Establishing safety**
  Establishing safety includes allowing the victim to regain control.

- **Tasks of remembrance and mourning**
  Retelling the story must be repetitive; eventually, the story no longer will arouse such intense feelings (Herman, 1997). Eventually, it becomes only a part of the survivor’s experience rather than the focus of it.

- **Reconnection with ordinary life**
  Victims must create a new self and a new future. As quoted by Herman (1997), psychiatrist Michael Stone describes this task (specific to his work with incest survivors) thusly:

  “All victims... have, by definition, been taught that the strong can do as they please, without regard for convention. ... *Re-education* is often indicated, pertaining to what is typical, average, wholesome, and ‘normal’ in the intimate life of ordinary people. Victims... tend to be woefully ignorant of these matters, owing to their skewed and secretive early environments. Although victims in their original homes, they are like strangers in a foreign country, once ‘safely’ outside.” - Michael Stone
Seven criteria for the resolution of trauma

• The physiological symptoms of PTSD have been brought within manageable limits;

• The survivor is able to bear the feelings associated with traumatic memories;

• The person has authority over the memories, e.g., she can either remember the event or put it aside;

• The memory is coherent and linked with feeling;

• The survivor’s self-esteem has been restored;

• Important relationships have been reestablished; and

• A coherent system of meaning and belief concerning the trauma has been constructed
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Treating Substance Use Issues in Traumatized Adolescents and Young Adults: Key Principles and Components
John Briere, Ph.D.
Cheryl Lanktree, Ph.D.

USC Adolescent Trauma Training Center (USC-ATTC)
National Child Traumatic Stress Network
Department of Psychiatry and Behavioral Sciences
Keck School of Medicine
University of Southern California
Los Angeles, California
CENTRAL PRINCIPLES OF RELEVANT TRAUMA TREATMENT

Do Not Screen Substance Users Out of Therapy or Terminate Treatment Because of Relapse Back into Substance Use and Abuse

- Sobriety problematic for many clients, including traumatized adolescents, who may be quite reluctant to discontinue the use of agents that successfully numb distress, and thus would not be able to access trauma treatment with a sobriety requirement.

- Clinicians should encourage clients to avoid significant substance use and abuse (SUA), but not require it—the youth is taken as he or she is, and assisted within the constraints of what he or she will accept or tolerate.

- In many cases, trauma survivors’ involvement in drugs or alcohol is, in part, a response to past or recent trauma exposure, and trauma therapy may eventually reduce or eliminate their reliance on psychoactive substances.
• Many traumatized youth, especially those involved in SUA, are at serious risk of victimization, injury, or even death at the time of seeking therapeutic services.

• This danger may reflect the risks associated not only with SUA, but also community violence, gang activity, criminal behavior, or prostitution, as well as specific life threats from previous perpetrators, sexual partners, stalkers, parents, or drug dealers/abusers.

• Young women are at significant risk of being raped or otherwise sexually abused by relatives, partners, and strangers—risk that may increase if they habitually use drugs or alcohol.

• SUA-involved adolescent may be self-endangering; either passively through unsafe sexual practices, driving under the influence of substances, or involvement in other risky behaviors or through more actively suicidal behaviors.
SAFETY FIRST

• Ensuring safety should be the first requirement of trauma therapy.

• We recommend initial and ongoing determination of acute safety when working with SUA-involved youth. These include assessment of any acute dangers in the client’s immediate environment, such as abusive family members, extra familial perpetrators, pimps, gang-related activity, or unsafe living conditions, such as homelessness or high levels of community violence.

• Suicidality and other forms of self-endangerment should be evaluated, including those associated with obtaining or using drugs or alcohol.

• Physical health is another concern for some SUA-involved youth, including acute illnesses and chronic untreated medical conditions such as AIDS, hepatitis C, or tuberculosis.

• Comorbid psychological conditions also may be present, including depression, posttraumatic or acute stress disorder, mania, psychosis, or substance-related brain syndromes.
SAFETY FIRST

If there are acute safety issues, intervention in these areas must precede or at least accompany treatment for less immediate psychological symptoms or problems. This may involve:

• notifying child welfare or protection services

• advocating for the client with police or the criminal justice system;

• working with the youth to separate himself or herself from gangs, prostitution, or domestic violence

• arranging medical evaluations and treatment, including, in some cases, medical or psychiatric hospitalization

• early therapeuetic and psychoeducational focus on self-harming or especially risky behaviors such as suicidality, deliberate self-injury, unsafe sex, and use of especially dangerous drugs (e.g., heroin, methamphetamine, OxyContin) and delivery systems (e.g., intravenous injections in general and needle sharing in particular
ESTABLISH A POSITIVE THERAPEUTIC RELATIONSHIP

• Traumatized youth with SUA issues may experience significant ambivalence—if not outright distrust—regarding any sort of sustained attachment to an older, more powerful figure.

• Others may appear to attach very quickly, but their connection may remain insecure, based primarily on relational hunger or neediness associated with early attachment deprivation rather than a true belief in safety.

• In either instance, therapy may be slowed or compromised by insufficient trust and, as a result, reduced openness to the healing aspects of therapy.

• The clinician can encourage, if not accelerate, a positive therapeutic relationship through: 1) relational safety; 2) a visible willingness to understand and accept; 3) active relatedness and emotional connection; 4) patience.
• Because danger is such a part of many trauma survivors’ lives, the therapist’s ability to communicate and demonstrate safety is a central component to relationship building.

• The adolescent is more likely to “let down his/her guard” and open himself or herself to a relationship if, repeatedly over time, there is little evidence of danger in the therapy process.

• Therapist behaviors and responses that increase the client’s sense of safety are likely to include: nonintrusiveness, visible positive regard, reliability, transparency, and clear demarcations of the limits of confidentiality.

• The therapist should be as honest and open as possible, and not appear to have a hidden agenda—including a covert alliance with parents or social institutions over what the youth believes to be his or her own needs.

• When the clinician must report to systems beyond the adolescent, he or she should disclose this to the client and, whenever possible, gain his or her consent to do so.

• At the initiation of treatment, the therapist also should be clear with the adolescent regarding his or her responsibility to report child abuse, client danger to self or others, or otherwise to intervene without the client’s permission when harm is likely to occur.
A major effect of traumatization is often the sense that one is alone, isolated from others, and, in some sense, unknowable; a phenomenon that may be increased by the illicit nature and effects of some forms of SUA.

Having the opportunity to interact regularly with someone who listens, and who seems to understand, can be an unusual experience for many maltreated youths—one that tends to strengthen the bond between client and therapist.

This process is typically facilitated when the clinician displays attunement, empathy, and acceptance.

This balance, between (a) being clear with the client about the inadvisability of illegal or dangerous behavior, while also (b) communicating acceptance and appreciation of the client’s inherent validity and entitlements to well-being, is often difficult to achieve and yet important to treatment success.
• It is important that the therapist be an active (as opposed to a passive or neutral) agent in therapy.

• When possible, he or she should make direct statements about the wrongness of the adolescent’s victimization, and show some level of emotional responsivity to the extent that it is helpful.

• The clinician should not give extensive, unsolicited advice, but, instead, actively assist the client in problem identification and problem-solving, generally supporting and encouraging him or her, emphasizing his or her strengths, and being consistently psychologically available.
PATIENCE

• Psychotherapy for youth with complex trauma effects rarely proceeds rapidly especially when chronic SUA is present.
• Yet, the adolescent and sometimes the therapist understandably wants rapid improvement.
• The client may become frustrated that, for example, cognitive insights do not always result in immediate behavior changes (including substance abstinence), or that an instance of talking about a trauma does not immediately desensitize emotional distress to it.
• Such experiences may lead to helplessness or self-criticism, as the youth interprets a lack of immediate distress reduction, or continued involvement in unhelpful behaviors like SUA, as evidence of personal failings.
• As the therapist counsels patience and a longer-term perspective, and remains invested in the therapeutic process, he or she communicates acceptance of the client and appreciation of the time it sometimes takes for enduring changes to emerge.
• It is important to treat trauma symptoms and drug related symptoms at roughly the same time.

• Focusing on SUA alone may delay needed trauma interventions, whereas attempting trauma treatment without attending to SUA may easily overwhelm the client and motivate avoidance.

• The exposure component of most trauma treatments may sometimes reinforce or even encourage drug or alcohol use as the client attempts to avoid activated trauma memories.

• Several adolescent trauma treatment components (e.g., trigger identification/intervention and affect regulation training, presented below) are helpful in both SUA and trauma domains, and thus can be tailored to either set of problems.

• How trauma treatment and intervention in SUA are applied in the same session varies from client to client.

• Therapist and client should directly connect the two problems: exploring ways that SUA has been used as a defense against overwhelming trauma-related distress, as well as the fact that SUA, itself, may increase the likelihood of further trauma and psychological distress, creating a vicious cycle.

• When discussing ways not to act on urges that result in problematic substance use, it may be helpful for the client to consider trauma-related triggers in his or her environment that make drinking or taking drugs more likely.

• Overall, the focus and messages should be that the youth’s trauma symptoms and SUA are interconnected, such that therapeutic attention to one almost inevitably will include some attention to the other.
FOCUS INITIALLY ON STABILIZATION AND COPING

• The substance abusing trauma survivor is often in crisis, psychologically and/or physically unsafe, and prone to “acting out” or self-harming behaviors when stressed—which may be much of the time.

• For this reason, effective therapy for such clients emphasizes relationship-building, a focus on safety, and affect regulation training.

• Although treatment ideally includes attention to both trauma and SUA issues, in many cases emotional (and sometimes life-style) stabilization is often indicated before extensive therapeutic exploration of—and exposure to—trauma memories can begin.

• Some adolescent clients will attempt to discuss trauma memories in great detail before they have developed sufficient capacity to tolerate the associated negative emotional states.

• The result may be overwhelming emotional states, and even greater involvement in avoidance activities.

• When this occurs, especially if the client is still involved in major SUA, we recommend that the client’s trauma disclosures be acknowledged and received as important parts of treatment, but with communication that such processing will likely occur to a greater extent later in therapy, when the client is more able to accommodate it.
**COMMUNICATE EMPOWERMENT, POSITIVITY, AND HOPE**

- It is important to consider a general philosophy of intervention—one that avoids blame and punishment, that communicates a positive view of the client and a hopeful perspective on his or her future.

- Such an approach reduces the likelihood that the client will feel pathologized, morally “bad,” powerless, or destined to a life of minimal satisfaction or happiness.

- The goals of SUA-relevant trauma therapy are not to cure a disease or punish an offender, but rather to empower the client to:
  - recover from painful life experiences
  - reduce or stop serious SUA
  - have the opportunity to pursue life stability and happiness
AVOID CONFRONTATION

• Confrontation typically involves directly and sometimes forcefully confronting the individual with his or her denial or misrepresentation of SUA and/or its impacts on the person or those around him or her.

• There is no real place for this modality in modern trauma therapy.

• Confrontation presents several problems:

  1. may easily increase, not decrease the youth’s defenses and avoidance, since it can be seen as aggressive;

  2. implies that the client is voluntarily engaging in a bad behavior that can easily be terminated;

  3. is opposite of the support, caring, and compassion that is a core relational aspect of most trauma treatment;

  4. may adversely affect the therapeutic relationship by implying critical judgment and devaluation.

• Rather than using confrontation, the clinician should help the client to understand the causes of SUA, especially as it involves posttraumatic coping, and communicate appreciation of what the client is “up against” in terms of trying to self-medicate overwhelmingly negative internal states and battling the physically addictive effects of some drugs.

• The role of the therapist is to work with, not against, the adolescent, and to help him or her to decrease or terminate SUA while, at the same time, being able to survive trauma-related distress.

• The goal is to collaboratively problem-solve, not to create an adversarial relationship.
Focus on empowerment

• SUA can sometimes reduce the adolescent’s sense of autonomy, because what he or she is facing (trauma) does not seem to get better, and some of his or her “solutions” (e.g., SUA) create problems of their own that seem unresolvable—for example addiction, exposure to violence or exploitation by others, illness, declining interpersonal and social functioning, possible arrest and incarceration, and increasingly lower self-esteem.

• Trigger identification, affect regulation skills development, and mindfulness training, on the other hand, focus on skills the youth can develop to increase self-control and his or her capacity to affect life outcomes.

• This perspective often helps the client to feel like an active participant in therapy, as opposed to a passive recipient of treatment.

• An overarching philosophy of treatment should be that the client is an equal partner in treatment, and that one of the goals of therapy is greater self-efficacy.

• This perspective is often appreciated by youth who do not trust authority and expect that letting one’s guard down means revictimization.
Treatment for the joint effects of trauma and SUA may be more effective to the extent that they are “idealistic,” encouraging the young survivor to aspire to a more positive future and regain a sense of hope.

Many trauma-exposed youth, have been demoralized and they may view themselves as unworthy and their future as essentially hopeless.

To the extent that therapy reinforces the notion that the client is intrinsically good, not bad, and helps the youth to identify self-attributes like courage, concern for others, and morality, it can confer self-esteem and self-compassion that otherwise might be illusive.

Clients involved in prostitution or gang-related activity, or the adversarial dynamics sometimes found among those addicted to drugs or alcohol, may have a difficult time noticing things he or she nevertheless did that were idealistic, such as helping a friend, worrying about someone’s well-being, protecting or standing up for someone, or sharing food, shelter, or advice. As the notion of being a “good person” and caring for others—regardless of one’s “bad history” more deeply permeate the adolescent’s perspective and becomes an explicit goal for the future, self-esteem and hopefulness can accrue.

Post-Traumatic Growth: To the extent that the therapist helps the client identify ways in which he or she triumphed over victimization by, for example, gaining useful survival skills or being more able to empathize with others who have been hurt, there may be an opportunity for shame or self-invalidation to be contradicted.
Specific Clinical Activities

• Provide Psychoeducation

• many adolescent survivors of interpersonal violence were victimized in the context of overwhelming emotion, narrowed or dissociated attention, and, in many cases, a relatively early stage of cognitive development; all of which potentially reduced the accuracy and coherence of their understanding of these traumatic events.

• interpersonal violence frequently involves a more powerful figure who justifies his or her aggression by distorting objective reality, for example by blaming victimization on the victim.

• these fragmented, incomplete, or inaccurate explanations of traumatic events are often carried by the survivor into adolescence and beyond.

• many youthful trauma survivors with SUA issues misperceive, misunderstand, or avoid awareness of the characteristics and actions of the drugs they use, and may not be completely aware of the toll that SUA is taking on their lives.
Therapists may be helpful in these areas:

- By providing **accurate information** on the nature of interpersonal trauma and its effects, including the need to engage in SUA.

- By working with the youth to **integrate this new information** into his or her overall perspective.

- **Accurate information** on the prevalence of abuse, the typical motives of perpetrators, and socially transmitted myths regarding victim complicity may less the client’s self-blaming.

- **Nonjudgmental** information on SUA may assist the youth in **identifying potential downsides** to chronic intoxication and the extent to which SUA may have begun to control his or her life..
• Includes the use of printed handouts, books, DVDs, and client-oriented websites.

• These materials typically present easily understood information on topics such as:
  ➢ prevalence and impacts of interpersonal violence
  ➢ common myths about victimization
  ➢ the effects of SUA
  ➢ social resources available to the survivor (e.g. the National Child Traumatic Stress Network [NCTSN] factsheets at: www.nctsnet.org/products)

• Most importantly, handouts should be considered tools in the psychoeducation process, not stand-alone sources of information.

• It is often more useful for the therapist to provide such information verbally during the therapy process, where it can be discussed and personalized to the youth’s specific situation.
GENERAL FOCUS OF PSYCHOEDUCATION

• The prevalence of the trauma

• Common myths associated with interpersonal victimization

• The usual reasons why perpetrators engage in interpersonal violence (e.g., to address their own needs or as a reflection of their own inadequacies)

• Typical immediate and longer-term responses to trauma (e.g., posttraumatic stress, anxiety, depression, dissociation, intimacy issues, or significant substance use)

• Gender issues, such as sex role stereotypes and social messages about how (or whether) males and females should react to trauma, express distress, and seek assistance

• Reframing SUA and other problematic behaviors as adaptive strategies that, nevertheless, may have serious negative consequences

• Negative effects of SUA, presented in manner that is not judgmental or fear based;

• If relevant, the effects of racism, sexism, poverty, and social marginalization as they relate to both trauma exposure and SUA

• Resources that might assist the trauma survivor, such as self-help groups (including, if appropriate, Narcotics Anonymous or Alcoholics Anonymous), shelters, advocacy groups, relevant religious or spiritual organizations, and supportive legal or law enforcement personnel.
TEACH HOW TO OBSERVE AND MANAGE ONE’S OWN THOUGHTS

• Teach trauma victims how to observe their own internal processes objectively, without becoming trapped by them—learning to identify how some traumatic event in the past is now causing thoughts about the present based on what happened earlier.

• For example, a traumatized youth might be triggered by minor relational conflict or unavailability in a love relationship, and subsequently experience rage or intense feelings of abandonment associated with prior childhood abuse or neglect.

• In such circumstances, the survivor may become quite reactive, and engage in behaviors that deaden the activated emotional states (e.g., SUA) or respond with self-injury, aggression, or other “impulsive” behavior.

• From the client’s perspective, he or she is responding to the current environment with problem-solving activities; in reality, he or she is confusing the past with the present, and engaging in inappropriate (not present-centered) behavior.
TEACH HOW TO OBSERVE AND MANAGE ONE’S OWN THOUGHTS

- Awareness of one’s own thinking would reflect the youth’s growing ability to detect such triggered states as *triggered states*, rather than real-time responses to the present.

- Even compelling thoughts and feelings can be seen as *events of the mind*, which may or may not be relevant to what is actually true in the here-and-now.

- This reduced identification with internal processes as necessarily “real” can help the adolescent manage the intensity of strong emotions by:
  
  1) identifying thoughts and feelings for what they are—transient, internal experiences
  2) learning that he or she doesn’t need to believe (or react to) everything he or she thinks or feels.

- For example, an adolescent might recognize that the boy- or girlfriend probably was not abandoning him, or viewing him as worthless, but rather only mildly annoyed—or perhaps even responding to something not related to the client at all.

- In this way, the youth may transition from “I am perceiving criticism and rejection” to “I am being triggered” or even “I am remembering the past, which is not actually relevant here.”
TEACH HOW TO OBSERVE AND MANAGE ONE’S OWN THOUGHTS

• The relevance of this process to SUA is important. Extensive SUA is often engaged in to defend the survivor from triggered emotional states, typically those associated with painful memories.

• In many cases, however, it is not just the memory that motivates substance use.

• The emergence of self-hating, fearful, or angry thoughts can seem so “real” that they drive the survivor to any source of refuge—including the numbing or distracting effects of drugs or alcohol.

• To the extent that learning thought awareness allows the survivor to understand that he or she is not currently being abused or abandoned, the need for SUA may decrease.
Over time, the youth typically comes to realize that thoughts and feelings are not always reflective of immediate reality.

This insight tends to reduce intense emotionality, and thereby decreases the need of the survivor to engage in SUA or other avoidance activities.

Marsha Linehan’s (1993) *Dialectical Behavior Therapy* is a treatment model in which mindfulness training and related activities have been shown to decrease involvement in a range of maladaptive behaviors, including substance abuse.

Trigger identification and intervention is a specific technique, in which the youth learns to recognize when he or she has been triggered by a relational stimulus, and then practices how to interpret and manage the attendant thoughts and feelings so that they do not overwhelm and motivate SUA, “acting out,” or other seemingly impulsive behaviors.

This process can be facilitated through use of the *Trigger Grid* which is available on the internet at attc.usc.edu.
ADDITIONAL CLINICAL ACTIVITIES

• TEACH AFFECT REGULATION SKILLS
  Relaxation
    Progressive relaxation
    Breath training
  Identify and discriminate emotions
  Identify and counter thoughts that underlie negative emotional states
  Encourage resistance to avoidance behaviors

• CULTIVATE MINDFULNESS
  Meditation
  Urge Surfing

• TITRATE EXPOSURE TO TRAUMA MEMORIES

• CONSIDER GROUP INTERVENTIONS

• INCLUDE CARETAKERS OF FAMILIES IN TREATMENT

• EXPECT AND MANAGE COUNTERTRANSFERENCE