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‘It’s Life or Death’: The Mental Health Crisis Among U.S. Teens

Depression, self-harm and suicide are rising among American adolescents. For one 13-year-old, the despair was almost too much to take.

By Matt Richtel
Photographs by Annie Flanagan

Matt Richtel spent more than a year interviewing adolescents and their families for this series on the mental health crisis.

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One evening last April, an anxious and free-spirited 13-year-old girl in suburban Minneapolis sprang furious from a chair in the living room and ran from the house — out a sliding door, across the patio, through the backyard and into the woods.

Moments earlier, the girl’s mother, Linda, had stolen a look at her daughter’s smartphone. The teenager, incensed by the intrusion, had grabbed the phone and fled. (The adolescent is being identified by an initial, M, and the parents by first name only, to protect the family’s privacy.)

Linda was alarmed by photos she had seen on the phone. Some showed blood on M’s ankles from intentional self-harm. Others were close-ups of M’s romantic obsession, the anime character Genocide Jack — a brunette girl with a long red tongue who, in a video series, kills high school classmates with scissors.

In the preceding two years, Linda had watched M spiral downward: severe depression, self-harm, a suicide attempt. Now, she followed M into the woods, frantic. “Please tell me where u r,” she texted. “I’m not mad.”

American adolescence is undergoing a drastic change. Three decades ago, the gravest public health threats to teenagers in the United States came from binge drinking, drunken driving, teenage pregnancy and smoking. These have since fallen sharply, replaced by a new public health concern: soaring rates of mental health disorders.

In 2019, 13 percent of adolescents reported having a major depressive episode, a 60 percent increase from 2007. Emergency room visits by children and adolescents in that period also rose sharply for anxiety, mood disorders and self-harm. And for people ages 10 to 24, suicide

rates, stable from 2000 to 2007, leaped nearly 60 percent by 2018, according to the Centers for Disease Control and Prevention.

The decline in mental health among teenagers was intensified by the Covid pandemic but predated it, spanning racial and ethnic groups, urban and rural areas and the socioeconomic divide. In December, in a rare public advisory, the U.S. surgeon general warned of a "devastating" mental health crisis among adolescents. Numerous hospital and doctor groups have called it a national emergency, citing rising levels of mental illness, a severe shortage of therapists and treatment options, and insufficient research to explain the trend.

"Young people are more educated; less likely to get pregnant, use drugs; less likely to die of accident or injury," said Candice Odgers, a psychologist at the University of California, Irvine. "By many markers, kids are doing fantastic and thriving. But there are these really important trends in anxiety, depression and suicide that stop us in our tracks."

"We need to figure it out," she said. "Because it's life or death for these kids."

The crisis is often attributed to the rise of social media, but solid data on the issue is limited, the findings are nuanced and often contradictory and some adolescents appear to be more vulnerable than others to the effects of screen time. Federal research shows that teenagers as a group are also getting less sleep and exercise and spending less in-person time with friends — all crucial for healthy development — at a period in life when it is typical to test boundaries and explore one's identity. The combined result for some adolescents is a kind of cognitive implosion: anxiety, depression, compulsive behaviors, self-harm and even suicide.

This surge has raised vexing questions. Are these issues inherent to adolescence that merely went unrecognized before — or are they being over diagnosed now? Historical comparisons are difficult, as some data around certain issues, like teen anxiety and depression, began to be collected relatively recently. But the rising rates of emergency-room visits for suicide and self-harm leave little doubt that the physical nature of the threat has changed significantly.

As M descended, Linda and her husband realized they were part of an unenviable club: bewildered parents of an adolescent in profound distress. Linda talked with parents of other struggling teenagers; not long before the night M fled into the forest, Linda was jolted by the news that a local girl had died by suicide.

"You have no control over what they're thinking," Linda said. "I just want to tell people what can happen."

'A typical outpatient'

M is one of dozens of teenagers who spoke to The New York Times for a yearlong project exploring the changing nature of adolescence in the United States. The Times was given permission by M and the family to speak with M's school counselor; M's medical records were

shared with The Times and, with the family's permission, reviewed by outside experts not involved in M's care.

"This is a typical outpatient," said Emily Pluhar, a child and adolescent psychologist at Harvard University, describing M as "an internalizer."

M, now 14, is tall, with red hair and blue eyes, and has a younger sister and older half-brother. By turns shy and outspoken, M has thought extensively about pronouns and currently prefers "they." At the beginning of seventh grade, M also asked to be called by the name of a popular Japanese anime character, whose first name starts with M. "I think we're similar in that she's, like, quiet and smart and plays electric bass, and I really like bass and guitars," M said.

When M was 4, a psychologist the family consulted to assess M's school readiness concluded that their "intellectual ability is in the very superior range," according to the report. M enrolled in kindergarten as one of the younger class members.

At 10, M got a smartphone. Linda and her husband, Tony, both of whom had busy work schedules, worried that the device might lead to heavy screen time, but they felt it was necessary to stay in touch. At 11, M hit another adolescent milestone: puberty.

Over the last century, the age of puberty onset has dropped markedly for girls, to 12 years old today from 14 years old in 1990; the age of onset for boys has followed a similar path. Experts say this shift probably now plays a role in the adolescent mental health crisis, although it is just one of many factors that researchers are still working to understand.

When puberty hits, the brain becomes hypersensitive to social and hierarchical information, even as media flood it with opportunities to explore one's identity and gauge self-worth. Laurence Steinberg, a psychologist at Temple University, said that ability to maturely grapple with the resulting questions — Who am I? Who are my friends? Where do I fit in? — typically lags behind.

The falling age of puberty, he said, has created a "widening gap" between incoming stimulation and what the young brain can process:

"They're being exposed to this deluge at a much earlier age."

M's first hint of trouble came in sixth grade, with challenges focusing in class. The school called a meeting with M's parents. One teacher suggested testing M for attention deficit hyperactivity disorder, but Linda and Tony were skeptical. The number of A.D.H.D. diagnoses in the United States rose 39 percent from 2003 to 2016, according to the C.D.C., and M's parents, both scientists in biomedical fields, were concerned that consulting an A.D.H.D. specialist would tilt the scales toward that diagnosis.

Instead, Linda tried to help M stay organized with an app that parents and students used to track assignments, test scores and grades. M felt put under a microscope.

“She would say, ‘Can you bring me your iPad so we can check Schoology?’” M recalled about Linda. “I would literally have an anxiety attack because I was so scared.”

By the fall of 2019 — seventh grade — M was struggling socially, too. A close friend got popular, while M often came home from school and got into bed. “I felt like a plus one,” M said. “I just wanted to be unconscious.” Other times, M said, “I just sat in my room and cried.”

The behavior seemed alien to Tony, who had lived a different childhood. As an adolescent in Vermont in the 1980s, he fished and played outdoors. By 15, he had his first serious girlfriend; in 1990, the summer before their senior year, he got her pregnant. Their son was born that December, and Tony and the mother shared custody.

Times have changed. Federal research shows that 38 percent of high-school-age teenagers report having had sex at least once, compared with roughly 50 percent in 1990. The teen birthrate has plummeted.

So has cigarette and alcohol use. In 2019, 4 percent of high school seniors reported having a cigarette in the last 30 days, down from 26.5 percent in 1997. Alcohol use by high schoolers hit 30-year lows at the same time. Use of OxyContin and other illicit drugs among high schoolers is down sharply over the last 20 years. Vaping of both nicotine and marijuana has risen in recent years, although both dropped sharply during the pandemic.

Experts cite multiple factors: public awareness campaigns, antismoking laws, parental oversight and a changing social lifestyle that is no longer strictly in-person.

Dr. Nora Volkow, director for the National Institute on Drug Abuse, described drug and alcohol use as “very much of a group dynamic.” She added: “To the extent that kids are not in the same place, one would expect a decrease in the behavior.”

A virtual crush

In the spring of 2020, M retreated further. Bewildered by online classes, M lied about participating, felt guilty and watched YouTube instead, devouring an anime series called “Danganronpa.” It is set in a high school where students learn from the evil headmaster, a bear, that the only way to graduate is to kill a peer.

M became enamored of one of the characters, Genocide Jack (sometimes known as Genocide Jill), who is described on one fan site as a witty “murderous fiend” who “kills handsome men” using scissors.

One night after dinner, M was upstairs and used scissors to cut both ankles. “I was mad at myself for not doing homework,” M said. “I was kind of thinking, ‘Oh, the pain feels good,’ like it was better than being stressed.” M couldn’t recall where the idea came from: “I wanted to hurt myself with anything.”

M’s parents noticed superficial scratches on M’s thighs that resembled cuts but did not raise the subject. Linda worried about the screen time but “it was pandemic,” she said.

When school ended for summer break, M’s mood improved. Over the summer, M discovered the mobile version of the “Danganronpa” video game and how to override the parental screen limits. M played all day.

“I was in front of my screen staring at Jack,” M said. “Then I was playing ‘Trigger Happy Havoc,’ and I was, like, more in love.”

“I was kind of just lonely,” M said. M fantasized about the future with Jack: “I’d want her to almost kill me but not, and then we could spend the rest of our lives together.”

An obsession with a virtual character is not uncommon, experts said. “This is a kid who is a bit lonely, a bit caught up in these narratives,” said Nick Allen, a psychologist at the University of Oregon. “There’s nothing new in coming up with stuff that freaks out their parents.”

Nonetheless, he added, “extremely powerful” online experiences like these can encourage users to think, “That is going to be my identity, my sense of the future, my sense of where I belong socially,” at a time when one’s identity is a work in progress.

Dr. Pluhar of Harvard noted that “the challenge and the progress” of modern adolescence “is there are so many types of identity” — more choices and possibilities, which in turn could be overwhelming. Among the factors shaping mental health, Dr. Pluhar said, is the mind’s churning and obsessing: “Rumination is a big piece of it.”

M had a name for the main source of their mental health challenges: “Loneliness.”

Elaniv

Health experts note that, for all its weight, the adolescent crisis at least is unfolding in a more accepting environment. Mental health issues have shed much of the stigma they carried three decades ago, and parents and adolescents alike are more at ease when discussing the subject among themselves and seeking help.

Indeed, Linda had begun having conversations with other parents who wondered whether the challenges their adolescents were facing represented typical moody teen behavior or something pathological. A colleague told Linda about her daughter’s eating disorder. A mother named Sarah confided that her middle-school-age daughter was in therapy for anxiety and depression. “I told her, ‘I understand where you’re at way better than you think,’” Sarah recalled.

In a nearby suburb, the parents of Elaniv Burnett were struggling to understand their daughter’s desperation. As a young child, Elaniv had been joyful, an eager student and graceful gymnast,

her father, Dr. Tatnai Burnett, a gynecological surgeon at the Mayo Clinic, recalled: “The kind of kid where you go, ‘Huh, we should have more kids.’”

But in 2014, when Elaniv was 9, her parents’ marriage began to fracture, and Elaniv injured her ankle; she developed chronic pain, which sidelined her from gymnastics, and she went through a dark period. Then, in 2016, Dr. Burnett, who is Black, was held at gunpoint at home by the police, in full view of the family, after officers responded to a call of a possible intruder.

Recent research has found that wealth, education and opportunity do not shield Black families from mental health issues to the same degree they do for white families. From 1991 to 2017, suicide attempts by Black adolescents rose 73 percent, compared with an 18 percent rise among white adolescents. (The overall suicide rate remains higher among white adolescents.) The suicide rate leaped particularly for Black girls, up 6.6 percent per year on average from 2003 to 2017, new research shows.

In the fall of 2019, Elaniv was diagnosed with major depressive disorder. In a poem in her journal, she wrote: “Thoughts like racecars zoom constant in my head/ Self-hate and worthlessness/ Perpetual, they speed ahead.”

Elaniv began therapy, took medications and enrolled in an outdoor inpatient program in Utah. “We worked on ourselves, worked on our parenting, we changed so many things to try to help meet Elaniv where she was,” Dr. Burnett said. “We controlled electronics, monitored friendships.”

Elaniv’s mother, Tania Gainza, a clinical social worker, saw a generational trend. She had counseled an adolescent for years who was terrified of not meeting expectations. She heard about a local boy who killed himself seemingly without warning.

“There’s something different about this era or generation that makes them much more susceptible or vulnerable,” Ms. Gainza said. “There’s not that community, I guess.”

A rise in loneliness is a key factor, experts said. Recent studies have shown that teenagers in the United States and worldwide increasingly report feeling lonely, even in a period when their internet use has exploded.

“They’re hanging out with friends, but no friends are there,” said Bonnie Nagel, a psychologist at the Oregon Health & Science University. “It’s not the same social connectedness we need and not the kind that prevents one from feeling lonely.”

Often, she said, online social connections amount to seeing “pictures of people hanging out, flaunting it, as if to say, ‘Hey, I’m very socially connected,’ and ‘Hey, look at you by yourself.’”

The pandemic factor

One day in the autumn of 2020, with the pandemic in full swing and eighth grade having gone fully remote, Linda found M sobbing in bed. M confessed to wanting to die.

Linda found an online therapist. After several sessions, "the therapist broke confidentiality," Linda said. "She said, 'You need to know about the knife.'"

In M's nightstand, Tony found a pocketknife and a box knife with a cat's paw image on the handle that M had surreptitiously bought on Amazon and was using to self-harm. One night, M went further, tightening a red hair tie around their neck. "I was trying to see how far I could take it," M said.

The following February, M entered full-day group therapy. A psychiatrist at the clinic notified the family that M had admitted to being unable to stop cutting, medical records show. Linda "de-knived the house," she said, and hid all the pills. Then M engaged in a different kind of self-harm: hitting their head with an eight-pound workout barbell.

Linda recalled feeling stunned: "Oh, now I have to get rid of the blunt objects, too."

M was discharged with a diagnosis of depression and a prescription for antidepressants. From 2015 to 2019, prescriptions for antidepressants rose 38 percent for teenagers compared with 15 percent for adults, according to Express Scripts, a major mail-order pharmacy.

Subsequently, M also received a diagnosis of attention deficit disorder, not A.D.H.D., and given a prescription for methylphenidate, the generic name for medications including Ritalin and Concerta. "I'm still not sure I believe it," Linda said.

M's middle school has a trained mental health counselor. In March 2021, M visited him for the first time. During that visit, on a scale of 0 to 10, M ranked hopelessness and anxiety at 9, expressing terror at returning to school, a fear of falling behind and a wish to die.

But M's mood improved; at a meeting a month later, M ranked hopelessness and sadness at 5 and anxiousness at 2. M felt therapy was crucial but wasn't sure the medications helped; the school counselor credited M's improvement to family support and getting back to school. He cautioned the parents, though, that the pendulum could swing back.

Into the forest

Around that time, Linda heard through the grapevine that a girl named Elaniv Burnett had died following an overdose. "I'm sorry, I can't take it anymore," Elaniv wrote in a note. Her mother rushed her, still conscious, to the hospital, where Elaniv expressed regret at the overdose and described her terror. She died four days later, at age 15.

The news was still on Linda's mind a few weeks later when M fled into the forest.

M’s family had recently returned from visiting both sets of grandparents. One set criticized M’s pronouns, the other M’s heavy screen use. Linda said she felt judged. She stole a look at M’s phone and saw the troubling photos.

“Let’s go for a walk,” she said to M and went upstairs briefly. When she returned, M had vanished, so she followed them into the woods, texting as she frantically looked for flashes of M’s white dress.

Finally M texted back: “I don’t want to talk to you.”

Linda returned home, and Tony went out. He found M along a commonly used trail. They walked, mostly in silence. “Then they were ready to come home,” he recalled.

The school year ended, and M improved, the anxiety ebbing. M took joy spending time with a friend, in person, walking home, strolling the forest.

But a few weeks later, a hurtful text from the friend plunged M into despair again, “like I was back to having no friends.”

M used an exfoliating blade to cut both ankles. “I don’t know how to stop it,” M said. “I can bet $20 that I’ll be in the hospital next year.”

When Linda saw the cuts, she confronted M, who handed over the blade. M let Linda examine the wounds.

“I think that’s good,” Linda said. “They let me look.”

How Matt Richtel spoke to adolescents and their parents for this series

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In mid-April, I was speaking to the mother of a suicidal teenager whose struggles I’ve been closely following. I asked how her daughter was doing.

Not well, the mother said: “If we can’t find something drastic to help this kid, this kid will not be here long term.” She started to cry. “It’s out of our hands, it’s out of our control,” she said. “We’re trying everything.”

She added: “It’s like waiting for the end.”

Over nearly 18 months of reporting, I got to know many adolescents and their families and interviewed dozens of doctors, therapists and experts in the science of adolescence. I heard wrenching stories of pain and uncertainty. From the outset, my editors and I discussed how best to handle the identities of people in crisis.

The Times sets a high bar for granting sources anonymity; our stylebook calls it “a last resort” for situations where important information can’t be published any other way. Often, the sources might face a threat to their career or even their safety, whether from a vindictive boss or a hostile government.

In this case, the need for anonymity had a different imperative: to protect the privacy of young, vulnerable adolescents. They have harmed themselves and attempted suicide, and some have threatened to try again. In recounting their stories, we had to be mindful that our first duty was to their safety.

If The Times published the names of these adolescents, they could be easily identified years later. Would that harm their employment opportunities? Would a teen — a legal minor — later regret having exposed his or her identity during a period of pain and struggle? Would seeing the story published amplify ongoing crises?

As a result, some teenagers are identified by first initial only; some of their parents are identified by first name or initial. Over months, I got to know M, J and C, and in Kentucky, I came to know struggling adolescents I identified only by their ages, 12, 13 and 15. In some stories, we did not publish precisely where the families lived.

Everyone I interviewed gave their own consent, and parents were typically present for the interviews with their adolescents. On a few occasions, a parent offered to leave the room, or an adolescent asked for privacy and the parent agreed.

In these articles, I heard grief, confusion and a desperate search for answers. The voices of adolescents and their parents, while shielded by anonymity, deepen an understanding of this mental health crisis.

Matt Richtel is a best-selling author and Pulitzer Prize-winning reporter based in San Francisco. He joined The Times in 2000, and his work has focused on science, technology, business and narrative-driven storytelling around these issues. @mrichtel