Mental health counselors identify treating suicidal clients as one of the most stressful aspects of their work. Treating suicidal adolescents poses a range of additional challenges. Literature on suicidal behavior continues to grow and potentially efficacious treatments are being developed, however clinicians in the field are provided few guidelines for treating suicidal clients. In this paper we provide a brief review of evidenced-based treatments with suicidal adolescents and offer guidelines for the treatment of suicidal adolescents within outpatient settings. We conclude with a brief overview of special considerations for treating adolescents who are suicidal.

Suicide remains a significant cause of death in the United States, particularly among youth. Suicide is the third leading cause of death among 15 to 19 year olds (National Center for Health Statistics, 2004), and rates of death from suicide increase with age from childhood through adulthood (Gould, Greenberg, Velting, & Shaffer, 2003). Consistent findings from the Youth Risk Behavior Survey conducted by the Center for Disease Control and Prevention have shown that significant numbers (e.g., 16.9%) of high school students reported serious suicidal ideation with plans in the proceeding year (Grunbaum, Kann, Kinches, et al., 2004). Furthermore, Grunbaum et al. (2004) documented that 8.5% of high school students reported attempting suicide within a 12-month...
period, and 2.9% made an attempt that required medical intervention. Thus, suicide remains a considerable problem among youth.

Suicidal behavior, including ideation and attempts, is one of the most commonly encountered emergencies for the mental health clinician (Beutler, Clarkin, & Bongar, 2000; Pope & Tabachnick, 1993), up to 20% of whom will have a client who dies by suicide during treatment (Campbell, 2006; Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988). Unfortunately, clinicians are often not adequately prepared for managing and treating suicidal clients (Bongar, 2002). Utilization of inpatient hospitalization for suicidal clients has significantly decreased in recent years due to the effects of managed care and findings that hospitalization confers little to no positive treatment effect (Comtois & Linehan, 2006; Rissmiller, Steer, Ranieri, Rissmiller, & Hogate, 1994). As a result, much of the responsibility for the care of a suicidal client falls upon clinicians working in outpatient care settings. Unfortunately, clinicians lack clear guidelines for treating suicidal persons; particularly suicidal youth. Our primary goals for this review are to provide a brief overview of empirically supported treatments for suicidal adolescents and to offer empirically based guidelines for working with suicidal youth. We will also briefly address special challenges specific to treating adolescents who are suicidal.

EMPIRICALLY SUPPORTED SUICIDE TREATMENT

The empirical literature regarding the treatment of suicidal persons is remarkably sparse, particularly with regard to suicidal adolescents (Gould et al., 2003; Hawton, et al., 1999; Miller & Glinski, 2000). Conclusions drawn from reviews of randomized controlled trials and uncontrolled studies of suicide treatments with adult samples are mixed at best. Generally, it appears as though cognitive-behavioral interventions that incorporate a problem-solving element have promise for reducing suicide ideation, attempts, and symptoms of concomitant disorders (Comtois & Linehan, 2006; Hawton, et al., 1998; Rudd, 2000). Furthermore, in a recent study of cognitive therapy, Brown and colleagues (2007) found that suicidal patients who received 10 sessions of cognitive therapy had significantly fewer suicide attempts and lower rates of depression at 18 months post-treatment. While it would appear that cognitive-behavioral based approaches may be best, other treatment modalities, such as interpersonal psychotherapy, have shown promise for reducing suicidality (e.g., Guthrie et al., 2001; Jobes & Drozd, 2004; Tryer et al., 2003). Based upon the limited existing research, it is premature to conclude that there is a single, preferred treatment approach for suicidal adults.

While much of the existing treatment literature relevant to suicidal adolescents focuses upon reducing co-occurring disorders such as depression (Emslie,
Kratochvil, Vitiello, & CSCS, 2006; March, Silva, Vitiello, & TADS Team, 2006; TADS team, 2004), there are a few studies that have directly target suicidality. The approach predominantly used within these studies consisted of a cognitive-behavioral and problem-solving orientation, and were delivered through highly varied formats ranging from individual psychotherapy to intensive home-based interventions.

**Individual Psychotherapy Approaches**

We were only able to identify three controlled studies of individual psychotherapy for suicidal adolescents. In the only known randomized controlled trial, Donaldson, Spirito, and Esposito-Smythers (2005) randomly assigned adolescents who previously attempted suicide into one of two treatment conditions: skills-based treatment (SBT) or supportive relationship treatment (SRT). The authors hypothesized that SBT would be more effective than SRT in reducing suicidal ideation and future attempts; however, the results did not support the hypothesis. Adolescents in both treatment groups had significant reductions in all symptom areas. However, a particular flaw to this study was that both treatments were provided by the same clinicians so it is unclear whether the lack of difference between groups is due to treatment carryover confounds.

More promising, are results from a pilot study of cognitive-behavioral therapy for suicidal adolescents with co-occurring alcohol abuse. Esposito-Smythers, Spirito, Uth, and LaChance (2006) enrolled six adolescents in outpatient therapy that utilized individual cognitive-behavioral psychotherapy with family sessions as needed. At the end of the treatment period, five participants had completed treatment and all showed significant decreases in alcohol use and suicidality, although two of the five had re-attempted suicide. The sample size is too small to draw strong conclusions, but the results provide tentative evidence that outpatient cognitive-behavioral treatment of high risk suicidal adolescents is feasible and potentially effective. Further supporting this idea, are results from Rathus and Miller’s (2002) quasi-experimental study of dialectical behavior therapy (DBT) with suicidal adolescents. The treatment consisted of 12 weeks of individual therapy and a family skills-training group (see Miller, 1999). At the end of treatment, adolescents in the DBT group had significantly fewer hospitalizations, higher rates of treatment completion than the treatment as usual group, as well as significant reductions in both suicidal ideation and general psychiatric symptoms from pre- to post-treatment. Based on these studies, it appears individual psychotherapy combined with family-based interventions that focus on skill building may prove useful in reducing suicidal behavior in adolescents. However, randomized controlled trials of specific individual treatments are greatly needed before strong conclusions can be drawn regarding effectiveness.
Group Therapy

Many group therapies for suicidal adolescents utilize a psychoeducational and skills-building approach that target areas such as social problem-solving and relationship building, which are believed to underlie the suicidal behavior (Hendin, Maltsberger, & Hass, 2004). For example, Wood and colleagues (2001) compared a group therapy that incorporated elements of problem-solving, cognitive-behavioral strategies, DBT, and psychodynamic elements to treatment as usual within a sample of 63 suicidal adolescents. At the 7-month follow-up period, adolescents who participated in the group therapy were significantly less likely to have repeated an act of self-harm, had better school attendance, and had fewer behavioral disorder symptoms. While the intervention was successful at reducing suicidal behaviors, it was no better than treatment as usual in reducing depressive affect or suicidal ideation. Within studies of older adolescents, age 18 to 25 years, social problem-solving groups have demonstrated moderate effectiveness in reducing suicidality (Joiner, Volez, & Rudd, 2001; Lerner & Clum, 1990; Rudd et al., 1996). It appears that problem-solving groups may be effective in reducing suicidality, but additional research is needed. Drawing conclusions regarding the effectiveness of group therapy for suicidal adolescents therefore, seems premature.

Systemic Interventions

Systemic interventions represent treatment efforts that target family or larger social environments of youth as the primary mechanism for reducing suicidality. Harrington et al (1998) randomly assigned adolescents recently discharged for self-poisoning to either routine care or to a five-session home based family problem-solving intervention. At six-month follow-up both groups showed similar reductions in suicidal behavior; however, a subgroup of depressed adolescents, those in the at-home family intervention group showed a significant reduction in suicidal ideation relative to the routine care group. Further, the parents of the at-home intervention were more pleased with treatment than the routine care parents, which can have important treatment implications when working with youth. More promising results were reported by Huey and colleagues (2004) who found that suicidal adolescents randomly assigned to multisystemic therapy (MST) demonstrated faster reductions in suicide attempts and comorbid symptoms than those assigned to inpatient treatment as usual. However, the findings are limited by the fact that 44% of the MST sample also received inpatient care during the study period. Thus, the effectiveness of intensive home-based interventions for reducing suicidal behavior in adolescents remains uncertain. Given the time-intensive nature, potential costs, and limited effectiveness for these interventions, they may not be practical for use within standard community outpatient settings at this time.
A promising new systemic approach developed by King, Kramer, and Preuss (2000) may be more feasible for general mental health counselors to use. The Youth-Nominated Support Team (YST; King et al., 2000) was designed to supplement standard care for suicidal adolescents. Within this intervention, suicidal youth are asked to nominate individuals from inside or outside their family (only one peer is allowed) who they believe are supportive. These support persons are provided with psychoeducation regarding suicide risk and the specific youth’s treatment plan. The support person meets with the adolescent on a weekly basis in a way that fosters supportive, therapeutic contact. These activities occur in addition to treatment as usual (e.g., psychotherapy, pharmacotherapy, partial hospitalization, etc.). In a randomized controlled trial of this intervention, King and colleagues (2006) found no main group differences on suicide ideation or attempts at six-month follow-up. However, among adolescent females, those in the YST group reported significantly greater reductions in suicidal ideation and mood-related symptoms. Thus, this social network intervention warrants further consideration, particularly for adolescent females.

GUIDELINES FOR TREATING SUICIDAL ADOLESCENTS

Due to the extreme paucity of empirical studies of treatments for suicidal adolescents, it is challenging for mental health clinicians to determine the best way to work with the suicidal adolescents they encounter. While the existing literature is grossly limited, it appears that cognitive-behavioral strategies that incorporate an additional element such as problem-solving, skills building, or family interventions may be best; but, there are a lack of comparison treatments. So, it is difficult to discern, from randomized controlled trials, what the best practice for treating suicidal adolescents should be. In this section we will outline some general guidelines drawn from treatment experts within the field of suicidology that can direct individual psychotherapy practices.

The essential guideline clinicians are encouraged to follow, is to treat the suicidal behavior first, then address the underlying predisposing factors and psychopathology (Harrington et al., 1998; Maris, Berman, & Silverman, 2000; Rudd, Joiner, & Rajab, 2001). Since more individuals with depression survive than complete or even attempt suicide, there are likely causes of suicide other than and potentially unrelated to depression or other psychopathology. A best practice approach to the treatment of suicidality will involve targeting the specifics of the suicidal crisis rather than the underlying psychiatric disorder (Rudd, Joiner, Jobes, & King, 1999). Using a treatment manual as a guide is strongly encouraged. There are a handful of manuals specific to treating suicidal behavior available for mental health clinicians (e.g., Henriques, Beck, & Brown, 2003; Jobes, 2006; Linehan, 1993; Miller, Rathus, & Linehan, 2007;
Rudd et al., 2001) that offer general approaches but are not necessarily tailored for adolescents, with the exception of the adolescent dialectical behavior therapy manual (Miller et al., 2007).

In addition to consulting with colleagues and reviewing suicide treatment manuals, adopting a model for how one approaches treatment with suicidal adolescents is also useful. We suggest a model that incorporates five elements: understand the suicidal mind, monitor suicide risk, use crisis management strategies, alleviate risk factors, and enhance protective factors.

UNDERSTANDING THE SUICIDAL MIND

Therapeutic Relationship

Researchers have noted many times that the relationship formed between clinician and client is important to therapy effectiveness, and it becomes vital for effective treatment of suicidal clients (Bongar & Harmatz, 1989; Jobes & Maltzberger, 1995; Orbach, 2001; Rudd et al., 2001; Schneidman, 1984). Some suggest that the relationship becomes the “vehicle of change” (Rudd et al., 2001, p. 14) for suicidal persons. Thus, forming this relationship becomes an imperative first step towards effectively treating a suicidal adolescent. One mechanism in which to develop a strong therapeutic alliance with suicidal youth is to understand their suicidal point of view, listening and empathizing with their current pain, yet avoiding agreement with the suicidal perspective. Being actively engaged in listening to the story the adolescent tells, recognizing the precipitants and the context surrounding the suicidal desire in a manner that conveys support, validation, and empathic understanding is essential to establishing the relationship because it communicates a willingness by the clinician to join the client where she or he is at without fear (Michel et al., 2004; Orbach, 2001; Schneidman, 1984).

Suicidal Cognitions

To better understand the suicidal mind of the adolescent, clinicians need to listen for themes connected to suicidal urges, cognitions linked to suicide (e.g., “things won’t get better”), and specific needs that are not being met within the current environment. Both Joiner (2005) and Schneidman (1998) argue that suicide is a direct consequence of unresolved psychic pain due to failures to meet psychological needs important to the individual (e.g., need to belong, need to be successful), and disconnection from others in the client’s life. These ideas are compatible with perspectives that view suicide as caused by unrelenting depression and hopelessness (Beck, Brown, Berchick, Stewart, & Steer, 1990) and a need to escape from aversive self-awareness (Baumeister, 1990). Thus, noting how precipitating events and existing contextual factors contribute to the client’s perception of psychological pain, faulty cognitions, and detachment
from others is important to understanding some of the dynamics influencing the suicidal desire. Further, the ability to empathically communicate understanding of the key elements underlying the adolescents’ suicidal state will help to build the treatment alliance, and set the stage for the clinician and adolescent to begin a partnership of combating suicide through treatment.

Monitor Suicide Risk

Suicidal ideation and intent tends to follow a fluctuating course and is rarely a static cognitive state. Therefore, it is imperative that treatment should include ongoing, repeated assessments of suicide risk (Jobes, 2006). A myriad of resources are available to guide legally sound suicide risk assessments (e.g., Bongar, 2002; Bryan & Rudd, 2006; Curkrowicz, Wingate, Driscoll, & Joiner, 2004; Rudd et al., 2001; Simon & Hales, 2006), but discussion of these well-established approaches is beyond the scope of this paper. What is necessary is a discussion of how to monitor suicide risk throughout therapy in a manner that provides valuable information about current risk.

We suggest beginning each session with a review of the adolescent’s current suicidal state. This may take the form of using a risk monitoring card (Rudd et al., 2001), diary card (Miller et al., 2007), the suicide status form (Jobes, 2006) or verbal check-in. Regardless of form, the review should include a brief assessment for warning signs that suggest a suicide attempt may occur. Warning signs, unlike risk factors, tend to be episodic and have direct relevance to the adolescent’s current psychological state, thus providing valuable data about a possible suicide crisis (Rudd, Berman, et al., 2006). While there is a dearth of empirical research on warning signs for suicide, recent expert consensus was obtained for a set of warning signs (Rudd, Berman, et al., 2006). The warning signs to monitor include: preparation for and/or increased suicidal intent; changes in mood state towards increased hopelessness, anger/rage, agitation, or anxiety; increased substance abuse; restlessness or insomnia; feelings of being trapped; participation in risky activities; withdrawal from family or friends; and dramatic changes in mood. In addition to these factors, Rudd, Berman et al. (2006) and Maltsberger (2006) highlight that most suicide attempts are precipitated by a negative life event, so clinicians need to be additionally sensitive to and monitor recent negative events in adolescents’ lives. Furthermore, it may be beneficial to have a global rating of current psychological pain and feelings of self-hate (Hendin et al., 2004; Jobes, 2006; Maltsberger, 2006) since these can also provide valuable information about immediate risk, and areas to focus on in treatment.

Crisis Management

The goal for crisis management is to return the adolescent to a pre-crisis state and continue with therapy. Research with adults has demonstrated that individ-
uals at high risk for suicide can be effectively managed through outpatient care (e.g., Comtois & Linehan, 2006), but hospitalization should be considered for adolescents when there is strong and persistent suicidal ideation or a notable abnormal psychiatric state, such as psychosis (American Academy of Child & Adolescent Psychiatry [ACCAP], 2001). Maintaining open communication with other treatment providers is also essential, particularly if the adolescent is prescribed an antidepressant (AACAP, 2001).

The main stance of the clinician during crisis management is an active, directive approach that simultaneously empowers the adolescent to engage in immediate problem-solving. Suicide is often viewed as a solution to problems within the adolescent’s life that appear to be unsolvable. Kalafat and Underwood (2005) recommend asking questions such as “What’s going on in your life right now that makes you think that death is the best way out?” (p. 165), and inquiring about the adolescent’s beliefs of what issues will be resolved through suicide. Questions such as this permit the client and therapist to examine the essential problems, barriers, and events contributing to the suicidal crisis in a concrete fashion that set the stage for exploring alternative ways in which to achieve the client’s goals or meet the client’s needs. While problem-solving, it is important to note that focusing on specific behaviors to modify or tasks to complete will probably be easier for adolescents than focusing on irrational cognitions when in this phase (Trautman, 1995).

In addition to fostering active problem solving, there are a number of other steps a clinician should consider during crisis management. The first are to decrease access to the means for suicide, and decrease personal isolation (Maris et al., 2000). These two steps will likely require involving a responsible family member who agrees to closely monitor the adolescent and provide a safe living environment. If the immediate family represents key stressors associated with the suicide urge, the clinician is encouraged to facilitate an alternative, temporary living environment for the adolescent with other family or close friends. Increasing treatment availability is also strongly encouraged and can take the form of lengthening, increasing the frequency of, or maintaining phone contact between sessions (Linehan, 1993; Maris et al., 2000). It is also important for the clinician and adolescent to negotiate safety contingencies for remaining in an outpatient setting. Research does not support the effectiveness of no-suicide contracts (Rudd, Mandrusiak, & Joiner, 2006; McConnell, 2007), but generating a commitment to treatment plan (Range, 2005; Rudd, Mandrusiak, & Joiner, 2006), or general safety plan, is recommended. Working collaboratively to establish safety contingencies has the added benefit of potentially strengthening the therapeutic relationship and therefore becomes an intervention on its own.
Alleviate Risk Factors

There are excellent reviews of common risk factors for suicide in adolescents (AACAP, 2001; Brent et al., 1999; Evans et al., 2004; Fergusson, Woodward, & Horwood, 2000), and each highlight the role of psychopathology, particularly depression, and environmental/family factors. Once the imminent risk for suicidal behavior is reduced, therapy can begin to focus on treating the underlying dynamic factors of the suicidality. The primary step should be on reducing symptoms of psychopathology, such as depression, through the use of psychotherapy and psychiatric medications when deemed necessary (Ash, 2006; March et al., 2004; 2006). Challenging and correcting cognitive distortions, enhancing problem-solving and coping skills, improving social skills, increasing emotion regulation and distress tolerance, and addressing family variables through family therapy are all recommended strategies to help alleviate risk factors for suicide (Ash, 2006; Lerner & Clum, 1990; Maris et al., 2000; Miller et al., 2007). A number of psychotherapies have demonstrated effectiveness in accomplishing these treatment tasks. It will be necessary for the clinician and adolescent to work together to identify the dominant factors contributing to suicidality for that adolescent, and treatment goals can then be created to address those unique elements. Clinicians are encouraged to draw upon empirically supported treatment methods when tailoring the treatment needs of each adolescent.

Enhance Protective Factors

Most suicidal persons experience ambivalent feelings regarding their desire to die (Kalafat & Underwood, 2005). Therefore, the best practice approach is to identify and normalize ambivalence, and candidly explore both sides of the ambivalent feelings. By examining both sides of an adolescent’s conflicted feelings, the therapist is in a better position to side with the part of the adolescent that wants to live and can therefore work with the client in activating a desire to live. A straightforward method for aligning with the adolescent’s desire to live is to engage in a detailed discussion of the reasons for living, building upon every element identified no matter how trivial the reason may seem. It can also be useful to assist the adolescent in identifying a short-term goal or future event he or she may want to participate in, using this to further strengthen motivation to live. Each therapy session should continue to expand upon and strengthen the client’s reasons for living. Having the client keep a list of his or her reasons for living that are readily available for review (e.g., on a notecard carried in a purse) in case suicidal urges intensify is another potentially effective strategy.

Adolescents may only be able to identify one or two reasons for living early in treatment; therefore it is important for the therapy to assist in building
additional reasons. One way to do this is to foster the accumulation of positive experiences and/or enhance meaningful connection to others. As Joiner (2005) has discussed, suicidal individuals often feel isolated or believe themselves to be burdensome to others. Consequently, a useful intervention to prevent suicidal behavior is to facilitate connections between the adolescent and others in the adolescent’s life who can offer support. Research has demonstrated that feeling connected to at least one person whether a teacher, friend, or family member can minimize suicide risk (Grossman & Rhodes, 2002; Resnick et al., 1997). Including a positive family member or other adult in the treatment is strongly recommended as this can foster a sense of importance and being valuable to someone (see King et al., 2006). The ability to identify and strengthen reasons for living can enhance an adolescent’s motivation to live and may also decrease feelings of hopelessness, thus reducing a significant factor associated with suicidal behavior.

**UNIQUE CHALLENGES TO TREATING SUICIDAL ADOLESCENTS**

We believe that using the model described above will greatly enhance mental health clinicians’ ability to work effectively with suicidal adolescents in an outpatient setting. However, there are a handful of other factors that impact treatment with suicidal adolescents that must be addressed in order to facilitate effective treatment. Probably the largest challenge clinicians must face are the limits of confidentiality that permeate treatment with adolescents. It is well known that confidentiality must be breached to ensure the safety of clients; however, adolescents’ confidentiality is generally tenuous because their guardians have legal access to treatment records. Breaking confidentiality, even when ethically required, can have detrimental effects on the treatment alliance, particularly with adolescents (Ash, 2006; Maltsberger, 2006). The best way to avoid an irreparable breach is to clearly describe the conditions upon which confidentiality will be broken at the outset of therapy to both the adolescent and guardians, and again prior to speaking with the guardians. We strongly advocate for including the adolescent in any communications with guardians regarding treatment and safety, as developmentally appropriate, so that any misunderstandings can be addressed and the adolescent can retain some autonomy in the process.

Another challenge clinicians must overcome is that many suicidal adolescents are being brought to treatment by their guardians and may be reluctant to engage in therapy (Ash, 2006). Research has identified that adolescents referred to outpatient care after a suicide attempt tend to have poor treatment adherence (Piacentini et al., 1995) and drop out of treatment prematurely (Trautman, Stewart, & Marishima, 1993). Further, research has documented that many adolescents are more likely to deny suicidal ideation, with 25%
believing they should keep it a secret (Gould et al., 2004). Thus, the clinician needs to be sensitive to factors affecting client motivation and willingness to engage in treatment. Adopting an inquisitive, non-judgmental approach that communicates an eagerness to collaborate with, rather than enforce treatment upon the adolescent could help mitigate these obstacles. Utilizing such an approach is consistent with forming the type of therapeutic alliance necessary for eliciting reliable suicide risk assessment data (Jobes & Matsberger, 1995; Shea, 2002). Clinicians may also want to draw upon commitment strategies described in motivational interviewing (Miller & Rollnick, 2002), and by Miller et al. (2007) that permit the adolescent to have some choices regarding treatment. Contracting for an abbreviated time period, or small number of sessions to start, may also help to enhance an adolescent’s willingness to engage in treatment because they know it will be time-limited.

Involving the family in the suicidal adolescent’s treatment is another main challenge. Experts agree that family involvement and family therapy is often necessary for effective treatment of suicidal adolescents (Ash, 2006; Maris et al., 2006; Miller et al., 2007). Family dysfunction and parental psychopathology tends to be more prevalent among suicidal adolescents’ families (King, Segal, Naylor, & Evans, 1993; Wagner, 1997). Further, the family environment often plays a role in adolescent’s suicidality; thus, treating family pathology can be a critical step in alleviating suicide risk in the adolescent. However, it can be difficult to engage families in therapy when they perceive the adolescent to be the sole person in need of treatment. As suggested by Miller, Glinski, Woodberry, Mithcell, & Indik (2002), it is imperative that the clinician use a non-blaming stance with family members and validate the difficulties and concerns they express related to their adolescent. From there, the clinician can engage the family in a discussion of how treatment will not only help alleviate their concerns related to the suicidal adolescent, but also improve family relationships and general functioning. The key is to tailor the discussion to elements the family would like to see improved and work on obtaining commitment to address these aspects (see Miller et al., 2007 for more detailed discussion).

CONCLUSION

Research with suicidal adults offers evidence that suicidal persons can be effectively treated within an outpatient setting, and it is assumed this finding translates to treating suicidal adolescents. We presented a set of general guidelines for approaching the treatment of suicidal adolescents within an outpatient setting that may contribute to increased effectiveness, as well as enhanced confidence in one’s ability to treat suicidal adolescents. Ultimately, the best approach is one that engages the adolescent in a collaborative, non-judgmental
analysis of the suicidal urge so that immediate, concrete steps can be designed to reduce the factors motivating the suicidality. Directly targeting the suicidal behavior and building reasons for living are the first lines of defense for moving the adolescent towards living. While our recommendations are based upon the available research, it becomes clear that the treatment of suicidal adolescents is grossly understudied. In addition, there are no known diversity related guidelines for working with suicidal adolescents from varied cultural groups. In a recent set of reviews, Colucci and Martin (2007a, b) discuss how rates and risk factors for suicidal behavior differ across cultural groups, which could have implications for treatment. Some culture-specific treatment suggestions are offered by Leong and Leach (2007), but focus on general recommendations that are not specific to adolescents. Further study of empirically supported models and approaches for treating suicidal youth from a range of cultural backgrounds is required so that clinicians can use state of the art technologies for advancing the mental health of our youth.

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