Self-Destructive Behaviors and Teen Suicide

March 1986

Report to Kevin W. Concannon, Commissioner
Department of Mental Health and Mental Retardation

Presented by

Child & Adolescent Service System Project

Rachel Olney, Ph.D
Director

Child and Adolescent Service System Project

Maine's Child and Adolescent Service System Project works to improve the availability and accessibility of appropriate services for severely emotionally disturbed children and adolescents. The Project is administered by the Department of Mental Health and Mental Retardation and works in cooperation with the Departments of Human Services, Education and Cultural Services, and Corrections.

At two pilot sites, one in York County and one in southern Penobscot County, staff provide case coordination for children and adolescents whose needs require services from two or more agencies. Regional Coordinators also work with representatives of community agencies on local Committees to assess and plan for the needs of individual children.

At the state level, staff represent the needs of severely emotionally disturbed children and adolescents in the coordinated management, planning and resource development activities of the state's four child-serving Departments. Information, training, public education and parent support activities enhance the Project's ability to meet these goals.

This report prepared and presented by the Maine Child and Adolescent Service System Project, supported by the National Institute of Mental Health, Grant # 5 H84 MH39824-02.

Maine Department of Mental Health and Mental Retardation

Bureau of Children with Special Needs

411 State Office Building, Station 40, Augusta, Maine 04333 (207) 289-4250 TTY (207) 289-2000
For the deaf

JOSEPH E. BRENNAN
Governor

KEVIN W. CONCANNON
Commissioner

March 13, 1986

Dear Commissioner Concannon:

In working with community members, parents, professionals and teenagers in Maine, the Child and Adolescent Service System Project finds widespread, long-standing concern with the prevalence and severity of adolescent self-destructive behaviors. At the present time, many communities and agencies are addressing these issues: nevertheless, concern mounts. It is our hope that, by outlining some of the dimensions of these issues the enclosed document may begin a broad-based effort to assess and prevent these tragedies.

Teenagers show self-destructive tendencies in many different ways, ranging from drunk driving, to violent crime, to suicide. These are only a few examples of the many ways in which teenagers' emotional problems, insecurities, or depression may lead them to jeopardize their health and safety. Because these behaviors also dramatically affect friends, families and communities, we believe that prevention and treatment strategies should be developed cooperatively by concerned citizens and families, as well as professionals and agency representatives. In this way, community-based, preventative strategies can be devised and implemented, with increased chances of long-term success.

This report represents a team effort. First, my thanks to Ron Welch for leadership and support throughout this effort. The report itself was researched, written, and complied by Paula Alderette, Jamie Morrill, James Harrod, Robert Foster, and Peter Ezzy, and myself. My special thanks to the CASSP Regional Coordinators, Jacquelyn Dodge and Kim Strom, for continually drawing to our attention the depth and seriousness of these tragedies; and to members of the CASSP Committees, in York County and in southern Penobscot County, for their ongoing work to address these problems in their regions.

These issues are an increasingly high priority for CASSP, as we continue to uncover the terrible effects of self-destructive behaviors on Maine adolescents, families, and communities. We are deeply grateful to the ongoing work of these families, professionals, and communities to address these problems, and look forward to a united effort to strengthen and enhance this work.

Respectfully,

Rachel Olney

Rachel Olney, Ph.D.
Director
Child & Adolescent Service System Project

Child & Adolescent Service System Project
Report to Commissioner Kevin W. Concannon
March 1986

SELF-DESTRUCTIVE BEHAVIOR AND TEEN SUICIDE

EXECUTIVE SUMMARY

In the hour that it takes you to read and reflect on this white paper, there is one chance in three that a Maine teenager will either run away from home; attempt or commit suicide; have their license suspended for O.U.I.; or become a parent at age 17 or under.

These incidents, while seemingly unrelated, have one theme in common. They and other similar acts are indicative, absolutely or by inference, of an alarming rise in adolescent self-destructive behaviors, behaviors which can have serious and sometimes tragic consequences for themselves, their families, friends, and community.

The Maine Department of Mental Health and Mental Retardation's Child and Adolescent Service System Project examined this phenomenon, its causes, manifestations, and implications for Maine's system of Children's Services. They strongly suggest that self-destructive behavior is a mental health issue of the first order, requiring concerted attention. The report points to the need for additional scrutiny by individuals representing all sectors of Maine communities and the need for a cooperative approach, using both formal and informal community resources in ways that differ from past practice.

Child & Adolescent Service System Project
Report to Commissioner Kevin W. Concannon

March 1986

SELF-DESTRUCTIVE BEHAVIORS AND TEEN SUICIDE

Problem Statement

Repeated tragedies have focused the concern and resources of many Maine families, schools and communities on adolescent self-destructive behaviors and suicide. Shocking, unexpected teenage deaths have dramatized the urgency of this problem. By overdosing, hanging, poisoning, shooting, and other means, these young people die - needlessly. Others die in automobile "accidents" which barely disguise their self-destructive intent. Many more children and adolescents inflict serious, often permanent, harm to themselves and others by dangerous abuse of alcohol, of recreational or prescription drugs; by promiscuity, prostitution, or unwanted pregnancy; and by other reckless, violent, or self-injurious means.

Each self-destructive or suicidal act represents much more than one teenager's personal, individual tragedy. However isolated and alone many of these young people may feel, each searches for his or her path to adulthood within a family, a peer group, and a community. Those who develop self-injurious, sometimes fatal solutions do so among friends, family, and concerned acquaintances who are often unable to recognize or to stop this dangerous trend. And where community resources do provide for identification and/or treatment of self-destructive and suicidal behaviors, the absence of coordination among professionals and natural support networks may limit the effectiveness of these efforts.

For Maine teenagers, suicide is the second leading cause of death. Over the past ten years in Maine, the suicide rate has averaged approximately 10 documented suicides per year--with the 17 suicides in 1984 representing a ten-year high (Maine Department of Human Services, 1985).

A recent survey of psychiatric emergency room admissions conducted by the Maine Medical Center (Hawkins, 1986) shows that during a typical month in 1985 there were eight (8) admissions of children and adolescents 18 years of age or younger for suicidal threats, gestures, or attempts and drug overdoses. Extrapolating from these data, there may be approximately 96 admissions per year at Maine Medical Center alone, and approximately 480 such admissions statewide.

These figures suggest that for every known, completed suicide in Maine during 1985, there were approximately 28 self-destructive threats or attempts known to hospital emergency rooms alone. This accords

with national prevalency estimates that for every known, completed suicide there are at least 10 and possibly 100 attempts (Eisenberg, 1980).

Suicide is clearly the most dramatic possible statement of self-destructive behavior. However, teenagers engage in many other, more subtle forms of self-destruction and self-injury in addition to suicide. Some of these methods, such as substance abuse and reckless driving, have obvious and immediate physical results for the teenagers (and often for others). The self-destructive nature of other actions is more subtle. Criminal activity, running away, early, unwanted or medically unsupervised pregnancy all result in considerable self-inflicted physical, emotional, or social damage. Taken together, these self-destructive behaviors along with suicide affect an increasing portion of our young people. Certainly all teenagers who act self-destructively are not suicidal; however, most suicidal teens were also self-destructive children or adolescents.

Substance abuse is perhaps the most common means of self-destruction for teenagers. As many as one-half of all teenagers who commit suicide also have a problem with alcohol or drugs.

The 1982 National Institute of Drug Abuse Household Survey of high school seniors thoughout the nation showed that 46% drank on a weekly basis, 41% were considered heavy drinkers, and 5% drank daily. The State of Maine Task Force on Adolescent Treatment Bed Needs (1985) concluded that 12% of Maine's high school students are currently chemically dependent and another 13% are at risk of dependency given their current use patterns.

National statistics document that drinking and drugging patterns have changed for the worse. A 1984 survey by the National Institute of Drug and Alcohol Abuse showed that the percentage of high school seniors who drink daily increased 20% between 1976 and 1984. The percentage of seniors smoking marijuana daily increased 50% during the same period, from 4% to 6%. Even more dramatic has been the increase in the percentage of high school seniors who report having used cocaine, which more than tripled from 3% in 1976 to 10% in 1984.

Individually and in groups, Maine teenagers injure and kill themselves on our streets and highways. Some "accidents" are overt suicide attempts; others are more veiled attempts at self-destruction or self-injury. In 1983, 19 Maine teenagers were killed while driving an automobile under the influence of alcohol. In 1984, the number increased to 23. Both within Maine and nationally, over half of all fatal accidents involving teenage drivers also involve alcohol and or drugs. Although teenagers account for 7% of all licensed drivers, they represent 14% of all highway fatalities and 19% of all alcohol related crashes. A much larger number of young people risk these same results: In 1984, over 1,087 Maine teenagers were arrested and an additional 1,457 had their licenses administratively suspended for OUI.

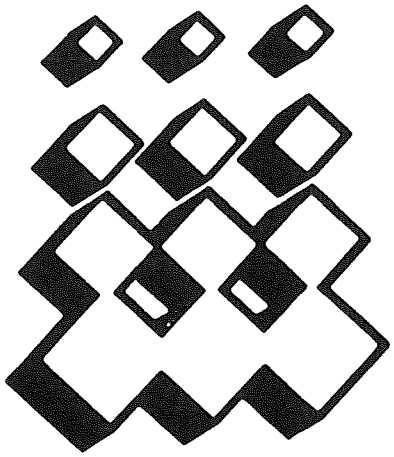
For some of Maine's teenagers these self-destructive, self-injurious or suicidal problems are severe enough to warrant removal from their families and communities. Alcohol and drugs are particularly common means of self-injury, which futher complicate other serious emotional and behavioral problems. Of all children in Maine's Residential Treatment Centers, 40% have active substance abuse problems. Of all children and adolescents admitted to Augusta Mental Health Institute, 50% have active substance abuse problems.

Maine's children and adolescents injure and kill themselves in many other ways. By running away from the safety of home, by prostitution, by criminal involvement, they endanger their own health and safety as well as

that of their communities. A recent study of runaways in New York found significant psychiatric problems among this population, including depression, antisocial behavior or a combination of these, as well as an unusually high rate of attempted suicides--at least one-third of the girls and one-sixth of the boys had at some time attempted suicide (Berman, 1985). In Maine, juveniles arrested for "running away" has significantly increased from a 1983 low of 472, to over 600 in 1985. Unprotected sexual activity constitutes a less recognized form of self-injurious behavior, leading some teenagers into physical danger, sexually transmitted diseases, or unwanted pregnancy. In 1984, 600 Maine girls age 17 or younger became mothers. Almost 100 of them were 15 years old or younger. Particularly for the younger, physically immature girls, the pregnancy itself constitutes a very real health risk, to themselves and to their babies.

Boys' self-destructive behaviors are more visible than girls' - they more often drink publicly, destroy property, commit violent crimes, etc. Severe emotional disturbance is more likely to be noticed (and treated) in boys than girls. In fact, boys outnumber girls 3 to 1 among the cases of severely emotionally disturbed youth referred to the Child and Adolescent Service System Project. Boys, who are socialized to control their expression of emotion, are more likely to channel their feelings aggressively. Therefore, their destructive behavior and suicide attempts are more violent and more lethal. Girls, on the other hand, are usually freer to experience and express their emotions. It would be dangerous, however, to conclude that girls are much less self-destructive than boys. Rather, their self-destruction differs in method and lethality: they may find quieter, more traditional ways to jeopardize their mental and physical health, and their educational and vocational futures. Pregnancy, eating disorders, and depression may exemplify this difference. The greater number of suicide attempts by girls (though boys, when they do attempt, tend to be more successful) further demonstrates the depth, and seriousness, of this tendency.

Such self-inflicted injury affects us all. For the self-injurious and suicidal teens themselves, there are obvious physical, emotional, social, educational and occupational consequences. Among friends and classmates, there is real danger of suicidal contagion: as in the well-publicized cluster of 11 completed teen suicides and more than two dozen attempts in Plano, Texas in the 2 years following a 17 year old boy's 1983 death in a drag racing accident (Ownby, 1985; Doan and Peterson, 1984). For friends and families, these suicidal or self-destructive acts may lead to feelings of guilt, helplessness, depression, and anger. For communities in Maine, and throughout the nation, these trends threaten not only our current safety and our mental health, but by hurting and killing our young people, endanger the future for us all.



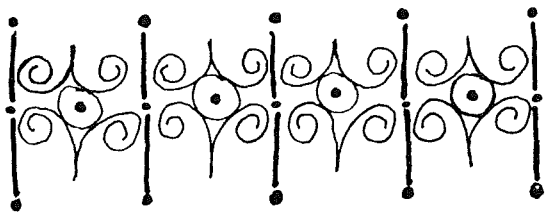
Mental Health Perspective.

One of the most prevalent problems among self-destructive and suicidal teenagers is depression. Among self-destructive adolescents, this depression may be less obvious than aggressive, destructive, antisocial behaviors. For some, these behaviors "mask" depression, while for others, these acting-out behaviors occur in addition to, or instead of, depression (Berndt and Zinn, 1984; McKenry, Tishler and Kelley, 1982; Gilead and Mulaik, 1983). Personality disorders occur with some frequency in this population. The seriously antisocial nature of many of the accompanying behaviors draws attention away from the teenagers' underlying mental health problems, and focuses instead on symptoms and behaviors: rudeness, rule violations, truancy, substance abuse, promiscuity, criminality, etc. These teenagers are particularly easy to misunderstand and misinterpret. Despite their many dislikable characteristics, these children and adolescents share with their more quietly depressed peers a dangerously self-destructive bent.

Although major depression is a frequent mental health problem among teenagers, it may be overlooked or misinterpreted, as its symptoms occur in some degree in many normal teenagers. Differentiating normal depressed moods from clinical depression may be difficult for parents and peers. This may be due to the changes which occur at the transition from childhood to adolescence. As teenagers, children may suddenly seem to be uncooperative, depressing, unpredictable strangers. This normal stage, however unpleasant, begins for many teens the important process of separating from home and family. By contrast, the many sudden, dramatic changes and uncharacteristic behaviors of seriously depressed teens do not serve this healthy, long-range goal. Parents may see their honor student suddenly lose interest in school and fail several classes; their star athlete become lethargic, quitting his/her teams; their healthy teen suddenly lose (or gain) a lot of weight; their sensible child take unreasonable and dangerous risks with liquor, drugs, cars, promiscuous sex; etc. These are typically not part of normal adolescent rebellion, and should cause parents and friends to suspect more serious, persistent depression.

Severe stress or crisis may exacerbate depression and lead to self-destructive and suicidal tendencies in depression prone teenagers. For them, normal life crises such as parental discord or divorce, breaking up with a boy/girl friend, school failure, or serious illness overtax their ability to cope. Even in times of crisis, these frequently socially isolated young people find little support among peers and family. This support may be unavailable, or may be available but unrecognized or unaccessed by the youngster. Without experiencing such support, feelings of self-blame, guilt, anger and futility produce serious results.

Self destructive and suicidal teenagers experience serious affective disorders, or even suicide, in their immediate families more often than do peers with other mental health problems (Friedman, Cora, Hurt, Fibel, Schulick, and Swirsky, 1984). Having learned a limited array of social and communicative skills, these children are ill prepared for normal adolescent physical, social, and emotional stresses, let alone for the more serious crises liable to occur at this stage within these chronically stressed families.



Collaborating on a Comprehensive Array of Services

The mental health system necessarily should play a pivotal role in addressing adolescent self-destructive behaviors and suicide. Our most immediate responsibility is for crisis intervention and emergency services. In cooperation with mental health personnel, the quick, effective response of highly skilled mental health professionals may impact the severity and length of the immediate crisis for the affected teenager, and for his/her peers, family, and community. This emergency intervention begins the longer treatment process, designed to prevent further self-injury, and to facilitate social and emotional adaptation for the individual and for the family.

These short and long-term mental health interventions, however critical, do not succeed alone. Mental health services are only one part of the comprehensive array of medical, social, educational, vocational and natural supports needed to successfully address these problems. In many Maine communities, key components already exist - but coordination among them is irregular or absent. In the two pilot regions, Maine's Child and Adolescent Service System Project has repeatedly demonstrated the benefits of such coordination for children and service providers alike. Many of these children and adolescents are severely disturbed, self-destructive or suicidal, with multiple, complex needs. Systematic collaboration among professionals and families is required to devise and execute comprehensive, individualized service plans to address their current crises, prevent future ones, and promote healthy adjustment.

The importance of peers, families, and community members for early identification of self-destructive and suicidal behaviors cannot be overestimated. During daily activities members of these natural support systems have observational opportunities not available to mental health professionals. The earliest expressions of suicidal ideation or threats occur at home, with friends, at school, on the street, etc. The frequency, intensity, and seriousness of such thoughts and gestures can be more comprehensively identified in these settings. Parents, teachers, friends, and neighbors see the signs of self-destructive and suicidal tendencies. They notice when teenagers lose interest in unusual activities; sleep too much (or too little); suddenly lose (or gain) too much weight; cut themselves off from friends; give away prized possessions; and in other ways act in alarming, atypical ways. Successful early intervention requires partnership between the community members (particularly peers) privy to this critical information, and the mental health professionals specifically trained to interpret it and intervene with it.

Prevention efforts clearly require similar broad-based participation and cooperation, as well as delicate planning and program design. Widespread dissemination among teenagers of information on self-destructive and suicidal behaviors will certainly increase their sensitivity on these issues, but risks suggestion and contagion (Berman, 1985). Broad distribution among teens and pre-teens of relevant developmental, mental and physical health information is undoubtedly critical to any prevention strategy. This will be most successful, however, when natural helping networks monitor the effects on behavior, in conjunction with highly skilled assistance from mental health practitioners.

Some Approaches to Prevention and Intervention

A number of states and localities across the country are implementing prevention and intervention strategies. Several states have enacted statutes in the last two years specifically addressing teen suicide. Although funding and program details differ, legislation in New Jersey, California, and Florida shares an emphasis on early identification and intervention through increased professional training and public education. New Jersey statutorily established three regional adolescent suicide awareness centers; California established two three year demonstration suicide prevention and crisis centers and a statewide youth suicide prevention school program; and Florida statute required an interagency plan for statewide youth suicide prevention and crisis intervention.

In some other states concerned agencies have initiated a variety of strategies to improve prevention and intervention. For example, Oklahoma is providing special training to Emergency Medical Workers and group homes. Colorado is providing training for teachers and counselors in each school district.

In these, and other states, leadership differs. For some, the state agency responsible for education administers training and public education efforts primarily through the schools. In others, similar training programs,in addition to crisis intervention and related therapeutic services are administered by the state mental health agency. Whether by statute, or by formal or informal agreement, interagency collaboration is the hallmark of effective efforts in many states, regardless of the identity of the lead agency.

In Maine, a number of communities have begun to undertake prevention, early identification, and public education programs. At Gardiner, the schools provide prevention workshops for sixth through twelfth grade teachers, and the coordinator of this project has done similar workshops in school districts in Maine and nationally. In the Kennebunks, concerned citizens and professionals formed the Suicide Prevention and Awareness Research Council to improve prevention and intervention in their communities. Somerset County's Crisis Stabilization Unit of Crisis and Counseling Inc., funded in part by the Bureau of Mental Health, with additional private foundation money, provides workshops and support services in schools affected by teen suicide. Franklin Memorial Hospital offers an innovative rural model for psychiatric emergency consultations. Additionally, community mental health programs provide emergency hotlines and other emergency services.

Teachers, parents, mental health professionals, peer counselors and others have begun to intervene to prevent self-destructive and suicidal behaviors. The success of their efforts depends on the degree of coordination among community services. Self-destructive and suicidal behaviors do not arise from any single, neatly identifiable cause, nor can they be prevented through interventions focused in a single environment or on a single behavioral issue. Intervention and prevention strategies must mirror this behavioral and environmental complexity. Coordination among agencies, families, and concerned citizens (through information sharing, joint training, planning, programming, and resource development) immeasurably increases the power and effectiveness of our efforts.

Recommendations

For a variety of state-level groups, and in many communities, teen suicide is identified as a major concern. Nevertheless, a coordinated state-wide strategy has yet to be devised and implemented to address the progression from self-destructive behaviors through completed suicide. To conduct an effective, state and regional campaign, state agencies, community groups, local program experts, families, concerned citizens and legislators must work as partners. Separately, we proceed with incomplete information and inadequate resources, guaranteeing fragmentation and eventual failure. Working together, we multiply our expertise and resources, thereby gaining unmatchable strength.

As the state's mandated mental health authority, the Department of Mental Health and Mental Retardation holds a necessary and pivotal role in such a cooperative campaign. Self-destructive and suicidal behavior constitute mental health problems. As such, the Department's responsibilities for appropriate care and treatment in Maine families and communities are clear. Through the Child and Adolescent Service System Project, and its systems of regional coordination, the Department can demonstrate its leadership and its commitment to community-based, comprehensive systems of services to address these child and adolescent mental health needs.

Clearly, several essential principles must guide this mental health campaign.

1. Self-destructive and suicidal behaviors are best addressed collectively. Suicide is the final, most dramatic act in a progression of self-destruction and self-injury.

2. Prevention represents the most effective, long-term intervention strategy. Although crisis and emergency services are unarguably essential, preventive efforts potentially impact a larger population, at an earlier and less dangerous point in this self-destructive progression.

3. The partnership of natural support networks and mental health professionals is critical to successful early intervention. Families, peers, school and other community members are uniquely qualified to observe and identify early indicators of suicidal or self-destructive tendencies. Partnership with professionals specifically trained to intervene in these behaviors is indispensable.

4. Community coordination among service providers and professionals identified with various departments, agencies and disciplines must address these problems in a comprehensive, integrated fashion. The inseparable nature of these teenagers' emotional, social, behavioral and physical problems demands such service integration.

In keeping with these principles, we recommend the establishment of a task force to consider self-destructive and suicidal behavior among Maine teenagers. The task force may wish to consider the following questions:

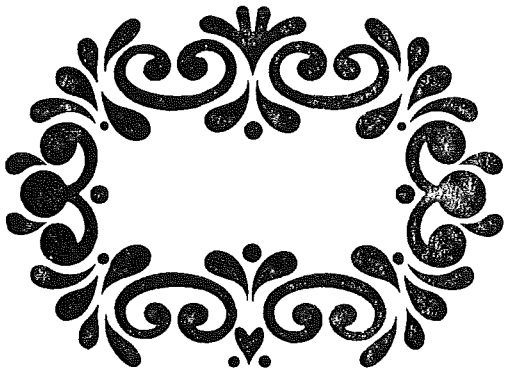
-To what extent are self- destructive behaviors (including suicide) a significant mental health problem for Maine teenagers?

-What types of self-destructive behaviors most seriously affect Maine's teenagers, families, and communities?

-What are the most effective ways of addressing adolescent self-destructive and suicidal behaviors in Maine?

-How Maine families, communities, mental health professionals and others can individually and collectively work to promote mental health among teenagers at-risk?

Through this diverse, community-based task force, all concerned with these serious issues advance toward practical, effective solutions.



Youth US Suicidal behavior
Suicide US present

REFERENCES

HV
6546

Abramson, R. et al. (1984) Suicide prevention curriculum packet. Gardiner, Maine, School Administrative District #11.

Berman, A.L. (1985). Testimony on Teenage Suicide. Hearing before the Subcommittee on Juvenile Justice of the Committee on the Judiciary. U.S. Senate, 98th Congress, October 3, 1984. Washington, D.C.: U.S. Government Printing Office, Serial No. J-98-143.

Berndt, D.J., & Zinn, D. (1984). Prominent features of depression in effective- and conduct- disordered inpatients. In D. Offer and K.I. Howard (Eds), Patterns of Adolescent Self-image. San Francisco: Jossey-Bass.

Cicchetti, D., & Schneider-Rosen, K. (Eds.) (1984). Childhood Depression. New Directions for Child Development, no. 26. San Francisco. Jossey-Bass.

Crumley, F.E. (1982). The Adolescent Suicide Attempt: a cardinal symptom of serious psychiatric disorder. American Journal of Psychotherapy, 1982, 158-165.

Doan, M., & Peterson, S. (November 12, 1984). As "cluster suicides" take toll of teenagers--" U.S. News and World Report, 97, 49-50.

Eisenberg, L. (1980). Adolescent Suicide: on taking arms against a sea of troubles. Pediatrics, 315-320.

Friedman, R.C., Corn, R., Hurt, S.W., Fibel, B., Schulick, J. & Swirsky, S., (1984). Family history of illness in the seriously suicidal adolescent: a life-cycle approach. American Journal of Orthopsychiatry, 54, 390-397.

Friedman, S.B., & Sarles, R.M. (1980). "Out of control" behavior in adolescents. Pediatric Clinics of North America, (Symposium on adolescent medicine), 27, 97-107.

Gilead, M.P., and Mulaik, J.S. (1983). Adolescent Suicide: a response to developmental crisis. Perspectives in Psychiatric Care, 11, 94-101.

Griffin, M., & Felsenthal, C. (1983). A Cry for Help. Garden City, N.Y.: Doubleday.

Hawkins, Suzanne (1986). Personal Communication. Psychiatric Emergency Department, Maine Medical Center, Portland, Maine.

Hawton, K., O'Grady, J., Osborn, M., & Cole, D. (1982). Adolescents who take overdoses: their characteristics, problems and contacts with helping agencies. British Journal of Psychiatry, 140, 118-123.

Kaplan, S.L., Landa, B., Weinhold, C., and Shenker, I.R. (1984). Adverse health behaviors and depressive symptomatology in adolescents. Journal of the American Academy of Child Psychiatry, 23, 595-601.

Maine Department of Human Services (1984). Division of Data and Research.

Maine Department of Human Services (1985). Maine Vital Statistics--1973-1984 Division of Data and Research.

Maine Department of Mental Health and Mental Retardation (1983). Residential Treatment Center Survey--1983.

Maine Department of Mental Health and Mental Retardation (1984). Augusta Mental Health Institute Adolescent Unit Survey--1984.

McCoy, K. (1982). Coping with Teenage Depression: A parents' guide. N.Y.: New American Library.

McKenry, P.C., Tishler, C.L., & Kelley, C. (1982). Adolescent Suicide. Clinical Pediatrics, 21, 266-270.

Montell, James (1985). Personal Communication. Maine Department of Public Safety.

Ownby, H. (1985). Testimony on Teenage Suicide. Hearing before the Subcommittee on Juvenile Justice of the Committee on the Judiciary. U.S. Senate, 98th Congress, October 3, 1984. Washington, D.C.: U.S. Government Printing Office, Serial No. J-98-143.

Robbins, D.R., & Alessi, N.E. (1985). Depressive Symptoms and Suicidal Behavior in Adolescents. American Journal of Psychiatry, 142, 588-592.

Senior, N., & Leehey, K. (1985, October). Suicide in Adolescents. Paper presented at the 37th Institute on Hospital and Community Psychiatry, Quebec, Canada.

Shaffer, D and Caton, C.L.M. (1984)Teenage Suicide. Hearing before the Committee on the Judiciary, United States Senate, October 3, 1984. Serial No. J-98-143. U.S. Government Printing Office, Washington, 1985.

Spang, David (1985). Personal Communication. Maine Department of Educational and Cultural Services, Drug and Alcohol Education Unit.

State Mental Health Representatives for Children and Youth. (1985, July). California First in Nation to Adopt a Community-based Youth Suicide School Prevention Plan. The Children and Youth Updates. Washington, D.C.: National Association of State Mental Health Program Directors.

State Mental Health Representatives for Children and Youth. (1985, July). Summary of SMHRCY Survey on Adolescent Suicide Prevention Programs. Presented at semi-annual meeting of State Mental Health Representatives for Children and Youth, Portland, Maine.

Sudak, H.S., Ford, A.B., & Rushforth, N.B. (1984). Adolescent Suicide: An Overview. American Journal of Psychotherapy, 38, 350-363.

Teicher, J.D., (1979). Suicide and Suicide Attempts. In J. Nospitz (Ed.). Basic Handbook of Child Psychiatry, vol. II. N.Y.: Basic Books.