YOUTH SUICIDE

INDEPENDENT STUDY

A FIVE CREDIT CLASS

Course # SS404u/SS504u

INSTRUCTOR:

DR. MICHAEL SEDLER

Email: mike@communicationplus.net

(509)443-1605

THE HERITAGE INSTITUTE

Please Do Not send in no more than 2 to 3 assignments at a time and I will send you back comments. Send them in numerical order (#1, #2, #3…).

Thank you for signing up for my independent study classes. You may take up to six months to complete this course and may obtain an additional 3 month extension. DO NOT send in any completed papers unless you have registered for the class!

The checklist in the manual is to help you plan your schedule to successfully complete this course. The last page of the manual includes a General Bibliography. If you prefer, you may choose an alternate book not on the suggested list.

On the following page, I have given you a brief biography/resume of my background. You will see that I have a Masters Degree in Social Work; my K-8 Teaching Certification and am a Licensed Social Worker with the State of Washington. My current primary role is as a consultant and trainer for schools, businesses and agencies. I also worked in education for 15 years as a Director of Special Education, a Behavior Intervention Specialist, School Social Worker, and Teacher.

I teach classes and seminars throughout the United States and in Canada. I am an adjunct professor through two Universities in Washington. I am available for on-site training, classes, and in services for agencies and schools. I anticipate this class will be enjoyable and full of learning. Please contact me if you would like me to be involved directly with your school or business.

Thank you, once again, for signing up for it and I look forward to working with you over the next weeks/months.

Sincerely,

Michael Sedler
(509) 443-1605
E-mail: mike@communicationplus.net
Website: www.michaelsedler.com
P.O. BOX 30310 - Spokane, WA. - 99223

** For those working in groups (400/500 level only!)- be sure to go to The Heritage Institute website at www.hol.edu and click on the "group collaboration" icon.
1. Each group member must pick a book to read (you may all choose the same book).
2. Each group member must read the entire manual.
3. Final evaluation/integration paper must be individually authored.

Please share about my classes with others. It is my main form of advertising.

MICHAEL SEDLER

(509) 443-1605 (w); (509) 939-6302 (c)
Email: mike@communicationplus.net or michael@michaelsedler.com
website: www.michaelsedler.com

Education

B.A., Political Science
Master Degree, Social Work
Master Degree, Divinity
Doctorate Degree, Ministry
Teaching Certificate

Work Experience

Consultant/Trainer/Counselor
Director of Special Education
Developmental Disabilities Administration-behavior consultant
Supervisor, Educational Services
School Social Worker (K-12)
Behavior Intervention Specialist (K-12)
Classroom Teacher (elementary and middle school)
Assistant Pastor

Other Experiences

State Correctional Facility for Juveniles, Counselor and Supervisor
Community Mental Health Therapist
State Trainer in Autism (State of Washington)
Adjunct Professor for several Universities
Student Teacher Supervisor
Consultant for schools, business, churches throughout United States
Provide weekend marriage retreats
Interview and Speech Coach/Trainer for Miss Arizona, 3rd runner-up Miss America 2012

Author

When to Speak Up and When To Shut Up. (Jan., 2006 Revell Books, $5.99). Book from faith-based perspective.
Communication book discussing conflict, power struggles, listening strategies, asking questions.
(Over 400,000 copies sold).

What To Do When Words Get Ugly. (October, 2016, Revell Books, $5.99).
Updated/edited version of "Stop The Runaway Conversation.") Two new chapters in addition to edits. Book from faith-based perspective. Importance of not listening to negative discussions and how they impact a person's attitude.

Books are available through all bookstores, at www.bakerbooks.com, by calling 800 877 2665, or by checking with various online book companies. Revell is a division of Baker Publishing Group. Both books are available on CD as audio books.

INDEPENDENT STUDY COLLEGE COURSES

THE HERITAGE INSTITUTE (credits through Antioch University, Seattle, WA)
MICHAEL SEDLER, INSTRUCTOR

Register for courses anytime. (6-month period for completion from the date you register). ***Collaborate with fellow educators-only one set of assignments turned into instructor.*** (Check out "Group Collaboration Guidelines" at www.hol.edu). **Clock hours available for partial course completion.

The following are **3 CREDIT CLASSES** (3 quarter credits = 2 semester credits)

1. **Increasing Motivation and Self-Esteem in Students** (SS401p/SS501p)
Strategies to help students feel confident and help educators find more successful approaches with them.

2. **Parents: Adversary or Ally--A Cooperative Approach** (SS401q/SS501q)
Specific ideas on connecting with parents and helping better communication between school and home.

3. **Social Skills: A Foundation For Learning** (SS401v/SS501v)
Activities and ideas to encourage students to improve their peer and social relations.

4. **Understanding & Connecting With Aggressive Students** (ED404d/ED504d)
Each person will increase their understanding of ways to de-escalate aggression and its' causes.

3 CREDIT COST: *$280-400/500* level; $195-clock hours (3 quarter = 2 semester)

The following are **5 CREDIT CLASSES**: **(5 quarter credits -3.3 semester credits)**

1. **Bullying Behaviors: Enough is Enough** (ED437q/ED537q)
Identification and interventions to reduce bullying behaviors and victim mentality within schools and community.

2. **Counseling Skills For Educators** (ED409r/ED509r)
Helpful ideas on listening skills, asking questions, and communicating with students.

3. **High Maintenance Behaviors & Interactions** (SS409f/SS509f)
This course investigates the many aspects of high needs people, behaviors and effective interactions.

4. **Mental Health Issues and Students** (HE402n/HE502n)
Understand various disorders (oppositional defiant, obsessive compulsive, bi-polar) and interventions.

5. **Nurturing Compassion Within Our Schools** (ED434y/ED534y)
Ideas to help adults and children learn to be more sensitive, kind, and compassionate toward one another.

6. **Organizational Teaching Skills** (ED429w/ED529w)
Increase your own organizational and time management skills as well as helping students in these areas.

7. **Stress Reduction in Staff and Students** *(HE401m/HE501m)*
Strategies to reduce stress, become more effective in life, and teach these skills to students.

8. **Student, Classroom and Whole-School Discipline** (ED419g/ED5I9g)
Focus is on negative talk, gossip and rumors within schools. Behavioral strategies for each above area.

9. **Youth Suicide** (SS404u/SS504u)
Specific discussions on signs and interventions for suicide prevention.

5- CREDIT COST: *$415-400/500* LEVEL; $315-clock hours (5 quarter = 3.3 semester)

NEXT PAGE FOR MORE CLASSES AND REGISTRATION INFORMATION

INDEPENDENT STUDY COLLEGE COURSES

THE HERITAGE INSTITUTE (credits through Antioch University, Seattle, WA)

MICHAEL SEDLER, INSTRUCTOR

The following are **6 CREDIT CLASSES**: **(6 quarter credits - 4 semester credits)**

1. **Autism: Questions and Answers** (ED445y/ED545y)

Understanding the general areas of autism, diagnosis, and overall strategies for interventions for children with special needs.

2. **Establishing Rules and Boundaries** (ED445x/ED545x)

Ideas to assist educators in setting up a successful work environment for children (rules, procedures, teaching tools).

3. **Inspirational Education** (ED452f/ED552f)

This course will re-charge the batteries and create a new excitement about teaching in each person.

4. **The Impact Of Trauma and Loss in Students** (ED464z/ED564z)

Strategies to support children who have experienced traumatic situations in life.

5. **Why Children Act Out** (ED458t/ED558t)

Recognize the underlying function of behaviors and interventions approaches.

6- CREDIT COST: $495--400/500 LEVEL; $380-clock hours (6 quarter = 4 semester)

REGISTRATION: **Call The Heritage Institute--** ***1 (360) 341-3020***
Or register on line at www.hol.edu

QUESTIONS: Please call Michael Sedler at (509) 443-1605. Leave message when necessary.
Email address: mike@communicationplus.net Website: www.michaelsedler.com

**For clock hours, only complete the first section of the course. Remember, clock hours may not transfer to other districts or states. You cannot go back and acquire credit once clock hours have been earned for a class.

COURSE TITLE: **YOUTH SUICIDE (SS404U/504U)**

NO. OF CREDITS: **5 QUARTER CREDITS** **CLOCK HRS: 50**
[Semester Cr Equivalent: 3.3] **PDU'S: 50**
CEU'S: 5.0 (50)
PENNSYLVANIA ACT 48: 50

INSTRUCTOR: **MICHAEL SEDLER, D. MIN., M.S.W.**
Box 30310
Spokane, WA. 99223
(509) 443-1605
E-MAIL: mike@communicationplus.net

ASSIGNMENT CHECKLIST

The assignment checklist will help you plan your schedule of work for this course. Check off items completed so that you can better monitor your progress. While you have six-months to complete your work, many will find a shorter time period convenient. **Complete no more than 2 to 3 assignments at a time for comments. Do NOT send further work until you receive comments from the instructor. Grades will be submitted once all assignments and the integration paper have been sent to instructor.**

***For Washington Clock Hours, Oregon Professional Development Units, Continuing Education Credits or Pennsylvania ACT 48,* please complete the first 8 assignments.**

Assignment #1:
Read the entire manual and send a **one page summary** of what you hope to learn in this class.

Assignment #2:
Read a book from the bibliography or one of student's choice. If taking this course in a group, each person should read a book. Only one person needs to write a summary.
Critique the book based on personal experiences and insights. Write a **2-3 page paper**.

Assignment #3:
Review literature (minimum of three magazines, journals) on general topic of suicide.
Create an annotated bibliography. The annotation should include Title, Author, Publisher (or URL), year of publication and your review of information contained. Add your opinion of the value of the contents of each article. Write a **1-2 page summary** of the articles.

Assignment #4:
Complete assignments for:
a) 10 Common Characteristics (pgs. 13-14)
b) Why Depression Gets Missed (p. 27)
c) Prevention of Teen Suicide (p. 35)
(Choose one of these pages and write a 2 page summary)

Assignment #5:
Read your local newspaper (or listen to local news, go online) and find an article (or story) pertaining to suicide. Write a summary of information you found. **1-2 pages.**

Assignment #6:
Develop a minimum of 5 questions (and maximum of 10) to be asked of a professional who has worked in the area of suicide prevention. Contact a counseling facility within your community (Mental Health, Hospital, Private Practice). [Sample questions in manual on page 51]. Also ask these same questions to an individual within your district (counselor, nurse administrator). Compare and contrast the answers from the community personnel and the school personnel. **Write a 2 page paper.**

Assignment #7:
Keep a daily self-reflective journal for 2 weeks. Each person is to write a minimum of three entries per week. The writings should reflect personal feelings and emotions of that particular day. The intent is to sensitize individuals to the daily "ups and downs" of life. Using your 2 week journal, write out (**in a 2 page paper**) the intervention strategies and coping mechanisms *you* use to minimize your "down" times.

Assignment #8:
Complete the case study found on page 19. Write a **two page summary** of your answers to the questions found on page 20.

This completes the assignments required for Washington Clock Hours, Oregon PDUs, or CEUs. Continue to the next section for additional assignments required for University Quarter Credit

ADDITIONAL ASSIGNMENTS REQUIRED for 400 or 500 LEVEL UNIVERSITY QUARTER CREDIT
In this section you will have an opportunity to apply your learning to your professional situation. This course assumes that most participants are classroom teachers who have access to students. If you are not teaching in a classroom, please contact the instructor for course modifications. If you start or need to complete this course during the summer, please try to apply your ideas when possible with youth from your neighborhood, at a local public library or parks department facility, (they will often be glad to sponsor community-based learning), with students in another teacher's summer classroom in session, students from past years, or use one of your own children or a relative.

Assignment #9: (Required for 400 and 500 Level)
Using the "sample" program (p. 49) within the manual as a guideline, develop a school wide or district wide post-intervention plan for suicidal behavior. If your school already has one in place, evaluate the effectiveness of the plan. Write **a 2 page paper**.

Assignment #10: You must choose either "A" or "B" (Required for 400 and 500 Level)

Assignment #A:

- Develop a lesson to reflect what you've learned in this course.
- Implement your lesson with students in your classroom.
- Write a **2 page commentary** on what worked well and what could be improved.
- Include any student feedback on your lesson.

OR

Assignment #B:
Use this option if you do not have a classroom available.

- Develop a lesson to reflect what you've learned in this course. (Do not implement it.)
- Write a **2 page summary** concerning any noteworthy success you've had as a teacher with one or more students.

500 LEVEL ASSIGNMENT
Assignment #11: (500 Level only)
In addition to the 400 level assignments complete **one (1)** of the following options:

Option A) Mentor another individual in the concepts of this class. Have them share two or three key concepts that they would like to implement within their work or social setting. Develop a plan for the implementation of these ideas. **(1-2 pages).**

OR

Option B) Create a PowerPoint presentation for your staff based on this course and focused on perspectives or strategies you feel would be beneficial for your school. **Minimum of 15 slides**. Save this as a pdf.

OR

Option C) Another assignment of your own design, with instructor prior approval.

400 & 500 LEVEL ASSIGNMENT (To be completed by all participants taking this for credit)
Integration Paper
Assignment #12: (Required for 400 and 500 Level Credit)
Write a **2 page** Integration Paper answering these specific questions:
1.What did you learn vs. what you expected to learn from this course?
2.What aspects of the course were most helpful and why?
3.What further knowledge and skills in this general area do you feel you need?
4.How, when and where will you use what you have learned?
5.How and with what other school or community members might you share what you learned?
Must be individually authored (name and course title) for those taking in a group.

QUALIFICATIONS FOR TEACHING THIS COURSE:
Mike Sedler, M.S.W., D. Min., brings over 40 year of educational experience as a special education director, social worker, behavior specialist and teacher to each of his classes. He provides consultation and seminars throughout the United States and Canada for schools, agencies and businesses. He has a graduate degree in Social Work, a Doctoral degree in Ministry, a Counseling license, as well as his teaching certification. Mike has worked with children of all ages, specifically with children exhibiting behavioral challenges, mental health concerns, and characteristics of Autism Spectrum Disorder. In addition, he taught general education classes in the elementary school and middle school arenas. All of Mike's classes are practical and "field tested" in schools and classrooms. Educators have found success in implementing Mike's clear and concise approaches. All of his course material may be immediately implemented into a school or a home.

NOTES: You may work collaboratively and submit joint assignments on all but the Integration Paper portion which must be individually authored. Alternatives to written assignments such as a video, audio tape, photo collage, etc. are permissible with prior approval of instructor.

Full credit will be given to each student as long as all work is turned in. If something is missing, I will be in contact with you. Failure is not an option. 😉

The suicide rate among people aged 10–24 remained stable from 2001 through 2007 and then increased 62% from 2007 through 2021 (from 6.8 deaths per 100,000 to 11.0). During 2001–2021, the largest annual increase in the homicide rate was from 2019 through 2020 (37%, from 7.8 to 10.7), and the largest annual increase in the suicide rate was from 2016 through 2017 (10%, from 9.6 to 10.6). Although suicide rates surpassed homicide rates in 2010 for people aged 10–24, by 2020, rates were similar due to the increase in homicide rates from 2019 through 2020. For people aged 10–14, suicide rates increased from 2007 through 2018, while homicide rates increased from 2016 through 2020. The suicide rate for people aged 10–14 declined from 2001 through 2007 (from 1.3 deaths per 100,000 to 0.9), tripled from 2007 through 2018 (from 0.9 to 2.9), and then did not change significantly through 2021. Homicide rates for people aged 10–14 declined from 2001 through 2016 (0.9 to 0.7), doubled through 2020 (1.4), and then remained unchanged in 2021.

During 2001–2021, the largest annual increase in the homicide rate was from 2019 through 2020 (56%, from 0.9 to 1.4), while the largest annual increase in the suicide rate was from 2008 through 2009 (30%, from 1.0 to 1.3). The suicide rate for people aged 10–14 was higher than the homicide rate from 2001 through 2005, similar from 2006 through 2008, and higher again from 2009 through 2021. Suicide rates for people aged 15–19 increased from 2009 through 2017, while homicide rates increased from 2014 through 2021. The suicide rate for people aged 15–19 did not change significantly from 2001 through 2009, then increased 57% from 2009 through 2017 (from 7.5 deaths per 100,000 to 11.8). From 2017 through 2021, the trend did not change significantly (Figure 3). Homicide rates for people aged 15–19 increased from 2001 (9.3) through 2006 (10.5), declined from 2006 through 2014 (6.7), and then increased 91% through 2021 (12.8). During 2001–2021, the largest annual increase in the homicide rate was from 2019 through 2020 (38%, from 8.9 to 12.3), while the largest annual increase in the suicide rate was from 2016 through 2017 (18%, from 10.0 to 11.8). In 2001, the homicide rate for people aged 15–19 was higher than the suicide rate and remained higher through 2010. From 2011 through 2019, the suicide rate was higher than the homicide rate, but homicide rates surpassed suicide rates again in 2020.

Suicide is the second leading cause of death among high school-aged youths 14–18 years after unintentional injuries. This report is from the CDC's 2019 Youth Risk Behavior Survey. Results are reported overall and by sex, grade, race/ethnicity, sexual identity, and sex of sexual contacts, overall and within sex groups. Trends in suicide attempts during 2009–2019 are also reported by sex, race/ethnicity, and grade. During 2009–2019, prevalence of suicide attempts increased overall and among female, non-Hispanic white, non-Hispanic black, and 12th-grade students. Data from 2019 reflect substantial differences by demographics regarding suicidal ideation and behaviors. For example, during 2019, a total of 18.8% of students reported having seriously considered suicide, with prevalence estimates highest among females (24.1%); white non-Hispanic students (19.1%); students who reported having sex with persons of the same sex or with both sexes (54.2%); and students who identified as lesbian, gay, or bisexual (46.8%). Among all students, 8.9% reported having attempted suicide, with prevalence estimates highest among females (11.0%); black non-Hispanic students (11.8%); students who reported having sex with persons of the same sex or with both sexes (30.3%); and students who identified as lesbian, gay, or bisexual (23.4%). Comprehensive suicide prevention can address these differences and reduce prevalence of suicidal ideation and behaviors by implementing programs, practices, and policies that prevent suicide (e.g., parenting programs), supporting persons currently at risk (e.g., psychotherapy), preventing reattempts (e.g., emergency department follow-up), and attending to persons who have lost a friend or loved one to suicide.

"One theory suggests that the recession caused more emotional trauma in whites, who tend not to have the same kind of church support and extended families as Blacks and Hispanics.

Another theory notes that white baby boomers have always had higher rates of depression and suicide, and that has held true as they've hit middle age.

One more possible contributor is the growing sale and abuse of prescription pain killers over the past decade. Some people commit suicide by overdose. In other cases, abuse of the drugs helps put people in a frame of mind to attempt suicide by other means."
(CDC Report)

GENERAL THOUGHTS ON SUICIDE

I. **Is there a typical suicidal person?**

Suicide statistics show a wide disbursement throughout the United States population. It affects all age groups, cultures, religions and socio-economic classes. However, there does seem to be some general observations about "typically" suicidal people and their tendencies toward attempting or completing suicide.

It is clear that the overwhelming majority of people who attempt suicide (some statistics are as high as 95%) **do not** want to die. In most situations, the individual desires to escape or seek relief from pain, hurt, stress, illness, anger or other apparent intolerable circumstances. The person is under the impression that the problem will not go away and their only alternative is suicide. The "typical" person wants a way out, wanting to be rescued, but is unsure as to where to receive help. This can clearly work to the advantage of the interventionist as the person is seeking for strong, confident direction. It is imperative, therefore, to know what to do and how to begin an intervention quickly and with certainty.

II. **Suicidal Life Patterns**

Most suicidal people experience a "suicidal life pattern" only once in their life. This means if we can successfully intervene and create an environment of protection, for a period of time, the likeliness of a repeated attempt is greatly reduced. Naturally, there are certain people (approximately l out of 20) who will attempt suicide again. Because our nervous systems are set up to take only so much stress, for only so much time, people become "acutely" or "severely" suicidal for a brief period of time (this may last minutes or hours). Again, most suicide attempts are to stop a horrible feeling at any cost. Like depression, suicidal people have good days and bad days. There are waves of emotions which may come against them. The key is setting up a system of support to help them cope during those down times. This will aid them from moving into the "acutely" suicidal feelings.

III. **The Three Legs Of The Seat Of Suicide**

There are three words which are used to describe the "typical suicidal person". The first word is ***Hopelessness***. This word is the strongest indicator as to the emotional stability of a suicidal person. Hope is the anchor, the support of life. It is hope which keeps us going, turning every corner of life and anticipating a brighter day. As long as an individual senses that "things will get better", this person will continue on with life. When a person has lost hope, suicide becomes their option. Therefore, whenever we are confronted with a suicidal person, hope is one word which must be placed in their path. This will help ensure a future. If you hear someone talking about "no hope", "no future", realize these are warning signs and should be addressed by someone (like you).

A second word which is connected to suicide is ***Helplessness.*** The suicidal person is not only likely to see themselves without hope, but also to view their situation as one which they have very little input into the problem. The issue here is one of control and authority over one's own life. This person begins to feel that the world is "doing it to me", "I have no control over my future". Extreme feelings of powerlessness begin to be a part of this person's life. The third leg of the seat is ***Haplessness.*** Many of those who attempt suicide have had very difficult and sad lives. About 25% of those who attempt suicide have a close relative who is drug involved, abused, mentally ill, suicidal, depressed or other forms of stressful situations. The suicidal person is having multiple problems, across many domains. Their marriage, their job, their family, their finances, etc. The general life perspective of this person is "my life is falling apart".

IV. **Hard-core Suicides.**

Are there some people who just want to die no matter what? According to Marv Miller, a renowned expert in the study of suicide, about 5% of the entire suicidal population fall into this category. They are difficult to identify as they show few warning signs. They do not appear to want help as they only want to complete their goal--"death". Many of these people find their way into a hospital, prison or jail setting. The rate of suicide within these environments are 20 to 30 times greater than the national suicide rate.

10 COMMON CHARACTERISTICS OF SUICIDE (connected to Assignment #4)

1. UNENDURABLE PSYCHOLOGICAL PAIN

The individual feels tortured by their thoughts. Constant, random negative thoughts seem to pervade the mind, escape is focus.

Intervention: reduce pressures and lower level of suffering. Connecting with family or friends to minimize immediate problems may stop suicide.

2. FRUSTRATED PSYCHOLOGICAL NEED

Social/emotion/mental needs are not being met. The person often feels like an outcast, isolated and rejected by peers and family.

Intervention: "Where do you hurt?" "What can I do to help?" are good questions. Personalize your approach; let them know you care about them.

3. THE SEARCH FOR A SOLUTION

Many options may have been explored, unsuccessfully, by this person. Typically, the options selected were poorly designed and effort was halfhearted.

Intervention: They want a way out of the problem. Find a viable solution and walk it out with them. They will need your help.

4. AN ATTEMPT TO END CONSCIOUSNESS

It is not uncommon to find drugs/alcohol utilized in an attempt to stop the pain.

Intervention: Encourage person by letting them know the pain is temporary, it has not always been there. Together, ways will be looked at to decrease the pain.

5. HELPLESSNESS, HOPELESSNESS, HAPLESSNESS

The 3 H's were discussed in the section on "General Thoughts... "

Intervention: See section on "General thought on Suicide". The person needs support, hope and empowerment.

6. CONSTRICTION OF OPTIONS

Due to psychological turmoil, many options seem unavailable. Attitude and lifestyle may affect willingness to receive support.

Intervention: Broaden their perspective. List options with pro/con view.

{continued on next page}

7. AMBIVALENCE

The individual is often unsure as to what they "really" want in life. Due to confusion and pain, it is difficult for them to make a commitment.

Intervention: Due to ambivalence, opportunities arise to shift the perspective from death to life.

8. COMMUNICATION OF INTENT

It is common for a person to give clear warnings about their state of mind. This is done both verbally and nonverbally.

Intervention: Be aware of warning signs. Educate oneself as to the indicators.

9. DEPARTURE

The person will emotionally/socially detach themselves from people. Running away, quitting a job, abandoning a family are escapes.

Intervention: Help the person see the difference between "wanting to get away" and "needing to end it all".

10. LIFELONG COPING PATTERNS

Historically, this person may have a pattern of poor decisions, withdrawal, substance abuse, etc. during life crisis situations.

Intervention: Be willing to get a quick history from others regarding the individual. Understanding their life patterns will give one increased options.

Not one of these 10 characteristics is lethal by itself, but in combination they form a deadly outlook on life. We can relieve pain, reduce constriction of thinking, give a sense of support. These interventions are much more than just "Band-Aids" on a problem. It can be likened to reducing a life threatening fever on a patient so life can continue and the professionals can then figure out the reason for the problem. It is important to know whether the fever is due to an illness or a snake bite. In the meantime, we have saved a life and allowed more time for diagnosis and intervention.

Write a **2 page reaction summary** to the 10 characteristics.

A SUICIDE QUIZ

ANSWER THE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. AT THE END OF THE QUIZ ARE THE ANSWERS. ALL ANSWERS ARE SUBJECT TO CHANGE DUE TO A CHANGE IN THE NATURE OF PEOPLE INVOLVED. (All questions relate to United States unless otherwise specified).

1. What method most efficiently turns a suicide attempt into a successful suicide?
a) drugs b) poison c) firearms d) hanging e) gas

2. What method is least efficient?
a) drugs b) poison c) firearms d) hanging e) gas

3. Do more males or females commit suicide each year?

4. The older you are, the more at risk you are for a suicide. True or False

5. What night of the week do we find more deaths occurring in the United States?

6. What night of the week do we find the greatest number of suicides occurring?

7. Suicide is typically at a high peak during a time of international war (W.W.I, W.W.II). True or False.

8. Suicide is typically at a high peak during a time of economic upheaval (depression, recession). True or False.

9. Since 2000 the suicide rate has: increased, decreased or stayed the same.

10. What U.S. State ranks the highest in suicide?

11. What ethnic group in the U.S. has the highest rate of suicide?

12. The United States has the highest suicide rate of any nation. True or False.

13. Name one of the 5 lowest nations for suicide.

ANSWERS (DON'T PEEK).

1. C 2. B 3. Males 4. True 5. All about the same 6. Monday (figures, huh?)
7. False 8. True 9. Increased 10. Alaska 11. Caucasian (white) 12. False (U.S. is in mid-30's; South Korea (highest), Lithuania, and Guyana. 13. Haiti (lowest), Antigua, Grenada, Egypt, and Syria are lowest five.

EARLY WARNING SIGNALS OF SUICIDAL RISK

A suicidal person who gives warning signals will present more than one, therefore you do not want to over-react after observing only one warning in isolation because each danger signal by itself is innocuous and means nothing. What you should look for is a clustering of warning signals within a negative or sad context of: recent loss, sadness, frustration, grief, alienation, depression, loneliness, physical pain, etc.

Suicidogenic Situations - Some situations are so conducive to suicidal thoughts and feelings that the situation itself constitutes the early warning signals. The individual does not have to do anything or say anything to indicate that this is indeed an early warning sign, merely being in the situation means that the person is now in a high risk category.

Depressive Symptoms

- insomnia
- inability to concentrate
- anorexia (loss of appetite)
- weight loss
- no libidinous desire (loss of sex drive)
- anhedonia (cannot experience any pleasure)
- lethargy (no energy)
- apathy (seems disinterested in everything)
- no desire to socialize
- seems withdrawn, preoccupied, sad
- often appears to be bored
- easily agitated
- personal appearance becomes sloppy
- crying
- feels worthless
- easily discouraged
- thinks of themselves as already defeated
- often lives in the past
- dwells on own problems
- has morbid views
- increased dependence on alcohol and drugs
- doesn't want to converse
- gives short replies when asked questions

Verbal Warnings - The mythology surrounding suicide leads people to believe that those who talk about killing themselves don't actually do so. As the list of verbal warnings below clearly indicates, nothing could be further from the truth.

- "I've decided to kill myself"
- "I wish I were dead"
- "I hate my life, I hate everyone and everything"
- "The only way out is for me to die"
- "You won't be seeing me around anymore"
- "If I don't see you again, thanks for everything"
- "You're going to regret how you've treated me"
- "Nobody needs me anymore"
- "If (such and such) happens, I'll kill myself"
- "Here, take this (cherished possession); I won't be needing it anymore"

Behavioral Warnings

- The giving away of a cherished object in a casual manner.
- The strongest behavioral warning is an attempted suicide

What to Look For

Here are some common signs for depression, organized by age group

Preschool

- Frequent unexplained stomach aches, headaches, and fatigue
- Over-activity or excessive restlessness
- Frequent sadness
- Low tolerance to frustration
- Irritability
- Loss of pleasure in previously enjoyed activities
- Tendency to portray the world as sad or bleak
- Frequent Fights with others
- Withdrawal

School Age

- Excessive worrying or anxiety
- Unprovoked hostility or aggression
- Frequent and unexplained physical complaints
- Significant weight loss or gain
- Expressions of sadness or helplessness
- Low self-esteem
- Changes in sleep patterns
- Tearfulness
- Refusal or reluctance to attend school
- Changes in school performance
- Little interest in playing with others
- Poor communication
- Thoughts about or efforts to run away
- Hyperactivity
- Frequent disobedience or aggression
- Easily frustrated, frequent crying, overly sensitive
- Suicidal thoughts

Adolescents

- Persistent, unhappiness, negativity, irritability, anger and rage
- Chronic worry, excessive fear & expression of guilt
- Drop in school grades or conduct
- Withdrawal from friends and activities
- Difficulty with relationships
- Feelings of sadness and hopelessness
- Lack of enthusiasm, energy or motivation
- Overreaction to criticism
- Feelings of being unable to satisfy expectations
- Extreme sensitivity to rejection or failure
- Poor self-esteem
- Indecision, lack of concentration or forgetfulness
- Restlessness and agitation
- Changes in eating or sleeping patterns
- Increased substance abuse
- Problems with authority
- Self-destructive behavior
- Inattention to appearance
- Preoccupation with death and dying
- Suicidal thoughts, plans or attempts

MYTHS ABOUT SUICIDE

- **PEOPLE WHO COMMIT SUICIDE ALWAYS LEAVE NOTES *(UNTRUE- MANY ARE LABELED AS ACCIDENTS DUE TO THIS MISCONCEPTION)***
- **PEOPLE WHO COMMIT SUICIDE ARE PSYCHOTIC OR MENTALLY ILL *(MANY PEOPLE ARE DEPRESSED)***
- **RICH PEOPLE COMMIT SUICIDE MORE OFTEN THAN POOR PEOPLE *(EVENLY DISTRIBUTED ALONG $$ CLASSES)***
- **PEOPLE WHO TALK ABOUT SUICIDE ARE JUST TRYING TO GET ATTENTION; PEOPLE WHO REALLY WANT TO COMMIT SUICIDE DON'T TALK ABOUT IT FIRST (8 *OUT OF* 10 *GIVE WARNING SIGNALS PRIOR TO SUICIDE)***
- **SUICIDE HAPPENS WITHOUT WARNING *(CLUES ARE BOTH VERBAL AND NONVERBAL)***
- **IF SOMEONE HAS DECIDED TO COMMIT SUICIDE, THERE IS NOTHING YOU CAN DO TO STOP HIM/HER *(MANY SUICIDES ARE PREVENTED BY BASIC CARING INTERVENTION5)***
- **A PERSON WHO IS SUICIDAL ONCE IS SUICIDAL FOREVER *(SUICIDAL IDEOLOGY MAYBE FOR BRIEF PERIOD)***
- **IF A PERSON ATTEMPTS SUICIDE AND SURVIVES, HE PROBABLY WON'T ATTEMPT AGAIN (4 *OUT OF* 5 *PEOPLE WHO WERE SUCCESSFUL AT SUICIDE HAD PREVIOUSLY ATTEMPTED)***
- **THE SECRET LIES IN GETTING SOMEONE OVER THE "HUMP"; IF YOU CAN JUST PULL SOMEONE OUT OF A DEPRESSION, HE WON'T TRY TO KILL HIMSELF *(MOST SUICIDES OCCUR WITHIN 3 MONTHS OF APPARENT EMOTIONAL IMPROVEMENT FROM CRISIS)***
- **TERMINALLY ILL PEOPLE ARE THE ONES MOST LIKELY TO COMMIT SUICIDE *(PEOPLE WHO HAVE LOST HOPE AND A SENSE OF THE FUTURE COMMIT SUICIDE. QUALITY OF LIFE CAN INFLUENCE THIS DECISION)***
- **SUICIDE IS HEREDITARY *(DOES RUN IN FAMILIES, BUT NOT A GENETIC TRAIT)***
- **THE MOST COMMON METHOD OF SUICIDE IS DRUG OVERDOSE *(LEADING CAUSE OF DEATH IS BY GUN)***
- **MOST SUICIDES HAPPEN LATE AT NIGHT *(MOST OCCUR IN AFTERNOON OR EARLY EVENING. REMEMBER, MOST SUICIDE ATTEMPTS ARE A CRY FOR HELP)***
- **YOU SHOULD NEVER TALK ABOUT SUICIDE TO SOMEONE WHO IS DEPRESSED, BECAUSE YOU'LL PROBABLY GIVE THEM THE IDEA *(YOU WILL NOT GIVE THEM THE IDEA. IT IS ALREADY WITHIN THEIR MIND)***
- **"KIDS" DON'T COMMIT SUICIDE--ESPECIALLY CHILDREN UNDER THE AGE OF FIFTEEN (3% *OF KIDS UNDER FIFTEEN ARE SUICIDAL)***
- **EVERYONE WHO COMMITS SUICIDE IS DEPRESSED *(DEPRESSION A FACTOR, BUT SO ARE ANXIETY, AGITATION, MENTAL STATUS)***

PEOPLE WHO COMMIT SUICIDE RARELY SEEK MEDICAL HELP *(AROUND 50% OF THOSE WHO COMMIT SUICIDE HAD SOUGHT MEDICAL HELP WITHIN THE LAST SIX MONTHS)*

CASE STUDY (connected to Assignment #4)

Kelly was an energetic and attractive 15 year old girl. She appeared to have many friends and support systems. When the opportunity came for cheerleading tryouts, it was assumed by all her friends and family that she would be a natural. However, when tryouts did occur, Kelly's lack of coordination and ability to do difficult routines became apparent. During one particular routine, Kelly fell down twice and turned the wrong way. Although her parent's told her they were proud of her effort, there were daily reminders of her failure. Some of the kids would mimic her and her apparent mistakes, those chosen as cheerleaders wore their uniforms each week and it seemed as if she didn't have as many friends as before the tryouts.

Kelly began to take gymnastics and over the summer went to a cheerleading camp. She was selected to the "honor squad" at the camp. When tryouts began in the fall, she would be ready. Her family was a little concerned as Kelly seemed to be consumed by making the team. She refused to get together with friends in order to practice routines. Instead of going to a movie with the family, Kelly chose to stay home and watch videotapes from the summer cheerleading camp. The day of the tryouts came and Kelly was very excited. She worked hard and had an excellent tryout. She was sure she would make the team.

However, as she came and looked at the list the next day, Kelly's name was absent from the list. She did not make the team. The last time any of her friends remember seeing Kelly was when she ran crying down the hallway and out the front door. Her mother found her daughter that afternoon, dead, from an overdose of pills.

On the following page, you will find a series of questions regarding this case study. Write a 2 page summary of the answers.

CASE STUDY QUESTIONS (connected to Assignment #4)

1. Have you ever known students in similar situations, trying out for a team, squad or section? If yes, give a brief description.

2. What kind of emotional/psychological factors were involved in Kelly's decision to commit suicide?

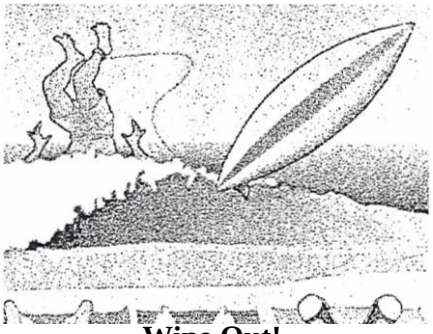
3. Make a list of any warning signals which Kelly may have shown to those around her.

4. If Kelly had been your student (or even your daughter), what type of interventions would you have attempted (in hindsight)?

MOTIVATION FOR SUICIDAL BEHAVIORS

Although the following list of possible motivations for committing suicide is not meant to be all inclusive, it does appear to cover a broad range of suicidal motivations. The list is not presented in any hierarchical order.

- wanting to escape from an intolerable situation
- wanting to join a deceased loved one
- wanting to improve one's condition
- wanting to gain attention
- wanting to manipulate the behavior of others



Wipe Out!

- wanting to be punished or avoid being punished
- wanting to punish survivors or get revenge
- wanting to avoid being tortured, raped or abused
- wanting to control when death will occur
- wanting to end an unresolvable conflict
- wanting to avoid becoming a burden to others
- responding to a voice during a "command hallucination"
- acting impulsively or capriciously
- wanting to avoid the effects of painful and/or degenerative diseases

RISK ASSESSMENT FOR CHILDREN

You may have one of your own children fill this out, complete this test for one of your own children, or look back on your own life, at a particular time, and fill this out. (This does not need to be sent to instructor).

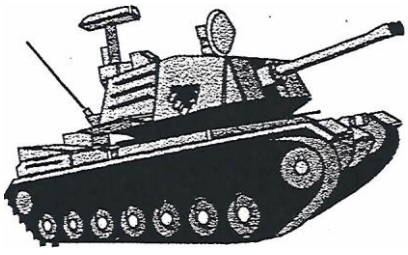
A child's stress may be analyzed based on the stressors he or she has undergone recently. The following scale gives an estimate of the impact of various changes in a child's life that may increase their stress and anxiety level. Add up the total points for all of the items your child has experienced *over the past year.* If your child scored **below 150,** he/she is about average with respect to stress load. If your child's score was **between 150 and 300,** he/she has a better than average chance of showing symptoms of stress. If the score is **over 300,** there is a strong likelihood that the child will display serious changes in health, behavior or emotional patterns. By using the interventions within this manual and within a chosen book, your skill level will be increased and positively affected.

Remember, each person has their own way of handling stress and different tolerance levels. This is not to be used as an exact science or as a way of diagnosing someone. It is only a tool. If you have questions or concerns regarding the results, please contact the instructor (but be nice).

STRESS	**POINTS**	**SCORE**
Parent dies	100	
Parents' divorce	73	
Parents' separate	65	
Parent travels as part of job	63	
Close family member dies	63	
Personal illness or injury	53	
Parent remarries	50	
Parent fired from job	47	
Parents reconcile	45	
Mother goes to work	45	
Change in health of a family member	44	
Mother becomes pregnant	40	
School difficulties	39	
Birth of a sibling	39	
School readjustment (new teacher or class)	39	
Change in family's financial condition	38	
Injury or illness to a close friend	37	
Starts a new (or changes) extracurricular activity	36	

{CONTINUED NEXT PAGE}

STRESS	POINTS	SCORE
Change in number of fights with siblings	35	
Threatened by violence in school	31	
Theft of personal possessions	30	
Changes in responsibilities at home	29	
Older brother or sister leaves home	29	
Trouble with grandparents	29	
Outstanding personal achievement	28	
Move to another city	26	
Move to another part of town	26	
Receives or loses a pet	25	
Changes personal habit	24	
Trouble with teacher	24	
Change in hours with baby-sitter/at daycare center	20	
Move to a new house	20	
Changes to a new school	20	
Changes play habits	19	
Vacations with family	19	
Changes friends	18	
Attends summer camp	17	
Changes sleeping habits	16	
Change in number of family get-togethers	15	
Changes in eating habits	15	
Changes amount of TV viewing	13	
Birthday party	12	
Punished for not "telling the truth"	11	



QUESTIONS AND ANSWERS

1. Why do some teenagers commit suicide? We don't know for sure, because when youth die by suicide they take the answers with them. But teens who attempt suicide and survive tell us that they wanted to die to end the pain of living. They are often experiencing a number of stressors and feel that they do not have the strength or desire to continue living. We also believe that the majority of youth who die by suicide have a mental disorder, like depression, which is often undiagnosed, untreated or both.

2. What are the most common warning signs? Some estimate as many as 80% of those thinking about suicide want others to be aware of their emotional pain and stop them from dying. A warning sign does not automatically mean a person is going to attempt suicide, but it should be taken seriously. The warning signs that we pay particular attention to are: a prior suicide attempt, talking about suicide and making a plan, giving away prized possessions, preoccupation with death, signs of depression, hopelessness and anxiety, increased drug and alcohol use.

3. How many people know about the warning signs and how to detect if a teen is going to commit suicide? Not enough, but more are learning every day. We believe that middle & high school students and college students can and should learn the warning signs and intervention strategies to help their friends. We don't expect them to conduct a professional assessment but we want them to befriend a person in despair and offer support and reassurance and referral to help.

4. Are there particular youth who are more at-risk of suicide? Some reports suggest that gay and lesbian youth are two to three times more likely to complete suicide than other youth. Alcohol and substance abuse also place a youth at higher risk for suicide.

S. Is there an increased risk for suicide because of bullying behavior? Yes; being a victim, perpetrator or even a witness to bullying has been associated with multiple behavioral, emotional, and social problems, including an increased risk for suicidal ideation.

6. Are the suicide rates different for males and females? Across the country, males are much more likely to die by suicide, while girls are more likely to make suicide attempts that result in hospitalization. Hanging and use of a firearm are the most frequently used methods for youth suicide. Cutting and overdose are the most frequency used methods for suicide attempts that result in hospitalization.

7. If someone suspects that a friend or family member is considering suicide, what should they do? There are three very important things to do if you notice the warning signs for suicide or the young person tells you directly that they are thinking about suicide. The first thing is to always show the person that you are concerned about them - listen without judgment, ask about

their feelings and avoid trying to come up with a solution to their problem. Next ask directly about suicide - be direct without being confrontational; say "are you feeling so bad that you are thinking about suicide?" Finally, if the answer to your question is "yes" or you think it is yes, go get help - call a crisis line, visit the school counselor, tell a parent or refer the teen to someone with professional skills to provide help. Never keep talk of suicide a secret!

8. Why has the suicide rate been increasing in the past few decades? Suicide rates in Washington and across the USA had actually decreased in the 1990's reaching a low in 2000. Since then there has been a steady rise. We are reading and hearing more about suicide. Media reports hopefully are educating about the warning signs and the resources for help.

9. Why are some states teenage suicide rates much higher than others? Youth suicide rates are highest in Alaska and the Rocky Mountain states. If you map the youth suicide rates by state, there is a striking difference between the eastern half of the USA and mountain regions in the west. We don't know for sure why these rates are higher, but some theories include the largely rural territory, the vast land allocations to Native American reservations, poverty and a lack of easy access to resources.

10. What are common myths about teen suicide? Some believe if you ask directly about suicide that you "plant" an idea in the brain of a teenager; this is just not true. Others think that teens who talk about suicide are not really serious about dying - they think they are just seeking attention.

11. How can schools and communities work together to prevent suicide? The Centers for Disease Control recommends that local mental health agencies, crisis centers, clergy, health departments, medical organizations, injury prevention agencies, schools and other community members should work together to develop goals and strategies to prevent suicide.

12. What is a family's reaction when a teen family member completes suicide? Most feel a combination of emotions: anger, sadness, guilt, shame and fear. They wonder what they could have done and why they didn't do more. Suicide is different from other kinds of sudden death because the reason for the death is difficult to understand. With a car accident there is an external explanation or cause - an icy road, loss of vehicle control, etc. With a homicide, the grief-stricken can point to a perpetrator. With suicide, we don't have an external cause, and so we ask ourselves over and over: 'why?'

13. Is it okay for a school to plant a tree or dedicate a bench in memory of a youth who has died by suicide? These types of memorials can keep the death 'alive' and serve as a grim reminder of the loss. Because of the real concern about contagion there is a delicate balance between commemorating the life of the deceased and glamorizing a suicide.

3.

ABOUT GRIEF AND LOSS

Motivation and self-esteem are impacted tremendously by the aspect of grief. In today's society, it is common for people to experience divorce, substance abuse, child abuse, death of a loved one (including pet), a family move, loss of a job, etc. All of these greatly impact the child. Abraham Maslow, in his hierarchy of needs, expresses how self-esteem can only be met once the physiological, safety, and social needs are met in one's life.(See Maslow Chart in packet). However, many of the children that one may work with in schools, agencies, and community are suffering from a lack in one of these needs.

In general terms, grief is the emotion attached to a person who has experienced some loss. These can clearly be seen in the stages of grief found in your packet. Perhaps the most famous is that of Elizabeth Kubler Ross and her five stages-- denial, anger, bargaining, depression and acceptance. She indicates that while it takes time to experience these stages and they are not mutually exclusive, a healthy individual experiences each stage.

In children, these stages are not as defined. Because a child may not clearly understand the impact of a loss, nor the finality, stages are less rigid. This may lead to a difficulty in the child reconciling issues and moving into acceptance. There are the constant questions which are difficult to answer. Another difficult issue is the sense by the child that they are somehow responsible. This often comes from their self-centered approach to life. They may feel if they had been better, not argued, stayed home, etc. the incident would not have happened. If this occurs while a child is involved in adolescence, the impact can be life changing, many times in detrimental ways (running away, substance abuse, sexual acting out).

Why Does Depression Sometimes Get Missed?(connected to Assignment #4)

- **Children and adolescents** don't always understand or express their feelings. So as parents and educators, we need to be able to recognize the warning signs, the changes in a child, and when we should seek assistance.
- **Not all health care practitioners** have been adequately trained to assess childhood depression. In fact it has only been since the early 1980's that childhood depression was recognized as a health disorder.
- **Adults often assume that moodiness** is a normal part of adolescence. Teens do experience different moods but adults need to be able to recognize when feeling moody has progressed to depression. Depression is not a normal part of adolescence.
- **Depression is not a weakness** or character flaw. Depression is a health disorder and needs to be treated.
- **There is a myth that talking about depression** will only make it worse. Actually talking about depression acknowledges that there is a problem and may help a family recognize the need for help.
- **Lack of insurance** or insurance coverage for mental health services can be a barrier to a family of a depressed child.
- **We are so busy** with our own lives that we may overlook and not notice obvious signs from another person. The more educated one becomes about depression, the more of a resource they will be for another person.
- **In this day and age of individual activities** such as video games, music, and watching television, it is easy to not communicate with others and really know about them. Days can go by and a family may have minimal communication. In our schools, students may pass from
  class to class without speaking to an adult.

What does depression look like in your students? What do you or your school do to prevent depression? **Write a 2 page summary.**

How to handle childhood grief

While there is no "right answer" in the area of grief, the following guidelines will help you to work with a child in this area.

Where to start?

Don't complicate it. Help the child to understand what occurred. Use phrases and words that are familiar to the child. This is not about you, but is for the child.

Explain as clearly as possible and answer the child's questions. Be honest, sensitive, and caring.

It is okay to share your own personal feelings. It may help the child to feel more confident and secure in the situation by knowing that you also struggle, worry, feel upset, or need to talk to people when confronted with loss.

The child will benefit from having someone connect with them on a regular basis. This may be you or someone else.

Let the child know who his/her resources are in life. Give them a lifeline and be sure they feel supported and secure in the situation.

Helpful ideas for parents

** Communicate with child immediately and answer any questions
** Reassure the child that you are there for them
** Just be with the child, hold them, hug them, cry with them
** Share positive feelings and memories
** Allow the child to see you grieve. Be real with them
** Validate feelings
** Encourage questions, explain feelings, death, life issues
** Teenagers may grieve differently including being silent, appearing disinterested, or angry at their world
** Encourage family togetherness, express love

EDUCATORS

** When appropriate, use above guidelines
** Allow extra free time (this is very cathartic). Don't worry about school work, the routines will return for the child
** Counseling may be helpful. This may be with a school counselor or just talking to an adult he/she trusts
** Allow private time with student to talk ... you are a resource to them
** Keep routines normal (with flexibility). The routines will help them to work through issues of life.
** Don't over-emphasize "schoolwork," but encourage effort and attempts

HUMAN GRIEF

THREE THEORIES about the Grief Process

Kubler-Ross

1. Denial/Isolation
2. Anger
3. Bargaining of Guilt
4. Depression
5. Acceptance

Lindemann's Acute Grief

1. Somatic Distress
2. Preoccupation with image of deceased
3. Guilt
4. Hostile reactions
5. Loss of patterns of conduct

Westberg's Ten Stages

1. State of Shock
2. Express emotions
3. Feel depressed/lonely
4. Experience physical symptoms of distress
5. Become panicky
6. Sense guilt
7. Filled with resentment and hostility
8. Unable to return to usual activities
9. Gradually hope comes through
10. Struggle to affirm reality

Time – 1 month to 2 years or more

1. Shock

2. Emotional release

3. Physical symptoms

4. Isolation and depression

5. Guilt

6. Panic

7. Hostility

8. Unable to return to usual

9. Struggle with new living patterns

10. Reaffirm reality

STAGES ***DO NOT*** FOLLOW IN ORDER

About Teen Suicide

When a teen commits suicide, everyone is affected. Family members, friends, teammates, nelqhbors, and sometimes even those who didn't know the teen well might experience feelings of grief, confusion, guilt - and the sense that if only they had done something differently, the suicide could have been prevented. The reasons behind a teen's suicide or attempted suicide are often complex.

To help sort through these issues, and to learn the warning signs that your teen might need help, it's important to understand the forces that can lead teens to suicide and to understand what you can do to help.

Suicide Statistics

Although suicide is relatively rare among children, the rate of suicide attempts and suicide deaths increases tremendously during adolescence. Suicide is the third-leading cause of death for 15- to 24-year-olds, according to the Centers for Disease Control and Prevention (CDC) surpassed only by accidents and homicide.

The risk of suicide increases dramatically when kids and teens have access to firearms at homer and nearly 60% of all suicides in the United States are committed with a gun. That's why any gun in your home should be unloaded, locked, and kept out of the reach of children and teens. Ammunition should be stored and locked apart from the gun and the keys for both should be kept in a different area from where you store your household keys. Always keep the keys to any firearms out of the reach of Children and adolescents.

It's important to understand how suicide rates are different for boys and girls. Girls think about and attempt suicide about twice as often as boys, and girls tend to attempt suicide by overdosing on drugs or cutting themselves. Boys die by suicide about four times as much as girls, perhaps because they tend to use more lethal methods, such as firearms, hanging, or jumping from heights.

Which Kids Are at Risk for Suicide?

Now that you're a parent, you might not remember how it felt to be a teen, caught in that gray area between childhood and adulthood. Sure, it's a time of great possibility, but it can also be a period of great confusion and anxiety. There's pressure to fit in socially, to perform academically, and to act responsibly. There's the awakening of sexual feelings, a growing self-identity, and a need for autonomy that often conflicts with the rules and expectations set by others.

A teen with an adequate support network of friends, family, religious affiliations, peer groups or extracurricular activities may have an outlet to deal with everyday frustrations. But many teens don't believe they have that, and feel disconnected and isolated from family and friends. These teens are at increased risk for suicide.

Factors that increase the risk of suicide among teens include:

- the presence of a psychological disorder, especially depression, bipolar disorder, and alcohol and drug use (in fact, approximately 95% of people who die by suicide have a psychological disorder at the time of death)
- feelings of distress, irritability, or agitation
- feelings of hopelessness and worthlessness that often accompany depression (a teen, for example, who experiences repeated failures at school, who is overwhelmed by violence at home, or who is isolated from peers is likely to experience such feelings)
- a previous suicide attempt
- a family history of depression or suicide (depressive illnesses may have a genetic component, so some teens may be predisposed to suffer major depression)
- having suffered physical or sexual abuse

- lack of a support network, poor relationships with parents or peers, and feelings of social isolation
- dealing with homosexuality in an unsupportive family or community or hostile school environment

Warning Signs

Suicide among teens often occurs following a stressful life event, such as a perceived failure at school, a breakup with a boyfriend or girlfriend, the death of a loved one, a divorce, or a major family conflict.

A teen who is thinking about suicide may:

- talk about suicide or death in general
- talk about "going away"
- talk about feeling hopeless or feeling guilty
- pull away from friends or family
- lose the desire to take part in favorite things or activities
- have trouble concentrating or thinking clearly
- experience changes in eating or sleeping habits
- self-destructive behavior (drinking alcohol, taking drugs, or driving too fast, for example)

What Can Parents Do?

Most teens who commit or attempt suicide have *given* some type of warning to loved ones ahead of time. So it's important for parents to know the warning signs so that kids who might be suicidal can get the help they need.

Watch and Listen

Keep a close eye on a kid who seems depressed and withdrawn. Poor grades, for example, may signal that your teen is withdrawing at school.

It's important to keep the lines of communication open and express your concern, support, and love. If your teen confides in you, it's important to show that you take those concerns seriously. A fight with a friend may not seem like a big deal to you in the larger scheme of things, but for a teen, a situation like that can seem immense and consuming. It's important not to minimize or discount what your teen is going through. This may increase his or her sense of hopelessness.

If your teen doesn't feel comfortable talking with you, you may want to suggest a more neutral person, such as another relative, a clergy member, a coach, a school counselor, or your child's doctor.

Ask Questions

Some parents are reluctant to ask teens if they have been thinking about suicide or hurting themselves. Some fear that if they ask, they will plant the idea of suicide in their teen's head.

It's always a good idea to ask, even though doing so can be difficult. Sometimes it helps to let someone know why you're asking. For instance, you might say: "I've noticed that you've been talking a lot about wanting to be dead. Have you been having thoughts about trying to kill yourself?"

Get Help

If you learn that your child is thinking about suicide, get help immediately. Your doctor can refer you to a psychologist or psychiatrist, or your local hospital's department of psychiatry can provide a list of doctors in your area. Your local mental health association or county medical society can also provide references. In an emergency, you can call **(800) SUICIDE** or **(SOD) 999-9999.**

If your teen is in an emergency situation, your local emergency room can conduct a comprehensive psychiatric evaluation and refer you to the appropriate resources. If you are unsure about whether or not you should bring your child to the emergency room, contact your doctor or call (800) SUICIDE for help.

If you've scheduled an appointment with a mental health professional, make sure to keep the appointment, even if your teen says he or she is feeling better. Suicidal thoughts do tend to come and go; however, it is important that your teen get help developing the skills necessary to decrease the likelihood that suicidal thoughts and behaviors will emerge again if a crisis arises in the future.

If your teen refuses to go to the appointment, discuss this with the mental health professional - you may consider attending the session and working with the clinician to make sure your teen has access to the help needed. The clinician may also be able to help you devise strategies to help your teen want to get help.

Remember that any ongoing conflicts between a parent and child can fuel the fire for a teen who is feeling isolated, misunderstood, devalued, or suicidal. Get help to air family problems and resolve them in a constructive way. Also let the mental health professional know if there is a history of depression, substance abuse, family violence, or other stresses at home, such as an ongoing environment of criticism.

Helping Teens Cope With Loss

What should you do if someone your teen knows, perhaps a friend or a classmate, has attempted or committed suicide? First, acknowledge your child's many emotions. Some teens say they feel guilty - especially those who felt they could have interpreted their friend's actions and words better.

Others say they feel angry with the person who committed or attempted suicide for having done something so selfish. Still others say they feel no strong emotions. All of these reactions are appropriate; emphasize to your teen that there is no right or wrong way to feel.

When someone attempts suicide and survives, people may be afraid of or uncomfortable about talking with him or her about it. Tell your teen to resist this urge; this is a time when a person absolutely needs to feel connected to others.

Many schools address a student's suicide by calling in special counselors to talk with the students and help them deal with their feelings. If your teen is having difficulty dealing with a friend or classmate's suicide, it's best to make use of these resources or to talk to you or another trusted adult.

If You've Lost a Child to Suicide

For parents, the death of a child is probably the most painful loss imaginable. For parents who've lost a child to suicide, the pain and grief may be intensified. Although these feelings may never completely go away, survivors of suicide can take steps to begin the healing process:

- Maintain contact with others. Suicide can be a very isolating experience for surviving family members because friends often don't know what to say or how to help. Seek out supportive people to talk with about your child and your feelings. If those around you seem uncomfortable about reaching out, initiate the conversation and ask for their help.

- Remember that your other family members are grieving, too, and that everyone expresses grief in their own way. Your other children, in particular, may try to deal with their pain alone so as not to burden you with additional worries. Be there for each other through the tears, anger, and silences - and, if necessary, seek help and support together.

- Expect that anniversaries, birthdays, and holidays may be difficult. Important days and holidays often reawaken a sense of loss and anxiety. On those days, do what's best for your emotional needs, whether that means surrounding yourself with family and friends or planning a quiet day of reflection.

- Understand that it's normal to feel guilty and to question how this could *have* happened, but it's also important to realize that you may never get the answers you are looking for. The healing that takes place over time comes from reaching a point of forgiveness - for both your child and yourself.

- Counseling and support groups can play a tremendous role in helping you to realize you are not alone.

UNDERSTANDING TEEN SUICIDE

Studies show that 4 out of 5 teen suicide attempts have been preceded by clear warning signs. Make sure you know them.

Teen suicide is a very real problem in the United States. With many pressures and a variety of emotional, social and family issues to confront, many teenagers find themselves having suicidal thoughts. Part of averting a teen suicide is being involved in your teen's life and watching for teen suicide warning signs. It is also important to note that many of the teen suicide warning signs are also indications of depression.

Teen suicide warning signs

It is important to take the warning signs of teen suicide seriously and to seek help if you think that you know a teenager who might be suicidal. Here are some of the things to look for:

Disinterest in favorite extracurricular activities

Problems at work and losing interest in a job

Substance abuse, including alcohol and drug (illegal and legal drugs) use

Behavioral problems

Withdrawing from family and friends

Sleep changes

Changes in eating habits

Begins to neglect hygiene and other matters of personal appearance

Emotional distress brings on physical complaints (aches, fatigues, migraines)

Hard time concentrating and paying attention

Declining grades in school

Loss of interest in schoolwork

Risk taking behaviors

Complains more frequently of boredom

Does not respond as before to praise

Not all of these teen suicide warning signs will be present in cases of possible teen suicide. There are many cases in which a good student commits suicide. It is important to watch for two or three signs as indications of depression, or even teen suicidal thoughts.

Teen suicide warning signs: indications of a suicide plan

There are some things that teens might do that could indicate that they are contemplating, or even planning, suicide. It is important that you make yourself aware of these actions, and use them as starting points to draw your teenager out and perhaps express what is bothering him or her. Here are some of the indications of a suicide plan:

Actually says, "I'm thinking of committing suicide" or "I want to kill myself' or "I wish I could die."

There are also verbal hints that could indicate suicidal thoughts or plans. These include such phrases as: "I want you to know something, in case something happens to me" or "I won't trouble you anymore."

Teenager begins giving away favorite belongings, or promising them to friends and family members.

Throws away important possessions.

Shows signs of extreme cheerfulness following periods of depression.

Creates suicide notes.

Expresses bizarre or unsettling thoughts on occasion.

Understanding that teen suicide warning signs are serious calls for help is important. Many teenagers share their thoughts and feelings in a desperate attempt to be acknowledged. In many cases, they don't know how to deal with their feelings and problems and are looking for someone to help them find assistance. Acknowledging these warning signs and seeking help for the problem, and offering support to a teenager who is working through his or her issues is very important, and can help prevent suicide. Teen suicide is a very real danger, and heeding the warning signs can truly save a life.

4.

PREVENTION OF TEENAGE SUICIDE--WHAT YOU CAN DO

(Connected to Assignment #4)

1. IF YOU NOTICE WARNING SIGNS, CONFRONT THE TEENAGER
2. LISTEN TO YOUR TEENAGER
3. REFRAIN FROM MAKING JUDGMENTS
4. DON'T DENY A ONE'S SUICIDAL THOUGHTS
5. DON'T USE REVERSE PSYCHOLOGY
6. HELP THE TEENAGER REALIZE THAT WHAT HE IS FEELING IS TEMPORARY AND WILL PASS
7. HELP TEENAGER REALIZE THAT DEATH IS A PERMANENT DECISION
8. ALLOW THE TEENAGER TO VENTILATE FEELINGS
9. BE BOLD IN EXPRESSING EMOTIONS
10. DO NOT LEAVE SUICIDAL TEENAGER ALONE
11. LET TEENAGER KNOW YOUR PLAN ON GETTING TO THE BOTTOM OF THE PROBLEM
12. GET HELP IMMEDIATELY
13. DON'T BE FOOLED BY TEMPORARY "HIGHS" AND APPARENTLY GETTING PAST SUICIDAL THOUGHTS
14. DON'T EXPECT INSTANT IMPROVEMENT

Choose 3-4 effective interventions and share how you (or your school) might implement these areas. **2 page summary.**

STEPS TO ASSISTING A CHILD IN NEED

Look for warning signs:

- current talk about suicide or making a suicide plan
- signs of serious depression, moodiness, hopelessness, and withdrawal
- strong wish to die, preoccupation with death, giving away possessions
- increased alcohol or drug use
- recent suicide attempts by a friend or family member
- impulsiveness and taking unnecessary risks
- perception that there is no one to talk to

If you are concerned about the person, then:

1. Show you care. Let the person know how you feel by talking about your feelings. Ask them about their feelings. Listen carefully to what is being said. For example "I am concerned about what you are saying. You are a part of this school and I want you to know I think you are important." "How are you feeling? It seems that you are feeling overwhelmed, is that true?"
2. Ask direct questions. Don't be hesitant to ask the person if they are thinking of suicide. "You seem very upset about life. Are you saying that you are thinking of hurting yourself?" Talking with the person about suicide will not give them the idea. Seriously, they have already contemplated it if you are sensing the concern. Be direct, but caring. "Are you thinking of suicide or do you just want the pain to stop?"
3. Get help. Don't do this alone. Contact a counselor, nurse, a member of your crisis team or some other trained individual. This may be a mental health professional or trained health professional.
4. If the person has a plan or has access to weapons, don't leave them alone. Get help immediately. If you can get them to agree to not hurt themselves, to wait for assistance, to allow you to be with them-it will temporarily avert the crisis. However, the person needs further assistance and ongoing counseling.

HOW YOU CAN HELP IN A SUICIDAL CRISIS

RECOGNIZE THE CLUES TO SUICIDE- Look for symptoms of deep depression and signs of hopelessness and helplessness. Listen for suicide threats and words of warning such as "I wish I were dead" or "I have nothing to live for." Watch for despairing actions and signals of loneliness; notice whether the person becomes withdrawn and isolated from others. Be alert to suicidal thoughts as a depression lifts.

TRUST YOUR OWN JUDGMENT- If you believe someone is in danger of suicide, act on your beliefs. Don't let others mislead you into ignoring suicidal signals.

TELL OTHERS- As quickly as possible share your knowledge with parents, friends, teachers, or other people who might help in a suicidal crisis. Don't worry about breaking a confidence if someone reveals suicidal plans to you. You may have to betray a secret to save a life.

STAY WITH A SUICIDAL PERSON- Don't leave a suicidal person alone if you think there is immediate danger. Stay with the person until help arrives or a crisis passes.

LISTEN INTELLIGENTLY- Encourage a suicidal person to talk to you. Don't give false reassurances that "everything will be OK." Listen and sympathize with what the person says.

URGE PROFESSIONAL HELP- Put pressure on a suicidal person to seek help from a psychiatrist, psychologist, social worker, or other professional during a suicidal crisis or after a suicide attempt. Encourage person to continue with therapy even if it becomes difficult.

BE SUPPORTIVE- Show the person that you care. Help the person feel worthwhile and wanted again.

Francine Klagbrun, Youth and Suicide-- Too Young To Die. New York: Kangaroo Books.

COPING STRATEGIES FOR TEENS (OR ANYONE ELSE) UNDER STRESS

- COMMUNICATE WITH FRIENDS AND FAMILY MEMBERS-BE OPEN WITH YOUR FEELINGS
- SEEK PROFESSIONAL HELP IF YOU FEEL OVERWHELMED OR IN TROUBLE
- DISCOVER IPRACTICE ACTIVITIES THAT ALLOW YOU TO RELIEVE ENERGY AND FRUSTRATION
- BE INVOLVED IN ACTIVITIES YOU ENJOY
- KEEP REMINDING YOURSELF THAT PROBLEMS ARE TEMPORARY
- DON'T USE DRUGS OR ALCOHOL AND DON'T SMOKE
- DON'T PUT UP WITH ANY FORM OF ABUSE FROM ANYONE. GET HELP IMMEDIATELY
- DON'T WITHDRAW. SPEND TIME WITH FRIENDS
- BE DISCRIMINATING REGARDING MEDIA CONSUMPTION- BOOKS, MAGAZINES, TV, MOVIES
- REGULARLY REMIND YOURSELF OF YOUR STRENGTHS AND ABILITIES
- HAVE FUN ON A REGULAR BASIS. PLAN THINGS YOU LOOK FORWARD TO
- MAKE SURE YOUR PERSONAL GOALS ARE REALISTIC
- EAT A WELL BALANCED DIET
- MAKE SURE YOU GET REGULAR ATHLETIC ACTIVITY
- LEARN TO LAUGH AT LIFE AND AT YOURSELF
- GET ENOUGH SLEEP
- ADMIT THAT CERTAIN THINGS ARE OUT OF YOUR CONTROL (YOUR HEIGHT. YOUR SHOE SIZE) AND MAKE THE BEST OF EACH SITUATION
- CLEARLY IDENTIFY SPECIFIC SOURCES OF STRESS IN YOUR LIFE AND ATTEMPT TO IDENTIFY A POTENTIAL SOLUTION FOR REDUCING THAT STRESS
- GET INVOLVED IN CLUBS AND ORGANIZATIONS
- DO VOLUNTEER WORK
- LISTEN TO RELAXING MUSIC
- GO TO EVENTS WITH FRIENDS AND FAMILY
- ON A REGULAR BASIS. SPEND SOME TIME ALONE TO THINK AND PLAN
- AVOID NEGATIVE THINKING
- REMIND YOURSELF THAT MOST PROBLEMS ARE UNIVERSAL AND THAT OTHERS ARE GOING THROUGH SIMILAR PROBLEMS
- PURSUE A HOBBY OR CRAFT
- USE YOUR TIME WISELY

ADD ADDITIONAL AREAS

-
-
-

SHORT VIGNETTES AND RESPONSES

WRITE OUT *YOUR ANSWERS* TO THE QUESTIONS FOLLOWING EACH EXAMPLE. YOU **DO NOT** SEND THESE TO THE INSTRUCTOR. AN OUTLINE OF EFFECTIVE RESPONSES MAY BE FOUND ON THE NEXT PAGE. (These could be modified, changed and used in your classroom).

A. A student you have known well for several years confides that he is very disturbed by thoughts of suicide. He is frightened and would like help, but is worried that if people find out about the problem it will damage his school and home life. What do you do? What would you avoid doing?

B. A girl who lives next door, whom you have been close to for years, but have not socialized with recently, has changed since her father's death. She stays to herself, has dropped out of activities, lost weight, looks unkempt, and the bedroom light is often on late at night. At first you thought the behavior was typical of mourning, but it has been over a year since the death and things seem to be getting worse instead of better. What do these signs suggest and what would you do about them?

C. A student tells you about a college student who is away from home for the first time and becomes anxious over his failure to get straight "A's", even though he is doing better than average. He breaks up with his girlfriend and begins drinking and using drugs. He talks about being a burden to his friends and a disappointment to his family. You know he recently tried to buy a gun saying it was a gift for his father. What would you do?

D. A thirteen year old girl has been emotionally unsettled by her parents' recent divorce. Always quiet, withdrawn, she has become even more so. She no longer sees her friends, she dropped out of the school orchestra and she spends most of her time alone in her room. Her father was always very close to her and you suspect that she feels deserted by him and she believes he would not have left if he really loved her. Her mother, with whom she lives and who feels guilty about the effect of the divorce on her daughter, tends to let her alone to do what she wants. What is your analysis of the problem and what would you do about it?

POSSIBLE RESPONSES TO VIGNETTES

VIGNETTE A:

1. Don't be judgmental. Do not act offended or appalled.
2. Talk freely and show a willingness to discuss it.
3. Ask questions, both general and specific.
4. DO NOT play it down by telling them everything is going to be all right.
5. If risk seems imminent, don't leave him alone.
6. Suggest "community" professional help or refer to school counselor.
7. If he refuses to get help, take initiative. Call suicide hot-line or Mental Health.

VIGNETTE B:

The girl appears to have a severe, possibly suicidal depression. The fact that the reaction has lingered on and is becoming worse indicates more than typical mourning. The symptoms- disturbed sleep, weight loss or loss of appetite, loss of interest in activities, neglect of her appearance- all suggest depression, one of the danger signs of suicide. The loss factor in her depression and her isolation are of a particular concern.

1. Open lines of communication--connect personally with them. Ask questions (as shared in Vignette A).
2. Encourage her to get counseling.
3. Alert relatives or someone who is close to her. Talking to her doctor or clergy person may be helpful.
4. Call suicide hot line or Mental Health for suggestions.

VIGNETTE C:

This behavior is one of acute suicidal risk. The exaggerated sense of failure, the changes of behavior, the breaking of relationships and the morbid conversations point clearly in that direction, and the attempt to buy a gun shows there is no time to waste.

1. Notify school authorities. Be sure they understand seriousness of situation.
2. If the student who shared this with you feels able, have them connect personally as a support system. Contacting other friends may be helpful.
3. Notify the family of the college student.
4. Find out something about their support systems (family, friends, etc.) and take the opportunity to educate them. Remember, this is life or death.

VIGNETTE D:

Childhood suicide is on the rise and can be precipitated by the disruption of the family unit. The tendency to be alone and inactive is a particularly dangerous sign.

1. Talk to the mother. Be honest, up front and specific.
2. If the mother refuses to act, talk with the father.
3. If neither respond, call school counselor, physician or other interested people.

Communication Skills To Use

.:. Reflective Listening- communicate with the person what you understand them to be saying. "So what you are saying is ... "

.:. Empathy- show an understanding of what the person may be feeling. "It sounds like you are feeling alone."

.:. Summarize- take several statements and reinforce the general concepts the person is sharing. "So, let me make sure I understand. You are feeling alone, like no one really cares, and that it doesn't matter what happens to you. Is that right?"

.:. Open-Ended Questions- these ask for a response that elaborates or shares. It avoids the "yes/no" answer. "Tell me what happened earlier to make you feel like this."

.:. Offer Choices- give the person options and the ability to make choices in their decision. Avoid challenging them or attempting to convince them of something .

.:. Re-Direct- talk to them and attempt to gently move the topic toward a more positive perspective. "I know you are really upset. But, I thought you were excited about the dance tomorrow. What are those like?"

.:. Affirm- give positive statements, compliments and genuine understanding to the person. "I like the way you are sharing your feelings. You do a nice job of looking at life situations."

.:. Resistance- avoid arguing, criticizing, blaming, or labeling. Don't tell them what you think or what should be.

.:. Don't make any promises. Affirm that you want to listen and assist them.

Be aware of the body language of the person. Look for closed nonverbal expressions such as arms folded, loss of eye contact, head down, slumped body posture, rigidity in body, etc. Also, note the verbal expressions including short answers, negative comments, attempts to deflect your comments, etc.

Allow for verbal venting. Look for small steps of success with the person (they allow you to talk to them, to sit with them). Remind them that you care and what to help them resolve the issues in life.

15.

FACT SHEET – WORKING WITH SUICIDAL PEOPLE

- If in doubt, ask questions. Example: Are your problems so big you are thinking of harming yourself? Do you wish to end it all? Have you been thinking of suicide?
- Try to establish a relationship with the person thinking of suicide.
- Be accepting and nonjudgmental
- Be confident that the person does not have to die by suicide, at least for today.
- Remove the suicidal person's access to the means of ending his or her life (e.g. get rid of guns, pills, etc.). Just getting in the way of Plan A will thwart many suicides.
- Help the person buy time to stay alive.
- Assess the person's resources. Who is impacted by the person living or dying? Mother, Father, siblings, coach, teacher? Can this person help now? If yes, get the help needed to build a wall of support around the suicidal person.
- Always take a positive approach, but don't make trivial that which the person is prepared to die for.
- Get help--as much for yourself as for the suicidal person.
- Don't sound shocked, dismayed or frightened. (There is no point in two of you being discouraged).
- Don't ignore the person's threats or statements that they wish to die. Even if they don't really mean what they're saying, can either of you afford to pretend?
- Don't focus on the shock, embarrassment or suffering the family or loved one will endure if they die, unless you are sure that isn't exactly what the person wants.
- Don't get into a debate on the merits of living or dying.
- Never put yourself at risk of injury (taking a gun or knife away) unless you are highly trained in this area.

Remember, if you believe someone may be thinking of suicide, go ahead and ask. If they weren't thinking of suicide, the worst they can do is be a little offended that you would think them capable of such an act; but if *they were thinking* of *suicide,* they will be forever grateful.

GENERAL DO'S AND DON'TS

DO

- Talk freely about the subject
- Get help
- Offer the person hope for tomorrow
- Suggest they call a suicide hot line, mental health or other counselor
- Suggest they talk with family, friends, clergy, teachers or other available support systems
- Ask them to agree to not harm themselves
- Have them commit to a contract which "chooses life"
- Contact other support people or professionals for help
- Surround them with love and understanding, but don't smother them
- Be honest and real
- Share your genuine concern for their safety

DON'T

- Assume the person isn't the type
- Assume the person wouldn't follow through with threats
- Respond with comparisons to other people
- Minimize their situation, no matter how silly or trivial it may appear
- Be afraid to talk freely about their feelings
- Be timid about mentioning the possibility of suicide
- Try to make them feel guilty, that will only fuel the fire
- Be afraid to appear disloyal by refusing to be a part of their "conspiracy of death". Take a stand for life
- Try to tell them how to feel
- Ask them for their permission to help them. Just Do It
- Find fault with parent, teacher, police or others. Just listen

THE "DIRT" APPROACH TO RISK

(abstracted from The Information Center, San Diego, Ca.)

FOUR FACTORS ARE CONSIDERED WHEN YOU ARE TRYING TO ASSESS THE CURRENT LEVEL OF RISK AND YOU KNOW THAT THERE HAS ALREADY BEEN A PREVIOUS ATTEMPT. BY USING THE ACRONYM "DIRT", WE CAN REMEMBER THE FOUR FACTORS.

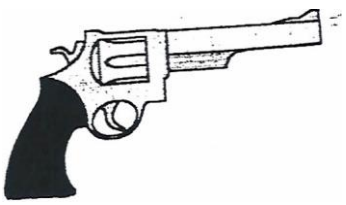
D=DANGEROUS. Did he or she ingest five aspirins or 75 barbiturates? Did he/she jump from a second story window or a tenth floor ledge? How dangerous was whatever he/she did to attempt suicide? The greater the dangerousness of the attempt, the higher the current level of risk.

I=IMPRESSION OF THE DEGREE OF RISK. Regardless of whether the act was dangerous or not, did the person attempting suicide feel it was dangerous. We must know the person's impression of the risk factor. Did he/she swallow five aspirin expecting it to kill them? If the person honestly believed that their act would produce death, the present level of risk is high.

R=RESCUE. What were the chances of someone intervening to rescue the person from the suicide attempt? Did the suicide occur with others in the next room? Were the pills taken right before mom was expected home? After taking the pills, did the person call for help? If the chances were good that the person would be rescued or if the person assisted in their own rescue, then the present level of risk is lower.

T=TIMING. How long ago did the most recent attempt occur? Was it 20 years ago or 20 days ago? Generally, the more recent the attempt, the higher the current level of risk.

THE PERIOD OF GREATEST SUICIDAL RISK IS NOT WHEN PEOPLE ARE IN THE DEPTHS OF DEPRESSION, BUT DURING THE FIRST 90 DAYS AFTER THE DEPRESSION BEGINS TO LIFT



THE "SLAP" APPROACH TO DETERMINING THE SERIOUSNESS OF RISK

(abstracted from the Information Center, San Diego, Ca.)

ALWAYS BEGIN YOUR ASSESSMENT BY ASKING "HOW WOULD YOU HARM YOURSELF?" THE ANSWER TO THAT QUESTION WILL LET YOU KNOW QUICKLY IF THE PERSON HAS A "PLAN OF ATTACK." WITHOUT ONE, HE/SHE IS MUCH LESS LIKELY TO ACT OUT IMMINENTLY. IF THE PERSON DOES HAVE A PLAN OF ATTACK IN MIND, USE THE ACRONYM "S L A P" TO HELP YOU REMEMBER THE FOUR FACTORS USED TO DETERMINE THE SERIOUSNESS OF RISK.

S= HOW (S)PECIFIC ARE THE DETAILS OF THE PLAN OF ATTACK? Does the person have a plan? If so, are the details "fuzzy" or "clear"? The greater the specificity of details in the plan, the higher the degree of risk.

L= WHAT IS THE LEVEL OF (L)ETHALITY OF THE PROPOSED METHOD OF ATTACK? How quickly would death be accomplished? Is the person going to shoot himself in the head or is he going to take a bottle of aspirin? The higher the level of lethality in the plan, the greater the degree of risk.

A= WHAT IS THE (A)VAILABILITY OF THE PROPOSED METHOD? Does the person have a loaded gun in front of them or do they need to go and buy a gun? Are the pills in the medicine chest at home or would the person need to go to a doctor and get a prescription? The more readily available the implement to be used is, the higher the degree of risk.

P= WHAT IS THE (P)ROXIMITY TO HELPING RESOURCES? How physically and geographically close is the person to others who could rescue them? Are there other people nearby who care about this person (relatives, friends, neighbors)? The greater the distance he/she is from those who could rescue the person in an emergency, the greater the degree of risk.

The SLAP approach is a very good one for getting you in and out of situations very quickly with an assessment of the degree and imminence of risk; however, it is by no means foolproof. The reliability of this method seriously decreases when working with people who are psychotic, substance abusers or other people with highly impulsive behaviors.

These are just general ideas that you might include in a Crisis Plan. The next page gives you another general outline for such a plan. Remember, the purpose of such a plan is to assist students and staff to be more effective when working with people that are suicidal. Unfortunately, our teams will also be used when a person has died and we need to support the friends, family, and staff.

Elements of a Comprehensive School Crisis Response Plan that addresses the risk for Suicide amongst students

RATIONALE/INTRODUCTION
1. The plan defines a "crisis" and under what circumstances the protocols and procedures will be used.
POSTVENTION COMPONENTS
2. .In the event of a completed suicide the plan provide specific, detailed information about the necessary action steps.
3. The plan includes sample announcements for faculty, students, parents and the media.
4. The plan includes strategies for debriefing the postvention process.
5. The plan includes a telephone tree that specifies the process by which staff and faculty are alerted to the crisis.
6. The plan includes a list of community resources that are accessible for additional support and assistance.
INTERVENTION COMPONENTS
7. The plan specifies to whom suicide threats and attempts are reported.
8. The plan specifies a process by which "high-risk" students are identified and appropriate action plans are determined.
9. The plan includes an updated referral list of community providers.
10. When concerned for a student's imminent safety, the plan specifies a procedure for notifying the parents and suggesting resources for immediate follow-up.
11. The plan includes tools for assessing suicide risk and/or generating a "no-harm" contract.
12. Following a suicide attempt - not a completion - the plan addresses the process by which a student is reintegrated into classes and school life.
PREVENTION COMPONENTS
13. The plan specifies a process by which staff/faculty are trained and/or updated on these crisis protocols and procedures.
14. The plan specifies a process by which parents and students are educated on the warning signs for depression and suicide, along with helpful intervention strategies.

Crisis Response Planning

One element of any school's suicide prevention efforts should be a written crisis plan that includes prevention, intervention and postvention strategies. Suicidal behavior is considerably more common than bomb threats ad earthquakes and deserves specific protocols. A school should have a plan for ensuring that teachers and school staff are trained (and occasionally refreshed) to recognize the symptoms for depression and the warning signs for suicide. In the event of a student death by suicide, a crisis plan provides clarity about such things as how to support grieving peers and how to handle the media. A crisis plan needs to include procedures for assessing and referring a suicidal student to help.

Steps in Enhancing Crisis Response Plans

If it is decided that the focus should be on **postvention,** develop answers/strategies to the following checklist of tasks:

- Who will be the contact for the bereaved family?
- Will we utilize a building or district crisis team? If so, what training have they had?
- Who will inform the faculty and staff of the student's suicide? How much information will they receive?
- Who will develop a script that each faculty member will be asked to read at a specific time during the day? How much information will the students receive?

  •Who will inform the parents of the death? What information will they receive and how: email, letter home in US Mail or home via their student?
- Where will we set up a "safe room" for students to gather? Who will staff that room?
- Will substitutes be available if a teacher's grief interferes with teaching?
- Will someone in the building or at the district handle media inquiries?
- How will other "high-risk" students be identified and referred to counseling services?
- How will we handle sticky situations, like a request for a memorial, or the student's locker, or a story in the school newspaper?

If it is decided that the focus should be on **intervention,** develop answers/strategies to the following checklist of tasks:

- Is staff trained in the signs and symptoms of depression and the warning signs for suicide?
- Are staff comfortable sharing their potentially vague concerns about a student who might be suicidal?
- Who is the designated person(s) that suicidal threats and attempts are reported?
- Are the designated person(s) competent to assess and refer suicidal students?

- What documentation is required to be completed regarding a suicidal student? Where is that documentation stored? Who can read it? Should an administrator formally review the assessment and intervention decisions?
- What is our primary resource for emergency psychiatric services?
  •Do we have an updated list of community resources? Who is responsible for updating each year?
- How/when do parents get notified of the student's suicidal behavior?
- How do we handle the suicidal student who asks that their parent not be notified?
- What do we do when we assess that the parents are unresponsive to our suicide concerns? How do we respond when the parents are unavailable or unreachable?
- If a student's suicidal behavior results in hospitalization, what is our process for re-integrating him/her back into classes and student life?

If it is decided that the focus should be on **prevention,** develop answers/strategies to the following checklist of tasks:

- How are students being educated on the warning signs for depression/suicide as well as helpful intervention strategies?
- Would most students know where to get help if they were worried about a suicidal friend?
  •What resources on anxiety, depression, suicide prevention, and grief/loss do we have in our school library?
- Do most staff - including front office staff - have some training in suicide awareness?
- How often should staff training be offered? Who should conduct the training?
- What do staff and faculty know about requests for confidentiality around suicide?
- Are the administration, staff and faculty clear about the school's legal rights and obligations in dealing with a suicidal student?
- When policies related to suicide are written and/or changed, how should they be disseminated?

SAMPLE SCHOOL/DISTRICT WIDE POSTVENTION PLAN

(connected to Assignment #9)

(The term Crisis Response Team-CRT- will be used throughout this plan)

WHO IS INVOLVED?

The CRT will be made up of specific district employees who have completed special training. The members of the CRT will be chosen by the building principals and a building representative. The total number to be involved should be sufficient to cover each school in the district with at least 2 people per building in the case of a district wide crisis. It *may* be helpful to train additional people to ensure availability during a crisis.

TYPE OF TRAINING.

Each team member should be experience in individual and/or group counseling. In addition, a community (or several) resources will be employed to further training. Specific areas will include stages of grief, grief counseling, system supports, community resources, medical resources, crisis intervention, district policy regarding rules and regulations, legal ramifications. Each member of the CRT will be required to have 10 hours of training each year. In addition, each member must read the selected book given to them *by* the district. (A book on suicide which best meets the needs of the district should be chosen).

WHAT IS THE PROCESS TO BE *FOLLOWED?*

Upon their deployment to a school, the CRT will offer support to the entire staff and students, as directed *by* the building administrator. They will facilitate the understanding of the grieving process, clarify issues and help maintain the safe milieu and school climate. Similar services will also be made available to impacted parents. If a staff member is pulled from their building or used within their own building, a substitute will be hired to cover their normal work duties.

PREPARATION PLANS.

It will be necessary to train the entire district personnel as to the process to make sure the process is adhered to *by* the schools. A written plan should be available to each school and on file in each building. This plan should be accepted *by* the local school board and parent groups.

WHILE THIS IS A GENERAL PLAN, YOUR PLAN SHOULD BE MORE SPECIFIC.
THIS IS DONE BY MENTIONING SCHOOLS, SPECIFIC STAFF, POSSIBLE TRAINERS, POSSIBLE TEXT BOOK TO BE USED, ETC. Write a **2 page summary.**

16.

HELPING THE GRIEVING CHILD

1. Comfort the child; assure the child that he/she will be taken care of and kept safe.

2. Talk about grief. Share a little of your own personal grief. Take *away* the mystery and uniqueness without downplaying their feelings. Let them know that their feelings are normal.

3. Listen and encourage the child to talk and ask questions.

4. Don't punish the child for being sad. It is a process and *may* take some time. The more *you* give them the freedom to experience pain and grief, the easier it will be to move through the process.

5. Don't assess the child's grief by saying 'you are handling this well" or "You're doing fine." You really don't know what is happening inside. Don't make assumptions.

6. Keep routines and minimize changes in the child's life.

7. Be reliable; do what you say. Don't make promises which can't be kept. Help the child to be able to trust.

8. Don't spoil the child. Keep limits, boundaries, and consequences as usual. Giving the child extra privileges do not help. Being consistent does help.

SAMPLE QUESTIONS FOR INTERVIEW (connected to Assignment #6)

1. What is the most common cause of an attempted suicide?

2. What is your most effective intervention?

3. What is the "typical" age of a suicidal person?

4. Please share the type of training and background which helped to prepare you.

5. Name some of the warning signs which you see in people.

6. Share some of the common resources used in this community.

7. Have you ever had someone succeed In their attempt of suicide? How did it affect those around the person?

8. Give a scenario of the type of person most prone to suicidal ideology.

9. Who are the most utilized support systems for people?

10. Is suicide increasing/decreasing in our community? Share your thoughts as to why.

FINAL REVIEW AND SUMMARY

What can be done to help someone who may be suicidal?

1. Take it seriously.

Myth: "The people who talk about it don't do it." Studies have found that more than 75% of all completed suicides did things in the few weeks or months prior to their deaths to indicate to others that they were in deep despair. Anyone expressing suicidal feelings needs immediate attention.

Myth: "Anyone who tries to kill himself has got to be crazy." Perhaps 10% of all suicidal people are psychotic or have delusional beliefs about reality. Most suicidal people suffer from the recognized mental illness of depression; but many depressed people adequately manage their daily affairs. The absence of "craziness" does not mean the absence of suicide risk.

"Those problems weren't enough to commit suicide over," is often said by people who knew a completed suicide. You cannot assume that because you feel something is not worth being suicidal about, that the person you are with feels the same way. It is not how bad the problem is, but how badly it's hurting the person who has it.

2. Remember: suicidal behavior is a cry for help.

Myth: "If someone is going to kill himself, nothing can stop him." The fact that a person is still alive is sufficient proof that part of him wants to remain alive. The suicidal person is ambivalent - part of him wants to live and part of him wants not so much death as he wants the pain to end. It is the part that wants to live that tells another "I feel suicidal." If a suicidal person turns to you it is likely that he believes that you are more caring, more informed about coping with misfortune, and more willing to protect his confidentiality. No matter how negative the manner and content of his talk, he is doing a positive thing and has a positive view of you.

3. Be willing to give and get help sooner rather than later.

Suicide prevention is not a last minute activity. Unfortunately, suicidal people are afraid that trying to get help may bring them more pain: being told they are stupid, foolish, sinful, or manipulative; rejection; punishment; suspension from school; written records of their condition; or involuntary commitment. You need to do everything you can to reduce pain, rather than increase or prolong it. Constructively involving yourself on the side of life as early as possible will reduce the risk of suicide.

4. Listen.

Give the person every opportunity to unburden his troubles and ventilate his feelings. You don't need to say much and there are no magic words. If you are concerned, your voice and manner

will show it. Give him relief from being alone with his pain; let him know you are glad he turned to you. At times everyone feels sad, hurt, or hopeless. You know what that's like; share your feelings. Let the child know he or she is not alone. Avoid arguments and advice giving. If the child's words or actions scare you, tell him/her. If worried or don't know what to do, say so.

5. ASK: "Are you having thoughts of suicide?"

Myth: "Talking about it may give someone the idea." People already have the idea; suicide is constantly in the media. If you ask a despairing person this question you are doing a good thing for them: you are showing him that you care about him, that you take him seriously, and that you are willing to let him share his pain with you. You are giving him further opportunity to discharge pent up and painful feelings. If the person is having thoughts of suicide, find out how far along his ideation has progressed.

6. If the person is acutely suicidal, do not leave him alone.

If the means are present, try to get rid of them. Detoxify the school or home.

7. Urge professional help.

Persistence and patience may be needed to seek, engage and continue with as many options as possible. In any referral situation, let the person know you care and want to maintain contact.

8. No secrets.

It is the part of the person that is afraid of more pain that says "Don't tell anyone." It is the part that wants to stay alive that tells you about it. Respond to that part of the person and persistently seek out a mature and compassionate person with whom you can review the situation. Distributing the anxieties and responsibilities of suicide prevention makes it easier and much more effective.

Interventions with a suicidal student:

Schools should have a written protocol for dealing with a student who shows signs of suicidal or other dangerous behavior. The following steps may be effective in dealing with a student who expresses active suicidal intent.

1. Calm the immediate crisis situation. Do not leave the suicidal student alone even for a minute. Ask whether he or she is in possession of any potentially dangerous objects or medications. If the student has dangerous items on his person, be calm and try to verbally persuade the student to give them to you. Do not engage in a physical struggle to get the items. Call administration or the designated crisis team. Escort the student away from other students to a safe place where the crisis team members can talk to him. Be sure that there is access to a telephone.

2. The crisis individuals then interview the student and determine the potential risk for suicide.

a. If the student is holding on to dangerous items, it is the highest risk situation. Staff should call an ambulance, the police and the student's parents. Staff should try to calm the student and ask for the dangerous items.

b. If the student has no dangerous objects, but appears to be an immediate suicide risk, it would be considered a high-risk situation. If the student is upset because of physical or sexual abuse, staff should notify the appropriate school personnel and contact the police. If there is no evidence of abuse or neglect, staff should contact parents and ask them to come in to pick up their child. Staff should inform them fully about the situation and strongly encourage them to take their child to a mental health professional for an evaluation. The team should give the parents a list of telephone numbers of crisis clinics. If the school is unable to contact parents, and if the police cannot intervene, designated staff should take the student to a nearby emergency room.

c. If the student has had suicidal thoughts but does not seem likely to hurt himself in the near future, the risk is more moderate. If abuse or neglect is involved, staff should proceed as in the high-risk process. If there is no evidence of abuse, the parents should still be called to come in. They should be encouraged to take their child for an immediate evaluation.

d. Follow-Up: It is important to document all actions taken. The crisis team may meet after the incident to go over the situation. Friends of the student should be given some limited information about what has transpired. Designated staff should follow up with the student and parents to determine whether the student is receiving appropriate mental health services. Follow-up is crucial, because most suicides occur within three months of the beginning of improvement in depressive symptoms, when the youth has the energy to carry out plans conceived earlier. Regularly scheduled supportive counseling should be provided to teach the youth coping mechanisms for managing stress accompanying a life crisis, as well as day-to-day stress.

In a counseling situation, a contract can be an effective prevention technique. The suicidal adolescent can be made to sign a card which states that he or she agrees not to take the final step of suicide while interacting with the counselor.

Role of the teachers

Teachers play an especially important part in prevention, because they spend so much time with their students. Along with holding parent-teacher meetings to discuss teenage suicide prevention, teachers can form referral networks with mental health professionals. They can increase student awareness by introducing the topic in health classes.

Some schools have automatic expulsion policies for students who engage in illegal or violent behavior. It is important to remember that teens who are violent or abuse drugs may be at increased risk for suicide. If someone is expelled, the school should attempt to help the parents arrange immediate and possibly intensive psychiatric and behavioral interventions.

Role of the peers

Peers are crucial to suicide prevention. According to one survey, 93% of the students reported that they would turn to a friend before a teacher, parent or spiritual guide in a time of crisis. Peers can form student support groups and, once educated themselves, can train others to be peer counselors.

Adolescents often will try to support a suicidal friend by themselves. They may feel bound to secrecy, or feel that adults are not to be trusted, and this may delay needed treatment. Ideally, a teenage friend should listen to the suicidal youth in an empathic way, but then insist on getting the youth immediate adult and professional help.

Role of the parents

Parents need to be as open and as attentive as possible to their adolescent children's difficulties. The most effective suicide prevention technique parents can exercise is to maintain open lines of communication with their children. Sometimes teens hide their problems, not wanting to burden the people they love. It is extremely important to assure teens that they can share their troubles, and gain support in the process. Parents are encouraged to talk about suicide with their children, and to educate themselves by attending parent-teacher or parent-counselor education sessions and from nearby libraries or the internet. Once trained, parents can help to staff a crisis hotline in their community. Parents also need to be involved in the counseling process if a teen has suicidal tendencies. These activities may both alleviate parents' fears of the unknown and assure teenagers that their parents care.

Postvention

The rationale for school-based postvention/crisis intervention is that a timely response to a suicide is likely to reduce subsequent morbidity and mortality in fellow students, including suicidality, the onset and exacerbation of psychiatric disorders, and other symptoms related to pathological bereavement.

An attempted or completed suicide can have a powerful effect on the staff and on the other students. One study found an increased incidence of major depression and posttraumatic stress disorder 1.5 to 3 years after the suicide. There have been clusters of suicides in adolescents, and some feel that media sensationalization or idealized obituaries of the deceased may contribute to this phenomenon.

The school should have plans in place to deal with a suicide or other major crisis in the school community. The administration or the designated individual should try to get as much information as soon as possible. He or she should meet with teachers and staff to inform them of the suicide. The teachers or other staff should inform each class of students. It is important that all of the students hear the same thing. After they have been informed, they should have the

opportunity to talk about it. Those who wish should be excused to talk to crisis counselors. The school should have extra counselors available for students and staff who need to talk. Students who appear to be the most severely affected may need parental notification and outside mental health referrals. Rumor control is important. There should be a designated person to deal with the media. Refusing to talk to the media takes away the chance to influence what information will be in the news. One should remind the media reporters that sensational reporting has the potential for increasing a contagion effect. They should ask the media to be careful in how they report the incident. Media should avoid repeated or sensationalistic coverage. They should not provide enough details of the suicide method to create a "how to" description. They should try not to glorify the individual or present the suicidal behavior as a legitimate strategy for coping with difficult situations.

It is imperative for crisis interventions to be well planned and evaluated; otherwise, not only may they not help survivors, but they may potentially exacerbate problems through the induction of imitation.

COMMUNITY BASED PREVENTION PROGRAMS

Crisis centers and hotlines are based on the premise that suicide is often associated with a critical stress event, it is usually approached with ambivalence, and the wish to commit suicide is seen as a way to solve an immediate problem. Crisis centers and hotlines are designed to deal with the immediate crisis, and use the individual's ambivalence to convince them that there are other means of solving the problem other than suicide.

Restricting access to lethal means:

The underlying rationale for means restriction is that suicidal individuals are often impulsive, they may be ambivalent about killing themselves, and the risk period for suicide is transient. Restricting access to lethal methods during this period may prevent suicides. The following steps may be useful:

* Safe storage of guns
* Fences on bridges
* Restricting drugs/poisons
* Other restrictions on guns

Educating the media

This includes educating media professionals about contagion, in order to yield stories that minimize them, and encouraging the media's positive role in educating the public about risks for suicide and shaping attitudes about suicide.

YOUTH SUICIDE
BIBLIOGRAPHY

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The following two books are written by your instructor and contain a faith based perspective and biblical references. These are available on line or through bookstores. Both books are available in CD format as audio books.

What To Do When Words Get Ugly. Michael Sedler. Revell Books, 2016 (edited/revised edition). Examines the topic of gossip and how it impacts people. (Adult) www.bakerbooks.com 1-800-877-2665

When to Speak Up and When to Shut Up. Michael Sedler. Revell Books, 2006. Communication book discussing conflict and encouragement. (Adult) www.bakerbooks.com 1-800-877-2665 **(over 400,000 copies sold).**