Published in final edited form as:

Child Psychiatry Hum Dev. 2017 October ; 48(5): 705–713. doi:10.1007/s10578-016-0696-6.

Prevalence and Clinical Differences of Suicidal Thoughts and Behaviors in a Community Sample of Youth Receiving Cognitive-Behavioral Therapy for Anxiety

Nicole M. McBride, B.S.¹, Carly Johnco, Ph.D.¹, Alison Salloum, LCSW, Ph.D.^{1,3}, Adam B. Lewin, Ph.D., ABPP^{1,4}, and Eric A. Storch, Ph.D.^{1,2,4,5,6,7}

¹Department of Pediatrics, University of South Florida, St. Petersburg, FL

²Department of Psychology, University of South Florida, Tampa, FL

³School of Social Work, University of South Florida, Tampa, FL

⁴Department of Psychiatry and Behavioral Neurosciences, University of South Florida, Tampa, FL

⁵Department of Health Policy and Management, University of South Florida, Tampa, FL

⁶Rogers Behavioral Health – Tampa Bay, Tampa, FL

⁷All Children's Hospital – Johns Hopkins Medicine, St. Petersburg, FL

Abstract

This study examined the incidence of suicidal thoughts and behaviors in youth with anxiety before initiating cognitive behavioral therapy, as well as the emergence of suicidal thoughts and behaviors during treatment. Overall, 30% of youth experienced suicidal thoughts and behaviors. Prior to treatment, 24% reported suicidal thoughts and behaviors, and 13.1% endorsed suicidal thoughts and behaviors during treatment. More than half who endorsed suicidal thoughts and behaviors during treatment were newly identified cases not detected prior to treatment. Disagreement among parent- and child-report measures of suicidality was found at baseline. Youth who experienced suicidal thoughts and behaviors had higher levels of loneliness, depressive symptoms, overt peer victimization, functional impairment, and externalizing symptoms. Findings suggest that the assessment of suicidality at a single time-point and from one informant is not sufficient to identify at-risk youth. Ongoing assessment of suicidal risk during treatment is important in this population

Keywords

anxiety; suicidal ideation; youth

Anxiety disorders are highly prevalent among youth [1, 2] and are associated with significant impairment in family [3], social [4], and academic functioning [5]. Left untreated, anxiety can persist into adulthood and have a detrimental effect on overall

functioning [6, 7]. Importantly, anxiety has been shown to be associated with concurrent [8, 9] and future suicidal ideation and attempts [10].

The Centers for Disease Control and Prevention (CDC) report that suicide is the second leading cause of death among youth aged 10 to 24 years [11]. The mechanisms that underlie suicidality in youth are complex and multifaceted. Identification of risk factors and clinical correlates is essential to allow for early intervention of at-risk youth. Suicidality in youth is associated with the male sex, lower socioeconomic status, poorer family functioning, presence of psychopathology, and exposure to adverse life events [see 12 for a review]. Regarding psychopathology, mood disorders (e.g., depression, dysthymia) are the most predictive of suicidality, with upwards of 40-80% of youth who attempted suicide having been diagnosed with depression [9]. The comorbidity of depression and anxiety in youth is well-documented [13, 14]; with up to 50% of youth diagnosed with depression also have a comorbid anxiety disorder, and up to 15% of youth diagnosed with an anxiety disorder have comorbid depression [15]. Given the overlapping relationship between anxiety and depression in youth and the shared etiological factors and theoretical constructs between these two disorders [14-16], there has been an increasing interest in suicidality among youth with anxiety.

Among anxious youth, between 22%-58% of youth report suicidal ideation [17-19]. However, studies that further examined the relationship between anxiety disorders and suicidality have yielded inconsistent results. Some studies have provided evidence to support the independent association between anxiety and suicidality, above and beyond the effect of depression [e.g., 17, 18-24], while others have not [e.g., 22, 25, 26]. O'Neil-Rodriguez and Kendall [18] found using an anxious sample of youth seen at an outpatient specialty clinic that even after controlling for depressive symptoms, emotion dysregulation, and distress tolerance, anxiety symptomatology still significantly predicted suicidal ideation. Conversely, Thompson, Mazza, Herting, Randell and Eggert [25] found that anxiety was not directly predictive of suicidal behaviors, but rather was more related to hopelessness and depression, which in turn influenced suicidality in a high school sample of youth at risk of dropout. Additionally, Bentley, *et al.* [24] conducted a meta-analysis and found that anxiety was a statistically significant predictor of suicidal ideation and attempts, however, it did not yield much importance in terms of clinical utility as the effect sizes and odds ratios were small.

Several explanations have been proposed to explain the discrepant findings examining the association between anxiety and suicidality [22]. First, methodological inconsistencies, including varied measures and definitions used to operationalize suicidality and anxiety, and the informant used to gather that information (e.g., clinical interviews versus self-report versus parent-report) are likely to explain some of these discrepancies. For example, Carter, Silverman, Allen and Ham [23] found that after controlling for depression, anxiety independently predicted suicidal ideation but only when using the brief version of a child-rated anxiety measure, not the full length version using a sample of youth aged 7-16 years old who were seen at an anxiety specialty research clinic. Second, some studies have examined the association between only anxiety and suicidality [21, 22], while others assessed this relationship while also accounting for the influence of other key variables [e.g., presence of depression, comorbid psychopathology; 18, 25]. The failure to account for

variance explained by other important risk factors may overestimate the relationship between anxiety and suicidal thoughts and behaviors (STB). Third, sample heterogeneity across studies [e.g., inpatient versus outpatient; 22], may influence clinical presentation [27, 28]. For example, a common exclusion criteria among youth presenting in an outpatient anxiety treatment trial is immediate threat of harm to self or others [29-31]; therefore, studies exploring suicidality from these populations may be limited. Conversely, studies exploring suicidality in anxious youth using an inpatient sample may not exclude these youth because any STB may be more closely monitored in this setting. Considering all these factors, it is imperative that more attention be focused on these two constructs in youth so more conclusive decisions can be drawn.

In addition to the above methodological variations in studies of pediatric anxiety and STB, most studies that have examined STB in pediatric anxiety have assessed it at a single time point using one informant. To date, there are no studies that have reported on changes and/or emergence of suicidal ideation during cognitive-behavioral therapy (CBT) for anxiety in youth. Given the potential for increased distress during treatment as avoidance behaviors are reduced and exposure to feared stimuli and situations begins, it is possible that STB symptoms may also fluctuate during the course of treatment. Accordingly, there is a need to examine whether STB may emerge during treatment.

This study aims to provide further information about the incidence of STB within a sample of youth with anxiety disorders seeking and/or receiving computer-assisted CBT (CCBT) in a community mental health setting. The first study aim was to examine the incidence of STB prior to receiving treatment, as well as examining the emergence of STB during treatment using a multiple-informant method. Based on previous findings [17-19], we expected between 25-50% of treatment-seeking youth with anxiety to endorse STB symptoms prior to treatment. Given the limited information of the emergence of STB during CBT, the remainder of our aims were exploratory; the second study aim sought to compare demographic and clinical profiles of youth who endorsed STB in comparison to those who did not. We anticipated STB would be associated with increased anxiety severity and depressive symptoms as reported elsewhere [17, 23]. Thirdly, the relative contribution of anxiety and depressive symptoms in predicting STB was assessed. We hypothesized that higher levels of anxiety severity and depressive symptoms would predict STB [17], with depression showing a stronger relationship to suicidality than anxiety. The fourth aim of the study was exploratory and examined differences in treatment response among those who endorsed STB versus those who did not.

Method

Participants were 100 youth (56% male) aged 7-13 ($M = 9.82$, $SD = 1.82$) and their parents who were recruited from three community mental health centers throughout Florida as part of a randomized controlled trial of CCBT for treating pediatric anxiety [see 29]. Briefly, youth were randomized to CCBT or treatment as usual (TAU). Upon completion of the TAU period, families were offered the same CCBT protocol. To meet inclusion criteria, all youth had to have a minimum score of 10 on the Pediatric Anxiety Rating Scale [PARS; 32] and meet diagnostic criteria (i.e., Clinical Severity Rating (CSR) ≥ 4) for separation anxiety

disorder, social phobia, generalized anxiety disorder, panic disorder, or specific phobia, as determined by the Anxiety Disorders Interview Schedule for DSM-IV [ADIS-IV; 33]. Youth who were unstable on psychiatric medications, had a lifetime diagnosis or schizophrenia, schizoaffective disorder, or autism spectrum disorder, or were receiving an additional psychological treatment targeting anxiety were excluded. Youth who were actively suicidal and presented as high-risk were excluded ($n = 3$) in the original trial [29] and therefore in this study sample. This is standard clinical practice in anxiety treatment trials as these youth need immediate care/evaluation outside the scope of what the study would provide. The study sample analyzing overall STB endorsement, either at baseline *and/or* during treatment, consisted of 100 youth.

Youth received an evidence-based CCBT treatment for childhood anxiety [i.e., Camp-Cope-A-Lot; 29, 34, 35] which consisted of 12 weekly sessions at a community mental health center with sessions 1-6 involving learning skills via computerized instruction and supervision by a therapist while sessions 7-12 were primarily therapist-led. The first half of sessions began with teaching youth coping skills for managing anxiety and then the second half led to gradual exposures to feared stimuli led by the therapist.

ADIS-IV: Child and Parent Versions [ADIS-IV-C/P; 33]

The ADIS-IV-C/P is a clinician-administered, semi-structured interview that assesses for the presence and severity using DSM-IV criteria for anxiety disorders as well as mood disorders and externalizing disorders. Each diagnosis is given a CSR based on a 0-8 scale, with higher scores indicating greater severity.

PARS [32]

The PARS is a clinician-rated scale assessing anxiety symptoms and the associated severity and impairment in children over the past week, with higher scores indicative of greater anxiety severity. The PARS 6-item total score was used for analysis in this study containing items which assess anxiety in terms of symptom frequency, severity, avoidance, physical symptom severity, interference at home, and interference outside of the home.

Clinical Global Impressions-Severity and -Improvement [CGI-S/I; 36]

The CGI-S is a single item 7-point clinician rating of severity of psychopathology. Severity ratings range from “no illness” to “extremely severe” and was administered at baseline. The CGI-I was administered post-treatment and rates the degree of anxiety symptom improvement on a 7-point scale relative to baseline. Scores on the CGI-I range from “very much worse” to “very much improvement” and scores of “much improved” and “very much improved” were operationalized as treatment responders.

Harm to Self and Others Form [Harm Form; 30, 37]

As used in the largest multi-modal pediatric anxiety treatment clinical trial to date [30], this is a structured 3-item clinician-administered form created to briefly assess suicidality at each treatment session to monitor symptoms and document any harm-related events. The 3 items asks whether the child has thoughts about not wanting to be alive, hurting him/herself, and thoughts about hurting others. Youth were operationalized as having suicidal ideation during

treatment if they answered “yes” at least once to one of the following questions regarding their previous visit: “did you have thoughts about not wanting to be alive?” or “did you have thoughts about hurting yourself?”

Child Behavior Checklist [CBCL; 38]

The CBCL is a widely-used 112-item scale that assesses child emotional and behavioral functioning (including externalizing and internalizing symptoms) from the parent's perspective. Consistent with O'Neil-Rodriguez and Kendall [18], parents who reported “somewhat true” or “very true” to item 18 (“deliberately harms self or attempts suicide”) or item 91 (“talks about killing self”) were operationalized as having suicidal behaviors at baseline. A prorated CBCL Internalizing total subscale score was used in which the STB item “talks about killing self” was subtracted from the original subscale total score.

Columbia Impairment Scale-Parent [CIS-P; 39]

The CIS-P is a well-established parent-reported 13-item scale that assesses impairment in several domains of functioning, including interpersonal relations, functioning in school, and social impairment. Items are rated on a 4-point Likert Scale, from 0 (no problem) to 3 (a very bad problem).

Children's Depression Inventory [CDI; 40]

The CDI is a child self-report measure of depression symptom severity in school-aged children. Consistent with O'Neil, Puleo, Benjamin, Podell and Kendall [17], children who endorsed the items, “I think about killing myself but I would not do it” or “I want to kill myself” on item 9 were operationalized as having suicidal ideation at baseline and a prorated CDI total score was used in which item 9 was subtracted from the original CDI total score.

Multidimensional Anxiety Scale-Children [MASC; 41]

The MASC is a 39-item child-report questionnaire that assesses childhood anxiety symptom using a 4-point Likert scale, with higher scores being indicative of greater anxiety symptomatology.

Asher Loneliness Scale [ALS; 42]

The ALS is a 24-item child-report measure of loneliness in youth over the past 2 weeks. A modified version of the ALS was used to minimize completion time, which excluded the 8 items that asked about hobbies and left the remaining 16 items which assessed loneliness and social acceptance. Each item was rated using a 5-point Likert scale, with higher scores indicative of greater loneliness.

Social Experience Questionnaire [SEQ; 43]

The SEQ is a 15-item child-report measure of peer victimization. The SEQ consists of three subscales, and each individual item is rated on a 5-point Likert scale anchored by 1=“never” to 5=“always”. Two subscales were used in this study: the overt victimization subscale assesses the frequency of being a target of physical aggression and relational victimization

assesses the frequency of which a child feels a peer intentionally uses their friendship as a target of harm (e.g., peer exclusion).

Study procedures were approved by the relevant institutional review boards. Written consent was obtained from parents and written assent from children to participate in the overall study. Anxiety diagnoses and severity were assessed by an independent evaluator, with supervision from a board certified child and adolescent psychologist, using semi-structured clinical interviews with the parent and child separately before and after treatment completion. Additionally, both parent and child completed a battery of questionnaires assessing the child's emotional and behavioral symptoms as entry into the clinical trial. All assessments were completed via a secure internet platform using a web camera.

The sample used in this study to analyze before and during treatment STB varied in two ways. To analyze STB before starting treatment, all youth who completed the baseline assessment and met inclusion criteria for the study ($n = 100$) were included [29]. To analyze STB during treatment, all youth who completed the first treatment session were included ($n = 84$). Of this sample ($n = 84$), 41.7% ($n = 35$) completed the CCBT treatment after 12 weeks in the TAU condition and all TAU participants included maintained meeting study inclusion criteria at the start of treatment. Regarding the 16 participants who were excluded from the original sample, 15 were randomized to TAU and either chose to not begin treatment when offered or no longer met inclusion criteria at the start of treatment. The one remaining participant completed the CCBT treatment and STB were monitored, but no actual Harm Form was documented during treatment so they were excluded. Youth across these two samples ($n = 100$ vs. $n = 84$) did not differ across gender, age, race, anxiety severity, or STB (p 's $> .05$). Due to no STB differences found between these two samples, all bivariate and multivariate analyses compared youth who endorsed STB at baseline and/or during treatment versus those who did not endorse STB at baseline or during treatment. To examine any differences between treatment response across STB endorsement, only youth who completed a post-treatment assessment were included ($n = 76$).

Presence of STB at baseline was operationalized based on the responses from CDI and CBCL items. One child did not fill out the CDI at baseline, therefore STB presence is solely based on parent-report. During treatment, positive STB status was operationalized if children endorsed STB on the Harm Form on at least one occasion during treatment. Overall presence of STB was operationalized if STB was endorsed either at baseline *and/or* during treatment. Basic frequencies were used to examine the incidence of STB prior to treatment and during (Aim 1). T-tests and chi-squared tests were used where appropriate to examine group differences between those who endorsed STB versus those who did not across various demographic and clinical variables (Aim 2). A logistic regression was conducted to examine whether anxiety severity (ADIS CSR) predicted positive STB over and above depressive symptoms (CDI) (Aim 3). A Pearson's chi-squared test was used to examine the association between treatment response (i.e., yes/no) and STB endorsement (i.e., yes/no) (Aim 4).

Results

At baseline, 24.0% ($n = 24$) of participants endorsed STB, with 21.2% ($n = 21$) of youth self-reporting suicidal ideation on the CDI and 9.0% ($n = 9$) of parents reporting that their child had engaged in suicidal or self-harming talk/behaviors on the CBCL. Notably, of the youth who self-reported suicidal ideation, 71.4% ($n = 15$) of parents did not report the same. Of parents who stated their child had engaged in suicidal behaviors or suicidal talk, there were 3 (33.3%) instances where the child did not report the same. Collectively, there was poor agreement between parent and child reports of baseline STB ($k = .32$). To examine the incidence of suicidal ideation during treatment, we examined the frequency of suicidal ideation reported during the weekly Harm Form assessment ($n = 84$). During treatment, 13.1% ($n = 11$) of youth endorsed suicidal ideation on at least one occasion. Of these, 54.5% ($n = 6$) were newly identified cases that did not endorse suicidal ideation at baseline. For these cases who endorsed STB during therapy, majority were endorsed during sessions 1-6 ($n = 7$; $n = 3$ for session 7-12). One individual endorsed STB at session 6 and at session 7. Overall, 30.0% ($n = 30$) of participants endorsed symptoms of STB either before or during treatment.

Table 1 summarizes group differences in demographic characteristics between youth who endorsed overall STB compared to those who did not. There were no statistically significant group differences across demographic variables (age, sex, race or ethnicity) or diagnostic profiles. Additionally, there were no statistically significant differences across various anxiety measures. Table 2 presents clinical characteristics of youth with and without STB. Youth who endorsed STB had significantly higher levels of loneliness (ALS), depressive symptoms (CDI) and overt victimization (SEQ) scores. Parent-rated functional impairment (CISP) was significantly higher among youth who experienced STB, as were externalizing symptoms (CBCL External).

Using logistic regression, the overall model for anxiety and depressive symptom severity predicting STB status was significant ($\chi^2(2) = 6.55$, $p = .038$; Nagelkerke's $R^2 = .091$). Higher child-rated depressive symptoms significantly predicted STB ($B = 0.06$, $SE(B) = 0.03$, Wald $\chi^2 = 4.75$, $p = .029$) although clinician-rated anxiety severity (ADIS CSR) did not predict STB status over and above the effect of depressive symptoms ($B = 0.26$, $SE(B) = 0.32$, Wald $\chi^2 = 0.67$, $p = .413$). For every one point-increase in depressive symptoms, youth were 1.06 times more likely to experience STB.

Overall, 29.6% ($n = 16$) of youth who endorsed STB met treatment responder criteria, in comparison to 70.4% ($n = 38$) of treatment responders who did not endorse STB. A chi-square test revealed no significant difference in treatment response between youth who experienced STB and those who did not ($\chi^2(1) = 0.33$, $p = .567$).

Discussion

This study examined the frequency of STB in youth with anxiety disorders before and during treatment. Overall, almost one third of children (30%) experienced STB either before or during treatment. Specifically, 24.0% of youth were identified as having STB prior to

receiving cognitive-behavioral therapy for anxiety, and 13.1% endorsed suicidal ideation on at least one occasion during treatment. Importantly, the majority of youth (54.5%) who endorsed STB during treatment were newly identified cases not captured at baseline. This may be because STB endorsed during treatment was gathered from clinician-report where baseline reports of STB were gathered from child- and parent-report, as well as different methods of gathering STB information (i.e., CDI item 9, CBCL items, Harm Form). Additionally, the phrasing of the items on the child, parent, and clinician report forms differed and could yield different responses, although all assessed suicide-related constructs (e.g., “killing myself” versus “hurting myself” versus “thoughts about not wanting to be alive”). Results suggest that there is a clear need to gather clinical information about STB from multiple informants. Of the youth who endorsed suicidal ideation prior to starting treatment, more than half of parents (71.4%) did not report the same. Similarly, 33.3% of the cases where parents reported suicidal talk or self-harming behaviors, the child did not report the same (i.e., child underreported symptoms). This discordance between child and parent report of STB is not uncommon and has been documented elsewhere [44-46]. Regardless of whether STB are identified when the child initially presents to treatment for anxiety, it should be monitored in an ongoing manner. Additionally, STB information should be collected from multiple informants (i.e., parent vs. child) and using varying methodologies (i.e., self-report vs. clinician administered).

While the identification of suicidality in youth during treatment has been monitored in the context of medication trials [47, 48], this study is the first to report on the emergence of suicidality in youth receiving therapy for anxiety, specifically CCBT. Results suggest that suicidality can emerge during treatment, even from youth who were not identified prior, although this was unusual, with only .06% of the sample endorsing STB for the first time during treatment. In most contexts, regular and ongoing assessment of STB is relevant for safety monitoring, especially given that symptoms may be temporarily exacerbated when reducing avoidance and safety behaviors. These findings yield important implications given the current trends towards low-intensity and self-directed formats of therapy for pediatric anxiety. Given that emergence of STB during treatment was determined using therapist administered questions, it would be important for future research to see whether results are replicated using self-report measures of STB to assess the feasibility of safety monitoring, especially within low-intensity and self-help treatment modalities. To examine if youth who endorsed STB before or during treatment differed from those who did not in regards to treatment response, we found no significant difference. This supports the idea that treatment response, at least when defined by anxiety symptom reduction on the CGI-I, is not affected by STB endorsement.

Our findings that child-rated symptoms of loneliness, depression, and overt peer victimization were significantly higher in youth who endorsed STB are consistent with existing literature in samples of youth with suicidal tendencies [18, 49-51]. Youth who experienced STB had higher levels of overall functional impairment, and externalizing symptoms, which is similar to previous findings [17, 52]. Anxiety symptomatology severity, as measured by clinician- and child-rated reports, was not higher in youth who endorsed STB, which is consistent with previous findings when examined in a similar population [see 22]. Perhaps the severity of specific anxiety disorder symptoms are more closely related to

STB rather than anxiety as measured on a continuum in terms of interference, distress, and avoidance. Lastly, when predicting STB using anxiety and depression, only depressive symptoms were significantly predictive, which adds to the conflicting literature of whether there is an independent association between suicidality and anxiety [22, 25, 29].

Though promising, this study has several limitations. Our use of single items from well-validated self-report measures instead of a more comprehensive continuous assessment of suicidality [e.g., Suicidal Ideation Questionnaire-Junior; 53] limits our ability to analyze variables in a continuous fashion, potentially obscuring smaller effects. Identification of highly sensitive and brief measures, such as that used for ongoing tracking of STB in the present study are needed. Although our definition of STB included ideation, plans, and behaviors, there may be more nuanced differences between these facets, particularly in terms of varying levels of youth risk. As the literature on suicidality in youth continues to develop, there is a need to develop consistent and standardized methods for operationalizing suicidality (i.e., ideation versus plans versus attempts) and its components (e.g., non-suicidal self-injury [NSSI]). Due to the items used to identify STB in this study, one child was classified as experiencing STB at baseline on the basis of what could be perceived as NSSI (i.e., classified as STB on the basis of a positive response to the CBCL item 'deliberately harms self or attempts suicide'), with no indication of STB on other baseline items or during treatment items. Additionally, baseline STB was operationalized from parent and child reports, while during treatment STB was operationalized from a clinician administered form. Although the use of multiple informants is beneficial, it may explain why rates of suicidality were lower in this sample than reported in previous studies and why results yielded different findings [17, 18]. Future research would benefit from having consistent informants of STB, with reports from all parties being most ideal. Finally, although recruitment was from community mental health centers, rather than a specialist university-based clinic, that is indeed a strength of this study, youth who were actively suicidal and presented a high-risk were excluded. This may have resulted in potentially excluding the sample where the relationship between anxiety and suicidality is the strongest.

Within these limitations, this study builds on the emerging literature to examine the incidence of STB in youth with anxiety disorders, as well as fluctuations in these symptoms during active treatment. Although anxiety was not independently predictive of STB over and above depression symptoms, significantly higher levels of depressive symptoms, peer victimization, functional impairment, internalizing, and externalizing symptoms were observed among youth with STB. Evident by this study and previous literature, STB appears to be associated more closely with a complex clinical presentation encompassing comorbid depressive symptoms than with anxiety per se. Nonetheless, evidence suggest that when working with anxious youth, clinicians should assess STB at baseline and throughout treatment.

Summary

The present study examined suicidal thoughts and behaviors (STB) in youth who underwent a computer-assisted cognitive-behavioral therapy program for anxiety before and during treatment. Demographic and clinical differences between youth who experienced STB either

before or during treatment versus those who did not were examined. One hundred youth (7-13 years old) and their parent completed a range of clinical measures prior to beginning treatment, including an assessment of STB. The child's therapist assessed for suicidal ideation at each therapy session using the Harm to Self and Others form. In this sample of 100 youth, 24% reported suicidal thoughts and behaviors prior to treatment, and 13.1% endorsed suicidal thoughts and behaviors during treatment. More than half of youth who endorsed suicidal ideation during treatment were newly identified cases not detected prior to treatment. Additionally, disagreement between STB endorsement between parent- and child-report measures was found. Of youth who endorsed STB at baseline, 71.4% of parents did not report the same. Of parents who endorsed child STB at baseline, 33.3% of youth did not report the same. Youth who experienced STB either before or during treatment had higher levels of child-rated depressive symptoms, loneliness, and overt peer victimization, parent-rated functional impairment and externalizing symptoms. When analyzing whether anxiety severity predicted suicidal thoughts and behaviors while controlling for depressive symptoms, no association was found. The relationship between those who endorsed STB and treatment response was examined and no difference was found, suggesting treatment response is unaffected by STB endorsement. These results add to the modest literature on STB in anxious youth, and suggest that assessment of STB at a single time-point and from one informant is not sufficient to identify at-risk youth. Ongoing assessment of suicidal risk is important in this population.

Acknowledgments

Funding:

This work was supported by a grant to the last author from the Agency for Healthcare Research and Quality (1R18HS018665-01A1). The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Agency for Healthcare Research and Quality.

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Table 1

Sample characteristics of youth who endorsed STB versus not at baseline and during treatment.

	STB (<i>n</i> =30)	No STB (<i>n</i> =70)	
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>t</i>
Age	9.87 (1.91)	9.80 (1.79)	-0.17
	<i>n</i> (%)	<i>n</i> (%)	χ^2
Sex			0.01
Male	17 (30.4)	39 (69.6)	
Female	13 (29.5)	31 (70.5)	
Ethnicity			0.07
Hispanic	4 (33.3)	8 (66.7)	
Non-hispanic	26 (29.5)	62 (70.5)	
Race			1.88
Caucasian	25 (29.8)	59 (70.2)	
Black	4 (36.4)	7 (63.6)	
Asian/Pacific Islander	0	3 (100)	
Other	1 (50)	1 (50)	
Currently on medication	9 (42.9)	12 (57.1)	2.09
Primary diagnosis			3.93
Separation anxiety	7 (30.4)	16 (69.6)	
Social phobia	8 (30.8)	18 (69.2)	
Specific phobia	1 (11)	8 (88.9)	
Panic disorder	1 (100)	0 (0)	
GAD	13 (31.7)	28 (68.3)	
Unipolar Mood Disorder ^a	3 (37.5)	5 (62.5)	0.23

Note.

* $p < .05$ ** $p < .01$ *** $p < .001$. STB = suicidal thoughts and behaviors.^aConsists of major depressive disorder and dysthymia.

Table 2

Clinical differences of youth who endorsed STB versus not at baseline and during treatment.

	STB (<i>n</i> =30)	No STB (<i>n</i> =70)	
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>t</i>
PARS (6 item)	16.53 (3.66)	16.66 (3.38)	0.16
Clinician CGI-S	3.47 (0.63)	3.39 (0.57)	−0.63
Primary diagnosis CSR	4.67 (0.71)	4.49 (0.70)	−1.18
ALS	39.63 (15.37)	31.47 (12.23)	−2.81**
MASC	59.53 (21.89)	51.96 (16.18)	−1.92
Prorated CDI	13.47 (10.32)	8.78 (7.56)	−2.53*
CISP	22.13 (8.78)	16.73 (9.43)	−2.68**
Prorated CBCL Internal	20.13 (8.53)	17.77 (9.21)	−1.20
CBCL External	13.77 (9.18)	9.67 (8.38)	−2.18*
SEQ: Overt victimization	5.93 (3.23)	4.53 (2.30)	−2.16*
SEQ: Relational victimization	11.33 (6.39)	9.01 (4.06)	−1.86

Note.

*** $p < .001$.

STB = suicidal thoughts and behaviors; PARS=Pediatric Anxiety Rating Scale; CGI-S; Clinical Global Impression-Severity; CSR = Clinical Severity Rating; ALS=Asher Loneliness Scale; MASC=Multidimensional Anxiety Scale-Children; CDI=Children's Depression Inventory; CISP=Columbia Impairment Scale-Parent; CBCL=Child Behavior Checklist; SEQ=Social Experience Questionnaire.

* $p < .05$

** $p < .01$