Coping with suicidal urges among youth seen in a psychiatric emergency department

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ARTICLE INFO

ABSTRACT

This study of youth seeking psychiatric emergency department (ED) services examined (1) youth self-efficacy to use suicide-specific coping strategies, (2) whether these self-efficacy beliefs varied by demographic and clinical characteristics, (3) and associations of these beliefs with suicide attempts and ED visits 3–5 months later. Participants were 286 psychiatric ED patients (59% Female), ages 13–25. Ratings of self-efficacy to engage in 10 suicide-specific coping behaviors were assessed at index visit. A total of 226 participants (79%) were assessed 3–5 months later. Youth endorsed low-to-moderate self-efficacy for different suicide-specific coping behaviors, with lowest ratings endorsed for limiting access to lethal means and accessing professional resources. More severe baseline psychopathology was associated with lower self-efficacy. Males endorsed higher self-efficacy for coping behaviors not requiring external support. Lower coping self-efficacy for some of the key strategies, and lower confidence that these strategies will be helpful, differentiated those with and without follow-up suicide attempts and ED visits. The generally low-to-moderate confidence in youths' ability to engage in coping behaviors to manage suicidal crises, and its association with follow-up suicidal crises, is concerning because many of these strategies are commonly included as part of discharge recommendations or safety planning. Implications of findings are discussed.

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1. Introduction

Suicide is one of the leading causes of death among adolescents and young adults (Centers for Disease Control and Prevention, 2013). Emergency departments (EDs) play a critical role in providing clinical care for suicidal patients, often serving as the first line of contact. Suicide attempt-related visits to EDs have been on the rise in the US (Larkin et al., 2008), and EDs treat large numbers of adolescents presenting with suicide-related concerns (Ting et al., 2012). Moreover, according to recent reports, over half of psychiatric ED visits among youth are related to suicidal ideation or attempts (Horwitz et al., 2015). A significant number of youth at risk for suicide seen in EDs later engage in suicidal behavior (Horwitz et al., 2015; King et al., 2015).

The Joint Commission's requirements for the clinical care of patients evaluated in hospitals and EDs for emotional or behavioral problems include providing suicide screening, assessing immediate safety needs, and providing resources and suicide prevention information for discharged patients (e.g. crisis hotline numbers) (Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2015). The Joint Commission guidelines were recently expanded to apply to all patients in all settings and to include additional requirements for care of at-risk individuals (e.g. safety planning, discharge, treatment, follow-up care) (JCAHO, 2016), which corresponds more closely to recommendations from suicidology experts. In addition to calling for an expansion of standard ED care to include universal suicide screening (Boudreaux et al., 2015; Horwitz et al., 2009; Wintersteen et al., 2007), experts in the field have also recommended enhancing standard discharge planning practices. The recent Suicide Prevention Resource Center Consensus Guide for EDs (Suicide Prevention Resource Center, 2015) outlines recommendations for incorporating at least one brief ED-based intervention—brief education, safety planning, lethal means counseling, rapid referral, or caring contacts—to provide discharged individuals with more comprehensive strategies and resources for managing post-discharge risk. Although the consensus guide was developed for adult ED

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patients, many of its recommendations (e.g., means restrictions education, developing alternative coping strategies) align with practice guidelines for emergency intervention with suicidal youth (Shaffer and Pfeffer, 2001).

Within this context of improving care for at-risk youth seen in EDs, this study focused on examining the extent to which adolescents and young adults seeking psychiatric ED services perceive themselves as being able to engage in suicide-specific coping behaviors usually recommended as part of safety planning or standard ED discharge recommendations. A safety plan—with its primary purpose to lower imminent risk of suicidal behavior—commonly includes elements such as coping strategies, clinical resources, and information about restricting access to lethal means. Safety planning has been incorporated into comprehensive treatment protocols for adults and youth (Brent et al., 2011; Stanley et al., 2009; Wenzel et al., 2009) and as a component of brief ED interventions with suicidal adolescents (Asarnow et al., 2011). Safety planning has also been proposed as a stand-alone intervention (Stanley and Brown, 2012; Stanley et al., 2008), and it is being evaluated across urban and Veteran Affairs Medical Center EDs (Boudreaux et al., 2013; Currier et al., 2015; Knox et al., 2011).

Although empirical evidence for its efficacy to reduce suicidal behavior is not yet established, safety planning is considered a "best practice" approach for intervening with those at elevated suicide risk (Jobes, 2006; King et al., 2013; Suicide Prevention Resource Center, 2008). An important clinical basis for safety planning is that acute suicidal crises tend to be short-lived. Moreover, suicidal youth tend to rely on less adaptive coping strategies (Evans et al., 2005; Guerreiro et al., 2013; Lewinsohn et al., 1993; Wilson et al., 1995) and may engage in suicidal behavior as a way of coping with distress (Wilson et al., 1995). As such, a safety plan might enable a suicidal individual to cope with suicidal urges long enough to decrease the imminent risk of engaging in suicidal behavior. While a number of studies have reported on patterns of less adaptive coping among suicidal youth, there are important unanswered questions about suicide-specific coping—i. e. coping behaviors for managing suicidal thoughts and impulses recommended as part of safety planning or standard care. Little is known about the perceptions of at-risk youth concerning their ability to utilize suicide-specific coping strategies and their subsequent associations with suicidal behavior.

In this study of adolescents and young adults presenting to a psychiatric ED, we describe youths' perceived self-efficacy, or confidence, to engage in 10 different coping strategies that correspond to important components of safety plans or discharge recommendations, the extent to which these perceptions might vary as a function of demographic and clinical characteristics, and the association between these self-efficacy perception and suicidal attempts in a critical risk period after an ED visit. Because youths' self-efficacy beliefs may influence their actual coping behavior or safety plan use post-discharge, examining these questions could add to the limited research on suicide-specific coping, with important implications for intervening with at-risk youth seeking ED services or psychiatric care.

2. Methods

2.1. Participants

Participants were 286 adolescents and emerging adults, ages 13–25, recruited from a psychiatric ED in the midwestern United States. Exclusion criteria included cognitive impairment, active psychosis, and severe aggression or agitation. Of the eligible participants, 79.7% consented to participate. The most common reason for visit was a suicide-related concern (suicidal ideation or attempt) (70%). Participants had a mean age of 18.0 years (SD 3.5), with 58% (n=165) being under 18 years of age. Fifty-nine percent (n=168) of participants were female. The racial distribution

was as follows: 77% Caucasian, 10% African-American/Black, 4% Asian, 3% Hispanic, and 6% Multi-racial. Sixty-four participants (22%) had no health insurance. A total of 226 (79%) participants completed the 3–5-month follow-up assessment. There were no differences between those who did and did not complete the follow-up on any demographic (e. g., age, sex, race, insurance) or clinical (e. g., history of suicide attempt, suicidal ideation severity, history of non-suicidal self-injury) characteristics.

2.2. Measures

Medical Chart Review: Electronic medical records were reviewed to obtain information on race/ethnicity, insurance, reason for index and return ED visits, disposition, number of past visits and hospitalizations, and suicide attempt history.

Hopelessness: The Brief Hopelessness Scale (Bolland et al., 2001), an adapted form of the Hopelessness Scale for Children (Kazdin et al., 1986), is a 6-item measure rated on a 4-point likert scale, from "strongly disagree" to "strongly agree." It has strong internal consistency ($\alpha=0.75$) and is comparable to the full measure of hopelessness (Bolland et al., 2001).

Suicide Coping Self-Efficacy: The Efficacy to Cope with Suicidal Thoughts and Urges scale was developed for this study to assess respondents' level of self efficacy, or confidence, to perform 10 coping responses (see Table 1) in the presence of suicidal thoughts and urges, consistent with theoretical and clinical recommendations. The 10 items had high internal consistency in this sample (alpha =0.87). Inter-item correlations (range 0.11–0.83) are shown in Table 2. The respondents were also asked to rate their confidence in these strategies being helpful. Answer choices ranged from 0 ("not at all confident") to 10 ("extremely confident"), with an anchor of 5 ("somewhat confident").

Non-suicidal Self-injury (NSSI): A self-report form for NSSI was adapted from the Non-Suicidal Self Injury portion of the Self-injurious Thoughts and Behaviors Interview (Nock et al., 2007). For the current report, we asked participants reporting any lifetime NSSI to rate the frequency on a 7-point scale from "once" to "more than 100 times." Participants were further asked to rate the frequency of 12-month NSSI on a 7-point scale from "never" to "every day."

Suicidal Ideation and Behavior: The Columbia-Suicide Severity Rating Scale (Posner et al., 2011), a semi-structured interview, assesses a range of suicidal thoughts and behaviors. Baseline C-SSRS ratings, administered as part of the clinical protocol at the study site, were obtained via medical record review. Last-week suicidal ideation severity, rated on a 6-point scale from a wish to be dead to suicidal intent with a specific plan, and suicide attempt history were obtained. At follow-up, last-month suicidal ideation severity and suicide attempts since baseline were assessed. The C-SSRS demonstrated strong psychometric characteristics (Posner et al., 2011), including predictive validity in adult and adolescent clinical samples (Gipson et al., 2015; Horwitz et al., 2015).

Service Utilization: Participants were asked whether they had, and reasons for, any ED visits since baseline assessment.

2.3. Procedures

Consecutively presenting eligible participants were approached for assent/consent (assent and parental consent for minors) 3–5 days per week during 2–10 pm shifts between June 2014 and January 2015. Telephone follow-up assessments were conducted by master's level clinicians and were supplemented with a medical chart review. Participants were remunerated $20 and $25 for the baseline and follow-up assessment, respectively. The study was approved by the Institutional Review Board.

2.4. Data analysis

Correlations were examined with Pearson-product-moment correlation coefficients with the exception of NSSI measures, which were examined using Spearman's rank-order correlation. Group differences in 10 suicide-specific coping strategies based on sex, suicide attempt history, disposition, future suicide attempts, and return ED visits for suicide-related concerns were examined with two-tailed independent samples t-tests. Where the assumption of homogeneity of variance was violated, the Welch's t-test was used, as indicated in Tables 1 and 3. We similarly compared group differences for the question assessing confidence in these strategies being helpful. Because multiple tests were conducted, we applied the Benjamini-Hochberg procedure (Benjamini and Hochberg, 1995) with a 0.05 false positive discovery rate. Comparisons meeting the adjusted threshold of statistical significance are marked in Tables 1 and 2.

Because lower statistical power precluded conducting more extensive multivariate analyses of longitudinal data, limited post-hoc multivariate analyses were carried out. First, because perception of coping helpfulness could be related to a general sense of hopelessness, we adjusted for its effect in an analysis of covariance (ANCOVA) for the suicide attempt and return ED visit outcomes. Second, to control for the influence of previous suicidal behavior on self-efficacy beliefs, we examined whether the relationship between self-efficacy to engage in specific coping strategies and future suicide attempts remained significant after controlling for