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Suicide Attempts among Emotionally and Behaviorally Disturbed Adolescents Removed from the Home

Faith M. Wanja

Fort Hays State University, fmwanja@mail.fhsu.edu

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SUICIDE ATTEMPTS AMONG EMOTIONALLY AND BEHAVIORALLY
DISTURBED ADOLESCENTS REMOVED FROM THE HOME

being

A Thesis Presented to the Graduate Faculty
of the Fort Hays State University in
Partial Fulfillment of the Requirements for
the Degree of Master of Science

by

Faith Wanja
B.A., Tabor College

Date _____

Approved _____
Major Professor

Approved _____
Chair, Graduate Council

ABSTRACT

This study was conducted to examine the relationship between adolescent suicide behavior and the age of removal from home amongst children with emotional and behavioral disturbance. The study aims to determine whether a child's removal from home can be counted as a viable basis for the development of suicide prevention programs and an expansion for evidence based practices. The study was conducted using archived de-identified data collected and provided by a private not-for-profit behavioral health treatment facility located in rural Kansas. The participants included male and female adolescents between the ages of thirteen to eighteen years old that were admitted into the facility between January 1st, 2011 and May 31st, 2011. The results did not indicate a significant relationship between adolescent suicide behavior and the age of the child's first removal from the home. However correlations revealed a significant relationship between multiple types of trauma experienced and the age of the child's first removal from the home. Further analyses revealed a positive correlation between multiple types of trauma experienced and suicide attempts. T-tests indicated little difference between genders in regards to suicide attempts or the child's first removal from the home. These results may have been influenced by an inadequate amount of participants and a limited pool of data. Adolescent suicide is a critical issue facing society today. Further research is needed to determine the effects of out-of-home placements as a possible predictor to adolescent suicide behavior in hopes of shedding more light to the issue of adolescent suicide.

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Suicide is a major preventable public health problem. In 2007, it was the tenth leading cause of death in the U.S., accounting for 34,598 deaths. The overall rate was 11.3 suicide deaths per 100,000 people. An estimated 11 attempted suicides occur per every suicide death. Suicide was the seventh leading cause of death for males and the fifteenth leading cause of death for females in 2007. Almost four times as many males as females die by suicide (Center for Disease Control and Prevention, 2011). Risk factors for nonfatal suicide attempts in general population can vary by age, gender, and ethnicity and may include depression and other mental disorders, alcohol and other substance abuse and separation or divorce (Kessler, Borges, & Walters, 1999). Furthermore, risk factors for attempted suicide by youth include depression, alcohol or other drug-use disorder, physical or sexual abuse, and disruptive behavior (Petronis, Samuels, Moscicki, & Anthony, 1990).

Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15-to-24-year-olds, and the sixth leading cause of death for 5-to-14-year-olds ("Facts for Families," 2008). It has been estimated that nearly 3 million adolescents between the ages of 12 and 17 years contemplated suicide each year of which 37% attempt suicide (Dunn, Goodrow, Givens, & Austin, 2008). In 2001, 19.0% of high school students had seriously considered attempting suicide, 14.8% nationwide had made a plan to commit suicide, and 8.8% actually had attempted suicide at least once. Overall, adolescent females (17.7 %) are more likely to consider and attempt suicide at higher rates than males (11.8%) (Pettingell et al., 2008). Suicide attempts are most prevalent in Caucasian females (5.6%) and Hispanic females (5.5%) and are least prevalent for African American males (1.6%) and Caucasian males (1.9%) (Rollins, 2001). However,

fatal suicide attempts among adolescents in the general population averaged 5 times more the rate of males than of females (Pettingell et al., 2008).

In comparison to other states, the state of Kansas ranked twenty ninth in the prevalence and seriousness of depression among its residents, with 13.5 suicides per 100,000 residents (Mark, Shern, Bagalman, & Cao, 2007) Though the numbers appear low, one must keep in mind that the numbers are skewed based on the state's population. In 2010, there were 62 suicides within the age group of 15- 24 years old in the state of Kansas which is an estimated 15.2 suicides per 100,000 residents within the age group. A substantially larger majority of the youth suicide within the age group were males compromising 51 out of the 62 youth suicides (The Kansas Department of Health and Environment). A number of studies have shown that rural areas tend to have higher suicide rates than urban locations in the United States (Sankaranarayanan, Carter, & Lewin, 2010; Singh & Siahpush, 2002). However, the suicide rates are substantially lower in the rural northwest region of Kansas as compared to its more urban counterparts of south central and northeast Kansas. In 2010, the northwest region recorded a total of 20 suicides with males constituting 85 percent of the suicide deaths in the region. Less than six recorded youth suicides occurred in Ellis County in the same year and altogether only seven youth suicide deaths recorded in Ellis County for residents within the 15-24 years age group over the past decade (The Kansas Department of Health and Environment, 2010).

Some risk factors for teen suicide include depression, feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty (Facts for Families,

2008), that can be due to realities of today's society such as divorce, single parents, drugs and alcohol, and physical and sexual abuse (Mazer, 1995). Further risk factors for adolescent suicide include mental health disorders, severe emotional and behavioral disturbance, and childhood trauma.

Purpose of Study

It is well known that adolescent suicide attempts are closely linked to mental health disorders. Studies continue to show a strong link between mental health disorders and increased risk of suicide attempts (Groholt & Ekeberg, 2009; Sankaranarayanan et al., 2010). Suicide completions and suicide attempts are most common in male psychiatric inpatients as well as in recently discharged psychiatric inpatients (Sankaranarayanan et al., 2010). Further studies have determined that adolescent suicide attempts requiring medical attention are strongly associated with psychiatric disorders. In fact adolescent suicide attempters treated in general hospitals have a high risk for later psychiatric disorders, especially depression, personality disorders, and anxiety (Groholt & Ekeberg, 2009).

A recent report on risk factors associated with serious suicide attempts and suicide among people less than 25 years of age determined that suicide was significantly associated with the male gender as well as exposure to recent stressful life events. Other factors such as lack of formal educational qualification, mood disorder in the preceding month, and history of care for mental health problems also contributed to increased suicide risk (Beautris, 2003).

In further support that suicide and suicide attempt rates are highly correlated with mental health disorders, suicide attempts and completions have been linked to higher levels of pessimism, aggressive/impulsive traits, and comorbidity with substance use disorders, following a major depressive disorder (MDD) episode. Similar studies have postulated increased risk for future suicidal behavior among men who have symptoms of a major depressive episode, aggression, hostility, and history of substance misuse, while the same is postulated among women who have depressive symptoms, a childhood history of abuse, fewer reasons for living, and borderline personality disorder (Oquende, Galfavy, Stefani, & Steven, 2004).

In spite of the strong links between mental health disorders, hospitalized patients, and suicide attempts/completions, very little research has been conducted on the study of suicide rates among adolescents hospitalized for mental disorders. One study observed adults receiving inpatient care in rural parts of Australia (Sankaranarayanan et al., 2010); however, a gap in literature exists for similar studies that focus on assessing suicide risk predictors among suicidal youth in rural areas of America, specifically Kansas.

Severely Emotionally and Behaviorally Disturbed (EBD) Adolescents

The fact is many mental disorders have their beginnings in childhood or adolescence. We refer to mental disorders using different “umbrella” terms such as emotional disturbance, behavioral disorders, or mental illness. Beneath these umbrella terms, there is actually a wide range of specific conditions that differ from one another in their characteristics and treatment. These include but are not limited to anxiety disorders, bipolar disorder, (sometimes called manic-depression), conduct disorders, eating

disorders, obsessive-compulsive disorder (OCD), and psychotic disorders (National Dissemination Center for Children with Disabilities, 2010).

The Individuals with Disabilities Education Act (IDEA, 2007) defines emotional disturbance as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: The first defining characteristic includes an inability to learn that cannot be explained by intellectual, sensory, or health factors. The second defining characteristic includes an inability to build or maintain satisfactory interpersonal relationships with peers and teachers. The third defining characteristic includes inappropriate types of behavior or feelings under normal circumstances. The fourth defining characteristic includes a general pervasive mood of unhappiness or depression. And lastly, the fifth defining characteristic is the tendency to develop physical symptoms or fears associated with personal or school problems (IDEA, 2007).

According to social cognitive learning theory, human behavior, including social and interpersonal behavior (e.g. communication, problem solving) and core thoughts and beliefs (e.g. beliefs regarding self, others, and future), is based on previous learning experiences. Therefore, destructive human behavior is commonly believed to result from faulty learning experiences, and expressed through maladaptive feelings, behaviors, and cognitions. Consistent with cognitive learning theory, adolescents who attempt suicide, relative to their non-attempting peers, are more likely to report faulty learning experiences that promote suicidal behavior and are likely to exhibit negative affect, problematic social behaviors, and maladaptive cognitive processes (Esposito, Spiritto,

Boergers, & Donaldson, 2003). According to a number of studies, a precipitating event triggers maladaptive cognitive processes such as suicidal thoughts, and negative beliefs regarding self, others and future. In turn, these thought patterns lead to low mood, anger, and guilt, which in turn trigger heightened psychological or emotional arousal.

Maladaptive behaviors such as suicidal ideation or attempts are then engaged in as a means to diffuse ruminative thought process, negative mood, and agitation (Caldwell, 2002; Esposito et al., 2003).

Change is the most prominent characteristic of adolescence. Adolescents undergo countless interrelated transitions including biological changes associated with puberty, advances in cognitive and moral development, emergence of personal identity, and the development of independence and new social roles (Kools & Spiers, 2002). Mental health needs are particularly prevalent in children in out-of-home care. Children, and particularly adolescents with behavioral impairments, have a different experience in out-of-home care than those without such impairments. An estimated two-thirds of the children who were the responsibility of a child welfare agency needed mental health care services. Many of these children were adolescents with behavioral and emotional problems (Kupsinel & Dubsky, 1999). Furthermore, it is estimated that mental health problems are experienced by 17% to 23% of U.S children and adolescents, or 11 million to 14 million children. Nearly half of these children experience severe emotional disturbance and more than half a million among this group live in out of home placements. The majority is placed in foster care; more than 29,000 are in residential treatment facilities. Though their numbers may appear low, children in intensive mental

health service settings, including psychiatric hospitals and residential treatment, consume an ominous 70% to 80% of the national child mental health expenditures (Kools & Spiers, 2002).

Studies have supported the high increase of the national child mental health expenses. In studying the length of time in care, one study showed that participation in special education was significantly longer in duration and children with emotional and personality problems generally remained in care for longer periods of time (Kupsinel & Dubsky, 1999). In fact there was a reduced likelihood of both “return to family or guardian and adoption. Behavior problems may make it more difficult for parents or parental surrogates to care for children who experience group care, and less likely for potential parents to adopt them. Up to 72% of children in out-of-home care were rated as displaying emotional disturbance. Subsequently, children with behavioral and emotional problems were about one-half as likely to be reunified with their families as children without identified behavioral and emotional problems. It has been estimated that the prevalence of psychiatric disorders in children in out-of-home care was between 41% and 63%, with one quarter of the children having two disorders and one third having three or more (Kupsinel & Dubsky, 1999).

Past Trauma and EBD Adolescents

Child Abuse. Current research on children's exposure to trauma paints a bleak picture. Trauma typically presents in the context of circumstances that may influence child adjustment, including type of trauma, the number and types of co-occurring adversities, the mental and physical health of the children and caregivers, and children's

developmental stages. Trauma events take many forms. Some traumatic events are acute, some chronic, some completed, and some continuing (Gewirtz, Forgatch, & Wieling, 2008). Different forms of child abuse commonly co-occur. Sadly the youth that are highly at risk for such exposure are youth from low income families and minority groups. Child abuse tends to occur more frequently within families characterized by high stress. Parental conflict and domestic violence are strongly associated with an occurrence of both childhood physical abuse and childhood sexual abuse (Gladstone et al., 2004).

Child Physical Abuse. The acts of violence children are exposed to in their homes and communities involve a number of frightening and dangerous events, including witnessing individuals being choked, stabbed, and shot. In addition, the majority of youth exposed to violence witness acts of violence across a variety of contexts and across prolonged periods of time (Garrido, Culhane, Raviv, & Tausigg, 2010). Severe physical abuse cases constituted about 14% of a total study of child trauma. Severe cases of trauma have a significantly higher proportion of lowest socio-economic status and a tendency to higher levels of unemployment. The children who have been subjected to severe abuse generally already known to Social Services and reports of child abuse have frequently been made. Furthermore, the number of cases of suspected child abuse reported to the police has increased by a factor of four during the past two decades (Annerbäck, Svedin, & Gustafsson, 2009).

Given the severity, pervasiveness, and chronicity of the violence that the youth witness, it is not surprising that researchers often find elevated levels of trauma symptomatology among youth exposed to community and/or family violence (Garrido,

Culhane, Raviv, & Tausigg, 2010). Violence is indeed a widespread problem in the United States. Both in inner-city neighborhoods and rural and suburban locales, witnessing of and victimization by violence among youths are alarmingly commonplace. Physical abuse affects children of all ages, ethnic backgrounds, socioeconomic groups, and genders.

Several replicated research studies have linked physical abuse to emotionally and behaviorally disturbed youth. These studies have found that exposure and victimization to violence predicts increased risk of depression, anxiety, and aggressive behavior, heightened levels of posttraumatic stress symptomatology, and attachment problems (O'Donelle, Joshi, & Lewin, 2007; Horsely, 2007).

In the case of suicidality, individuals with a childhood history of sexual or physical abuse have been found to be at greater risk for future self-harm, suicidal ideation, and suicidal behaviors. In a study examining the distribution and determinants of suicidal ideation and suicide attempts in a community sample of women with major depressive disorder and a history of childhood physical abuse, approximately one-quarter of the [participants with major depressive disorder reported that they had made a suicide attempt, and more than half (55.6%) had experienced suicidal ideation (McHolm, MacMillan, & Jamison, 2003).

Child Sexual Abuse. Child sexual abuse is a societal problem recognized as a key risk factor for depression both during childhood and adulthood (Gladstone et al., 2004; Walker, Scott, & Koppersmith, 1998). An estimated 14 out of every 1,000 U.S children are victims of mistreatment and an estimated 9% of these cases are cases of

sexual abuse (Walker et al., 1998). Studies suggest that childhood sexual abuse may have its effect as a distal risk factor for suicidal behavior largely by predisposing to the development of psychiatric disorder. A history of childhood sexual abuse is associated with persons diagnosed with bipolar disorder, poses higher risks of depression and is often a predictor of a chronic course of depression particularly in females. Psychotic and schizotypal symptoms and poor social adjustment are associated with both child sexual abuse and suicidal behavior, (Gladstone et al., 2004; Roy & Janal, 2006; Soloff, Feski, & Fabio, 2008).

Childhood sexual abuse is associated with an increased risk of suicidal behavior. Studies show a strikingly increased risk for suicide attempts in women sexually abused before 16 years of age. Nearly fourteen percent of women sexually assaulted as children attempted suicide (Roy & Janal, 2006). A recent study shows that sexual abuse was strongly associated with a history of suicide attempts as well as of suicidal intent and was more common in women. The population risk fraction was considerably greater in female respondents (28%) than in male respondents (7%), which is consistent with more prevalent exposure to sexual abuse among women. It is important to keep in mind that although females are estimated to have more suicidal behaviors than males (such as suicidal ideation and suicidal attempts), males tend to have a higher rate of suicide completions. These results are also consistent among the adolescent population (Bebbington, Cooper, & Jenkins, 2009).

In a study examining youth risk behavior estimating the prevalence of child sexual abuse among high school students, 20.9% of the 2,332 students had been sexually

abused; females (33.1%) were much more likely to have ever been abused than were males (8.1%). Females (10.3%) also were more likely than males (3.4%) to have been sexually abused within the past year. High school students sexually abused in the past year engaged in many high risk health behaviors such as weapon carrying, substance abuse, and seriously considering suicide in the past year (Nelson, Higginson, & Grant-Worley, 1994).

Out of Home Care. Several studies link youth who are in out of home care to trauma, mental health problems, and risk taking behaviors, factors that have been closely linked to adolescent suicide. Previous studies have reported high rates of mental health problems among youth in welfare systems. For example, several studies conducted in the mid-seventies to mid-nineties, estimated that the prevalence of mental health problems ranged from 29% to 96% among adolescent youth and 60% of 11-17-year olds referred to out-of-home care in South Australia in 1998-99 had conduct problems. Furthermore, child welfare clients in Sweden were reported to be more likely than their peers to have been hospitalized for suicide attempts (Sawyer, Carbone, Searle, & Robinson, 2007).

Removal from home as linking trauma to suicidal behaviors

Children transform early interactions with primary care givers into cognitive-affective schemas of self and other that regulates and directs subsequent behavior (Blatt, Stayner, Auerbach, & Behrends, 1996). It has been found that children who were in out of home care for long periods of time have assumed that the experience itself was a harmful influence. Many children in out-of-home-care suffer the consequences, both biological and psychological, of parents who are emotionally disturbed, alcoholic, or drug

addicted. These children are more vulnerable to and ill prepared for the stress of placement in out of home care, which may include the temporary or permanent loss of their biological parents, or an adjustment to a new family or culture. In addition, children who come from families where violence was reported, behaviorally impaired children without handicaps were more likely to be physically abused, whereas behaviorally impaired children with other handicaps were more likely to be sexually abused (Kupsinel & Dubsky, 1999). Family context of parental neglect and childhood physical abuse may also place children at high risk of sexual abuse by perpetrators outside the home.

Studies in the U.S estimated 45% of the 513,000 children in the foster care system are adolescents. These youth are removed from their biological families for a variety of reasons, which include physical abuse (12-25%), neglect (50-75%), sexual abuse (2-9%), abandonment (9-35%), and parents who were incarcerated or unable to provide care (15-30%). Youth in group homes may have been placed there due to significant treatment needs, such as behavioral or mental health problems and are estimated to have a risk taking behavior along with youth who had experienced a parental death, or had a history of physical or emotional abuse or attempted suicide (Gramkowski, Kools, Paul, Cherie, & Monasterio, 2009).

A recent study was performed by Sawyer et al., (2007) to identify the prevalence of mental health problems, rates of suicidal ideation and behavior, and use of professional mental health services among children and adolescents residing in home-based foster care. The study found a predominance of behavior problems and suicidal ideation among the participants. Sixty one percent of children and adolescents living in home-based

foster care scored above the recommended cut-off for behavior problems on the Child Behavior Checklist and 35.2% of adolescents scored above the cut-off on the Youth Self Report. Six point seven percent of 13-17- year olds in home-based foster care reported a suicide attempt that required medical treatment during the previous year. The study concluded that children in home-based foster care experience high rates of mental health problems but only a minority receive professional help for their problems (Sawyer et al., 2007).

However, placement into out-of-home care such as foster care or residential treatment is only one piece of the picture. Another important element is returning these youth home. Emotional and behavioral functioning are the two most consistently reported factors involved in reunification. Youth with more psychiatric problems, or with problems that deteriorate during out of- home placement, are less likely to be reunited. Likewise, youth with such elevated levels of problems are also more likely to experience multiple placement disruptions (and hence placements) across time, and a history of placement disruptions, in turn, is associated with failure of family reunification (Farmer, Southerland, Mustillo, & Burns, 2009).

Theory Application. The application of Emile Durkheim's theory of social cognition can be supported by Durkheim's work on suicide which suggests that the disruption of social cohesion results in a greater risk of morbidity including self-destructive behaviors and suicide (Ritzer & Goodman, 2004). The most applicable aspect of Durkheim's theory is the view of egoistic suicide as a consequence of the deterioration of social and familial bonds (Kushner & Sterk, 2005). Durkheim's theory of egoistic

suicide is an example of a social system analysis that explains differences in suicide rates between groups and an example of a social system analysis of behavior ordinarily regarded as a highly personal act. Durkheim's focus on integration and regulation dealt primarily with the social control over behavior and aspirations that kept suicide in check, thus putting major emphasis on the impact of social control on suicide (Berk, 2006). Low levels of familial bonds, low levels of connectedness to the community, and multiple series of caregivers represent a poor impact of social control. According to Durkheim, low levels of social integration are associated with high suicide rates. Durkheim defined social integration as being attached to social groups, maintaining interpersonal ties and feeling allegiance to social groups (Singh & Siahpush, 2002). Low levels or an absence of social integration as measured by lack of familial contact, multiple placement disruptions, multiple out-of-home-care placements, and multiple school enrollments represent social isolation and the atomization of emotionally and behaviorally disturbed adolescents in out of home care.

Current Study

The current study examined the effects of removal from home on adolescent suicidal behavior. Evidence from a wide range of psychological disciplines converges to suggest that trauma and mental health problems are primary issues concerned with adolescent suicide. Numerous amounts of studies have examined various attributes to suicide prevention. However evidence shows that the issue of adolescent suicide prevention is in dire need of further research that could help identify specific factors leading to suicide among specific adolescent groups. This study purposed to examine a

possible suicide relationship for emotionally and behaviorally disturbed (EBD) adolescents in out-of-home care.

The lack of adequate research on suicide rates among rural EBD adolescents is remarkable. Collective research has shown higher rates of suicide attempts and suicide completions in rural versus urban areas. Research has also identified EBD children as at risk for suicidal attempts and suicidal behavior compared to their non EBD counterparts. However, very little research exists on suicide and suicidal behavior among rural EBD youth. Furthermore, research has shown adolescents in out-of-home care are at higher risk of suicidal behavior than their peers. However, little research examines the link between suicide attempt rates and adolescents in residential treatment facilities. This study addressed these issues by examining the number of suicidal attempts among EBD adolescents in a psychiatric residential setting in rural Kansas.

The study was conducted with the use of archival data from KVC Wheatland Hospital. Data were collected from a de-identified database provided by KVC Wheatland. All data remained confidential and appropriate measures were implemented to ensure the confidentiality of the participants and the confidentiality of the hospital. The researcher contacted the clinical director of KVC Wheatland PRTF to obtain consent to access archival database for the purpose of this study.

Hypothesis One

This study predicted that the number of suicide attempts in emotionally or behaviorally disturbed adolescents who have been removed from the home will be higher for those adolescents that were removed from the home at an earlier age than a later age.

Studies reveal that children in foster care had significant emotional or behavioral problems. Compared to those without a history of foster care placement, the prevalence of past-year suicidal ideation (26.8% vs. 11.4%) and attempts (15.3% vs. 4.2%) among adolescents involved with foster care was markedly elevated (Pilowsky & Wu, 2006).

There are some reports suggest that living away from both parents increases the risk of suicide attempts and of those diagnosed with mood disorders, the mortality rate because of suicide is approximately 2%-15% and even higher among those patients who have history of hospitalization 15%-20% (Oquendo et al., 2004).

Hypothesis Two

This study predicted that the number of suicide attempts in emotionally and behaviorally disturbed adolescents who have been removed from the home will be higher for those adolescents who have experienced more than one type of trauma than those who have experienced only one type of trauma. There is evidence that traumatic events such as childhood abuse and other types of trauma may increase a person's suicide risk (Hudenko & Crenshaw, 2007).

Hypothesis Three

This study predicted that the younger the EBD child was when first removed from the home, the more likely the child is to have experienced multiple (more than one) type of trauma. Studies show that children who are in out-of-home placement are at likely to endure multiple traumatic events and are at risk of repetition of trauma and proximity to trauma (Hieger, 2012). Logically, an EBD child is likely to be exposed to higher risk of trauma for a longer amount if the child is removed from the home at a young age.

Hypothesis Four

This study predicted that females will have a higher number of suicide attempts compared to their male counterparts. Research points out that women attempt suicide at a rate three times higher than do men. The issue of suicide amongst the different genders is an interesting topic that leaves a lot of room for discussion and differing opinions (Mental Health Realities, 2011).

Hypothesis Five

Finally, this study predicted that females are more likely to be removed from the home at a young age compared to their male counterparts. This prediction coincides with studies that indicate that females are more likely to seek out help (Doherty & Kartalova-O'Doherty, 2010). This would consequentially lead to the likelihood of females being removed from the home at an earlier age as postulated in the previous hypothesis.

Methods

Data Collection

Participants. Participants consisted of 75 emotionally and behaviorally disturbed adolescent male and female clients between the ages of 13 – 17 years old admitted into KVC Wheatland Hospital as of January 1st 2011 to May 31st 2011. The study was an archival case study. Any participants that were enrolled in treatment during data collection were not considered in the study.

Procedure. The archival data was collected from the KVC Wheatland Hospital's database. All database information stemmed from data collected through the use of two

primary forms; the KVC Wheatland social work admission form and the KVC Wheatland bio-psycho-social form. No identifying information was necessary to the study therefore the clients' information and the nature of the KVC Wheatland Behavioral Health Hospital was not disclosed within the study.

The attribute variables observed and coded included: age (in years), gender, trauma history, and year of the participants' first removal from the home. Data included the initial age of removal from home and the number of past suicide attempts, and number of reported types of trauma experienced.

Measures

Code Sheet. A code sheet was developed to collect the archived data from the KVC Wheatland Behavioral Health Hospital de-identified Trauma History data sheet. Each client was randomly assigned an identification number (1, 2, 3...10) along the first column, followed by a representation of each stated attribute variable along the following columns. The following is a description of the representation of the attribute variables coded.

Information on the participants' initial out-of-home placement was collected from the section titled If in Custody, When. The variable was represented as Yr.Removed on the code sheet. The initial out-of-home placement was recorded by the year that the client was first removed from the home.

The participants' number of suicide attempts was collected from the section titled Suicide Attempts. The variable was represented as Suicide Attempts on the code sheet.

The number of suicide attempts will be recorded in number of suicide attempts reported on the data sheet.

The participants' trauma history was collected from the section titled Trauma. The trauma history was defined as types of trauma experienced. The types of trauma were determined by four different categories of trauma reported in each participant's history. The four different categories of trauma were physical abuse, sexual abuse, emotional abuse, and neglect. The variable codes range from 0-4: 0 being no reported trauma, 1 being one type of trauma recorded, 2 being two types of trauma recorded, 3 being three types of trauma recorded and 4 being the presence of all four types of trauma recorded in the participant's reported history. The trauma history variable was represented as SevTrauma on the code sheet.

The participants' age was collected from the section titled age on the data sheet. The age was recorded in years and represented as Age on the code sheet. The participants' gender was collected from the section titled Gender on the data sheet. The gender was recorded as male (0), female (1) and was represented as Gender on the code sheet.

Results

Hypothesis One. Three bivariate Pearson correlations were completed each with one independent variable (X1) and one dependent variable (Y). Hypothesis one predicted that the number of suicide attempts in emotionally or behaviorally disturbed adolescents who have been removed from the home will be higher for those adolescents that were removed from the home at an earlier age than a later age. A Pearson correlation was

performed on $n=75$ participants to assess the relationship between (X) the age that a participant is removed from the home ($M=12.33$, $SD=4.23$) and (Y) the amount of suicide attempts that occur in adolescent children ($M=1.08$, $SD=1.46$). The bivariate correlation reported was not statistically significant. The relationship between (X) and (Y) was $r(73) = -.12$, $p > .05$.

Hypothesis Two. Upon examining the results of the first bivariate correlation, a further series of bivariate correlations and independent sample t-tests were conducted to test the remaining hypotheses. Hypothesis two predicted that the number of suicide attempts in emotionally and behaviorally disturbed adolescents who have been removed from the home will be higher for those adolescents who have experienced more than one type of trauma than those who have experienced only one type of trauma. A second Pearson correlation was completed between number of Types of Trauma and Suicide Attempts. The study expected that the variables will have a positive correlation. Past types of trauma included sexual abuse, physical abuse, and mental or emotional abuse. The data was analyzed based on the number of types of trauma that the participant experienced. The Pearson Correlation was performed on $n=75$ participants to assess the relationship between (X) number of types of trauma ($M=1.23$, $SD=.94$) and (Y) suicide attempts that occur in adolescent children ($M=1.08$, $SD=1.46$). The correlation between the variable (X) and the variable (Y) was not statistically significant, $r(73) = .04$, $p > .05$.

Hypothesis Three. The third hypothesis predicted that the younger the EBD child was when first removed from the home, the more likely the child is to have experienced multiple (more than one) type of trauma. A third Pearson Correlation was

performed on participants ($n= 75$) to assess the relationship between (X) number of types of trauma ($M= 1.23$, $SD= .94$) and (Y) age that participant was removed from the home ($M= 12.33$, $SD= 4.23$). The correlation between the variable X and the variable Y was significant, $r (73) = -.28$, $p < .05$. This relationship suggests that children removed from the home at a younger age are more likely to have experienced more than one type of trauma. Understanding the relationship effects of past trauma on suicidal behavior will play a part in supporting and understanding the overall effects of trauma since majority of treatment models that have been and are currently being developed for this targeted population are primarily trauma based. For example, providers such as Kaw Valley Center (KVC) or Youthville (and quite a number of other providers) have adapted trauma based treatment techniques.

Hypothesis Four. Additionally, independent t-tests were performed to further validate the study. Hypothesis four predicted that females will have a higher number of suicide attempts compared to their male counterparts. An independent sample t-test was performed to assess whether suicide attempts differed significantly for males ($M = .93$, $SD = 1.16$) compared to females ($M = 1.26$, $SD = 1.74$). The suicide attempts did not differ significantly, $t (73) = -.98$, $p > .05$. The mean number of suicide attempts for males was slightly lower than the mean number of suicide attempts for females.

Hypothesis Five: Hypothesis five predicted that females are more likely to be removed from the home at a young age compared to their male counterparts. A second independent sample t-test was performed to assess whether the age that the participant was removed from the home significantly differed between males ($M = 12.18$, $SD = 4.16$)

and females ($M = 12.51$, $SD = 4.37$). The age that participants were removed from the home did not differ significantly $t(73) = -.34$, $p > .05$. The mean age of removal from home for males was slightly lower than the mean age of removal from home for females.

Discussion

The current study examined the effects of removal from home on adolescent suicidal behavior. Data for the study was archival and contained no identifying information. Five different analyses were conducted in this study to help further determine the effects of the age of removal from home and adolescent suicide behavior. This study consisted of three sets of Pearson correlation analyses and two sets of independent t-test analyses. It should be noted that due to limitations based on HIPPA privacy protection, this researcher was unable to collect data and conduct independent t-test studies as previously discussed regarding custody status, psychological diagnosis at time of admission and presenting issue at time of admission.

The first hypothesis predicted that the number of suicide attempts in emotionally or behaviorally disturbed adolescents who have been removed from the home will be higher for those adolescents that were removed from the home at an earlier age. The results of this study did not indicate a significant relationship between suicide attempts among participants and the age that the child was first removed from the home and in fact demonstrated a negative correlation between the two variables. These results are inconsistent with the previous studies which indicate that increased length of time living away from both parents significantly increases the risk of suicide attempts (Oquendo et al., 2004).

Other results showed that suicide attempts did not have a significant relationship with pre-existing types of trauma. Trauma is typically a factor associated with suicidal behavior. Traumatic events take many forms such as sexual abuse, physical abuse, emotional abuse, and neglect. Some traumatic events are acute, some chronic, and some complex (Gewirtz, Forgatch, & Wieling, 2008). Complex trauma is defined as the presence of more than one type of trauma. This study examined the relationship between suicide attempts and complex trauma. Again, severity of trauma was defined as the number of types of trauma experienced. Though the findings were not significant, the results indicated a positive correlation between complex trauma and increased suicidal ideation. The results determined that the amount of suicide attempts was higher for those individuals who had a history of more than one type of trauma. This is consistent with studies linking children in out-of-home care at a greater risk of physical and sexual abuse (Kupsinel & Dubsky, 1999) and consequently at higher risk of demonstrating suicidal ideation and attempts (Pilowsky & Wu, 2006).

Further results indicated a positive relationship between gender and the age that the child was removed from the home. These results indicate that both males and females are at relatively equal risk of exposure to complex trauma which has been understood to put both males and females at greater risk for future self-harm, suicidal ideation, and suicidal behaviors (McHolm, MacMillan, & Jamison, 2003).

Overall, results do not clearly indicate that removal of a child from the home at an early age has a significant effect on the adolescent suicidal behavior. However this may be due to a few limitations. Three main limitations exist in the present study. Those three

main limitations are lack of statistical power, lack of control over how the data was presented, and questionable accuracy. The absence of a significance finding may be due to inadequate statistical power resulting from too few participants as the data was limited in regards to the number of participants. This study would have gained statistical power had there been approximately 175 male and female participants with roughly equal gender representation. Secondly, the data collected was archival, de-identified, and reflected unequal numbers between age groups. This meant that the researcher had no control of how the given variables were represented in the data sheet. Therefore, the information lacked much specificity and depth such as the number of suicide attempts that occurred specifically after the initial removal from the home or how many times a child experienced each type of trauma. This information would allow for a clearer understanding of how the removal from the home acts as a specific, isolated event in a child's life in relation to suicide attempts. This information would also be beneficial in further understanding the effects of trauma of emotionally and behaviorally disturbed children who have been removed from the home. Lastly, there is questionable accuracy in the sense that some suicide attempts or types of trauma experienced may not have been reported. It is also possible that some of the recorded time of the child's first removal from home may be inaccurate.

The said limitations may be improved by conducting a non-archival study, allowing future researchers the opportunity to collect variables with more depth, specificity, and accuracy. Future research can also address the limitation of participant numbers by allotting the appropriate amount of time as well as undertake the appropriate

privacy law procedures to allow for a number of live interviews greater than the number of participants in this archival study.

With these limitations addressed, researchers may come closer to discovering possible predictors to adolescent suicidal behaviors. This would prove helpful in identifying children who are at risk of demonstrating suicidal behavior at a more effective rate. Identifying these factors can serve as a basis for the development of suicide prevention programs that will enable care providers to target the said population with appropriate interventions uniquely developed to address their needs. Future research is needed in order to develop evidence based practices that can be effectively administered by treatment care providers in out-patient, in-patient, and residential treatment facilities.

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Appendix A
Consent to Collect Data



Wheatland
Psychiatric Hospital
 205 E. 7th Street
 Hays, Kansas 67601
 785-624-6000
 785-650-0620 Fax

Corporate Office
 21350 West 153rd Street
 Olathe, Kansas 66061-5413
 913-322-4900
 www.kvc.org

15 November 2012

Institutional Review Board for the Protection of Human
 Subjects

Fort Hays State University

600 Park Street

Hays, KS 67601

Dear Members of the Committee:

On behalf of KVC Wheatland Hospital, I am writing to formally indicate our awareness of the research proposed by Ms. Faith Wanja, a student at FHSU. We are aware that Ms. Wanja intends to conduct her research by collecting de-identified data located in our company database.

I am responsible for employee relations and am an executive officer of the company. I give Ms. Wanja permission to conduct her research in our company.

If you have any questions or concerns, please feel free to contact my office at 785-624-6000

Sincerely,



James Roberson

Assistant Director, KVC Wheatland Hospital

Appendix B

Code Sheet

Code Sheet

Child	Suicide Attempts	Age	Birth Year	Yr.Removed	AgeCust	SevTraum	Gender
1	0	17.00	1994.00	2011.00	17.00	2.00	.00
2	0	17.00	1994.00	2011.00	17.00	2.00	.00
3	2	17.00	1994.00	2002.00	8.00	1.00	.00
4	1	17.00	1994.00	2011.00	17.00	.00	.00
5	1	17.00	1994.00	1998.00	4.00	2.00	.00
6	1	17.00	1994.00	2011.00	17.00	1.00	1.00
7	0	17.00	1994.00	2011.00	17.00	1.00	1.00
8	0	17.00	1994.00	2009.00	15.00	3.00	.00
9	4	17.00	1994.00	2009.00	15.00	1.00	1.00
10	4	17.00	1994.00	2007.00	13.00	1.00	.00
11	1	17.00	1994.00	2011.00	17.00	3.00	.00
12	0	17.00	1994.00	2011.00	17.00	1.00	1.00
13	1	17.00	1994.00	2010.00	16.00	1.00	.00
14	1	17.00	1994.00	2011.00	17.00	1.00	.00
15	0	17.00	1994.00	2011.00	17.00	.00	.00
16	1	17.00	1994.00	2011.00	17.00	2.00	1.00
17	1	17.00	1994.00	2010.00	16.00	1.00	1.00
18	1	16.00	1995.00	2011.00	16.00	2.00	.00
19	2	16.00	1995.00	2009.00	14.00	.00	.00
20	0	16.00	1995.00	2000.00	5.00	2.00	1.00
21	1	16.00	1995.00	2001.00	6.00	3.00	1.00
22	1	16.00	1995.00	2010.00	15.00	1.00	.00
23	1	16.00	1995.00	2007.00	12.00	2.00	.00
24	0	16.00	1995.00	2011.00	16.00	1.00	1.00
25	0	16.00	1995.00	2011.00	16.00	.00	.00
26	0	16.00	1995.00	1996.00	1.00	1.00	1.00
27	1	16.00	1995.00	2009.00	14.00	2.00	.00
28	2	16.00	1995.00	2011.00	16.00	1.00	.00
29	2	16.00	1995.00	2001.00	6.00	2.00	.00
30	3	16.00	1995.00	1999.00	4.00	2.00	.00
31	6	16.00	1995.00	2004.00	9.00	1.00	1.00
32	1	16.00	1995.00	1998.00	3.00	2.00	.00
33	0	16.00	1995.00	2011.00	16.00	.00	.00
34	1	16.00	1995.00	2002.00	7.00	1.00	.00
35	1	16.00	1995.00	2007.00	12.00	.00	.00
36	1	16.00	1995.00	2006.00	11.00	2.00	1.00
37	1	15.00	1996.00	2011.00	15.00	.00	1.00
38	0	15.00	1996.00	2006.00	10.00	3.00	.00
39	0	15.00	1996.00	2011.00	15.00	2.00	1.00

40	7	15.00	1996.00	2011.00	15.00	1.00	1.00
41	0	15.00	1996.00	2002.00	6.00	1.00	.00
42	4	15.00	1996.00	2004.00	8.00	1.00	.00
43	4	15.00	1996.00	2006.00	10.00	3.00	1.00
44	1	15.00	1996.00	2010.00	14.00	1.00	.00
45	0	15.00	1996.00	2011.00	15.00	.00	1.00
46	0	15.00	1996.00	2011.00	15.00	.00	.00
47	1	15.00	1996.00	2011.00	15.00	.00	1.00
48	0	15.00	1996.00	2011.00	15.00	1.00	1.00
49	2	15.00	1996.00	2011.00	15.00	3.00	1.00
50	1	15.00	1996.00	2011.00	15.00	.00	1.00
51	3	14.00	1997.00	2011.00	14.00	.00	1.00
52	0	14.00	1997.00	2011.00	14.00	3.00	1.00
53	1	14.00	1997.00	2011.00	14.00	1.00	1.00
54	0	14.00	1997.00	2010.00	13.00	1.00	.00
55	0	14.00	1997.00	2010.00	13.00	1.00	.00
56	0	14.00	1997.00	2011.00	14.00	1.00	1.00
57	0	14.00	1997.00	2009.00	12.00	3.00	1.00
58	0	14.00	1997.00	2011.00	14.00	2.00	1.00
59	1	14.00	1997.00	2011.00	14.00	.00	1.00
60	0	14.00	1997.00	2011.00	14.00	.00	.00
61	3	14.00	1997.00	1999.00	2.00	2.00	1.00
62	0	14.00	1997.00	2011.00	14.00	.00	.00
63	4	14.00	1997.00	2010.00	13.00	1.00	.00
64	0	14.00	1997.00	2005.00	8.00	2.00	1.00
65	0	13.00	1998.00	2005.00	7.00	2.00	.00
66	0	13.00	1998.00	2006.00	8.00	.00	.00
67	0	13.00	1998.00	2011.00	13.00	.00	1.00
68	2	13.00	1998.00	2011.00	13.00	1.00	1.00
69	1	13.00	1998.00	2010.00	12.00	2.00	.00
70	0	13.00	1998.00	2011.00	13.00	.00	1.00
71	1	13.00	1998.00	2001.00	3.00	2.00	1.00
72	0	13.00	1998.00	2007.00	9.00	1.00	.00
73	2	13.00	1998.00	2011.00	13.00	1.00	1.00
74	0	13.00	1998.00	2009.00	11.00	1.00	.00
75	0	13.00	1998.00	2009.00	11.00	1.00	.00

Appendix C
Approval Letter

OFFICE OF SCHOLARSHIP AND SPONSORED PROJECTS

DATE: March 29, 2013

TO: Faith Wanja

FROM: Fort Hays State University IRB

STUDY TITLE: [370052-1] Suicide Attempts among Emotionally and Behaviorally Disturbed Adolescents Removed from the Home

IRB REFERENCE #: 13-050

SUBMISSION TYPE: New Project

ACTION: APPROVED

APPROVAL DATE: March 28, 2013

EXPIRATION DATE: March 27, 2014

REVIEW TYPE: Full Committee Review

Thank you for your submission of New Project materials for this research study. Fort Hays State University IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Full Committee Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form unless documentation of consent has been waived by the IRB. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document. The IRB-approved consent document must be used.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.

Please note that all research records must be retained for a minimum of three years.

Based on the risks, this project requires Continuing Review by this office on an annual basis. Please use the appropriate renewal forms for this procedure.

If you have any questions, please contact Leslie Paige at 785-628-4349 or lpaige@fhsu.edu. Please include your study title and reference number in all correspondence with this office.