

## Suicide in adolescent males: A research perspective

Between 2003 and 2007, 22 Idaho adolescent males were reported as committing suicide (IDHW Vital Statistics, 2009). In Idaho, suicide is the 3rd leading cause of death for males (Vital Stats), while across the national suicide is the third leading cause of death among young males, following motor vehicle accidents and homicide (National Center for Injury Prevention and Control, 2006). Because each suicide affects an average of 15 people, the impact of 22 suicides is far reaching. In response to the high rate of suicides among Idaho's adolescent males, the Idaho Department of Health & Welfare has selected adolescent males as one of four special 'at-risk' populations for further study. The hope is that the research literature summarized below will support suicide prevention community in their efforts to understand adolescent male suicide, identify youth at risk and raise family, school and community awareness of the signs, symptoms and costs of adolescent male suicides.

The high prevalence of suicide among adolescent males has given rise to a wide and active research focus. The following framework attempts to give an overview of the research literature. Where available, Internet links point to abstracts or full text of the research articles. We have also included Idaho-specific information on adolescent male suicides provided by the Idaho Bureau of Vital Records and Health Statistics at the Idaho Department of Health & Welfare to illustrate the extent of the research topics in Idaho.

### Rates and trends of adolescent male suicide

In 2007, the general suicide rate for the United States was 10.9 per 100,000, but the rate for adolescent males was much higher – 20.3 per 100,000 (National Center for Injury Prevention and Control, 2006). Among adolescent males, age 15 to 24, suicide is the third leading cause of death (Kochanek, Murphy, Anderson & Scott, 2002), and occurs at four to five times the rate of suicide in adolescent females (e.g. 12.6 vs. 3.5 per 100,000; National Center for Injury Prevention and Control, 2006; Prevention of Suicide in Adolescents, 2006). As in the general population, adolescent females attempt suicide four to five times more often than adolescent males, but adolescent males successfully complete suicide far more often. Figure 1 shows the adolescent suicide rates from 1981 to 2002 (Guild & Freeman, 2006).

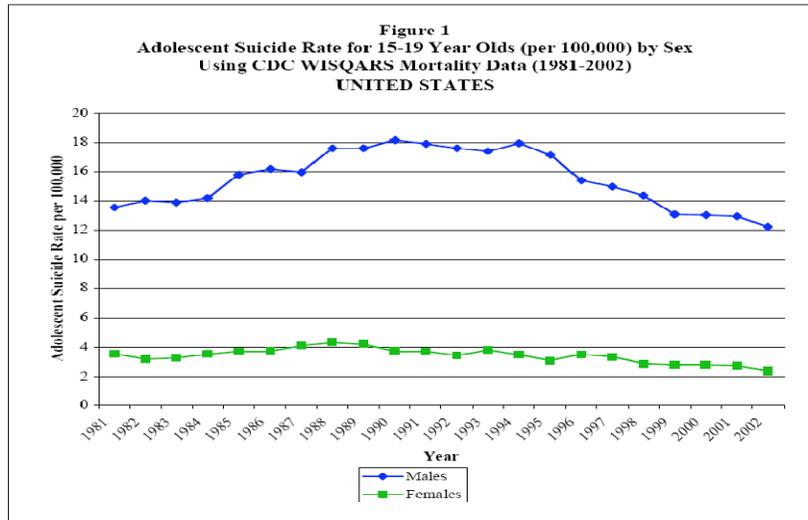


Figure 1 – United States adolescent suicide rates from 1981 to 2002.

As can be seen in Figure 1, the general rate for adolescent suicide has risen from 2.7 per 100,000 in 1950 to 11.3 per 100,000 in 1988, an increase of nearly 400%. The adolescent suicide rate peaked at approximately 18.2% for adolescent males in 1990 and at approximately 4.2% in 1988 for adolescent females. National suicide rates for male and female adolescents have been in decline since the early 1990s, dropping below the 1981 rates in 2002.

**Idaho Teen Male Suicide Data**

Capturing accurate suicide data in rural and frontier communities is believed to be problematic due to several factors, including variability in reporting standards and a potential bias against recording deaths as suicides to avoid stigmatizing the victim’s family. Similarly, it is possible that Native American deaths are reported differently by the different Tribes in Idaho, as well as differently from the general population. The effect is that the actual suicide rate is probably higher than the reported rate. The Idaho Bureau of Vital Records and Health Statistics at the Idaho Department of Health & Welfare (IDHW) tabulates data from death certificates for all deaths. Table 1 shows the number of Idaho adolescent male suicides reported to IDHW between 2003 and 2007.

<b>Idaho Resident Suicide Deaths - Teen males, aged 15-17 by Single-age and Year of death, 2003-2007</b>				
Year of Death	TOTAL	15-17		
		15	16	17
2003	5	1	2	2
2004	3	-	-	3
2005	3	1	1	1
2006	6	-	-	6
2007	5	1	3	1
TOTAL	22	3	6	13
Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (03/2009)				

Table 1. Incidence of adolescent male suicides in Idaho from 2003 – 2007.

**Racial incidence of adolescent male suicides**

Nationally, there are strong racial trends in adolescent male suicides. White and Native American adolescents and young men have significantly higher suicide rates than African American, Latino or Asian adolescents (Prevention of Suicide in Adolescents, 2006). Native American adolescent males are twice as likely to commit suicide as other adolescent males. In 2003, the suicide rate for Native American adolescent males was 24.3 per 100,000 – twice the rate of White adolescent males at 12.7 per 100,000 and 11 times as high as Native American females. Among Native American males, suicide is the second leading cause of death. In comparison, Black, Hispanic and Asian/Pacific Island adolescent and young males are less likely to commit suicide: 8.6 per 100,000, 8.0 per 100,000 and 6.2 per 100,000, respectively (National Center for Injury Prevention and Control, 2006).

Due to the relatively low numbers available, it is difficult to identify as firm a pattern in the Idaho Vital Statistics data for adolescent male suicides. However, the trends observed in the national rates for White and Native American adolescent males are visible in the data for Idaho, presented in Table 2.

Idaho Resident Suicide Deaths, Teen males, aged 15-17							
Race by Year of death, 2003-2007							
	TOTAL	Race					
		White	Black	American Indian/ Alaska Native	Asian/Pacific Islander	Other Race	Hispanic
2003	5	4	-	1	-	-	1
2004	3	3	-	-	-	-	-
2005	3	3	-	-	-	-	-
2006	6	6	-	-	-	-	1
2007	5	4	-	1	-	-	-
TOTAL	22	20	-	2	-	-	2

Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (03/2009). Race and Hispanic origin of the decedent are reported on the Idaho death certificate. Persons of Hispanic origin may be of any race. The number of deaths and death rates for Hispanics should be interpreted with caution. According to the National Center for Health Statistics (NCHS), Hispanic ethnicity is underreported on the death certificate, and there are inconsistencies in reporting Hispanic origin on the death certificate as compared with ethnicity on censuses, surveys, and birth certificates.

Table 2. Adolescent male suicides by Race in Idaho from 2003 – 2007.

**Suicide Methods used in adolescent males**

One of the common themes in gender-based suicide data is that, in general, males choose more aggressive and violent means of committing suicide. In addition to higher lethality (Breland and Park, 2008), the suicide methods chosen by males tend to be faster acting (e.g., firearms, hanging) than the methods used by females (e.g., overdosing on medication), which leaves a shorter time-frame for detection and intervention (Vannatta, 1997). Combined, these two factors may account for the higher male suicide completion rate. Both trends, lethality and immediacy, are also evident in the adolescent male suicide data (Breland & Park, 2008). Table 3 shows the methods of suicide used by US 15 to 19 year old males from 1991 to 2002. For comparison, Table 4 shows the same data for adolescent females.

MALES	Firearms	Poisoning	Suffocation	Other
1991	70.9%	7.1%	17.6%	4.4%
1992	71.5%	6.8%	18.0%	3.7%
1993	70.7%	6.4%	18.4%	4.5%
1994	73.0%	4.1%	18.2%	4.7%
1995	69.3%	5.0%	19.8%	5.9%
1996	66.3%	5.7%	22.7%	5.2%
1997	65.4%	3.4%	25.7%	5.4%
1998	64.9%	4.5%	24.9%	5.7%
1999	64.4%	4.2%	25.8%	5.7%
2000	58.7%	5.2%	30.6%	5.5%
2001	55.2%	4.9%	33.7%	6.2%
2002	52.2%	5.9%	35.4%	6.6%

Death Data Downloaded from CDC WISQARS Mortality Data (1992-2002).  
 Obtained from the Internet on March 3, 2009:  
<http://www.shepscenter.unc.edu/publications/suicidepreventionFLA.pdf>

Table 3. National suicide mechanisms for 15 – 19 year old males from 1991 to 2002.

<b>FEMALES</b>	<b>Firearms</b>	<b>Poisoning</b>	<b>Suffocation</b>	<b>Other</b>
1991	49.5%	29.6%	16.1%	4.8%
1992	47.4%	30.0%	18.1%	4.5%
1993	52.6%	24.1%	16.4%	6.8%
1994	57.9%	21.4%	14.7%	3.0%
1995	53.6%	20.1%	18.6%	8.0%
1996	48.3%	14.6%	29.3%	7.8%
1997	51.3%	14.1%	28.8%	5.8%
1998	50.4%	13.5%	28.5%	7.7%
1999	40.3%	17.5%	32.5%	9.7%
2000	38.5%	15.2%	37.0%	9.3%
2001	35.7%	19.2%	36.8%	8.3%
2002	31.8%	18.5%	41.6%	8.2%
Death Data Downloaded from CDC WISQARS Mortality Data (1992-2002). Obtained from the Internet on March 3, 2009: <a href="http://www.shepscenter.unc.edu/publications/suicidepreventionFLA.pdf">http://www.shepscenter.unc.edu/publications/suicidepreventionFLA.pdf</a>				

Table 4. National suicide mechanisms for 15 – 19 year old females from 1991 to 2002.

### **Mechanisms of suicide for adolescent males in Idaho**

The mechanisms of suicide used by adolescent males in Idaho parallel those of the national data – the primary methods are firearms followed by suffocation. Table 5 shows the suicide mechanisms used by adolescent males in Idaho from 2003 to 2007.

<b>Idaho Resident Suicide Deaths, Teen males, aged 15-17</b>						
<b>Mechanism by Year of death</b>						
	TOTAL	2003	2004	2005	2006	2007
Suicides by poisoning	1	-	-	-	1	-
Suicides by suffocation	7	3	-	-	-	4
Suicides by discharge of firearms	13	1	3	3	5	1
Suicides by fall	1	1	-	-	-	-
<b>TOTAL</b>	<b>22</b>	<b>5</b>	<b>3</b>	<b>3</b>	<b>6</b>	<b>5</b>
Bureau of Vital Records and Health Statistics, Idaho Department of Health and Welfare (03/2009). Intentional self-harm by 'other' includes those deaths that were designated as 'other, classifiable'; 'other, not classifiable'; or 'other, unspecified' mechanism. (Some mechanisms were omitted from Table 5 by Benchmark if they were not employed between 2003 and 2007).						

Table 5. Idaho suicide mechanisms for 15 – 17 year old males from 2003 to 2007.

### Means Substitution and Means Restriction

One trend identified in the research literature concerns means substitution. In response to the high number of suicides committed with firearms, a number of initiatives have sought to reduce the availability of firearms in an attempt to reduce the overall suicide rate. The general finding, however, is that while reduction in the number firearms reduces the number of suicides committed by firearms, there is no impact on the overall suicide rate. The utilization rates of other suicide methods, mostly suffocation by hanging, rise to fill in the gap. The general conclusion is that if the person is determined to commit suicide, they will find a means to do so (Beautrais, Fergusson and Horwood, 2006; Birmaher, Brent, and Benson, 1998).

An apparent means substitution trend can be seen in Table 2 and Table 3 – as the firearm rate decreases, the suffocation rate rises. The National Center for Injury Prevention and Control estimates

that suffocation now accounts for more than one third of all suicidal deaths among 15 to 19 year-olds in the United States (National Center for Injury Prevention and Control, 2006).

Note that *means substitution* does not obviate the need for *means restriction* – a suicide prevention and post-attempt intervention that seeks to remove convenient methods of suicide from an at-risk person’s environment. Means restriction may be especially important during the crisis period following a suicide attempt, when the chance of a second attempt is high. But even when a suicidal person’s friends and family conduct a thorough means restriction, means substitution can still occur if the person is sufficiently determined.

### **Causes of adolescent male suicide**

As with adult suicide, there are many individual reasons of adolescent male suicide. The risk factors listed in the risk and protective factor section catalogue common themes for adolescent male suicide identified in the research literature. There are two main themes in the published literature that shed some light on adolescent male suicides: depression, especially when combined with substance use, and a tendency of males to solve problems directly, impulsively and violently.

#### Depression, the adolescent male and suicide

In adolescents and adults, mood disorders such as severe depression and bipolar disorder are associated with a higher risk for suicide and other self-harmful behaviors. For adolescent males, the prevalence of depression among adolescents males is estimated to be around 14.0% compared with 8% for adults of both gender 18 years or older (Breland and Park, 2008; NSDUH Report 2005). Research has also found that approximately 7% of adolescents who develop a major depressive disorder commit suicide by the end of the young adult years (Jackson and Lurie, 2006; Weissman, Wolk, Goldstein, Moreau, Adams, Greenwald, Klier, Ryan, Dahl, and Wickramaratne, 1999). Credence to the role that depression plays in suicides, including those of adolescent males, is the success of recent interventions that manage depression through a combination of antidepressants and cognitive behavioral therapy.

Adolescent males tend to be unwilling or unable to discuss their feelings, viewing that as weak or unmanly. For the same reasons, adolescent males may be unwilling to seek professional help for depression and other mood disorders. Many adolescents, knowingly or unknowingly, may be self-medicating with drugs and alcohol. Sadly, when there is alcohol or other substance abuse, the risk of suicide rises even higher (Shaffer and Craft, 1999). It seems tragic that the natural response of adolescent males leads them away from seeking mental health services for their depression and toward the use of a depressant (alcohol) in an attempt to regulate it.

#### Gender specific issues of adolescent male suicide

Several researchers have focused on characteristics specific to males in general, and among male adolescents in particular, that increase the likelihood of attempting and successfully completing suicide. Among these characteristics are the reticence of males to understand or discuss their feelings, the tendency to act aggressively and impulsively to stress or to solve problems (Vannatta, 1997), and the tendency of males to use more lethal and immediate forms of self-harm (Breland and Park, 2008).

The combination of impulsiveness and the use of lethal, fast-acting methods create a situation where there is very little time between the decision to end one’s life and the suicide attempt for someone to intervene and prevent the person from completing their suicide. In short, the higher suicide rate found among men may simply result from a higher efficiency at suicide and acting quickly once the decision has been made.

**Risk & Protective Factors for adolescent male suicide**

Risk and protective factor models typically present characteristics that have been found to correlate with a problem behavior. It is important to bear in mind that the risk and protective factors do not cause or prevent suicide; they are simply commonly associated with suicide in many cases. For example, while there is a relationship between suicide and growing up in ‘non-intact’ families, forcing a family to fit a conventional mode may or may not change the suicidal tendencies of family members. The list of risk (Table 6) and protective factors (Table 7) are compiled from the work of several researchers. Each factor is marked to indicate the source.

<b>Risk factors for adolescent male suicide</b>	
<ul style="list-style-type: none"> <li>○ <u>Personal characteristics</u> <ul style="list-style-type: none"> <li>▪ History of a prior suicide<sup>1,2</sup></li> <li>▪ Impulsive aggressive behaviors in response to stressors<sup>2</sup></li> <li>▪ Psychopathology, including psychiatric conditions like depressive disorders</li> <li>▪ Substance abuse, especially among older adolescent males<sup>1,2</sup></li> <li>▪ Biological factors, especially abnormalities in serotonin functioning<sup>1</sup></li> <li>▪ Cognitive and personality factors<sup>1</sup></li> <li>▪ Feelings of hopelessness<sup>1,2</sup></li> <li>▪ Poor interpersonal problem-solving ability<sup>1</sup></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>○ <u>Family characteristics</u> <ul style="list-style-type: none"> <li>▪ Family history of suicidal behavior<sup>1,2</sup></li> <li>▪ Parental psychopathology, particularly depression and substance abuse<sup>1</sup></li> <li>▪ Impaired parent-child relationships<sup>1</sup></li> <li>▪ Childhood neglect or physical abuse<sup>1,2</sup></li> <li>▪ Sexual abuse, although the effect is reduced after controlling for other issues<sup>1</sup></li> <li>▪ Coming from a non-intact family<sup>1</sup></li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>○ <u>Adverse life circumstances</u> <ul style="list-style-type: none"> <li>▪ Stressful life events<sup>1,2</sup></li> <li>▪ Interpersonal losses<sup>1</sup></li> <li>▪ Acute relationship problems, especially romantic difficulties among older adolescents<sup>1,2</sup></li> <li>▪ Legal or disciplinary problems<sup>1</sup></li> <li>▪ Bullying<sup>1,2</sup></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>○ <u>Social, environmental and contextual factors</u> <ul style="list-style-type: none"> <li>▪ Difficulties in school<sup>1,2</sup></li> <li>▪ Neither working nor being in school<sup>1</sup></li> <li>▪ Not getting to go to college<sup>1</sup></li> <li>▪ Impact of the media supporting the notion of suicide contagion<sup>1,3</sup></li> <li>▪ Celebrity suicides<sup>3</sup></li> </ul> </li> </ul>
<p>1 - Gould, Greenberg, Velting, &amp; Shaffer, 2003.                  2 - Brent &amp; Mann, 2006                  3 -Yip, Fu, Yang, Ip, Chan, Chen, Lee, Law, &amp; Hawton, 2006</p>	

Table 6. Research- based risk factors for adolescent male suicide.

<b>Protective factors for adolescent male suicide</b>	
<ul style="list-style-type: none"> <li>○ <u>Personal characteristics</u><sup>1</sup> <ul style="list-style-type: none"> <li>▪ Self esteem</li> <li>▪ Self direction</li> <li>▪ Mission</li> <li>▪ Determination</li> <li>▪ Perseverance</li> <li>▪ Optimism</li> <li>▪ Empathy</li> <li>▪ Coping and problem solving skills</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>○ <u>General protective factors</u><sup>1</sup> <ul style="list-style-type: none"> <li>▪ Family cohesion</li> <li>▪ Religiosity</li> <li>▪ Resiliency</li> <li>▪ Social support and close relationships</li> <li>▪ Availability of caring adult</li> <li>▪ Participation and bond with school or community groups</li> </ul> </li> </ul>

Protective factors for adolescent male suicide	
<ul style="list-style-type: none"> <li>▪ Insight</li> <li>▪ Intellectual competence</li> </ul>	
1 - Gould, Greenberg, Velting, & Shaffer, 2003	

Table 7. Research- based protective factors for adolescent male suicide.

### Signs & symptoms of an adolescent at-risk for suicide

Numerous lists of signs and symptoms for suicide exist. The list below presents elements common among the signs and symptoms lists for teens (Washington State Department of Health).

- Previous suicide attempts
- Talk of suicide, or making a plan
- Giving away prized possessions
- Expressions of hopelessness, helplessness and anger at oneself or the world
- Themes of death or depression in conversation, writing, reading or art
- Statements of not being missed if dead
- Recent loss of a friend or family member through death or suicide
- Other losses, such as loss of a parent through divorce
- Strong personality changes, withdrawal, aggressiveness or moodiness
- New involvement with high-risk activities
- Sudden dramatic decline or improvement in schoolwork
- Use or increased use of drugs and/or alcohol

### Suicide Prevention

There are several categories of evidence-based suicide prevention initiatives. While there are many approaches to suicide prevention, only the main categories of evidence-based suicide prevention programs are presented below.

- Community programs
  - Awareness-raising about the signs and symptoms of someone considering suicide and the scope of the problem
  - Safe medication storage education and destruction of old medication programs
- School-based programs
  - Suicide education, screening, and risk assessment
  - Life skills and emotional management, including a program specifically designed for Native American teens
  - How to respond to a suicidal friend
- Emergency-room programs
  - A “Means restriction” for parents following a teen suicide attempt on how to eliminate or reduce access to convenient methods of suicide in the teen’s environment
  - Post-attempt intervention for suicidal teen females and parents.

Information regarding specific evidence-based suicide prevention programs may be found at:

- [http://www.sprc.org/featured\\_resources/bpr/ebpp.asp](http://www.sprc.org/featured_resources/bpr/ebpp.asp)
- [http://www.sprc.org/featured\\_resources/bpr/nrepp\\_bpr.asp](http://www.sprc.org/featured_resources/bpr/nrepp_bpr.asp)

- <http://www.idahosuicide.info/SuicideData.aspx>

For a recent, extensive review of promising practices and strategies for adolescent suicide prevention, see Guild & Freeman's 2006: <http://www.shepscenter.unc.edu/publications/suicidepreventionFLA.pdf>.

### **Treatment of suicidal tendencies or attempted suicides in adolescents**

The main approach to suicide prevention in adolescents identified as at-risk for suicide, whether through detection of signs and symptoms, screenings, or previous attempts, is to address the underlying depression or other mood disorders through a combination of psychotherapy and psychoactive medications. Many suicide treatment programs also address academic issues, social skills, family functioning, and other factors identified during psychotherapy as contributing to the adolescent's depression and suicidal tendencies (Brent and Birmaher, 2002; Birmaher, Brent, and Benson, 1998).

Psychotherapies commonly used to manage depression and suicidal tendencies include cognitive behavioral therapy (CBT) and Multi-Systemic Therapy with Psychiatric Supports (MST-Psychiatric). CBT seeks to associate the triggers of negative thoughts and feelings that lead to self-harm and suicidal behavior with neutral or positive thoughts and feelings (Birmaher, Brent, and Benson, 1998). The CBT for adolescents' model developed by Dr. David Brent and associates incorporates a number of nuances to make it more accessible for adolescents. MST-Psychiatric was developed to manage a number of adolescent behavioral and mental health problems. MST-Psychiatric utilizes a wide array of family, social, coping and individual psychotherapy to relieve the underlying mental distress that can lead to suicide (Huey, Henggeler, Rowland, Halliday-Boykins, Cunningham, Pickrel, & Edwards, 2004).

Numerous studies have found that the addition of an antidepressant to traditional forms of psychotherapy provides the highest clinical success of reversing adolescent depression and subsequent risk for suicide. Although the adolescents taking antidepressants require close monitoring for side effects, research has found that serotonin reuptake inhibitors, especially fluoxetine, allows for quick stabilization of depression and mood disorders, giving the psychotherapy time to take effect (Brent and Birmaher, 2002; Jackson and Lurie, 2006; March, Silva, Petrycki, Curry, Wells, Fairbank, Burns, Domino, McNulty, Vitiello, and Severe, 2004).

It is tempting to project that pre-emptive use of antidepressants and psychotherapy with adolescents exhibiting signs and symptoms that they are considering suicide may someday dramatically reduce the incidence of adolescent suicide. Research is ongoing.

### **Research Bibliography**

An extensive research bibliography on suicide in adolescent males may be found at <http://www.idahosuicide.info/Research.aspx>.

### **Referenced Bibliography**

2006 Fact Sheet on Suicide: Adolescents & Young Adults. National Adolescent Health Information Center. Retrieved from the Internet on March 16, 2009: <http://nahic.ucsf.edu/downloads/Suicide.pdf>.

Depression among Adults, 2005 National Survey on Drug Use and Health. Retrieved from the Internet on March 26, 2009: <http://www.oas.samhsa.gov/2k5/depression/depression.htm>.

Information for Adults Who Care About Teens. Washington State Department of Health. Retrieved from the Internet on March 26, 2009:

[http://www.doh.wa.gov/cfh/adfactsheets/whatsup\\_depression.htm](http://www.doh.wa.gov/cfh/adfactsheets/whatsup_depression.htm).

Leading Causes of Death and Fatal Injuries: Mortality Reports. (2006). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (2006). Retrieved from the Internet on March 16, 2009: <http://www.cdc.gov/ncipc/wisqars/>.

Prevention of Suicide in Adolescents. (2006). Retrieved from the Internet on March 18, 2009:

<http://pedclerk.bsd.uchicago.edu/Suicideprevention.html>.

Beautrais, AL, Fergusson, DM & Horwood, LJ. (2006). Firearms legislation and reductions in firearm-related suicide deaths in New Zealand. *Australian and New Zealand Journal of Psychiatry*. 40, 253–259. <http://www.ncbi.nlm.nih.gov/pubmed/16476153>.

Birmaher, B., Brent, D. A., & Benson, R. S. (1998). Summary of the practice parameters for the assessment and treatment of children and adolescents with depressive disorders. *American Academy of Child and Adolescent Psychiatry. Journal of the American Academy of Child and Adolescent Psychiatry*, 37(11), 1234-1238. <http://www.ncbi.nlm.nih.gov/pubmed/10075518>.

Breland, DJ & Park, MJ. (2008). Depression: Focus on the Adolescent Male. *American Journal of Men's Health* 2; 87. <http://jmh.sagepub.com/cgi/reprint/2/1/87>.

Brent, D. A., & Birmaher, B. (2002). Clinical practice. Adolescent depression. *New England Journal of Medicine*, 347(9), 667-671.

Brent, DA, & Mann, JJ. (2006). Familial Pathways to Suicidal Behavior — Understanding and Preventing Suicide among Adolescents. *New England Journal of Medicine*, 355, 2719-2721.

<http://content.nejm.org/cgi/content/full/355/26/2719>.

Gould MS, Greenberg T, Velting DM, & Shaffer D. (2003). Youth suicide risk and preventive interventions: a review of the past 10 years. *Journal of the American Academy of Child Adolescent Psychiatry*. 42(4), 386-405. <http://www.ncbi.nlm.nih.gov/pubmed/12649626>.

Guild, PA, & Victoria A. Freeman, R.N., Dr.P.H. (2006). Promising Practices to Prevent Adolescent Suicide: What Can We Learn from Florida?. *Cecil G. Sheps Center for health services research. University of North Carolina at Chapel Hill*. Retrieved from the Internet on March 11, 2009:

<http://www.shepscenter.unc.edu/publications/suicidepreventionFLA.pdf>.

Huey, S. J., Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., & Edwards, J. (2004). Multi-systemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(2), 183-190.

[http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=14726725&ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed\\_ResultsPanel.Pubmed\\_RVDocSum](http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=14726725&ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum).

Jackson, B., & Lurie, S. (2006). Adolescent depression: Challenges and opportunities: A review and current recommendations for clinical practice. *Advances in Pediatrics*, 53, 111-163.

<http://www.ncbi.nlm.nih.gov/pubmed/17089865>.

Kochanek KD, Murphy SL, Anderson, RN, Scott, C. (2004). Deaths: final data for 2002. Hyattsville, Maryland: U.S. Department of Health and Human Services, 2004; National Vital Statistics Report 53(5). [http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53\\_05.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_05.pdf).

March J, Silva S, Petrycki S, Curry J, Wells K, Fairbank J, Burns B, Domino M, McNulty S, Vitiello B, Severe J. (2004). Fluoxetine, cognitive behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association*, 292(7), 807-20. <http://www.ncbi.nlm.nih.gov/pubmed/15315995>.

Shaffer D, & Craft L. (1999). Methods of adolescent suicide prevention. *Journal of Clinical Psychiatry*, 60(Suppl 2): 70-4; discussion 75-6, 113-6. <http://www.ncbi.nlm.nih.gov/pubmed/10073391>.

Vannatta, R. (1997). Adolescent Gender Differences in Suicide-Related Behaviors. *Journal of Youth and Adolescence*, 26(5), 559-68. <http://linkinghub.elsevier.com/retrieve/pii/S1054139X05001230>.

Weissman MM, Wolk S, Goldstein RB, Moreau D, Adams P, Greenwald S, Klier CM, Ryan ND, Dahl RE, & Wickramaratne P. (1999). Depressed adolescents grown up. *Journal of the American Medical Association*, 281(18), 1701-13. <http://www.ncbi.nlm.nih.gov/pubmed/10328070>.

Yip, SFP, Fu, KW, Yang, KCT, Ip, BYT, Chan, CLW, Chen, EYH, Lee, DTS, Law, FYW and Hawton, K. (2006). The effects of a celebrity suicide on suicide rates in Hong Kong, *Journal of Affective Disorders*, 93, Issues 1-3, 245-252. <http://www.medscape.com/viewarticle/567458>.