Cognitive-Behavioral Therapy for Child Anxiety Confers Long-Term Protection From Suicidality

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Objective: Evidence for an independent relationship between anxiety and suicidality has been mixed. Few studies have examined this relationship in youth seeking treatment for anxiety. The present study examined the relationship between response to treatment for an anxiety disorder in childhood and suicidal ideation, plans, and attempts at a follow-up interval of 7 to 19 years. We hypothesized that successful treatment for an anxiety disorder in childhood would be protective against later suicidality.

Method: The present study was a 7- to 19-year (mean = 16.24 years; SD = 3.56 years) follow-up study. Adults (N = 66) completed cognitive-behavioral treatment (CBT) for anxiety as children. Information regarding suicidality at follow-up was obtained via the World Mental Health Survey Initiative version of the World Health Organization Composite International Diagnostic Interview (CIDI) and the Beck Depression Inventory–II (BDI-II).

Results: Results indicate that participants who responded favorably to CBT during childhood were less likely to endorse lifetime, past-month, and past–2-week suicidal ideation than treatment nonresponders. This was consistent across self-report and interview-report of suicidal ideation. Treatment response was not significantly associated with suicide plans or attempts, although the infrequent occurrence of both limited the ability to detect findings.

Conclusion: Results suggest more chronic and enduring patterns of suicidal ideation among individuals with anxiety in childhood that is not successfully treated. This study adds to the literature that suggests that successful CBT for childhood anxiety confers long-term benefits and underscores the importance of the identification and evidence-based treatment of youth anxiety.

Key Words: anxiety, suicide, suicidality, cognitive-behavioral therapy, evidence-based treatment

J Am Acad Child Adolesc Psychiatry 2015;54(3):175–179.

The relationship between anxiety disorders in children and adolescents and the emergence of later depressive disorders has been well established.[1-3] Given the risk conferred by depressive disorders for suicidal ideation[4,5] and the overlap between anxiety and depressive disorders, it seems likely that a relationship exists between anxiety disorders and suicidal ideation. However, evidence for an independent relationship between anxiety and suicidality (i.e., the range of suicidal behavior including suicidal ideation, plans, attempts, and completed suicides) has been somewhat mixed,[6] and few studies have examined this relationship in treatment-seeking youth.

Previous studies examining anxiety and suicidality have used primarily community samples. For example, Boden *et al.*[7] examined anxiety and suicidality longitudinally in a large New Zealand birth cohort study (i.e., The Christchurch Health and Development Study). An independent relationship between anxiety and risk for suicidal ideation and attempts was identified. However, in data from the Great Smoky Mountains Study, an epidemiological survey of youth from the southeastern United States, anxiety disorders alone were not proximally related to suicidality.[8]

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Research on samples of youth seeking outpatient treatment for an anxiety disorder have demonstrated an independent association between anxiety and suicidal ideation.[9,10] However, most studies of suicidality in youth with anxiety have been limited by cross-sectional designs and reliance on a single-item self-report of suicidal ideation, ignoring other suicidal behavior (i.e., plans, attempts, and completed suicide). Discrepancies between self-report and interviews about suicidality have been demonstrated, supporting the need for multi-method approaches to suicide assessment.[11,12] Research to date has not investigated the relationship between anxiety disorders and suicidality in youth after treatment with cognitive-behavioral therapy (CBT) to investigate whether successful treatment provides a buffer against prospective suicidality risk. Given the public health impact of suicidality as a leading cause of injury death in the United States,[13] this potential for secondary prevention[14,15] warrants investigation.

The present study examined, using multi-method measurement, suicidality, including ideation, plans, and attempts, in a sample of adults treated as youth 7 to 19 years earlier with CBT for an anxiety disorder. We hypothesized that successful treatment for an anxiety disorder in childhood would be protective against later emergence of suicidality.

METHOD

The present study was approved by and conducted in compliance with the Temple

University Institutional Review Board. The sample was drawn from 2 separate randomized controlled trials (RCTs) evaluating CBT for child anxiety reported by Kendall *et al.* in 1997[16] and 2008.[17] Both RCTs had participants randomized to therapist and to treatment condition. Treatment consisted of the Coping Cat program for childhood anxiety disorders.[18,19] At follow-up, assessors (independent evaluators) were blind to participants' initial study treatment response.

The reader is referred to Benjamin *et al.*[20] for detailed recruitment and interview procedures, response rate, posttreatment service use, and complete participant demographics from the 7- to 19-year follow-up study of youth with anxiety from which these data were obtained. Briefly, 150 individuals were eligible to participate. Of these, 66 were located and participated, 16 were reached and declined participation, and 3 were reached, agreed to participate, and then became unreachable before participation. In addition, 35 could not be located. For the remaining 30 individuals, potential contact information was obtained; however, individuals and/or their parents were never reached directly. These follow-up study participants were compared with nonparticipants (those unable to be contacted or unwilling to participate) to examine differences on key demographic variables and dependent measures. Participation was not significantly associated with gender, age, pretreatment principal diagnosis, or treatment response.[20] In addition, treatment response was not associated with differentially using therapeutic services after initial study treatment.[20]

On average, participants received treatment 16.24 years (SD = 3.56 years, range = 6.72–19.17 years) prior. Participants were 7 to 14 years of age at intake for initial treatment. All received CBT for a primary anxiety disorder in childhood. At the 7- to 19-year follow-up, participants were a mean age of 27.23 years (SD = 3.54). Participants were 51.5% female and predominantly of white ethnicity (84.8%). Pretreatment primary diagnoses were: 56.1% generalized anxiety disorder/overanxious disorder of childhood, 27.3% social phobia/avoidant disorder, and 16.7% separation anxiety disorder. Participants were excluded if they had a primary depressive disorder diagnosis at pretreatment, although 12.1% met diagnostic criteria for a secondary or past depressive disorder at the time of initial study treatment (i.e., major depressive disorder, dysthymic disorder). Treatment outcome was defined as the principal anxiety disorder at pretreatment that was no longer present at posttreatment. At posttreatment, 40 individuals (60.6%) in the sample were classified as treatment responders, and 26 (39.4%) were classified as treatment nonresponders. At 7- to 19-year follow-up, treatment responders had significantly lower rates of panic disorder, alcohol dependence, and drug abuse in adulthood when compared to treatment nonresponders.[20] No significant differences in other anxiety disorders or depressive disorder diagnoses were evidenced. At 7- to 19-year follow-up, 15 participants (22.7%) reported being prescribed 1 or more antidepressant medications in the past 12 months. It was unknown whether the medication was prescribed for the purposes of managing mood and/or anxiety symptoms.

Assessment Instruments

World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). Collected at 7- to 19-year follow-up, the CIDI[21,22] is a fully structured lifetime interview to obtain information on mood disorders, anxiety disorders, other relevant disorders, along with demographic information. Diagnoses are consistent with *DSM-IV*[23] and the *International Classification of Diseases, 10th Revision (ICD-10)*.[24] CIDI diagnoses are related to independent clinical diagnoses, and retest reliability is high.[21] The CIDI, used in the National Comorbidity Survey–Replication study (NCS-R),[25] allows for comparisons between this sample and the NCS-R community sample.

All participants were asked whether they had experienced suicidal ideation in their lifetime. Those who responded affirmatively were then queried about ideation in the past 12 months. Those who endorsed a history of ideation were also asked if they had ever made a plan (and, if so, had they done so within the past 12 months), as well as whether they had ever attempted suicide (and if so, had they done so within the past 12 months). Those who reported any attempts in the past 12 months were asked additional questions about the lethality and method of attempts. Kessler *et al.*[25,26] provides additional details regarding suicidality assessment in the CIDI.

Beck Depression Inventory–II (BDI-II). Collected at 7- to 19-year follow-up, the BDI-II[27] is a 21-item self-report measure of depressive symptoms during the past 2 weeks. Each item has 4 statements reflecting the degree of symptom severity, and 1 item (Item 9) that queries specifically about suicidality (i.e., 0 = "I don't have any thoughts of killing myself," 1 = "I have thoughts of killing myself, but I would not carry them out," 2 = "I would like to kill myself," or 3 = "I would kill myself if I had the chance"). The psychometric properties of the BDI-II, including internal consistency, factorial validity, criterion validity, convergent and discriminant validity, and internal reliability, have been well established across diverse samples.[28-34]

Anxiety Disorders Interview Schedule for Children (ADIS-C/P). Before initial treatment in childhood, diagnoses were determined using the ADIS-C/P,[35] a semi-structured interview administered separately to parents and children. The ADIS-C/P queries about the symptoms, course, etiology, and severity of anxiety, mood, and externalizing disorders in youth. Diagnosticians provided a clinical severity rating (CSR) on a continuous scale. The ADIS-C/P has demonstrated favorable psychometric properties (e.g., $\kappa = 0.52$ to 0.99) and is considered the gold-standard semi-structured interview for anxiety disorders.[36,37]

The CSRs of anxiety for those individuals who participated in the Kendall *et al.* (1997)[16] study were based on the scale in use at that time (0–4 scale). Individuals who participated in the subsequent Kendall *et al.* (2008)[17] study were based on a scale of 0 to 8. The first author reviewed participant posttreatment diagnostic reports for participants in Kendall *et al.* (2008)[17] and converted scores to a rating of 0 to 4 for consistency.

RESULTS

At 7- to 19-year follow-up (N = 66), 18 participants (27.3%) reported experiencing suicidal ideation in their lifetime, 9 (13.6%) endorsed having made 1 or more suicide plans, and 6 (9.1%) described 1 or more suicide attempt in their lifetime on the CIDI. Retrospective report indicated suicidal ideation had a mean age of onset of 15.83 years (SD = 6.40 years) and had occurred most recently (i.e., age at which participant reported last experiencing suicidal ideation) at the mean age of 19.61 years (SD = 6.41 years). Mean ages of onset and recency for suicide plans were 18.00 years (SD = 6.06 years) and 19.13 years (SD = 5.14 years), respectively. Onset and recency of suicide attempts occurred at a mean age of 18.33 years (SD = 4.76 years) and 19.40 years (SD = 4.45 years), respectively. Among only those participants who endorsed suicide plans, suicidal ideation had a mean age of onset of 16.44 years (SD = 6.91 years) and had occurred most recently at the mean age of 20.44 years (SD = 5.73 years). Among only those participants endorsing a history of suicide attempts, suicidal ideation had a mean age of onset of

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