

Identifying and Managing Suicidality in Children and Adolescents with Chronic Pain: Evidence-Based Treatment Strategies

Timothy Rice, Leo Sher

Department of Psychiatry, Icahn School of Medicine at Mount Sinai, New York, NY, USA

Correspondence: Timothy Rice, Department of Psychiatry, Icahn School of Medicine at Mount Sinai, 1090 Amsterdam Avenue, 13th Floor, Suite A, Office 5, New York, NY, 10025, USA, Tel +1 212 523 5635, Fax +1 212 523 5650, Email timothy.rice@mountsinai.org

Abstract: Children and adolescents with chronic pain are at an increased risk of suicidality. This narrative review article aims to inform clinical practice in the assessment and management of suicidality in youth with chronic pain. The article begins with a survey of the background and prevalence of youth with chronic pain. A review of the current evidence behind the increased risk of suicidality in youth with chronic pain follows. Contextualization of this data with general tenets of child and adolescent suicide risk and risk assessment is provided. Suicidology theory including the interpersonal theory of suicide is overviewed to help clinicians to conceptualize the reviewed data. Guiding parameters for the suicide risk assessment and management planning is presented. Concluding recommendations are made to guide clinical practice in the assessment and management of suicidality in youth with chronic pain.

Keywords: chronic pain, suicidality, suicide risk, suicide assessment, children, adolescents

Introduction

Considerable evidence suggests that pain regardless of type is an independent risk factor for suicidal ideation and behavior in individuals of all ages.¹⁻⁴ It has been suggested that depressive symptoms, alcohol and drug abuse, a history of childhood or adulthood adversities, family history of depression, and/or prior suicidal behavior are risk factors for future suicidal behavior in individuals with pain. Inadequately managing pain has been identified as a risk for suicidal behavior. The incidence of chronic pain disorders among youth often increases with time and persists into adulthood,⁵ positioning childhood and adolescence as an important developmental period in which to consider the lifetime implications of chronic pain, including on suicidality. In addition, the implication of increased risk of suicidality in individuals with pain disorders is an important, as according to updated 2020 data among youth in the United States, suicide is the second most common cause of mortality among youth in late childhood and early adolescence (youth aged 10–14) and the third most common cause of mortality among youth in late adolescence (youth aged 15–24).⁶

Chronic pain disorders in children and adolescents relative to adults are less well-appreciated and understood. The assessment and management of suicidality is a crucial task of comprehensive care for youth with chronic pain.^{7,8} To date, no work provides clinical guidance specifically focused on the assessment and management of suicidality in this population.

This narrative review is written for the wide range of clinicians who provide care for this population. This includes pediatricians, family physicians, nurse practitioners, physical and occupational therapists, social workers, psychologists, and child and adolescent psychiatrists and pain specialists. Many children and adolescents with chronic pain will already be linked with specialist providers. Others will require immediate assessment, management, and referrals to the correct level of mental health care. Referrals can include for routine outpatient appointment, for a crisis appointment within

several days, or for a direct transfer to an emergency department setting. It is important for all involved front-line clinicians to be familiar with suicidality in this special population.

Background and Prevalence of Chronic Pain

Chronic pain is defined as pain lasting for more than three months.⁹ It may be persistent or recurrent. Common types of community chronic pain among children and adolescents include headaches and migraines, abdominal pains including dysmenorrhea, oral and dental pain, limb or “growing” pains, back pains, chest pains, and multiple pains.¹⁰ Youth pains commonly encountered in hospital settings, such as cancer-related pain or that related to sickle cell disease, are also significant.

A 2011 systematic review of 41 published papers on the epidemiology of chronic pain in children and adolescents found generally low- to moderate- quality studies with wide ranges in estimated prevalence by the type of pain (11 to 38%).¹¹ Commentary on the review¹² nonetheless noted the methodological progress of this review relative to the existing literature. Efforts to further advance methodology and to update the results are underway,¹³ though limitations presented by methodological heterogeneity in the existing studies and heterogeneity among surveyed populations may continue to preclude further specification of true prevalence. Nonetheless, the studies reviewed demonstrate general themes across the types of child and adolescent pain disorders.

First, there are age-dependent considerations. Most studies find that pain disorders increase in prevalence with age.¹¹ A notable exception is abdominal pain, which has a peak prevalence in childhood. In this common type of childhood pain, the prevalence increases linearly from infancy through late childhood at about 6% per year.¹⁴ Amongst all pain disorders, the trend towards greater prevalence in chronic pain with increasing age may be more significant among girls than among boys.¹⁵

Second, the prevalence of chronic pain is gender-specific. The prevalence of chronic pain in female adolescents is higher than that in males.¹¹ Whereas most pain types do not differ in prevalence by gender, lower limb chronic pain was significantly more common among boys than among girls, whereas diffuse pain was more common among girls than among boys.¹⁵ Severe pain is more commonly experienced by girls relative to boys.¹⁵

Third, psychosocial factors are notable. Most studies show that low socioeconomic status confers risk for most pain disorders.¹¹ Other studied social factors which appear to increase the prevalence of chronic pain conditions include low parental education, and mental health status, type of residence, and time spent watching television.¹¹ Amongst children with abdominal pain, lower emotional control in toddlerhood and higher parental concern and parental stress are also risk factors.¹⁴

The severity of chronic pain is important. Approximately 5% of chronic pain disorders manifest with pain that is so severe that it impacts daily functioning for the child or adolescent in daily life.¹⁵ These youth represent a special group when considering suicide risk. Headaches were the most common pain type to have severe episodes, while limb pain was the least common.¹⁵ The more severe the pain, the more frequent are the episodes.¹⁵

The data of this landmark 2011 systematic review can be compared to a more recent 2022 review of youth chronic pain in low and middle-income countries.¹⁶ This review analyzed 27 studies representing twenty low- and middle-income countries and found an 8% pooled average prevalence of youth chronic pain. Female youth were again found to have higher chronic pain prevalence relative to male youth.

Youth history and neuropsychological factors affect pain prevalence and presentation. In an animal study, early life factors including maternal separation were found to alter nociception and neurobiological functioning.¹⁷ Amongst patients, previous adverse childhood events raise the risk of pain disorders, and female youth may be more impacted by prior adverse events than male youth.¹⁸ A prior history of trauma may decrease pain sensitivity through the promotion of a capability to dissociate, yet it increases pain catastrophizing.¹⁹ Post-traumatic stress disorder (PTSD) among adults is understood to impact the reward system and related circuits related to pain and pain-relief,²⁰ and the origins of this association may begin among children and adolescents with childhood trauma. Targeting the stress response through psychosocial interventions such as cognitive-behavioral therapy and mindfulness-based stress reduction in youth show promise through impacting such neuropsychological variables.²¹

In one study, just under a third (28%) of children referred to a specialty pain clinic had diagnosable psychiatric disorders.²² Internalizing symptoms such as depressive symptoms may precede the onset of chronic pain,²³ and evidence-

based interventions to promote psychological health may help youth with chronic pain and prevent the onset of such disorders.²⁴ Positive affect is associated with greater activity engagement and less pain interference and activity avoidance.²⁵ How a youth copes with pain appears important, though conclusions are difficult to draw. The low conceptual clarity among studies published on the topic identified in a recent a scoping review²⁶ highlights the importance of methodological clarity in further studies.

Adequate sleep may be particularly important,²⁷ and excessive daytime sleepiness²⁸ and inadequate sleep²⁹ has been shown to relate to pain. Sleep deprivation may influence pain progression biologically through its negative impacts on inflammatory markers, the hypothalamic-pituitary axis, and dopaminergic signaling. Sleep deprivation also impacts the youth's psychosocial life: altered receptivity and resilience to the pain's emotional-affective components and decreased availability and reserve to engage in social activities and supports due to the pain are two examples of pathways.²⁷

Chronic pain in childhood and adolescence commonly persists into adulthood. Approximately 17% of adults with chronic pain identified their pain as having originated in childhood or adolescence.³⁰ Headaches in childhood and adolescence persists into the early adulthood in approximately 19% of individuals; in 8.4%, the headaches are weekly or more.³¹ Abdominal pain persists at a rate of 35%.³² Chronic pain in adolescence raises the risk of opioid use disorders in adulthood,³³ which itself is a significant risk factor for suicide.³⁴

Further studies will be needed to overcome limitations in heterogeneity and to best reflect the prevalence of chronic pain in our current times. For example, despite the increase in contextual factors associated with pain vulnerability during the COVID-19 pandemic,³⁵ at least one study to date found prevalence to decrease during the COVID-19 pandemic.³⁶

Chronic Pain and Suicide: The Evidence

In 2019, a systematic review concerning the relationship between pain and suicidal vulnerability in adolescence (10–19 years of age)⁴ identified 25 relevant observational studies, with 80% of the studies having been published subsequent to 2010. The authors found that chronic pain approximately doubles the risk of suicide in adolescence.⁴ This is comparable to the two-to-three times increased risk of suicidality identified in adult populations with chronic pain.² The existing evidence is sparse and inconclusive, and it may fail to identify important developmental differences.

The review found that the association between pain and suicidal ideation was studied in 11 articles.^{37–47} The association between pain and suicidal behavior was studied in 9 articles,^{38,41,48–54} and two studies explored the association between pain and death by suicide.^{50,55}

Beyond the finding of a doubling of suicide risk among youth with chronic pain, several key points concerning youth suicide risk emerge from these findings.

First, in both community and clinic settings, the risk of suicidal ideation and of suicidal behaviors are elevated among youth with chronic pain. However, the statistical significance of these risks is mostly lost when controlling for depression. This demonstrates the importance of evaluating and assessing for depression when working with youth with chronic pain. Depression is a major predictor of suicidal behavior.⁵⁶

Second, one study found that the probability of suicidal ideation is raised when multiple pains are reported.³⁹ This encourages special attention to youth with multiple pain sites or concurrent (eg, headache and abdominal pain) conditions.

Third, more frequent pain is associated with suicidal ideation,⁴³ behavior,⁵⁴ and future hospitalization for self-harm.⁴⁸ In addition to pain multiplicity, frequency is also important.

Fourth, recurrent pain is associated with suicidal behavior.⁵¹ In a 2022 study³ that was not available to be included in the 2019 systematic review, persisting or recurrent pain was found to predict future suicidality at a level of statistical significance. Female youth were four times as likely to demonstrate this pain course relative to male youth.³ Youth with histories of psychological trauma or of psychiatric disorders were also more likely to have persisting or recurring pain.³

Fifth, pain severity is a risk factor for suicidal behaviors^{50,52} but not for suicidal ideation.⁴⁶ Pain intensity was also not found to increase the risk of suicidal ideation.

Sixth, pain duration raises the risk of suicidal ideation.⁴⁶ Depression mediates this association.⁴⁶

Seventh, pain distress and pain sensitivity have relationships with suicidality. Emerging adults with suicidal ideation have higher levels of pain distress than those with suicidal behaviors or healthy controls.⁵⁷ This means that adolescents who engage in suicidal behaviors may have an increased comfort and reduced anxiety in considering suicide and its

associated pains. While this study unexpectedly found that emerging adults with suicidal behaviors to have higher pain sensitivity,⁵⁷ another study found that adolescents with suicidal behavior have higher pain tolerance relative to healthy controls.⁵⁸

Eighth, studies which explored the impact on disability secondary to pain upon suicidality were mixed. Of six studies evaluating disability, two^{40,43} found increased risks of suicidal ideation among adolescents with greater disability, although these findings became insignificant upon controlling for variables including depression. Two other studies did not find a significant association between suicidal ideation and disability,^{44,46} and another did not find mobility impairment to serve as a moderator of suicidality.³⁸ Higher reported quality of life did associate with reduced suicidality.⁴⁰

Youth and Suicide Risk

The heterogeneity of the populations sampled within the studies included in the systematic review complicate abstracting points of clinical relevance. For example, findings drawn from samples of older adolescents do not necessarily apply to younger children. These findings specific to youth with chronic pain are best considered within the context of general knowledge of child and adolescent suicidology. Here we focus on two key demographic variables, age and gender.

Age

Older adolescents are at an elevated risk of suicide relative to younger adolescents.⁵⁹ This fact is important in light of the increased prevalence of pain disorders with advancing age.¹¹ Older adolescents more commonly have increased means of access to harm by virtue of their more capable adult bodies, have less supervision, and have a greater incidence of substance use disorders and other psychiatric conditions.

Suicide rates not only increase as youth age but also change in nature, including in their methods and precipitants.⁶⁰ Younger adolescents more commonly die by suicide through hanging relative to older adolescents.⁶⁰ Precipitants amongst younger adolescents are more often parent-child conflict, bullying, and abuse, while amongst older adolescents' relationship issues and alcohol intoxication are more common precipitants.⁶⁰ Younger adolescents are less likely to have psychiatric disorders than older adolescents who die by suicide.⁶⁰ There is mixed data concerning whether age plays a role in whether adolescents have suicidal ideation or a history of attempts prior to a suicide.⁶⁰

Taken together, these findings emphasize the importance of incorporating social and developmental factors in risk assessment.

Gender

Gender has repeatedly been identified as an important variable in child and adolescent suicidology.⁶¹ Female youth attempt suicide more frequently than male youth,⁶²⁻⁶⁴ though male adolescents more commonly die by suicide.^{62,64} Pain disorders are more common among female adolescents relative to male adolescents, and so the clinician treating youth with chronic pain disorders may more commonly encounter female adolescents who have a history of suicide attempts. Clinicians will need to pay particular attention to suicide risk when working with male adolescents with chronic pain disorders, as males are at an increased risk of death by suicide.

Reasons for the disparity between male and female adolescents in suicide attempt and suicide death prevalence include that male adolescents' more frequently use more lethal means in their suicidal behaviors to female adolescents.^{65,66} For example, among a population of Swiss adolescents, males more commonly died by suicide through firearm relative to females.⁶⁷ Adult men have greater suicidal intent relative to women,⁶⁸ and this may apply to adolescents as well. American adolescents perceive nonfatal suicidal behavior as more feminine and less potent than killing oneself, and these cultural narratives may influence male adolescents' decisions concerning their suicidal behavior.⁶⁹ Adolescents may be very susceptible to these narratives on account of the incomplete maturation of their capacities for decentered and abstract thinking. Adolescents' active developmental work of identity formation and consolidation creates an open-system relative to adults which may also increase their susceptibility to such narratives.

Other factors such as greater impulsivity, aggression, and disruptive behaviors in males; male-specific risk factors for suicide include drug abuse, externalizing disorders, and access to means.⁶⁴ As adolescents age, the rates of male suicide increase to a greater degree than the rates of female adolescents.⁶⁰

An evaluation of trends in youth suicide over approximately the last half-century shows that there is a trend towards dissipation of the increased risk of suicide among male adolescents for both younger and older youth.⁷⁰ The rates of youth suicide are also increasing.⁷⁰ Data will need to be continually updated to provide the most accurate depiction of trends amongst youth today. For the clinician caring for youth with chronic pain disorders, attention must be taken with both male and female adolescents.

Theory

Theory may help the clinician to organize their thoughts in assessing the specific adolescent for suicide risk. The interpersonal theory of suicide^{71,72} is one theory of suicidality that merits special attention in relation to pain disorders. This theory posits that suicidal individuals experience perceived burdensomeness and thwarted belongingness and progress to action through an acquired capability for suicide. It has accrued substantial evidence.⁷³

Adolescents with chronic pain may perceive being a burden due to their pain, and that their pain may separate them from belonging to a group of healthy individuals. They may conceal pain to avoid judgement, avoid being a burden, or through a desire to be treated normally.⁷⁴ The higher pain tolerance found in adolescents with suicidal ideation and behavior⁵⁸ may facilitate their tolerance of pain associated with suicide attempts.

Additionally, adolescents with chronic pain may be provided access to medications. Opioids to reduce pain may further increase their tolerance of pain associated with suicide. Benzodiazepines to reduce anxiety may also reduce emotional barriers to considering suicide and impair judgement. Youth with chronic pain may misuse opioids,⁷⁵ and emotion regulation deficiencies may underly both pain and opioid misuse.⁷⁶

Females with lower pain severity scores were significantly more likely to use pain medication than males.¹⁵ This may have implications for suicide attempts relative to desensitization of taking medication.

Pain-, stress- and analgesic drug-induced opponent and proponent states of the mesolimbic dopaminergic pathways may render reward and anti-reward systems vulnerable to sensitization, cross-sensitization and aberrant learning of contents and contexts associated with suicidal acts and behaviors.⁷⁷ These findings suggest that pain patients exhibit alterations in the brain circuits mediating reward (depressed function) and anti-reward (sensitized function) that may affect their proclivity for suicide and support pain and suicidality classification among other “reward deficiency syndromes” and a new proposal for “enhanced anti-reward syndromes”. Pain and suicidal tendencies may be potentially explained by recursive partly shared neural systems. Interventions intended at restoring the balance between the reward and anti-reward networks in patients with chronic pain may help decreasing their suicide risk. It may be helpful to treat adolescent suicidal patients with pharmacological agents that mitigate sensitization. For example, mood stabilizing anticonvulsants (carbamazepine and divalproex sodium) are effective for suicidality in bipolar disorder.⁷⁸

The Suicide Risk Assessment

A pediatric suicide risk assessment^{79,80} entails a formulation of risk through a consideration of multiple modifiable and static risk factors for suicide. This can be complicated in youth with pain disorders. For example, youth may present to emergency departments with use of medication at a level of life-threatening danger yet may state that medications were taken for pain relief. Some patients will deny suicidal thoughts for various reasons, such as shame or lack of trust in the questioning clinician. Others will withhold information about planned suicidal behavior, for reasons such as to ensure that the clinician will not prevent them from suicide. These factors contribute to the fact that an accurate suicide risk assessment is a complex task. In what follows we guide the clinician to assess for key risk and protective factors and provide recommendations for management and suicide prevention.

Management Considerations

Assess for Suicidal Ideation

Youth with chronic pain are at an increased risk of suicidal thoughts.⁴ Amongst all adolescents with suicidal ideation, approximately a third will go on to develop a suicide plan, of which just under two-thirds will go on to make an attempt.⁸¹ Healthcare providers should ask all youth with chronic pain about suicidal thoughts.

Suicidal ideation may be withheld if it is not directly assessed.⁸² There is no iatrogenic risk to suicide screening.⁸³ Asking about suicidal ideation does not put the thought into the youth. Suicidal ideation may be delineated as passive (eg, “I wish I could go to sleep and never wake up”) or active (eg, “I want to kill myself”). When active suicidal thoughts are present, evaluating for the presence of a plan (eg, “I intend to kill myself by swallowing all of my pain medication”) is an important next step.

In the time preceding a suicide, the majority of youth do report suicidal ideation.⁸⁴ Direct questioning, simple empathic support, and attentiveness yield the greatest rates of emotional and behavioral disclosure from adolescents.⁸⁵ Youth with high levels of pain distress⁵⁷ including those who have not yet made a suicide attempt as well as those with more numerous³⁹ and more frequent pain⁵¹ and pain of a longer duration⁴⁶ are particularly worth screening. In contrast, the available evidence suggests that pain severity and intensity do not raise the risk of suicidal ideation, though they do raise the risk of suicidal behaviors.^{46,50,52}

Parents and caregivers should also be asked whether they have heard their children make suicidal statements. Again, direct questioning is most conducive to disclosure in discussing psychosocial issues with parents.⁸⁶ Parents often may not know about an adolescent’s suicidal thoughts, or they may overreport concerns.⁸⁷ In a study of psychiatrically hospitalized adolescents and their parents, adolescents reported significantly more suicidal ideation, plans, and attempts than their parents.⁸⁸ Parental collateral and report is nonetheless an important data point in constructing a risk assessment.

Though asking about suicidal thoughts may appear obvious, few non-mental health specialists report engaging in screening,⁸⁹ and in one study, only 7% of youth in the community reported receiving such screening at their last clinical encounter.⁹⁰ Providing this single service to youth with chronic pain may make a sizeable impact. Providers of youth identified with suicidal ideation may require consultation to determine the appropriate level of care for the youth, with referral to an outpatient mental health specialist or to an emergency department for assessment of indication for hospitalization crucial.

Integrate Mental Status Findings

While we believe that all youth with chronic pain should be directly assessed for suicidal ideation, certain signs derived from the mental status examination⁹¹ may help to identify youth who may be at an increased risk of suicidal thoughts and tendencies. In assessing a youth’s *appearance*, the presence of any scars or healing injuries suggestive of non-suicidal self-injury (NSSI) is pertinent. While these will most commonly be located on the medial forearm of the nondominant arm, evidence of self-cutting in other areas such as the neck or chest is significant, as self-injury at these sites may confer an even higher suicide risk.⁹² In assessing *speech*, soft, slow, and nonspontaneous output may indicate the presence of depression, whereas unanticipated changes in the tone or quality in speech when discussing elements surrounding suicidality may suggest dissimulation or the presence of conflictual feelings. Similarly, in a youth’s *behavior*, excessive fidgeting and avoidance of eye contact around questioning about suicide may suggest discomfort with the topic and the need for further questioning. A youth with psychomotor retardation as evidenced by minimal spontaneous movements or a fixed, slumped posture may point to depression, while psychomotor agitation may suggest impulse control deficits or significant anxiety, which are both risk factors for suicide.^{93,94} Questioning directly a youth’s *mood* is worthwhile to attain their subjective assessment of their emotional wellbeing, whereas noting in a youth’s *affect* the presence of any incongruence (eg, a youth who states they are fine but carries a restricted, dysphoric affect) may suggest the need for compassionate further questioning. Inappropriate laughter or rapid fluctuations in affect around questioning about suicidality may be indicative of discomfort with the topic. These signs offer an opportunity to normalize for the youth the practice of creating a space with a caring professional to safely discuss these topics and to access help should it be needed. A *thought process* that becomes more disorganized or erratic upon assessment of suicidality is another sign for concern, whereas *thought content* that includes preoccupations or ruminations around matters of decreased self-worth, hopelessness, or helplessness are three additional cardinal signs of concern.⁹⁵ A youth whose spontaneous thoughts turn to loneliness or feelings of not fitting-in are also notable, and as their chronic pain may contribute to self-isolation and disengagement,⁹⁶ they are worth questioning. A youth who alludes to romanticization of alcohol and drug abuse or death and morbid topics as two examples of a wide range of potential topics to note would also signal danger. The presence of

auditory hallucinations as may occur in severe depression or primary psychotic illnesses in an assessment of *perception* may be surveyed by asking a youth if they ever hear the voice or whispers of people who are not present, particularly at moments when they are feeling down or under duress; noting a youth's internal preoccupied or responsiveness to stimuli that appear internal can be an objective sign of active perceptual disturbances in a youth who may withhold his or her history of experiencing hallucinations. Deficits in *cognition* such as poor attention and concentration may allude to static qualities or to active substance abuse, whereas an overall assessment of *insight* and *judgement* can help to determine a youth's capabilities of understanding and appropriately acting on needs for help. Whereas the mental status examination in youth is complex and carries nuances that are beyond the scope of this brief survey, children and adolescents who raise alarm may be identified as in need for additional attention, including a referral to a behavioral health specialist.

Screen for Depression Specifically as Well as Other Psychiatric Comorbidities

Depression is the strongest risk factor for suicide among the adolescent psychiatric disorders.⁹⁷ Psychiatric disorders including depression are commonly comorbid in youth with chronic pain.⁹⁸ The interplay between depression and chronic pain is well developed.⁹⁹ In many of the reviewed studies, the increased risk of suicidality among youth with chronic pain became insignificant when depression was controlled.⁴

Though depression is very prevalent, only approximately a third of youth with depression or anxiety are detected by their pediatricians.¹⁰⁰ The use of screeners such as the two or nine-item Patient Health Questionnaire (PHQ-2 or PHQ-9) is validated for use amongst adolescents.¹⁰¹ When the PHQ-9 is employed, the ninth item screens for both passive and active suicidal ideation, although the use of this item may have limitations in patients with chronic medical illness,¹⁰² and direct questioning remains a superior method.¹⁰³

Youth with histories of trauma or of psychiatric disorders are more likely to have persisting or recurring pain, which is a risk factor for suicidal behaviors.³ Identifying psychiatric comorbidities and including a management plan for their address in the overall treatment planning is crucial for the reduction of suicide risk.

Assess for Non-Suicidal Self-Injury and Prior Suicide Attempts

A history of NSSI¹⁰⁴ and prior suicide attempts¹⁰⁵ are both strong risk factors for future suicide. The two phenomena are closely related.¹⁰⁴ Younger and female adolescents more commonly have prior episodes of NSSI and prior attempts.⁶⁰ Engaging in NSSI is the strongest predictor of conversion of suicidal thoughts to attempts among adolescents.¹⁰⁶ Engaging in self-harm increases with age and consists of self-cutting, head-banging, biting, scratching, hitting oneself, self-poisoning, and burning in declining order of prevalence.¹⁰⁷

Depressed patients with chronic pain and NSSI have a higher pain tolerance.¹⁰⁸ In alignment with the acquired capability for suicide model, this may facilitate their tolerance of pain associated with suicide attempts. This relates to the finding that adolescents with chronic pain and suicidal behavior have higher pain tolerance relative to healthy controls.⁵⁸

Adolescents are more likely to die as a consequence of their first suicide attempt relative to subsequent attempts.⁷⁰ However, adolescents who make an attempt and survive are a very increased risk of engaging in a future attempt. A prior suicide attempt is the greatest risk factor for a future attempt.¹⁰⁵ Therefore, clinicians should pay extra attention to youth with histories of prior suicide attempts.

Consider Pain Variables

While all youth with chronic pain are at an increased risk for suicidal ideation,⁴ youth with multiple pains,³⁹ more frequent pain,⁴³ and prolonged pain,⁴⁶ have heightened risk. Pain severity and intensity are not a risk factors for suicidal ideation according to the available evidence,⁴⁶ but these qualities raise the risk of suicidal behaviors^{50,52} and should be considered and assessed. Reduced quality of life is also associated with increased suicidality.⁴⁰ The data is mixed^{40,43,44,46} whether other factors such as reduced adaptive functioning specifically raises the risk of suicidal ideation, and further studies are needed.

Attend to Male Youth

Adolescents with chronic pain conditions are more commonly female. When a male adolescent with a chronic pain presents, pay particular attention to suicide risk, as the rate of completed suicide is much higher for male adolescents than female adolescents.^{62,64} Female youth are more likely to make suicide attempts, though male youth are more likely to die by suicide.^{62,64}

Female adolescents relative to male adolescents are more responsive to existing efforts at suicide prevention.¹⁰⁹ This is true across school-based, community-based, and healthcare-based suicide prevention. Male adolescents show a greater hesitancy to disclose and reduced active engagement in school-based programming, limiting their effectiveness. Female adolescents may benefit to a greater degree by virtue of their increased concern for peers and openness to communication and engagement in curricula. Female adolescents' greater willingness to seek help and greater use of community- and healthcare-based interventions contribute to the greater effectiveness of these interventions for female adolescents relative to males.¹⁰⁹

Masculine ideals and tendency to independence, autonomy, and stoicism may prevent male adolescents from making use of services.¹¹⁰ Attention to male youth and their suicide risk¹¹¹ may help to overcome these barriers.

Assess for Access to Means of Harm

In one study of a primary care setting, only 13% of adolescents who endorsed a suicidal risk item on screening were subsequently asked whether weapons were present in the home.¹¹² Asking the family about firearm possession and providing education on its removal or safekeeping is very effective.

As many youths will be prescribed analgesics and other medications for their chronic pain, assessing how these medications and others in the home are stored is important. Though suicide attempts by ingestion are less lethal than other means, they are more common. Use of a firearm is the most lethal method of suicide among children and adolescents,¹¹³ and firearm removal may particularly help young men who more often choose such a means of suicide.

Data shows that interventions to remove access to medication are effective, and more so than firearm removal interventions.¹¹⁴ Interventions to effect removal of means to access harm are not only effective but can both be received favorably by parents and produce high recall of information by parents.¹¹⁵

Assess Family Risk Factors

Factors such as heightened parental concern for the child and increased parental stress are enriched among children with abdominal pain.¹⁴

A negative parent-child relationship is a risk factor for early emergence of suicidal ideation among children and adolescents.¹¹⁶ This may be prevalent amongst stressed parents preoccupied with their children. When assessing a youth's safety, it is important to also assess family functioning and integrate assistive interventions into the care and safety planning. A responsible family capable of providing superior youth supervision, following-through with referrals, and sanitizing the home including removing means of harm such as unsupervised access to prescription and non-prescription medications and firearms may evoke less concern than a family unable to provide such functions for a youth.

Anxiety and depressive symptoms are more prevalent in parents of children with chronic pain.¹¹⁷ Parents' depressive and anxious symptomatology correlate with decreased pain-related functioning in youth with chronic pain.¹¹⁸ Parental worry about their adolescents' physical pain correlates with adolescent disability.¹¹⁹ Clinicians should assess for parents' functioning and reactions. Validated measures of negative parental responses to youth pain exist.¹²⁰ Parents may receive support and counseling to reduce negative reactions to their children's chronic pain, such as overprotection, and may be referred for psychosocial interventions to increase adaptive responses.¹²¹ For example, in one study, children's fear of pain and parental knowledge of pain were favorably affected by a neuroscience education intervention.¹²²

Construct a Safety Plan

Clinicians have positive attitudes about safety planning, but they may not believe in their efficacy to prevent suicide.¹²³ Only 7% of adolescents who endorsed a suicidal risk item on screening were subsequently asked whether

they had a safety plan.¹¹² In contrast to a no-suicide contract, an intervention lacking evidence where a patient simply agrees to not kill themselves,¹²⁴ a safety plan reminds patients of the tools available to help them through a suicidal crisis.

A commonly used safety plan consists of a list of personal warning signs, coping strategies, people to seek for comfort and distraction and those to ask for help, clinicians available for outreach, and means to keep the environment safe.¹²⁵ When a safety plan does not exist, clinicians can use safety planning to collaborate with youth and their families to codify and to secure an internal (warning signs and coping strategies) and external (individuals and home) environment conducive to safe passage to a referral. Discussing an assessment of the youths' risk openly and candidly with children, adolescents, and their families in the rationale for the construction of the plan helps to raise awareness and build trust and security in the treatment relationship.

Clinicians need to be trained in how to construct an efficacious safety plan. Studies such as one conducted from a pediatric emergency department setting suggest that clinicians have a desire for learning evidence-based interventions for adolescent safety planning, as well as that their attitudes towards and knowledge of safety planning increases with training.¹²⁶ These Institutions may advance practices for children and adolescents throughout hospital- and clinic-based settings through education and support amongst clinicians in safety planning.

Referral

In one study, the average time of chronic pain amongst children referred to a specialized pain clinic was 34 months.¹²⁷ As many as a quarter (25%) and more than one in ten (13%) of these children had missed diagnoses of anxiety or depression, respectively.¹²⁷ Referral to a pain clinic may shorten suffering and provide a means to assess psychiatric health and prevent suicide. The most common reason provided by parents for accessing mental health was a lack of information about where to seek help.¹²⁸ Forming relationships with available specialty providers and guiding families to referrals when indicated is important.

A key component of referral is using the information obtained by the assessment of suicidality risk on the acuity of the youth's presentation and need for level of care. Youth with active suicidal ideation and a history of NSSI or suicide attempts may be at the greatest risk. Incorporating the presence of psychiatric symptomatology, access to means of harm, family functioning, and an ability or lack of an ability to safety plan is important.

Referral to a local emergency department is indicated for youth with the highest risk, while a crisis visit in a short duration of time between referral and clinical encounter with an outpatient provider may be appropriate for youth with lower risk. Routine referral may provide the least inconvenience to families, though wait times can often be significant. In one Canadian study, less than one in ten (8.6%) of clinics providing mental health services reported an absence of waiting lists.¹²⁹ In another study, the average wait time for entry into a pain clinic was almost two-hundred (197.5) days.¹³⁰ Having relationships with psychiatric providers in the community and/or pain specialty clinics with mental health capabilities can reduce time to access of services. When a routine referral is made, the provider must be confident in their risk assessment given the length of time the child or adolescent may be in the community prior to specialty service initiation.

Tailoring the level of intervention to youth risk is crucial, and erring on the side of safety is a valuable mindset for the clinician in working with youth with chronic pain.

Conclusion

As with adult populations,² chronic pain raises the risk of suicide in children and adolescents.⁴ Familiarity with common tenets of suicide risk assessment and of practice in basic management and referral is crucial for the general provider. When referring youth with chronic pain to specialty care, confidence in risk assessment and comfort with the construction of a safety plan to secure planning while awaiting specialty support is paramount.

This review began with a survey of the background and prevalence of youth chronic pain. We noted in the literature the wide ranges in estimated prevalence by the type of pain (11 to 38%) and the impact of age, gender, and psychosocial factors on prevalence. Pain severity was noted to be of importance when considering prevalence rates, and the clinical significance of a youth's developmental history and psychiatric co-occurring disorders was described. The importance of

sleep on pain progression, and rates of the persistence of youth chronic pain into adulthood, were commented upon. In our next session, we reviewed the evidence associating youth chronic pain with suicidality through summary of a landmark 2019 systematic review by Hinze et al on the topic. The importance of depression, multiple pains, more frequent pain, recurrent pain, pain severity, pain duration, pain distress and sensitivity, and pain disability in suicide risk were surveyed. We proceeded to focus on age and gender as two key demographic variables affecting suicide risk: older adolescents are at increased risk, while male gender confers a lower risk of suicide attempts yet a higher risk of death by suicide. We turned to theory to introduce organizing models supplied by the interpersonal theory of suicide and the reward deficiency theory. We introduced the suicide risk assessment through practice summaries of assessing for suicidal ideation, performing a suicide risk-oriented mental status examination, screening for depression, assessing for NSSI and prior suicide attempts, considering pain variables, attending to male youth, assessing for access to means of harm, assessing family risk factors, constructing a safety plan, and referring at-risk youth to specialists.

The future of pain management and suicidality in children and adolescents will be advanced through future studies to explore specific risk factors within the field of heterogeneous pain disorders. This may be particularly important in light of the difference in lived experiences between a youth with recurrent hospitalizations for sickle-cell or cancer-related pain, for example, and those with anxiety-induced functional abdominal pain and other conditions commonly encountered in the community. While Hinze et al noted these differences in their systematic review,⁴ additional studies of the former group are needed to arrive at more clear clinical conclusions from the data. Another area meriting further study exists in studying the factors associated with the quality of pain among greater population samples. Understanding if the negative findings surrounding certain qualities of pain hold with increased sample sizes will be enlightening, for example, and whether select characteristics emerge as key markers of interest to clinicians.

As this area is further developed, specific treatment and intervention approaches tailored to the unique situation of the youth with chronic pain will be further developed, guiding the clinician in future assessment and management. Psychiatrists and other specialists in suicide risk assessment will benefit from understanding the impact of pain upon suicidality,¹³¹ including among child and adolescent populations. The area remains in need of further study, and it is hoped this review provides today's clinician with evidence-based material to advance their care of today's youth with chronic pain.

Acknowledgments

There are no acknowledgements to report.

Disclosure

The authors report no conflicts of interest in this work.

References

1. Santos J, Martins S, Azevedo LF, Fernandes L. Pain as a risk factor for suicidal behavior in older adults: a systematic review. *Arch Gerontol Geriatr.* 2020;87:104000. doi:10.1016/j.archger.2019.104000
2. Racine M. Chronic pain and suicide risk: a comprehensive review. *Prog Neuropsychopharmacol Biol Psychiatry.* 2018;87(Pt B):269–280. doi:10.1016/j.pnpbp.2017.08.020
3. Hinze V, Karl A, Ford T, Gjelsvik B. Pain and suicidality in children and adolescents: a longitudinal population-based study. *Eur Child Adolesc Psychiatry.* 2022. doi:10.1007/s00787-022-01963-2
4. Hinze V, Crane C, Ford T, Buivydaite R, Qiu L, Gjelsvik B. The relationship between pain and suicidal vulnerability in adolescence: a systematic review. *Lancet Child Adolesc Health.* 2019;3(12):899–916. doi:10.1016/S2352-4642(19)30267-6
5. Burton KA, Clarke RD, McClune TD, Tillotson MK. The natural history of low back pain in adolescents. *Spine.* 1996;21(20):2323–2328. doi:10.1097/00007632-199610150-00004
6. Centers for Disease Control and Prevention. *Web-Based Injury Statistics Query and Reporting System (WISQARS)*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer); 2022.
7. Baweja R, Arshad SH, Samsel C, Friedberg RD. Chronic pain and its impact on child mental health: management challenges and clinical guidance for child and adolescent psychiatrists. *J Am Acad Child Adolesc Psychiatry.* 2022. doi:10.1016/j.jaac.2022.04.008
8. Baweja R, Walco G. Chronic pain and its impact on pediatric mental health. *J Am Acad Child Adolesc Psychiatry.* 2020;59(10):S41. doi:10.1016/j.jaac.2020.07.173
9. Treede RD, Rief W, Barke A, et al. A classification of chronic pain for ICD-11. *Pain.* 2015;156(6):1003–1007. doi:10.1097/j.pain.000000000000160
10. Goodman JE, McGrath PJ. The epidemiology of pain in children and adolescents: a review. *Pain.* 1991;46(3):247–264. doi:10.1016/0304-3959(91)90108-A

11. King S, Chambers CT, Huguet A, et al. The epidemiology of chronic pain in children and adolescents revisited: a systematic review. *Pain*. 2011;152(12):2729–2738. doi:10.1016/j.pain.2011.07.016
12. von Baeyer CL. Interpreting the high prevalence of pediatric chronic pain revealed in community surveys. *Pain*. 2011;152(12):2683–2684. doi:10.1016/j.pain.2011.08.023
13. Tutelman PR, Langley CL, Chambers CT, et al. Epidemiology of chronic pain in children and adolescents: a protocol for a systematic review update. *BMJ Open*. 2021;11(2):e043675. doi:10.1136/bmjopen-2020-043675
14. Jones MP, Faresjö Å, Beath A, Faresjö T, Ludvigsson J. Abdominal pain in children develops with age and increases with psychosocial factors. *Clin Gastroenterol Hepatol*. 2020;18(2):360–367.e1. doi:10.1016/j.cgh.2019.04.036
15. Huguet A, Miró J. The severity of chronic pediatric pain: an epidemiological study. *J Pain*. 2008;9(3):226–236. doi:10.1016/j.jpain.2007.10.015
16. Liao ZW, Le C, Kynes JM, et al. Paediatric chronic pain prevalence in low- and middle-income countries: a systematic review and meta-analysis. *EclinicalMedicine*. 2022;45:101296. doi:10.1016/j.eclinm.2022.101296
17. Salberg S, Yamakawa GR, Griep Y, et al. Pain in the developing brain: early life factors alter nociception and neurobiological function in adolescent rats. *Cereb Cortex Commun*. 2021;2(2). doi:10.1093/texcom/tgab014
18. Lucas R, Brandão M, Gorito V, Talih M. Refining the prediction of multisite pain in 13-year-old boys and girls by using parent-reported pain experiences in the first decade of life. *Eur J Pain*. 2022;26(3):695–708. doi:10.1002/ejp.1898
19. Janssen J, Abou-Assaly E, Rasic N, Noel M, Miller JV. Trauma and pain sensitization in youth with chronic pain. *Pain Rep*. 2022;7(2):e992. doi:10.1097/PR9.0000000000000992
20. Elman I, Borsook D. The failing cascade: comorbid post traumatic stress- and opioid use disorders. *Neurosci Biobehav Rev*. 2019;103:374–383. doi:10.1016/j.neubiorev.2019.04.023
21. Nelson S, Borsook D, Bosquet Enlow M. Targeting the stress response in pediatric pain: current evidence for psychosocial intervention and avenues for future investigation. *Pain Rep*. 2021;6(3):e953. doi:10.1097/PR9.0000000000000953
22. Knook LME, Konijnenberg AY, van der Hoeven J, et al. Psychiatric disorders in children and adolescents presenting with unexplained chronic pain: what is the prevalence and clinical relevancy? *Eur Child Adolesc Psychiatry*. 2011;20(1):39–48. doi:10.1007/s00787-010-0146-0
23. Kolaitis G, van der Ende J, Zaravinos-Tsakos F, et al. The occurrence of internalizing problems and chronic pain symptoms in early childhood: what comes first? *Eur Child Adolesc Psychiatry*. 2021. doi:10.1007/s00787-021-01821-7
24. Palermo TM. Pain prevention and management must begin in childhood: the key role of psychological interventions. *Pain*. 2020;161 (Supplement 1):S114–S121. doi:10.1097/j.pain.0000000000001862
25. Koechlin H, Beeckman M, Meier AH, et al. Association of parental and adolescent emotion-related factors with adolescent chronic pain behaviors. *Pain*. 2022;163(7):e888–e898. doi:10.1097/j.pain.0000000000002508
26. Nabbijohn AN, Tomlinson RM, Lee S, Morrongiello BA, McMurtry CM. The measurement and conceptualization of coping responses in pediatric chronic pain populations: a scoping review. *Front Psychol*. 2021;12. doi:10.3389/fpsyg.2021.680277
27. Andreucci A, Groenewald CB, Rathleff MS, Palermo TM. The role of sleep in the transition from acute to chronic musculoskeletal pain in youth—a narrative review. *Children*. 2021;8(3):241. doi:10.3390/children8030241
28. Liu X, Liu ZZ, Yang Y, Jia CX. Associations of frequent pain symptoms with excessive daytime sleepiness in adolescents: a longitudinal study. *J Clin Sleep Med*. 2021;17(12):2415–2423. doi:10.5664/jcsm.9444
29. Haraldstad K, Stea TH. Associations between pain, self-efficacy, sleep duration, and symptoms of depression in adolescents: a cross-sectional survey. *BMC Public Health*. 2021;21(1):1617. doi:10.1186/s12889-021-11680-1
30. Hassett AL, Hilliard PE, Goesling J, Clauw DJ, Harte SE, Brummett CM. Reports of chronic pain in childhood and adolescence among patients at a tertiary care pain clinic. *J Pain*. 2013;14(11):1390–1397. doi:10.1016/j.jpain.2013.06.010
31. Larsson B, Sigurdson JF, Sund AM. Long-term follow-up of a community sample of adolescents with frequent headaches. *J Headache Pain*. 2018;19(1):79. doi:10.1186/s10194-018-0908-5
32. Walker LS, Dengler-Criss CM, Rippel S, Bruehl S. Functional abdominal pain in childhood and adolescence increases risk for chronic pain in adulthood. *Pain*. 2010;150(3):568–572. doi:10.1016/j.pain.2010.06.018
33. Groenewald CB, Law EF, Fisher E, Beals-Erickson SE, Palermo TM. Associations between adolescent chronic pain and prescription opioid misuse in adulthood. *J Pain*. 2019;20(1):28–37. doi:10.1016/j.jpain.2018.07.007
34. Mack KA, Jones CM, Ballesteros MF. Illicit drug use, illicit drug use disorders, and drug overdose deaths in metropolitan and nonmetropolitan areas — United States. *MMWR Surveill Summaries*. 2017;66(19):1–12. doi:10.15585/mmwr.ss6619a1
35. Richardson PA, Kundu A. Pain management in children during the COVID-19 pandemic. *Curr Anesthesiol Rep*. 2021;11(3):214–222. doi:10.1007/s40140-021-00475-0
36. Rau LM, Grothus S, Sommer A, et al. Chronic pain in schoolchildren and its association with psychological wellbeing before and during the COVID-19 pandemic. *J Adolesc Health*. 2021;69(5):721–728. doi:10.1016/j.jadohealth.2021.07.027
37. Strandheim A, Bjerkeset O, Gunnell D, Bjornelv S, Holmen TL, Bentzen N. Risk factors for suicidal thoughts in adolescence—A prospective cohort study: the young-HUNT study. *BMJ Open*. 2014;4(8):e005867–e005867. doi:10.1136/bmjopen-2014-005867
38. Alriksson-Schmidt A. Depressive symptomatology and suicide attempts in adolescents with mobility limitations. *Diss Abstr Int*. 2008;68(11–B):7688.
39. Halvorsen J, Dalgard F, Thoresen M, Bjertness E, Lien L. Itch and pain in adolescents are associated with suicidal ideation: a population-based cross-sectional study. *Acta Dermato Venereologica*. 2012;92(5):543–546. doi:10.2340/00015555-1251
40. Fuller-Thomson E, Hamelin GP, Granger SJR. Suicidal ideation in a population-based sample of adolescents: implications for family medicine practice. *ISRN Fam Med*. 2013;2013:1–11. doi:10.5402/2013/282378
41. van Tilburg MAL, Spence NJ, Whitehead WE, Bangdiwala S, Goldston DB. Chronic pain in adolescents is associated with suicidal thoughts and behaviors. *J Pain*. 2011;12(10):1032–1039. doi:10.1016/j.jpain.2011.03.004
42. Chan WSC, Law CK, Liu KY, Wong PWC, Law YW, Yip PSF. Suicidality in Chinese adolescents in Hong Kong: the role of family and cultural influences. *Soc Psychiatry Psychiatr Epidemiol*. 2009;44(4):278–284. doi:10.1007/s00127-008-0434-x
43. Wang SJ, Fuh JL, Juang KD, Lu SR. Migraine and suicidal ideation in adolescents aged 13 to 15 years. *Neurology*. 2009;72(13):1146–1152. doi:10.1212/01.wnl.0000345362.91734.b3

44. Bromberg MH, Law EF, Palermo TM. Suicidal ideation in adolescents with and without chronic pain. *Clin J Pain*. 2017;33(1):21–27. doi:10.1097/AJP.0000000000000366
45. Eliacik K, Kanik A, Bolat N, et al. Anxiety, depression, suicidal ideation, and stressful life events in non-cardiac adolescent chest pain: a comparative study about the hidden part of the iceberg. *Cardiol Young*. 2017;27(6):1098–1103. doi:10.1017/S1047951116002109
46. Lewcun B, Kennedy TM, Tress J, Miller KS, Sherker J, Sherry DD. Predicting suicidal ideation in adolescents with chronic amplified pain: the roles of depression and pain duration. *Psychol Serv*. 2018;15(3):309–315. doi:10.1037/ser0000210
47. Wang SJ, Juang KD, Fuh JL, Lu SR. Psychiatric comorbidity and suicide risk in adolescents with chronic daily headache. *Neurology*. 2007;68(18):1468–1473. doi:10.1212/01.wnl.0000260607.90634.d6
48. Junker A, Bjørngaard JH, Bjerkeset O. Adolescent health and subsequent risk of self-harm hospitalisation: a 15-year follow-up of the young-HUNT cohort. *Child Adolesc Psychiatry Ment Health*. 2017;11(1):25. doi:10.1186/s13034-017-0161-8
49. Bayramoglu A, Saritemur M, Tuna Akgol Gur S, Emet M. Demographic and clinical differences of aggressive and non-aggressive suicide attempts in the emergency department in the eastern region of Turkey. *Iran Red Crescent Med J*. 2015;17(2). doi:10.5812/iremj.24666
50. Hogstedt C, Forsell Y, Hemmingsson T, Lundberg I, Lundin A. Psychological symptoms in late adolescence and long-term risk of suicide and suicide attempt. *Suicide Life Threat Behav*. 2018;48(3):315–327. doi:10.1111/sltb.12362
51. Koenig J, Oelkers-Ax R, Parzer P, et al. The association of self-injurious behaviour and suicide attempts with recurrent idiopathic pain in adolescents: evidence from a population-based study. *Child Adolesc Psychiatry Ment Health*. 2015;9(1):32. doi:10.1186/s13034-015-0069-0
52. Liu X, Liu ZZ, Fan F, Jia CX. Menarche and menstrual problems are associated with non-suicidal self-injury in adolescent girls. *Arch Womens Ment Health*. 2018;21(6):649–656. doi:10.1007/s00737-018-0861-y
53. Tsai MH, Chen YH, Chen CD, Hsiao CY, Chien CH. Deliberate self-harm by Taiwanese adolescents. *Acta Paediatr*. 2011;100(11):e223–e226. doi:10.1111/j.1651-2227.2011.02357.x
54. Reigstad B, Jørgensen K, Wichstrøm L. Pain in adolescent psychiatric patients. *Child Adolesc Ment Health*. 2006;11(4):185–191. doi:10.1111/j.1475-3588.2006.00408.x
55. Ekholm O, Kurita GP, Hjsted J, Juel K, Sjgren P. Chronic pain, opioid prescriptions, and mortality in Denmark: a population-based cohort study. *Pain*. 2014;155(12):2486–2490. doi:10.1016/j.pain.2014.07.006
56. Mann JJ. A current perspective of suicide and attempted suicide. *Ann Intern Med*. 2002;136(4):302. doi:10.7326/0003-4819-136-4-200202190-00010
57. Kirtley OJ, O'Connor RC, O'Carroll RE. Hurting inside and out? Emotional and physical pain in self-harm ideation and enactment. *Int J Cogn Ther*. 2015;8(2):156–171. doi:10.1521/ijct.2015.8.2.156
58. Ren Y, You J, Zhang X, et al. Differentiating suicide attempters from suicide ideators: the role of capability for suicide. *Arch Suicide Res*. 2019;23(1):64–81. doi:10.1080/13811118.2018.1426507
59. Cha CB, Franz PJ, Guzmán M, Glenn CR, Kleiman EM, Nock MK. Annual research review: suicide among youth - epidemiology, (potential) etiology, and treatment. *J Child Psychol Psychiatry*. 2018;59(4):460–482. doi:10.1111/jcpp.12831
60. Lee S, Dwyer J, Paul E, Clarke D, Treleaven S, Roseby R. Differences by age and sex in adolescent suicide. *Aust N Z J Public Health*. 2019;43(3):248–253. doi:10.1111/1753-6405.12877
61. Beautrais AL. Gender issues in youth suicidal behaviour. *Emerg Med*. 2002;14(1):35–42. doi:10.1046/j.1442-2026.2002.00283.x
62. Roh BR, Jung EH, Hong HJ. A comparative study of suicide rates among 10–19-year-olds in 29 OECD countries. *Psychiatry Investig*. 2018;15(4):376–383. doi:10.30773/pi.2017.08.02
63. Lewinsohn PM, Rohde P, Seeley JR, Baldwin CL. Gender differences in suicide attempts from adolescence to young adulthood. *J Am Acad Child Adolesc Psychiatry*. 2001;40(4):427–434. doi:10.1097/00004583-200104000-00011
64. Miranda-Mendizabal A, Castellvi P, Parés-Badell O, et al. Gender differences in suicidal behavior in adolescents and young adults: systematic review and meta-analysis of longitudinal studies. *Int J Public Health*. 2019;64(2):265–283. doi:10.1007/s00038-018-1196-1
65. Tsigotis K, Gruszczynski W, Tsigotis-Woloszczak M. Gender differentiation in methods of suicide attempts. *Med Sci Monit*. 2011;17(8):PH65–PH70. doi:10.12659/MSM.881887
66. Ohberg A, Lonnqvist J, Sarna S, Vuori E. Violent methods associated with high suicide mortality among the young. *J Am Acad Child Adolesc Psychiatry*. 1996;35(2):144–153. doi:10.1097/00004583-199602000-00006
67. Hepp U, Stulz N, Unger-Köppel J, Ajdacic-Gross V. Methods of suicide used by children and adolescents. *Eur Child Adolesc Psychiatry*. 2012;21(2):67–73. doi:10.1007/s00787-011-0232-y
68. Freeman A, Mergl R, Kohls E, et al. A cross-national study on gender differences in suicide intent. *BMC Psychiatry*. 2017;17(1):234. doi:10.1186/s12888-017-1398-8
69. Canetto SS. Meanings of gender and suicidal behavior during adolescence. *Suicide Life Threat Behav*. 1997;27(4):339–351. doi:10.1111/j.1943-278X.1997.tb00513.x
70. Ruch DA, Sheftall AH, Schlagbaum P, Rausch J, Campo JV, Bridge JA. Trends in suicide among youth aged 10 to 19 years in the United States, 1975 to 2016. *JAMA Netw Open*. 2019;2(5):e193886. doi:10.1001/jamanetworkopen.2019.3886
71. van Orden KA, Witte TK, Cukrowicz KC, Braithwaite SR, Selby EA, Joiner TE. The interpersonal theory of suicide. *Psychol Rev*. 2010;117(2):575–600. doi:10.1037/a0018697
72. Joiner T. *Why People Die by Suicide*. Harvard University Press; 2005.
73. Chu C, Buchman-Schmitt JM, Stanley IH, et al. The interpersonal theory of suicide: a systematic review and meta-analysis of a decade of cross-national research. *Psychol Bull*. 2017;143(12):1313–1345. doi:10.1037/bul0000123
74. Wakefield EO, Puhl RM, Litt MD, Zempsky WT. “If it ever really hurts, I try not to let them know”: the use of concealment as a coping strategy among adolescents with chronic pain. *Front Psychol*. 2021;12. doi:10.3389/fpsyg.2021.666275
75. Pielech M, Lunde CE, Becker SJ, Vowles KE, Sieberg CB. Comorbid chronic pain and opioid misuse in youth: knowns, unknowns, and implications for behavioral treatment. *Am Psychol*. 2020;75(6):811–824. doi:10.1037/amp0000655
76. Aaron RV, Finan PH, Wegener ST, Keefe FJ, Lumley MA. Emotion regulation as a transdiagnostic factor underlying co-occurring chronic pain and problematic opioid use. *Am Psychol*. 2020;75(6):796–810. doi:10.1037/amp0000678
77. Elman I, Borsook D, Volkow ND. Pain and suicidality: insights from reward and addiction neuroscience. *Prog Neurobiol*. 2013;109:1–27. doi:10.1016/j.pneurobio.2013.06.003

78. Caley CF, Perriello E, Golden J. Antiepileptic drugs and suicide-related outcomes in bipolar disorder: a descriptive review of published data. *Ment Health Clin.* 2018;8(3):138–147. doi:10.9740/mhc.2018.05.138
79. Cwik MF, O'Keefe VM, Haroz EE. Suicide in the pediatric population: screening, risk assessment and treatment. *Int Rev Psychiatry.* 2020;32(3):254–264. doi:10.1080/09540261.2019.1693351
80. Pettit JW, Buitron V, Green KL. Assessment and management of suicide risk in children and adolescents; 2018. Available from: www.elsevier.com/locate/cabp. Accessed November 23, 2022.
81. Nock MK, Green JG, Hwang I, et al. Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents. *JAMA Psychiatry.* 2013;70(3):300. doi:10.1001/2013.jamapsychiatry.55
82. Isometsä ET, Heikkinen ME, Marttunen MJ, Henriksson MM, Aro HM, Lönnqvist JK. The last appointment before suicide: is suicide intent communicated? *Am J Psychiatry.* 1995;152(6):919–922. doi:10.1176/ajp.152.6.919
83. Gould MS, Marrocco FA, Kleinman M, et al. Evaluating iatrogenic risk of youth suicide screening programs. *JAMA.* 2005;293(13):1635. doi:10.1001/jama.293.13.1635
84. Portzky G, Audenaert K, van Heeringen K. Suicide among adolescents. A psychological autopsy study of psychiatric, psychosocial and personality-related risk factors. *Soc Psychiatry Psychiatr Epidemiol.* 2005;40(11):922–930. doi:10.1007/s00127-005-0977-x
85. Cox A, Holbrook D, Rutter M. Psychiatric interviewing techniques VI. Experimental study: eliciting feelings. *Br J Psychiatry.* 1981;139(2):144–152. doi:10.1192/bjp.139.2.144
86. Wissow LS, Roter DL, Wilson MEH. Pediatrician interview style and mothers' disclosure of psychosocial issues. *Pediatrics.* 1994;93(2):289–295. doi:10.1542/peds.93.2.289
87. Jones JD, Boyd RC, Calkins ME, et al. Parent-adolescent agreement about adolescents' suicidal thoughts. *Pediatrics.* 2019;143(2). doi:10.1542/peds.2018-1771
88. Klaus NM, Mobilio A, King CA. Parent-adolescent agreement concerning adolescents' suicidal thoughts and behaviors. *J Clin Child Adolesc Psychol.* 2009;38(2):245–255. doi:10.1080/15374410802698412
89. Halpern-Felsher BL, Ozer EM, Millstein SG, et al. Preventive services in a health maintenance organization: how well do pediatricians screen and educate adolescent patients? *Arch Pediatr Adolesc Med.* 2000;154(2):173–179. doi:10.1001/archpedi.154.2.173
90. Klein JD, Allan MJ, Elster AB, et al. Improving adolescent preventive care in community health centers. *Pediatrics.* 2001;107(2):318–327. doi:10.1542/peds.107.2.318
91. Goodman J, Sours J. *The Child Mental Status Examination*. Expanded ed. Rowman & Littlefield; 2006.
92. Carroll R, Thomas KH, Bramley K, et al. Self-cutting and risk of subsequent suicide. *J Affect Disord.* 2016;192:8–10. doi:10.1016/j.jad.2015.12.007
93. McHugh CM, Chun Lee RS, Hermens DF, Corderoy A, Large M, Hickie IB. Impulsivity in the self-harm and suicidal behavior of young people: a systematic review and meta-analysis. *J Psychiatr Res.* 2019;116:51–60. doi:10.1016/j.jpsychires.2019.05.012
94. Ohring R, Apter A, Ratzoni G, Weizman R, Tyano S, Plutchik R. State and trait anxiety in adolescent suicide attempters. *J Am Acad Child Adolesc Psychiatry.* 1996;35(2):154–157. doi:10.1097/00004583-199602000-00007
95. Chang HJ, Lin MF, Lin KC. The mediating and moderating roles of the cognitive triad on adolescent suicidal ideation. *Nurs Res.* 2007;56(4):252–259. doi:10.1097/01.NNR.0000280611.00997.0e
96. Claar RL, Baber KF, Simons LE, Logan DE, Walker LS. Pain coping profiles in adolescents with chronic pain. *Pain.* 2008;140(2):368–375. doi:10.1016/j.pain.2008.09.007
97. Andrews JA, Lewinsohn PM. Suicidal attempts among older adolescents: prevalence and co-occurrence with psychiatric disorders. *J Am Acad Child Adolesc Psychiatry.* 1992;31(4):655–662. doi:10.1097/00004583-199207000-00012
98. Tegethoff M, Belardi A, Stalujanis E, Meinschmidt G. Comorbidity of mental disorders and chronic pain: chronology of onset in adolescents of a national representative cohort. *J Pain.* 2015;16(10):1054–1064. doi:10.1016/j.jpain.2015.06.009
99. Lee PH, Yeh YC, Hsiao RC, Yen CF, Hu HF. Pain-related quality of life related to mental health and sociodemographic indicators in adolescents. *Arch Clin Psychiatry.* 2017;44(3):67–72. doi:10.1590/0101-60830000000122
100. Richardson LP, Russo JE, Lozano P, McCauley E, Katon W. Factors associated with detection and receipt of treatment for youth with depression and anxiety disorders. *Acad Pediatr.* 2009;10(1):36–40. doi:10.1016/j.acap.2009.09.011
101. Allgaier AK, Pietsch K, Frühe B, Sigl-Glöckner J, Schulte-Körne G. Screening for depression in adolescents: validity of the patient health questionnaire in pediatric care. *Depress Anxiety.* 2012;29(10):906–913. doi:10.1002/da.21971
102. Walker J, Hansen CH, Hodges L, et al. Screening for suicidality in cancer patients using Item 9 of the nine-item patient health questionnaire; does the item score predict who requires further assessment? *Gen Hosp Psychiatry.* 2009;32(2):218–220. doi:10.1016/j.genhosppsy.2009.11.011
103. Horowitz LM, Bridge JA, Pao M, Boudreaux ED. Screening youth for suicide risk in medical settings: time to ask questions. *Am J Prev Med.* 2014;47(3 Suppl 2):S170–5. doi:10.1016/j.amepre.2014.06.002
104. Grandclerc S, de Labrouhe D, Spodenkiewicz M, Lachal J, Moro MR. Relations between nonsuicidal self-injury and suicidal behavior in adolescence: a systematic review. *PLoS One.* 2016;11(4):e0153760. doi:10.1371/journal.pone.0153760
105. Burstein B, Agostino H, Greenfield B. Suicidal attempts and ideation among children and adolescents in US emergency departments, 2007–2015. *JAMA Pediatr.* 2019;173(6):598–600. doi:10.1001/jamapediatrics.2019.0464
106. Mars B, Heron J, Klonsky ED, et al. Predictors of future suicide attempt among adolescents with suicidal thoughts or non-suicidal self-harm: a population-based birth cohort study. *Lancet Psychiatry.* 2019;6(4):327–337. doi:10.1016/S2215-0366(19)30030-6
107. Gillies D, Christou MA, Dixon AC, et al. Prevalence and characteristics of self-harm in adolescents: meta-analyses of community-based studies 1990–2015. *J Am Acad Child Adolesc Psychiatry.* 2018;57(10):733–741. doi:10.1016/j.jaac.2018.06.018
108. Kim DJ, Job A, Gokarakonda S, et al. Synergistic effect of chronic pain and nonsuicidal self-harm on pain sensitivity. *Eur Arch Psychiatry Clin Neurosci.* 2022;272(3):371–380. doi:10.1007/s00406-021-01283-7
109. Hamilton E, Klimes-Dougan B. Klimes-Dougan differences in suicide prevention responses: implications for adolescents based on an illustrative review of the literature. *Int J Environ Res Public Health.* 2015;12(3):2359–2372. doi:10.3390/ijerph120302359
110. Eckert TL, Miller DN, Riley-Tillman TC, DuPaul GJ. Adolescent suicide prevention: gender differences in students' perceptions of the acceptability and intrusiveness of school-based screening programs. *J Sch Psychol.* 2006;44(4):271–285. doi:10.1016/j.jsp.2006.05.001

111. Conroy A, Dickinson T. Male adolescent suicidality: a literature review. *Ment Health Pract.* 2018;21(8):50–55. doi:10.7748/mhp.2018.e1293
112. Aalsma M, Keys J, Ferrin S, et al. Adolescent suicide assessment and management in primary care. *BMC Pediatr.* 2022;22(1):389. doi:10.1186/s12887-022-03454-4
113. Kølves K, de Leo D. Suicide methods in children and adolescents. *Eur Child Adolesc Psychiatry.* 2017;26(2):155–164. doi:10.1007/s00787-016-0865-y
114. Miller M, Salhi C, Barber C, et al. Changes in firearm and medication storage practices in homes of youths at risk for suicide: results of the SAFETY study, a clustered, emergency department-based, multisite, stepped-wedge trial. *Ann Emerg Med.* 2020;76(2):194–205. doi:10.1016/j.annemergmed.2020.02.007
115. Runyan CW, Becker A, Brandspigel S, Barber C, Trudeau A, Novins D. Lethal means counseling for parents of youth seeking emergency care for suicidality. *West J Emerg Med.* 2016;17(1):8–14. doi:10.5811/westjem.2015.11.28590
116. Oppenheimer CW, Stone LB, Hankin BL. The influence of family factors on time to suicidal ideation onsets during the adolescent developmental period. *J Psychiatr Res.* 2018;104:72–77. doi:10.1016/j.jpsychires.2018.06.016
117. Campo JV, Bridge J, Lucas A, et al. Physical and emotional health of mothers of youth with functional abdominal pain. *Arch Pediatr Adolesc Med.* 2007;161(2):131. doi:10.1001/archpedi.161.2.131
118. Donnelly TJ, Palermo TM, Newton-John TRO. Parent cognitive, behavioural, and affective factors and their relation to child pain and functioning in pediatric chronic pain: a systematic review and meta-analysis. *Pain.* 2020;161(7):1401–1419. doi:10.1097/j.pain.0000000000001833
119. Guite JW, Logan DE, McCue R, Sherry DD, Rose JB. Parental beliefs and worries regarding adolescent chronic pain. *Clin J Pain.* 2009;25(3):223–232. doi:10.1097/AJP.0b013e31818a7467
120. Beveridge JK, Pavlova M, Katz J, Noel M. The parent version of the sensitivity to pain traumatization scale (SPTS-P): a preliminary validation. *Children.* 2021;8(7):537. doi:10.3390/children8070537
121. Palermo TM, Law EF, Essner B, Jessen-Fiddick T, Eccleston C. Adaptation of problem-solving skills training (PSST) for parent caregivers of youth with chronic pain. *Clin Pract Pediatr Psychol.* 2014;2(3):212–223. doi:10.1037/cpp0000067
122. Bacardit Pintó P, Ickmans K, Rheel E, et al. Do parental pain knowledge, catastrophizing, and hypervigilance improve following pain neuroscience education in healthy children? *Children.* 2021;8(5):420. doi:10.3390/children8050420
123. Reyes-Portillo JA, McGlinchey EL, Toso-Salman J, Chin EM, Fisher PW, Mufson L. Clinician experience and attitudes toward safety planning with adolescents at risk for suicide. *Arch Suicide Res.* 2019;23(2):222–233. doi:10.1080/13811118.2018.1456382
124. Rudd MD, Mandrusiak M, Joiner TE. The case against no-suicide contracts: the commitment to treatment statement as a practice alternative. *J Clin Psychol.* 2006;62(2):243–251. doi:10.1002/jclp.20227
125. Stanley B, Brown GK. Safety planning intervention: a brief intervention to mitigate suicide risk. *Cogn Behav Pract.* 2012;19(2):256–264. doi:10.1016/j.cbpra.2011.01.001
126. Bettis AH, Donise KR, MacPherson HA, Bagatelas P, Wolff JC. Safety planning intervention for adolescents: provider attitudes and response to training in the emergency services setting. *Psychiatr Services.* 2020;71(11):1136–1142. doi:10.1176/appi.ps.201900563
127. Cucchiaro G, Schwartz J, Hutchason A, Ormelas B. Chronic pain in children: a look at the referral process to a pediatric pain clinic. *Int J Pediatr.* 2017;2017:1–7. doi:10.1155/2017/8769402
128. Hansen AS, Telléus GK, Mohr-Jensen C, Lauritsen MB. Parent-perceived barriers to accessing services for their child's mental health problems. *Child Adolesc Psychiatry Ment Health.* 2021;15(1):4. doi:10.1186/s13034-021-00357-7
129. Kowalewski K, McLennan JD, McGrath PJ. A preliminary investigation of wait times for child and adolescent mental health services in Canada. *J Can Acad Child Adolesc Psychiatry.* 2011;20(2):112–119.
130. Palermo TM, Slack M, Zhou C, Aaron R, Fisher E, Rodriguez S. Waiting for a pediatric chronic pain clinic evaluation: a prospective study characterizing waiting times and symptom trajectories. *J Pain.* 2019;20(3):339–347. doi:10.1016/j.jpain.2018.09.009
131. Elman I, Zubieta JK, Borsook D. The missing P in psychiatric training. *Arch Gen Psychiatry.* 2011;68(1):12. doi:10.1001/archgenpsychiatry.2010.174

Psychology Research and Behavior Management

Dovepress

Publish your work in this journal

Psychology Research and Behavior Management is an international, peer-reviewed, open access journal focusing on the science of psychology and its application in behavior management to develop improved outcomes in the clinical, educational, sports and business arenas. Specific topics covered in the journal include: Neuroscience, memory and decision making; Behavior modification and management; Clinical applications; Business and sports performance management; Social and developmental studies; Animal studies. The manuscript management system is completely online and includes a very quick and fair peer-review system, which is all easy to use. Visit <http://www.dovepress.com/testimonials.php> to read real quotes from published authors.

Submit your manuscript here: <https://www.dovepress.com/psychology-research-and-behavior-management-journal>