Risk Assessment and Decision Making Regarding Imminent Suicidality in Pediatric Settings

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Risk assessment for suicidality and related clinical decision making raises a number of ethical, clinical, and professional challenges for pediatric psychologists across the many clinical settings and professional roles in which these risk assessments may be conducted. Prior work has focused on ethical issues related to imminent risk concerns and the development of risk assessment protocols for use in clinical work or research. However, little work has attended to the real-world clinical scenarios in which risk assessment occurs, specifically within pediatric settings, and the unique clinical decision-making dilemmas faced by pediatric psychologists in these risk assessment scenarios. After a review of the ethical, clinical, and professional challenges often faced by pediatric psychologists in evaluating and addressing imminent risk among youth, a series of case vignettes is presented to illustrate these challenges and the clinical decision-making skills utilized to resolve such challenges.

Keywords: suicide, risk assessment, imminent risk, ethics

Pediatric psychologists often are called to wear a number of different professional "hats"—clinician, researcher, and consultant/liaison, among others. Indeed, it is the uniquely fast-paced environments in which pediatric psychologists work and a variety of professional roles in which they engage that draw many individuals to the field, yet this style of work presents a number of unique clinical challenges as well (e.g., Drotar, 2013). One area in which these challenges are particularly striking is the area of suicide risk assessment—an area where the stakes are high and decision making may vary significantly dependent upon which "hat" a pediatric psychologist is wearing at a given moment of practice. The purpose of this article is to review clinical decision making with regard to suicide risk assessments from the perspective of the varied roles characteristic of pediatric psychologists, including clinical, re-

search, and consulting roles with a variety of levels of prior or future involvement with the youth being assessed. Consistent with the myriad ethical, clinical, and practical challenges often faced in real-world settings, a variety of case vignettes will be presented, along with recommendations for practice and future research in the field.

Suicide remains the second leading cause of death among young people ages 10 to 24 years old, and nonfatal suicide attempts may occur at a rate 25 times greater than the rate of completed attempts (e.g., CDC, 2013; Prinstein, 2008). Given the frequency with which youth present to primary care and hospital settings with suicidal ideation or recent attempts (Bryan & Rudd, 2011; Ting, Sullivan, Boudreaux, Miller, & Camargo, 2012), pediatric psychologists often face clinical situations characterized by challenging risk-based decision making. For pediatric psychologists working with youth via hospital-based research protocols, outpatient consultation clinics, or acute inpatient admissions, suicide risk assessment may occur in settings characterized by limited prior relationships or intent for future clinical interactions. Conversely, for on-call pediatric psychologists, risk assessment may occur with youth who already are known via prior working relationships (e.g., through ongoing consultation and liaison

roles). These prior roles may obfuscate the current working relationship or boundaries of a given "on-call" interaction. In sum, it is clear that the varied roles of pediatric psychologists may contribute to unique challenges in risk assessment scenarios that vary greatly from those faced by clinicians in other settings or with more singularly defined client-provider roles (e.g., individual psychotherapy).

A number of useful clinical resources exist for psychologists engaged in suicide risk-assessments. For example, several professional organizations provide Web sites, hotlines, and other resources for clinicians and families (e.g., American Association of Suicidology, American Foundation for Suicide Prevention, International Association for Suicide Prevention, Suicide Prevention Resource Center). Additionally, a large body of work has examined ethical and legal considerations with regard to suicidality, including informed consent, confidentiality, and training issues (e.g., Amchin, Wettstein, & Roth, 1990; Bongar & Sullivan, 2013; Coverdale, Roberts, & Louie, 2007; Lothen-Kline, Howard, Hamburger, Worrell, & Boekeloo, 2003; Wilson & Christensen, 2012). Specific tools have been validated for measuring phenomena related to suicide (see Goldston, 2003, for a review), such as suicidal ideation (Beck Scale for Suicidal Ideation; Beck & Steer, 1991), hopelessness (Hopelessness Scale for Children; Kazdin, Rodgers, & Colbus, 1986), and protective factors (Reasons for Living Inventory for Adolescents; Osman et al., 1998). A variety of suicide risk assessment protocols and practice guidelines also have been developed (American Academy of Child & Adolescent Psychiatry, 2001; American Psychiatric Association, 2003; Gutierrez, 2006; Jacobs, Brewer, & Klein-Benheim, 1999; Linehan, Comtois, & Ward-Ciesielski, 2012), including specialized recommendations and protocols for unique populations (e.g., juvenile offenders; Roberts & Bender, 2006; youth in residential settings; de C. Braga, 1989; youth with intellectual disabilities; Ludi et al., 2012). However, little work has addressed the role of pediatric psychologists in performing risk assessments or unique implications of the pediatric setting or populations for such work. Therefore, the purpose of this article is to highlight the challenges often faced in real-world pediatric settings, where tensions between ethical, clinical, and professional concerns can lead to challenges in decision making.

Ethical Challenges

Ethically, psychologists are called to the aspirational goals of beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity (American Psychological Association, 2002). There are few professional roles in which psychologists engage where the challenge to help clients, honor their rights to privacy and self-determination, and avoid doing harm may be more at the forefront than in the area of suicide risk assessment. Specific ethical standards also relate directly to performing risk assessments, including standards on boundaries of competence, human relations, privacy and confidentiality, and record-keeping (APA, 2002). Yet, as is often the case in the practice of psychology, the application of these types of standards can be challenging in real-world risk assessment situations, where ambiguity, contextual complexity, and other clinical or institutional barriers may exist. For example, given the varied and multiple roles characteristic of pediatric psychologists, understanding the ethical implications of avoiding harmful multiple relationships may be important when managing suicide risk in multiple professional domains. Pediatric psychologists may perform risk assessments in research contexts where they also see clients for individual therapy or engage in inpatient or outpatient consultation, and considering the potential impact of these or other multiple relationships is critical in advance of engaging in clinical or research-based interactions. Similarly, obtaining and documenting informed consent (including discussion of limits of confidentiality) is imperative *prior* to engaging in suicide risk assessments or other therapeutic interactions, and significant ethical challenges can arise when risk issues emerge if these discussions have been overlooked. Whereas Institutional Review Boards may require that research studies have detailed, written informed consent and risk assessment protocols, these forms of documentation may be less common (yet no less important) in other clinical or consultative settings.

Ethical considerations regarding boundaries of competence also are critical with regard to

risk assessment. Particularly within medical settings, trainees and professionals often work side-by-side on multidisciplinary teams, offering rich opportunities for gaining competence in areas such as risk assessment, while also raising unique challenges for both supervisees and supervisors who must not only navigate the complexities of psychosocial service provision, but also integrate effectively within consultative roles with nonpsychosocially trained professionals as well (e.g., Duff & Bryon, 2005; Spirito et al., 2003). Mindfulness of the roles of graduate students, interns, postdoctoral fellows, licensed supervisors, and other multidisciplinary team members in clinical risk assessment is critical. Particularly when working with youth, the unique challenges of determining whether and how to break confidentiality if imminent risk is suspected necessitate advanced clinical decision making and should be made at least in close consultation with, if not under the direct supervision of licensed providers. Furthermore, supervisors must gain and maintain core competencies in risk assessment (Rudd, Cukrowicz, & Bryan, 2008) if they are to provide appropriate supervision and training of mentees—an area of noted weakness in the current mental health training and licensing realms (Schmitz et al., 2012).

In assessing risk, psychologists most often are asked to determine whether "imminent" risk exists, with the ethical duty to report instances when this type of risk is present and to take action to protect an individual until such "imminence" has passed. Unfortunately, very limited data exist on what constitutes "imminent" signs of risk for suicide, nor what exact timeframe would constitute an "imminent" period (e.g., Rudd et al., 2006). Certainly most individuals would agree that someone with a specific plan and intent to commit suicide within the next few minutes, hours, or days would likely be at "imminent" risk; yet, what if that individual reports thoughts of suicide without a plan, or a plan without intent? What if individuals are at risk for suicide within the next year, months, or weeks? These and other questions represent only the beginning of the complexity faced by psychologists in performing risk assessments. Furthermore, psychologists' roles in suicide risk assessments and rights to sign involuntary commitment papers may vary across state lines based on local laws or regulations.

The APA Ethics Code only stipulates that psychologists disclose confidential information when mandated or permitted by law to protect individuals from harm (APA, 2002). Thus, whereas legal regulations may dictate a "black-or-white" approach to disclosing risk once a certain threshold of danger has been determined, often psychologists may experience the challenge of mapping a "shades of gray" phenomenon (i.e., the continuum of potential suicide risk and variables that may exacerbate or attenuate that risk) onto a dichotomized choice: breaking confidentiality to disclose potential risk to a parent or caregiver versus nondisclosure.

Given the obvious potential risks associated with *not* breaking confidentiality when any *hint* of suicide risk emerges in a clinical interaction, an overcautious approach of *always* choosing to err on the side of disclosure might superficially seem to represent the best interest of the youth being assessed. However, it is important to remember that the act of breaking confidentiality may itself carry risks for harm, and it is an ethical duty of psychologists to avoid that harm, when *possible* (i.e., avoiding disclosure may *not* be possible when significant risks are present, but might be considered when milder, nonimminent risks exist). For example, a violation of confidence in instances when a child or adolescent discloses some risk factors for suicide but is not actually in imminent danger may lead to decreased faith in the mental health field or reluctance by the youth to share personal information in the future, perhaps even on future occasions when a true imminent risk is present. In families with high levels of conflict or low levels of support, a disclosure by a psychologist may actually lead to punitive or nonsupportive responses from parents, which may exacerbate negative family dynamics or related stressors for youth. Of note, even within the general population, a significant number of adolescents may think about suicide at some point in a given year (15.8% annual prevalence) or form a suicide plan (12.8% annual prevalence; CDC YRBSS, 2013). Far more individuals will think about suicide in their lifetime, particularly among samples of youth with mental and/or physical health concerns (as high as 64% prevalence; Barnes, Eisenberg, & Resnick, 2010). Yet few of these individuals will actually go on to attempt suicide (7.8% annual prevalence),

and fewer still will attempt with such serious methods that they require medical attention (2.4% annual prevalence; CDC YRBSS, 2013) or die by suicide (.002%; CDC, 2013). Although it is the ethical duty of psychologists to report *all* cases of "imminent" risk, other nonimminent risks are not necessarily subject to this duty to report, and discerning the difference between these varied clinical presentations is a challenging but essential task.

Clinical Challenges

Clinical determination of imminent risk requires a thorough assessment of risk factors, which may vary from distal (e.g., broad history of affective/social functioning) to proximal factors (e.g., details regarding a specific recent stressful event). Table 1 provides an overview of the types of information that should be considered when determining imminent risk for

Table 1
Key Questions for Risk Assessment Probing and Follow-Up Decision Making[1]

What is the youth's affective/ social/physical background and history?	■ Affect stable versus changing (particularly sudden change, positive or negative) ■ History of low-level suicidality ongoing for years versus acute suicidality emergent ■ Specific stressful precipitants versus chronic stressors at home/school ■ Social support versus isolation (peers and adults) ■ Physical health concerns, unmanaged pain, recent change in health functioning or diagnosis ■ Sleep difficulty ■ Substance use/abuse ■ Family history
What is the nature of the suicidal ideation?	■ Active versus passive ■ Frequency, recency, intensity ■ Stated intent to act on the ideation versus stated barriers to enacting a plan
What is the nature (if any) of suicide plans?	■ General thoughts about types of methods versus forming a specific plan ■ How realistic is the plan? ■ Is there access to the means required to execute the plan ■ Is there easy access to other means that might be used as an alternative to the plan in a crisis
What prior behaviors have occurred?	■ Prior nonsuicidal self-injury ■ Prior suicide attempts: threatened, aborted (by self), interrupted (by others), executed ■ Among prior attempts: lethality of methods, requirement of medical attention ■ Preparations made: Writing a suicide note, giving away possessions, gathering materials/means, saying goodbyes
Who else is aware?	■ Parents/guardians ■ Outpatient therapist, psychiatrist ■ Other key professionals (social workers, physicians, other multidisciplinary team members) ■ How do you know they are aware (based on whose report)?
What (specifically) do others know?	■ General awareness of ongoing distress versus specific knowledge of suicidality ■ Level of parental monitoring ■ Knowledge of most recent instance of ideation, plan, attempt, etc. ■ Date of last session with outpatient mental health providers/Date of next session?
Current safety?	■ Subjectively, how safe does the youth say he/she is feeling today? ■ What safety plans are in place? Who is managing/overseeing the safety plan? ■ What risks still exist (monitoring, restriction of access to means/implements, etc.)? ■ What, if any, protective factors exist? How are they being leveraged? ■ In an emergency, what would happen? (clinician on-call, suicide hotlines, inpatient admission)?

[1] The following references informed the development of Table 1: APA, 2003; de C. Braga, 1989; Fowler, 2012; Gutierrez, 2006; Jacobs et al., 1999; Linehan et al., 2012; Ludi et al., 2012; Roberts & Bender, 2006; Rudd et al., 2008; Tang & Crane, 2006.

suicide, based on a review of risk and protective factors identified in the extant literature and previously published risk assessment tools (e.g., APA, 2003; de C. Braga, 1989; Fowler, 2012; Gutierrez, 2006; Jacobs et al., 1999; Linehan et al., 2012; Ludi et al., 2012; Roberts & Bender, 2006; Rudd et al., 2008; Tang & Crane, 2006). Depending on the nature of the professional interaction, some pieces of data already may be known from prior interactions with the youth or via supplemental research measures or medical records. Unfortunately, some questions may not be answerable prior to being called to make a clinical decision in a particular case, such as when risk information is gathered in large-scale studies or youth are only available remotely. It is critical for the psychologist performing a risk assessment to evaluate how each piece of information is known or interpreted (e.g., by whose report, to whom was that disclosure made, under what circumstance was the information shared, what affective or behavioral cues impact the interpretation of the data) prior to determining imminent risk or pursuing a breach of confidentiality. For example, a psychologist often might lend more weight to recently disclosed information over historical data; however, other contextual variables may call into question the validity of one or both sources of data, irrespective of their recency. Additional probing or follow-up may be important for information disclosed within a large-scale research survey or on measures with unknown validity, whereas clinical and interpersonal data may contribute to decision making during in-person interactions. By contrast, the perceived anonymity of one form of responding or fear of consequences for in-person disclosures may color a psychologist's interpretation of either form of data as well. Furthermore, developing a shared understanding of the specific meaning and interpretation of various terms (e.g., active vs. passive ideation, suicidal "intent") by both the psychologist and the client is essential and often challenging, given the variability in suicidal nomenclature (e.g., Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007). Similarly, understanding the function of certain behaviors, such as nonsuicidal self-injury, can be important in evaluating risk for future suicidal behaviors (e. g., Guan, Fox, & Prinstein, 2012; Nock, Prinstein, & Sterba, 2010; Whitlock et al., 2013). In sum, whereas answers to the questions within

Table 1 may contribute to the determination of imminent risk, ultimately, psychologists face the challenging clinical task of having to integrate various types of data, often from various sources and with potential discrepancies that are not readily or obviously reduced into a single, cohesive narrative for imminent risk determination.

The notion of "imminent" risk often suggests a dichotomy of sorts: instances when ethical requirements dictate that confidentiality must be broken versus all other levels of "nonimminent" risk. In practice, more often what emerges throughout the process of conducting risk assessments is a more nuanced continuum of risk. Table 2 illustrates one example of a clinically informed heuristic on "levels" of risk; applicable university, hospital, and/or IRB protocols may also be relevant when making these determinations. At the lowest levels of risk (Levels 1 and 2), some history of risk factors may be present, yet there is no clear current or recent enough risk to be consistent with most definitions of "imminent" risk. Although clinicians may feel pulled personally or professionally to help or intervene with youth at these lower levels of risk, there is typically no ethical obligation to break confidentiality, unless other agreements explicitly have been made with youth or families in earlier consenting procedures. By contrast, at the highest levels of risk (Levels 4–6), "imminent" risk likely has been established, and despite personal reservations based on specific circumstances, in virtually any of these situations, psychologists ethically would be required to break youths' confidentiality to alert caregivers and explore treatment options, if required for stabilization. Whereas executing these disclosures to families can be quite difficult, the decision-making paradoxically can feel easier, because such high levels of risk almost always negate all options other than disclosure of risk.

Indeed, often the most challenging points of clinical decision making occur in the midrange of this continuum (Level 3), where significant risk exists, yet the definition of "imminent" risk is uncertain. Particularly in consultative or research roles, with limited prior knowledge of or opportunity for ongoing involvement with a family, at this point on the continuum, psychologists may be faced with evaluating a cost/benefit picture—weighing what new informa-

Table 2
Response Options to Consider, When Some Level of Risk Is Determined

Nature of concern	Possible response options
Level 1	
■ Generally elevated levels of depression or affective/social risk factors	■ Provide resources/community referrals
■ Possible history of passive ideation, not recent or severe	■ Discuss importance of open communication between teens and parents
	■ Share information only with adolescent's permission
Level 2	
■ Possible history of passive ideation in context of emotion dysregulation or other general risks for self-harm; no specific imminent risk	■ Provide resources/community referrals
■ May have history of active ideation but not recent or current	■ Increased focus on psychoeducation with parents (e.g., discuss impulsivity, emotion regulation, general risks for self-harm in adolescents overall)
	■ Share information only with adolescent's permission or share only very general concerns about psychosocial functioning, possibly partially already known to parents with some reframing based on current context
Level 3	
■ Recent active ideation but not current	■ Evaluate possible methods for increasing parental awareness without violating youth's confidence if possible
■ Some safety measures are in place	■ Consider "gray zone" disclosures, such as alerting parents to concerns about risks without sharing specific details of recent events or describing patterns of risk in "typical" adolescents that may be similar to their own child
■ Parents may have general knowledge about risk history, but lack specific knowledge of every recent event	■ Unless contraindicated for clinical or safety reasons, be sure youth is either present for the disclosure or aware of exactly what will be shared with the parent, to avoid damage to rapport via these "gray zone" conversations
Level 4	
■ Very recent or current ideation, particularly with plans/means available	■ Break confidentiality, regardless of youth preferences
■ Recent attempt unknown to parents/therapist	■ Consider safety plans, particularly addressing youth's access to means associated with any specific suicide plans (e.g., removing firearms, restricting access to medications)
■ Recent aborted attempt with ongoing access to means (e.g., medication stockpile)	■ Consider need for additional services, including possible inpatient admission or crisis stabilization
	■ Defer to/communicate with primary therapist if youth is in ongoing treatment
Level 5	
■ Imminent risk and parent minimizes/denies concern when confidentiality is broken	■ Extended conversation following disclosure to parent, with increased emphasis on level of concern for safety and need for specific safety plans/involvement of outside resources prior to allowing youth to leave your setting
Level 6	
■ Imminent risk and parent explicitly refuses to appropriately manage the youth's needs	■ Contact Child Protective Services if concerns about neglect
	■ Call 911 if youth is in immediate danger at home/other location
	■ Pursue possible involuntary commitment if threat to self/others

tion may have been gained via one's circumscribed role versus what already may be known more generally to the family or outpatient mental health providers. If confidentiality is to be broken in these cases, psychologists should take care to ensure that the disclosure of information against a youth's will is not potentially more damaging to his or her treatment and future relationships with psychologists, relative to the incremental safety to be gained via the

specific disclosure. In these cases, somewhat of a "gray zone" approach may be implemented, wherein clinicians seek common ground with youth regarding partial disclosure of specific information to increase safety without full violation of privacy on nonessential pieces of information. Alternatively, more general information may be shared with parents to increase their monitoring, realert them to already known risks, spur greater conversation between parents, youth, and outpatient therapists, or other targeted clinical goals. In sum, although the decision to break confidentiality may exist as a dichotomous choice, *how* information is disclosed, *which* specific pieces of information are disclosed, and *how* youth or families are engaged in the process can be quite varied, often balancing the challenges of maintaining respect and autonomy while also establishing safety.

One specific situation that may contribute to challenges in decision making and necessitate a "gray zone" approach to risk disclosure occurs when psychologists have limited or no ability for direct clinical assessment with the youth at-risk for suicide. For example, in large-scale, survey-based research (e.g., school-wide mental health assessment) or emerging forms of telehealth research and treatment, psychologists may only know specific responses to risk assessment items or only have remote access to youth or families. Additional safeguards may be necessary in such instances (e.g., American Psychological Association, 2013), including considering in advance how risk issues will be managed and making appropriate arrangements with relevant parties (e.g., school personnel, families of youth receiving services remotely). Dependent upon stipulations of these types of advanced arrangements and consent procedures, Table 3 presents a series of clinical talking points that may be helpful in guiding parents through an understanding of both the level of risk detected, as well as the limitations to the interpretability of the available data (i.e., striving for a balance of disclosure without over- or underalarming, given the potentially limited clinical information available to a psychologist in this position). Strategies such as these may be particularly relevant when planning research studies involving suicide risk and can be provided to university IRBs as part of a risk management protocol.

Professional and Logistical Challenges

Given the varied professional roles often assumed in pediatric settings, psychologists must define for themselves, their clients, and other multidisciplinary team members the nature and scope of their role in a given interaction. Particularly within pediatric settings, a single provider might be asked to perform multiple risk assessments in a single day or week, each with varying purposes or in varying roles (e.g., consultant to a medical clinic, investigator on a research study, clinician with a long-term therapy client). Superficially, each of these risk assessments may appear quite similar or even identical—particularly if standardized questionnaires or risk assessment protocols are utilized. Ostensibly, the purpose of each clinical interaction is to elicit responses that guide clinical decision making and safety planning for a child or teen. Yet, within different roles, risk assessment and clinical interviewing more generally may actually serve quite different purposes and require quite different decision-making frameworks. Often, individuals may experience difficulty in separating out the various professional roles in which they are performing risk assessments, particularly early in training and when new roles are being assumed. Table 4 provides a helpful heuristic for training in pediatric psychology, where multiple roles simultaneously may be pursued. Despite the significant overlap across clinical, research, and consultative interviewing, pediatric psychologists may enter into these various roles with slightly different professional frameworks, personal agendas for the interaction, styles of discourse or rapport-building, or other personal or professional boundaries. Explicitly highlighting these often subtle differences may be helpful in establishing the appropriate professional framework for a given interaction and preventing the unintended ethical or logistical complications that may arise when challenging risk assessment situations unfold.

In light of these considerations, it is unsurprising that pediatric psychologists may feel "pulled" in different directions, based on competing demands of ethical obligations, institutional policies, clinical judgments, and simply the desire to "do the right thing" for the clients or families being seen. In a perfect world, the "overlap" of these (and other) competing de-

Table 3

Possible Talking Points When Breaking Confidentiality in Large-Scale, Survey-Based Research or Clinical/Research Settings in Which the Lack of In-Person Contact Limits Interpretation of Data in Determining "Imminent" Risk

1. Remind parents of your role with their child	■ Large-scale research study in their school/medical department/community ■ Focused telehealth intervention as an adjunct to their outpatient mental health services ■ Other circumscribed and distant relationship ■ Important to highlight the limited scope of your clinical role with the child
2. Let parents know you have some information about their child, but also have some limitations in your ability to interpret that information	■ We use screening protocols to make sure kids are safe ■ Our research measures are *not* clinical instruments and cannot be used to detect psychological processes with absolute certainty ■ Even if we had "perfect" clinical tools, we still have no (or extremely limited) relationship with their child, and limited clinical insight about them as a result
3. Because of our concerns, as well as our limitations, we want to proceed with caution	■ We cannot be sure there is reason for major concern ■ We would rather be safe than sorry ■ We want to alert parents to *possible* risks for self-harm, but these risks need to be further explored outside of the limited scope of our role with their child ■ Keeping all of this in mind, their child's responses to specific items were as follows . . . ■ Explain that these responses are quite rare, which is why we are concerned that they may indicate a risk
4. Pause and assess	■ Is this a surprise for the parents? (often it is not—the child is already in treatment) ■ Has the child engaged in any self-harm previously, as far as the parents know? ■ Are the parents aware of any specific, current risk factors that might influence our thinking about next steps?
5. Discuss further evaluation of the child	■ Help the parents think about how to get a psychological evaluation (important to have referrals in their area, understand insurance or financial implications) ■ Encourage parents to get further *clinical* assessment for their child ■ If risk is more severe or substantiated by the parents in a way that is concerning, instruct parents to: increase supervision of the child, remove means for engaging in self-harm, and/or go to the emergency room
6. Remind parents of psychosocial implications	■ It was likely hard for their child to disclose this information ■ Maintaining open communication is critical for future disclosures and safety ■ Avoiding being punitive or awkward with their child is important
7. Allow plenty of time for questions or further discussion	■ Remember this may be the first time parents have heard this information ■ Parents themselves may be experiencing psychological distress (related or unrelated to this specific disclosure)
8. Provide additional information	■ Provide the parents with a referral list or information about resources in their area ■ Provide your contact information for future questions ■ Provide hospital or community crisis phone numbers, if available ■ Provide national or local suicide hotlines verbally as well as in written referral information

mands would be great; personal conviction, clinical intuition, professional boundaries, legal requirements, institutional resources, and other sources of potential strain would align them-selves seamlessly. In practice, the subjective experience of clinicians charged with conduct-ing complicated risk assessments unfortunately is often quite divergent. For example, legally,

Table 4
Heuristic Illustrating Differences in Interviewing Across Clinical, Research, and Consultative Roles

Clinical interviewing	Research interviewing	Consultative interviewing
Build rapport for longer-term clinical agenda	Build rapport for duration of research study	Build or maintain rapport within and between families and multidisciplinary teams
Establish caring environment and therapeutic relationship	Establish a professional environment and research relationship	Establish collaborative environment with possible short- or long-term clinical implications
Personalized approach for each individual client	Standardized approach applied to all participants	Tailored approach based on clinic needs and specific consultation questions
Discuss and explore clinically-relevant information	Gather answers to specific, research-relevant questions	Investigate and elucidate topics of relevance for the consultative role
Socratic questioning to elicit areas for clinical change	Structured questioning to elicit factual responses to research items	Tailored questioning to elicit helpful responses for the unique consultation questions
Help clients discover new truths about themselves in their pursuit for improved functioning or reduction of symptoms as individuals	Help scientists to discover new truths about people in general in the pursuit of greater knowledge that may be applied or disseminated broadly	Help teams and families communicate and interface effectively in the pursuit of medical or psychosocial goals

ethically, and/or institutionally, psychologists may be required to report imminent risk for harm, yet in a given case, clinical judgment may suggest that the parent to whom a report would be made is herself quite limited in functioning or poorly equipped to help manage a child or teen's crisis. Similarly, as a compassionate human being, a psychologist or trainee may feel pulled to engage with youth and families to manage a crisis, despite institutional guidelines or practical limitations on the scope of one's practice in a given professional setting. When tensions exist between competing demands, psychologists may have difficulty effectively resolving ethical dilemmas, managing liability, or minimizing the risk of harm (e.g., Miller, Tabakin, & Schimmel, 2000). These and other ethical and practical challenges in risk assessment contribute to the complexity of the task and are only exacerbated by the many different roles pediatric psychologists may take on within a professional environment.

In the following sections, we apply the ethical, clinical, and professional concepts reviewed above across various clinical vignettes, highlighting a variety of professional roles and challenges with risk assessment. These vignettes are offered as illustrative examples of the types of challenges clinicians may face; however, it is also important to keep in mind that actual clinical situations are often more nuanced or complex than can be captured within such brief illustrations. As such, individual clinical decision making should rely on thorough assessment, knowledge of local regulations or guidelines, consultation with colleagues, advice from ethicists or professional boards, and a solid foundation in clinical training.

Clinical Vignette 1: Interpreting Risk From Afar

Vignette 1

As the pediatric psychologist for a pilot study on rural health among adolescent girls, you coordinate a telehealth campaign involving several key components. At baseline, you meet for a 1-hr intake session with adolescent girls and their mothers, where consent forms are reviewed (including provisions for breach of confidentiality in cases of imminent risk), and families complete brief physical and mental health measures. Next, you collaborate with a multidisciplinary team who develops and implements a 6-month, biweekly, Internet-based curriculum, where girls learn about health-related topics such as nutrition, exercise, and self-esteem, along with submitting private daily diaries assessing health behaviors and affect. At the conclusion of the project, you meet with girls and their mothers for a final in-person session for

gathering final data and engaging in concluding and debriefing elements of the study. Within the online diary submission is a single free-response item, where girls are asked to share their thoughts or feelings about themselves that day. As part of an IRB-required safety monitoring plan, a graduate student reviews all of these free-response items daily and alerts you if questions or concerns arise. Through this routine screening of responses, a graduate student discovers that a 14-year-old girl has disclosed that she has been thinking about killing herself by overdosing on medications. You are immediately notified of the issue and are faced with the decision of how to proceed. Your memory of the 1-hr intake session from 4 months ago is limited, but there were no indications of risk at that time and none of the baseline or follow-up measures are significantly elevated on indices of depression, anxiety, or other clinical concerns. All indicators from the online curriculum suggest that the adolescent has been engaged and participating regularly with the health-promotion program.

Clinical Considerations and Decision Making

Given the limited scope of clinical involvement with this girl, a number of ethical, clinical, and practical questions may arise. In light of the consenting procedures, a psychologist might feel comfortable with the idea of breaking confidentiality *if* imminent risk is determined; however, given the "diary" format in which the adolescent made her disclosure, lack of other data suggesting a profile of risk for harm, and lack of direct clinical assessment of the youth, a psychologist also might feel concerned about violating confidentiality if the girl is not actually in imminent danger. Making this determination of imminent risk may be clinically challenging, and the full picture of costs and benefits may not be able to be known in advance of reaching out to the family.

A number of possible options might be considered in such a case, including contacting the girl by phone to gather additional data, contacting the parents to alert them to the safety concerns, or waiting for the next in-person session to determine how best to proceed. Ethically, a psychologist might fear that breaking confidentiality could increase a child's risk for harm, such as by damag-

ing the girl's trust in mental health professionals or if her parents are unhelpful or punitive in response. Logistically, the remote nature of this relationship might exacerbate such concerns, because the opportunity for a direct clinical intervention after a disclosure is likely limited or nonexistent. However, the fear that a child could go on to act on the thoughts articulated in her diary would likely outweigh these concerns, particularly in a case with active stated suicidal ideation with a plan that may be both accessible and lethal. In this particular case, the lengthy period between in-person visits likely would preclude the option of waiting for an in-person intervention, although in other situations, this clinical decision point might vary, particularly in cases of lower levels of risk (e.g., passive rather than active ideation) and more frequent contact. Given the decision to reach out to this family, several additional issues may arise. For example, if a psychologist decided to attempt to reach an adolescent by phone, prior to disclosing information to a parent, a decision would need to be made regarding what type of message to leave for her and how long to wait on a response if the girl didn't answer. Difficult clinical decisions may arise regarding next steps if she does not agree to the psychologist disclosing information to her family, offers contradictory information on the phone, or explains her diary response in a way that adds ambiguity to the situation.

In sum, given the unprompted disclosure of active suicidal ideation with a specific plan that is potentially accessible and lethal, breach of confidentiality to a parent would likely be necessary in this case, even though reasonable concerns about the negative impact of that disclosure on the participant may still exist. Critical points to be conveyed to the parents by phone (see Table 3) would be the very limited scope of interaction with their daughter, limited clinical insight based on the current working relationship, and importance that they seek outside assessment from a clinician who can help to intervene if needed.

Clinical Vignette 2: Complexities With Confidentiality and Consultation Roles

Vignette 2

A 15-year-old boy's mother, Mrs. Williams, asks near the end of a routine outpatient spe-

cialty clinic appointment if she can speak with the clinic's psychologist. As the team's routine care provider, you were in clinic earlier that day and are paged to please return. Although you did meet with her son, Tyson, individually and briefly for the administration of a new psychosocial screener being piloted in several of the hospital's pediatric subspecialty clinics, you have not spoken at length with Mrs. Williams. Based on your presence in this clinic, you generally are aware that the family is known by the medical team as being well-organized, adherent to treatments, and high functioning psychosocially.

During your meeting with Tyson earlier, he had endorsed a few mild symptoms of depression, mostly somatic in nature and not clearly unrelated to his medical presentation (e.g., changes in appetite, sleep disruption). He also reported that on one occasion a few months ago he had very briefly considered what it would be like to "not be here anymore," but he denied thinking more actively about killing himself and denied ever forming plans for self-harm. He denied any current suicidal ideation and reported feeling completely safe. He reported that on the one occasion when he had experienced passive ideation, he went for a walk with his dog to "clear his head" and immediately felt better. He reported that he *could* talk to his mother or his outpatient therapist about these issues if they ever came up again, but declined to share his prior thoughts with his mother currently because she "has been going through a tough time" and he did not want to burden her with an issue that was "over and done with a long time ago."

Upon your arrival back in clinic, Mrs. Williams is found to be pacing in the hallway, and she appears somewhat anxiously distressed, although not angry or agitated. Before you can reintroduce yourself, Mrs. Williams pulls you toward a back hallway, away from the treatment room where Tyson is sitting by himself. She sheepishly admits that she had been "snooping" on her son's responses to your interview earlier that morning, by lingering in the hallway, despite the medical team's request that she wait in the waiting room during this portion of his care. She quickly adds that, "Parents these days have to do whatever it takes to stay on top of what their teens are doing" and explains that she doesn't want you to think she's a "bad parent"

for having "snooped." Mrs. Williams then begins to tear up and says that up until that conversation, she had been unaware that her son had a history of "wanting to kill himself." She shares with you in great length her concerns for her son's safety, adding that she will do "anything and everything to help him get better." Mrs. Williams is not accusatory or upset with you for not having broken confidentiality, but now that she has this information, she wants you to call Tyson's outpatient psychologist and tell him that he needs to change his treatment agenda to address Tyson's "suicidality." When asked, the mother reports that she has not yet told Tyson about what she overheard, but adds that she *wants* to talk to him in a family therapy session once the outpatient therapist is brought up-to-speed. She says that she is worried the conversation won't go well because her son will "probably overreact if he thinks I was spying on him." She requests that you not disclose her knowledge to Tyson, so that they can discuss it with the outpatient therapist, with whom Tyson has a better working relationship.

Clinical Considerations and Decision Making

A number of ethical and clinical issues are highlighted within this vignette, particularly with regard to confidentiality in situations involving nonimminent risk. A psychologist in this position might be expected to feel caught off-guard or even defensive about his or her involvement with the adolescent and clinical decision making about nondisclosure. In this or similar scenarios, it would be important to understand the limits of confidentiality and informed consent that occurred prior to the clinical interaction, and potentially to remind a parent of their prior agreement to those boundaries in a collaborative and nondefensive manner. Furthermore, a consulting psychologist might need to consider additional professional concerns, such as his or her larger role within the clinic, prior or anticipated future interactions with the family, expectations of the medical team, purpose behind the psychosocial screenings, or other clinical factors that might influence next steps.

Given that clinical judgment following the individual interview with Tyson suggested no imminent risk was present, the primary goal

for resolution in this case would be to provide support and education for Mrs. Williams, reaffirm alliance with both the family's clinical needs and the clinic's goals in conducting the individual screenings, and protect rapport and the clinical interests of Tyson. A first step in this process might be to provide general psychoeducation to Mrs. Williams regarding differences between passive and active ideation, reaffirming that confidentiality *would* be broken in the future if concerns about imminent risk or safety ever arose, while also using caution to avoid disclosing *new* information other than specifically what she (rather than Tyson) has shared directly. Additional points of discussion with Mrs. Williams might include strategies for open, honest communication with adolescents—both from the professional perspective of a mental health provider, as well as potentially addressing parent–child dynamics, boundaries, and possible motivators behind her "snooping" that might be helpful to address with the outpatient psychologist. Within this discussion, it would be relevant to explain the potential risks of violating an adolescent's trust (i.e., including the threat to your rapport with Tyson as the medical clinic's psychologist, as well as more general threats to Tyson's willingness to open up to future professionals if he fears they will "go behind his back" and disclose private information).

One part of the conversation with Mrs. Williams also might involve explanation of differences in professional roles of psychologists, and differing types of data collected in brief health screenings versus longer-term clinical relationships. A consulting psychologist in this situation might appropriately suggest that Mrs. Williams could discuss her concerns privately with the outpatient clinician, given that he knows Tyson's overall clinical picture better than you would in this brief interaction and also is likely to have more general knowledge of family dynamics and a better working relationship with the family as a whole. Although Mrs. Williams may have the right to access her son's medical records and share them directly with the outpatient provider, your role in ethically resolving this situation may include educating her about your inability to dictate that therapist's course of treatment with Tyson, as well as possible contraindications of doing so, given your lim-

ited knowledge of her son's broader clinical presentation.

Clinical Vignettes 3 and 4: A Researcher's Versus a Clinician's Decision Making

Vignette 3

Maria, a 15-year-old girl, reports to a graduate research assistant during a structured, in-person lab visit for a hospital-based research study that she has a history of suicidal ideation and several suicide attempts over the past 2 years. She reports that she was hospitalized once 6 months ago and once 1 year ago, both for suicide attempts. She states that she recently has had frequent, nearly daily thoughts of suicide, and she says that 2 weeks ago she took "a bunch of pills" and then went to bed without telling anyone, in an attempt to end her life. Maria denies recollection of exactly how many or which pills she took. She explains that when she woke up, she felt somewhat disappointed that it had not worked, but then realized it was a "dumb thing to have done." She states that she has experienced suicidal ideation most recently 2–3 days ago, but she denies having any current suicidal thoughts or plans. She states that she does feel completely safe right now, but she is not sure if she will have suicidal thoughts again at some point in the future. As the on-call psychologist for this research study, you are called into the lab to perform a risk assessment and determine what, if any, further action needs to be taken, including possible breach of confidentiality to the parents. The research assistant advises you that in addition to the adolescent's research data, she conducted an in-person interview with Maria's mother, who confirmed that she had general knowledge of Maria's history of suicidality and depression, as well as monthly contact with Maria's outpatient therapist.

Vignette 4

Amy, a 16-year-old girl you've been seeing in weekly individual therapy for nearly a year, shares during a routine session that she has had suicidal ideation several times during the past week, including once 2 days ago. She says that she is *not* having any suicidal ideation today and denies having a plan at all in the past few months, although prior plans over the past few

years have included overdose on medication or cutting her wrists. Through your ongoing work with this adolescent, you are aware of her full clinical history, including significant depressive symptoms and ongoing suicidal ideation over the past year, as well as multiple inpatient admissions over the prior 3 years for crisis stabilization (most recently 11 months ago, following an aborted suicide attempt). Subjectively, during the session, the girl is characteristically soft-spoken, but appropriately responsive, engaged, and forthcoming.

Clinical Considerations and Decision Making

Both girls present with significant symptoms and high levels of suicide risk factors, including prior inpatient admissions for crisis stabilization, frequent and ongoing suicidal ideation as recently as several days ago, and prior suicide plans with possible access to means for completing these plans. However, several key factors may impact clinical decision making in each case, including characteristics of the girls' histories and presentations, as well as elements of the varying professional roles of the provider in each instance. Maria's recent suicide attempt is particularly concerning given that: (a) no one is aware of the attempt; (b) she apparently gained access to means for the attempt despite an elevated baseline risk profile that might otherwise have suggested a clinical need for increased monitoring or safety plans in the home precluding such access; and (c) she is unable or unwilling to define how many pills she took, thus effectively precluding your ability to discern what continued access to pills she secretly may have at home (i.e., via pill counts in prescription bottles at home). By contrast, Amy's most recent suicide attempt was self-aborted, nearly 1 year prior, and she has been in weekly therapy with you ever since the inpatient admission that occurred as a result of that attempt.

Professionally, the roles of each psychologist may also bear consideration with regard to clinical decision-making. In the case of Maria, an on-call psychologist may have limited opportunity to build rapport or maintain aftercare. As such, a safety plan could be developed but likely not monitored or managed long term, in comparison to the role of an ongoing relationship with an outpatient provider. In the case of

Amy, an outpatient provider may have better knowledge of the family and greater collaborative "buy-in" when managing a safety plan with them over time. Knowledge of each adolescent's clinical trajectory may also be highly relevant, as Maria's recent suicidal ideation may be occurring in the context of a period of decompensation, whereas Amy's recent suicidal ideation may be more of an anomaly in an otherwise upward course of recovery or more of a chronic but mild form of suicidal ideation that is less related to a specific acute episode. Finally, prior informed consent or professional policies may be important, as rules of breaking confidentiality on the research study may be very specifically defined, and plans for when/how to break confidentiality in a clinical setting may be part of an ongoing safety plan or family treatment contract.

In the case of Maria, the recency and potential lethality of her suicide attempt, the lack of parental knowledge of that attempt, and the recency of her other suicidal ideation all contribute to an emerging picture of "imminent" risk that ethically must be addressed prior to the conclusion of her study visit. Although Maria may beneficially be engaged in discussing how her confidentiality will be broken (e.g., offering her options to self-disclose with you present vs. waiting with a research assistant while you privately disclose to her mother), the disclosure of her attempt and ongoing ideation should almost certainly be made. Furthermore, given the uncertainty around her potential stockpiling of medications at home or access to other possible suicide means, an on-call psychologist in this position would likely feel more comfortable knowing that further action is being taken to safeguard this girl's well-being. Because this research protocol was being conducted in a hospital setting, Maria and her mother might be escorted to a walk-in crisis stabilization unit or even directly to an inpatient unit, if further assessment suggests the emergent need for an admission. In the event of specific parental preferences (e.g., distance from hospital, preference for admission elsewhere), an on-call psychologist in this situation might develop a very specific plan with the parent for monitoring and safely transporting Maria to another location, if needed.

By contrast, clinical decision making for Amy would occur in the very different context

of a long-term clinical relationship focused on the direct monitoring and treatment of her risk symptoms. The larger clinical picture of Amy's social and affective functioning might contribute to decisions about whether and how to disclose information to her parents. Furthermore, given the primary focus on safety throughout the course of treatment, a provider in this case should have specific plans for communication with parents, as part of a safety plan or treatment agreement.

Clinical Vignettes 5 and 6: Examining Two Strategies for Managing "The Gray Zone"

Vignette 5

James, a 12-year-old boy, reports on a follow-up phone call for a research study run by your university's psychology department that he has had some suicidal ideation in the past 6 months. Approximately 1 month ago, following a major altercation in his home wherein his father was arrested by police, James engaged in his first suicide attempt: He reports attempting to kill himself by suffocating himself with a pillow over his face when he fell asleep. He reports that he was relieved when he woke up the next morning and he has not had any suicidal ideation since that occasion, but states that he never told anyone about his suicide attempt. James reports that he has never made other plans to self-harm, and he describes his attempt as having been fairly impulsive. During the research phone call, he endorses several items on a depression screener, but generally is not clinically elevated on depression or any other of the screeners administered. He states that he does feel safe today and denies any thoughts or plans for future self-harm. The graduate research assistant performing the study phone call advises the boy that a study supervisor will be calling him right back to talk further, and then shares the above information with you, as the study's on-call clinician. When you call James back, he identifies a number of protective factors, including a supportive relationship with his mother, faith-based support, positive peer relationships, and strong academic engagement. He also reiterates that he has never had suicidal ideation, aside from this one occasion 1 month ago, and states that he feels completely safe at this time.

Vignette 6

Monique, a 13-year-old girl, reports to a pediatric nurse during an inpatient admission that she has been feeling really sad lately. Monique becomes briefly tearful with her nurse as she spontaneously elaborates that, "Sometimes I just want to go to heaven so I can see my dad again," but her affect quickly returns to normal as she begins to discuss other topics. When the nurse asks Monique if her mother, step-father, or friends can help her when she's feeling sad, Monique says that her friends at school discourage her from trying to kill herself, but adds that her friends sometimes engage in cutting behaviors when they feel stressed, which she recently has tried several times—three or four times when she was stressed about school and twice in an attempt to kill herself. The nurse bumps into you in the hallway on the pediatric floor a few minutes later, and she asks you to speak with the girl further. When you speak with Monique in more detail about her prior "cutting" behaviors, she states that on each occasion she has scraped her skin superficially with her house key, which she takes to school each day to let herself into her home until her mother and stepfather get home 30 min later in the afternoon. She denies ever using any other implements for cutting, and denies ever drawing blood or requiring medical care for her injuries. She reports that she has been in therapy off-and-on since the death of her father, 4 years ago, but states that she has not spoken to her therapist recently.

Clinical Considerations and Decision Making

A number of similarities exist across these two scenarios, including the presence of significant familial stressors (i.e., incarceration and death of primary support figures), recent attempts at self-harm that are unknown to caregivers, and the youths' apparent lack of awareness of the low probability of lethality in the selected methods (i.e., suffocation by pillow without other implements and superficial scraping of the skin). Each child is also young enough that an appreciation for their developmental status and cognitive functioning may be relevant when considering their understanding of death and suicide, as well as your role in

assessing their current safety. In each case, there is a mix of risk and protection, contributing to complexity in determining whether imminent risk for future harm exists and how risk should be addressed with caregivers, particularly if such disclosure is to be made against the youths' will.

Situations involving moderate levels of risk may be candidates for discussion or negotiation with youth, prior to breaking confidentiality. If further assessment reveals additional risk factors that would suggest imminent risk is present, then ethical standards may preclude all options other than direct disclosure to the parents. However, if further assessment increases your confidence in the youths' safety, some lingering concerns may still contribute to your desire to share *some* information with parents, if such disclosure is not clinically contraindicated and if the disclosure is expected to increase the youths' safety. In the case of James, an adolescent with a close and supportive relationship with his mother, with clinical support and encouragement from you by phone, he might be willing to self-disclose his recent struggles to his mother, thus lifting the burden of breaking confidentiality and also supporting his ongoing communication at home. Given his significant recent stressors, you might choose to discuss options for therapeutic resources with his mother, with or without the explicit disclosure of his attempted suffocation. Similarly, for Monique, problem solving with parents about increased monitoring in the afternoons might be an appropriate therapeutic goal, regardless of their specific knowledge of her skin-scraping behaviors. Unlike James, who reports high levels of current safety and support, Monique's pattern of ongoing peer stress and self-harm ideation might increase your concerns about her safety and influence the level of specificity in your disclosure to her parents (i.e., assuming she were unwilling to self-disclose). These or other "gray zone" approaches may help to balance the ethical, clinical, and professional tensions inherent in risk assessment situations, specifically by maintaining rapport with youth, while also involving parents to the extent necessary to manage their clinical needs but without violating their confidentiality or trust.

Conclusions

Performing risk assessments for suicidality, determining the presence of imminent risk, and carrying out appropriate follow-up steps, including breaking a youth's confidentiality, are challenging tasks that require significant training and ongoing professional development. These tasks may vary, dependent upon a psychologist's clinical, research, or consultative roles in a given interaction, and the often multiple professional roles held by pediatric psychologists may serve to increase the perceived complexities involved. However, little work has addressed suicide risk assessment from the perspective of pediatric psychology. Although a growing body of research has begun to explore the epidemiology, assessment, and management of suicidality, the clinical challenge of identifying causal mechanisms and specific indicators that reliably distinguish between individuals at "imminent" risk of dying by suicide versus those who remain at more moderate levels of risk for mental health problems or suicidal ideation looms large within our field (e.g., Brent, 2011; Jobes, 2012; Nock, 2012; Prinstein, 2008; Rudd et al., 2006). Furthermore, little empirical evidence is available on the clinical implications of breaking confidentiality and ways to minimize potential harm for youth in these clinical situations—in part, due to the very nature of research methodology and the ethics involved in protecting participants from harm (i.e., informed consent and breaking confidentiality are required, and thus cannot be randomized and studied empirically to determine their effects on reporting biases and clinical outcomes; e.g., Lothen-Kline et al., 2003; Prinstein, 2008).

A number of specific factors such as gender, race/ethnicity, religious background, sexual orientation, and other sociocultural variables have been associated with risk for suicide in large-scale epidemiological research. For example, in general, research suggests that there are higher rates of suicide ideation and attempts among females, higher rates of completed suicides among males, and higher risk for suicidality among American Indian/Alaskan Natives and sexual minorities (e.g., Evans, Hawton, Rodham, & Deeks, 2005; CDC, 2013; Russell, 2003). A variety of suicide prevention programs and educational materials have been developed and evaluated on diverse populations (for a re-

view of evidence-based programs, see the Best Practices Registry; SPRC, 2013; see also Gould, Greenberg, Velting, & Shaffer, 2003); however, less work has attended to the evidence base on actually assessing suicide risk across demographically diverse populations or differential methods of risk identification among diverse samples. One specific intervention that may be appropriate across diverse samples and regardless of a psychologist's determination of risk severity or decision to break confidentiality is the development of a safety plan. Research on safety planning with suicidal clients suggests that even brief interventions that involve discussion of protective factors and coping strategies can help to reduce a client's risk or promote their own management of risk in future situations. Such plans typically should involve a client's recognition of their own risk or warning signs, identification of intra- and interpersonal coping strategies, identification of sources of professional support they could contact, and restriction of access to potential methods for self-harm (see Stanley & Brown, 2012).

Finally, and particularly for pediatric psychologists, youth's psychological functioning and risks for suicide must be considered within the context of their physical health. In practical terms, this may imply unique concerns for safety planning among children or adolescents with access to large quantities of medications or medical devices (e.g., central access lines) that could serve as a means for self-harm. More abstractly, pediatric psychologists performing risk assessments among youth with significant, chronic, or potentially life-threatening conditions may require greater awareness of existential concerns and ways that physical health conditions may relate to a youth's active or passive suicidal thinking. The increased prevalence of suicidality among youth with chronic illness has been established (e.g., Barnes et al., 2010), but further research is needed to examine whether or how risk assessment should be tailored for youth with acute or chronic medical conditions, and how best to manage suicidality in this population.

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