Suicide Risk and Psychotic Experiences: Considerations for Safety Planning with Adolescents

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ABSTRACT

Individuals with psychosis-spectrum conditions have strikingly high rates of suicidal thoughts and behaviors, especially in the early stages of illness. Given increasing rates of suicide among adolescents, and given that psychosis symptoms often emerge during this developmental period, it is important that practitioners working with adolescents are attuned to the intersection of psychotic experiences and suicide risk. Furthermore, youth with emerging signs of psychosis often struggle with other mental health concerns that are linked to suicidal thoughts and behaviors, including depression, anxiety, mania, trauma, and substance use. Taken together, these factors indicate that identifying early signs of psychosis can be critical for addressing suicide risk, and psychosis-spectrum symptoms are important experiences to include in safety planning for youth. Herein we discuss considerations for safety planning for adolescents experiencing psychosis-spectrum symptoms, drawn from clinical observations and pilot data collected from adolescents in a psychiatric inpatient unit and their families.

KEYWORDS: adolescence, psychosis, suicidality, safety planning

INTRODUCTION

Suicide is a major public health concern for youth, as it is the second leading cause of death for those aged 10–24 years.[1] Individuals with psychosis-spectrum conditions have a markedly elevated risk for suicide in the early stage of illness, with even higher risk for those under the age of 18 and in the months before and after first presentation for psychiatric care.[2,3] The time surrounding an individual's first episode of psychosis, typically occurring in late adolescence or young adulthood, is linked to increased suicidal ideation, attempts, and death by suicide.[3,4] Suicide risk is also elevated during the clinical high risk (CHR) phase of illness,[5] when individuals begin to experience lower-intensity psychosis-spectrum experiences that put them at high risk for developing full-threshold psychosis. The CHR phase of psychosis often emerges in adolescence and is characterized by the persistence of distressing and/or impairing positive symptoms (e.g., hallucinations or delusions) which are attenuated or below the threshold for a psychotic-disorder diagnosis (e.g., experiences are less intense, more fleeting, and lacking full conviction).[6] Examples of attenuated experiences include hearing indistinct whispers or intermittent voices that are recognized as not being real, or recurrent thoughts of being targeted by others, accompanied by doubt as to whether this is truly occurring. Approximately two-thirds of individuals at CHR endorse suicidal ideation, and an estimated 18% of people at CHR attempt suicide.[5] Given that suicide risk may be particularly high for those with untreated psychosis-spectrum symptoms, under the age of 18, and within the first year of psychosis onset,[4,5,7] health professionals working with adolescents need to be attuned to psychosis-spectrum symptoms and the intersection of psychosis and suicidal thoughts and behaviors (STBs).

PSYCHOSIS-SPECTRUM CONDITIONS

Although psychotic disorders are relatively rare, with less than 1% estimated prevalence of psychotic diagnoses among adults, psychotic experiences are far more common, especially among adolescents. Research indicates that 10–25% of adolescents report some level of psychosis-spectrum experiences; however, the clinical significance of these experiences varies greatly across individuals.[8] Notably, among adults with psychotic disorders, 20% report symptom onset prior to the age of 18, and distressing symptoms, compared to benign experiences, are linked to higher risk for future psychosis and comorbid concerns, including suicidality. Taken together, these findings indicate that psychosis-spectrum experiences are relatively common and individuals' reactions to these experiences may influence their clinical relevance and associated risk.

Individuals with full-threshold psychosis are often identified by providers due to observable disorganized and/or alarming thoughts, behavior, and communication. For those at CHR, however, attenuated psychosis symptoms may not be readily disclosed and/or perceived by providers due to lower-level symptom presentation (e.g., less severe, distressing, and impairing symptoms) that may be masked because of stigma, embarrassment, confusion, lack of insight, or relational factors that impede disclosure (e.g., lack of trust, rapport, or supportive environment to open up about

experiences). Thus, providers may not be aware of important psychosis-spectrum symptoms associated with suicide risk without screening for them specifically and probing the impact of these experiences on STBs and other risk factors for STBs (e.g., stress, hopelessness, etc.). Notably, adolescents at CHR commonly experience comorbid mental health concerns including depression, anxiety, PTSD, mania, and substance abuse.[9,10] These comorbid difficulties often motivate help-seeking behavior and may predominate over attenuated psychosis, and they are also associated with increased suicide risk. While co-occurring mental health concerns such as depression may account for some STBs for youth with psychosis-spectrum conditions, research indicates that positive symptoms of psychosis such as hallucinations and delusions may be uniquely associated with STBs (beyond the effects of other mental health diagnoses and symptoms).[11-15]

PSYCHOSIS-SPECTRUM EXPERIENCES AND SUICIDALITY

Although more research is needed to be better understand the co-occurrence of psychosis and STBs, it is evident that identifying early signs of psychosis can be critical for reducing suicide risk for some youth, and psychosis-spectrum symptoms can be important factors to include in safety planning for these individuals. Pilot data collected by the authors from hospitalized adolescents in a psychiatric inpatient setting suggest that for some youth with psychosis-spectrum symptoms, unsafe behaviors labelled as "suicidal" are a function of positive symptoms (e.g., hallucinations or delusions), and subsequent life-threatening behaviors may lack intent or desire to die.[16] For example, unsafe behaviors may stem from experiences such as command hallucinations (e.g., voices encouraging suicide), delusions of grandeur (e.g., believing oneself is invincible), impaired reality testing (e.g., believing that the world, oneself, or threats are not real), or other psychotic processes (e.g., injuring oneself to stop or silence voices or thoughts perceived to be externally controlled). These experiences are distinct from symptoms that typically drive suicidal intent (e.g., hopelessness, a desire to escape), and strategies to mitigate risks related to intent to die may not be helpful for these types of psychosis-driven experiences. As such, these contributing factors have important treatment implications and require unique consideration in the context of safety planning.

SAFETY-PLANNING CONSIDERATIONS

The goal of safety planning is to mitigate future risk by helping youth identify vulnerabilities, triggers, and warning signs, and find solutions for future occurrences of suicidal ideation by planning coping skills, help-seeking strategies, and ways to keep one's environment safe (e.g., by limited access to lethal means).[17] Although safety planning has been shown to reduce occurrences of suicidal behaviors, some evidence suggests that safety planning may not be as effective for individuals with severe mental illness.[18] This may be particularly true for certain psychiatric conditions, such as psychotic disorders, that impede insight and distort perceptions of reality, necessary faculties for effective problem solving. Furthermore, elements of traditional safety planning that focus on hopelessness and intent to die may not be as applicable to unsafe behaviors linked to hallucinations, delusions, and distorted reality. For these reasons, safety planning for youth with psychosis-spectrum conditions warrants special considerations aimed at improving the applicability and helpfulness for these adolescents and their caregivers. Outlined below are several steps that providers can take to help reduce safety-related risk for this population.

1. Screen for psychosis-spectrum experiences in mental-health settings serving adolescents

There are several validated screening tools that can be used across settings to screen for potential psychosis-spectrum experiences in youth.[19] Screening tools that are designed to measure attenuated psychosis are helpful tools to capture the full spectrum of experiences, rather than focusing on full-threshold psychotic experiences. These measures include broader, tentative, and perhaps gentler language (e.g., "Do you ever think that you may hear voices or other sounds that others don't seem to hear?"). This approach allows for endorsement of lower-level experiences, as compared to probing overt psychotic experiences that may be met with trepidation or symptom denial due to perceived connotation of saying "yes" to the experience (e.g., "Do you hear voices that are not really there?"). Some validated, open-source options for screening include the PRIME Screen-Revised,[20] the Prodromal Questionnaire-Brief (PQ-B),[21] and the Youth Psychosis At-Risk Questionnaire (YPARQ).[22]

2. Explore the clinical characteristics of potential psychosis-spectrum experiences

Follow up on screening questions to explore why adolescents have endorsed specific items. If adolescents are not asked explicitly about symptoms, they may be less likely to spontaneously disclose or open up about their experiences. Ask follow-up questions in an open and non-judgmental manner, remaining calm and supportive throughout the conversation. Empathize with the individual's emotional experiences in reaction to symptoms, and refrain from challenging the veracity of experiences such as hallucinations or delusions, as this may impede rapport and/or rupture trust. As you seek to understand the adolescent's experience, it may be helpful to probe specific characteristics that influence the intensity or severity of symptoms: duration (how long the experience lasts), frequency (how often it happens), conviction (how real it feels versus self-generated doubt), distress (how it makes them feel), impairment (how it interferes with functioning),

meaning (how does the adolescent understand the experience and what it means), reactions (how the adolescent behaves in response to symptoms), and patterns (co-occurrence with other mental health or behavioral experiences; are symptoms linked to specific triggers or contexts).[23] Having a full understanding of the adolescent's experiences will help you to probe how psychosis-spectrum symptoms may intersect with STBs. Keep in mind that for some individuals, psychosis-spectrum experiences may not be considered clinically significant (i.e., they do not cause significant distress or impairment), and they may not need to be included in a safety plan, underscoring the need for conversation around the impact of these experiences.

3. Discuss safety in relation to psychosis-spectrum experiences

Once you have a better understanding of an individual's psychosis-spectrum experiences, ask about how these experiences might impact safety, mood, anxiety, stress, substance use, and other mental-health experiences that may influence STBs. Psychosis symptoms may directly impact safety and/or indirectly influence STBs via other factors (e.g., depression or hopelessness).[24] Alternatively, psychosis-spectrum experiences and STBs may not be related for some individuals. Attend to how psychosis-spectrum experiences may exacerbate stress and coincide with other risk factors that are relevant for the individual. Try to avoid making assumptions about the nature and impact of symptoms by using Socratic questioning (e.g., clear, neutral, and focused questions asked with genuine curiosity) and open-ended prompts to explore how the individual understands their experiences (e.g., "What do you mean when you say X?" "How does that make you feel?"). Another important thing to keep in mind is that among individuals with early psychosis, higher levels of insight and beliefs about negative outcomes for psychosis have been uniquely linked to suicidality, beyond the effects of depression.[25] Insight and negative beliefs may also directly impact depression.[3,26] These findings indicate that a person's understanding of their illness and their beliefs about what psychosis might mean for their future may play an important role in their experience of STBs. Although more research is needed to better understand how to address psychosis-related stigma in youth,[27] normalizing adolescents' experiences, instilling hope, and taking a recovery-based approach to care may help individuals to be more future-oriented in their goals and perspectives.[28]

4. Tailor the safety plan components specifically to psychosis-spectrum experiences

As you start to create a safety plan, include as many psychosis-spectrum experiences related to safety as possible. It may even be helpful to generate a separate safety plan for psychosis-specific experiences, in addition to one created for general mood-related suicidality. Discuss ways to reduce exposure to triggers for hallucinations or delusions, identifying early warning signs of these experiences, listing unique coping or grounding skills effective for psychotic experiences, and naming trusted people to go to for distraction or adults to go to for help when specific experiences occur. It is particularly important to discuss ways to cope with each psychosis experience, and it could be helpful to provide a battery of coping options, including a variety of ideas for what someone can do on their own and what others may be able to do to offer support or direction when they notice signs of distress. For example, some coping skills for hearing voices might include listening to music, wearing an earplug in one ear, practicing vocal activities (singing, humming, reading or counting aloud, talking, or whispering), or using general grounding skills to orient oneself to the present reality. Remember that finding the right coping skills may be a process of trial and error, and more options will increase the likelihood of finding something that works.

5. Include caregivers in the process of safety planning

It is important to include caregivers in safety planning as much as possible, as they may be able to offer unique insight into the adolescent's behavior patterns, especially in situations where the individual may have limited insight. Caregivers may also benefit from hearing about and understanding their adolescents' experiences, as this insight may help them support the individual in different ways. Caregivers may need support in coping with their adolescent's mental-health struggles, and they will likely benefit from efforts to enhance their own self-efficacy in coping with a crisis. It may be helpful to ask the caregiver to create a safety plan for the adolescent from their perspective, outlining their observations of triggers and warning signs, ways that they can support coping, ways that they can avoid contributing to distress and minimize triggers, considerations for keeping the environment safe (e.g., locking up sharps and medications), and options for help to utilize in times of crisis. The method of safety planning alone with the adolescent, alone with the parent, and then together in a joint session has been shown to be helpful and well received by families coping with adolescent suicidality.[29] It may also be helpful to tailor safety plans to various contexts such as school or multiple households to help support the adolescent across settings. It might take some additional time to discuss the adolescent's willingness to share their plan with supportive adults and find solutions for barriers that may get in the way of discussing or using their plan in different contexts.

6. Incorporate a crisis plan

Include in the safety plan signs of mental-health deterioration and stress that may indicate a need for hospitalization (for psychosis or safety concerns). This might include increasing signs of disorganization, such as difficulty communicating one's thoughts, expressing bizarre ideas or not

making sense, believing ideas that may influence unsafe behaviors, having difficulty participating in daily routines such as hygiene or work/school responsibilities, or demonstrating odd behaviors or changes in appearance that may indicate disconnection from reality. Other signs of crisis might include an individual skipping or refusing medication, social withdrawal or isolation, impulsive or risky behaviors, and expressing a desire or plan to end one's life or leave the world. Collaborative crisis planning should include a discussion of the adolescent's preferences for care in crisis situations, and a clear plan for seeking appropriate treatment in the event of crisis (who to include in the conversation and where to go for help). Crisis planning has been shown to reduce involuntary admissions among adults with psychosis,[30] and this type of planning may reduce the likelihood of the adolescent experiencing traumatic psychiatric admissions.

7. Discuss strategies to maintain a healthy lifestyle and manage stress

While some individuals may report a direct influence of psychotic experience on STBs (e.g., command hallucination encouraging suicide), other individuals with psychosis-spectrum experiences report that STBs seem to be driven primarily by other mental health concerns such as depression and anxiety. For these youth, psychosis-spectrum symptoms may indirectly influence STBs by exacerbating stress, mood, anxiety, and other risk factors. In either case, it is important to discuss the impact of lifestyle choices and stress on mood, psychosis, STBs, and other risk factors relevant for the individual. Early psychosis is linked to high rates of substance misuse,[31] and misuse of substances, particularly marijuana, is linked to higher suicide risk among those experiencing their first episode of psychosis.[2] Youth with psychosis symptoms may be especially vulnerable to negative effects from marijuana use,[32] including exacerbation of mental health distress, so it is important to discuss this openly and brainstorm alternatives to using.

8. Consider and frame safety planning as an ongoing, iterative process

Lastly, take your time with safety planning. It may take s everal sessions to complete a comprehensive draft and ensure that the individual and caregiver(s) understand all of the components and are willing and able to use it effectively. As families try to implement their safety plans, they may face barriers to address via problem solving and role playing.[19] Consider the safety plan a living document that may need to evolve over time and with experience. It is helpful to complete a safety plan in a format that is editable (e.g., via an app, word doc, cloud or Google drive, etc.) and accessible across settings (e.g., on an app or saved as a picture on one's phone or other devices). Families should be encouraged to add to and edit their safety plan as needed, or create a new one altogether, especially as strategies are determined to be helpful (or not). Remember that an individual's safety-planning needs may change over the course of treatment, and it is helpful to check in periodically to ensure that the safety plan stays relevant.

CONCLUSION

Assessing suicide risk and safety planning are important components of treatment for many adolescents experiencing mental health difficulties. Given the high risk for suicide associated with psychosis, practitioners working with adolescents may benefit from implementing procedures to screen for psychosis-spectrum symptoms and assess how these experiences may influence STBs. Helpful safety planning considerations for youth at CHR or with early psychosis might include reducing exposure to triggers for hallucinations or delusions, identifying early warning signs of these experiences, listing unique coping or grounding skills effective for psychotic experiences, and incorporating parent input to provide insight that may be unrecognized by the teen. A careful process of safety planning may be a critical preventative measure for the unique population of adolescents experiencing psychosis-spectrum symptoms who are at markedly high risk for suicide.

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