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Treating Suicidality in African American Adolescents
with Cognitive-Behavioral Therapy

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Abstract

Methods for preventing adolescent suicide are surveyed, and cognitive-behavioral therapy (CBT) is explored as a method for serving suicidal African American adolescents. Strengths, limitations, and compatibility of CBT with social work values are examined. Although CBT shows much promise in helping suicidal African American adolescents, research on the efficacy and effectiveness of CBT with this population is lacking. Suicide risk and protective factors and social inequities are evaluated as they relate to African American adolescents generally. In addition to relieving suicidal symptoms, CBT potentially could facilitate social liberation for this population.

Keywords: suicide, African American, cognitive-behavioral therapy, adolescent

Treating Suicidality in African American Adolescents with Cognitive-Behavioral Therapy

The purpose of this study is to examine the potential of cognitive-behavioral therapy in treating suicidality among African American adolescents. Although suicide is the 11th most common cause of all deaths in the United States, it is the 3rd most common cause of death for adolescents (Institute of Medicine, 2002). Despite the fact that suicide rates for all African Americans tend to be lower than for Whites, suicide rates for African Americans aged 10-19 increased 114% between 1980 and 1995 (U.S. Department of Health and Human Services, 1998). This significantly reduced the difference between suicide rates for Black and White youth. Unfortunately, efforts at preventing suicide have demonstrated little effect on suicide rates in the U.S. (Moskos, Achilles, & Gray, 2004).

One reason that suicide is difficult to prevent is the absence of reliable means of predicting who will and will not commit suicide. However, Barbe, Bridge, Birmaher, Kolko, and Brent's (2004) finding that "up to 60% of adolescent suicide victims have a depressive disorder at the time of death" (p. 44) suggests that cognitive-behavioral therapy (CBT), with its usefulness in treating depression in adults, may show promise in treating adolescent suicidality. This paper will examine risk factors for suicide and their applicability to African American adolescents, the use of CBT with depressed, suicidal adolescents, the strengths and pitfalls of CBT, and CBT's compatibility with social work practice and ethics, focusing on African American adolescents.

African Americans and Risk Factors for Suicide

Risk factors for suicidality include mental illness (particularly when combined with substance abuse), barriers to mental health services, access to firearms, inappropriate media coverage of suicide, suicide of a relative, belief that suicide can be appropriate, hopelessness, and aggressive or impulsive tendencies (Institute of Medicine, 2002; U.S. Public Health Service, 1999). These suicide risk factors as they apply to African Americans, especially youth, will be examined in turn.

First, nearly all adolescents who complete suicide have at least one psychiatric diagnosis, usually a mood disorder and either substance abuse or behavior problems (Moskos, Achilles, & Gray, 2004). Indeed, although the racial demographics were unclear, the highest prevalence of co-occurring disorders was among adolescents and young adults aged 15 to 24 (U.S. Department of Health and Human Services, 1999). Therefore, identifying and treating teens with these disorders is vital to preventing adolescent suicide.

Second, studies have found evidence of disparities in the diagnosis and treatment of mood disorders in African Americans and other peoples of color. For example, African Americans were found to be "less likely to receive guideline-adherent treatment when suffering from anxiety disorders and depression" (Snowden, 2003, p. 240). In addition, African Americans were less likely than Whites to receive psychotropic medications; when administered to African Americans, the dosage tended to be much higher than for Whites (Snowden, 2003). African Americans are overrepresented in inpatient mental health treatment facilities (Snowden, 2003). Unfortunately, African Americans are under-represented among psychiatrist, psychologist, and social work professionals—comprising only 2%, 2%, and 4% of each of these groups, respectively (U.S. Department of Health and

Human Services, 2001a). Moreover, almost 25% of African Americans lack health insurance, which would increase access to mental health services. (U.S. Department of Health and Human Services, 2001a). The extent to which these disparities specifically affect African American adolescents is unclear from the literature but is likely comparable to the African American population as a whole.

In addition to these structural barriers, African Americans also face attitudinal barriers. These include a cultural tendency to overcome hardship by trying harder, and a preference for community, religious, and spiritual forms of support compared with use of the formal mental health system (U.S. Department of Health and Human Services, 1999). Stigma associated with mental disorders discourages many from seeking help (U.S. Department of Health and Human Services, 2001). Of these barriers, low socioeconomic status seems to be the most important (U.S. Department of Health and Human Services, 1999).

Third, access to firearms is a critical factor in African American adolescent suicide. A U.S. government study found that, between 1980 and 1995, guns provided the means for 69% of suicides among African Americans (male and female) aged 15-19, and 72% of suicides by African American teenaged males. Finally, “[f]irearm-related suicides accounted for 96% of the increase in the suicide rate for blacks aged 10-19 years” (U.S. Department of Health and Human Services, 1998).

Finally, family history of suicidal behavior (Qin, Agerbo, & Mortensen, 2002), hopelessness, and impulsive or aggressive tendencies are further risk factors for adolescent suicide. Although hopelessness alone seems not to significantly predict suicide among African American adolescents, depressed mood helped predict it among adolescent girls (Ialongo et al, 2004). The suicide literature shows a strong

association of impulsivity and aggression with suicidal ideation and suicide attempts among adolescent males both African American and White (Conner, Meldrum, Wieczorek, & Duberstein, 2004). This supports the Surgeon General's classification of impulsivity and aggression as risk factors for suicide and undermines Stack's (2000) view (noted above) that aggression serves as a protective factor against suicide.

Prevention of Adolescent Suicide

Even though a good deal is known about suicide risk factors and despite prevention efforts, rates of suicide, both adult and adolescent, have remained unchanged. Even so, many prevention approaches—with varying levels of demonstrated effectiveness—are available. There are two basic categories in preventive approaches: “case finding” and “risk factor reduction” (Gould, Greenberg, Velting, & Shaffer, 2003). While case finding is identifying youth at risk of suicidal behavior and intervening directly with them, risk factor reduction is an environmental, policy-oriented approach. Suicide-prevention programs are implemented in schools, communities, health-care settings, and through the media. Some of these will be briefly described below.

One school-based method is suicide-awareness training, which involves teaching adolescents the warning signs of suicidality and how to help a peer who is exhibiting those signs. While such programs have taken place for many years, results have not been encouraging. Evaluations of such programs have generated mixed results, with effects ranging from beneficial to detrimental (Gould, Greenberg, Velting, & Shaffer, 2003).

Although research about a less direct approach to suicide prevention seems inconclusive, current findings on social skills training seem more encouraging. The goal of this

approach is inoculation against suicide by enhancing adolescents' skills for self-efficacy and social support. Although more research is needed, existing studies provide some evidence that social skills training does reduce the incidence of suicidal behavior (Gould, Greenberg, Velting, & Shaffer, 2003). Examples of promising school-based programs for social skills training with youth deemed at risk for suicidal behavior include the *Reconnecting Youth* class, Counselors CARE (C-CARE), and Project CAST (Coping and Support Training). *Reconnecting Youth* (Substance Abuse and Mental Health Services Administration, n.d.) is an elective 1- or 2-semester high school course, while C-CARE and Project CAST (Randall, Eggert, & Pike, 2001) involve skills-training support groups and case management for at-risk youth.

Another school-based method—screening of students for suicidal ideation, drug use, and depression—can be useful in identifying at-risk youth but also has limitations. The main advantage of this approach is that by screening the student body, the school proactively identifies students most in need and refers them to help. Limitations include the need for multiple screenings and unpopularity of screening with school principals (Gould, Greenberg, Velting, and Shaffer, 2003).

A related strategy that is more acceptable to principals is gatekeeper training. The term *gatekeeper* refers to school staff who are trained in the risk factors for suicidal behavior and how to refer students for help. Although Gould, Greenberg, Velting, and Shaffer (2003) found research on gatekeeper training of teachers and other school staff to be limited, existing research is encouraging.

In addition to school staff and students, physicians are potentially important gatekeepers for discovering adolescent suicidality. The Institute of Medicine (2002) found that 34-38% of people who died by suicide had visited a primary-care

physician within a month of their deaths; within a week of their deaths, 16-20% of such people had visited a doctor. In recognition of the potential value of physicians as gatekeepers, Objective 7.9 of the National Strategy for Suicide Prevention is to “incorporate screening for depression, substance abuse and suicide risk as a minimum standard of care for assessment in primary care settings...for all Federally-supported healthcare programs” (U.S. Department of Health and Human Services, 2001b).

Other common suicide-prevention methods also need more research. These include peer helping, in which students are trained as gatekeepers, crisis hotlines, school-based crisis intervention after a student's suicide (postvention), and restricting access to firearms (Gould, Greenberg, Velting, and Shaffer, 2003).

Finally, the way in which media covers suicides can dramatically affect the suicide rate. “Following the implementation of media guidelines [for reporting suicides in the news] in Austria, suicide rates declined 7% in the first year, nearly 20% in the 4-year follow-up period, and subway suicides (a particular focus of the media guidelines) decreased by 75%” (Gould, Greenberg, Velting, and Shaffer, 2003, p. 397). An international workgroup including the U.S. Surgeon General and the World Health Organization developed media guidelines (American Foundation for Suicide Prevention, 2001) that could be used in the United States. None of the studies reviewed here present data about how prevention efforts specifically affect African American adolescents or other youth of color.

Adolescent Depression, Suicide, and Cognitive-Behavioral Therapy

As the name suggests, cognitive-behavioral therapy combines cognitive and behavioral strategies. Beck (1976) explains, "In the broadest sense, cognitive therapy consists of all the approaches that alleviate psychological distress through the medium of correcting faulty conceptions and self-signals" (p. 214). He continues, "The 'behavioral' approach [in CBT] encourages the development of specific forms of behavior that lead to more general changes in the way the patient views himself [or herself] and the real world" (p. 215).

When using CBT with adolescents, of special importance are the building of rapport and the negotiation of confidentiality (Geldard & Geldard, 2004). The worker should discuss confidentiality in the presence of both the adolescent and the parents or guardians so that all involved will understand what information the worker will and will not hold in confidence (Geldard & Geldard, 2004). When the worker must communicate unpleasant information (such as suicidal ideation) to the adolescent's parents or guardians, the worker could ask the client how that information should be communicated (Friedberg & McClure, 2002).

Friedberg and McClure (2002) recommend that intake and assessment of adolescents include asking direct questions about suicidal ideation. They name two popular standardized self-report measures for assessing depression, including suicidal ideation: the Child Depression Inventory (Kovacs, 1992) and the Revised Children's Depression Rating Scale (Poznanski, Freeman, & Mokros, 1985). The adolescent's "age, level of cognitive development, severity of depression, and prerequisite skills" also should be assessed (Friedberg and McClure, 2002, p. 189). If the social worker suspects suicidal ideation in the youth, he or she should assess whether the

adolescent has a plan of self-harm, the lethality of the plan, and its specificity. If suicide risk appears very high, the worker should consult another qualified professional to assess whether hospitalization is required. Even when hospitalization is not necessary, if suicide risk is apparent, the worker should ask the client's guardians to secure or remove firearms and medications (American Academy of Child and Adolescent Psychiatry, 2001).

After the initial assessment, CBT offers a wide range of intervention techniques. Basic methods include problem-solving, social skills training, self-monitoring, hypothesis testing, and time projection (Beck, 1976; Burns, 1980; Friedberg & McClure, 2002; Hersen, Gross, & Drabman, 2005; Regehr, 2001). If the client has difficulty understanding abstract talk about thoughts and feelings, then stories such as *The Emperor's New Clothes* (Anderson, 2004) can convey the power of thought in influencing behavior (Harrington & Saleem, 2003).

Clinicians can use these techniques with clients individually, in groups, and with families. Asarnow, Jaycox, and Tompson (2001) found two studies that found favorable outcomes for a group CBT course for depressed adolescents called "Coping with Depression," while a pre-experimental study found a high attrition rate for severely and chronically depressed adolescents and overall remission rate of 35% for course completers (Swan, Sorrell, MacVicar, Durham, & Matthews, 2004). Asarnow, Jaycox, and Tompson (2001) found that adding a 9-week group for parents of the treated adolescents added no significant outcome improvement. Also, when depressed adolescents received group CBT in addition to the clinic's usual treatment in one study, no incremental benefit was found (Clarke, Hornbrook, & Lynch, 2002). Therefore,

research on the efficacy of CBT group work with depressed adolescents appears inconclusive at this time.

Family-based CBT offers many potential advantages for families with depressed adolescents. According to Carr (2002), family-based CBT should be used whenever possible because it can improve family communication and promote problem solving. Furthermore, directly involving parents in the treatment also increases their ability to reinforce gains made in therapy at home (Ehrenreich, Kyle-Linkovich, & Rojas-Vilches, 2005). However, as with group CBT with adolescents, more efficacy and effectiveness research is needed.

Indeed, the treatment of depression in children and adolescents is a field that needs more research. For example, Kaslow and Thompson (1998), in a frequently cited literature review, found that existing literature on the subject suffered from many limitations. Furthermore, in applying the criteria for empirically supported treatments developed by the American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures to these studies, they could not rate any treatment approaches to mood disorders with children and adolescents, including CBT, as well established. Also, existing studies tend to be of treatment efficacy under tightly-controlled conditions rather than studies of the treatments' effectiveness under the conditions of community counseling centers (Lonigan, Elbert, & Johnson, 1998). Even so, "[c]ognitive-behavioral therapies (CBTs) are the psychosocial treatments best supported by the literature" (McClellan & Werry, 2003), perhaps because, as Asarnow, Jaycox, and Tompson (2001) found, they are the best researched. In fact, CBT appears to be the treatment modality of choice for adolescents with anxiety and depression (Compton et al, 2004).

Unfortunately, research on CBT with diverse populations is scarce. This survey found only one recent peer-reviewed study (Rosselló & Bernal, 1999) that focused specifically on CBT with adolescents of color. As Lantz (1996) observed, "The cognitive treatment tradition would be improved by the implementation of research studies focusing upon race, class, and gender" (p. 102).

Strengths and Weaknesses of CBT with Adolescents

As the promising research results suggest, CBT treatment with suicidal adolescents has several strengths. Besides being the best-researched psychosocial treatment modality for adolescents, its value in treating major depression and suicidality is well established with adults (Burns, 1980). CBT can be used in family-based, group, and individual treatment settings and at varying developmental levels. CBT empowers adolescent clients by giving them a voice in setting treatment goals that is equal to that of their parents and by teaching them to better regulate their own thoughts and feelings by means of psychoeducation (Ehrenreich, Kyle-Linkovich, & Rojas-Vilches, 2005). Another strength is the simplicity of CBT theory, which is usually understandable for adolescent clients and enables them to participate actively in therapy (Regehr, 2001). Advantages for clinicians in using cognitive behavioral therapy include clear treatment techniques and shared responsibility with the client for outcomes (Regehr, 2001).

Cognitive behavioral therapy with adolescents does have some pitfalls, however. Regehr (2001) identifies several temptations for CBT therapists. First, the abundance of CBT techniques may tempt clinicians to focus on technique at the expense of the therapeutic relationship with the adolescent client. Second, the therapists might focus too much on the

cognitive dimension of the client's problem and neglect the affective realm. Third, the therapist may become satisfied with symptom relief rather than uncovering the underlying irrational beliefs that are the origin of the symptoms.

Ehrenreich, Kyle-Linkovich and Rojas-Vilches (2005) identified some further pitfalls. CBT treatment manuals seldom specifically target adolescents. Second, although CBT often gives rapid relief from mild depressive symptoms (Renaud et al, 1998), for the results to last, it is best for the client to practice CBT techniques in many different settings, which is often difficult to do during therapy (Ehrenreich, Kyle-Linkovich, and Rojas-Vilches, 2005).

Compatibility of CBT with Social Work Practice and Ethics

Even with these potential pitfalls, cognitive behavioral therapy is highly compatible with social work practice and ethics (Regehr, 2001; Lantz, 1996). It is useful in a wide range of practice settings and for treating a wide range of problems, not just suicidality or depression (Lantz, 1996). The collaborative and educational nature of CBT fits well with the social work values of respect for the dignity of individuals, importance of human relationships, and social justice.

A vision of how cognitive-behavioral therapy can further social justice is offered by Hanna, Talley, and Guindon (2000). In addition to relieving depressive symptoms such as suicidal ideation, CBT can assist in achieving political and social liberation for oppressed “groups such as ethnic minorities; gay, lesbian, and bisexual persons; women; and persons with disabilities; to victims of physical, verbal, and sexual abuse, and at-risk children and adolescents” (p. 430). Oppression has a cognitive dimension. For oppressors, oppression requires denigration of—and suppression of empathy for—the oppressed. For the victims of oppression, the cognitive result tends to be acceptance, in varying degrees, of

the oppressors' view of them, which lowers their self-efficacy and may contribute to depression or suicidal ideation. Oppressed people frequently feel rage and self-loathing. The authors recommend using CBT to “discover the irrational beliefs of the oppressor's mind-set, whether the oppressor is a group or an individual. *In other words, it is not the irrational beliefs of the oppressed person that is the focus but the irrational beliefs of the oppressive person or system to which the oppressed person has agreed*” (Hanna, Talley, & Guindon, 2000, p. 437).

Because so many people fit into these categories of oppressor, oppressed, and both oppressor and oppressed, social workers should pay attention to power relations in the lives of their adolescent clients and how power may affect their depressive or suicidal symptoms. If addressed carefully with concern for processing the feelings associated with oppression and combined with skills training and problem-solving, the result may be a plan of change not only for the individual client but perhaps for the client's family, school, and society.

Conclusion

Although more supporting research on CBT with depressed and suicidal adolescents is needed, current research and clinical practice appear encouraging. CBT is consistent with social work values and includes a flexible set of techniques for a wide range of clients and treatment settings. Although generally time-limited as a treatment, CBT has the potential for lifelong impact and—perhaps—liberation in a wider sense.

Unfortunately, research on both suicide prevention programs and CBT specifically with adolescents of color such as African Americans seems to be lacking. Indeed, the rapid increase in suicides among African American adolescents during the 1990s has received insufficient attention. For

example, the National Strategy for Suicide Prevention (U.S. Department of Health and Human Services, 2001b) contains only one goal designed to directly help people of color—and it is for Native Americans. Studies of the efficacy and effectiveness of cognitive-behavioral therapy with African American adolescents and other youth of color not only would improve the research base of CBT with adolescents but likely would yield knowledge about adapting CBT to youth of different racial backgrounds.

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