Suicide Prevention Resource Center

Creating a Therapeutic Alliance in the Early Stages of Treatment With Adolescents at Risk for Suicide: A Tip Sheet for Clinicians

Building a meaningful connection can help clinicians establish and strengthen a therapeutic alliance with adolescent clients at risk for suicide.

Why the Therapeutic Alliance Matters

Studies have demonstrated that strong therapeutic bonds between clinicians and adolescent clients can contribute to better treatment outcomes in working with adolescents at risk for suicide.[1-3] However, clinicians face documented challenges in creating strong therapeutic alliances (TA) with adolescent clients and engaging them early in the therapeutic process.

For this reason, it is essential that clinicians who work with adolescent clients at risk for suicide possess the skills to develop strong therapeutic alliances with these clients. This resource offers practical suggestions for clinicians working to build and strengthen therapeutic alliances, with a focus on adolescent clients at risk of suicide.

What the Research Says

Data from the Youth Risk Behavior Survey indicated that, in 2021, 30% of female youth and 14% of male youth reported having seriously considered attempting suicide in the 12 months before the survey. Further, it is estimated that approximately half of an individual's lifetime mental health problems begin in adolescence.[4-6]

Over the past two decades, the percentage of adolescents receiving mental health care in inpatient and outpatient settings has increased.[7] Some adolescents who seek mental health care are at risk for suicide, but not all of these adolescents readily disclose suicidal

thoughts or behaviors to their health care provider.[2,8,9] One community-based study found that 39% of adolescents who were experiencing suicidal thoughts had never disclosed these thoughts to a mental health provider.

Research suggests that adolescents are more likely to disclose suicidal thoughts to their peers and family members than to health care providers.[9] Research also suggests that a large proportion of adolescents who receive treatment for self-harm and depression discontinue therapy before their clinician believes the adolescent client is ready to discontinue therapy, resulting in poor clinical outcomes.[10-12] Reluctance to share information and disengagement from treatment create obstacles to the therapeutic journey and successful treatment outcomes.

Establishing a solid therapeutic alliance early in treatment can support clients in feeling safe disclosing suicide risk and engaging in the therapeutic process.

While it can be challenging for clinicians to develop a meaningful connection with clients experiencing suicidal thoughts and behaviors, establishing a solid therapeutic alliance early in treatment can support clients in feeling safe disclosing suicide risk and engaging in the therapeutic process.[13]

The Therapeutic Alliance

A therapeutic alliance is defined by two characteristics:

- A relational, affective connection between the client and clinician
- Agreement between the client and clinician on intervention tasks and goals[13]

A strong therapeutic alliance and the formation of an emotionally secure attachment early in treatment encourage open communication and strengthen an adolescent client's commitment to therapy, allowing the clinician to more accurately identify potential risks.[14,15] Healthy therapeutic connections promote effective intervention delivery.[13]

Tips for Supporting a Strong Therapeutic Alliance With Adolescent Clients

The following tips, which emphasize building a meaningful connection, can help clinicians establish and strengthen a therapeutic alliance with adolescent clients at risk for suicide.

- **Ask direct questions.** The initial session is an appropriate time to ask the client direct questions to ascertain whether they are experiencing suicidal thoughts and behaviors. Studies have shown that adolescents are more motivated to discuss suicidal thoughts with a mental health professional if they are directly asked.

- **Express empathy.** Expressing empathy for the client's suicidal ideation as a real experience facilitates therapeutic collaboration and helps you understand the client's experience while providing non-judgmental support. Empathy can be applied through active listening.

- **Be self-aware.** Be mindful of what you bring to the therapeutic space. Your attributes (demographics, behaviors, characteristics, qualities, style, energy, etc.) can influence the therapeutic alliance and, thus, your ability to work with the client to address their suicide risk.[9,16-18]

- **Acknowledge therapeutic presence.** Acknowledge the importance of your therapeutic presence. Adolescent clients can sense when their clinician is distracted, nervous, or lacks interest. Be fully present in the moment. Maintain a state of "intention for presence, to be with, and for the client's healing process."[19] Stay grounded and centered. A grounded clinician can convey a sense of calm to an adolescent who is experiencing suicidal thoughts or behaviors, is in crisis, or is unable to regulate on their own.[9,19-21,22]

- **Promote collaboration.** During the initial session, establish a collaborative relationship with both the adolescent client and their parents/caregivers. Collaboration with caregivers can play an important role in helping an adolescent struggling with suicidal thoughts or behaviors.[1,23,24]

- **Promote autonomy and agency.** An approach to care that respects the client's autonomy and agency can go a long way toward securing a therapeutic alliance. One of the main reasons youths cite for not disclosing their suicidal thoughts is a fear of loss of confidentiality, autonomy, and agency. Demystify the treatment process with age-appropriate guidance and be transparent with the client and their parents/caregivers about confidentiality policies. Early in treatment, encourage the client to engage in learning activities that support them in developing interpersonal skills. Another way to promote autonomy and agency is to encourage the adolescent client to practice self-reflection, which may improve insight and the ability to identify positive coping strategies.[2,8,9]

- **Assess current psychopathology.** Psychopathology may affect the client's ability to form stable attachments. It is important to assess current psychopathology and not assume past assessments are still accurate. Consider the full context of the client's mental health history and adjust your approach accordingly.[25]

- **Practice intentional case formulation.** From the first session, practice intentional case formulation, which includes obtaining the client's narrative, as this can help guide treatment. Using intentional case formulation in treatment planning may entail providing the adolescent client with moment-to-moment support and interventions tailored to their specific needs. There is no one-size-fits-all treatment plan.[1,26]

- **Enhance meaningful connection.** Assist the client in identifying and building meaningful connections with supportive family members, caregivers, peers, and their community to foster social connectivity. Social connectedness is a protective factor against suicide.[27,28]

- **Set realistic priorities.** It may be challenging to fully address an adolescent client's suicide risk in the first session. Address immediate risks to safety first, and then prioritize next steps based on the client's clinical presentation and circumstances.[9]

- **Support distress reduction.** If your adolescent client appears to be struggling with self-regulation in the first session, they may find it difficult to participate in discussions, collaborative treatment planning, and therapy. During the first session, introduce self-regulation skills such as breathing exercises, which may help the client engage in the initial therapeutic alliance building effort.[29]

References

[1] Meza, J. I., Zullo, L., Vargas, S. M., Ougrin, D., & Asarnow, J. R. (2023). Practitioner review: Common elements in treatments for youth suicide attempts and self-harm - a practitioner review based on review of treatment elements associated with intervention benefits. *Journal of Child Psychology and Psychiatry*, *64*(10), 1409-1421. https://doi.org/10.1111/jcpp.13780

[2] Rice, S. M., McKechnie, B., Mitchell, J., Robinson, J., & Davey, C. G. (2018). A clinician's quick guide to evidence-based approaches: Managing suicide risk in young people. *Clinical Psychologist*, *22*(3), 355-356. https://doi.org/10.1111/cp.12173

[3] Van Der Spek, N., Dekker, W., Peen, J., Santens, T., Cuijpers, P., Bosmans, G., & Dekker, J. (2024). Attachment-based family therapy for adolescents and young adults with suicide ideation and depression. *Crisis*, *45*(1), 48-56. https://doi.org/10.1027/0227-5910/a000916

[4] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, *62*(6), 593-602. https://doi.org/10.1001/archpsyc.62.6.593

[5] Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., Salazar de Pablo, G., Shin, J. I., Kirkbride, J. B., Jones, P., Kim, J. H., Kim, J. Y., Carvalho, A. F., Seeman, M. V., Correll, C. U., Fusar-Poli, P. (2022). Age at onset of mental disorders worldwide: Large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry*, *27*(1), 281-295. https://doi.org/10.1038/s41380-021-01161-7

6 Gaylor, E. M., Krause, K. H., Welder, L. E., Cooper, A. C., Ashley, C., Mack, K. A., Crosby, A. E., Trinh, E., Ivey-Stephenson, A. Z., & Whittle, L. (2021). Suicidal thoughts and behaviors among high school students — Youth risk behavior survey, United States, 2021. *Morbidity and Mortality Weekly Report Supplements, 72*(1), 45–54. http://dx.doi.org/10.15585/mmwr.su7201a6

[7] Agency for Healthcare Research and Quality (US). (2022, October). *National healthcare quality and disparities report*. *Child and adolescent mental health*. Retrieved August 25, 2024, from https://www.ncbi.nlm.nih.gov/books/NBK587174/#

[8] Radez, J., Reardon, T., Creswell, C., Lawrence, P. J., Evdoka-Burton, G., & Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European Child and Adolescent Psychiatry*, *30*(2), 183-211. https://doi.org/10.1007/s00787-019-01469-4

[9] McGillivray, L., Rheinberger, D., Wang, J., Burnett, A., & Torok, M. (2022). Non-disclosing youth: A cross sectional study to understand why young people do not disclose suicidal thoughts to their mental health professional. *BMC Psychiatry*, *22*(1), 3-3. https://doi.org/10.1186/s12888-021-03636-x

[10] Wright, I., Mughal, F., Bowers, G., & Meiser-Stedman, R. (2021). Dropout from randomised controlled trials of psychological treatments for depression in

children and youth: A systematic review and meta-analyses. *Journal of Affective Disorders*, *281*, 880-890. https://doi.org/10.1016/j.jad.2020.11.039

[11] Yuan, S. N. V., Kwok, K. H. R., & Ougrin, D. (2019). Treatment engagement in specific psychological treatment vs. treatment as usual for adolescents with self-harm: Systematic review and meta-analysis. *Frontiers in Psychology*, *10*, 104. https://doi.org/10.3389/fpsyg.2019.00104

[12] Reis, B. F., & Brown, L. G. (1999). Reducing psychotherapy dropouts: Maximizing perspective convergence in the psychotherapy dyad. *Psychotherapy: Theory, Research, Practice, Training, 36*(2), 123-136. https://doi.org/10.1037/h0087822

[13] Kim, H., Munson, M. R., & McKay, M. M. (2012). Engagement in mental health treatment among adolescents and young adults: A systematic review. *Child & Adolescent Social Work Journal*, *29*(3), 241-266. https://doi.org/10.1007/s10560-012-0256-2

[14] Siefert, C. J., & Hilsenroth, M. J. (2015). Client attachment status and changes in therapeutic alliance early in treatment. *Clinical Psychology and Psychotherapy*, *22*(6), 677-686. https://doi.org/10.1002/cpp.1927

[15] Wasserman, D., Carli, V., Iosue, M., Javed, A., & Herrman, H. (2021). Suicide prevention in childhood and adolescence: A narrative review of current knowledge on risk and protective factors and effectiveness of interventions. *Asia Pacific Psychiatry*, *13*(3), e12452. https://doi.org/10.1111/appy.12452

[16] Ryan, R., Berry, K., & Hartley, S. (2023). Review: Therapist factors and their impact on therapeutic alliance and outcomes in child and adolescent mental health – a systematic review. *Child and Adolescent Mental Health*, *28*(2), 195-211. https://doi.org/10.1111/camh.12518

[17] Aponte, H. J. (2022). The soul of therapy: The therapist's use of self in the therapeutic relationship. *Contemporary Family Therapy*, *44*(2), 136-143. https://doi.org/10.1007/s10591-021-09614-5

[18] Satir, V. (1987). The therapist story. *Journal of Psychotherapy & the Family*, *3*(1), 17-25. https://doi.org/10.1300/J287v03n01_04

[19] Geller, S. M. & Greenberg, L. S. (2012). *Therapeutic presence : A mindful approach to effective therapy.* American Psychological Association. https://doi.org/10.1037/13485-000

[20] Grad, R. I. (2022). Therapeutic alliance and childhood interpersonal trauma: The role of attachment, cultural humility, and therapeutic presence. *Journal of Counseling and Development*, *100*(3), 296-307. https://doi.org/10.1002/jcad.12423

[21] Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *The American Psychologist*, *62*(8), 857-873. https://doi.org/10.1037/0003-066X.62.8.857

[22] Geller, S. M. (2017). *A practical guide to cultivating therapeutic presence* (1st ed.). American Psychological Association. https://doi.org/10.1037/0000025-000

[23] King, C. A., Arango, A., Kramer, A., Busby, D., Czyz, E., Foster, C. E., & Gillespie, B. W. (2019). Association of the youth-nominated support team intervention for suicidal adolescents with 11- to 14-year mortality outcomes: Secondary analysis of a randomized clinical trial. *JAMA Psychiatry*, *76*(5), 492-498. https://doi.org/10.1001/jamapsychiatry.2018.4358

[24] National Institute of Health and Clinical Excellence (NICE). (2022, September 7, 2022). *Self-harm: Longer-term management*. Retrieved February 20, 2024, from https://www.nice.org.uk/guidance/ng225

[25] Jobes, D. A., Vergara, G. A., Lanzillo, E. C., & Ridge-Anderson, A. (2019). The potential use of CAMS for suicidal youth: Building on epidemiology and clinical interventions. *Children's Health Care*, *48*(4), 444-468. https://doi.org/10.1080/02739615.2019.1630279

[26] Raymond, I. J. (2023). Intentional practice: A common language, approach and set of methods to design, adapt and implement contextualised wellbeing solutions. *Frontiers in Health Services*, *3*, 963029-963029. https://doi.org/10.3389/frhs.2023.963029

[27] Humensky, J. L., Coronel, B., Gil, R., Mazzula, S., & Lewis-Fernández, R. (2016). Life is precious: A community-based program to reduce suicidal behavior in Latina adolescents. *Archives of Suicide Research*, *21*(4), 659-671. https://doi.org/10.1080/13811118.2016.1242442

[28] Whitlock, J., Wyman, P. A., & Moore, S. R. (2014). Connectedness and suicide prevention in adolescents: Pathways and implications. *Suicide and Life-Threatening Behavior*, *44*(3), 246-272. https://doi.org/10.1111/sltb.12071

[29] Briere, J., & Lanktree, C. (2013). *Chapter seven – distress reduction and affect regulation training*. USC Adolescent Trauma Training Center (USC-ATTC). Retrieved February 23, 2024, from https://keck2.usc.edu/adolescent-trauma-training-center/treatment-guide/chapter-7-distress-reduction-and-affect-regulation-training/