Trauma-informed approach to supporting youth at risk of suicide

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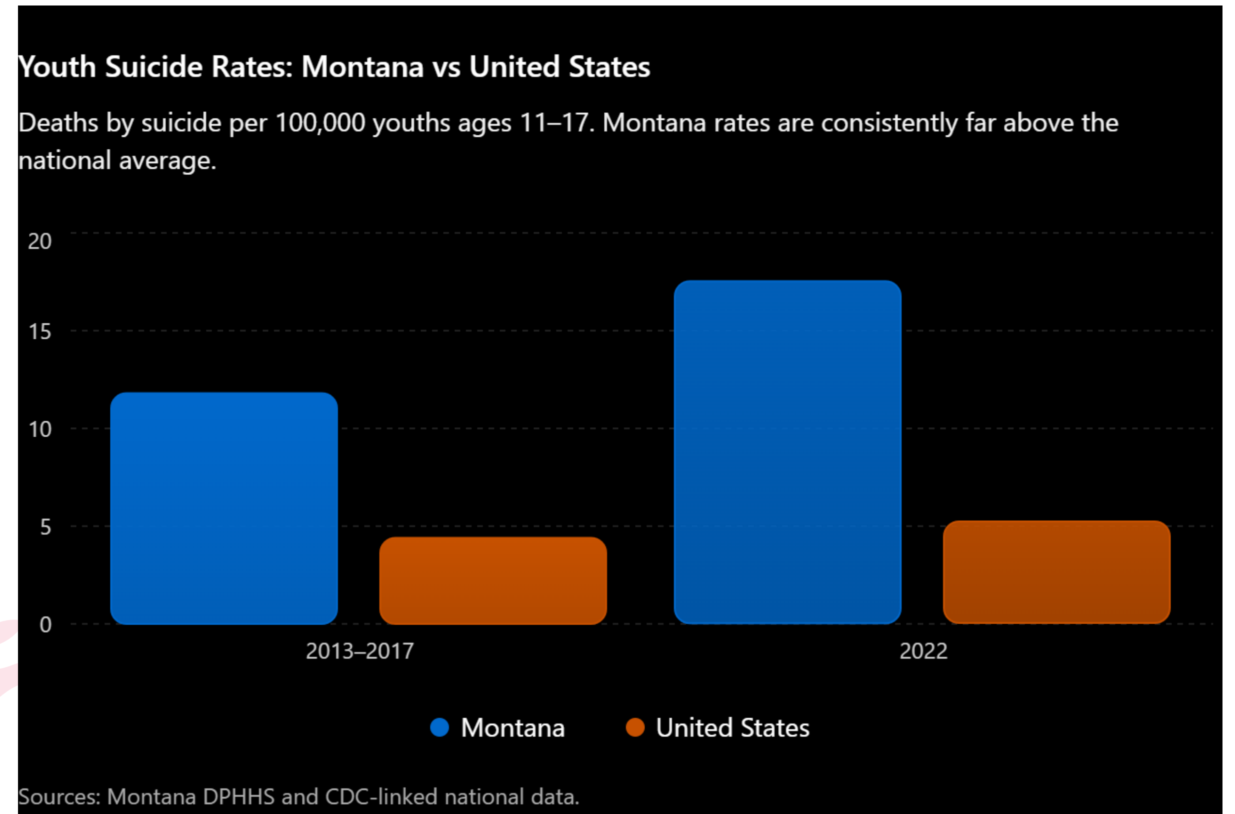
The Problem

Pediatric Suicidality Prevalence

- Suicide is the second leading cause of death for adolescents in the US
- There are notable geographic differences in the incidence of adolescent suicide, with more rural, Rocky Mountain states representing the highest rates.
- Alaska, South Dakota, Wyoming, and Montana have the highest rates of suicides for youths aged 10–19 years

Montana Pediatric Youth Suicide Prevalence



Risk factors associated with pediatric suicidality

- Diagnosis of PTSD
- Trauma exposure:
  - Bullying
  - Abuse
  - Neglect
  - Exposures to IPV
  - Sexual abuse
  - Adoption/foster care
    - (Hink et al., 2022)

Risk factors associated with pediatric suicidality

Experiencing a major life stressor or crisis (e.g., breakup with a dating partner or having a fight with a parent increases the risk of suicide).

housing insecurity, and living in a corrections facility or residential facility

Traumatic injury

Exposure to community firearm violence

- (Hink et al., 2022)

Trauma/PTSD, and
suicidality comorbidity

Risk factors associated with pediatric suicidality

- Child maltreatment
  - Results suggest that, for children and adolescents, reexperiencing and avoidance symptoms are most strongly related to suicidal behaviors (McRae et al., 2022)

PTSD symptomatology and suicidality

DSM-V

Negative mood and cognition

- negative beliefs about oneself or others,
- persistent negative emotional state,
- and feelings of detachment or estrangement from others.

Reexperiencing

Avoidance/numbing

Hyperarousal

Provocative experiences

- Provocative and painful experiences increase risk of suicide
  - For example, Bond et al. (2021) found tying a noose, using intravenous drugs, or having injuries that required medical attention were associated with greater odds of attempting suicide

Traditional mental health treatment

- Emergency Department
  - EmPATH units
- Inpatient and residential
  - Trauma informed care (TIC)
  - System change (Bryson et al., 2017)

Trauma informed care
for youth suicidality

- Therapeutic stance
- Psychoeducation and normalization (Mirick et al., 2022).

SAMHSA principles of trauma-informed care

- safety,
- trustworthiness and transparency,
- peer support,
- collaboration and mutuality,
- empowerment, voice, and choice, and
- cultural, historical, and gender issues.

Trauma informed care

1. caregiver involvement and acknowledging caregiver distress;

2. clinician authenticity, genuineness, and warmth; and

3. clinician knowledge about trauma and the impact of traumatic stress on suicide risk (Inscoe, 2021).

Screening and
assessment

Screening and assessment of suicidality

Ask Suicide-Screening Questions (ASQ)

Columbia-Suicide Severity Rating Scale (C-SSRS)

Screening

- Trauma-exposed youth should be routinely screened for
  - Suicidality &
  - PTSD
  - However:
    - Less than 50% of all patients are screened for suicidality, 25% for depression, and 7% for PTSD symptoms at level I and II trauma centers across the USA (Love et al, 2014).

Screening: Trauma & PSTD

Adverse Childhood Experiences Screener (ACES Screener)

Child PTSD Symptom Scale (CPSS)

PTSD Checklist for DSM-5 (PCL-5)

Trauma-informed language

- Died by suicide instead of committed suicide
- Patients experiencing suicidal thoughts instead of suicidal patients
- Suicide instead successful suicide
- Non-lethal suicide attempt versus failed or unsuccessful suicide attempt

Trauma-informed approaches to screening and safety planning

- Collaborative with parent involvement
- Balance between acceptance and change strategies
- Collaborative learning between youth and clinician/assessor on youth's emotional reactions (e.g., thermometer)
- Broaden to include larger social support network
- Developmentally appropriate (e.g., role plays, discuss obstacles) Asarnow et al. (2020).

Lethal means counseling

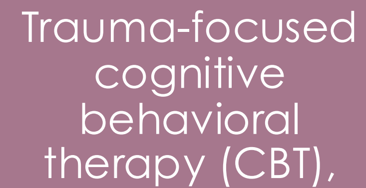
- Consider all types of lethal means and the influence of gender
- Videos, psychoeducation
- Provide storage devices
- Stance
  - Non-judgemental
  - Collaborative (Ketabchi et al., 2025)

Treatment

Trauma informed care: Acute

- Trauma-informed therapeutic stance
- Promote physical and psychological safety
- Recognize traumatic stress
- Mobilize youth, family and community strengths to enhance resilience
- Trauma-informed assessment and brief interventions
- Ongoing treatment and monitoring (Tunno et al., 2021).

Trauma-focused treatments



- Trauma-focused cognitive behavioral therapy (CBT),
- Parent–Child Interaction Therapy (PCIT),
- Cognitive processing therapy (CPT)
- The Attachment, Self-Regulation, and Competency (ARC) Framework (Arvidson et al., 2011

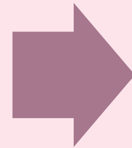
Suicidality treatments

- Cognitive Behavior Therapy (CBT) for suicidality
- Dialectical Behavioral for Therapy (DBT)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Psycho-pharmocological approach
- Community-school-medical collaboration

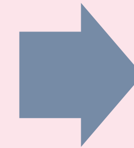
Clinical Case Example

CASE EXAMPLE

Patient X is a 16-year-old female identifying as multiracial.



The following case examines a suicidal patient who presented to the ED with suicidality and a significant history of prior trauma exposure.



At the time of the ED visit, the patient's Ask Suicide-Screening Questions (ASQ) indicated significant suicidal thoughts in the past week and past suicide attempt(s). The patient had been inpatient hospitalized for suicidality several times in past two years.

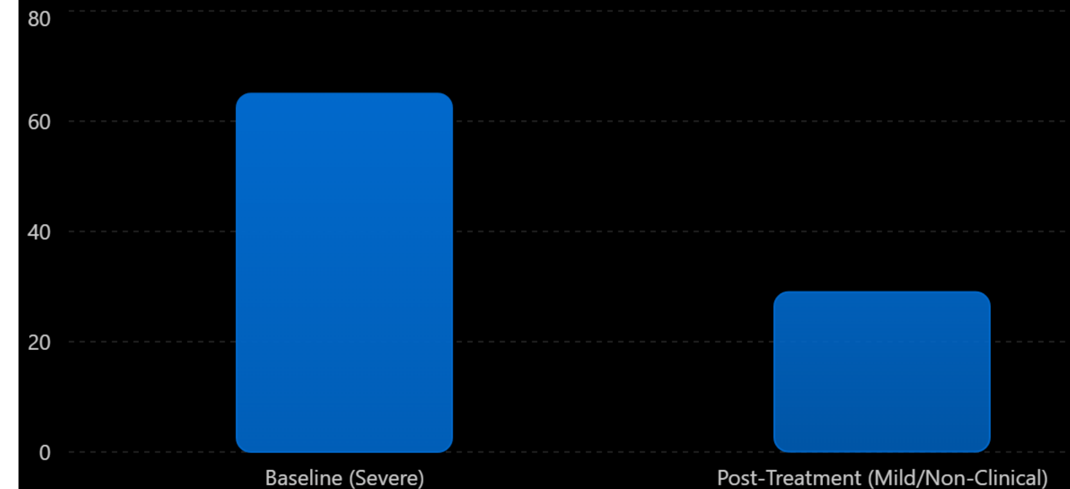
CASE EXAMPLE

The ED referred the patient to the crisis clinic. Using CAMS, the patient self-identified what causing her suicidal thinking and behaviors which was feelings of guilt associated with her trauma exposure. The patient participated in 8 weekly CAMS sessions that targeted her self-identified driver of suicidality.

Within the framework of CAMS, the patient received the trauma-focused intervention of Cognitive Processing Therapy (CPT) for posttraumatic stress disorder (PTSD) to treat her driver of suicidality. CPT is an evidence-based, trauma-focused intervention that focuses on challenging stuck points or cognitions associated with trauma exposure (Ferguson, 2019).

CASE EXAMPLE

- The patient displayed a significant reduction in suicidal behaviors, suicidal ideation, (met discontinuation criteria for CAMS, or no longer acutely suicidal) and posttraumatic stress symptoms (PCL baseline = 65, severe; PCL post-treatment = 29, mild or non-clinically significant) from pre- to post-treatment.



CASE EXAMPLE

- This novel, yet well-supported in the literature, approach/model to treating adolescents' suicidality—using a trauma-focused intervention while continuously assessing and safety planning for suicide risk—could be lifesaving and may reduce the costly revolving door of youth cycling through the ED and inpatient settings with little sustainable improvement in functioning and well-being over time

Q&A
Discussion

Discussion question

- How does this case example highlight use of trauma-informed practices?

Questions?

Discussion

- How can medical and mental health professionals integrate trauma-informed care with suicide-focused interventions to effectively support suicidal youth while maintaining safety, trust, and long-term therapeutic engagement?

- Crisis Services

- As of late 2025, Montana law (SB 435) allows mental health professionals to initiate a 72-hour involuntary hold for individuals in acute crisis who are a danger to themselves or others. This hold, which can occur at local facilities, requires an evaluation within 24 hours and replaces previous, more limited emergency detention laws.

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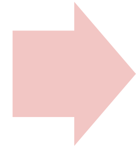

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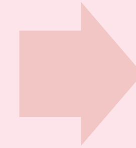

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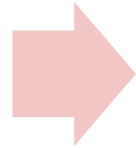

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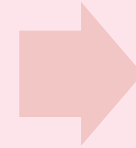

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