

University of Northern Iowa  
**UNI ScholarWorks**

---

Graduate Research Papers

Student Work

---


2005

## Reducing suicide risk among adolescents : treatment and intervention

Angie Kippe  
*University of Northern Iowa*

Copyright ©2005 Angie Kippe

Follow this and additional works at: <https://scholarworks.uni.edu/grp>

 Part of the [Counseling Commons](#), and the [Education Commons](#)

*Let us know how access to this document benefits you*

---

### Recommended Citation

Kippe, Angie, "Reducing suicide risk among adolescents : treatment and intervention" (2005). *Graduate Research Papers*. 1002.

<https://scholarworks.uni.edu/grp/1002>

This Open Access Graduate Research Paper is brought to you for free and open access by the Student Work at UNI ScholarWorks. It has been accepted for inclusion in Graduate Research Papers by an authorized administrator of UNI ScholarWorks. For more information, please contact [scholarworks@uni.edu](mailto:scholarworks@uni.edu).

---

## Reducing suicide risk among adolescents : treatment and intervention

### Abstract

Adolescent suicide is very disturbing. Formulating effective prevention and treatment can be elusive. Counselors must become aware of many factors when assessing and treating adolescent suicide ideation and attempts. Facts about suicide and how suicide interfaces with other mental disorders will be examined.

**Reducing Suicide Risk Among Adolescents: Treatment and Intervention**

**A Research Paper**

**Presented to**

**The Department of Educational Leadership, Counseling,  
and Postsecondary Education**

**University of Northern Iowa**

**In Partial Fulfillment**

**of the Requirements for the Degree of Master of Arts**

**by**

**Angie Kippe**

**July 2005**

This Research Paper by: Angie Kippe

Entitled: Reducing Suicide Risk Among Adolescents: Treatment and Intervention

has been approved as meeting the research paper requirements for the Degree of Master of Arts

6-23-05

---

Date Approved

---

Adviser/Director of Research/Paper

John K. Smith

7/7/05  

---

Date Received

---

Head, Department of Education Leadership,  
Counseling, and Postsecondary Education

Adolescent suicide is very disturbing. Formulating effective prevention and treatment can be elusive. Counselors must become aware of many factors when assessing and treating adolescent suicide ideation and attempts. Facts about suicide and how suicide interfaces with other mental disorders will be examined.

Suicide is the eleventh leading cause of death among all Americans and the third leading cause of death among adolescents in the United States. According to Paulson and Worth (2002), there has been a dramatic increase in youth suicide over the past few decades. Sean and Marcus (2003) found that "a previous suicide attempt is the most significant determinant of whether an adolescent will complete suicide" (p. 4).

However, Beautrais (2003) found that previous research has linked suicide and suicide attempts to a series of factors, including gender, the economic and educationally disadvantaged, childhood and family adversity, mental health problems, and exposure to stressful circumstances. Some related disorders include depression, anxiety and panic disorders, and substance use and abuse. Suicide is very mysterious, and the possible causes and theories surrounding suicide can be very complex (House, 2002).

The purpose of this paper is to provide greater knowledge about adolescent suicide. Areas of exploration will include adolescent stressors, associated mental disorders, personal and environmental risk factors, and effective interventions for adolescents who are potentially suicidal. This information is designed to facilitate overall awareness and new avenues of study aimed at developing possible prevention strategies for future work with suicidal ideation among adolescents.

#### Assessing Adolescent Suicide Risk and Risk Predictors

It is important for counselors to identify significant risk factors during an intake interview. Once counselors are aware of potential risk factors they will become more skilled in asking pertinent questions to help them identify risk and other potential mental and emotional disorders or underlying issues. Laux (2002) reported that "it is unwise to operate under the assumption that all risk factors have been considered and recognized"

(p. 5). Counselors should also be alert to more specific differences between adolescent risk and actual suicide completion.

Family characteristics, personal information, and demographics are important factors to evaluate when assessing adolescent suicide risk (House, 2002). Specifically, any family maladjustment, domestic abuse, mood disorders, psychosis or substance abuse, antisocial or borderline personality disorders, and any family medical disorders should be explored (House, 2002). Conducting a complete individual and family mental health history is necessary. Disorders which pose a higher risk for suicide are eating, panic, substance, and conduct disorders (House, 2002).

In any interview, a behavioral observation is critical to understanding the psychological state of the client. Some of the common things to look for include a depressed state, hopelessness, feelings of isolation and loneliness, and difficulty finding reasons for living (House, 2002). Other important factors which contribute to a higher risk of suicide are failing grades or unmet expectations, exposure to recent suicides or other forms of death, unresolved loss issues, and unhealthy stress management (Kirkcaldy, Eysenck, & Siefen, 2004). Questions regarding the living environment are also necessary in order to find out about access to means, such as firearms, in the home.

There are some demographics which suggest that males, Caucasians, Native Americans, and older adolescents pose greater risk for attempts and completion (House, 2002). Other common risk factors include victims of sexual abuse, loners with deficits in social skills, people with inferior communication abilities, the gifted, rigid people, overachieving youths, and psychotic adolescents with delusions and hallucinations (Kirkcaldy et al., 2004).

### *Developmental Factors and Suicide Risk*

According to Portes, Sandhu and Grice (2002), there is a correlation between the inability to develop healthy identity formation and an increased suicide risk. Adolescence is a time for exploration and a time to form some core beliefs about identity. It is important to look at underlying emotional factors like identity formation, which may result in maladaptive behaviors as a way of dealing with life's potential stressors. In the midst of the exploration and need for intimacy and relationships, the adolescent will naturally experience rejection. The way in which an adolescent handles this rejection can also be a determining factor in healthy identity formation (Portes et al. 2002). According to Portes et al. (2002), suicide seems to occur when a combination of factors are present, such as the failure to develop healthy stress management and coping skills, and a lack of emotional closeness and undeveloped cognitive levels.

### *Mental Disorders and Suicide Risk*

Mental disorders and associated risky behaviors are important to consider in evaluating an adolescents' overall suicide risk. Some of the more common high risk behaviors during adolescence are driving at high dangerous speeds, binge drinking, and other self harming behaviors such as self-mutilation (Gutierrez & Meuhlenkamp, 2001).

### *Self-Mutilation and Suicide Risk*

Self-mutilating behavior has been on a steady rise in the adolescent population (Kirkcaldy et al., 2001). According to a study by Kirkcaldy et al. (2001), self injurious behavior poses some confusion as to whether it is an actual suicide threat. There is more correlation between depression and self -mutilation than actual completed suicide and self injurious behaviors (Kirkcaldy et al.). This is an important distinction when



formulating possible assessment and treatment options. Gutierrez and Muehlenkamp (2004) reported that "Self injurious behavior is viewed as phenomenologically distinct from suicide in that SIB is seen as a life preserving action or as an attempt to avert suicide, while a suicide attempt is seen as an act to end life" (p. 14).

### *Depressive Disorders and Suicide Risk*

Depression and other psychiatric problems are not uncommon during adolescence (Cohen, Gerardin, Philippe, Purper Ouakil, & Falament, 2001). Depression is very common among adolescents with suicidal thoughts and there is also a strong correlation between depressive disorders and suicide completion (Hazler & Mellin, 2004). Throughout childhood and pre-adolescence, depression among males and females tends to be fairly equal, but at the age of about 14 females experience depression at twice the rate of male adolescents (Hazler & Mellin, 2004). This could be key information for prevention considering the fact that although more males complete suicide, females attempt much more frequently (Hazler & Mellin, 2004). Compton et al. (2004) reported that one in four adolescent girls will experience mild to moderate depressive symptoms. One reason for the difference in these increases for girls are social pressures, which change during junior high for girls, while the male expectations remain more constant (Compton et al, 2004) It is important to look at more gender related needs when counselors are attempting to treat depression in adolescents. Males and females have different social and personal expectations while growing up, and this is an important focus when counseling the youth.

According to Hazler and Mellin (2004), counselors need to be aware of connections between the signs of depression and the developmental struggles for females. A more

complete investigation is needed to determine the underlying cause of symptoms and whether depression is present. Hazler and Mellin (2004) found a combination of symptoms such as helplessness, extreme boredom, and weight and substance issues place these girls at higher risk for suicidal thinking. It is also important to note that a depressive disorder can be present with periods of high functioning and different somatic symptoms such as migraines. These symptoms do not always correlate with the DSM-IV TR criteria, and thus lead to an improper diagnosis and a failure to identify potential risk factors for suicide, according to Hazler.

#### *Disruptive Disorders and Suicide Risk*

Disruptive disorders also pose some greater risk for suicidal ideation and attempts. Brent, Renaud, Birmaher, Chiapettas and Bridge (1999) found that disruptive disorders have been reported to be a risk factor for suicide in at least 3 separate psychological autopsy studies. One study looked at disruptive disorders coupled with substance and mood disorders, which increased risk for suicide. Brent et al. (1999) found that even in the absence of a mood disorder, disruptive disorders are a very important for assessing suicide risk. Conduct disorders with specific bullying behaviors are also a significant risk factor. Awareness about the effects of bullying is a significant preventative factor for mental health and school professionals to be aware of. The disruptive disorder risk is strengthened when coupled with co-morbid conditions featuring depressive disorder (Kirkcaldy et al., 2004).

#### *Anxiety Disorders and Suicide Risk*

Panic and anxiety disorders are also common disorders during adolescence (Pilowsky, Wu, & Anthony, 1999). The many changes adolescents face, including the goals of

autonomy, socialization, sexuality, and many other pressures can all contribute to some normal anxiety. Some anxiety, however, can cross the line and become more serious. Adolescents with a lifetime history of panic attacks pose a greater risk of suicide ideation and attempts (Pilowsky et al., 1999). Mental health professionals should be aware of the importance of a skilled and thorough questioning regarding suicidal ideation or self-harming thoughts during an intake with a client who presents with a history of panic attacks (Pilowsky et al., 1999). It is also important to look at co-morbid disorders, like the presence of alcohol and substance use as a possible explanation for anxiety and panic.

### *Substance Use and Suicide Risk*

Substance use, depression, and suicide ideation can be a destructive combination. Adolescents often use substances as a coping mechanism, and there is some evidence of substance use and increased levels of suicide ideation and attempts (Kirkcaldy et al., 2004). According to Gould et al. (2004), "one fourth to one third of depressed or suicidal students were more likely to subscribe to the view that drugs and alcohol are a good way to stop depressive feelings" (p. 6).

It is also important to look at family history during the intake interviews and treatment planning. There are inherited tendencies toward depression or substance use. Brent et al. (1999) found that there are both genetic components and environmental factors contributing to the risk in developing substance use as well as psychopathology in adolescents. Family history informs counselors about patterns as well as provides awareness and possible preventative measures for many problems.

### Adolescent Coping Styles and Gender Differences

Coping skills are very important because many times forms of coping become familiar and learned behavior. Gould et al. (2004) found that an identification of potential problems and seeking help and guidance with these issues correlates with a more well adjusted adolescent. Adolescents are very focused on image, peer interaction and acceptance. It is important to understand who teens look to when they are troubled and how they choose to communicate and work on their problems. Gould et al. (2004) found that studies on help seeking attitudes concluded that adolescents with suicidal thoughts are more likely to report this information to their peers rather than adults. This should provide some level of awareness for professionals concerning the importance of open communication among adolescents and adults.

Although every person has individual behaviors and coping styles, it is well known that many males may not be as open and willing to communicate their feelings. Gould et al. (2004) found that females are more likely to seek adult guidance for a suicidal peer. It appears that some learned gender behaviors could play a part in how males and females seek appropriate services. It is important for counselors to become aware of some of the more common coping styles for males and females which could aid in more thorough assessments. One of the main concerns are negative coping styles coupled with increased isolation. According to a study by Gould et al. (2004) approximately one third of at risk students with suicidal ideation and behavior, depression, or substance abuse preferred methods of self-reliance rather than seeking out other adults or professionals for guidance.

This raises some important questions regarding support for adolescents who may need outside services for problems. King (2001) found that "more than one-half of high school students report they would not feel comfortable talking to a school professional about a personal problem, and only one in three would feel comfortable talking to a counselor if they had problems" (p. 135 ). Handling intense feelings and emotions alone or with peer support exclusively could lead to more negative forms of coping. It is important that clinicians assess adolescent support systems, and provide resources and outlets which can help alleviate the pressure of handling problems independently.

### *Cultural and Gender Differences*

There are some reported differences in males and female behaviors, with the strongest gender differences seen primarily with methods used in suicide. According to Beautrais (2003), male fatal and non-fatal suicide attempts involved highly lethal methods such as hanging, vehicle exhaust gas, firearms, and jumping. In contrast, female attempts involved less lethal methods, particularly self- poisoning.

It is also interesting to look at cultural differences. The Western culture has a higher completion rate among males and more attempts made by females (Beautrais, 2003). The suicide data from China found a slightly higher rate of suicide among young women and was most likely correlated with the use of agricultural pesticides (Beautrais, 2003).

According to Lester (2003), the highest suicide rates in 1995 for men aged 15 to 24 were found in Russia, Lithuania, New Zealand, Kazakhstan, Latvia, and Finland. For women, the highest rates were found in Cuba, New Zealand, Singapore, Mauritius, Kazakhstan, and Kyrgyzstan. In further research it may be helpful to look at the problems adolescents face in other countries and compare these pressures with those in the United States. The

use of coping styles and the treatment of mental disorders is an important factor to consider.

### Interventions and Treatment for Suicide Ideation Among Adolescents

#### *Psychotherapy and Medication*

According to Cohen, Gerardin, Philippe, Purper-Quakil and Falament (2001), treatment for suicidal ideation and risk often involves treatment for depression and other disorders. Interventions can take the form of specific counseling approaches for the suicidal patient and prevention techniques like school education. Counseling the suicidal patient can be quite challenging. For example, if the adolescent is not suicidal during the initial assessment the counselor must be aware of the possibility that the client may become suicidal during treatment or at a later time.

According to Wu et al. (2001), psychotherapy is always the preferred method of treatment. Medications are often used with a diagnosis of more severe depression, bipolar, and other psychotic disorders where therapy alone is not enough. Wu et al. (2001) found that children with depression are more likely to receive antidepressants if they have some life threatening or severe symptoms such as a suicide attempt or drug abuse. It is also important to treat these disorders with a combination of drugs and therapy. Cohen et al. (2001) reported a greater emphasis on treatments with an appropriate psychotherapeutic and psychosocial interventions. This combined plan is most holistic and has proven to be more effective. There will also be times when psychotherapy will not work alone and medication will become the preferred method of treatment. Cohen et al. found that "psychotherapy is not appropriate in many clinical situations such as adolescent refusal, psychotic depression and stuporous catatonia. In

the most severe cases antidepressant drugs and electroconvulsive therapy is recommended" (p.20).

*Medication knowledge.* Greater awareness is needed concerning the safety and effectiveness regarding adolescents and psychotropic medication. It is very important for mental health professionals to understand the different classes of drugs, specific reasons for use, and the side effects in order to formulate effective treatment plans. Knowledge about medication during an initial assessment can lead to more specific and effective questioning.

One reason for the increased use of medication is the rise of ADHD, as well as the rise of comorbid conditions. Cohen et al. (2001) found that "in adolescents, major depression and dysthmic disorders are frequent, incapacitating, recurrent, and often familiar disorders that tend to continue into adulthood" ( p. 19 ). The two classified medications mostly prescribed for adolescents are tricyclic antidepressants (TCA's) and selective serotonin reuptake inhibitors (SSRI's). Cohen et al. reported that all of the medication studies tend to prefer the use of SSRI's as the safest choice.

There is some reported controversy regarding the use of medication and an increased risk of suicide. Olfson, Shaffer, Marcus, and Greenburg (2003) found that the use of medication in the United States and other industrialized countries may have a part in the recent decline of adolescent suicide. Other recent concerns focus on the possibility of these drugs increasing the likelihood of completing suicide. Olfson et al. (2003) reported that one explanation for higher suicide rates is the fact that "communities with high rates of suicide and high rates of psychiatric disorders may simply tend to use more antidepressant medications than communities with lower rates" (p. 3). According to

Cohen et. al. (2001) there are several reasons further study is needed in the area of psychotropic treatments for adolescents. First, there is concern about the safety and efficacy in the use anti-depressants compared with adults. Also, there is concern about recent over-prescribing of certain drugs such as fluoxetine and sertraline. Finally, the need for more effective holistic treatment like pharmacotherapy is needed (Cohen et al., 2001).

### *Cognitive Behavioral Therapy*

Mellin and Beamish (2002) found that cognitive behavioral therapy (CBT) is one of the tested therapeutic approaches used for depression in adolescents. These authors reported that the empirical data suggests CBT may be more effective in treating adolescents with less severe depression and for those functioning better at the initial intake.

CBT is the use of cognitive restructuring, understanding the effects of coping skills, and effective problem solving. Compton et al. (2004) reported that "CBT is a diverse collection of complex and subtle interventions that must each be mastered and understood from the social learning context" (p. 9). There is growing consensus on its effectiveness on treating many internalizing disorders in youth and is seen as the preferred method of choice for adolescents (Compton et al.) One of the reasons CBT is so effective is because children acquire different skills over time. A delay or difficulty in applying some of these skills at the right time can cause competency problems. CBT offers a tailored program designed to specifically target the constraints to normal development and helps resume normal developmental skills for effective coping, self reliance, and problem solving (Compton et al., 2002).



Compton et al. (2004) identified several skills used in CBT for adolescents. First, counselor serves as a role model for understanding and tolerance. Second, CBT helps the client learn to explore options and problem solve, as well as recognize both effective and ineffective thinking patterns and effective decision making. Interventions are used to modify behavioral patterns and help clients identify and utilize personal skills for independent learning and change. Rapport, trust, and a certain degree of counselor and client connection are also required for effective intervention.

Compton et al. (2004) found that cognitive behavioral therapy has proven to be effective with depressed and anxious adolescents because of the unique specific problem solving approach and that one cause of depression is the way one chooses to perceive events and the meaning attached to these events.

### *Interpersonal Therapy*

According to Mellin and Beamish (2002), another form of therapy used for adolescents suffering from more severe depression is IPT or interpersonal therapy. Interpersonal therapy is a brief time limited therapy originally used for adults and in the past years has been modified for use with adolescents with more severe depression. Mellin and Beamish (2002) stated that the use of interpersonal psychotherapy (IPT-A) for adolescents was developed to fill gaps in theoretical and empirical information available for the treatment of adolescent depression, with alterations made for the needs of depressed adolescents. The goals of (IPT-A) focus on interpersonal deficits, role transitions, interpersonal role disputes, and grief. Interpersonal deficits are seen as major areas which can cause problems for adolescents. Mellin and Beamish (2002) stated that “issues identified in IPT-A include individuating from parents, peer pressures, romantic

relationships, experiences with death, and issues of control and authority with parents” (p. 4).

Additional research in the areas of adolescent suicide, prevention, depression and treatment is needed. Paulson and Worth (2002) found that most published studies on the treatment of suicidal clients contain limited descriptions of helpful factors in the treatment process. It is also important to look at the research regarding what is safe and recommended regarding psychotropic medications. Many times counselors and parents are faced with the hard choice of whether to use medications or not. According to Cohen et al. (2001), this decision is made even more difficult in light of the fact that there is little data on the long-term effects in children, as well as the fact that many areas of medication use have never been studied. Cohen et al. reported that "there is an urgent need to promote research in the field of child and adolescent psychopharmacology. Researchers are faced with complex ethical dilemmas"(p, 28).

#### Therapeutic Considerations and Suicide Ideation

Other treatment options always include therapeutic approaches and often compliments psychotropic treatment. One particular study by Paulson and Worth (2002), looked at a client's perspective for what is effective in treating suicidal patients. The clients' point of view is seen as an essential element in the successful treatment of suicidal ideation. Paulson and Worth (2002) found that "additional preliminary studies researching the resolution of suicidality suggest that essential factors include a positive therapeutic relationship, connection to others, and expression of feelings"(p. 3 ). There appear to be some approaches which tend to be more effective and vital. It may be hard to know what is essential knowledge when treating a suicide ideation. Some treatment

approaches are found to be very effective for the suicidal patient while some other approaches should be avoided.

According to Paulson and Worth (2002), there are some errors in treatment to be aware of, such as the therapist's inability to foster and process his or her personal anxieties regarding death. An inability to deal with a client's strong feelings during the session and a failure to properly assess a client's support system is also something to be aware of. The therapist should also be properly educated about planning effective intervention regarding a client's decision or plan for suicide. Understanding the client's issues with dependency is critical, as well as eliminating any messages that suicide may be inevitable or the situation hopeless.

Awareness and elimination of these errors is one of the ways professionals can improve their efforts when working with suicidal clients. Almost all professionals will encounter a time they are faced with this type of crisis, so it is important to recognize potential errors in order to provide the best services possible.

Failure to understand the individual is something more commonly found when working with adolescents. Understanding their world and what is important to them is critical. Identifying the degree of importance an adolescent places on a particular problem and how this may differ from the counselor's perception of that same problem is important. A misperception could result in the adolescent feeling misunderstood. Clarification and empathy for the problem is vital on the part of the counselor. The ability to relate on some level to the adolescents' needs could be vital to treatment outcomes. Paulson and Worth (2002), found that "a positive therapeutic relationship and in session emotional intensity are consistent with the professional literature that suggests

that these are two of the best predictors of a positive outcome, regardless of the type of therapy use" ( p. 86).

It is also important for counselors to look at the stigmas associated with suicide in the American culture. Counselors must become aware of their own personal beliefs regarding suicide which may interfere with their ethical duties. It is not uncommon for some to believe the subject of suicide is taboo. Shea (1999) discussed some important questions the counselors must ask themselves when working with suicidal clients. Counselors must learn to explore their biases, attitudes and beliefs about suicide. It is important to understand how judgmental or open minded you are regarding those who present with suicidal ideation. For example, if a counselor believes suicide is a sin, something to be ashamed of or immoral for religious or other personal reasons, this could affect the overall effectiveness of the chosen interventions. Counselors also need to assess their own personal experiences with suicide. Finally, counselors must understand that suicide can be a taboo topic for many individuals and different cultures. This is something to keep in mind when working with people who have lost a loved one to suicide.

#### Prevention Measures for Suicide Risk

When talking about adolescent suicide, the issue of prevention is always part of intervention. It is important to look at how many adolescents have actually contemplated suicide. A study conducted by Kirkcaldy et al. (2004) found compelling evidence that suicide ideation is astonishingly common, even in a non-clinical sample. According to Kirkcaldy et al. "Fifty four percent of females wished they were dead on at least one occasion and males were at twenty eight percent" (p. 304).

One place that prevention, intervention, and education can take place is in the schools. Adolescents spend so much of their lives in schools, and it is in many ways the perfect time to educate students and faculty about depression and suicide. This could prompt adolescents to take action if they think they are depressed or if they have friends who have shared suicidal thoughts.

One option for greater awareness on the subjects of depression and suicidal thinking among adolescents is a school based suicide prevention program. King (2001) found that suicide prevention programs for school professionals produce increased awareness for suicide warnings, knowledge of treatment resources, and a willingness to make referrals. School counselors could hold periodic informational meetings for parents which explain the importance of understanding the signs of depression in adolescents. Information through newsletters and workshops are other options for increasing knowledge on the subject of depression and an increased suicide risk. Counselors could also implement specific informational programs targeted at helping adolescents understand not only the signs of depression, but specific knowledge about resources and people who can help. Counselors could facilitate self-injurious groups aimed at identifying and changing irrational thoughts regarding the use of coping mechanisms. Guest speakers who have expertise on the subject of self injury and the signs of depression are also valuable learning tools and topics for group discussion. It is ultimately up to the school professionals to provide a safe place students feel comfortable asking for help after they are provided with the proper education and awareness. King (2001) reported that it very important to evaluate whether students feel they belong and are accepted within the

school environment. The school could provide and promote a safe environment, and implement goals for students to feel more connected on many levels.

### Conclusion and Implications for Counselors

Adolescent suicide remains a mystery on many levels. However, there are studies that can help the practitioner feel more prepared when confronted with this crisis. Both mental health and school counselors can do their part to learn about the most prevalent adolescent disorders and how they relate to suicide. There are several effective things school counselors can do such as educate parents through literature. They can find ways to help students feel comfortable enough to seek and find adults when faced with depressive symptoms, feelings of hopelessness, and self harming thoughts. The hope is that counselors can learn what there is to know about adolescent suicide and combine their compassion and the art of counseling to become more effective in dealing with this problem.

## References

- Beautrais, A. L. (2003). Suicide and serious attempts in youth: A multi group comparison study. *The American Journal of Psychiatry, 160*, 1093-1099.
- Brent, A. D., Renaud, J., Birmaher, B., Chiappettas, L., & Bridge J. (1999). Suicide in Adolescence with disruptive disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 846-852.
- Cohen, D., Gerardin, P., Philippe, M., Purper-Ouakil, D., & Falament, M.F. (2004) Pharmacological treatment of adolescent major depression. *Journal of Child and Adolescent Psychopharmacology, 14*, 19-31.
- Compton, S. N., March, J. S., Brent, D., Albano, A. M., Wersing R. V., & Curry J. (2004) Cognitive behavioral psychotherapy for anxiety and depressive disorders in children and adolescents: an evidence based medicine review. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 930-960.
- Gould, M. S., Velting, D., Kelinman, M., Lucas, C., Thomas, J.G., & Chung, M. (2004) Teenagers' attitudes about coping strategies and help seeking behavior for suicidality. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 1124-1134.
- Gutierrez, P. M., & Muehlenkamp, J. J. (2004) An investigation of differences between Self injurious behavior and suicide attempts in a sample of adolescents. *Suicide and Life-Threatening Behavior, 34*, 12-24.
- Hazler, R. J., & Mellin, E.A. (2004). The development origins and treatment needs of female adolescents with depression. *Journal of Counseling and Development, 82*, 18-25.

- House, A. E. (2002). *The first session with children and adolescents*. New York, NY  
Guilford Publications Inc.
- King, K. (2001). Developing a comprehensive school suicide prevention program  
*Journal of School Health, 71*, 132-140.
- Kirkcaldy, B. D., Eysenck, M. W., & Siefen, G. R. (2004) Psychological and social  
predictors of suicidal ideation among young adolescents. *School Psychology  
International, 25*, 301-316.
- Laux, J. M. (2002). A primer on suicidology: implications for counselors. *Journal of  
Counseling Development, 80*, 380-384.
- Lester, D. (2003). Adolescent suicide from and international perspective. *American  
Behavioral Scientist, 46*, 1157-1170.
- Mellin, E. A., & Beamish, P. M. (2002). Interpersonal theory and adolescents with  
depression. *Journal of Mental Health Counseling, 24*, 110-126.
- Olfson, M. Shaffer, S. C., Marcus, S. T., & Greenberg, T. (2003). Relationship between  
Antidepressant medication treatment and suicide in adolescence. *Archives  
of General Psychiatry, 60*, 978-982.
- Paulson, B. L., & Worth, M. (2002). Counseling for suicide: client perspectives. *Journal  
of Counseling Development, 80*, 86-94.
- Pilowsky, D. J., Wu, L., & Anthony, J. (1999). Panic attacks and suicide attempts in  
mid adolescence. *The American Journal of Psychiatry, 156*, 1545-1549.



- Portes, P. R., Sandhu, D. S., Grice, & R. L. (2002). Understanding adolescent suicide; A psychosocial interpretation of developmental and contextual factors *Adolescence*, 37, 805-815.
- Sean, J., & Marcus, S. C. (2003). Datapoints: Trends by race and gender in suicide Attempts among U.S. adolescents, 1991-2001. *American Psychiatric Association*, 54, 454-457.
- Shea, S. C. (1999). *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors*. Hoboken, New Jersey: John Wiley & Sons.
- Wu, P., Hoven, C. W., Cohen, P., Xinhua, L., Moore, R. E., Tiet, O., Okezie, N., Weiks, J., & Bird, H. (2001). Factors associated with the use of mental health services for depression by children and adolescents. *American Psychiatric Association*, 52, 189-195.