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Informing Suicide Risk Assessment Practices of High-Risk Preteens: Qualitative Insights from Youth and Caregivers

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Abstract

Objective: This study marks the first phase of the development of a reliable and valid suicide risk assessment tool for preteen youth. In this phase, authors sought to understand the lived experiences of preteens with suicidal thoughts and behaviors (STBs) and their caregivers, with the goal of informing our understanding and improving the assessment of STBs in preteens.

Method: We conducted qualitative interviews with youth in acute care settings who had onset of STBs during their preteen years (i.e., 8–12 years of age; n= 11) and caregivers of preteens with STBs (n=11). We queried about suicidal ideation, pre-suicide attempt warning signs and risk factors, ways in which suicidal risk was communicated by preteens, suicide attempt planning and intent, and early detection of risk.

Results: Youth and caregivers provided perspectives on the lived experiences of preteen STBs, identifying critical risk factors and warning signs (e.g., increasing isolation, major shifts in typical behaviors), barriers to communication of risk (e.g., fear of hospitalization, fear of punishment), importance of family-centered and individualized risk assessment that takes into consideration personal and cultural identities (e.g., minoritized identities, religious beliefs), and ways to better support preteens (e.g., asking direct questions about STBs, checking in on mood and well-being more regularly).

Conclusion: Qualitative interviews provided valuable insights regarding the lived experiences of preteens reporting STBs and their caregivers. This research highlights the need for family-centered, individualized, and culturally sensitive approaches to understanding, assessing, and

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mitigating preteen STBs and the development and validation of comprehensive risk assessment tools and practices explicitly designed for preteens.

Keywords

preteen; child; suicidal ideation; suicide attempt; qualitative research; risk assessment

Introduction

There has been a troubling increase in death by suicide among preteens in the United States with suicide deaths rising 135% between 2010 and 2019 in youth 5–12 years old (Bridge et al., 2023). From 2018–2022, approximately 840 children aged 8 to 12 years old died by suicide (CDC, 2018). A recent meta-analysis focused on the prevalence of suicidal ideation and self-harm behaviors in children before age 13 found that 7.5% experienced suicidal ideation, 2.2% made a suicide plan, 1.3% attempted suicide, and 1.4% engaged in self-harm (Geoffroy et al., 2022). Furthermore, there is concern that rates of STBs are rising disproportionally in youth from minoritized racial backgrounds. One of the few studies examining STB trends in younger children found a steady rise in rates of STBs for Black youth aged 8–12 years old presenting to Emergency Departments (ED) since 2016 (Prichett et al., 2024). Notably, 18% of preteen patients presenting to the ED for medical and psychiatric reasons in 2019 reported past suicidal behavior and nearly half reported onset of suicidal behavior at or before age 10 (Lanzillo et al., 2019). Youth who attempt suicide in childhood are up to six times more likely to re-attempt during adolescence (Ruch et al., 2021). These data underscore the importance of detecting STBs in younger children.

Despite these alarming trends, research on preteen STBs remains sparse, hindering the development of strategies to effectively assess risk and appropriately intervene in this population. In 2021, the National Institute of Mental Health (NIMH) recognized child suicide as an emerging public health problem and convened a round table series to identify means to mitigate child suicide risk (Bridge et al., 2023). These dialogues highlighted the need to improve our understanding of the unique risk and resilience factors for STBs in this age group in a reliable, valid, and developmentally sensitive way. For example, the existing literature, although limited, has identified irritability and difficulty regulating negative affect as more robust risk factors for suicidal behavior in preteens compared to older individuals (Benton et al., 2021). Other studies have demonstrated that preteens, compared to adolescents, may become more emotionally and behaviorally dysregulated during periods of emotional crisis, thus increasing the risk for suicidal behavior (Ridge Anderson et al., 2016; Wagner, 2009). Another study revealed 60% of children aged 5 to 11 who died by suicide experienced difficulties with friends and/or family members, and that a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) was nearly twice as prevalent as depression (Sheftall et al., 2016). The accumulation of various risk factors over time contributes to death by suicide in children, including prior suicidal behavior, trauma, and issues related to family, peers, and school (Ruch et al., 2021).

The findings described above indicate that children with STBs exhibit some common, but also some distinct, behavioral presentations and risk factors compared to adolescents.

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Consequently, the procedures for clinical assessment and informant reports for preteens may need to differ from standardized assessments used for evaluating risk in adolescents. For example, the Suicidal Ideation Questionnaire (SIQ), a commonly used self-report measure, includes a question stating, "I thought about writing a will." It is unlikely that suicidal preteens would have considered writing a will which, in turn, would lower their total score on the SIQ and possibly result in missing an at-risk child. Numerous other self-report and interview items may be appropriate for adolescents and adults but may not be suitable for preteens. For instance, while measures like the Ask Suicide-Screening Questions (ASQ; Horowitz et al., 2012) and the Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2008) have been adapted for younger children, the ASQ is limited to screening and the C-SSRS offers only modest predictive value for this age group (odds ratios between 1.10–1.16; Mayes et al., 2023). Given the dearth of validated assessments and rising suicide rates in preteens, the NIH issued a 2022 Notice of Special Interest emphasizing the critical gap in assessing suicidal thoughts and behaviors among children and preteens.

One promising avenue for improving assessment tools for preteens is to incorporate input from individuals with lived experience of STBs, who can provide critical insight into how suicide risk manifests and is best identified. Lived experience of STBs is defined as "having experienced suicidal thoughts, survived a suicide attempt (SA), cared for someone through suicidal crisis, or been bereaved by suicide" (Lived Experience of Suicide, 2016). The inclusion of individuals with lived experience of STBs in the design and development of suicide assessments and interventions, which historically was limited, is now increasingly recognized as essential (Hawgood et al., 2023). Individuals with lived experience have unique insights about optimal approaches to enhance both assessment and intervention (Hawgood et al., 2023). In Australia, for example, it is now considered vital to include people with lived experience in suicide prevention efforts (National Suicide Prevention Advisor, 2020). Qualitative research, either on its own or in conjunction with quantitative data, with individuals who have lived experience may be particularly useful because it has the potential to uncover individual-level risk and protective factors that might be missed in large scale projects.

Qualitative methods hold significant promise for advancing the development of effective, culturally sensitive assessment tools for preteen STB. Through open-ended, guided discussions, children and caregivers with lived experience may feel more comfortable sharing nuanced feelings and observations, leading to a richer understanding of developmental and situational risk factors. Furthermore, qualitative interviews can identify barriers to accurately assessing suicide risk in this population. For example, some impulsive behaviors in preteens may increase suicidal risk, but caregivers often find it difficult to infer intent in such behaviors; such nuances are not captured in standard quantitative assessments (Schwartz et al., 2010). By facilitating a more comprehensive exploration of cultural, developmental, and contextual components, qualitative research may inform the creation of more sensitive and valid tools tailored to the unique needs of preteen populations.

The current study represents the first phase of an iterative effort to improve the identification and assessment of STBs in preteen children. The primary aim of this phase was to gain insight into caregiver and child lived experiences of STBs through qualitative interviews.

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These findings will contribute to the development of a comprehensive, developmentally, and culturally sensitive interview of STBs in preteens.

Methods

Participants

Semi-structured interviews were conducted with youth participants (*n*=11) who had experienced onset of STB before age 12 and were receiving treatment at an inpatient or partial hospitalization program at a Northeastern academic medical center. Caregiver participants *(n*=11), who were recruited separately, were eligible to participate if they had a preteen child who was hospitalized for STBs before age 12. Medical records for inpatient and partial hospital programs were reviewed to identify charts of youth who had onset of STBs before age 12. With the permission of clinical staff, study personnel contacted eligible children and their caregivers to explain the aims of the study and gauge interest in participating. We individually approached children and caregivers for participation. Youth participants were purposefully selected and approached based on their history of STBs, with the goal of capturing a diverse range of perspectives, identities, and experiences. Caregivers completed informed consent procedures prior to participating in their own interviews or on behalf of their child. Youth provided assent to take part in the interview. Interviews occurred on average 10 days into the youth's hospitalization (*Range*= 4–20 days; *M*=10.33, *SD*= 4.71). Interviews were conducted until data saturation was reached (as defined by Saunders et al., 2018). All study procedures were approved by the hospital Institutional Review Board.

Data Collection

Interview Guides. Semi-structured interview guides for youth and caregivers were used to facilitate discussions between interviewers and participants. See supplementary materials for copies of the youth and caregiver interview guides. At the beginning of each interview, youth participants were oriented to discuss the onset of STBs during the preteen years (versus any more chronologically recent STB for the older adolescents). Each interview question addressed a broad topic of interest (e.g., warning signs leading up to the SA, degree of preparation for the SA). Probing prompts were used to encourage participants to clarify or expand upon their responses naturally, without steering them toward specific answers. The interviews were intentionally broad to capture diverse perspectives. Key domains covered included: thoughts/feelings/actions related to suicidal ideation; timing/plans or preparation for suicidal behavior; consequences, warning signs, and communication regarding suicidal behavior; understanding of death/suicide; factors related to race, ethnicity, and culture that should be assessed; and what professionals should assess when a child is suicidal.

Interview Procedures and Transcription. All interviews were conducted by study personnel trained in qualitative interview processes. The qualitative team of study personnel consisted of four doctoral level psychologists, one child psychiatry fellow, and three Bachelor's-level research assistants. Interviews were video-recorded using HIPAA-compliant Zoom or Microsoft Teams platforms and transcribed using the Zoom and Microsoft Team auto-transcription software. Upon completion of the interview, participants were compensated with a $50 gift card. Post-baccalaureate and undergraduate research

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assistants compared the audio and auto-transcriptions and made corrections as needed to ensure the accuracy of content derived from the auto-transcription software.

Qualitative Analysis Part I: Summarization of Individual Transcripts

A double-coded, rapid qualitative analysis approach was used to analyze transcripts. This method was selected as it has been shown to yield similar themes as traditional coding methods (Gale et al., 2019; Nevedal et al., 2021). Furthermore, it has several benefits relevant to this study including offering a speedy and resource-efficient first step toward developing an iterative, developmentally sensitive suicide risk assessment for preteen youth by allowing us to quickly extract actionable insights to inform measure development.

All coders were trained in the study coding practices and collectively coded an interview as a group before continuing to independently code interviews in dyads (i.e., each interview was coded individually by two coders). Transcripts were first coded in the prespecified domains (aligning with each interview question) and then entered in a summary table consistent with guidelines from Gale et al. (2019). For each domain, coders summarized key points and collected illustrative quotes. Weekly coding meetings were attended by all members of the coding team and were used to review coding practices, address double-coding discrepancies, and edit the summary table as needed.

Qualitative Analysis Part II: Creation and Analysis of Coding Matrices

All key points and exemplar quotes for each domain were summarized in a framework matrix (Estave et al.,2021) with columns for each domain (interview guide question) and rows for each participant. Qualitative team members (JW, KT, ER, AH, SG, MM, MLM) independently reviewed the key points and exemplar quotes for each domain (column) to identify themes for that domain. Then, the qualitative team collaboratively reviewed the matrix until consensus around themes was reached during multiple virtual meetings. These data were then coalesced into a separate “themes/analysis” column for each domain.

Results

Participant Demographics

Youth participants ranged in age from 9–16 years (*M*=13.92, *SD*=2.35; see Table 1). This wide age range allowed us to sample diverse experiences, capitalizing on older adolescents’ ability to reflect on their younger selves while also benefitting from accounts of younger participants’ more recent experiences. Most youth participants identified as female (81.8%) and 36.6% identified as White, 18.2% Black, 18.2%% multi-racial, and 27.3% Hispanic. Nearly all youth (*n*=10) experienced an SA before age 12. For the caregiver participants, the majority were maternal caregivers (87.5%) and 45.5% identified as white, 18.2% Black, 9.1% Hispanic, and 27.3% did not provide information on race.

Qualitative Interview Findings

On average, the child and caregiver interviews were approximately 45 minutes in duration. Nine themes were identified from the qualitative interviews with youth and caregivers. Below we report on the findings, first presenting the youth perspective followed by the

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caregiver perspective. We present the themes and representative quotes from the rapid qualitative analysis for youth in Table 2 and for caregivers in Table 3.

Risk Factors and Warning Signs

Youth. Interviews with youth revealed a variety of internal experiences, observable behaviors, and situational stressors that brought on their desire to die. In terms of internal experiences, youth recalled feelings of sadness, anxiety, loneliness, anger, and hopelessness, which they reported often culminating in feeling "overwhelmed." One youth described being "so unhappy that I didn't feel worth living," while another shared that, "[With] all those emotions bottling up… I just decided to do it," reflecting the intense emotional distress they were facing during the time leading up to the SA.

With respect to observable behaviors, youth recalled changes in sleep and appetite, increased isolation from their peers and family, withdrawing from activities, and avoiding school. Some reported increased cell phone use during periods of isolation. Many youth also reported an increase in engagement in nonsuicidal self-injury preceding SI or SAs. Youth also frequently recalled increases in bullying, problems at school, academic stress, feeling as though they don't belong, and stress/conflict at home as precursors to their attempts.

Trauma exposure, particularly experiences of sexual and physical assault, were noted as precursors to STBs and one youth reported a direct connection between self-harm and trauma exposure. Peer conflict and being bullied by peers were often brought up as contributing elements to increased risk. Youth also highlighted their exposure to depictions and discussions of STBs through peers and especially social media. One youth noted, "I don't know how they know how I feel in the brain, but every time I scroll it's like all suicidal stuff, and I'm like I can do that. I can like take the pain away." A few youth mentioned that these risks may be greater in the context of unrestricted internet access, especially when children are younger.

Importantly, despite these worrisome internal and external indicators of risk, a common theme across youth interviews was a sense of emotional isolation and disconnection, with many describing difficulties expressing their distress and believing that others would not understand or be able to help. One youth said, "not really anyone knew how I was feeling," and another said, "I felt like I couldn't talk to anyone… because people wouldn't understand how I felt." Others expressed feeling like their emotions would be a burden to others. Some youth expressed a desire for others to notice these behaviors and recognize their need for support. These accounts illustrate the complex interaction between emotional distress, maladaptive coping strategies, and isolation that often precedes SAs.

Caregiver. Interviews with caregivers yielded largely concordant reports of the internal and external experiences and the precipitating events that led to their child's SA. Emotionally, caregivers observed a recognizable shift in their child's mood, characterized by increased anger, stress, anxiety, irritability, and frustration. Importantly, they emphasized that these mood changes were often "visible" and at times volatile, with one caregiver reporting, "he was just too sad and too angry [to go on]." Interestingly, caregiver interviews focused

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more on their child's anger, while youth report focused primarily on internal emotional experiences such as sadness and anxiety.

Behaviorally, caregivers reported observing increases in nonsuicidal self-injury, greater social isolation, and statements about STBs. For example, some caregivers stated that their children often discussed SI and STBs or engaged in self-injurious behaviors more frequently, with one caregiver stating, "he had said we needed to lock up the knives." Notably, while caregivers reported that their youth vocalized risk, the youth themselves did not identify this as a warning sign. Caregivers noted that these mood and behavior changes and social withdrawal significantly impaired their children's ability to participate in school and other activities.

Similar to youth reports, caregivers highlighted the importance of understanding children's exposure to trauma as well as interpersonal stress and conflict with their family and peers. While caregivers agreed that social media is an important context in which children may be exposed to STBs, they also noted the significance of exposure to suicidal or self-injurious content through peers and family members. For example, several caregivers mentioned that their children knew individuals who had either made suicidal statements or had engaged in suicidal behaviors. They also reported that peers may even encourage children to engage in suicidal behaviors with one caregiver stating, "and then her other friends post something about depression on Tik Tok or Snapchat: 'I wanna die.' I think social media is playing a big part too. Because everything, it's going on Tik Tok." Another caregiver stated, "...the cause of the attempt was two of her friends, two [of] her best friends on social media and in school, they got in a fight and these two little girls both told her to kill herself."

Youth's Understanding of Death

Youth. Youth generally reported understanding the permanence of death at the time they made an SA as a preteen. Personal experiences, including death in the family, religious and cultural beliefs, and exposure through social media or other sources appeared to have affected youth's beliefs surrounding death. For some youth, religious beliefs appeared to be a protective factor, as they feared going to hell or being "punished" for dying by suicide. Several youth reported believing in reincarnation or going to heaven, and one perceived death as an opportunity to go to "a better place or come back as a different and better person," in a different body with a different life. For several of the youth, thoughts of death or suicide were related to curiosity about death, or the idea of finding an "escape" or a transformation of the current situation.

Caregiver. Similar to children's reports, many caregivers reported believing that their preteen children understood the concept of death, specifically its permanence and that one does not "come back." However, several caregivers voiced uncertainty and noted that they did not believe that their child "fully understood what it meant to die when they attempted" and that they were "mostly focused on it just happening." One caregiver indicated that their child's difficulties with comprehending death were likely due to their "cognitive limitations." Several caregivers shared that their child believed in and wondered about life after death as preteens. The primary differences among parental views on child

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understanding of death appeared to be related to each families' own experiences with death. These included passing of a family member, death being normalized due to a caregiver's profession, religion/culture-related beliefs, or the caregiver's willingness to discuss and answer questions regarding death with their child.

Methods of Communicating Risk

Youth. Youth reported various ways they attempted to communicate their suicidal thoughts and feelings to others when they were preteens, although often these signals were indirect. Some reported communicating through changes in their behavior, particularly engaging in nonsuicidal self-harm. One youth explained their behavior as a preteen by describing, "Self-harm, as much of a relief it was, was also like a cry for help." Another theme was a desire for adults, particularly caregivers, to take the initiative in asking about their feelings and potential suicidal thoughts. Some expressed frustration or sadness that their emotional pain went unnoticed or was not directly addressed by those around them. One adolescent shared, "I wish my mom would've noticed how I felt or asked how I felt." Many also expressed significant barriers to openly discussing their suicidal thoughts. A common concern was the fear of burdening others or overwhelming them with their problems. One youth explained, "I thought that it would be too much for other people to handle and that I would just be a burden to them, and I didn't wanna do that, so I never said anything to anybody." Others referenced being worried about being sent to the hospital, "I didn't wanna end up being at a psych hospital at that age, so I didn't talk to the school counselor, my caregivers, teachers." These findings indicate that preteens often communicated their distress indirectly, faced challenges in discussing their suicidal thoughts, and desired more direct inquiries from adults.

Caregiver. Caregivers reported a variety of ways their children attempted to communicate suicidal thoughts, with some being more explicit than others. Some caregivers noted that their children were able to verbalize their suicidal thoughts directly, either to them or to other trusted adults. In other cases, children expressed their distress indirectly, such as through notes left for teachers. Caregivers reported that they believed their child hesitated to disclose details due to fear of getting into trouble, being hospitalized, or causing additional distress to their caregivers. One caregiver recounted, "She said she didn't want to put more stress on me because I have enough on my plate, and she didn't want to be more of a burden." Another significant method of communication noted by caregivers was through their children's creative expressions, such as drawing, journaling, and writing notes. These creative outlets sometimes took on "dark" or violent themes, which caregivers recognized as alarming. One caregiver described, "I saw all the pictures that she was drawing, all the things that she was writing about it. And it was kind of scary."

Preparation and Method for SA

Youth. Youth described mixed degrees of premeditated planning for their SAs as preteens, with many reporting planning for days and even weeks before the SA. For instance, one youth shared, "For like a week I started planning the suicide, and I started thinking of ways I could do it and least painful ways," while another reflected that they had spent "one to two weeks thinking about it constantly, constantly, constantly." Several youths

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reported researching methods before their SA, "I looked on YouTube." Others reported more impulsive, unplanned SAs, like this youth who shared, "I never had a plan. I never planned anything… [in the moment thought] 'tonight will be the night that I would try to die.'"

Caregiver. While youth reported a mix of premeditated and more impulsive SAs, most caregivers reported believing that their child's SA was an "impulsive," "split second" decision with little to no planning. For instance, one caregiver shared, "I think it is on impulse. I don't think it's something that just sits in her brain." While another shared, "I hadn't seen any indication of a plan." With regard to methods, both adolescents and their caregivers recounted various degrees of lethality, from lower-risk behaviors, such as attempting to suffocate with a pillow to more dangerous methods, such as hanging and overdosing on medication. Many caregivers reported only finding out that their child wanted to kill themselves or had made a previous SA while at the hospital for a suicide-related crisis, "I found out, at the emergency room, that she tried to choke herself."

Intention/Consequences of SA

Youth. A majority of youth indicated that they believed their preteen SAs would be fatal. One participant recounted, "I thought I was gonna die." Another echoed this sentiment, stating, "I thought it would just shut [my thoughts] up. I thought I would stop breathing." However, a few adolescents expressed ambivalence about the outcome of their SA, indicating that they were uncertain about their desire to die. One adolescent shared, "I was scared and I was like, 'I want this to end, but do I really want to die?'" This ambivalence was further highlighted by another participant who stated, "I didn't really, really wanna die, but I was like, if it happened, it happened. But I just wanted for my caregivers to find me and take me to the hospital and finally see that I was struggling." Many of the youth also expressed a belief that something better would happen if they died. One adolescent recalled, "I felt like I was going to go somewhere better and finally be happy." These reflections illustrate the complex and varied intentions behind their SAs, ranging from a genuine desire to die to wishing for an escape from or acknowledgment of their pain.

Caregiver. Caregivers also referenced the complexities observed in their children's intentions and expected outcomes of SAs. Some caregivers believed that their child fully intended to die, even when the method of the SA was not inherently lethal (e.g., using their own hands to choke themselves). Several caregivers perceived their child's actions as a means to gain support or attention, rather than a definitive wish to die. One caregiver articulated this by saying, "They don't know how to express it, and it just feels like they're trapped in a way and so it's almost like for them it feels more like a cry for help." This perception highlights the idea that some SAs were driven by a need for others to recognize their distress and offer support. A consistent theme across caregiver interviews was the belief that their children were driven by a desire to escape their negative emotions. Many caregivers described their child's SA as a way to make their pain disappear. As one caregiver expressed, "I don't know if she actually wanted to kill herself, or if she just wanted to take another vacation somewhere, or just remove herself from that situation because that situation was so painful." Similarly, another caregiver remarked, "I think it's more to get away from the thoughts and the feelings." These reflections underscore the role of emotional pain and

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the desire for relief as central motivators behind the SAs, whether the intent was to die or to escape overwhelming emotions.

Factors Related to Culture and Identity

Youth. Youth commonly reported that feelings of "otherness" and perceived low self-worth contributed to the development of their suicidal thoughts and feelings. More specifically, some children expressed feeling insecure about having prominent, visible differences associated with race, such as their skin color or hair. As one child described, "I felt uncomfortable in my own body…because of my race. I didn't like how I look…which led me to hurt myself." For many children, religion seems to have influenced understanding of an afterlife and deterred some individuals from acting on their suicidal thoughts as preteens (e.g. "I thought I was gonna go to hell"). Youth also shared that experiences of prejudice based on gender and sexuality may have contributed to their suicidal thoughts and feelings. Additionally, youth interviews revealed that gender matching between a youth and their counselor or therapist can be important to consider, as some youth expressed feeling more comfortable opening up to someone of the same gender as themselves.

Caregiver. Caregivers similarly reflected on the ways in which cultural identities can influence one's beliefs about mental health and identity. For instance, some caregivers discussed how their racial and ethnic backgrounds shaped their views on gender identity, like this caregiver who shared that "For us Latinos … it's hard for all of us to deal with those identities kind of things like homosexual or bisexual stuff, for the Latino people, is so big that kids shut down, don't say anything about it." Caregivers also noted their family's religious background might have influenced their preteen's beliefs about death or suicide. Some acknowledged that religion can also be viewed as harmful if children feel pressured to abide by certain religious expectations or feel that certain aspects of religion are oppressive and invalidating of certain aspects of their identity. Additionally, caregivers acknowledged the unique struggles faced by sexual and gender-diverse youth, even as preteens, and highlighted the importance of therapists and educators being educated in LGBTQ topics and providing supportive spaces for those who identify as such.

How Professionals/Other People Can Help

Youth. Youth reported the importance of being asked direct questions about their emotional state by trusted adults, such as teachers and doctors, specifically identifying the utility of regular check-ins on how they are feeling and whether help is needed. In addition to being asked about their feelings when they were preteens, youth noted that it is necessary for adults to pay close attention to changes in children's behavior. For example, they highlighted the importance of noticing warning signs, such as withdrawing and losing interest in previously enjoyed activities. One youth stated, "I wish they [teachers, and other adults] would ask like 'Hey, we noticed you're a bit quiet. I noticed you stopped doing the things you like. Are you good? Is everything okay?" Youth highlighted the importance of adults being caring, validating, and affirming in contrast to minimizing feelings and being judgmental. Relatedly, youth stated the importance of having trust in relationships to support disclosure and honest responding. Finally, youth shared that it is necessary for trusted adults to assess the "why" they want to die as well as contributing factors for STBs.

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Caregiver. Caregiver respondents similarly highlighted the importance of directly asking about STBs. For example, one caregiver stated, "I think being truthful about the real, real truth about suicide ideation and things like that is the best approach. To not, you know, dance around it, like be right up front with kids about it and how important it is to have a person to reach out to." Caregivers also expressed concern about exposing children to new information on suicide. For example, a caregiver shared a previous experience in which they felt like the clinician interview forced the child to think of a suicide plan, by asking detailed questions about suicide planning. Caregivers also noted the importance of taking a non-judgmental approach and of validating the caregivers' experiences and opinions on treatment. For example, caregivers commented on previous experiences in which they felt their information or perspective was dismissed or minimized, "and then a lot of doctors they don't listen to the parents…We really do know our kids and what's going on." Caregivers suggested taking an individualized approach and not making broad assumptions based on cultural backgrounds. Caregivers also called for more professionals of diverse backgrounds to join the mental health field, and expressed a need for more culturally sensitive assessment and treatment practices. Some caregivers also disclosed feelings of distrust in mental health professionals due to a lack of shared experience, "they can't really help you, because they have no idea what you are going through." As such, caregivers urged professionals to develop a more empathic understanding of the experiences of marginalized individuals. Caregivers also commented on the importance of paying attention to changes in the child's emotions and behaviors. Caregivers identified opportunities to enhance discussion of emotions within school settings to increase understanding and awareness and to broaden the support network (e.g., emotion "check-ins" by trusted adults).

Discussion

The current study aimed to inform the assessment of STBs in preteens by gaining insight from the lived experiences and recommendations of both youth who experienced STBs before age 12 and caregivers of youth who had these experiences. Qualitative interviews yielded several key findings about children's general understanding of death and the precipitating internal and external contributors to STBs, degree of premeditation and planning of SAs, methods of communicating risk, and areas to target in prevention and intervention efforts. Youth and caregiver reports often aligned with a few notable discrepancies.

Research has demonstrated that children as young as eight understand the finality and permanence of death (Speece & Brent, 1984). However, individual differences, as well as societal and cultural beliefs, may shape how fully children grasp the concept of suicide. In the present study, both youth and caregivers noted that youth beliefs about death were largely influenced by family experiences, religious beliefs, and other factors. Youth consistently reported a clear understanding of the permanence of death at the time they were thinking about suicide. While most caregivers believed that their child understood the permanence of death, some reported that they were unsure if their child fully understood its implications because many caregivers also reported not having any, or at least no in-depth, conversations with their child about death. Some caregivers mentioned that religious and cultural beliefs (such as reincarnation, going to heaven) may influence the extent to

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which their child could fully appreciate the permanence of death. These findings suggest that clinicians should not assume based on age that children fully understand the broader implications of death; instead, both the child and caregiver perspectives should be directly assessed and clarified.

In addition to understanding children's beliefs about death, examining the broader context of stressors and interpersonal influences is a critical component of risk assessment. Youth and caregivers both reported intense sadness, anxiety, social isolation, and external pressures, such as bullying, family conflict, and academic stress, as key precursors to preteen STBs. Both caregivers and children emphasized exposure to trauma, interpersonal conflict, and social media (e.g., content related to STBs) as contributors to children's risk for engaging in STBs or the exacerbation of STBs. Importantly, both children and caregivers discussed how children's knowledge of family members' or peers' STBs, as well as peer encouragement to engage in STBs, increased their risk. Taken together, this speaks to the need to query for these experiences during risk assessment and underscores the potential importance of trauma-informed care to ensure assessments and interventions consider prior trauma and its impact on STB risk.

Alarmingly, despite the significant distress experienced by youth, many reported concealing their feelings out of fear of being misunderstood, burdening others, or fear of the consequences (e.g., punishment or hospitalization). Importantly, several caregivers reported being unaware of their child's suicide risk until their hospitalization, and many youth said they "wished" their caregivers would have recognized that they were upset and would have asked more direct questions about their mood and suicidal thoughts. These findings are consistent with prior literature (e.g., Shin et al., 2024; Hallford et al., 2023), and highlight the addressable matter of miscommunication between caregivers and youth. Fostering direct discussions between caregivers and children about suicide risk, such as discussions about barriers to disclosure and preferred ways the caregiver may respond to risk should begin and be modeled during the risk assessment and subsequent safety planning. Indeed, research has shown that asking about suicidal ideation does not increase distress or SI in adolescents (Gould et al., 2005) or preteen youth (Shin et al., 2024). Regardless, caregivers may be reluctant to ask their child about thoughts of suicide, and it is important for clinicians to work sensitively with caregivers so they can use words they are comfortable with during these conversations. Supporting caregivers in recognizing indirect signals (such as changes in usual behavior, drawing or writing about emotional distress, and engaging in nonsuicidal self-harm), and increasing and normalizing conversations between children and their caregivers around emotions may create a safer environment for preteens to express their suicidal thoughts and seek help. Children should understand that talking about STBs is to be encouraged while at the same time appreciating that suicidal behaviors should be avoided. Although assessment of STBs is critical in acute care settings, there is limited research on the iatrogenic potential of such questions in younger children, and developmental factors, such as suggestibility, emotional sensitivity, and reactive responses warrant further exploration.

One of the largest discrepancies between youth and caregiver reports was the discrepancy in perceptions about the degree of planning and intention of youth SAs. Youth reported

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varied degrees of planning for their SAs as preteens, with many reporting planning methods and timing over the course of several days. Most caregivers, however, reported believing that their child's SAs were impulsive. This discrepancy is important to consider in light of the potential gap in caregivers' understanding of their child's warning signs and degree of risk. While impulsivity is certainly a risk factor for suicide (see McHugh et al., 2019), and there is reason to believe that younger individuals may engage in impulsive suicidal behavior more frequently than older individuals (Steinberg et al., 2008), findings from this sample indicate a need for the type of risk assessment that occurs with adolescents, including querying for suicide plans. Indeed, research has demonstrated that there are distinctions between individuals who make unplanned, "impulsive" SAs and those who do make plans for the SA, with the latter generally being higher risk in the long-term for repeat attempts and even death by suicide (Chaudhury et al., 2016). Asking directly about potential suicide plans should be incorporated in routine risk assessment practices by mental health providers, and caregivers should also be encouraged to do so to inform their response and support means-reduction efforts.

Both youth and caregivers emphasized the importance of direct, compassionate, and culturally aware engagement from adults. Both caregiver and child interviews emphasized the importance of recognizing how identity-related factors, such as gender, sexuality, race, religion, and cultural background may impact one's beliefs and attitudes surrounding mental health, treatment, and suicide. For example, in certain cultures, seeking help may be seen as a sign of weakness and therefore may deter individuals from disclosing their struggles. To help address this, youth and caregivers called for mental health professionals and others in "helping" roles (e.g. teachers, coaches) to use an individualized approach that avoids assumptions and respects diverse experiences. They also called for increased cultural responsiveness among mental health providers and emphasized a need for more professionals from diverse backgrounds.

Clinical Implications

The findings from this study provide early guidance for improving the assessment and detection of STBs in preteens. Many risk assessment principles mirror those used with adolescents, such as attending to sadness, trauma, and conflict, assessing for intent to die, and using direct questioning. Preteen, compared to adolescent, risk assessments typically require greater involvement of caregivers, who can provide critical insights such as subtle emotional and behavioral changes of the child, family dynamics, important developmental history, and contextual stressors that the child may not verbalize. Given the potential for discrepant reports between caregivers and youth it is recommended that clinicians meet with preteens and caregivers both individually and together to capture differing perspectives and ensure a comprehensive understanding of the child's risk profile. Engaging caregivers as active participants in risk assessment is critical not only because of the additional insights they may be able to provide but also because they may need additional support and guidance to recognize warning signs and their child's level of suicidal intent.

Relatedly, to better understand the preteen's risk, clinicians should directly assess suicidal thoughts, intent, and planning, while recognizing that some preteens may conceal distress

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or communicate risk indirectly through nonverbal behavior or creative expression (e.g., drawings, letters, stories). Importantly, while adults, and even some clinicians, may be apprehensive about asking preteens direct questions about suicide, nearly all preteens mentioned a desire for adults to check in with them, to ask them how they were feeling, and to directly ask about suicide. Normalizing these conversations, supporting caregivers and other adults who frequently interact with children (such as teachers and coaches) to feel more comfortable discussing emotions and suicide, and equipping them with the skills to respond effectively can help facilitate earlier detection of risk.

Cultural and contextual factors should also be considered and assessed through open-ended questions that explore how a family's background may shape their beliefs about death, suicide, and mental health. These conversations can guide clinicians in tailoring language, resources, and strategies to families' beliefs and experiences. Although derived from high-acuity inpatient youth, principles such as caregiver engagement, direct conversations about suicidal intent, attention to indirect warning signs, and culturally responsive communication are largely applicable across outpatient, school-based, and primary care settings, with adaptations made for time and resource needs.

Limitations

The study's findings should be considered alongside its limitations. First, the study relied heavily on retrospective self-reports from both youth and caregivers, which are inherently vulnerable to recall biases and memory-related inaccuracies. Accurate self-reporting requires conscious awareness of the past and the ability, willingness and motivation to accurately disclose their experiences. Prior research has shown that caregivers often underreport their children's STBs (Brahmbhatt, & Grupp-Phelan, 2019), which may impact the accuracy of parental reports. Another related factor is that some caregivers may have difficulty acknowledging or accepting their child's had experience of STBs. This may partially explain discrepancies between caregiver and child reports, particularly regarding suicidal intent, with most youth reporting that they understood and experienced suicidal intent, while many caregivers expressed uncertainty about their child's suicidal intent or believed that their child did not intend to die. Similarly, youth may lack a complete or accurate memory of the past, which could affect the reliability of their reports. Despite these challenges with retrospective self-report, we believe the present study still provides a useful and meaningful account of lived STB experiences from an important and underrepresented group in the STB literature.

Second, the study's recruitment of high-acuity children limits the generalizability of the findings to broader, less acute populations, and future work is necessary to uncover the needs of those populations. However, we believe that our focus on high-acuity children is appropriate given the low base rate of suicide attempts and deaths in the general population, and the fact that they represent a vulnerable group with significantly elevated risk for future suicide attempts and death. So, while this focus may overlook important characteristics of the broader population of youth, our focus on a high-risk sample provides valuable insights for the most vulnerable children.

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Third, nearly 80% of the sample (youth and caregivers) identified as female, which means that our findings may not be as relevant to males. While there are reported sex differences in STBs among older youth and adults, research suggests that sex differences in depression before puberty are minimal (e.g., Hankin et al., 2015; Nolen-Hoeksema & Girgus, 1994). Nonetheless, it remains important to consider how sex may impact the experience of STBs, the expression of distress, and help-seeking in this age group. For instance, irritability is a risk factor for suicide in adolescent males and may be particularly important to assess in preteen boys. Future research should also explore whether the conclusions derived here hold across a more gender-diverse sample.

Fourth, the overrepresentation of maternal caregivers in our sample may have influenced our findings because mothers typically are more involved in emotional caregiving and the day-to-day monitoring of youth behavior than fathers (Craig, 2006; Fagan et al., 2014). These differences may shape how mothers interpret and respond to their child's STBs. Maternal caregivers are also more likely than paternal caregivers to seek mental health services for their children and to participate in research studies (Phares et al., 2005), which likely suggests that our sample represents caregivers who are more engaged or more attuned to their child's mental health.

Fifth, while rapid qualitative analysis methods have been shown to yield similar themes as traditional coding methods (Gale et al., 2019; Nevedal et al., 2021), this approach carries the risk of rater bias, and it may compromise the depth of interpretation and understanding of complex issues related to preteen assessment. However, these concerns are often deemed acceptable in early-stage or exploratory research like ours, where the goal is to quickly identify themes to inform ongoing or future work.

Conclusion

The ultimate goal of this work is to improve the identification and assessment of STBs in preteen youth. Our qualitative interviews yielded rich information about the lived experiences of both youth who experience the onset of STB before age 12 and caregivers of youth with the onset of STB before age 12, improving our understanding of suicide risk in this population. Study findings will be used to enhance the development of a comprehensive suicide risk assessment tailored for preteen youth in keeping with our long-term goal of improving outcomes and care for preteen youth experiencing STBs.

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Data Availability Statement

The participants in this study did not give written consent for their data to be shared publicly. Due to the sensitive nature of the research, supporting data is not available.

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Table 1.

Participant Demographics

	Adolescent (*n*=11)		Parent (*n*=11)	
	N (%)	**Mean (SD)**	**N (%)**	**Mean (SD)**
Age (in years)	12 (100.0%)	13.2 (2.4)	7 (58.3%)	41.7 (4.3)
Age Unknown	0 (0.0%)		5 (41.7%)	
Race				
Black or African American	2 (16.7%)		2 (16.7%)	
Asian	0 (0.0%)		0 (0.0%)	
American Indian or Alaska Native	0 (0.0%)		0 (0.0%)	
White	5 (41.7%)		8 (66.7%)	
Multi-racial	1 (8.3%)		0 (0.0%)	
Unknown	4 (33.3%)		1 (8.3%)	
Ethnicity				
Hispanic/Latinx	4 (33.3%)		1 (8.3%)	
Non-Hispanic/Latinx	8 (66.7%)		11 (91.7%)	
Sex at birth				
Male	2 (16.7%)		3 (25.0%)	
Female	10 (83.3%)		9 (75.0%)	
Prior Partial Hospitalization[+]	4 (33.3%)		N/A	
Prior Inpatient Hospitalization[+]	6 (50%)		N/A	
Suicide Attempt History[+]	8 (66.7%)		NA	

Note:

[+]signifies a past episode and does not reflect the patient's hospitalization status at the time of recruitment, which is indicated in text.

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Table 2.

Themes and representative quotes for rapid qualitative analysis (Child)

Domain	Theme	Exemplar Quote
Risk Factors and Warning Signs	Internalizing symptoms (sadness, anxiety, hopelessness) and a sense of feeling overwhelmed	"I was just so unhappy that I didn't feel worth living and stuff like that." "All those emotions bottling up, that I just decided to do it."
	Increased engagement in nonsuicidal self-injury	"I was just...cutting like always."
	Changes in behavior (appetite, sleep, social activities, isolation)	"I was not interested in anything and I just wanted to sleep. I barely ate and just wanted to be [alone] in my room." "I started self-harming, which was new for me."
	Family conflict and strained relationship with family	"My parents were always fighting. They were separated time-to-time. And then I felt left out by siblings. The more I got older, the more I got less social with my family. So then that was when I had my first attempt."
	Bullying	"I wanted to fit in and I couldn't fit in...and I used to get bullied."
	Not feeling like they belong	"Sometimes I would feel like I wasn't like the other kids, I wanted to be like the other kids so bad."
	Exposure to STBs in social media	"I don't know how they [social media] know how I feel in the brain, but every time I scroll it's like all suicidal stuff, and I'm like I can do that. I can take the pain away."
	Exposure to trauma, especially sexual and physical assault	"I was dealing with... something really traumatic."
Preparation and Method for SA	Mixed degree of planning SA	"For like a week I started planning the suicide and I started thinking of ways I could do it and least painful ways because I was still afraid of pain." "I never had a plan. I never planned anything, but...I would think oh yeah, tonight will be the night that I would, you know, try to die."
	SA often prompted by intensifying suicidal thoughts and buildup of distress and suffering	"One to two weeks of just thinking about it constantly, constantly, constantly."
	Varied degrees of method lethality	"I tried to put a pillow over my head. That was the first ever attempt." "I took loads of Benadryl."
Intention/Consequences of SA	Believed they would die from SA	"I thought I was gonna die. It was the idea that if I took pills and the right amount, I thought I was going to die."
	Expressed ambivalence about surviving their attempt	"I was scared and I was like I want this to end but do I really want to die?"
	Expected something better would happen if they died	"I felt like I was going to go somewhere better and finally be happy."
Methods of Communicating Risk	Changes in behavior	"I wouldn't go to school or I would have a hard time getting up for school or I would fight my mom on going to school and I wouldn't eat or I would overeat."
	Wished others had asked them directly about suicide	"I wish my mom would've noticed how I felt or asked how I felt."
	Tried to conceal thoughts and mental state	"I didn't let anybody know because I thought that it would be too much for other people to handle and that I would just be a burden to them and I didn't wanna do that."
	Barriers to communication	"I felt like I couldn't talk to anyone. I couldn't express how I felt towards anyone because people wouldn't understand how I felt."
Youth's Understanding of Death	Beliefs about existence of an afterlife versus complete non-existence	"They went to the afterlife or heaven, hell." "That you're done. Game over. That's it. There's no more after that."
	Religious, cultural, and societal perceptions of death	"Being Catholic in my family, it was like committing suicide is a sin so you would automatically go to hell, which is another reason why I was scared."

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Domain	Theme	Exemplar Quote
	and suicide shaped child's beliefs	
	Understood permanence of death	"I knew [death] was permanent."
Factors Related to Culture and Identity	Feeling different or "other" than peers	"I get to the point where I feel like I have to hurt myself because I feel different." "Cause when you feel like you're different, That's where it really starts."
	Experiences of prejudice based on gender, sexuality, race, or ethnicity	"I am gay and I knew that for people [who are] LGBTQ it can be especially hard because a lot of them are shamed nowadays."
	Self-worth influenced by perception of physical characteristics associated with race	"The reason why I didn't like me or I wanted to kill myself because...I didn't like my race. I didn't like the color of my skin, I didn't like my hair. I wanted to be...white...I didn't like how I looked."
	Cultural stereotypes	"Yeah, It's kind of like a stereotype. Hispanic and Latino and Latinx people. Parents don't really believe in mental health and everything, so It's kind of harder for the kids to express and talk about it."
	Religious influences	"If God doesn't want you to die yet, I feel like he's gonna either try to stop you or you just wake up after you pass out from hurting yourself or whatever."
	Gender matching	"Some girls feel more comfortable talking to other girls and boys talking to other boys…So kind of regardless of whether you're talking to your doctor or talking to a friend, it might be more helpful if they share the same gender identity."
How Professionals/ Other People Can Help	Ask direct questions about suicide	"If adults asked directly about experiencing self-harm or suicidal thoughts, then it shows they care."
	More regular check-ins	"Always check in with them and make sure that they're doing OK because you never know who's struggling."
	Pay attention to changes in the child's behaviors	"It's always hard because we're not always honest and especially as children, we don't always have the easiest time telling the truth. So again That's why It's important to watch the behaviors."
	Validate feelings and disclosure of SI	"People should definitely be patient and give the kids time to answer. Just think about how the kids in that position are feeling and get in their shoes a little bit so you don't hurt their feelings or anything and don't, especiallŷdon't minimize their feelings."
	Asses why kid may be experiencing SI/self-harm;	"What's making you feel [this way], and why do you feel the need to end your own life and how?"
	Building trust is important for disclosure	"Setting them up with a therapist. Somebody they actually enjoy talking to and can trust."

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Table 3.

Themes and representative quotes for rapid qualitative analysis (Caregiver)

Domain	Theme	Exemplar Quote
Risk Factors and Warning Signs	Verbal: Direct and indirect suicidal statements	"Whenever [child] felt a lot of shame or like she really screwed up in a situation, she would often say, 'I don't want to be here anymore.'" "The words were 'I want to kill myself.'"
	Behaviors: self-injury, increased agitation and aggression	"She had some scratch marks because she said when she gets upset and anxiety, she just…scratches herself."
	Emotions: loneliness, anger,frustration, sadness, feeling overwhelmed	"Said that he'd be better off as dead. That he was just too sad and too angry. Couldn't do it anymore."
	Changes in behavior: increased isolation, discussions of suicide and engagement in self-harm	"Being standoff-ish, she doesn't want to be bothered with nobody and nothing, just laying and sleeping."
	Struggling in school and difficulty engaging in usual activities	"A lot of times for him, it has been [difficult] going to school…The work at school stresses him out."
	Bullying, trauma, exposure to violence	"School, it's tough, because she's been bullied about her body because she's skinny."
	Changes in family environment	"we're going through a divorce, and moved, and while it's better it's also hard on a kid either way."
	Exposure to suicide content from family, social media, and peers	"A teenage girl there [on social media], and this was when she was [even] younger, taught her how to [die by] suicide. Basically, the girl said [gesturing to wrist] it's not this way, it's this way."
	Peer group challenges	"Two of her best friends on social media and in school, got into a fight and these two little girls both told her to kill herself. They told her that she should die, that she shouldn't be alive and that she should kill herself then."
Preparation and Method of SA	Minimal planning for SAs	"I haven't seen any indication of a plan. They haven't vocalized any indication of a plan."
	SA defined as "impulsive" or abrupt	"I think it's on impulse. I don't think it's something that just sits in her brain. It just comes out when she's upset or whatever."
	Learned child was thinking about suicide only after SA	"I found out, at the emergency room, that she tried to choke herself."
Intention/Consequences of SA	SA as a means to gain support or receive attention	"They don't know how to express it, and it just feels like they're trapped in a way and so it's almost like…a cry for help."
	Actually die from SA, even SAs with nonlethal means	"He knows that he wouldn't come back."
	Negative emotions would go away	"I think it's [SA] more to get away from the thoughts and the feelings."
Methods of Communicating Risk	Verbalized SI either explicitly to parents and teachers or indirectly expressing a desire to die	"He's actually very good at verbalizing how he's feeling. I feel like every time he verbalized that he was at that point where he didn't know what else to do."
	Did not disclose particular methods or means due to fear of getting into trouble, returning to the hospital or hurting the parent.	"She said she didn't want to put more stress on me because I have enough on my plate and she didn't want to be more of a burden."
	Dark or violent themes (sometimes related to SI) in drawing, journaling, and notes	"I saw all the pictures that she was drawing, all the things that she was writing about it [SA]. And it was…kind of scary…the drawings and stuff like little people hanging in, like, hang yourself, kill yourself."
Youth's Understanding of Death	Belief in an afterlife	"The way she sees it is like you die, and then if you're a good person, you go to heaven."
	General understanding of permanence of death, though some doubt about whether child fully understood death	"He is aware of the permanence, but I think he's hopeful that he would come back somehow." "She knows that once they die, they don't come back. So she understands death."

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Domain	Theme	Exemplar Quote
	Mixed reports of having and not having direct conversations about death with child	"We don't really talk about death a lot. We haven't had a lot of loss in our family, so I'm not sure that he quite understands that it's permanent." "He understands that you don't come back…We talked about it, and I've said, 'No one really knows for sure what happens.'"
	Shaped by personal experiences	"She understands death because she's lost a lot of people in her life. she's lost my mom. she's lost my cousin."
Factors Related to Culture and Identity	Professionals should recognize intersecting identities and how cultural identities may impact beliefs about mental health	"I feel like for us for Latino people it's hard for all of us to deal with those identities kind of thing…the homosexual or bisexual stuff, for the Latino people is so big that kids shut down, don't say anything about it." "Well, for culture and race, my people, Cape Verdean and Black, I've been through that generation that if you tell your parents something [how you're feeling]…they hit you or they think it's a joke."
	Important for parents and clinicians to validate and try to understand lived experience of gender diverse and LGBT identifying youth.	"As a parent, reassuring your child that they are supported in their gender expression. I'm like, 'Look, you know, I support you with it, 100% of this.'"
	Importance of taking an individualized approach and not making broad assumptions	"I feel like everybody's culture is different…So I think that just being as individualized as possible is the best way to approach it. And just ask. Ask questions, not just assume, ask the questions even if you don't know or if you think you know you may not know. I think the best way is to just ask."
	More professionals of diverse backgrounds to join the field	"[Need] more people like us to actually actually listen, to understand."
	Distrust in the mental health communities	"Yes, because we grew up in a different environment. When I say we, mostly black and brown people, poor people. You [white providers] go out and you watch a couple of movies or visit a couple of places and think you understand. But you don't, because you're not actually in it, and people is good on putting on a show to try to I don't know what they trying to do, but it ain't helping nobody."
	Beliefs about death shaped by cultural/religious influences	"She understands that they go to a better place when they die. That's my religion. You go to heaven."
How Professionals/Other People can Help	Directly ask about suicide and be careful not to "expose" children to more than they already knowabout suicide	"I think she got quite the education when she went to the hospital that night of what it really was, and the questions they asked her, I think didn't need to be asked really." "Important to ask 'Do you want to hurt yourself?'"
	Pay attention to child's emotions and changes in behavior	"Behaviors. If they act this way, they used to be happy, chatty, and they start to shut down and don't say much. Quiet. Just pay attention to notice the behavior. Just to see, there's something there, let's take a look."
	Take a non-judgmental/validating approach in discussing STBs	"It's allowing the child to understand that they're in a safe space, and that what they're telling that teacher, doctor, professional, whatever the case may be that it is a safe space, and their thoughts and their feelings are valid."
	Talk about emotions more openly in school settings	"I just really think it is those frequent check-ins. I can't say enough about that. I feel like even in the school system, if they knew how to check in."
	Validate children AND parent's experiences/opinions on treatment	"A lot of doctors they don't listen to the parents…I know we're not anything like the professionals. But we do study and know our kids, too… But we really do know our kids. And what's going on. What is best for them." "It's a validation piece. I guess I would just [have them] say, 'Hey, you know you [the child] are wanted, you have something to offer the world. I know you feel terrible right now…but we're here to help you realize your potential and hopefully help you navigate this…difficult circumstance that you're dealing with."