SOS

Runaways and Teen Suicides: Coded Cries for Help

Training Manual for Suicide Prevention

Human Services Development Institute
Center for Research and Advanced Study
University of Southern Maine
Portland, Maine

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RUNAWAYS AND TEEN SUICIDES:

CODED CRIES FOR HELP

Training Manual for
Suicide Prevention

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Runaway Suicide Prevention Training

Leaders Guide

Contents

INTRODUCTION

Why This Training?

The Human Services Development Institute (HSDI) of the University of Southern Maine, with a grant funded by the Department of Health and Human Services, designed this training to strengthen the ability of staff of teen runaway shelters to identify and assess suicidal risk and intervene positively. This training was field-tested in four runaway shelters in Maine. Runaway shelters have been chosen as a focus for training because:

* Runaway shelters are natural points of contact with depressed youth attempting to gain help. Suicidal adolescents may make up to two-thirds of the runaway shelter population. In one study, up to 33 percent of females and 15 percent of males in shelters had previously attempted suicide, and another third of the females and a quarter of the males had thought about suicide and how they would commit it (Shaffer and Caton, 1984).

* Many of the issues and difficulties faced by the troubled adolescent are intensified in the teen who runs away from home. The act of running away brings to a head many of the difficulties experienced by the adolescent in crisis.

* Adolescents have difficulty in communicating their pain and distress (and have difficulty being understood), and frequently offer "coded messages" that require a special awareness on our part to recognize and understand. Running away can be one of these coded messages, and, if the message is not heard, can be a precursor to further self-destructive behavior.

* The background and issues of the teen who runs from home are similar to those of the teen who attempts or commits suicide.

This twelve-hour training will provide a common base of knowledge and skills to runaway shelter staff for understanding the depressed or suicidal adolescent, recognizing clues and coded messages that indicate a potential for suicide, assessing the level of suicidal risk, and intervening appropriately.

The Runaway Suicide Prevention Training uses presentation/lecture material, participatory exercises, audio-visual aids and handouts. The training is divided into six sessions, each of which may be delivered in two hours. Session III runs 45 minutes over the two hours if you choose to incorporate the training videotape, "SOS... Runaways and Teen Suicides: Coded Cries for Help."

In development and initial delivery of the training, HSDI found it most effective to hold the sessions as close together in time as possible. Weekly or bi-weekly two-hour sessions are suggested. While some material may be deleted if adequate time is a problem, the training is designed to provide a comprehensive understanding of adolescent suicide with the material and skills presented in sequence.

This manual is designed to assist the in-house or professional staff trainer in delivering effective training in recognition and prevention of self-destructive or suicidal behavior among adolescents. The material in the manual is presented with the adult learner in mind, recognizing that the most effective model for adult learning involves participation, identification and attention to individual needs, and ample opportunity to apply the course material to personal needs.

Goals of the Runaway Suicide Prevention Training

Following this training, runaway shelter staff should be able to:

* Identify the signs of adolescent depression and suicidal ideation.

* Understand an adolescent's concept of death, and the messages being communicated by self-destructive or suicidal behavior.

* Recognize and follow up on suicidal clues and "coded messages."

* Identify the components of suicidal risk, and gather this information from an adolescent in an interview.

* Determine level of suicidal risk, and use skills to intervene appropriately.

This training also addresses certain values among runaway shelter staff that are essential to working effectively with the suicidal teen. These include:

* The belief that suicidal adolescents are ambivalent about dying, that there is a part of them that does not want to die which needs to be validated and supported.

* The belief that self-destructive or suicidal behavior is never an appropriate solution to a teen's distress.

* The understanding that self-destructive or suicidal behavior should be dealt with directly and immediately when clues or messages are detected.

* The confidence that individual staff (and staff working as a team) can make a difference in preventing suicidal behavior of youth at runaway shelters.

* The understanding that taking care of one's self (through self-awareness and team support) is a crucial component in staff effectiveness.

Preparing Course Materials and Yourself

This section will help you, the trainer, in preparation and delivery of the Runaway Suicide Prevention Training.

* **Be sure of a firm commitment of time and schedule for the training.** Try not to spread the training sessions too far apart. Holding the training during regularly scheduled staff meetings may interfere with normal staff business; it is best to have a separate time scheduled for training.

* **Have your materials together for each training session.** Materials required are listed at the beginning of each session. This manual contains master copies of handouts, models for newsprint illustrations, case studies, and role play scripts. In addition, it is strongly recommended that HSDI's video, "SOS... Runaways and Teen Suicides: Coded Cries for Help," be incorporated into the training. You will need:

    (1) newsprint paper and easel (flipchart), with marking pens;

    (2) a copying machine for preparation of handouts;

    (3) an audiotape player (Session II); and

    (4) (optional) a videotape player (Session IV).

* **Try to establish an environment conducive to training.** Such an environment would be a comfortable room with minimal distractions and sufficient space for staff to relax and not feel crowded. Some trainers like to provide coffee or a snack to encourage informality. Be sure that your materials are organized and equipment is functional. Set up and preview the audiotape and videotape.

* **Start on time.** Starting late puts you, the trainer, in a position where you feel pressured to condense or hurry the material. Some trainers like to schedule the session ten to fifteen minutes before actual training starts, to allow people to mingle, grab a snack, or ask questions. This extra time helps to put people "on task." Each session has 15-20 minutes at the end for discussion, which can be shortened if other parts of the session go overtime.

* **Familiarize yourself with the training content.** Read over the entire training manual before beginning the training, and identify any sections with which you may have difficulty. Review each session's material before delivery. Each session offers supportive background material with information cited to references in the bibliography if you are interested in gaining more information.

* **Be aware of your role as a trainer.** While you need to be familiar with your material, you do not have to be an "expert" or present yourself as one, although the more comfortable you are with your material (including knowledge, interest, and motivation) the more effective you will be. A trainer of adults acts more as a "sharer" of information than a "deliverer" of information. Your role is most likely to be that of a facilitator--organizing, summarizing, directing discussion, and being aware of and addressing the needs of your individual learners.

* **Keep the sessions on task.** Each section of the sessions has a suggested length. Although there is certainly room for flexibility, use the time designations as a guide to work through the material. Allow time for open discussion to fit personal needs, but keep discussions on task. Share the schedule with participants so sticking to it can be a cooperative effort.

A. SESSION ONE
INTRODUCTION TO ADOLESCENT SUICIDE

CONTENT: (Suggested number of minutes for each step is included in parentheses.)

1. Introduction (15)
2. Adolescence--Reflecting on Changes (A Guided Exercise) (10)
3. Conceptions and Misconceptions about Suicide (30)
   -Break- (10)
4. The Scope of Adolescent Suicide (15)
5. Runaways and Suicide Potential (20)
6. Discussion and Preview Next Session (20)

CONTEXT:

In this first session we will begin to look at adolescent suicide. We will reflect on the stress we faced in our own adolescence, examine our values about suicide, and look at the epidemic of adolescent suicide and why runaways are at high risk.

1. INTRODUCTION

PURPOSE:

* To welcome participants.
* To introduce trainer and goals of training.
* To introduce schedule and content of this session.
* To allow participants to introduce themselves and discuss briefly their experience and needs.

MATERIALS:

* Handout: "Training Outline"
* Training schedule (prepared by trainer)
* Flipchart (and markers) showing content and schedule of this session

FORMAT:

* Introduction and discussion (15 minutes)

SEQUENCE:

1. Transition: In this six-session training on suicide prevention we will take an in-depth look at why suicide is a problem for residents in runaway shelters. We will begin to strengthen our skills to handle this problem.

2. Review the goals of the Runaway Suicide Prevention Training (found on Page 2).

3. Pass out and review training outline and schedule.

4. Have participants introduce themselves individually and discuss briefly their experience and needs.

5. Review the content and schedule of this session.

2. ADOLESCENCE--REFLECTING ON CHANGES

PURPOSE:

* To encourage staff to reflect on how their personal lives, and those of some of their shelter residents, were affected by the many changes that happen to an adolescent. To realize that adolescence is a stressful period for even the most "well adjusted" individuals.

MATERIALS:

* None

FORMAT:

* Guided experience (10 minutes)

SEQUENCE:

1. Ask the participants to relax, close their eyes, and think back to their own adolescence when they were going through many stressful changes. Help them to visualize this time by suggesting that they focus on where they live, how old their brothers and sisters are, who their best friends are, and what they are studying in school. Then ask them to focus on their changes in the four major areas of development (social, emotional, physical and cognitive). Ask what changes or events seemed to be the most stressful for them. Ask them to consider the coping skills they used to get through this period.

2. Now ask participants to think of a particular shelter resident. Focus on the changes this resident is experiencing, mentioning the developmental areas individually and identify skills the resident has to cope with these changes.

3. Ask participants if they would like to share some of their experiences, and guide any discussion toward how they coped with these changes. (Since this is very personal information, listen with support, and if no one wishes to share, that's OK.)

4. Summarize: It is important for us to reflect on our own adolescence so we can get in touch with the stress of that period and understand the challenges our residents must face. We all used coping mechanisms to help us live through this difficult period. As we continue through the training, we will learn how the lack of coping mechanisms increases the risk for suicide.

3. CONCEPTIONS AND MISCONCEPTIONS ABOUT SUICIDE

PURPOSE:

* To encourage staff to explore their own beliefs and values about suicide.
* To expose some common myths about suicide.
* To help staff understand that their personal beliefs and values influence their ability to counsel a suicidal resident.

MATERIALS

* Flip Chart - Copy answer guide onto flipchart.
* Handout - "Conceptions and Misconceptions About Suicide, Exercise Sheet."
* Handout - "Conceptions and Misconceptions About Suicide."

FORMAT:

* Transition, exercise and discussion (30 minutes).

SEQUENCE:

1. Explain to participants the purpose of the exercise: It is an exploration of personal beliefs and values about suicide. Our beliefs and values are not "right or wrong," but this exercise may point out that certain myths may interfere with our efforts to deal constructively with a potentially suicidal resident.

2. Provide all participants with "Conceptions and Misconceptions About Suicide Exercise Sheet." Instruct them to respond to the statements as they believe personally instead of using knowledge they may possess about the truth of the statement.

3. Read each statement, allowing time for participants to record their answers on the exercise sheet. Repeat a statement if requested. Do not allow discussion of what the statement "means;" rather ask participants to respond to what they interpret it to mean.

4. Provide participants with handout, "Conceptions and Misconceptions About Suicide." Allow time for them to compare their beliefs with the answers provided.

5. Discussion - Encourage participants to discuss any particular statements they found interesting, confusing, or difficult. Support and encourage discussion, but avoid a "right" or "wrong" orientation. If there is minimal discussion, focus on the statements that involve values, notably Numbers 1, 2, 4, 6, 8, 17, 19 and 20.

6. Summarize - Have a volunteer explain how values and beliefs can affect the ability to counsel.

- BREAK - (10 minutes)

4. THE SCOPE OF ADOLESCENT SUICIDE

PURPOSE:

* To increase awareness of the magnitude of the suicide epidemic.
* To point out the importance of the runaway shelter as a point of intervention.

MATERIALS:

* Leader's Support Material: "The Scope of Adolescent Suicide."
* Flip chart - Copy five charts as shown onto flipchart sheets prior to presentation.

FORMAT:

* Transition, chart presentation and discussion (15 minutes)

SEQUENCE:

1. With the aid of pre-prepared charts, conduct the presentation offered on the following pages.

2. Summarize: Although you may not witness much active suicidal behavior at your shelter, there is a good chance that many of your residents have some kind of suicidal ideas. This is why this training has been developed.

3. Discussion: Allow staff to react to the presentation. Encourage discussion on the incidence of suicidal risk at runaway shelters.

LEADER'S SUPPORT
THE SCOPE OF ADOLESCENT SUICIDE

Chart #1 - Leading Causes of Death

Suicide is the third leading cause of death for 15-to-24-year-olds nationwide (White, 1985). The first cause is accidents.

* Some researchers report that up to 50 percent of deaths reported as accidents are merely "uncounted teen suicides." These include drug overdoses, fatal automobile accidents, and related self-destructive eating and alcoholic disorders (Peck, 1981; Menninger, 1938; Blake, 1971; Tabachnick, 1973; Klagsburn, 1976).

* Sieden (1984) notes that "suicides tend to be under-recorded because of the social, legal, religious, and economic stigma that still attaches to self-destruction." The increased social stigma is an issue for parents who may think that their child's suicide indicates that they are bad parents.

* Some homicides can even be viewed as self-destructive behavior--a person may kill in an effort to be caught, for instance. Often suicide follows homicide.

Charts #2 and #3 - Incidence of Suicide

Keeping in mind that the number of suicides is under-reported, the National Institute of Mental Health (NIMH) reported early in 1985 that every 90 minutes an American teenager commits suicide. This adds up to 16 suicides each day (Stewart, 1985). NIMH also noted that every day more than 1,000 young people attempt to kill themselves, and during 1984, 6,000 succeeded. In the last two decades, the suicide rate among American adolescents has tripled (while the rate for the general public during the same period rose less than 20 percent).

* Broken down, these rates equate to one teen suicide attempt every one-and-a-half minutes nationally.

Chart #4 - The Rate of Suicide

The national rate is about 12 per 100,000 residents.

To compare your state's rate, supply information from the chart below.

* _____(state)'s rate averages _____ suicides per 100,000 young people each year.

* _____(state)'s rate is (higher/lower) than the national average. (Has this been the trend?)

* _____(state) was ranked _____th nationally.

States Ranked by Suicide Rates Per 100,000 Population (1983)

Rank	Rate	State	Rank	Rate	State
1	23.5	Nevada	26	12.0	South Dakota
2	20.3	Wyoming	27	11.9	Michigan
3	18.1	Colorado	28	11.9	Arkansas
4	17.7	New Mexico	29	11.7	Indiana
5	17.1	Montana	30	11.6	Alaska
6	16.8	Arizona	31	11.5	Maryland
7	16.1	Florida	32	11.4	New Hampshire
8	16.0	Idaho	33	11.4	Georgia
9	15.5	Oregon	34	11.3	Pennsylvania
10	14.4	California	35	11.2	Iowa
11	14.3	Washington	36	11.1	Ohio
12	14.1	Vermont	37	10.9	Delaware
13	13.9	Maine	38	10.8	Dist. of Columbia
14	13.7	Missouri	39	10.7	Minnesota
15	13.2	Oklahoma	40	10.7	Alabama
16	13.2	Louisiana	41	10.4	Rhode Island
17	13.1	Utah	42	10.1	South Carolina
18	13.0	Wisconsin	43	10.0	Illinois
19	13.0	Kentucky	44	9.8	North Dakota
20	12.9	Tennessee	45	9.8	Mississippi
21	12.9	Virginia	46	9.2	Hawaii
22	12.8	Texas	47	9.2	Massachusetts
23	12.8	West Virginia	48	9.2	Nebraska
24	12.3	North Carolina	49	8.3	Connecticut
25	12.2	Kansas	50	7.7	New York
	12.1	U.S.A.	51	7.6	New Jersey

(Miller, 1986)

Chart #5 - Suicide and Runaway Shelters

Up to two-thirds of runaway shelter residents may have some kind of suicidal ideas.

* Shaffer and Caton of Columbia University (1984) found in a survey of runaway shelters in New York City that 33 percent of the females and 15 percent of the males in shelters had previously attempted suicide. Further, another third of the females and almost a fourth of the males had thought about suicide and how they would commit it.

* Because runaway shelters serve as a unique channel in the human services system through which a large number of disturbed and depressed youths pass, they offer a focal point for research and intervention. Runaway shelters are natural points of contact with suicidal youth attempting to gain help.

5. RUNAWAYS AND SUICIDE POTENTIAL

PURPOSE:

* To explain why runaways in shelters are at a higher risk for suicide potential.

MATERIALS:

* Leader Support Guide: "Runaways and Suicide Potential"
* Handout: "Runaways and Suicide Potential"

FORMAT:

* Transition, presentation and discussion (20 minutes)

SEQUENCE:

1. Transition. There are several reasons why the runaway population has been identified as a focal point for recognition of suicidal ideation and staff interventions. As a group, let us look at the connection between runaways and suicide potential.

2. Pass out handouts: "Runaways and Suicide Potential."

3. Either have leader or group volunteer(s) read items. Stop after each paragraph and discuss: Has this been your experience? Can you think of residents who fit in this description?

4. Summarize: Have each participant share whether his or her perception of the number of residents at risk for suicide has changed as a result of this presentation and discussion.

LEADERS SUPPORT
RUNAWAYS AND SUICIDE POTENTIAL

* Many of the issues and difficulties faced by the troubled adolescent are intensified in the teen who runs away from home. The act of running away brings to a head many of the difficulties experienced by the adolescent in crisis. Both running away from home and suicidal behavior are coping mechanisms to escape from life's problems.

* Suicidal adolescents may make up to two-thirds of the runaway shelter population. Shaffer and Caton (1984) found that 33 percent of the girls and 15 percent of the boys in shelters had previously attempted suicide. Further, another third of the girls and almost a fourth of the boys had thought about suicide and how they would commit it. Runaway shelters are natural points of contact with suicidal youth attempting to gain help.

* Adolescents have difficulty in communicating their pain and distress (and have difficulty being understood), and frequently offer "coded messages" that require a special awareness on our part to recognize and understand. As stress increases, an adolescent with limited coping mechanisms may view his/her options as limited or non-existent--a "tunnel vision" forms in which running away or self-destructive behavior seem to be the only options. A message of distress communicated by running away, if not heard, may lead the teen to more drastic measures. Thus, we can view running away as a step in a progression toward limited options and self-destructive behavior.

* Many of the causes that contribute to running from home are similar to causes for self-destructive behavior. Profiles of the runaway and suicide attempter are similar in a number of respects. These include:

  Broken homes--The majority of runaways have suffered the loss of a parent. Suicidal adolescents also have typically experienced a real or perceived loss. Many have lost a parent through death or divorce.

  Physical or sexual abuse--This is frequently a characteristic of the runaway's family. Forty-two percent of suicide attempters also report some kind of physical violence in the family (Peck and Litman, 1975).

Conflict with parents--Sixty percent of runaways cite difficulty in communicating with parents (U.S. Dept. H.E.W., 1975). Most conflicts concern control and supervision, inability to express hostility, lack of acceptance, and scapegoating. Ninety percent of suicidal teens feel that their families don't understand them (Peck and Litman, 1975). Communication breakdown is a factor contributing to the progressing risk of suicide (Teicher, 1970; Jacobs, 1971).

Economic difficulties and family stresses--Stress on parents becomes an added stress for the teen who is already struggling to define his/her role, and feels some responsibility but little power to help. Frequently, the family lacks future orientation and provides neither direction nor role modeling. Hopelessness about the future was present in 90 percent of suicide attempters who eventually killed themselves (Beck, 1973).

Problems at school--Runaways generally have lower grades, difficulty interacting with teachers and peers, less involvement in the support system of extracurricular activities, and higher absenteeism. Up to 50 percent of adolescent suicide victims have learning disabilities (Peck, 1985).

* Social isolation and hopelessness are two factors which indicate high risk of suicide. Runaways, especially those who have become "systems kids," often feel that they have no control over their future. Decisions about their placement often are made without their input. This lack of control contributes to an overwhelming sense of hopelessness. Constant movement to various placements contributes to the runaway's social isolation. Runaways often find it difficult to develop a social support system, a lifeline that would support them through a suicidal crisis.

6. DISCUSSION AND PREVIEW NEXT SESSION

PURPOSE:

* To allow for feedback on Session One and further discussion.
* To point out what material is to be covered in the next session.

MATERIALS:

* None

FORMAT:

* Discussion (20 minutes)

SEQUENCE:

1. Allow participants to give feedback about the past session.
2. Use this time to finish any discussion brought up during the session.
3. Present content for next session as below. Encourage all to attend next session.

PROFILE OF THE SUICIDAL ADOLESCENT

Internal Factor - Adolescent Depression
The Suicidal Adolescent - Profile and Categories
External Factors Leading to Suicide
Suicide--The Intended Message
The Adolescent Concept of Death

SESSION ONE

CHARTS AND HANDOUTS

(in order of presentation)

EXERCISE GUIDE

Explore your own beliefs about suicide

Do you . . .

1 **SA** = Strongly Agree

2 **AS** = Agree Somewhat

3 **DS** = Disagree Somewhat

4 **SD** = Strongly Disagree

. . . with the statement?

CONCEPTIONS AND MISCONCEPTIONS ABOUT SUICIDE

EXERCISE SHEET

The purpose of this exercise is to explore your own beliefs about suicide. We would also hope to dispel some very common myths about suicide, as well as provide you with some initial information on the scope of the problem.

As the trainer reads each statement, please jot down whether you:

1. SA = Strongly Agree
2. AS = Agree Somewhat
3. DS = Disagree Somewhat
4. SD = Strongly Disagree

This sheet will be for your own use; your answers need not be shared with the rest of the group.

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

CONCEPTIONS AND MISCONCEPTIONS OF SUICIDE

The exercise you participated in was designed for you to examine your values on adolescent suicide. Below you will see which of the statements read to you were actually common myths about suicide.

1. Most teenagers who attempt to commit suicide really want to die.

   Not true. Most teens are very ambivalent about dying. Usually a suicide attempt is a desperate cry for help. To provide that help, we must try to tip the scales toward life.

2. Suicide can be an appropriate solution for ending the misery experienced by some adolescents.

   Of course there must be a better answer. Adolescents, especially those who are depressed, have difficulty believing they will survive adolescence. They often think their conflicts can never be resolved, see their problems as never-ending and their situation as hopeless. Teens do not view death as a permanent situation and may see suicide as a "temporary" solution. As caregivers we must show them that there is always a more appropriate solution than ending their lives.

3. Suicide is the third most frequent cause of death for 15-24 year olds nationwide.

   True. It ranks only behind accidents (many of which are considered to be unreported suicides) and homicides (many of which are considered to have suicidal intent). (White, 1985).

4. Nothing can be done to stop an adolescent from killing himself once he has decided to commit suicide.

   Not true. The "suicidal crisis" is usually brief, only lasting a few hours. If the adolescent is helped through this crisis he will be thankful to be alive.

5. The adolescent who fails at suicide the first time will eventually succeed.

   Not true. Most adolescents attempt suicide to call attention to the emotional pain they are suffering. If they receive the help for which they are asking, they have no need to attempt suicide again. Only one percent of all survivors of suicide attempts kill themselves within one year, and only ten percent within ten years. (Giffin & Felsenthal, 1983).

6. Talking about suicide with depressed teens may prompt them to kill themselves.

Not true. This is a very widely held myth. Actually, talking with teens directly about suicide has been found to be the most effective method of assessing and preventing suicide. It shows that you are willing to discuss the feelings most frightening to teens. They are relieved to discuss what has so obsessed them.

7. Suicides often occur out of the blue without any warning.

Not true. Eighty percent of suicidal adolescents have given warnings or threats before attempting suicide (Giffin & Felsenthal, 1983). This is why it is so important to be able to recognize the warning signs.

8. Adolescents who talk about killing themselves are looking for attention and are not serious about killing themselves. They should be ignored.

Not true. Teens who talk about killing themselves may be looking for attention, but such an act is a desperate cry for help. If we ignore this message, the teen might have to try something more drastic next time.

9. Two-thirds of adolescents in runaway shelters may be actively thinking about suicide.

True. Shaffer and Caton (1984) found this in their survey of runaway shelters in New York.

10. There is a certain type of adolescent who commits suicide--usually one who is from a poor family or mentally ill.

Not true. Suicide claims the lives of adolescents from all ethnic and financial backgrounds. These adolescents may be grossly unhappy but not necessarily mentally ill.

11. A first step in preventing suicide is to talk about it directly.

True. Discussing suicide openly is one of the most helpful things you can do. It shows that you are taking the person seriously and that you care and it relieves the teen of a very heavy burden.

12. When a depressed person begins to cheer up, the danger of suicide has passed.

Not true. A teen who "seems to be getting better" may in fact be very much at risk. The reason is that depression often dulls the ability to act. While in the depths of depression, the person may wish to die and may actually plan to end his life but lack the will power or energy to do it. As depression lifts, the ability and energy to act returns and suicide plans made earlier can now be carried out. Improvement in depression should not necessarily be interpreted as meaning that someone is totally out of danger (Lee & Ross).

13. Suicide runs in families, so you can't do much to prevent it.

Not true. Suicide is not hereditary. However, suicidal behavior can be modeled on a relative or close friend, so it is important that you help the adolescent learn that there is a better way of coping with problems than ending life.

14. Once a person tries to kill himself and fails, the excruciating pain and shame will keep him from trying again.

Not true. Without the proper help, a person may suffer more guilt about his feelings and actions than ever. The pain and shame of an unsuccessful attempt might lead to a fatal attempt. Once the barrier between thought and action is crossed, subsequent attempts are easier, if conditions that brought about the first attempt haven't improved.

15. People seeing a psychiatrist rarely commit suicide.

Not true. Don't assume that the person has divulged his suicidal feelings to the psychiatrist and is receiving proper attention. If the person seems suicidal you should take action; don't assume that he or she is under control.

16. Young people can't really commit suicide because they do not fully understand the meaning of death.

Not true. Although most teens can't understand the finality of death nor understand the lethal nature of their actions, it doesn't prevent their actions from being lethal. You don't have to comprehend death to die.

17. Adolescents who attempt suicide and immediately tell someone are just being manipulative.

True, they may be manipulative, but a suicide attempt is their method for expressing a cry for help. Take them seriously, as they are trying to let you know how serious their pain is. We need to help them learn more positive ways of getting attention.

18. Adolescent boys are more likely to commit suicide than adolescent girls.

True. Girls account for 90 percent of all adolescent suicide attempts, but boys account for 75 percent of completed suicides (Cantor, 1985).

19. Assessing suicidal risk is best left to mental health professionals.

Not true. Preliminary assessment can and should be effectively done at runaway shelters or wherever we recognize behavioral messages or cries for help. Waiting for an appointment with a mental health professional may waste crucial time.

20. Staff at runaway shelters can have a significant impact in preventing adolescent suicide.

True. You can make a difference by being a significant adult, seeing a youth at the point he/she enters service, being aware of a teen's behavior, accurately assessing suicidal risk, and helping with short-term interventions.

- Some material is drawn from Giffin & Felsenthal (1983).

LEADING CAUSES OF DEATH
for 15—24-year-olds in the United States

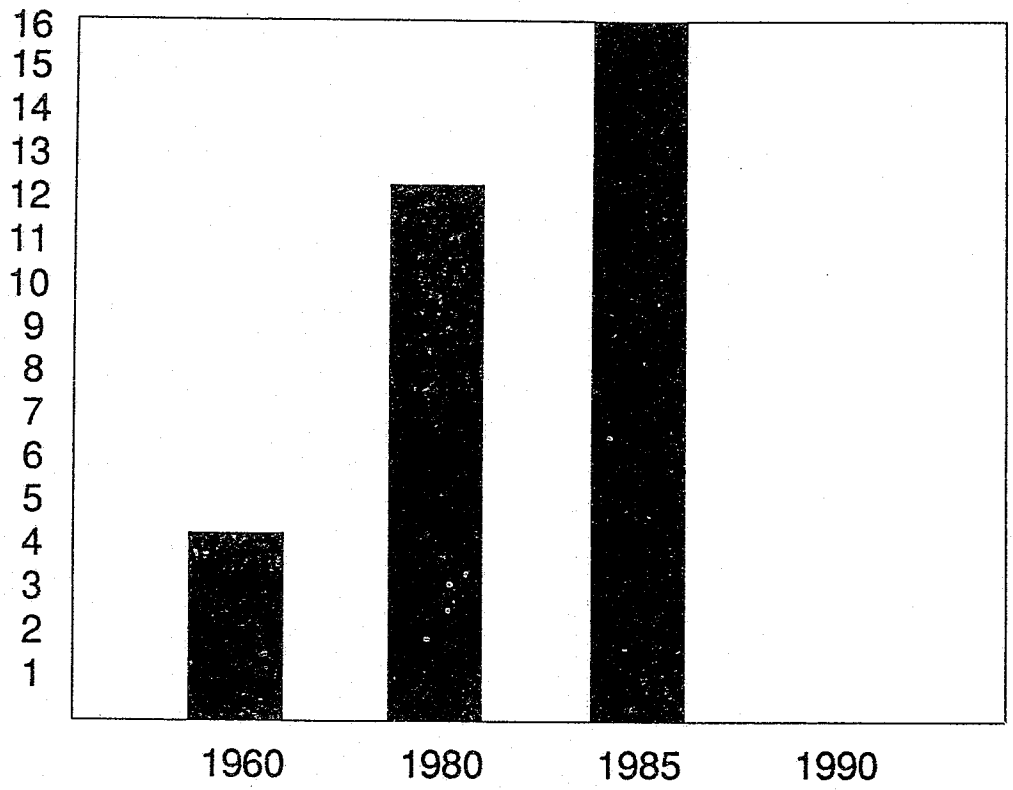
1 ACCIDENT

2 HOMICIDE

3 SUICIDE

50% of accidents may actually be uncounted teen suicides.

Every 90 minutes a teenager in the United States commits suicide.



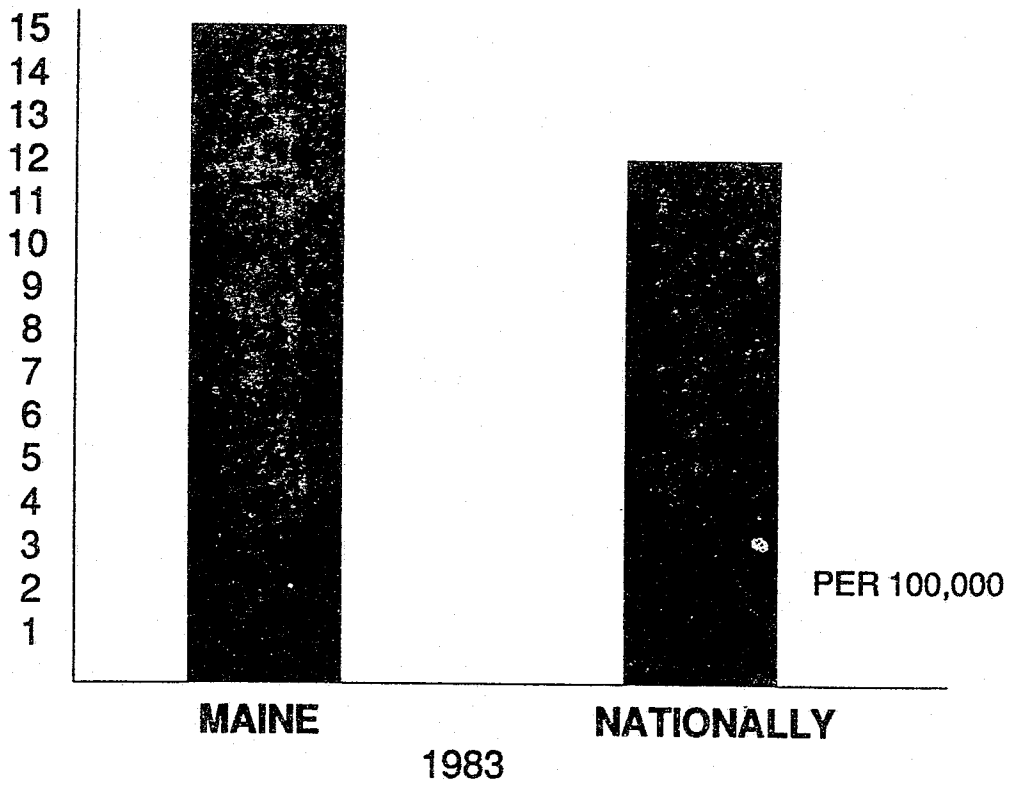
Number of Teenage Suicides a Day in United States

Every day at least 1,000 U.S. teenagers attempt suicide.

4 attempts every 5 minutes

These numbers only reflect reported suicides and attempts.

YEARLY RATE
for 15 — 24-year-olds



MAINE HAS BEEN RANKED 13TH NATIONALLY.

Runaway shelters are natural points of contact for youth attempting to get help.

1984 New York Study of Youth in Shelter

1/3 of the girls and 1/8 of the boys had previous suicide attempts.

Another 1/3 of the girls and 1/4 of the boys have contemplated suicide.

2/3 of runaways at shelter may be at high risk of suicide.

RUNAWAYS AND SUICIDE POTENTIAL

There are several reasons why the runaway population has been identified as a focal point for recognition of suicidal ideation and staff interventions:

* Many of the issues and difficulties faced by the troubled adolescent are intensified in the teen who runs away from home. The act of running away brings to a head many of the difficulties experienced by the adolescent in crisis. Both running away from home and suicidal behavior are coping mechanisms to escape from life's problems.

* Suicidal adolescents may make up to two-thirds of the runaway shelter population. Shaffer and Caton (1984) found that 33 percent of the girls and 15 percent of the boys in shelters had previously attempted suicide. Further, another third of the girls and almost a fourth of the boys had thought about suicide and how they would commit it. Runaway shelters are natural points of contact with suicidal youth attempting to gain help.

* Adolescents have difficulty in communicating their pain and distress (and have difficulty being understood), and frequently offer "coded messages" that require a special awareness on our part to recognize and understand. As stress increases, an adolescent with limited coping mechanisms may view his/her options as limited or non-existent--a "tunnel vision" forms in which running away or self-destructive behavior seem to be the only options. A message of distress communicated by running away, if not heard, may lead the teen to more drastic measures. Thus, we can view running away as a step in a progression toward limited options and self-destructive behavior.

* Many of the causes that contribute to running from home are similar to causes for self-destructive behavior. Profiles of the runaway and suicide attempter are similar in a number of respects. These include:

  Broken homes--The majority of runaways have suffered the loss of a parent. Suicidal adolescents also have typically experienced a real or perceived loss. Many have lost a parent through death or divorce.

Physical or sexual abuse--This is frequently a characteristic of the runaway's family. Forty-two percent of suicide attempters also report some kind of physical violence in the family (Peck and Litman, 1975).

Conflict with parents--Sixty percent of runaways cite difficulty in communicating with parents (U.S. Dept. H.E.W., 1975). Most conflicts concern control and supervision, inability to express hostility, lack of acceptance, and scapegoating. Ninety percent of suicidal teens feel that their families don't understand them (Peck and Litman, 1975). Communication breakdown is a factor contributing to the progressing risk of suicide (Teicher, 1970; Jacobs, 1971).

Economic difficulties and family stresses--Stress on parents becomes an added stress for the teen who is already struggling to define his/her role, and feels some responsibility but little power to help. Frequently, the family lacks future orientation and provides neither direction nor role modeling. Hopelessness about the future was present in 90 percent of suicide attempters who eventually killed themselves (Beck, 1973).

Problems at school--Runaways generally have lower grades, difficulty interacting with teachers and peers, less involvement in the support system of extracurricular activities, and higher absenteeism. Up to 50 percent of adolescent suicide victims have learning disabilities (Peck, 1985).

* Social isolation and hopelessness are two factors which indicate high risk of suicide. Runaways, especially those who have become "systems kids," often feel that they have no control over their future. Decisions about their placement often are made without their input. This lack of control contributes to an overwhelming sense of hopelessness. Constant movement to various placements contributes to the runaway's social isolation. Runaways often find it difficult to develop a social support system, a lifeline that would support them through a suicidal crisis.

B. SESSION TWO
PROFILE OF THE SUICIDAL ADOLESCENT

CONTENT:

1. Introduction and Review (10)
2. Internal Factor--Adolescent Depression (25)
3. The Suicidal Adolescent--Profile and Categories (20)
   -Break- (10)
4. External Factors Leading to Suicide (10)
5. Suicide--The Intended Message (10)
6. Adolescent Concept of Death (20)
7. Discussion and Preview Next Session (15)

CONTEXT:

In this second session we will take a more in-depth look at the suicidal adolescent. We will explore internal and external factors which can lead to suicide. We will also look at the adolescent's concept of death and the messages teens convey with suicidal behavior.

1. INTRODUCTION AND REVIEW

PURPOSE:

* To give participants an opportunity to discuss briefly any issues or questions brought up by last session.
* To summarize points of last session.
* To introduce content and schedule of this session.

MATERIALS:

* Flip chart and markers--write content and schedule of this session on chart.

FORMAT:

* Transition and discussion (10 minutes)

SEQUENCE:

1. Transition: During the last session we looked at the incidence of teen suicide nationally, statewide and at runaway shelters. We explored our own beliefs about suicide and reflected on our own adolescence.

2. Encourage participants to voice any issues or questions they had from the last session.

3. Request volunteer(s) to summarize key points of last session.

4. Preview the content and schedule of this session.

2. INTERNAL FACTOR -- ADOLESCENT DEPRESSION

PURPOSE:

* To understand the relationship between depression and teen suicide.
* To share some of the reasons why adolescents become depressed.
* To identify and be aware of some "classic" signs of depression.
* To define and recognize some signs of "masked" depression.

MATERIALS:

* Blackboard/chalk or flipchart/marker
* Leader's Support Material: "Signs of Depression" and "Causes of Depression"
* Handout: "Signs of Adolescent Depression"

FORMAT:

* Transition, small group discussion, whole group discussion/summary (25 minutes)

SEQUENCE:

1. Transition: Two-thirds of teenagers who commit suicide suffer from depression (Peck, 1975). We could describe many of the teens we see at the shelter as "depressed." Not all teens can come to us with a verbal message of "I'm depressed. Can you help me?" We need to be able to recognize the signs of teen depression so that we can respond when needed. If a depressed young person doesn't get help for his depression it is possible that he may become suicidal. The risk of suicide is 50 percent greater for people who are depressed (Rosenblatt, 1981).

2. Small group discussion (10 minutes):

   * Task: to identify as many signs of teen depression as time will allow. Have recorders list ideas. Encourage participants to brainstorm and draw from their own experiences.

   * Define small groups and begin.

   * At close of time, draw group together and have group recorders take turns reporting items on their lists. Encourage illustrations with personal experiences, or relate to current shelter residents. Supplement the list with signs listed in your Leader's Support "Signs of Depression."

   * NOTE: It is important to make a distinction between "classic" signs of depression, and "masked" depression. Many of the responses in your discussion will be "classic" signs; if a "masked" sign comes up, pause to make the distinction very clear. Refer to Leader's Support material.

3. Group discussion: Encourage group to explore causes of depression. Refer to Leader's Support "Causes of Depression," which covers developmental, physiological and environmental factors. Keep this discussion brief but touch on the three areas above.

4. Summary: Not everyone who is depressed feels suicidal, but most who are suicidal are also depressed. While temporary depression is normal for teens (as well as for older people), it is the more serious depression, or the ineffective way in which adolescents deal with their depression, that can lead to a greater suicidal risk.

   Regardless of the types of signs of depression a teen exhibits, the need for help is present. If the young person doesn't get help for his depression it is possible that he may become suicidal. Our contribution involves awareness of the signs of depression and availability as a listener, referral agent, and helper.

   Provide participants with "Signs of Adolescent Depression" handout.

LEADER'S SUPPORT

SIGNS OF DEPRESSION

Use this material to support discussion on Signs of Depression in Session Two.

"CLASSIC" SIGNS OF ADOLESCENT DEPRESSION INCLUDE:

* Changes in sleeping habits (either insomnia and early awakening or oversleeping), nightmares, "tired feeling"
* Loss of appetite and weight (5-10 pounds unplanned weight loss in a short period of time)--may be exhibited in some adolescents as eating disorders:
    * Anorexia nervosa usually strikes adolescent girls. Excessive dieting leads to starving themselves to death.
    * Bulimia involves binging and purging, and strikes young women who are extremely depressed.
* Sadness and withdrawal (crying spells, isolation)
* Lack of interest in activities previously enjoyed (as in dropping out of club or athletic activity at school)
* Apathy and fatigue ("I don't care" attitude)
* Social isolation (loss or lack of friends)
* Pessimistism, irritability.
* Loss of sexual interest
* Difficulty in carrying out routine tasks (problems with concentrating and a decline in grades at school)
* Sense of futility (hopelessness), pessimistism about the future, lack of a future orientation
* Feeling worthless (belief that is victimized by society)
* Feelings of guilt and self-blame (poor self-esteem)
* Somatic complaints (headaches, stomach aches, tightness around the head, constipation, inability to swallow food, etc.)

* Drug or alcohol dependence (even an increase in cigarette smoking)

* Anxiety and stress (may be agitated or restless)

* Fear of losing control, going crazy, harming self or others

* Suicidal thoughts (preoccupation with notion of death)

THE DISTINCTION BETWEEN "CLASSIC" AND "MASKED" DEPRESSION:

An adolescent may exhibit none of the classic signs of depression yet still be extremely depressed. It is very common in adolescence to "mask" depression. This is why it was thought for years that teens were never depressed. The clinical definition of depression is "anger turned inward." A teen who is angry (even unconsciously) at a significant other (usually parents), but feels guilty about this hostility or has no way to express it, often turns the hostility towards him/herself. Since adolescence is a time of intense guilt feelings, the adolescent may find the sense of depression intolerable, so he disguises it. Whereas depressed adults are sad, lethargic and immobilized by depression, teenagers may become reckless and aggressive. They use this "exciting" behavior to hide the deep pain they feel inside.

Parents and other adults frequently react to this type of "acting-out" behavior with anger and frustration, rather than understanding and willingness to help. These adolescents often are considered to be "beyond control" and unworkable. It certainly does not help that they are usually nonverbal, distrustful, hostile and uncommunicative to adults. But we must understand the reasons behind a teen's "acting out," and be ready to respond with what the teen really needs.

"MASKED" SIGNS OF ADOLESCENT DEPRESSION INCLUDE:

* Truancy

* Learning problems of psychic origin

* Sexual promiscuity

* Temper tantrums and hostile behavior

* Rebelliousness/defiance

* Running away from home

* Delinquent/antisocial acts (vandalism, fights, setting fires, etc.)

* Accident prone behavior (the teen who is constantly hurting him or herself may unconsciously want to do so.)

* Reckless behavior (driving too fast, taking drugs, etc.)

* Obsessive/compulsive rituals (the teen who needs to keep personal control by keeping the environment "in order.")

* Boredom and restlessness

* Somatic complaints (the person who complains often about physical problems that don't seem to exist, or who handles stress with an internal physical response)

LEADER'S SUPPORT

CAUSES OF DEPRESSION

Use the following factors to supplement staff contributions to produce a list of causes of depression. These most easily can be organized into developmental, physiological, and family/environmental factors.

DEVELOPMENTAL FACTORS:

* The "maturational crisis"
  - Adolescence is a period of great biochemical changes which can create depression.
  - In addition, the sheer magnitude of changes, stresses and pressures can add to the depression.
* Introspection intensifies.
  - Adolescents are supercritical of themselves; they may experience the "imaginary audience" (Elkind, 1981), which occurs when the egocentric adolescent believes that others are equally concerned with his/her appearance, feelings and thoughts.
* Guilt over sexuality
  - Experimentation with masturbation, homosexuality, sex play and intercourse creates feelings of guilt which can lead to depression.
* Mourning the loss of childhood
  - The teen who is striving for adulthood still has ambivalent feelings about leaving the security of childhood.
  - Cutting parental ties and turning to self and peers may cause self-doubt and depression.
* Loss of the ideal parent
  - With the ability to think abstractly, the teen can construct an image of an ideal parent. The reality can be devastating.

PHYSIOLOGICAL (MEDICAL) FACTORS:

* Depression may be the result of numerous chemical imbalances, including hypothyroidism, diabetes, nutritional imbalances, neurological impairment, manic-depressive illness and birth control pills (Gould, 1965).

  NOTE: A positive step when you recognize depression in a teen may be to refer the resident for a physical check-up. It is a good way of letting the resident know you care about his/her physical and mental health.

ENVIRONMENTAL FACTORS (INCLUDE FAMILIAL AND SOCIAL FACTORS):

* Environmental factors may lead to reactive depression which is triggered by an event or on-going problem in the adolescent's life. The types of reactive depression are:

  1. Acute--this usually occurs as a result of a major loss such as parental death, divorce, or an unexpected move (including a move to a runaway shelter!). Two key features of this depression are an excessive longing for the lost person or place, and the inability to utilize substitutes. Usually the young people who experience this type of depression had functioned well before the loss and generally improve quickly with the reappearance or provision of a caring person.

  2. Chronic--usually one or both of the young person's parents are also depressed. The young person who suffers from this form of depression may have been subjected to frequent separations from parents in the past. This could lead to feeling unappreciated or rejected.

  3. Masked depression (as discussed previously).

  (McConville, Boad, & Puromit, 1973)

* Family dysfunctions:

  - NOTE: Most often depression in an adolescent is an indicator that there is dysfunction in the family.

  - Alcoholism/drug addiction

  - Child physical, sexual, and emotional abuse or neglect

  - Poor family communication, resulting in emotional isolation or unreasonable parental expectations

3. THE SUICIDAL ADOLESCENT-- PROFILE AND CATEGORIES

PURPOSE:

* To identify background information about teens who attempt and commit suicide.

MATERIALS:

* Leader's Support Material: "Profile of the Suicidal Adolescent" and "Categories of Suicidal Adolescents"
* Flip chart: Copy following "Profile of Suicidal Adolescent" (2 pages) and "Categories of Suicide Adolescents"
* Handouts: "Profile of the Suicidal Adolescent," and "Categories of Suicidal Adolescents"

FORMAT:

* Transition, chart presentation, discussion (20 minutes).

SEQUENCE:

1. Transition: There is no "typical" suicidal adolescent--suicide strikes teens of different socio-economic, ethnic, and geographic backgrounds. Nor can suicide be "predicted" by looking at background factors—each teen is an individual, and reasons for suicide differ. However, profiles have been developed of teens who have attempted suicide. Understanding these profiles may help us to recognize others at risk and why some teens use suicide as a way of coping.

2. Chart presentation: Read each chart and supplement with information from your Leader's Support "Profile of the Suicidal Adolescent" and "Categories of Suicidal Adolescents."

3. Discussion. Encourage questions and discuss openly.

4. Summary. Profiles can help us understand the types of situations that can lead an adolescent to suicide. Profiles are not predictors of suicide. Please don't think that if an adolescent you think is suicidal doesn't fit neatly into a profile that he/she is out of danger.

- BREAK - (10 minutes)

PROFILE OF THE SUICIDAL ADOLESCENT

LEADER'S SUPPORT

This material supports the two charts on "Profile of the Suicidal Adolescent."

Although there is no "typical" suicidal adolescent, profiles have been constructed from data on reported attempts and suicides. It is difficult to predict suicidal behavior based on background. This is a profile, not a predictor of suicidal adolescents.

(This profile is drawn from Cantor (1985), Frederick (1976), and Gould (1965).

Chart #1: Suicide Profile (Female):

* Ninety percent (90%) of adolescent suicide attempters are female.

  Suggested explanations for this are that (1) suicide is less of a cultural taboo as a coping mechanism for females, (2) they have less outlet for aggression, and (3) females have less cultural permission to turn hostility outward and so they direct feelings inward.

* Typically has a self-centered mother.

  The typical suicidal female usually is very close to her mother.

* Typically has a weak or absent father.

  The father is absent, either physically or psychologically.

* Typically is very vulnerable to loss.

  The teen assumes a lot of responsibility for family problems, including divorce, and views herself as being abandoned.

* May turn to boyfriends as father substitutes.

  The boyfriend meets some of her needs for the absent father. An unusually dependent relationship develops and loss of such a relationship is devastating.

* Is able to give but not receive help.

Chart #1: Suicide Profile (Male):

* Seventy-five percent (75%) of completed suicides are boys.

  A possible explanation of this is that those who kill themselves are more disturbed. The male is more likely to complete the act because he can't bear to be seen as a coward.

  Also, males tend to have access to, and use, more lethal means to attempt suicide. (Most females use "passive" means such as drug overdoses, while boys use more "non-reversible" means, such as guns.)

* Typically is separated from father before age 16.

  This separation may be through divorce, death or emotional detachment.

* Where father is present, relationship is distant and inadequate.

* Typically feels unappreciated, as if efforts are not recognized.

  He tries to please, but his efforts aren't noticed. The oldest child, especially, feels responsibility for family problems, but has little power to resolve them.

* Typically feels rejected, anxious and neglected.

* Typically feels intense pressure to achieve.

Chart #2: Suicide Profile (Common):

* Is socially isolated, having few friends.

  May lose interest in friends.

* Has poor communication skills.

  These may show up with peers or with authority figures such as parents or teachers. A suicide attempt becomes a desperate means of communication.

* Is out of step with peers.

  Is "behind" socially or in other developmental ways.

* Is not involved with school activities.

  This teen does not participate in extracurricular activities, has poor supportive relationships with teachers and peers, and does not use school as a support network.

* Is on bad terms with family.

  Ninety percent of these teens report that their families don't understand them (Peck and Litman, 1975).

* Has experienced family disturbance.

  These disturbances may include divorce, death of parent, depressed or suicidal parent, alcoholism, drug abuse, or child abuse.

* Has poor self-esteem; is experiencing depression.

(This profile is drawn from Cantor (1985), Frederick (1976), and Gould (1965).

CATEGORIES OF SUICIDAL ADOLESCENTS
LEADER'S SUPPORT

Dr. Peck (1981, 1985) of the Suicide Prevention Center in Los Angeles has separated suicidal adolescents into six categories:

1. CRY FOR HELP - Suicide is used as a form of communication. This category is seen most often. The usual avenues for the expression of frustrated feelings become blocked. Lethalness of attempts is almost always low. This cry is often used to open emotional barriers.

2. THE LONER - Suicidal behavior may emerge at age 14-15 but often a suicide attempt does not occur until late teens. The teen is highly likely to be a white male. This adolescent is characterized by loneliness, isolation, lack of friends, and poor communication with parents and peers. The family is intact but parents interpret their child's problems as reflecting their own incompetence. This often results in their reacting defensively, by insisting that the teen is really not unhappy and has nothing to complain about. The teen learns to distrust his own feelings and ceases to talk to anyone about unhappy thoughts or feelings. Such teenagers become high risks for suicide.

3. LEARNING DISABLED - Up to 50 percent of adolescent suicide victims may have learning disabilities. These adolescents may suffer from loss of self-esteem or feel extremely frustrated. They may feel pressure from parents to be "normal," or experience a sense of hopelessness.

4. ACTING OUT DEPRESSION - This teen is often impulsive, hostile, and disruptive. These are signs of masked depression. These adolescents are likely to take drugs and alcohol, commit petty crimes, run away from home, and even become violent. They are likely to come from broken homes where inconsistency and substance abuse are common. The adolescent wants and needs help, but his hostile behavior (which is used to disguise his depressed feelings) turns others away. When the pain of depression can no longer be masked, a suicidal attempt is likely. This group is very familiar to runaway shelter staff.

5. CRISIS SUICIDE - This is a small category, less than 15 percent of suicidal adolescents. These teens have no history of emotional problems, have experienced normal development, and come from stable families. However, when faced with sudden traumatic change (e.g. loss of loved one, loss of academic or athletic status at school) these adolescents may go through drastic behavior changes and show classic depression symptoms.

6. PSYCHOTIC ADOLESCENTS - There is a small category of less than 10 percent of suicidal adolescents with mental illness. These adolescents have delusions or hallucinations and hear voices telling them to kill themselves. They often come from a one-parent home. Sometimes one or both of the adolescent's parents are also psychotic (and/or alcoholic). The psychosis may be hereditary or linked to a role model.

4. EXTERNAL FACTORS LEADING TO SUICIDE

PURPOSE:

* To explore factors leading to suicide that are external (environmental and familial) rather than internal (depression)

MATERIALS:

* Leader's Support Materials: "External Factors Leading to Suicide"
* Flip chart: "Factors Contributing to Suicide"
* Handout: "External Factors Contributing to Suicide"

FORMAT:

* Transition, chart presentation, discussion (10 minutes)

SEQUENCE:

1. Transition: While depression is a leading factor in adolescent suicide, a number of external factors increase stress, loneliness or despair. An adolescent who has difficulty coping with stress or communicating feelings is at increased risk for self-destructive or suicidal behavior.

2. Chart presentation: Read the chart and supplement with information from your Leader's Support "External Factors Leading to Suicide." Pass out handout.

3. Discussion: Encourage participants to provide examples of residents who have developed a sense of hopelessness due to external factors. Encourage participants to add to the list from their experience.

4. Summary: Remember, not every adolescent faced with these factors will be suicidal, but these factors do lead to feelings of loneliness, despair and depression. If adolescents are unable to form appropriate coping mechanisms or communicate their feelings, they have a greater risk of self-destructive or suicidal behavior.

LEADER'S SUPPORT

EXTERNAL FACTORS LEADING TO SUICIDE

FAMILY FACTORS

* Alienation from family as a support network
This leads to emotional isolation. The mother possibly did not bond well with the young child. Nearly two-thirds of suicide attempters report that they are on poor terms with their families (Peck and Litman, 1975). Often families give indirect "messages" to unruly and defiant adolescents that the family would be happier if the adolescent weren't around ("We'd be better off with one less mouth to feed").

* Divorce
This leaves the child feeling responsible, guilty and abandoned.

* Disturbed family structures
Forty-two percent of suicide attempters report physical violence in the family (Peck and Litman, 1975). Disturbances may also include alcoholism, drug abuse and poor patterns of interactive communication.

* Experience of loss
Loss is a leading indicator for suicidal behavior. This loss may include the death of a loved one (especially death of a parent when the child was young), loss of status/"face," loss of love (either real or perceived), or loss of health.

* Prior suicidal behavior in family, close friend, or peer
While suicidal behavior is not hereditary, prior suicide behavior of a loved one can serve as a "deadly role model." If a loved one has decided to cope with stress in this manner, suicide becomes a learned coping behavior.

ENVIRONMENTAL FACTORS

* Increased mobility
Families in today's society are constantly on the move. (The "average" family moves every three years.) This can lead to social isolation, as the adolescent is unable to establish a stable peer group.

* Greater sense of social turmoil
The modern adult world seems increasingly "crazy" to a teen, and the teen may fear being unable to cope with such a world.

* Changing value systems
An increasingly materialistic society conflicts with traditional family values, and the adolescent may be confused about goals or unable to develop them.

* Competition and pressure to succeed
The teen feels pressure to succeed from family, school and society. This ties in to the "hurried child" problem discussed earlier. This is especially difficult for a teen with an intense sense of responsibility.

* Complexity of social environment
This may lead to feelings of personal ineffectiveness and insignificance.

* Unemployment or underemployment
A sense of future orientation is most important for a teen. A limited employment picture takes away this future orientation, creates intense pressure to achieve, and is frustrating to an adolescent who is trying to establish a sense of identity and self-worth.

* Dangers of nuclear power
Many young children and teens think that they will not live to adulthood because of the inevitability of a nuclear war or accident. In light of this it is difficult to establish any future orientation.

* Violence in mass media
The level of violence reported or presented in newspapers or television give a message that violence (either outwardly or inwardly directed) is an acceptable way of coping with stress.

* The availability of guns
Guns are more available to adolescents than ever. Guns are an extremely lethal means of committing suicide, and remove the "ambivalence" for a teen who is balancing between life or death. A teen who attempts suicide with a gun has little chance of rescue or reversal.

* Threat of AIDS
As with the threat of nuclear war, many young people fear that death is inevitable at an early age, due to the epidemic of AIDS. This leaves them with little hope for the future.

5. SUICIDE--THE INTENDED MESSAGE

PURPOSE:

* To relate that most suicide attempts are meant to communicate a message to someone.
* To understand what these messages may be, and how to respond.

MATERIALS:

* "Leader's Support: "Suicide Messages"
* Flip chart: "Suicide Messages"
* Handout: "Suicide Messages"

FORMAT:

* Transition, chart presentation, discussion (10 minutes)

SEQUENCE:

1. Transition: Suicide almost always is intended to send a message to someone. It is a last desperate attempt to communicate. What is the message that the adolescent is trying to communicate through a suicide attempt?

2. Chart presentation: Read the chart and supplement with information from your Leader's Support "Suicide Messages." Pass out "Suicide Messages" handout.

3. Discussion: Encourage any questions and discuss openly. Encourage staff to illustrate with examples.

4. Summary: Some of these "messages" (internalized anger, attempting to manipulate, and distress signals) are also communicated (or attempted to be communicated) by running away from home. So, be aware of those adolescents who don't seem to have communicated their runaway message effectively enough, because a suicide attempt may be seen as the next step. If they don't get the attention or help they need by running away, they may feel forced to take more drastic measures.

LEADER'S SUPPORT

SUICIDE MESSAGES

Suicide almost always is intended to send a message to someone. It is a last desperate attempt to communicate. SOME OF THESE MESSAGES ARE ALSO COMMUNICATED BY RUNNING AWAY FROM HOME. Toolan (1968) puts these messages into five categories:

* ANGER AT ANOTHER, internalized in the form of guilt and depression

  Adolescents who have been abused may hate their parents so much they might want to kill them. This leads to enormous feelings of guilt. Such teens may fear they are unable to control their impulses so they turn the hate and hostility inward.

* ATTEMPTS TO MANIPULATE ANOTHER, to gain love, attention, or affection, or to punish

  This message is common to the adolescent who feels unappreciated and unloved by parents. The attempt will either call attention to the adolescent (parents will reassure the adolescent that he/she is loved), or the adolescent sends the message that the suicide attempt is the parents' "fault" and wants them to feel guilty.

* A SIGNAL OF DISTRESS, which is a desperate cry for help

  These adolescents are unable to communicate distress in any other way. Either they are unable to express anger and pain, or communication is blocked with parents who refuse to respond to emotional injuries. The teens inflict physical injuries on themselves to prove they are in pain.

* REACTIONS TO FEELINGS OF INNER DISINTEGRATION

  This applies to teens who are "losing it." In the face of losing control, self-destruction may appear to be the only way out. This more disturbed adolescent is searching for inner peace.

* DESIRE TO JOIN A DEAD RELATIVE OR LOVE OBJECT

  Many suicide attempts happen on the anniversary of a suicide by a relative or loved one. If someone a teen loved used suicide as a way of coping with problems, that person may serve as a "deadly role model." Joining with the powerful lost love object is an effort to gain support, strength and security.

6. THE ADOLESCENT CONCEPT OF DEATH

PURPOSE:

* To understand an adolescent's concept of death.
* To recognize that a teen suicide attempt does not reflect a fully thought-out decision to die.

MATERIALS:

* Leader's Support: "The Adolescent's Concept of Death"
* An audio tape of Elton John's "I Think I'm Gonna Kill Myself" and a tape player, or lyrics of song as a handout
* Flipchart: "Adolescent's Concept of Death"
* Handout: "The Adolescent Concept of Death"

FORMAT:

* Transition, audio tape, discussion, chart presentation (20 minutes)

SEQUENCE:

1. Transition: Adolescents who contemplate suicide are very ambivalent about dying. As we learned, their behavior is actually a drastic form of communication. One of the tragedies of teen suicide is that teens do not have the experience (or the outlook) that things get better, nor do they have a true concept of the finality of death or the irreversibility of suicide. One view of a teen's concept of death is presented in Elton John's song, "I Think I'm Gonna Kill Myself."

2. Audio Tape (or distribute handout if audio tape is not available):

   * Task: Listen for "messages" of suicide and for the teen's concept of death.

   * Play the tape.

3. Discussion:

   * Elicit feedback on what the singer's "message" of suicide seems to be. (The singer is sending a message of manipulation and anger.) Refer to material in Section 5.

   * Elicit feedback on the singer's concept of death. (He thinks he'll be around to see the results of his suicide—cause a scandal, read the headline news.)

   * Ask participants for other teen concepts of death. List their ideas on flipchart.

4. Chart presentation. Read the chart and supplement with information from your Leader's Support "The Adolescent's Concept of Death." Pass out handout "The Adolescent's Concept of Death."

5. Summary: The idea of suicide can exist in an adolescent's mind without being accompanied by any real desire for it. It is normal for adolescents to think about death. But if the adolescent's obsession with death is combined with other factors which lead to suicide, it is important to take heed.

THE ADOLESCENT'S CONCEPT OF DEATH

LEADER'S SUPPORT

It is important for us to understand the adolescent's concept of death to understand why suicide is often intended as a cry for help and not really an end to life.

In A Cry for Help, Dr. Giffin and Carol Felsenthal discuss certain notions that adolescent suicide attempters may have about death. Most often, death does not mean the "end" to them. Instead, it may mean:

1. REVENGE - Suicidal teens want to punish parents (or significant others) for wrongdoings they felt they suffered. An adolescent's view of death almost always includes the belief that after death he or she will remain behind, invisibly viewing the scene, relishing and gloating over the parents' grief. Typically, those adolescents who attempt suicide for revenge do so following an argument with parents.

2. THE ROMANCE OF SUICIDE - These adolescents share the hope that they would find in death the romance amd adulation that eluded them in life. They imagine themselves the talk of the school, and are seduced by the prospect of being the center of attention at long last. This may explain some "cluster suicides" (the phenomenon where one adolescent suicide is followed by a rash of adolescent suicides in the same area), especially when the school emphasizes the situation by scheduling a day off in memorium of the first suicide.

3. "INTIMATIONS OF IMMORTALITY" - Young people who commit suicide often lack a sense of their own mortality. To them, death is still a somewhat vague notion. This notion may fascinate them; it isn't uncommon for a teenager to become obsessed with thinking about death. Teenagers often have a sense of "personal fable" (Elkind, 1981), and view themselves as immortal. Suicide may be a means of testing these feelings of immortality. Unfortunately, for many young people it takes a serious suicide attempt to make them realize that they're not immortal.

4. END TO PAIN - Those who attempt suicide may be preoccupied with death, considering it a pleasant and temporary state. They see it as a way to end pain, to make their lives better.

5. The "NOW GENERATION" - Adolescents have a "right now" orientation. They have no sense of the future. Impatience and impulsiveness comes with the territory of adolescence. Teen suicides are characterized as much more impulsive that adult suicide. However, don't confuse an impulsive suicide with a spontaneous suicide. A fight with parents may send an impulsive teenager to the medicine cabinet to overdose on pills, but suicidal thoughts must have been present prior to the attempt. An adolescent, although impulsive, does not instantaneously transform from a non-suicidal person into a highly suicidal person (Miller, 1986).

Many teens think about death because: (1) they are just developing the ability to think abstractly and visualize the concept of death, (2) manipulating the idea of death helps teens to understand it, (3) understanding death helps teens to know themselves and master their own death impulses, and (4) having the power to end one's life is the ultimate power, especially to a person who has little.

Adolescents have to defend themselves against the anxiety that accompanies the uncertainty of death. By thinking that they may voluntarily bring death upon themselves, they are reassuring themselves against the uncertainty about when and how death will occur (Haim, 1974).

7. DISCUSSION AND PREVIEW NEXT SESSION

PURPOSE:

* To allow for feedback on Session Two and further discussion.
* To point out material to be covered in the next session.

MATERIALS:

* None

FORMAT:

* Discussion (15 minutes)

SEQUENCE:

1. Allow participants to give feedback about the past session.

2. Use this time to finish any discussion brought up during the session.

3. Present content for next session as below. Encourage all to attend next session.

ASSESSING SUICIDAL RISK

Stages of Suicidal Risk
Signs of Suicidal Risk
Video (optional)
"SOS... Runaways and Teen Suicides:
Coded Cries for Help"
Assessment of Suicidal Risk

SESSION TWO

CHARTS AND HANDOUTS

(in order of presentation)

SIGNS OF ADOLESCENT DEPRESSION

Adolescent depression can result from a number of developmental, physiological, and environmental factors that include:

* Maturational crisis
* Chemical imbalances
* Intensified introspection
* Imaginary audience
* Intensified sexuality
* Development of abstract thinking, ideals
* Family dysfunction
* Poor family communication
* Intense period of loss

Adolescents can experience the same classic signs of depression as adults. They include:

* Change in sleeping habits
* Change in eating habits
* Sadness and withdrawal
* Lack of investment in interests
* Apathy, fatigue
* Social isolation
* Pessimism, irritability
* Loss of sexual interest
* Inability to concentrate
* Hopelessness
* Helplessness
* Haplessness
* Poor self-esteem
* Drug or alcohol dependence
* Anxiety and stress
* Suicidal thoughts

An adolescent may not exhibit any of these classic symptoms of depression, yet still be extremely depressed. It is common for adolescents to "mask" depression. "Masked" depression occurs when depression, or "anger turned inward," is intolerable or unacceptable. To hide the true pain and intense sadness of depression, the teen disguises anger in other, more aggressive ways.

* Truancy
* Learning problems
* Sexual promiscuity
* Temper tantrums
* Hostile behavior
* Rebelliousness
* Defiance
* Running away
* Delinquency
* Accident-prone behavior
* Reckless behavior
* Obsessive/compulsive rituals
* Boredom, restlessness
* Somatic complaints

Our reactions to masked depression are frequently anger and frustration, and these reactions just add fuel to the fire of a teen who is already distrustful, hostile or uncommunicative. Regardless of the signs of depression an adolescent exhibits, the need for help is present.

PROFILE OF THE SUICIDAL ADOLESCENT

FEMALE

90% of adolescent suicide attempters
Has a self-centered mother
Weak or absent father
Vulnerable to loss/feels abandoned
Use boyfriend as father substitute
Able to give but not accept help

MALE

75% of completed suicides
Separated or distant from father
Feels unappreciated
Feels intense pressure to achieve
Feels anxious, rejected, and neglected

PROFILE OF THE SUICIDAL ADOLESCENT

OTHER COMMON FACTORS

Socially isolated

Out of step with peers

Not involved with school activities

On bad terms with family

Experienced family disturbance

Poor communication skills

Poor self-esteem/depressed

CATEGORIES OF SUICIDAL ADOLESCENTS

1 CRY FOR HELP

2 THE LONER

3 LEARNING DISABLED

4 ACTING OUT DEPRESSION

5 CRISIS SUICIDE

6 PSYCHOTIC ADOLESCENTS

PROFILE OF THE SUICIDAL ADOLESCENT

Although there is no "typical" suicidal adolescent, profiles have been constructed based on data from reported attempts and suicides. This is a profile, not a predictor, of suicidal adolescents.

Female:

* Ninety percent (90%) of adolescent suicide attempters are female.
* Typically has a self-centered mother.
* Typically has a weak or absent father.
* Typically is very vulnerable to loss.
* May turn to boyfriends as father substitutes.
* Is able to give, but not receive, help.

Male:

* Seventy-five percent (75%) of completed suicides are male.
* Typically is separated from father before age 16.
* Where father is present, relationship is distant and inadequate.
* Typically feels unappreciated, as if efforts are not recognized.
* Typically feels rejected, anxious, and neglected.

Common:

* Is socially isolated, having few friends.
* Has poor communication skills; suicide attempt is desperate means of communication.
* Is out of step with peers.
* Is not involved with school activities.
* Is on bad terms with family (90% think that families don't understand them).
* Has experienced family disturbance.
* Has poor self esteem; is experiencing depression.

- From Cantor (1985), Frederick (1976), Gould (1965), Peck and Litman (1975).

CATEGORIES OF SUICIDAL ADOLESCENTS

Dr. Peck (1981, 1985) of the Suicide Prevention Center in Los Angeles has separated suicidal adolescents into six categories:

1. CRY FOR HELP - Suicide is used as a form of communication. This category is seen most often. The usual avenues for the expression of frustrated feelings become blocked. Lethalness of attempts is almost always low. This cry is often used to open emotional barriers.

2. THE LONER - Suicidal behavior may emerge at age 14-15 but often a suicide attempt does not occur until late teens. The teen is highly likely to be a white male. This adolescent is characterized by loneliness, isolation, lack of friends, and poor communication with parents and peers. The family is intact but parents interpret their child's problems as reflecting their own incompetence. This often results in their reacting defensively, by insisting that the teen is really not unhappy and has nothing to complain about. The teen learns to distrust his own feelings and ceases to talk to anyone about unhappy thoughts or feelings. Such teenagers become high risks for suicide.

3. LEARNING DISABLED - Up to 50 percent of adolescent suicide victims may have learning disabilities. These adolescents may suffer from loss of self-esteem or feel extremely frustrated. They may feel pressure from parents to be "normal," or experience a sense of hopelessness.

4. ACTING OUT DEPRESSION - This teen is often impulsive, hostile, and disruptive. These are signs of masked depression. These adolescents are likely to take drugs and alcohol, commit petty crimes, run away from home, and even become violent. They are likely to come from broken homes where inconsistency and substance abuse are common. The adolescent wants and needs help, but his hostile behavior (which is used to disguise his depressed feelings) turns others away. When the pain of depression can no longer be masked, a suicidal attempt is likely. This group is very familiar to runaway shelter staff.

5. CRISIS SUICIDE - This is a small category, less than 15 percent of suicidal adolescents. These teens have no history of emotional problems, have experienced normal development, and come from stable families. However, when faced with sudden traumatic change (e.g. loss of loved one, loss of academic or athletic status at school) these adolescents may go through drastic behavior changes and show classic depression symptoms.

6. PSYCHOTIC ADOLESCENTS - There is a small category of less than 10 percent of suicidal adolescents with mental illness. These adolescents have delusions or hallucinations and hear voices telling them to kill themselves. They often come from a one-parent home. Sometimes one or both of the adolescent's parents are also psychotic (and/or alcoholic). The psychosis may be hereditary or linked to a role model.

FACTORS CONTRIBUTING TO SUICIDE

INTERNAL

- Depression
- Inner Disintegration
- Hopelessness

EXTERNAL

- Alienation From Family
- Divorce
- Disturbed Family Functioning
- Experience of Death/Loss
- Suicide in Family/Peer Group
- Increased Mobility
- Social Turmoil/Changing Values
- Competition/Pressure to Succeed
- Complexity of Social Environment
- Unemployment
- Nuclear Threat
- Violence in Mass Media
- Availability of Guns
- Threat of AIDS

EXTERNAL FACTORS CONTRIBUTING TO SUICIDE

While depression is a leading factor in adolescent suicide, a number of external factors increase stress, loneliness, or despair. An adolescent who has difficulty coping with stress or communicating feelings is at increased risk for self-destructive or suicidal behavior. Among the external factors that have been identified are:

Family:

* Alienation from family as a support network
* Divorce
* Disturbed family structure
* Experience of loss
* Prior suicidal behavior in family, close friend or peer

Environment:

* Increased mobility
* Greater sense of social turmoil
* Changing value system
* Competition and pressure to succeed
* Complexity of social environment
* Unemployment or underemployment
* The nuclear world
* Violence in mass media
* The availability of guns
* The threat of AIDS

SUICIDE MESSAGES

Internalized Anger

Signal of Distress

Manipulation

Inner Disintegration

Join Dead Relative

SUICIDE MESSAGES

Suicide almost always is intended to send a message to someone. It is a last desperate attempt to communicate. Some of these messages are also communicated by running away from home. Toolan (1968) puts these messages into five categories:

* Anger at another, which anger is internalized in the form of guilt and depression

* Attempts to manipulate another, to gain love or affection, or to punish

* A signal of distress, which is a desperate cry for help

* Reactions to feelings of inner disintegration

* Desire to join a dead relative or love object

"I Think I'm Going to Kill Myself"
Elton John and Bernie Taupin

Getting bored, being part of mankind
There's not a lot to do no more,
This race is a waste of time.
People rushing everywhere,
Swarming 'round like flies,
Think I'll buy a .44
Give them all a surprise.

Think I'm gonna kill myself
Cause a little suicide
Stick around for a couple of days
What a scandal if I die.

Ya, I'm gonna kill myself
Get a little headline news
I'd like to see what the papers say
On the state of teenage blues.

A riff in my family
I can't use the car
I gotta be in by ten o'clock
Who do they think they are?
I'll make an exception
If you want to save my life
Bridgette Bardot got to come
To see me every night.

I think I'm gonna kill myself
Cause a little suicide
Stick around for a couple of days
What a scandal if I die.

Ya, I'm gonna kill myself
Get a little headline news
I'd like to see what the papers say
On the state of teenage blues.

(from the album Honky Chateau
)

ADOLESCENT CONCEPT OF DEATH

Revenge

Romance of Suicide

Intimations of Immortality

Suicide Is Painless

The "Now Generation"

THE ADOLESCENT CONCEPT OF DEATH

Thinking about death is possible with the development of abstract thought. It is normal to consider death at this age, and even to be preoccupied with it. The teen can manipulate the concept of death to increase understanding, define and know himself, gain control of death impulses, and find limits to his own freedom. Intellectualization and obsession with death is a positive defense.

A teen's ambivalence about death can be complicated by an inability to conceptualize death as "the end." Several ways that a teen can distort his view of death include:

* Revenge - The teen is angry enough to punish someone with his/her death. The teen conceptualizes viewing the results of the revenge from "the other side."

* The Romance of Suicide - The teen hopes to find some of the excitement and adventure not present in life, and sees him/herself as the center of attention when gone.

* "Intimations of Immortality" - The teen's egocentricity builds up to feelings of invincibility and immortality. Suicide is an attempt to test that immortality.

* End to Pain - Death is seen as a temporary state that relieves the pain and stress of life.

* The "Now Generation" - This teen is impatient, impulsive, with no future orientation. He or she does not think of future states.

- Concept from Giffin and Felsenthal (1983).

C. SESSION THREE

ASSESSING SUICIDAL RISK

CONTENT:

1. Introduction and Review (10)
2. Stages of Suicidal Risk (20)
3. Signs of Suicidal Risk (20)
   -Break- (10)
- (Optional Video): "SOS... Runaways and Teen Suicides:
   Coded Cries for Help (30)
   With discussion (15)
4. Assessment of Suicidal Risk (45)
5. Discussion and Preview Next Session (15)

CONTEXT:

To intervene in a helping manner with a teen who is at suicidal risk, we must identify the level of risk and the nature and extent of a teen's crisis. In many respects, a caring and thorough assessment of risk is in fact an intervention, in that it shows caring and openness, provides a sense of control, and identifies resources that can later be mobilized.

1. INTRODUCTION AND REVIEW

PURPOSE:

* To give participants an opportunity to briefly discuss any issues or questions brought up during the last session.
* To summarize points of the last session.
* To introduce content and schedule of this session.

MATERIALS:

* Flip chart - Write schedule and content of this session on chart.

FORMAT:

* Transition, discussion (10 minutes).

SEQUENCE:

1. Encourage participants to voice any issues or questions they had from last session.
2. Request that volunteer summarize the major points of last session.
3. Preview the content and schedule of this session.

2. THE STAGES OF SUICIDE

PURPOSE:

* To relate that the cause of suicide goes beyond what appears to be the "immediate" cause, but involves a much longer background, and to identify the stages of this background.
* To relate that our assessment and interventions frequently must go beyond the "immediate" cause.

MATERIALS:

* Leader's Support Material for exercise "The Mountain Concept"
* Blackboard/chalk, or newsprint easel/marker (flipchart)
* Leader's Support - "Stages of Suicidal Risk"
* Handout - "Stages of Suicidal Risk"

FORMAT:

* Transition, exercise, presentation, discussion (20 minutes)

SEQUENCE:

1. Transition: If a teen tells us the reason he/she attempted suicide or is thinking about it, the reason may seem trivial to us as adults. A teen may say, "I failed my math test," and we know that that reason doesn't justify a suicidal response. This will point out that the real reasons for a suicide attempt extend well beyond that "final straw."

2. Exercise: "The Mountain Concept." Refer to Leader's Support material to guide this exercise. (10 minutes)

3. Presentation: Write chart "Stages of Suicide Risk" on flip chart or blackboard. Use Leader's Guide to describe the three stages leading to suicidal risk. Distribute handout.

4. Discussion: Encourage participants to discuss their reactions to the Mountain Concept exercise and the Stages of Suicidal Risk material.

5. Summary: Two points can be made about the exercise and presentation of the stages of suicide. First, adolescents do not become suicidal spontaneously or overnight. Rather, this is a long process, often starting early in childhood, and reflects a history of problems, communication breakdown, and isolation. Second, the "last straw," the precipitating event that occurs just prior to a suicide attempt, is not the "cause" of the attempt. In our assessments we must look for the full picture, the history which built up to this attempt.

LEADER'S SUPPORT

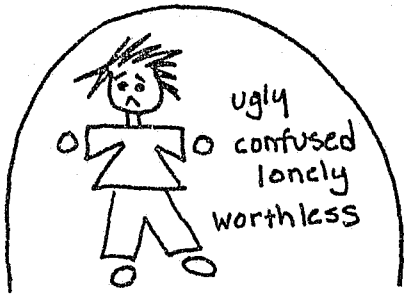
THE MOUNTAIN CONCEPT

Ask participants to engage in this activity to help them create a picture of how young people can become so burdened with painful feelings and problems that they become suicidal.

Mountain Concept Activity (Joan, 1986)
This activity requires a sheet of large paper or a flip chart. Each step adds "layers" to the mountain.

a. Start with drawing an unhappy stick figure of "Karen," our example teen.

b. Talk about how Karen is feeling. We don't know much about Karen's story, but we do know that she is experiencing unpleasant feelings.



c. What could have happened to Karen at home that might be hard for her to deal with or cause her to become unhappy? Divorce or loss of a parent is a usual response by group members, but any combination of painful possibilities can be used to build a mountain over Karen.

d. How might a divorce in the family make her feel? Possibilities include:

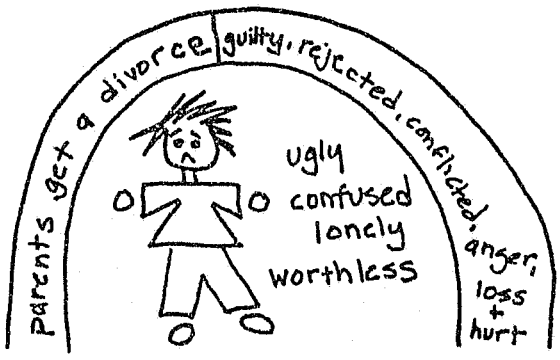
Guilty - Maybe if she'd done this or that, her parents might have stayed together.

Rejected - Maybe she's not very lovable because her dad (or mom) moved out.

Conflict-ridden - Who should she live with? If she chooses one parent will the other one be hurt? She doesn't want to hurt either of her parents.

Angry - This divorce is hard to talk about with either parent.

Loss and Hurt - She misses the way things were, or misses the parent who has left.

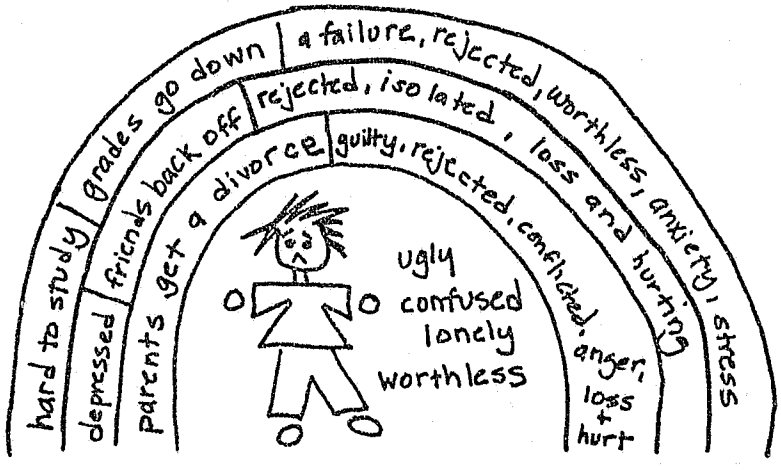


e. How might this situation at home affect Karen at school? One can't just shut the door when one leaves home in the morning and leave one's feelings at home, too. Karen may be feeling pretty depressed.

If Karen is depressed, is that likely to affect her relationships with her friends and peers? A person who is depressed is no fun to be around. Friends may back off and she may feel rejection, loss, and isolation at school as well as at home. Already many negative, painful feelings are piling up over Karen.

f. Is this situation likely to affect Karen's school work and grades? When one is depressed, it is extremely hard to study. It can be impossible to concentrate when many problems are on one's mind. Often teachers and other adults don't understand that the decline in grades is due to depression. They scold the youth for "not being responsible." This can increase the depression, leaving the person feeling worthless, like a failure.

The situation for Karen appears to be spiraling, with one problem piling onto another. She could begin to feel trapped, and unable to see a way out.



g. Let's suppose that the one thing Karen feels really positive about is being on the swim team. But since her grades have gone down, she is kicked off the swim team. This is the "last straw" event. Can you imagine the possibility that Karen might feel suicidal?

LEADER'S SUPPORT
STAGES OF SUICIDAL RISK

It is important to understand that an adolescent does not become suicidal spontaneously, but progresses through stages prior to the suicidal act (Teicher, 1970; Jacobs, 1971).

1. The Initial Phase. - This stage consists of a long-standing history of relatively minor emotional and behavioral problems, beginning early in childhood (e.g., bedwetting, truancy, or running away). There are usually numerous emotional separations for this child early in life. As the child grows older, problems tend to increase in severity, leading to a growing sense of discord in the family.

2. The Escalation Phase - This phase begins at the onset of adolescence. Adolescent development tends to accentuate earlier problems. The tasks for development are to establish an identity and to gain autonomy. Adolescents often achieve these through rebellion. In this phase, the adolescent's parents do not deal with his or her behavior. The adolescent may feel misunderstood and attempt to rebel or may run away from home. This action may lead to parents being enraged. They may become restrictive and try to punish the adolescent. The punishment only acts to increase the adolescent's acting-out behavior. The adolescent becomes more lonely and gloomy and feels isolated and alienated. At the same time that the parents are feeling frustrated because they can't understand or control their teen, the adolescent is feeling frustrated because he isn't understood. It is at this phase that the adolescent may begin to think of suicide as the only solution to problems.

3. The Final Precipitant Phase - At this phase the social relationship with parents has ceased. Communication with parents is blocked so the adolescent has no means of expressing his distress. He may also become alienated from friends, increasing his feelings of isolation. The adolescent may very much want to return to that time in his life when he was dependent on and cared for by his mother. Often what happens is the adolescent will form a relationship with another lonely young person. This relationship is one of extreme dependence and intensity, which the second young person is incapable of handling, so the relationship breaks off. It is the break-up that is the final straw. It is after this final precipitant that the attempted suicide is likely to occur. The final precipitant does not have to be the loss of a relationship. It may be the loss of a pet, expulsion from the swim team, a failing grade in school, or a final fight with parents.

Adults may not take suicide attempts very seriously because they think the precipitating factor was the full reason why the adolescent wanted to end his life. Adults may respond by pointing out that the final precipitant was not such a big deal ("there's other fish in the sea," or "there will be time to make up that grade"). We must keep in mind that the final precipitant is the last straw--the adolescent may have acted impulsively due to this last straw but the stage had already been set for suicidal behavior. If we can assess suicidal risk and intervene prior to phase III (the precipitating event) we may be able to save lives.

3. SIGNS OF SUICIDAL RISK

PURPOSE:

* To relate the importance of identifying signs and "coded messages."
* To identify the progression of signs of suicidal risk.

MATERIALS:

* Flip chart - copy chart "Signs of Suicidal Risk"
* Handout and Leader's Support - "Signs of Suicidal Risk"
* Video (optional) - "SOS... Runaways and Teen Suicide: Coded Cries for Help," and Leader's Support Guide for Videotape
* Appropriate video playback machine and monitor.

FORMAT:

* Transition, presentation/handout, discussion, summary (20 minutes)
* Optional video (30 minutes), discussion/summary (15 minutes)

SEQUENCE:

1. Transition: Our biggest challenge is being able to recognize the signs of suicide risk that a teen may send us. These clues may be verbal but, due to a teen's difficulty in talking with adults and the taboo topic of suicide, the clues are more likely to be behavioral or "coded messages."

   "Coded messages" are behavioral or verbal messages of which we need to be particularly aware. A teen may seem cryptic or tangential, and we must take the time to look past the words into the meaning of a message. Examples of coded messages are: "You'd be better off without me" or "You won't have to worry about me anymore."

   This handout breaks signs of suicidal risk into three levels: (1) General Distress Signals, (2) Specific Behavior Changes, and (3) Final Precipitants. The clues to suicidal risk follow a progression like the Stages of Suicidal Risk.

2. Pass out the handout, "Signs of Suicidal Risk," and illustrate with chart. Read the introduction aloud, then review each sign of risk. Encourage staff to discuss and provide examples from their experience.

3. Summary: Reinforce the idea that most young people, at some stage of their adolescence, will exhibit one or more of these danger signals, which may be part of normal growth. But if these danger signals persist for more than a month or if the adolescent exhibits several danger signs simultaneously, it is important to take control immediately. Taking control means doing a suicidal risk assessment.

- BREAK - (10 minutes)

4. (Optional) Video. "SOS... Runaways and Teen Suicides: Coded Cries for Help."

   Introduce video as a 30-minute docudrama. It is a story of an adolescent named David who killed himself. Interviews with those close to David reconstruct the last few months of his life.

   Before you start the tape, instruct participants that as they watch, they should jot down the clues to suicide evident to each of the people interviewed in the videotape. Have them put the clues in the three categories: General Distress Signals, Specific Behavior Changes, and Final Precipitants.

5. Show videotape (30 minutes).

6. Discussion: Use Leader's Guide for Videotape to support discussion. Have participants list signs. Write them on flipchart under the three categories. You can encourage participation by asking about each character in the video and which signs they may have seen.

7. Summary: As in most cases of suicide, David's story was one of progressing risk leading to the final act. There were signs all along the way. It is up to us to recognize these signs and intervene before the final precipitant, thus preventing suicide.

LEADER'S SUPPORT

SIGNS OF SUICIDAL RISK

Once we understand the progression of suicidal risk, it is important to be aware of specific clues. These signs of trouble can be broken down into three basic categories, general distress signals, specific behavior changes, and final precipitants.

1. General Distress Signals

These behaviors set the stage for trouble. The danger here is that parents and other adult caretakers become so accustomed to these traits that they accept them as normal rather than aberrant features of the adolescent's personality. Such forms of behavior would probably not in themselves trigger suicide, but they are the soil in which grow other problems that do lead directly to suicide. These general distress signals are behaviors with which shelter staff are quite familiar. They include:

a. Acts of aggression: Rebelliousness, hostile behavior, committing petty crimes, running away from home, fighting, sexual promiscuity, violence--behaviors that generate excitement and cover up painful, depressed feelings (masked depression).

b. Passive behavior: As opposed to those who act out their distress, many suicidal adolescents become withdrawn. These adolescents are afraid to get angry, fearing they might explode and perhaps hurt someone. Beneath their lifeless and compliant manner (depression) is enormous rage that seems best extinguished by thinking about suicide (anger turned inward).

c. Alcohol and drug abuse: Nearly half of the adolescents who commit suicide are drunk or high shortly before their deaths (Peck and Litman, 1975). Alcohol not only exacerbates depression but also affects judgement. It may temper the fear of death. Alcohol deepens aggression, which, when turned against oneself, often results in suicide.

d. Changes in eating habits: An abrupt change in eating habits is an early sign of trouble and of depression. It is characterized by a ten-pound weight change due to loss of appetite, or by eating disorders.

e. Changes in sleeping habits: The teen either sleeps too little or too much, but always feels fatigued.

2. Specific Behavior Changes

These behavior changes indicate loss of control. In this stage, the adolescent becomes preoccupied with thoughts of death.

a. Sudden changes in personality: The gregarious youth becomes withdrawn, or the normally reserved teen starts seeking thrills. The adolescent seems unable or unwilling to communicate.

b. Sudden mood swings: Moodiness is normal for adolescents, but "roller coaster" moodiness that continues over a long period of time should be taken as a warning. Also, watch for an inability to tolerate frustration and control impulses.

c. Slackening interest in school work and decline in grades: Because school is the major activity in a teen's life, it is also one of the best barometers of emotional health. The adolescent may show difficulty with concentration.

d. Loss or lack of friends: Pre-suicidal adolescents tend to be loners. Some young people, as they move closer to suicide, drop their friends or become so obnoxious that their friends drop them. Others never had friends to lose. Feelings of loneliness and isolation result.

3. Final Precipitants

These usually spell impending doom. At this point, the adolescent feels totally and relentlessly plagued by a sense of hopelessness, caring only about ending his life.

a. Loss of an important person or thing in the adolescent's life: This could be an intangible, like the loss of an ideal or self-esteem. Coupled with other problems, such losses can push a troubled teen into suicide.

b. An angry argument: This was found as the precipitant for 78 percent of suicide attempts in one study (Trautman, 1984).

c. Hopelessness: Beck (1973) found hopelessness present in 90% of suicide attempters who eventually killed themselves. This can be displayed in more than one way. Adolescents may become apathetic, losing interest in things that used to give them pleasure. They may lose interest in their appearance or be caught up in self-deprecation.

d. Hints of suicidal intent: The adolescent may start giving verbal hints about suicide either directly ("I might as well be dead") or indirectly ("You'd be better off without me"). Eighty percent of adolescent suicide victims have given warnings or threats before attempting suicide (Giffin and Felsenthal, 1983). The adolescent may become careless or accident-prone--possible conscious or unconscious behavioral hints of suicidal intent.

e. Attempts to secure the means: This indicates a high risk when the adolescent actually prepares for suicide.

f. The sudden lift of depression: The first three months following a depression is a critical time of suicidal risk.

g. Making a will: The adolescent may give away prized possessions, getting her or his affairs in order.

(From Giffin and Felsenthal, 1983.)

LEADER'S SUPPORT GUIDE FOR VIDEOTAPE
"SOS... Runaways and Teen Suicides: Coded Cries for Help"

Signals given by David that indicated he was potentially suicidal include:

General Distress Signals

* Running away from home
* Described as being depressed most of the time
* Drug and alcohol use
* Described as being very sensitive, and would escape into himself through meditation or drugs

Specific Behavior Changes

* Mood swings (very uneven)
* Began skipping more classes at school
* Communication break-down:
  - Unable to communicate with father
  - Unwilling to tell friends what was wrong
  - Unable to communicate his pain with his mother. She saw the pain in his eyes but turned away, and also was unwilling to talk to him about his statements about dying young

Final Precipitants

* Experienced many losses:
  - His grandfather died
  - His parents divorced
  - Recent break-up with girlfriend
* Gave away his record collection to his friend
* Became energetic and his depression lifted. "It was as if he had come to terms with something"--the decision to commit suicide.
* Gave a coded message about his intentions of suicide. He told his mother that he was going to die young.

4. ASSESSMENT OF SUICIDAL RISK

PURPOSE:

* To distinguish between imminent danger and potential risk of suicide, and why we need to do so.
* To identify the role of assessment in the process of suicide prevention and intervention.
* To identify guidelines to use in assessing suicide risk.

MATERIALS:

* Leader's Support: "Assessment of Risk (Introduction)," "Guidelines to Assessment," and "The Distressometer"
* Flipchart: Copy charts "Factors in Suicide Risk Assessment," "High-Risk Factors of Suicide," and "The S.L.A.P. Scale"
* Handouts: "Guidelines to Assessment," "The Distressometer," and "The S.L.A.P. Scale"

FORMAT:

* Transition, presentation/handout, discussion (45 minutes)

SEQUENCE:

1. Transition: When you recognize signs of suicidal risk, do something about it. The first step involves a thorough assessment of risk. Assessment is the first step of intervention. It is gathering essential information which will be used in your next steps of intervention.

2. Present points on assessment from Leader's Support "Assessment of Risk (Introduction)." These may be listed on the flipchart.

3. Present/discuss factors of risk assessment, as outlined in Leader's Support "Guidelines to Assessment." Distribute handout. Use charts "Factors in Suicide Risk Assessment," "High-Risk Factors of Suicide," and "The S.L.A.P. Scale." Integrate information from Leader's Support "The Distressometer" during the section of guidelines called "The Crisis."

4. Discussion: Encourage participants to react to the information presented. Do they find the guidelines useful? Are the levels of risk clear?

5. Summary: The most important point in assessing risk is to take every suicidal threat or hunch seriously. Even if you determine through your assessment that a resident is at low risk of suicidal behavior, it is important that he/she receive help and attention for his/her suicidal thoughts.

LEADER'S SUPPORT

ASSESSMENT OF RISK (INTRODUCTION)

Make these points to introduce a discussion of factors of risk assessment:

THE VALUE OF TALKING DIRECTLY

Sitting down to talk directly with a teenager about his/her suicidal thoughts indicates that you care and are willing to deal with a very difficult and personal topic. This can be a relief to a teen. IT IS A MYTH THAT TALKING DIRECTLY WITH A TEEN ABOUT SUICIDE WILL PUT THE IDEA IN A TEEN'S HEAD!

Discussing suicide openly shows that you are taking the person seriously and that you care.

IDENTIFY LEVEL OF RISK

Our intervention will be based on a teen's level of suicidal risk. IDENTIFYING THE LEVEL OF RISK IS FUNDAMENTAL TO OUR ASSESSMENT. A teen who is talking about suicide will require different action than one who is holding a razor blade at his/her wrist. We can identify risk and define our interventions in two categories:

* Potential Risk: At this level, a teen is showing signs of suicidal risk, and you may recognize in his/her behavior or history some factors that might put this teen at risk. You suspect that this teen has potential for suicide in the future.

* Imminent Danger: At this level, the teen is in crisis and may commit suicide if left unattended. This is an "emergency" situation.

WHEN TO DO AN ASSESSMENT

Some suicidal clues are common and "normal." But when you see a series of signs, or when a teen gives you "coded messages," it is best to initiate an assessment. TRUST YOUR INTUITION! Do the assessment right away; don't wait for the situation to become more grave. If there is no risk, you have certainly done no harm and have let the teen know that you are open for help if the situation arises.

Suicidal risk assessment should be done at intake or any time that you suspect a resident to have suicidal ideas. Intake is not too early to start assessing risk--in fact, it may put residents at ease to know that this is a place where they can discuss their feelings, pains and fears without judgment.

BE AN ACTIVE LISTENER

Treat all suicidal messages and coded messages seriously. Encourage the teen to give you information, and AVOID JUDGEMENTS. Teens feel guilty about having these "taboo" feelings, and judgments may make them feel more guilty or more entrenched in their intentions.

Establish trust and rapport with the resident. Part of the reason that adolescents are suicidal may be because they have no one with whom to share their thoughts and pain.

ASSESSMENT IS INTERVENTION

Although in this training we are considering assessment and intervention as separate steps, assessment is the first step in intervention.

* Assessment opens up a relationship around the content of suicide. Sometimes just having someone listen and care can reduce a teen's level of crisis.

* Assessment provides us with "building blocks" to help with our intervention. During assessment, we define coping mechanisms, personal resources, and sources of help for a teen that may be helpful in our intervention.

PRECAUTION

Although we are able to assess the level of suicidal risk (no risk, potential risk or imminent danger) it is impossible to predict a suicidal attempt.

Adolescents tend to be very impulsive. They do not plan suicides in advance as an adult might. Trautman, et al. (1984) found that although 52 percent of suicide attempters in his study talked about and gave warnings about their suicide, most did so one to six months prior to the attempt. The typical adolescent in this study did not plan the attempt more than fifteen minutes in advance, and none of the adolescents had planned their actions more than a day in advance. For this reason we must be aware that a resident we assess to be at "potential risk" could quite quickly slip into a suicidal crisis and become in "imminent danger" of an attempt.

A reminder--impulsive suicidal behavior is not spontaneous behavior. A final precipitant such as an angry argument can result in an impulsive suicidal attempt, but that adolescent had progressed through stages of risk to arrive at that point.

LEADER'S SUPPORT

ASSESSMENT OF RISK (INTRODUCTION)

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A reminder--impulsive suicidal behavior is not spontaneous behavior. A final precipitant such as an angry argument can result in an impulsive suicidal attempt, but that adolescent had progressed through stages of risk to arrive at that point.

LEADER'S SUPPORT

GUIDELINES TO ASSESSMENT

Use the following information to support your presentation of these assessment factors. When assessing, it is useful to have some guidelines to help us obtain valuable information and to control and guide the conversation (Hatton, Valente and Rink, 1977).

THE HAZARD

* The HAZARD is the precipitating incident.

* The hazard is most commonly an event such as a loss, anniversary, or threat of change (court date, family change, program change, change in social position).

* It is important to ascertain not only the event but the MEANING of the event to the resident. A precipitant may have little meaning or significance for us, but a lot for the teen.

* Ask this question: "What is it that has you feeling so badly today?" (Encourage participants to personalize their own ways of asking this question.)

THE CRISIS

* CRISIS is the level of feeling that a teen is experiencing.

* A major clue to the level of suicide risk is the severity of a resident's depression.

* What is the person feeling inside?

* How bad is this teen feeling? Has he/she ever felt this badly before? What helped him/her to feel better? (Note that this gives us some information for our intervention.)

* Is the resident feeling hopeless?

* Using the DISTRESSOMETER: The Distressometer is a tool which may be helpful with adolescents who have a difficult time verbalizing their pain or distress. Not all participants (and not all teens) will be comfortable using this tool. However, just presenting the tool helps the adolescent to relate visually to the intensity of his/her distress. Pass out the Distressometer and illustrate the directions on the reverse side.

* If participant or resident is uncomfortable using the Distressometer, identifying the level of feeling and possible ways of dealing with it must be incorporated into assessment in whatever manner is comfortable.

COPING STRATEGIES

* COPING STRATEGIES are ways that the resident has handled such problems or intensity of feeling in the past.

* Is the resident impulsive? Does he/she react to crisis in an impulsive manner, such as by running away?

* Has the resident faced similar crises in the past? How were they handled? Have these techniques been used for the current crisis? What does the resident think will reduce the level of stress?

* Does the resident use drugs or alcohol as a coping mechanism? Remember that, because this is not acceptable at the shelter, the resident may be left with no available coping mechanisms.

SIGNIFICANT OTHERS

* SIGNIFICANT OTHERS are people upon whom the resident relies in times of stress.

* Can the resident identify someone (real or imaginary) who might be helpful? It could be a pet, friend or relative.

* Identify and use these resources if feasible.

* Remember, a significant other may or may not be available, and in fact might be imaginary or fantasized. However, we can find clues for our intervention by identifying the nature of what might help the teen.

PAST ATTEMPTS

* PAST ATTEMPTS at suicide indicate high risk. Eighty percent of teens who eventually commit suicide have made past attempts (Den Houter, 1981).

* Has the resident made attempts before?
  - How serious? The more serious the attempt, the higher the risk.
  - How recently? The more recent the attempt, the higher the risk.
  - How often? A series of attempts, especially those with an increase in level of lethalness, put a teen at especially high risk.
  - Did the resident receive help following the attempt, or are the problems which led to the attempt still present?

PSYCHIATRIC HISTORY

* Assessing PSYCHIATRIC HISTORY lets us get a handle on possible helping resources: not only people, but what might have worked to relieve the teen's distress.

* What was the event that caused the involvement of psychiatric care? Was the resident hospitalized?

* Did the help that the resident received at that time work? What worked? What didn't work?

CURRENT PSYCHIATRIC CARE

* Is the teen receiving CURRENT PSYCHIATRIC CARE?

* What is it? Is it helpful?

* Identifying the nature of psychiatric care can, once again, give us resources for intervention.

* Don't assume that if a resident is receiving psychiatric care that he is not at risk for suicide. Oftentimes if the psychiatric relationship is not working, the resident will not let the therapist know of suicidal feelings.

LIFE STYLE

* Is there stability or success in the resident's LIFE STYLE?

* Do coping strategies fit life style?

* An unstable life style or inappropriate coping mechanisms increase the level of risk. For example, a resident who has changed placements several times recently may not have stayed anywhere long enough to establish relationships with potential significant others. This instability is part of the problem.

THE PLAN

* A suicide PLAN, especially a well-formulated, realistic plan, puts a resident at very high risk. It indicates a high level of intent to die.

* The S.L.A.P. Scale (Miller, 1986) helps to determine seriousness of risk by measuring several key elements of the plan.

* Pass out and review the S.L.A.P. Scale at this time.
(NOTE: The S.L.A.P. Scale is a tool, not a predictor.)

S = How specific are the details of the plan?

* The more specific the plan, the higher degree of risk.

* KEEP IN MIND THAT ADOLESCENTS ARE IMPULSIVE and may attempt suicide without first making a plan. The teen with a well-developed plan is at very high risk, but we cannot assume that a teen without a plan is without risk. It doesn't take much forethought to run out in front of a car.

* How intent is the adolescent on dying?

L = Level of lethalness of the proposed method.

* The more lethal, the greater the risk.

* Is the method reversible? Suicide by firearms is more lethal than taking pills because of the minimal level of reversibility.

* KEEP IN MIND that if the teen thinks that a method is lethal, even if it is not, the risk is high. If the resident plans to drink Windex and believes that Windex will kill him, he is at high risk.

* High-risk methods limit the ambivalence that goes along with suicide. An adolescent who doesn't understand the finality of death may choose to kill himself with a firearm, even if he doesn't really want to die.

A = The availability of the proposed method.

* The more readily available the method, the higher the degree of risk. The teen who possesses the means is at very high risk.

* KEEP IN MIND that it doesn't take long for a teen to find a means. While a teen who possesses the means is at high risk, lack of means does not assure that the teen is safe.

P = Proximity to helping resources.

* How close physically, geographically, and emotionally is the resident to others who could rescue him/her if necessary?

* The greater distance he/she is from those who could rescue him or her in an emergency, the greater the degree of risk.

* An adolescent who plans to take a gun out into the woods is at much higher risk than an adolescent who plans to take pills in the bathroom when a parent is at home.

HIGH RISK FACTORS - These factors put a teen at especially high risk:

* Multiple highly lethal attempts--The more lethal, recent, and/or frequent an attempt, the higher the risk.

* Alcohol or drug abuse--Alcohol and drugs, which may be used as coping mechanisms, can increase depression, lower inhibition and increase impulsiveness.

* Isolation/withdrawal--The withdrawn teen limits contacts that may help during a suicidal crisis.

* Disoriented or disorganized thinking--A teen who is having trouble with reality does not have a good sense of personal control and is at especially high risk.

* Impulsiveness--A teen who acts on impulse is at especially high risk. It is difficult to accurately assess risk for an impulsive teen.

* Hopelessness--Ninety percent of suicide attempters who eventually killed themselves had reported feelings of hopelessness, lack of alternatives, and no future orientation (Beck, 1973).

* Suicidal behavior modeled on family or peers--Suicide is not hereditary, but a teen may have seen a close relative or friend use suicide as a way of handling problems. It is a deadly role model.

IMMINENT DANGER vs. POTENTIAL RISK

Factors that are especially indicative of imminent danger:

* An extremely high level of CRISIS

* A history of PAST ATTEMPTS

* A lack of effective COPING STRATEGIES

* A well-developed PLAN

* Any of the HIGH RISK FACTORS

LEADER'S SUPPORT

THE DISTRESSOMETER

The DISTRESSOMETER may help assess the amount of CRISIS OR CURRENT EMOTIONAL LEVEL OF A TEEN. Frequently a teen will have difficulty talking about feelings or their intensity. At these times, we can help by offering a visual tool as a concrete way to express abstract thoughts.

NOTE: Using the DISTRESSOMETER may not be comfortable for all participants or teens. Participants should not be encouraged to use it if uncomfortable with it, or if they recognize that the teen is put off by it. It is important, however, to discuss some of the concepts that the DISTRESSOMETER illustrates.

The resident is presented with a drawing of a DISTRESSOMETER, a thermometer which is labeled with extremes of mood, with "Most Depressed" at the top and "Most Happy" at the bottom.

Use of the DISTRESSOMETER can:

* Help the resident to describe his/her current emotional state: "Where are you on the scale right now?" "Where were you when you were kicked out (or ran away)?"

* Provide a baseline, or a place to compare the level of current stress: "Where are you when you are having a 'normal' day?"

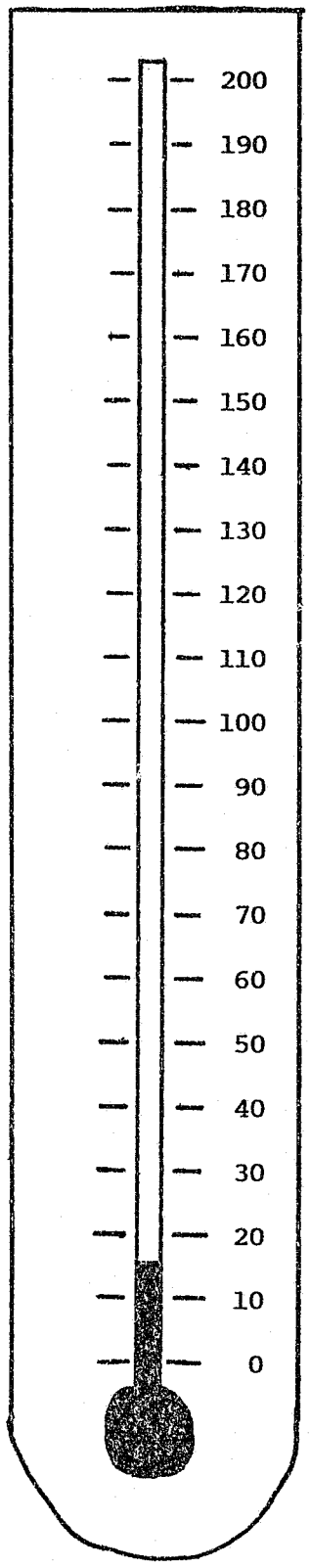
* Help to define coping strategies: "What kind of things can make your temperature go down?"

* Provide stressors, or patterns of stress: "What types of things happen that make your temperature rise?" or "How often does your temperature rise and fall in a 'normal' day?"

* Reassure a resident that things can get better: It can be pointed out that although the teen was high on the scale before, the temperature came back down.

The DISTRESSOMETER illustrates the importance of identifying the source and level of a resident's feelings, and of helping the resident to identify ways to deal with those feelings.

Visual Analog Scale (VAS)
(Aitken, 1974)



MOST DEPRESSED

MOST HAPPY

5. DISCUSSION AND PREVIEW NEXT SESSION

PURPOSE:

* To allow for feedback on Session Three and further discussion.

* To point out material to be covered in the next session.

MATERIALS:

* None

FORMAT:

* Discussion (15 minutes)

SEQUENCE:

1. Allow participants to give feedback about the past session.
2. Use this time to finish any discussions brought up during the session.
3. Present content for next session as below. Encourage all to attend next session.

ASSESSING SUICIDAL RISK - PRACTICE SESSION

Interview Questions--A Suggested Guide
Suicidal Risk Assessment Role Plays

SESSION THREE

CHARTS AND HANDOUTS

(in order of presentation)

STAGES OF SUICIDAL RISK

Initial Phase

Escalation Phase

Final Precipitant Phase

STAGES OF SUICIDAL RISK

It is important to understand that an adolescent does not become suicidal spontaneously, but progresses through stages prior to the suicidal act (Teicher, 1970; Jacobs, 1971).

1. The Initial Phase. - This stage consists of a long-standing history of relatively minor emotional and behavioral problems, beginning early in childhood (e.g., bedwetting, truancy, or running away). There are usually numerous emotional separations for this child early in life. As the child grows older, problems tend to increase in severity, leading to a growing sense of discord in the family.

2. The Escalation Phase - This phase begins at the onset of adolescence. Adolescent development tends to accentuate earlier problems. The tasks for development are to establish an identity and to gain autonomy. Adolescents often achieve these through rebellion. In this phase, the adolescent's parents do not deal with his or her behavior. The adolescent may feel misunderstood and attempt to rebel or may run away from home. This action may lead to parents being enraged. They may become restrictive and try to punish the adolescent. The punishment only acts to increase the adolescent's acting-out behavior. The adolescent becomes more lonely and gloomy and feels isolated and alienated. At the same time that the parents are feeling frustrated because they can't understand or control their teen, the adolescent is feeling frustrated because he isn't understood. It is at this phase that the adolescent may begin to think of suicide as the only solution to problems.

3. The Final Precipitant Phase - At this phase the social relationship with parents has ceased. Communication with parents is blocked so the adolescent has no means of expressing his distress. He may also become alienated from friends, increasing his feelings of isolation. The adolescent may very much want to return to that time in his life when he was dependent on and cared for by his mother. Often what happens is the adolescent will form a relationship with another lonely young person. This relationship is one of extreme dependence and intensity, which the second young person is incapable of handling, so the relationship breaks off. It is the break-up that is the final straw. It is after this final precipitant that the attempted suicide is likely to occur. The final precipitant does not have to be the loss of a relationship. It may be the loss of a pet, expulsion from the swim team, a failing grade in school, or a final fight with parents.

Adults may not take suicide attempts very seriously because they think the precipitating factor was the full reason why the adolescent wanted to end his life. Adults may respond by pointing out that the final precipitant was not such a big deal ("there's other fish in the sea," or "there will be time to make up that grade"). We must keep in mind that the final precipitant is the last straw--the adolescent may have acted impulsively due to this last straw but the stage had already been set for suicidal behavior. If we can assess suicidal risk and intervene prior to phase III (the precipitating event) we may be able to save lives.

SIGNS OF SUICIDAL RISK

GENERAL DISTRESS SIGNALS

- Acts of Aggression
- Passive Behavior
- Alcohol and Drug Abuse
- Changes in Eating/Sleeping Habits

SPECIFIC BEHAVIOR CHANGES

- Sudden Change in Personality
- Sudden Mood Swings
- Difficulty in Concentration
- Decline in School Performance
- Loss or Lack of Friends

FINAL PRECIPITANTS

- Loss of Someone/Thing Important
- Angry Argument
- Hopelessness
- Hints of Suicidal Intent/Securing Means
- Lift of Depression
- Making a Will

SIGNS OF SUICIDAL RISK

Once we understand the progression of suicidal risk, it is important to be aware of specific clues. These signs of trouble can be broken down into three basic categories, general distress signals, specific behavior changes, and final precipitants.

1. General Distress Signals

These behaviors set the stage for trouble. The danger here is that parents and other adult caretakers become so accustomed to these traits that they accept them as normal rather than aberrant features of the adolescent's personality. Such forms of behavior would probably not in themselves trigger suicide, but they are the soil in which grow other problems that do lead directly to suicide. These general distress signals are behaviors with which shelter staff are quite familiar. They include:

a. Acts of aggression: Rebelliousness, hostile behavior, committing petty crimes, running away from home, fighting, sexual promiscuity, violence--behaviors that generate excitement and cover up painful, depressed feelings (masked depression).

b. Passive behavior: As opposed to those who act out their distress, many suicidal adolescents become withdrawn. These adolescents are afraid to get angry, fearing they might explode and perhaps hurt someone. Beneath their lifeless and compliant manner (depression) is enormous rage that seems best extinguished by thinking about suicide (anger turned inward).

c. Alcohol and drug abuse: Nearly half of the adolescents who commit suicide are drunk or high shortly before their deaths (Peck and Litman, 1975). Alcohol not only exacerbates depression but also affects judgement. It may temper the fear of death. Alcohol deepens aggression, which, when turned against oneself, often results in suicide.

d. Changes in eating habits: An abrupt change in eating habits is an early sign of trouble and of depression. It is characterized by a ten-pound weight change due to loss of appetite, or by eating disorders.

e. Changes in sleeping habits: The teen either sleeps too little or too much, but always feels fatigued.

2. Specific Behavior Changes

These behavior changes indicate loss of control. In this stage, the adolescent becomes preoccupied with thoughts of death.

a. Sudden changes in personality: The gregarious youth becomes withdrawn, or the normally reserved teen starts seeking thrills. The adolescent seems unable or unwilling to communicate.

b. Sudden mood swings: Moodiness is normal for adolescents, but "roller coaster" moodiness that continues over a long period of time should be taken as a warning. Also, watch for an inability to tolerate frustration and control impulses.

c. Slackening interest in school work and decline in grades: Because school is the major activity in a teen's life, it is also one of the best barometers of emotional health. The adolescent may show difficulty with concentration.

d. Loss or lack of friends: Pre-suicidal adolescents tend to be loners. Some young people, as they move closer to suicide, drop their friends or become so obnoxious that their friends drop them. Others never had friends to lose. Feelings of loneliness and isolation result.

3. Final Precipitants

These usually spell impending doom. At this point, the adolescent feels totally and relentlessly plagued by a sense of hopelessness, caring only about ending his life.

a. Loss of an important person or thing in the adolescent's life: This could be an intangible, like the loss of an ideal or self-esteem. Coupled with other problems, such losses can push a troubled teen into suicide.

b. An angry argument: This was found as the precipitant for 78 percent of suicide attempts in one study (Trautman, 1984).

c. Hopelessness: Beck (1973) found hopelessness present in 90% of suicide attempters who eventually killed themselves. This can be displayed in more than one way. Adolescents may become apathetic, losing interest in things that used to give them pleasure. They may lose interest in their appearance or be caught up in self-deprecation.

d. Hints of suicidal intent: The adolescent may start giving verbal hints about suicide either directly ("I might as well be dead") or indirectly ("You'd be better off without me"). Eighty percent of adolescent suicide victims have given warnings or threats before attempting suicide (Giffin and Felsenthal, 1983). The adolescent may become careless or accident-prone--possible conscious or unconscious behavioral hints of suicidal intent.

e. Attempts to secure the means: This indicates a high risk when the adolescent actually prepares for suicide.

f. The sudden lift of depression: The first three months following a depression is a critical time of suicidal risk.

g. Making a will: The adolescent may give away prized possessions, getting her or his affairs in order.

(From Giffin and Felsenthal, 1983.)

FACTORS IN SUICIDE RISK ASSESSMENT

Hazard

* Crisis

* Coping Strategies

Significant Others

Psychiatric Care/History

Past Attempts

Life Style

* Plan

High-Risk Factors

*Assess Imminent Danger

THE SLAP SCALE

To Assess Suicidal Plan

S = How **Specific** are the details of the plan?

L = What is the level of **Lethality** of the means?

A = What is the **Availability** of the proposed method?

P = What is the **Proximity** to helping resources?

HIGH-RISK FACTORS OF SUICIDE

Multiple High Lethality Attempts

Alcohol or Drug Abuse

Isolation/Withdrawal

Disoriented/Disorganized Thinking

Impulsivity

Hopelessness

Modeled Suicidal Behavior

GUIDELINES TO ASSESSMENT

In addition to everyday awareness and communication, there are times when a more complete suicidal assessment is indicated. These times include: (1) when we recognize signs of imminent risk, (2) when we recognize a pattern to signs, (3) when final precipitants are observed, or (4) when our intuition tells us so.

When assessing, these guidelines help us to obtain valuable information and control and to direct the conversation.

* The Hazard

  Ascertain the precipitating event and the meaning of the event to the client.

* The Crisis

  Ascertain how badly the person is feeling (severity of depression or hopelessness).

  Ascertain level of anxiety and observe behavioral clues.

  If possible, direct energy more positively.

* Coping Strategies

  If the client has faced similar crises, how were they handled previously? Were these outcomes successful?

  Assess level of impulse control.

  Assess intensity of "tunnel vision"; does the teen envision alternatives or a future?

  What are the teen's resources to reduce stress?

  Is there drug or alcohol abuse (which increases impulsiveness)?

* Significant Others

  On whom would the client rely in bad times?

  Is there anyone, real or imaginary, who might help?

* Past Attempts

  Has the resident attempted suicide before?

  How recently?

  What was the outcome of the attempt?

* Psychiatric History--Current Psychiatric Care

  What was the event that caused the involvement of psychiatric care, and what was the meaning of the event?

  Was care received helpful?

* Life Style

  How much stability? How much success?

  Identify coping strategies that work.

* The Plan--The S.L.A.P. Scale

  S = Specificity (of plan)

  L = Lethal nature (of means)

  A = Availability (of means)

  P = Proximity (of helping resources

* High Risk Factors

  Multiple highly lethal attempts

  Alcohol or drug abuse

  Isolation/withdrawal

  Disoriented or disorganized thinking

  Decreased reality orientation

  Impulsiveness

  Hopelessness

  Suicidal behavior modeled on family or peers

Assessment areas from Hatton, Valente & Rink (1977).
S.L.A.P. Scale from Miller (1986).

THE DISTRESSOMETER

(Visual Analog Scale: Aitken, 1974)

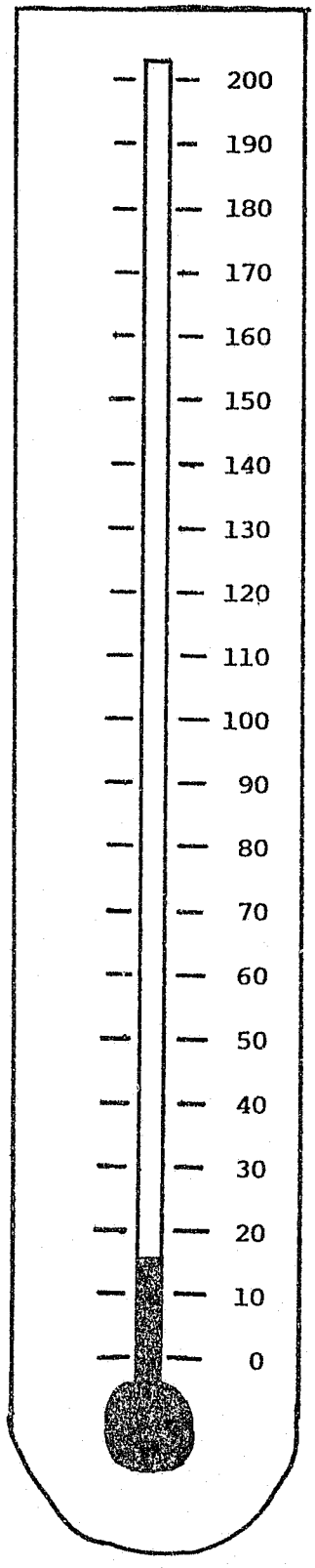
Sometimes it's hard to express in words how you feel. Maybe you could pinpoint on the thermometer how you are (were) feeling. Zero degrees is the temperature when you are feeling most happy. Two hundred degrees is when you are feeling most depressed.

Ask the resident to mark where on the thermometer he/she feels:

- when having a "normal" day
- when he/she ran away
- right now

You can continue to use the Distressometer as a tool to accompany such questions as:

- What types of things that happen in your life make your temperature rise?
- How often does your temperature rise and fall in a "normal" day?
- What things can make your temperature go down?
- How long has it been since you were at "normal" or "most happy"? What was happening in your life then?
- What was the highest temperature you ever had? What was happening in your life then?



MOST DEPRESSED

MOST HAPPY

THE S.L.A.P. SCALE

Development of a plan of suicide is a major indicator of the seriousness of suicidal ideas. A well-developed plan can be measured by the following factors, referred to as the S.L.A.P. Scale. This is not a foolproof method of assessing risk, but it can be a helpful tool.

S = How SPECIFIC are the details of the plan?

* The greater the specificity, the higher the risk.
* Adolescents may, however, be impulsive and act without a plan.

S = How LETHAL is the intended method?

* The more lethal, the higher the risk.
* How reversible are the means?
* How intent is the adolescent on dying?
* Adolescents, who have difficulty with the concept of the finality of death, may use a more lethal means than they intend.

A = What is the AVAILABILITY of the proposed method?

* The more available the means, the higher the risk.

P = What is the PROXIMITY to helping resources?

* The greater the distance from rescue, the higher the risk.
* Proximity is measured in physical, geographical, and emotional terms.

Developed by Miller (1986).

D. SESSION FOUR

ASSESSMENT OF SUICIDAL RISK--PRACTICE SESSION

CONTENT:

1. Introduction and Review (15)
2. Interview Questions--A Suggested Guide (15)
3. Guidelines for Role Plays (10)
   -Break- (10)
4. Suicide Risk Assessment Role Plays (60)
5. Discussion and Preview Next Session (10)

CONTEXT:

This unit stresses the skills involved in assessing suicidal risk. In many ways, this unit is a synthesis of what we have done so far. It allows participants to practice skills of suicide risk assessment with role plays, utilize counseling skills to identify depression and suicidal signs, and assess suicidal risk using guidelines from the last session.

1. INTRODUCTION AND REVIEW

PURPOSE:

* To give participants an opportunity to briefly discuss issues or questions brought up in the last session.
* To summarize points of the last session.
* To introduce the content and schedule of this session.

MATERIALS:

* Flipchart: Chart from Session Three, "Factors in Risk Assessment"
* Put schedule and content of this session on chart

FORMAT:

* Transition, discussion (15 minutes)

SEQUENCE:

1. Encourage participants to voice any questions or issues raised from last session.

2. Request volunteers to summarize major points of the Guideline to Assessment from last session. Use the flip chart "Factors in Risk Assessment" as a guide.

3. Introduce the content and schedule for this session: During the last session, we discussed the progression, signs or clues, and guidelines to assessment of suicidal risk. Today, we will practice these assessment skills in role plays.

2. INTERVIEW QUESTIONS -- A SUGGESTED GUIDE

PURPOSE:

* To provide a sample format of interview questions which guide a suicide risk assessment.
* To help participants begin to format their own questions to be used later in the Suicide Risk Assessment Role Plays.

MATERIALS:

* Leader's Support: "Sample Interview Questions"
* Handout: "Sample Interview Questions"
* Flip chart: From Session Three "Factors in Risk Assessment"

FORMAT:

* Transition, group participation (15 minutes)

SEQUENCE:

1. Transition: Today we are going to ask you to practice the assessment skills that we have presented. Suicide has long been a taboo subject. Even as counselors we may find it a difficult subject to discuss with residents. Our instinct is to avoid the uncomfortable. But, as we learned, talking to a resident about it directly is the most effective means of assessing risk. Practicing skills of assessment will help us to become more comfortable with this topic.

2. Pass out handout "Sample Interview Questions." Use your Leader's Support material to introduce the exercise.

3. Ask for volunteers, or go around participants in a circle. Have each question read out loud. As a group, discuss the factor in the Guidelines to Assessment that each question addresses. Use your Leader's Support material for answers. After reading each question and relating to the Guidelines for Assessment, have a volunteer suggest another way to phrase the same question, or an alternative way to gather the same information.

4. Summary: It is important to become more comfortable with the topic of suicide to be successful in an assessment interview. We have reviewed a series of sample questions, but you should phrase the questions in a manner that is most comfortable for you.

   NOTE: It is not recommended that a participant take the "Sample Interview Questions" into a real interview situation. This could lead to an uncomfortable and potentially cold interaction.

LEADER'S SUPPORT

SAMPLE INTERVIEW QUESTIONS

In addition to offering the teen a sense of relief and hope, the questions you ask will help you evaluate the seriousness of the suicide risk. Ask questions clearly and calmly. Following are some suggestions of questions to ask when assessing suicide risk, and some of the specifics to look for in your questioning. Phrase them however you feel most comfortable. It is difficult to be direct with a subject like this, but the more direct you are, the more the adolescent will feel that you are comfortable and confident with the topic. If you can be comfortable, he/she may feel it easier to talk with you. These questions can and should be asked at the time of intake or any time that you suspect a resident to have suicidal ideas. Intake is not too early to start assessing risk--in fact, it may put an adolescent at ease to know that this is a place where he/she can discuss feelings, pain, and fear without judgement.

Pass out handout. Relate questions to Guidelines to Assessment.

1. What is happening in your life right now that brings you to the shelter? (Relates to Hazard)

2. Have you been feeling depressed lately? (Crisis)

3. Do you ever feel that there is no hope in your life? (Crisis)

4. Have you ever wanted to die? (Crisis, Past Attempts, Psych History)

5. How many times? How frequent were the thoughts? How long did the thoughts last? (Past Attempts, Psych History)

6. Have you ever tried to kill yourself? (Past Attempts, High Risk Factors)

7. How did you do it? (Past Attempts, High Risk)

8. Why did it fail? Did you receive help? From whom? Was it beneficial? (Coping Strategies, Significant Others, Psych. History)

9. What was going on in your life then? (Crisis, Psych. History)

10. How did you learn to cope following the suicide attempt? (Coping Strategies, Significant Others, Psych. History)

11. Are you thinking about killing yourself right now? Would you tell me if you were? How often do you have these thoughts? How long do the thoughts last? (Crisis, Plan, Coping Strategies)

12. Did a specific event occur in your life that made you decide to act now? (Hazard, Lifestyle)

13. Do you have a plan? What is it? (Plan)

14. How would you do it? Do you have the means? (Plan)

Take the time here to assess how operational the attempt is. The risk of suicide is increased if the adolescent:

* has tried . . before,
* has serious thoughts about it,
* has a plan, and/or
* has the means.

Remember, the more specific the plan, the greater the risk. This doesn't mean that someone with only vague suicidal thoughts shouldn't be taken seriously. Adolescents are characterized by their impulsiveness. They may attempt suicide without giving much thought to planning or details.

Also, to assess emotional state, you can continue with questions like:

15. Is there any hope for the future? Next week? Next year? (Crisis, Coping Strategies, High Risk)

16. Do you have any thoughts about the future? Any way out of this? (Crisis, Coping Strategies)

17. Do you have anyone you can turn to for support? Are you seeing a therapist? Is it helping? (Coping Strategies, Significant Others, Current Psychiatric Care, High Risk)

These questions will help you determine how low the adolescent is feeling. The more hopeless the adolescent feels, the higher the risk.

It is also important to determine if the resident has had someone to model suicidal behavior after. He/she is at higher risk if someone in his/her family or peer group used suicide as a way out of pain. This makes it easier for the adolescent to justify suicide as a problem solver. You can ask:

18. Has anyone in your family every talked about killing themselves? Attempted it? Committed suicide? (High Risk)

19. Have any of your friends ever talked about killing themselves? Attempted it? Committed suicide? (High Risk)

3. GUIDELINES FOR ROLE PLAYS

PURPOSE:

* To set the stage for the practice session.
* To provide guidelines that set up the experience as "safe" and "supportive."

MATERIALS:

* Leader's Support "Guidelines for Role Plays"

FORMAT:

* Presentation and discussion (10 minutes)

SEQUENCE:

1. Transition: In this session we are going to practice suicidal risk assessments in a role play format. Our objective is to assess whether the resident is at risk, and to determine the level of risk (potential risk or imminent danger). While, in reality, assessment cannot be separated from intervention, we are practicing these skills separately to best utilize these concepts.

2. Define the process of role plays and rules for feedback using the Leader's Support "Guidelines for Role Plays."

3. Give an opportunity to ask questions and discuss.

4. Have participants break into groups of three. Move chairs to allow for three-person role plays (use other rooms for more quiet, if possible).

- BREAK - (10 minutes)

LEADER'S SUPPORT
GUIDELINES FOR ROLE PLAYS

Now we will have you practice suicide risk assessment by doing role plays. First, we'd like to describe the "process" and some important role play rules. We will break up into groups of three. In each role play we will have a counselor, a potentially suicidal resident and an observer. Each of you will have a chance to play each part. The object of the role plays is for the counselor to assess if the resident is in imminent danger of suicide, or is a possible long-term suicidal risk. We will provide instructions for each of the role plays that will explain the situational background and each character's role, but for all role plays:

1. The observer is silent. Your task is to be an objective evaluator of the interview. You will not be made privy to the background and character information. You are not to participate in the role play or disturb the process in any way. Try to be invisible.

2. The resident should get into the part as much as possible. Don't interject your own opinions and feelings--try to stay in your role. Do not be too hard or too easy on the counselor. The instructions will specify the intensity of your role.

3. The counselor should try to utilize the communication and assessment skills that we have discussed to assess the resident's level of suicide risk. Give it your best shot. Don't be overly critical of yourself or your performance; we will not rate how you do. This is a learning exercise, not a test. No one is expected to be perfect--that's why we're practicing. If you get "stuck," stop the role play. You can call the shots. You may want to take a "time out" to regroup your thoughts, or stop altogether and process the events that led you to the roadblock.

4. At the end of each role play, we will have a discussion. All feedback is to be constructive. To keep this discussion "safe" for all involved, we'll focus on:
   * The behavior of the role players and the process, rather than the individuals
   * Observations rather than inferences
   * Description rather than judgement
   * Sharing ideas rather than giving advice
   * Exploration of alternatives rather than absolute answers and solutions
   * The value our feedback has for the recipient, rather than the value (or "release") that it provides the person giving the feedback
   * The amount of information the person can use rather than the amount that you'd like to give (Lehner)

4. SUICIDE RISK ASSESSMENT ROLE PLAYS

PURPOSE:

* To give participants practical experience in applying guidelines to assessment.
* To help participants become more comfortable doing suicide risk assessments by allowing them to practice in a supportive setting.

MATERIALS:

* Leader's Support "Suicide Risk Assessment Role Plays"
* Handouts - Observer's Role, Counselor's and Resident's Roles for Role Plays #1, 2, 3, and 4.

FORMAT:

* Role Plays and Discussions (60 minutes total)

SEQUENCE:

1. Transition: You will all have an opportunity to play each part in a role play (counselor, resident and observer). Let's try hard to make this a good learning experience for all.

2. Have each participant (already in groups of three) decide which part they will play first.

3. Pass out instructions. Allow sufficient time to read parts. Remind participants not to share information from each other's roles.

4. Begin role plays. Allow 10-15 minutes for each. Give two-minute warnings to wrap up at end.

5. Conduct discussion, using Leader's Support as guide.

6. Repeat process until each person has a chance to play each role. If time allows, have volunteers participate in Role Play #4.

LEADER'S SUPPORT

SUICIDE RISK ASSESSMENT ROLE PLAYS

Before the session, review each role play and mark those areas of content that help you with YOUR assessment. It would be helpful to review, for yourself and for the participants, the rules of constructive feedback provided in Section 3. Most important, encourage and support participants' efforts and accept and be open to any feelings of anxiety, frustration, or confusion.

* Begin role plays by asking participants to do as thorough an assessment as possible, using their knowledge and information-gathering skills.

* Organize discussion by having all participants, observers, residents and counselors respond in turn (a preferred order is listed below).

* The discussion can follow the form of the Guidelines to Assessment. (Identify the HAZARD and its meaning, the CRISIS and its level, etc.)

* Begin by discussing this resident's assessed level of risk, and ask participants and counselors to provide support for their assessment.

* Expand, illustrate and support their assessment by focusing on the Guidelines to Assessment and your own impressions of the role play's information and process.

* This is also an opportunity to consolidate learning from prior sessions: What is the message that the teen may be trying to communicate? What are some signs of depression? How do we tell this behavior from "normal"?, etc.

ROLE PLAY #1:

Purpose: To allow participants to utilize the Guidelines to Assessment to form an opinion of the resident's level of suicidal risk, and to become comfortable with the role play format. In discussion, be supportive and identify information by referring to the Guidelines to Assessment.

Discussion order: Counselor, resident, observer.

ROLE PLAY #2:

Purpose: To demonstrate the effect of an insensitive, judgemental counselor. The resident wants to discuss his problem (fear of father), but runs into blocks in trying to do so. Discussion likely will focus on the resident's discomfort with the counselor's judgements, lack of caring and inability to communicate. Discuss the effect of these feelings on the communication process. Review information in terms of Guidelines to Assessment and discuss how communication blocks interfere with effective information-gathering.

Discussion order: Resident, counselor, observer.

ROLE PLAY #3:

Purpose: To allow the counselor to deal with a teen who is angry, distressed, depressed and guarded. The counselor must try to establish a sense of trust with this resident. Discussion will focus on the skills used by the counselor to establish this trust and break through the teen's guardedness, and on content of the Guidelines to Assessment.

Discussion order: Observer, resident, counselor.

ROLE PLAY #4:

Purpose: To experience an intake interview situation. At intake, no pattern of communication or trust exists between staff and resident, and both must work to establish that relationship. Counselors should provide as much assessment information as possible, following the Guidelines for Assessment. Discussion will focus on assessment content and skills used to establish a working relationship.

Discussion order: Counselor, resident, observer.

5. DISCUSSION AND PREVIEW NEXT SESSION

PURPOSE:

* To allow for feedback on Session Four and further discussion.
* To point out material to be covered in the next session.

MATERIALS:

* None

FORMAT:

* Discussion (10 minutes)

SEQUENCE:

1. Allow participants to give feedback about the past session. Did they find role plays to be a helpful learning experience?

2. Use this time to finish any discussion brought up during the session.

3. Present content for next session as below. Encourage all to attend next session.

INTERVENTIONS AT TIME OF SUICIDAL RISK

Taking Care of Ourselves
Interventions at Time of Suicidal Risk
Case Discussion
The Issue of Hospitalization

SESSION FOUR

CHARTS AND HANDOUTS

(in order of presentation)

SAMPLE INTERVIEW QUESTIONS

When trying to determine suicidal risk or danger, it is helpful to have a series of questions to assess risk factors. The following questions address the factors listed in Guidelines for Assessment.

It is important to phrase the questions in a manner with which you feel most comfortable.

1. What is happening in your life right now that brings you to the shelter?
2. Have you been feeling depressed lately?
3. Do you ever feel that there is no hope in your life?
4. Have you ever wanted to die?
5. How many times? How frequent were the thoughts? How long did the thoughts last?
6. Have you ever tried to kill yourself?
7. How did you do it?
8. Why did it fail? Did you receive help? From whom? Was it beneficial?
9. What was going on in your life then?
10. How did you learn to cope following the suicide attempt?
11. Are you thinking about killing yourself right now? Would you tell me if you were? How often do you have these thoughts? How long do the thoughts last?
12. Did a specific event occur in your life that made you decide to act now?
13. Do you have a plan? What is it?
14. How would you do it? Do you have the means?

Take the time here to assess how operational the attempt is. The risk of suicide is increased if: (1) the teen has tried it before, (2) he/she has serious thoughts about it, (3) he/she has a plan, and/or (4) he/she has the means. Remember, the more specific the plan, the greater the risk. This doesn't mean that someone with only vague suicidal thoughts shouldn't be taken seriously. Adolescents are characterized by their impulsiveness. They may attempt suicide without giving much thought to planning or details.

Some questions will allow you to assess the resident's emotional state--how the adolescent is feeling. The more hopeless the adolescent feels, the greater the risk.

15. Is there any hope for the future? Next week? Next year?

16. Do you have any thoughts about the future? Any way out of this?

17. Do you have anyone you can turn to for support? Are you seeing a therapist? Is it helping?

It is also important to determine if the resident has had someone to model suicidal behavior after. He/she is at higher risk if someone in his/her family or peer group used suicide as a way out of pain. This makes it easier for the adolescent to justify suicide as a problem solver. You can ask:

18. Has anyone in your family ever talked about killing themselves? Attempted it? Committed suicide?

19. Have any of your friends ever talked about killing themselves? Attempted it? Committed suicide?

Role Plays
Observer's Role

The observer's role is the same for all role plays.

As the observer, your task is to be a silent and objective evaluator of the interview. You will not share the background and character information. Try to identify some of the resident's risk indicators and the participant's listening and information-gathering skills.

While observing the interview between the counselor and the shelter resident, be aware of:

* body language
* what the counselor says or does that facilitates suicide risk assessment
* factors of assessment on which the counselor focuses
* any blocks in communication and how the counselor gets around them, or could have done so
* your own assessment of this shelter resident's suicide risk at this time

Role Play #1
Counselor's Role

As the counselor, you should try to utilize the Guidelines to Assessment and your listening and information-gathering skills to assess this resident's level of suicide risk. Try to get as much support for your assessment as you can. If you get "stuck," stop the role play and regroup.

The areas of the assessment guidelines are listed here as a focus:

____	Hazard	High Risk Factors:	
____	Crisis	____	Multiple attempts
____	Coping Strategies	____	Alcohol/drug abuse
____	Significant Others	____	Isolation/withdrawal
____	Past Attempts	____	Disoriented/disorganized
____	Psychiatric History	____	Impulsiveness
____	Life Style	____	Hopelessness
____	Plan (S.L.A.P.)	____	Modeled Behavior

* * *

A fifteen-year-old female resident who has been at your shelter for three days has become extremely withdrawn. She seems to have been on the verge of tears all day. You know she had a physical exam this morning but you don't know anything about the results. You know that she ran away from home in an act of rebellion against her parents' strict rules and dominance. She is a first-time runaway. Reunification with parents is expected.

You are concerned about her sudden change in behavior and have called her in to talk about it. Assess whether she is at any risk of self-destructive or suicidal behavior.

Role Play #1
Resident's Role

As the resident you should try to get into the part as much as possible and stay in your role. Do not be too hard or too easy on the counselor.

* * *

You are a fifteen-year-old female. You have been a resident at this shelter for three days. You ran away from home for the first time when you came here. You ran away because your parents are very overbearing and strict. You weren't allowed to go out with friends at night or even after school. You were not allowed to date. You had the responsibility of caring for two younger siblings and various cooking/housekeeping chores, as both of your parents work. You feel you need more freedom to be a teenager. You especially want to spend time with your new boyfriend. Your parents don't know that you had been sneaking out of the house at night to see him.

The first two days at the shelter went well. You are outgoing and made instant friends. Even though the shelter has rules it felt more lenient than home. Your parents gave permission for you to stay for a week and it seems like they may loosen up a little at home as a result of this exposure of the problems.

But this morning you had a physical exam. You had requested it but told no one why. You've missed two periods and found out for certain today that you are pregnant. As a reaction, you have become depressed and withdrawn. You are on the verge of tears but you haven't told anyone what is wrong. You feel trapped by the situation because:

1. This surely will make your parents more strict.
2. You think your parents will "kill" you--you don't think you could ever face telling them because then they'll know you've been sneaking out and dating.
3. You are a strict Catholic and don't believe in abortion.
4. You're not sure that your boyfriend Tony (an 18-year-old high school dropout) will stick by you on this one.

You are ashamed and scared. You have no solutions and can't think of anyone to turn to. You have some vague feelings that the only way out of this situation is to kill yourself. You have no concrete plan of suicide. The counselor at the shelter has asked to talk to you.

You trust this counselor but at this point you don't think anyone can help you out of this mess. There is no easy answer for you right now. Suicide seems like the only solution. If the counselor asks you about a suicide plan, be clear that you don't have a plan yet.

Role Play #2
Counselor's Role

As the counselor, you should try to utilize the guidelines to assessment and your listening and information-gathering skills to assess this resident's level of suicide risk. Try to get as much support for your assessment as you can. If you get "stuck," stop the role play and regroup.

The areas of the assessment guidelines are listed here as a focus:

____	Hazard	High Risk Factors:	
____	Crisis	____	Multiple attempts
____	Coping Strategies	____	Alcohol/drug abuse
____	Significant Others	____	Isolation/withdrawal
____	Past Attempts	____	Disoriented/disorganized
____	Psychiatric History	____	Impulsiveness
____	Life Style	____	Hopelessness
____	Plan (S.L.A.P.)	____	Modeled Behavior

* * *

You are interviewing a 14-year-old male runaway as part of an intake into your shelter. He ran away from home because he got a failing math grade on his report card. You suspect he may be suicidal for the same reason.

You need to assess suicidal risk. For the sake of this role play, we want you to do an <u>ineffective</u> suicide risk assessment. Do the "don'ts" of assessment. You think that running away and killing yourself over grades is ridiculous. Don't dig for deeper reasons for this youth's desperate actions. Don't take threats of suicide seriously.

Role Play #2
Resident's Role

As the resident you should try to get into the part as much as possible and stay in your role. Do not be too hard or too easy on the counselor.

* * *

You are a 14-year-old male runaway. This is your intake interview at the shelter. You have already told the counselor that the reason you ran away was due to a failing math grade on your report card. You are devastated by this failing grade.

The bad grade on your report card is just "the last straw." You are terrified of what your father will do when he finds out. You think he will try to kill you. He has beaten you severely in the past, often without cause. Your mother is an alcoholic and remains detached from the situation. You hate your parents, especially your father, and think that your suicide will be an appropriate revenge.

You haven't told the counselor that you are planning to kill yourself. You have tried suicide twice in the past. This time you are going to hang yourself. You know exactly how to do it. You have a piece of rope in your bag.

You are ambivalent about dying. Really all you want is for your father to stop abusing you and for your mother to take an interest in you.

You need a caring person to talk you out of your plan. At this point you feel that your time is limited. You'll have to kill yourself before your parents find out that you are at the shelter. Otherwise, your father will come and take you home.

You are very frightened. You are terrified of your father and of what you might do to yourself. You just met this counselor and you don't know whether you trust him or not. Reveal all aspects of your problems at home and of your suicide plan but only when asked.

Role Play #3
Counselor's Role

As the counselor, you should try to utilize the guidelines to assessment and your listening and information-gathering skills to assess this resident's level of suicide risk. Try to get as much support for your assessment as you can. If you get "stuck," stop the role play and regroup.

The areas of the assessment guidelines are listed here as a focus:

____	Hazard	High Risk Factors:	
____	Crisis	____	Multiple attempts
____	Coping Strategies	____	Alcohol/drug abuse
____	Significant Others	____	Isolation/withdrawal
____	Past Attempts	____	Disoriented/disorganized
____	Psychiatric History	____	Impulsiveness
____	Life Style	____	Hopelessness
____	Plan (S.L.A.P.)	____	Modeled Behavior

* * *

A shelter resident has come to you in confidence. He/she is worried because his/her roommate at the shelter has been dropping hints about suicide. He/she leaves "suicide notes" around the room. The resident who told you this feels guilty for betraying the suicidal resident as he/she was sworn to secrecy. The suicidal resident has admitted to having a stash of pills. You have asked to talk with the resident who might be suicidal, but he/she doesn't know yet why he/she has been called in to talk. You need to assess the seriousness of the situation.

Role Play #3
Resident's Role

As the resident you should try to get into the part as much as possible and stay in your role. Do not be too hard or too easy on the counselor.

* * *

You are a shelter resident who has been hinting to your shelter roommate that you are having suicidal thoughts. You have been writing suicide notes and leaving them around the room for your roommate to find. You have told your roommate that you have some pills. You really don't have any pills, but you think you could get some when you need them. You have sworn your roommate to absolute secrecy.

You have been feeling depressed lately. You have a hard time sleeping and have lost weight. You've lost interest in school and friends. You are frightened by your suicidal thoughts. You fear that you are losing control and are going crazy. You've tried to get help from parents but they don't take you seriously. They say you are "just going through a phase," and to "lighten up."

You ran away from home to call attention to your problems. Your parents have brushed it off as a "typical teenage prank." You think that they aren't listening to you. You are extremely angry at your parents (and adults).

You think a suicide attempt may get your parents to listen. You don't want to die. You don't want the counselors to know about it because they are adults and probably won't understand. You feel desperate. Deep down you don't even want to attempt suicide, but right now you think it's the only way to get your parents' attention.

You don't know why you are being called in to see the counselor. When the counselor tells you that a suicide attempt is suspected, focus on your anger and betrayal. Be somewhat hostile to the counselor, telling him/her that it's none of his/her concern. Be guarded about information. Respond positively to the counselor only if you think that he/she is caring and can be trusted.

Role Play #4
Counselor's Role

As the counselor, you should try to utilize the guidelines to assessment and your listening and information-gathering skills to assess this resident's level of suicide risk. Try to get as much support for your assessment as you can. If you get "stuck," stop the role play and regroup.

The areas of the assessment guidelines are listed here as a focus:

____ Hazard

____ Crisis

____ Coping Strategies

____ Significant Others

____ Past Attempts

____ Psychiatric History

____ Life Style

____ Plan (S.L.A.P.)

High Risk Factors:

____ Multiple attempts

____ Alcohol/drug abuse

____ Isolation/withdrawal

____ Disoriented/disorganized

____ Impulsiveness

____ Hopelessness

____ Modeled Behavior

* * *

A 16-year-old male has just entered your shelter for intake. His father dropped him off out front, bag and baggage, and drove off. This teen was unexpected, but you do have an available bed. He seems quiet and withdrawn. It appears that he has been crying. You need to do an intake interview. Focus on his feelings and assess if he is in imminent danger of suicide. (Use the "distressometer" if you think it is appropriate.)

Role Play #4
Resident's Role

As the resident you should try to get into the part as much as possible and stay in your role. Do not be too hard or too easy on the counselor.

* * *

You are a 16-year-old male who has just been dropped off at the shelter by your father. You are totally overwhelmed. You have been crying for hours.

Your world came tumbling down yesterday. In a matter of a few days you have been kicked off the varsity hockey team, lost all your friends and were disowned by your family. This all happened because after a few beers the other night, you confided to a group of your friends that you thought you were gay. The homophobic hysteria spread like wildfire. Your friends immediately shunned you. They told the coach, who then suspended you from the team. The coach called your parents. Even they treated you like an alien. After a big fight with your father about it, your father decided to disown you. This is how you ended up at the shelter.

You are totally confused. You don't want to be at the shelter. You wished you had kept your mouth shut about being gay. You don't want to be gay. You want to be "normal" and accepted. You feel as if your life has just ended. You are so confused you really aren't in touch with your emotions. You are withdrawn and fairly uncommunicative with the counselor who is about to interview you. You've had some fleeting thoughts about suicide, but those thoughts frighten you as much as your gay feelings. Right now you just don't know how you feel.

E. SESSION FIVE

INTERVENTIONS AT TIME OF SUICIDAL RISK

CONTENT:

1. Introduction and Review (10)
2. Taking Care of Ourselves (20)
3. Interventions at Time of Suicidal Risk (30)
   -Break- (10)
4. Case Discussion (20)
5. The Issue of Hospitalization (15)
6. Discussion and Preview Next Session (15)

CONTEXT:

In this section we will define some positive interventions which staff can employ after assessing the level of suicidal risk. Intervention begins at the time of suicidal risk assessment. We will also discuss the important need to take care of ourselves during the difficult challenge of helping a suicidal youth.

1. INTRODUCTION AND REVIEW

PURPOSE:

* To give participants an opportunity to discuss briefly any issues or questions brought up during the last session.
* To summarize points of the last session.
* To introduce content and schedule of this session.

MATERIALS:

* Flip chart and markers: Write content and schedule of this session on chart.

FORMAT:

* Transition and discussion (10 minutes)

SEQUENCE:

1. Transition: In the last session, we practiced suicidal risk assessment. Our goal was to define the level of suicidal risk in role play situations. Today we will discuss appropriate interventions to be employed for different levels of suicidal risk.

2. Encourage participants to voice any issues or questions they had from the last session.

3. Request a volunteer to summarize his/her experience participating in role plays as a way to learn suicidal risk assessment skills.

4. Preview the content and schedule of this session.

2. TAKING CARE OF OURSELVES

PURPOSE:

* To understand that no one is expected to handle a suicidal resident alone.
* To share ways in which participants can and should support each other during a suicidal intervention.
* To impress that taking care of ourselves is as important as helping the suicidal resident.

MATERIALS:

* Handout: "Taking Care of Ourselves"
* Flipchart - Copy chart "Taking Care of Ourselves"

FORMAT:

* Transition, group participation and discussion (20 minutes)

SEQUENCE:

1. Transition: Dealing with a suicidal resident is one of the more difficult challenges with which we will be faced in our lives. In addition to our responsibilities to the resident, we also have responsibilities to ourselves and to one another. Let us discuss ways which we may take care of ourselves during a suicidal intervention.

2. Ask for volunteers, or go around participants in a circle, with each person reading one section of the handout, "Taking Care of Ourselves." Allow for discussion after each section. Encourage participants to personalize each section with accounts of their own experiences.

3. Review with participants the protocol for dealing with emergencies at your shelter. How should participants involve other staff members? Who should they involve? Is there someone on call to help out? Relate this information to the points made in Taking Care of Ourselves.

4. Summary: It is as important to take care of ourselves during an intervention with a suicidal resident as it is to take care of the resident. If we allow ourselves to become over-involved or intervene without the support of others, our interventions may be ineffective, even harmful. Review major points of discussion using the flip chart.

LEADER'S SUPPORT

TAKING CARE OF OURSELVES

Dealing with a suicidal resident is one of the more difficult challenges with which we will be faced in our lives. In addition to our responsibilities to the resident, we also have responsibilties to ourselves and to one another.

Here are some hints for taking care of ourselves:

* Seek support and validation from other staff. We tend to be very critical of ourselves in such tough situations. It is common for us to question our judgement when we are assessing and intervening in a suicidal situation. The best way to deal with that is to share the responsibilities of decision-making.

* Although involvement in a life-saving situation carries a lot of responsibility, you cannot be fully responsible for the resident's life. You must try to prevent a suicide, but the ultimate decision rests with the resident.

* A suicidal crisis will always bring out our intense feelings as caregivers. Sometimes feelings from the caregiver's own past experience are displaced onto the client (counter-transference). The caregiver may feel angry or may resent the resident because he or she reminds the caregiver of unresolved conflicts. If you have these intense feelings, acknowledging their existence may help you understand their causes. Once you understand the root of the problem feelings, try to keep them in check. It may be helpful to talk to another staff member. If you don't think you can deal with a resident effectively without interference from these feelings, you should try to get another staff member to handle the suicidal resident.

* Sometimes dealing with a suicidal resident can arouse suicidal feelings in the caregiver. It is essential that you gain a clear and comfortable understanding of your own feelings and seek professional counseling if necessary (Hatton, Valente, Rink, 1977). Share your feelings with another staff member.

* Avoid over-involvement. You must be able to resist the desire to be omnipotent. An intensely dependent resident can attribute tremendous power to you as a potential rescuer (Aguiler and Messick, 1982). But this power gives you too much responsibility for another's life. Emotional over-involvement of caregivers in an emergency is unhelpful and at times destructive.

Sometimes there is a fine line between being involved and over-involved. When we are over-involved we don't always know it. It is the responsibility of other staff members to confront the staff person who they sense has become over-involved.

* You are not alone. Use other staff members. You may simply need consultation. You may want to share responsibility for the situation to relieve the pressure on you. Know your own limits. If you don't think you can handle the situation, you must get help. No one is expected to be perfect.

* Afterwards, it is important that you "process" the incident with the whole staff. A suicidal incident is such an emotionally charged situation that it will always leave you with leftover feelings. It is the responsibility of the staff to give you support at this time. Go over the incident in detail to confirm that you dealt with the situation as best you could, and to consider with others what might be done in the future.

It is important for your co-workers to support the notion that no one is expected to be perfect. We need each other as resources and for support.

3. INTERVENTIONS AT TIME OF SUICIDAL RISK

PURPOSE:

* To provide some guidelines for interventions to be used when dealing with residents who have been assessed at suicidal risk.
* To differentiate between interventions for residents at potential risk for suicide and residents in imminent danger of suicide.

MATERIALS:

* Leader's Support - "General Guidelines for Suicide Interventions" and "Guidelines for Intervention--Potential Risk and Imminent Danger"
* Handouts - "General Guidelines for Suicide Interventions" and "Guidelines for Intervention--Potential Risk and Imminent Danger"
* Flip charts - Copy charts on "Do's and Don'ts in Suicide Interventions" (2)

FORMAT:

* Transition, presentation/discussion (30 minutes)

SEQUENCE:

1. Transition: We have already begun our intervention by establishing a relationship with the teen and showing our caring and openness by doing our assessment of risk. Today we will use what we know about teens and the information gained from our assessment to conduct positive suicide interventions.

2. Presentation/discussion: In this presentation, you, the trainer, will provide guidelines for intervention.

   a. Start with "General Guidelines for Suicide Interventions." Put up the chart "Do's and Don'ts in Suicide Interventions" and pass out handout "General Guidelines for Suicide Interventions." Use your Leader's Support to introduce and fill in the information from the chart and handout. Have participants discuss the importance of all the points.

   b. Continue with "Guidelines for Suicide Intervention--Potential Risk and Imminent Danger." Pass out handout. Have participants discuss the importance of all points.

3. Summary: Although interventions will vary depending on the level of suicidal risk and the specific circumstances of the case, there are general guidelines you can follow. Remember, no one is expected to be perfect; just do the best job that you can.

- Break - (10 minutes)

LEADER'S SUPPORT

GENERAL GUIDELINES FOR SUICIDE INTERVENTIONS

INTRODUCTION

In Session Three we discussed the difference between "potential risk" and "imminent danger" of suicide. (Ask one of the participants to differentiate the two and put on flip chart). To review, assessing a teen as at "potential risk" means that he/she is likely to attempt suicide sometime in the future. Whereas, "imminent danger" means that an adolescent is currently in a suicidal crisis and may attempt to harm himself immediately. These two levels of risk (crisis vs. long term risk) call for different steps in intervention.

As counselors, we have had it drilled into our heads that we should take all suicidal talk and gestures seriously. We know that there must be a good reason for this, although we are often troubled when deciding which behavior should be diagnosed as true suicidal risk. Often it may seem that suicidal talk or gestures are manipulative in nature and not self-destructive at all.

Diagnostically, it is often fairly easy to establish whether a suicidal act has been a gesture or a manipulation. The first is the lethalness of the method. The second is the probability of intervention. Those attempts using a less lethal method most likely also have a high probability of intervention or rescue. An example is the resident who swallows a few pills or scratches his/her wrists superficially, and then immediately tells someone. Most gestures are of both low lethalness and high probability of rescue.

Differentiating an attempt from a gesture may be helpful for your own peace of mind, knowing that gestures are not lethal in nature. As tedious and aggravating as it sometimes becomes (especially after a rash of suicidal gestures from one or more residents), it is important to treat suicidal gestures as seriously as suicidal attempts. The suicidal gesture is a desperate cry for help. If it is dismissed as manipulative (or hysterical) the risk of a legitimate attempt dramatically increases (Hipple & Cimbolic, 1979). The resident needs to know that you will take his or her problem and pain seriously. The gesture is his/her attempt to communicate that pain. The fact that the message was communicated in such a disturbed manner is enough indication that you should take heed.

But what does it mean to, "take them seriously?" What do we as counselors have to do or say to show that we are taking the resident seriously? Aside from actual steps to get the client help (such as bringing him or her to the hospital for a psychological evaluation), what type of message or behavior can we exhibit to show the residents that we take them seriously? This is where we begin our intervention.

Your intervention will be based upon your knowledge of the resident, your relationship with him/her, and the result of your assessment of his/her suicidal risk. The latter will determine the nature of your intervention, but whether the resident is at POTENTIAL RISK of suicide, or is in IMMINENT DANGER, there are some common guidelines to follow.

We will start by reviewing the "General Guidelines for Suicide Interventions" before we look at the interventions for specific cases at Potential Risk and in Imminent Danger of suicide.

Go over each point on the chart, giving additional information from this guide.

DO'S--MOST IMPORTANTLY:

DO something and do it now. If you suspect a resident may be suicidal, don't wait until the situation becomes more serious. You will not put the idea of suicide into the resident's head, so if you suspect something is wrong, find out about it. You may prevent a suicide attempt that could be deadly.

WHAT TO DO:

1. Be a calming influence. It is important for you to maintain control and good judgement. The resident may feel out of control and will need you to provide a sense of control and security.

2. Take a positive approach by emphasizing the person's most desirable alternatives. Give hope and reassurance in a positive and realistic way.

3. Clarify the problems. Try to understand the root of this deep pain and conflict. Use constructive questions to help separate and define the person's problems and remove some of his confusion.

4. Clarify the concept of death for the adolescent who may be confused and ambivalent. Remind the youth that suicide is a permanent resolution of a temporary problem.

5. Expand alternatives/Reinforce coping skills. By the time a person is in a suicide crisis, his thinking has become so rigid, constricted and "tunnelized" that he sees no other options. Don't accept an either/or logic from a resident in terms of suicide. You must actively help the resident to increase his options. Make a list of all the alternatives (as many as the two of you can think of), including suicide, and discuss each one. Making a list may itself counter the constriction of thought (Shneidman, 1985).

6. Mobilize resources (discover a lifeline). Work with the resident to identify sources of support. With the resident's permission, mobilize these resources.

7. Establish a contract. Even if the resident isn't currently at risk of suicide, if there is any potential of suicidal risk it is often helpful to establish a contract. The resident makes a contract with himself not to hurt himself. The more specific the contract the better, as adolescents always seem to be testing limits. Get an agreement for the longest possible period of time.

   Example: "I will not kill myself or otherwise hurt myself on purpose for the three weeks I stay at the shelter. If I feel like I want to hurt myself I will come and talk to a counselor first." Once a contract is made, it is essential to reinforce success. You must let the resident know that his life-saving efforts are being noticed and appreciated. Remember, a contract is not a guarantee.

8. Formulate a realistic plan with the resident to deal with situations which may lead to a suicidal crisis. Make this plan as specific and concrete as possible. Often the resident is experiencing multiple problems, which build up and cause a tunnel vision effect. Try to help the resident separate these problems and look at each individually in terms of a realistic coping plan. Reinforce coping skills that have been identified as useful in the past. Also, help develop new coping mechanisms and problem-solving techniques. Again, as with the contract, it is important to reinforce any progress made.

9. Monitor the suicidal resident. It is not necessary to keep the potentially suicidal resident in sight at all times but it is important to check in with this resident a few times a day. Although this resident may have one primary counselor, it is important that all counselors share the responsibility for his well-being. The resident must know that he is safe and can trust all staff, as his primary counselor may not be near when he is feeling the most down.

10. Try to reduce the pain. If possible, in counseling try to have the resident identify the source of distress. Use the "distressometer" if you think it could help the resident identify his feelings. Convey to the resident that you offer a safe place to express true feelings. Determine the meaning of the distress to the resident. You may be able to be instrumental in alleviating some pain for the resident once you can locate the source of the problem. If you can reduce the level of suffering, often just a bit, the person may choose to live (Schneidman, 1985).

11. Key into the resident's ambivalence. The resident may be experiencing hopelessness at the same time that he is hoping to be rescued. Often the factors for and against suicide are so evenly balanced that if you respond in a warm, concerned and sincere way, the scales could be tipped in favor of life (Grollman, 1971).

HOW TO DO IT

1. Talk about suicidal thoughts (and actions) in a direct way. This shows that you are interested in how the resident feels, and are not afraid to talk about the subject.

2. Show you care. Build trust and a realistic rapport with the client. Your concern and attention should be conveyed both verbally and nonverbally.

3. Take your time. The suicidal crisis is of short duration, and often it is just a matter of time before it has passed.

4. Speak slowly, softly and simply. You can be a calming influence on a confused resident. What you say is less important than how you say it.

5. Know your limits. Learn to take care of yourself as well as the resident. Be aware of your values and how they may affect your ability to counsel. Refer the resident to another staff member or make an outside referral if you know you cannot handle the situation.

6. Keep control. Your behavior will set the tone for the intervention. It is important not to over react, even if the suicide attempt has been made or is in process. The resident may be panicked by his own lack of control and will feel safer if he is assured that you can provide control.

DON'TS—MOST IMPORTANTLY:

DON'T give up hope. A suicidal resident may think that suicide is his/her only alternative. Find alternatives for this youth. Even if the situation seems bleak, it can't deserve such a drastic measure as suicide. You must provide hope for that resident.

HOW TO KEEP THE INTERACTION FLOWING:

1. Avoid responding with shock to anything the resident tells you. The resident is put off by your reaction of rejection, indifference or derision, and such a response will block further communication or ability to help.

2. Avoid causing the resident to feel any more guilt. Don't stress the shock, embarrassment and pain that the suicide would cause his family. It may make him feel more guilty and more determined to punish himself.

3. Avoid arguing about whether the resident should live or die. Help the resident to see that the crisis will pass and there are things to live for. If you debate, you may not only lose the debate but the resident as well.

4. Avoid minimizing the problem. It may not seem like a life-and-death situation to you, but it is a crisis for the resident. The resident must see that you are taking the situation seriously.

HOW TO KEEP FROM LOSING CONTROL:

1. Never try to remove a weapon physically from a suicidal person. You and the suicidal resident could get hurt.

2. Never promise total confidentiality. Explain that you may need to involve other people in order to get proper help for him. You can promise that you will at least discuss any contacts before and after they are made.

3. Don't give the resident choices that are not his to make. You must offer a realistic situation and ways to cope with the reality.

4. Avoid getting over-involved. Try to keep a perspective on your limits and role. You cannot be omnipotent and will not always be around to help the resident through crises.

5. Never leave the resident alone if you think he/she may be in imminent danger. Suicide-proof the surroundings. Get rid of lethal weapons.

LEADER'S SUPPORT

GUIDELINES FOR INTERVENTION-- POTENTIAL RISK AND IMMINENT DANGER

A few steps of intervention will require different treatment depending on the level of suicide risk. The General Guidelines for Suicide Intervention apply at any level of suicidal risk. If the resident has been assessed at "Potential Risk" for suicide, it is important to:

1. Assess the impulsiveness of the resident. Does this resident have a history of impulsive behavior? If so, be warned that this resident could move impulsively from the level of potential risk to the level of imminent danger very quickly. It would probably be best to treat this resident as in imminent danger of suicidal behavior.

2. Convey that you are taking any suicidal ideas seriously. Let the resident know that you are actively interested in his/her well-being. This is important even if you feel the resident is using suicidal talk/behavior in a manipulative way. The resident desperately needs your attention.

3. Monitor the resident. It is not necessary to keep the potentially suicidal resident in sight at all times, but check in with this resident at least a few times a day. All counselors must share the responsibility for his well-being. The resident must know that he is safe and can trust all staff, as his primary counselor may not be around when he is feeling the most down.

4. Follow shelter protocol in involving the resident's family or other potential lifelines. It is usually best not to involve other residents, as that often results in staff losing control of the situation.

5. Most importantly, a referral should be made for mental health follow-up. Do this however protocol allows. Involve the resident's worker, whether the worker is expected to make the referral or just be informed of the referrals you make. Your responsibility to a meaningful referral includes:

   * Translating effectively to the resident how the concern for his/her life takes precedence over the concerns of confidentiality. But always try to involve the resident in decisions involving referrals.

* Talking to the resident about the mental health referral. Try to demystify the mental health process and reduce the resident's fear of it. Help the resident to understand what to expect and how it can help.

* Relating proper background information to the referral source. Let the referral source know on what basis you suspect the resident to be at potential risk of suicide.

* Following up on the referral. Make sure the resident makes it to the appointment. Obtain any follow-up information that you can.

If the resident has been assessed to be in "Imminent Danger" of suicide, there are a few different steps to take because the situation is much more critical.

Remember what constitutes imminent danger:

1. High intent on self-destruction.
2. A specific plan or a highly agitated and impulsive resident.
3. Availability of means (remember the means could be jumping in front of a truck).
4. An attempt has been made or is in process (e.g., a resident has taken some pills or is locked in the bathroom with a razor blade).

These steps probably should be part of your intervention:

1. Remember - Time and talk are the principle tools for dealing with a suicide crisis. The longer you can talk to the resident and keep him from carrying out the suicide, the better your chances of ultimately getting him to change his mind (American Association of Suicidology, 1977). A suicide crisis is of limited duration. Even at this stage the resident is torn between the desire to live and the desire to die. The actual suicidal crisis when the resident is in the most danger may last only a few minutes or hours.

2. Providing realistic hope is essential. Try to discover what still matters to the resident. Always emphasize the positive. The element of realistic hope must be communicated in an honest, convincing and caring manner. Try to find something that will make things a bit better, even if just a tiny bit. Even a little improvement and sense of hope can save a life (Shneidman, 1985).

3. Don't let this resident out of your sight. Adolescents in suicidal crisis can be very impulsive. You may want to involve more than one counselor at a time, or switch off to give each other a break. Don't even let the resident go into the bathroom alone. You should not lose control.

4. Isolate the suicidal resident from other residents during the crisis. Don't let other residents get involved. Another staff member should deal with the other residents concerning their fears and suicidal issues.

5. If the resident is extremely agitated it may be helpful to reduce the resident's stress by having him take deep breaths. Speak in a calm and quiet manner. Try to reduce any outside confusion or interference.

6. Attempt to suicide-proof the environment. If the resident has suicidal means, attempt to remove it. Remember not to take away weapons by force. Once you have the weapon, get rid of it.

7. Follow shelter protocol in notifying others in a suicidal crisis.

8. Get professional help. The method of involving professional help will depend on the urgency of the situation. Use the following as a guide:

   You may want to handle the crisis at the shelter if:

   * the suicidal attempt, gesture or plan is not very lethal, and

   * the resident seems to have some control over his/her actions, and

   * the resident is approachable and willing to let you be involved.

   You may want to get immediate professional help through a hospital emergency room or mental health clinic if:

   * the suicidal attempt, gesture or plan is highly lethal, or

   * the resident seems agitated and has lost self-control, or

   * the resident is unreceptive to your intervention efforts.

4. CASE DISCUSSION

PURPOSE:

* For participants to apply their knowledge of suicidal interventions in a real case situation.
* To allow participants to work through a suicidal intervention case in a group situation.

MATERIALS:

* Flip chart and markers

FORMAT:

* Transition, case presentation and discussion (20 minutes)

SEQUENCE:

1. Transition: Now that we have discussed general and specific guidelines for interventions, let's try to apply them to an actual case. As a group we will discuss what steps we will take when intervening in this particular situation.

2. Call on a volunteer or come prepared to present a case which has occurred or is currently active at your shelter. It is up to the group trainer to decide the case to present. You may choose:

   (a) the most recent suicidal situation
   (b) the situation known best by most of the participants
   (c) a situation which participants found difficult to handle
   (d) if necessary, create a fictitious case.

   Have the volunteer be brief in presentation. Ask the volunteer to give details about the level of risk and the present situation. Request that the volunteer not give any information about the steps of intervention that had been employed.

3. Allow the other participants a few minutes to ask questions pertinent to assessing the level of suicidal risk. Discourage questions about what interventions had been employed.

4. Encourage participants to take the intervention process step by step. If this situation were currently occurring what would they do? List these steps on the flip chart. Refer to Guidelines for Intervention if necessary.

5. Allow participants to discuss the suicide intervention plan. Did it fit shelter protocol? Did it follow guidelines? Did participants take measures to take care of themselves?

6. Ask a volunteer to summarize the process.

5. THE ISSUE OF HOSPITALIZATION

PURPOSE:

* To encourage participants to explore the many issues surrounding hospitalization.
* To help participants explain the realities of hospitalization to a suicidal resident.

MATERIALS:

* Leader's Support, "The Issue of Hospitalization"

FORMAT:

* Transition, discussion, presentation (15 minutes)

SEQUENCE:

1. Transition: Many issues surround the decision whether to hospitalize a suicidal resident. The staff at the shelter must decide whether to recommend hospitalization, and the staff at the hospital must decide whether they agree with that recommendation. Differences in opinion are very common.

2. Have volunteer(s) describe a situation that concerned the decision of hospitalization. NOTE: A common experience is when staff and a suicidal resident are sent away from the hospital because the hospital staff determine the resident not to be in imminent danger of suicide.

3. Using the Leader's Support "The Issue of Hospitalization," go over the various issues which surround this decision. Allow staff to respond to the points.

4. Summary: Making the decision about hospitalization requires a team effort. The ideal team includes staff from the shelter and staff from the hospital. The bottom line is, if the staff at the shelter agree that the shelter will not be a safe place for the resident, then it will require assertiveness to find a safer place for the resident. But remember not to abandon the resident; he/she is counting on you to provide safety and control.

LEADER'S SUPPORT

THE ISSUE OF HOSPITALIZATION

Many issues surround the decision whether to hospitalize a suicidal resident. Many different people must agree that hospitalization is a necessary action. Often there will be conflicts in opinion. Let us look at these issues.

1. The first issue is the decision you must make as to whether to try to have your suicidal resident hospitalized. Of course, some situations mandate hospitalization, as with the resident who makes a highly lethal attempt or who is intent on suicide and refuses to make a contract to stay alive, but other situations are not so cut and dried, and necessitate a judgment on your part. If possible do not make that decision alone. Involve your supervisor, program director, or at least another staff member on duty (follow protocol). In deciding when to hospitalize, weigh the pros and cons of the process and its effects on the current resident and situation. What will be the impact on the resident, his family and the other shelter residents? Is hospitalization for the resident's benefit or for yours? What are the alternatives? Is there a less drastic but realistic alternative to hospitalization? Having a resident hospitalized will have a long-term effect (positive and/or negative), so make your decision wisely.

   For our training, take a moment to describe your shelter's protocol for deciding about hospitalization. Who must be consulted? What is the procedure?

2. Another issue presents itself after you've made the decision to hospitalize, but the hospital's emergency psychological evaluation concludes that the resident's condition does not necessitate such a drastic measure. This can be a very frustrating experience as well as a very common one. When this happens it is first important to determine why it happened. Often just the process (and time involved) in bringing a resident in for emergency psychological treatment will alleviate the crisis. Although the resident may have been a high risk while at the shelter, the level of risk may become defused and the need for hospitalization unnecessary. It is sometimes difficult for us as counselors to readjust to the new situation (of lowered risk) because of our intense involvement in the crisis phase. Remember that the situation of suicidal crisis is usually brief.

3. Another similar issue occurs when the hospital's emergency psychological evaluation assesses the suicidal risk to be lower than your assessment. This could be a more accurate assessment and it is in the resident's best interest to take him back to the shelter. Or the hospital's psychological evaluation may have inaccurately assessed the situation. If you truly believe that the client is in imminent danger and will benefit from hospitalization, you must fight for it. Ask what criteria was used to determine the assessment. Is it because no beds are available? Inform the doctor (mental health professional) about criteria you used to make your assessment. Be thorough in describing the situation that led you to that assessment. Usually a highly lethal attempt isn't enough to warrant hospitalization; it must include a high intent to die. The fact that you have made an educated assessment and are able to substantiate it should carry weight at the hospital.

If you feel very strongly about hospitalization and are having no success, involve the resident's social worker. He or she has ultimate responsibility for the resident. If you do not think the client will be safe at the shelter, do not bring that resident back. Let the client's worker make the decision whether to continue pushing for hospitalization or to seek another appropriate and safe alternative for the resident. Don't ever abandon the resident but also don't allow the resident into an unsafe situation if you can help it.

For our training, take a moment to describe your shelter's protocol for involving the resident's social worker.

If the crisis seems to have passed and you will be bringing the resident back to the shelter it is best if you can feel at ease with the situation. It is important to keep the lines of communication open. It is counter-productive to pretend that the situation never happened. Remember, if the situation that caused the suicidal crisis has not changed, then the resident is still at potential suicidal risk. Follow the suggested procedure for a resident at potential risk. Make a referral for continuing mental health counseling. A suicide attempt is always a serious sign of risk, so don't assume that the danger is over.

6. DISCUSSION AND PREVIEW NEXT SESSION

PURPOSE:

* To allow for feedback on Session Five and further discussion.
* To point out material to be covered in the next session.

MATERIALS:

* None

FORMAT:

* Discussion (15 minutes)

SEQUENCE:

1. Allow participants to give feedback about the past session.
2. Use this time to finish any discussions brought up during the session.
3. Present content for next session as below. Encourage all to participate.

INTERVENTIONS--PRACTICE SESSION

Intervention Role Plays
Training Wrap-Up

SESSION FIVE

CHARTS AND HANDOUTS

(in order of presentation)

TAKING CARE OF OURSELVES

* Seek Support and Validation From Other Staff
* Avoid Over-involvement
* Get in Touch With Own Feelings
* Share Responsibility -- Avoid Putting You and Client "On an Island"
* Know Your Limits and Respect Them
* Process Incident When It's Over
* No One Is Expected to Be Perfect

TAKING CARE OF OURSELVES

Dealing with a suicidal resident is one of the more difficult challenges with which we will be faced in our lives. In addition to our responsibilities to the resident, we also have responsibilties to ourselves and to one another.

Here are some hints for taking care of ourselves:

* Seek support and validation from other staff. We tend to be very critical of ourselves in such tough situations. It is common for us to question our judgement when we are assessing and intervening in a suicidal situation. The best way to deal with that is to share the responsibilities of decision-making.

* Although involvement in a life-saving situation carries a lot of responsibility, you cannot be fully responsible for the resident's life. You must try to prevent a suicide, but the ultimate decision rests with the resident.

* A suicidal crisis will always bring out our intense feelings as caregivers. Sometimes feelings from the caregiver's own past experience are displaced onto the client (counter-transference). The caregiver may feel angry or may resent the resident because he or she reminds the caregiver of unresolved conflicts. If you have these intense feelings, acknowledging their existence may help you understand their causes. Once you understand the root of the problem feelings, try to keep them in check. It may be helpful to talk to another staff member. If you don't think you can deal with a resident effectively without interference from these feelings, you should try to get another staff member to handle the suicidal resident.

* Sometimes dealing with a suicidal resident can arouse suicidal feelings in the caregiver. It is essential that you gain a clear and comfortable understanding of your own feelings and seek professional counseling if necessary (Hatton, Valente, Rink, 1977). Share your feelings with another staff member.

* Avoid over-involvement. You must be able to resist the desire to be omnipotent. An intensely dependent resident can attribute tremendous power to you as a potential rescuer (Aguiler and Messick, 1982). But this power gives you too much responsibility for another's life. Emotional over-involvement of caregivers in an emergency is unhelpful and at times destructive.

Sometimes there is a fine line between being involved and over-involved. When we are over-involved we don't always know it. It is the responsibility of other staff members to confront the staff person who they sense has become over-involved.

* You are not alone. Use other staff members. You may simply need consultation. You may want to share responsibility for the situation to relieve the pressure on you. Know your own limits. If you don't think you can handle the situation, you must get help. No one is expected to be perfect.

* Afterwards, it is important that you "process" the incident with the whole staff. A suicidal incident is such an emotionally charged situation that it will always leave you with leftover feelings. It is the rsponsibility of the staff to give you support at this time. Go over the incident in detail to confirm that you dealt with the situation as best you could, and to consider with others what might be done in the future.

It is important for your co-workers to support the notion that no one is expected to be perfect. We need each other as resources and for support.

GENERAL GUIDELINES FOR SUICIDE INTERVENTIONS

DO'S — — DO SOMETHING AND DO IT NOW!

What to do:

* provide calming influence
* take positive approach/be reassuring
* clarify the problem and concept of death/suicide
* expand alternatives/reinforce coping skills
* mobilize resources/discover a lifeline
* establish a contract
* formulate a realistic plan
* monitor the suicidal resident
* try to reduce pain
* key into the resident's ambivalence

How to do it:

* talk directly
* show you care
* take your time
* know your limits/make referral
* keep control

GENERAL GUIDELINES FOR SUICIDE INTERVENTIONS

DON'TS — — **DON'T GIVE UP HOPE!**

How to keep the interaction flowing:

** avoid acting shocked
** avoid causing the teen to feel more guilt
** avoid arguing whether it is right or wrong
** avoid minimizing the problem

How to keep from losing control:

** never try to physically remove the weapon
** never promise total confidentiality
** don't promise the teen options which aren't realistic
** avoid getting over-involved
** never leave the teen alone if in imminent danger of suicide

GENERAL GUIDELINES FOR SUICIDE INTERVENTIONS

DO'S

MOST IMPORTANTLY -- DO SOMETHING AND DO IT NOW!

WHAT TO DO:

1. Be a calming influence.
2. Take a positive approach/Be reassuring.
3. Clarify the problems.
4. Clarify concept of death/suicide.
5. Expand alternatives/Reinforce coping skills.
6. Mobilize resources/Discover a lifeline.
7. Establish a contract.
8. Formulate a realistic plan.
9. Monitor suicidal youth.
10. Try to reduce the pain.
11. Key into ambivalence and tip scale toward life.

HOW TO DO IT:

1. Talk directly.
2. Show you care.
3. Take your time.
4. Speak slowly, softly and simply.
5. Know your limits/Make referral.
6. Keep control.

DON'TS

MOST IMPORTANTLY -- DON'T GIVE UP HOPE

HOW TO KEEP THE INTERACTION FLOWING:

1. Avoid acting shocked.
2. Avoid causing more guilt.
3. Avoid arguing whether suicide is right or wrong.
4. Avoid minimizing the problem.

HOW TO KEEP FROM LOSING CONTROL:

1. Never try to remove the weapon physically.
2. Never promise total confidentiality.
3. Don't offer choices that aren't available.
4. Avoid getting over-involved.
5. Never leave youth alone if in imminent danger of suicide.

GUIDELINES FOR INTERVENTION--

POTENTIAL RISK AND IMMINENT DANGER

In addition to the steps of intervention suggested by the "General Guidelines for Suicide Intervention," steps require different treatment depending on the level of suicidal risk.

If you assess the resident to be at potential risk you should:

1. Assess the impulsiveness of the resident. If extremely impulsive, he/she should be treated as in imminent danger of suicide.
2. Take all suicidal ideas seriously, even if you think they are manipulative.
3. Monitor the resident.
4. Follow protocol in involving the resident's family and other potential lifelines.
5. Avoid involving other residents.
6. Make and follow up on a mental health referral.

If you assess the resident to be in imminent danger of suicide:

1. Remember that a suicidal crisis is of limited duration.
2. Provide realistic hope. The resident needs your confidence.
3. Don't let the resident out of your sight.
4. Isolate the suicidal resident from other residents.
5. Reduce the resident's stress and confusion.
6. Suicide-proof the environment.
7. Follow shelter protocol in notifying proper authorities about the crisis.
8. Get professional help.

F. SESSION SIX
INTERVENTIONS--PRACTICE SESSION

CONTENT:

1. Introduction and Review (15)
2. Guidelines for Role Plays (10)
3. Intervention Role Plays (60)
   -Break- (10)
4. Discussion and Wrap-up (25)

CONTEXT:

In this final session participants will use role plays to practice skills in suicide interventions at the various levels of suicidal risk. Decisions will be made for "next steps" in the plan for treating the suicidal resident. Emphasis will be on teamwork and "Taking Care of Ourselves."

1. INTRODUCTION AND REVIEW

PURPOSE:

* To give participants an opportunity to discuss briefly any issues or questions brought up by last session.
* To summarize points of last session.
* To introduce content and schedule of this session.

MATERIALS:

* Flip chart and markers--while content and schedule of this session on chart.

FORMAT:

* Transition and discussion (15 minutes)

SEQUENCE:

1. Encourage participants to voice any issues or questions they had from last session.

2. Request volunteers to summarize the major points of the "General Guidelines to Suicide Interventions." Also summarize points on Suicide Interventions for Potential Risk and Imminent Danger.

3. Introduce the content and schedule of this session. During last session we discussed guidelines for suicidal interventions at times of possible risk and potential danger. Today we will be practicing these intervention skills in role play situations.

2. GUIDELINES FOR ROLE PLAYS

PURPOSE:

* To set the stage for the practice session.
* To provide guidelines that set up the experience as "safe" and "supportive."

MATERIALS:

* Leader's Support Material "Guidelines for Role Plays" from Session Four, Part 3

FORMAT:

* Presentation and discussion (10 minutes)

SEQUENCE:

1. Transition: In this session, we will practice suicidal interventions in a role play format. Once we've assessed the level of risk (potential risk or imminent danger), our objective is to intervene appropriately, using the guidelines for suicidal intervention.

2. Review the process of role plays and rules for feedback using the Leader's Support "Guidelines for Role Plays" found in Session Four.

   NOTE: There is one change of role in this set of role plays. The one major difference this time is that the OBSERVER will no longer be silent. If the COUNSELOR in the role play situation needs assistance, he/she can call upon the OBSERVER as another staff member to provide support. The COUNSELOR can decide to use the OBSERVER as a consultant or as a second staff member in a more active role. The OBSERVER must wait for the COUNSELOR to ask for help and to define the role before joining in the role play. Using the OBSERVER is a way to practice "Taking Care of Ourselves."

3. Give participants an opportunity to ask questions and discuss.

4. Have participants break into groups of three. Move chairs to allow for three-person role plays. (Spread to other rooms for more quiet, if possible).

3. INTERVENTION ROLE PLAYS

PURPOSE:

* To practice tools of positive intervention in role plays.
* To help participants become more comfortable doing suicidal interventions by allowing them to practice in a supportive setting.

MATERIALS:

* Leader's Support, "Intervention Role Plays"
* Handouts-- Counselor's, Observer's and Resident's Roles for Intervention Role Plays #1, 2, 3, and 4

FORMAT:

* Role plays (60 minutes)

SEQUENCE:

1. Transition: As with the Risk Assessment Role Plays, you will all have an opportunity to assume each role (counselor, resident and observer). Let's try hard to make this a good learning experience for all.

2. Have each participant (already in groups of three) decide which part to play first.

3. Pass out instructions. Allow sufficient time to read parts. NOTE: During this session all three players will have equal information about the situation.

4. Begin role plays where the COUNSELOR asks, "Are you thinking of hurting yourself?" Give each group five minutes to do a quick assessment. Remind RESIDENTS to be open with COUNSELORS to allow a quick assessment of risk.

5. After five minutes, quickly go around to each group to report which level of suicide risk they have found. NOTE: Each group does not have to agree to move on.

6. Instruct the COUNSELORS to continue role plays based on the determined level of risk. Give groups 10-15 minutes to do this. Give a five-minute warning to wrap up at the end. In wrapping up, the COUNSELOR should note what "next steps" will be in the plan for this resident.

7. Conduct discussion, using Leader's Support as guide.

8. Repeat process until each person has had a chance to play each role. If time allows, have volunteers participate in Role Play #4.

Take a 10-minute break
mid-way through role plays

LEADER'S SUPPORT

INTERVENTION ROLE PLAYS

Before the session, review each role play and make notes on steps you would take in intervention. Keep in mind the "Guidelines for Interventions" and "Taking Care of Ourselves." It would be helpful to review, for yourself and for participants, the rules of constructive feedback provided in Session Four, Part 3. Most important, encourage and support participants' efforts and accept and be open to any feelings of anxiety, frustration, or confusion.

* Begin role plays by asking participants to do a quick suicidal risk assessment. Have them start where they ask the resident, "Are you thinking of hurting yourself?" In essence, we are beginning the role play in the middle of an assessment interview. We can assume that the counselor and resident have been in this interview for awhile.

* After five minutes, stop the role plays and ask each of the counselors to report on the level of suicidal risk they have found. NOTE: Each group does not have to agree.

* Reconvene the role plays and move into interventions based on the assessed level of suicidal risk.

* Encourage counselors to take care of themselves by engaging the assistance of the observer. They can use the observer as a consultant or as an active staff member in the intervention.

* The discussion should follow the Guidelines for Intervention. Begin by asking the counselors if they engaged the observer. Have the counselors and observers describe the steps they took in intervention. Have them spell out their "next steps" in the plan for this suicidal resident.

* Have the residents respond to how they were feeling. Were the counselors able to lessen their suicidal crisis? What "next steps" would they think most helpful?

* Point out differences in group strategies to illustrate that there is no one "right" way to intervene in a suicidal situation. Rather, each individual situation dictates its own response.

SUGGESTED MINIMAL INTERVENTIONS FOR EACH ROLE PLAY

Role Play #1

In this role play it would be appropriate to expand the alternatives of this suicidal resident, who is experiencing "tunnel vision." In discussion, find out which counselors were able to do this and what other techniques were used.

Discussion order: Counselor, observer, resident.

Role Play #2

In this role play the situation is more grave. Did the counselors contract with the resident and were they able to remove the suicidal means? It would be appropriate in this situation to key into the resident's fear of his father and attempt to alleviate the fear. The resident may be able to get past the crisis stage if he believes his father will not be able to come and hurt him.

Discussion order: Observer, resident, counselor.

Role Play #3

In this role play it is important for the counselor to get past the block in communication put up by the resident. The counselor must build trust and rapport before effective intervention can occur. An appropriate technique in this role play is to help the resident define a clearer concept of death and to expand alternatives.

Discussion order: Resident, counselor, observer.

Role Play #4

In this role play it is appropriate to help the resident clarify the problem. Once clarified, steps can be taken to develop a realistic plan.

Discussion order: Counselor, observer, resident.

SESSION SIX

CHARTS AND HANDOUTS

(in order of presentation)

INTERVENTION ROLE PLAY #1
Counselor's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. You may call upon the observer for help as a consultant or as another staff member if you wish. Begin this role play where you ask, "Are you thinking of hurting yourself?"

Remember to use the following guidelines in your intervention:

___ Take Action	___ Reinforce Coping Skills
___ Provide Support and Control	___ Mobilize Resources
___ Provide Hope	___ Establish a Contract
___ Expand Alternatives	___ Formulate a Realistic Plan
___ Ease Confusion/Reduce Crisis	___ Monitor Resident
___ Clarify Concept of Death	___ Try to Reduce Pain
___ Take Care of Yourself	___ Key Into Ambivalence

* * *

The resident is a fifteen-year-old female who has run away from home because her parents are very strict. She wants more freedom to be with friends, especially her boyfriend. She has not been allowed to go out with friends at night or even after school. She has the responsibility of caring for two younger siblings and various cooking/housekeeping chores, as both parents work.

After three days at the shelter, her behavior and emotions drastically change. This is due to a physical exam that confirms that she is pregnant. This behavior change alerts the counselor to do a risk assessment.

The resident is feeling constricted in thought (tunnel vision) and feels trapped by the situation: (1) she thinks that this situation will make her parents more strict, (2) she fears that her parents will "kill her" because of sneaking out to date her boyfriend and getting pregnant, (3) she is a strict Catholic who doesn't believe in abortion, and (4) she thinks her boyfriend will abandon her.

The suicide risk assessment reveals that this resident has thoughts that suicide may be her only solution to the problem. She has not made a plan, but is experiencing a "tunnel vision" view of the situation.

INTERVENTION ROLE PLAY #1
Observer's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. You, the observer, will take a more active role in this situation: you may be called upon for help, or asked to act as another staff member. The counselor will begin this role play by asking the resident, "Are you thinking of hurting yourself?"

Help the counselor to use the following guidelines in the intervention:

___ Take Action	___ Reinforce Coping Skills
___ Provide Support and Control	___ Mobilize Resources
___ Provide Hope	___ Establish a Contract
___ Expand Alternatives	___ Formulate a Realistic Plan
___ Ease Confusion/Reduce Crisis	___ Monitor Resident
___ Clarify Concept of Death	___ Try to Reduce Pain
___ Take Care of Yourself	___ Key Into Ambivalence

* * *

The resident is a fifteen-year-old female who has run away from home because her parents are very strict. She wants more freedom to be with friends, especially her boyfriend. She has not been allowed to go out with friends at night or even after school. She has the responsibility of caring for two younger siblings and various cooking/housekeeping chores, as both parents work.

After three days at the shelter, her behavior and emotions drastically change. This is due to a physical exam that confirms that she is pregnant. This behavior change alerts the counselor to do a risk assessment.

The resident is feeling constricted in thought (tunnel vision) and feels trapped by the situation: (1) she thinks that this situation will make her parents more strict, (2) she fears that her parents will "kill her" because of sneaking out to date her boyfriend and getting pregnant, (3) she is a strict Catholic who doesn't believe in abortion, and (4) she thinks her boyfriend will abandon her.

The suicide risk assessment reveals that this resident has thoughts that suicide may be her only solution to the problem. She has not made a plan, but is experiencing a "tunnel vision" view of the situation.

INTERVENTION ROLE PLAY #1
Resident's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. The counselor will begin this role play by asking the resident, "Are you thinking of hurting yourself?"

* * *

You are a fifteen-year-old female who has run away from home because your parents are very strict. You want more freedom to be with friends, especially your boyfriend. You have not been allowed to go out with friends at night or even after school. You have the responsibility of caring for two younger siblings and various cooking/housekeeping chores, as both your parents work.

After three days at the shelter, your behavior and emotions drastically change. This is due to a physical exam that confirms that you are pregnant. Your behavior change alerts the counselor to do a risk assessment.

You are feeling constricted in thought (tunnel vision) and feel trapped by the situation: (1) you think that this situation will make your parents more strict, (2) you fear that your parents will "kill" you because of sneaking out to date your boyfriend and getting pregnant, (3) you are a strict Catholic who doesn't believe in abortion, and (4) you think your boyfriend will abandon you.

The suicide risk assessment done by the counselor reveals that you think that suicide may be your only solution to the problem. You have not made a plan, but are experiencing a "tunnel vision" view of the situation.

INTERVENTION ROLE PLAY #2
Counselor's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. The observer may be called upon for help as a consultant or as another staff member if you wish. Begin this role play where you ask the resident, "Are you thinking of hurting yourself?"

Remember to use the following guidelines in your intervention:

___ Take Action	___ Reinforce Coping Skills
___ Provide Support and Control	___ Mobilize Resources
___ Provide Hope	___ Establish a Contract
___ Expand Alternatives	___ Formulate a Realistic Plan
___ Ease Confusion/Reduce Crisis	___ Monitor Resident
___ Clarify Concept of Death	___ Try to Reduce Pain
___ Take Care of Yourself	___ Key Into Ambivalence

* * *

A fourteen-year-old male runs to the shelter because he got a failing mark on his report card. The failing mark was the last straw for him. He is terrified of what his father will do when he finds out. This teen has suffered severe physical abuse in the past. This time the youth fears his father will kill him. He feels no support from his mother, who is an alcoholic and is emotionally detached.

This youth hates his parents and thinks that if he commits suicide it would be an appropriate revenge. He has attempted suicide twice in the past and has decided that he will hang himself this time. He knows how to do it and has the means (some rope) in his bag. He feels he must kill himself before his parents find out where he is. Otherwise, his father will come and take him home.

The youth is ambivalent about dying. He really only wants the situation at home to change (for his mother to take interest and for his father to stop abusing him) but he doesn't think it will happen. At this point the youth is feeling trapped and terrified.

INTERVENTION ROLE PLAY #2
Observer's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. You, the observer, will take a more active role in this situation: you may be called upon for help, or asked to act as another staff member. The counselor will begin this role play by asking the resident, "Are you thinking of hurting yourself?"

Help the counselor to use the following guidelines in the intervention:

___ Take Action	___ Reinforce Coping Skills
___ Provide Support and Control	___ Mobilize Resources
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___ Expand Alternatives	___ Formulate a Realistic Plan
___ Ease Confusion/Reduce Crisis	___ Monitor Resident
___ Clarify Concept of Death	___ Try to Reduce Pain
___ Take Care of Yourself	___ Key Into Ambivalence

* * *

A fourteen-year-old male runs to the shelter because he got a failing mark on his report card. The failing mark was the last straw for him. He is terrified of what his father will do when he finds out. The teen has suffered severe physical abuse in the past. This time the youth fears his father will kill him. He feels no support from his mother, who is an alcoholic and is emotionally detached.

This youth hates his parents and thinks that if he commits suicide it would be an appropriate revenge. He has attempted suicide twice in the past and has decided that he will hang himself this time. He knows how to do it and has the means (some rope) in his bag. He feels he must kill himself before his parents find out where he is. Otherwise, his father will come and take him home.

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INTERVENTION ROLE PLAY #2
Resident's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. The counselor will begin this role play by asking the resident, "Are you thinking of hurting yourself?"

* * *

You are a fourteen-year-old male who runs to the shelter because you got a failing mark on your report card. The failing mark was the last straw. You are terrified of what your father will do when he finds out. You have suffered severe physical abuse in the past. This time you fear your father will kill you. You feel no support from your mother, who is an alcoholic and is emotionally detached.

You hate your parents and think that committing suicide would be an appropriate revenge. You have attempted suicide twice in the past and have decided to hang yourself this time. You know how to do it and have the means (some rope) in your bag. You feel you must kill yourself before your parents find out where you are. Otherwise, your father will come and take you home.

You are ambivalent about dying. You really only want the situation at home to change (for your mother to take interest and for your father to stop abusing you) but you don't think it will happen. At this point you feel trapped and terrified.

INTERVENTION ROLE PLAY #3
Counselor's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. The observer may be called upon for help as a consultant or as another staff member if you wish. Begin this role play where you ask, "Are you thinking of hurting yourself?"

Remember to use the following guidelines in your intervention:

___ Take Action	___ Reinforce Coping Skills
___ Provide Support and Control	___ Mobilize Resources
___ Provide Hope	___ Establish a Contract
___ Expand Alternatives	___ Formulate a Realistic Plan
___ Ease Confusion/Reduce Crisis	___ Monitor Resident
___ Clarify Concept of Death	___ Try to Reduce Pain
___ Take Care of Yourself	___ Key Into Ambivalence

* * *

The suicidal ideas of this shelter resident came to the attention of the counselor by way of another resident, who is worried because this roommate has been dropping suicidal hints. The suicidal resident has been writing suicide notes and talking about having some pills. In reality, the suicidal resident doesn't have any pills, but knows where to find some. This suicidal resident has been experiencing many symptoms of depression and is frightened by suicidal thoughts. His/her parents are not taking the problem seriously.

This youth ran away from home to call attention to the serious nature of his/her problems. Being very angry at his/her parents because they are not listening to the "cry for help," this youth thinks that a suicide attempt is needed to get them to listen. This youth does not want to commit suicide. Rather, he/she wants help. In fact, this youth doesn't even want to attempt suicide, but thinks that it is the only way to get attention.

When the counselor was doing the suicide risk assessment, a communication block surfaced because the resident felt that his/her confidence was betrayed by the roommate. The suicidal resident fears that the counselor's involvement may make matters worse. The counselor will need to get through these hostile and guarded feelings of the resident. Focus on intervention.

INTERVENTION ROLE PLAY #3
Observer's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. You, the observer, will take a more active role in this situation: you may be called upon for help, or asked to act as another staff member. The counselor will begin this role play by asking the resident, "Are you thinking of hurting yourself?"

Help the counselor to use the following guidelines in the intervention:

___ Take Action	___ Reinforce Coping Skills
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The suicidal ideas of this shelter resident came to the attention of the counselor by way of another resident, who is worried because this roommate has been dropping suicidal hints. The suicidal resident has been writing suicide notes and talking about having some pills. In reality, the suicidal resident doesn't have any pills, but knows where to find some. This suicidal resident has been experiencing many symptoms of depression and is frightened by suicidal thoughts. His/her parents are not taking the problem seriously.

This youth ran away from home to call attention to the serious nature of his/her problems. Being very angry at his/her parents because they are not listening to the "cry for help," this youth thinks that a suicide attempt is needed to get them to listen. This youth does not want to commit suicide. Rather, he/she wants help. In fact, this youth doesn't even want to attempt suicide, but thinks that it is the only way to get attention.

When the counselor was doing the suicide risk assessment, a communication block surfaced because the resident felt that confidence was betrayed by the roommate. The suicidal resident fears that the counselor's involvement may make matters worse. The counselor will need to get through the hostile and guarded feelings of the resident. Focus on intervention.

INTERVENTION ROLE PLAY #3
Resident's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. The counselor will begin this role play by asking the resident, "Are you thinking of hurting yourself?"

* * *

Your suicidal ideas came to the attention of the counselor by way of another resident (your roommate), who is worried because you have been dropping suicidal hints, writing suicide notes and talking about having some pills. In reality, you don't have any pills but you do know where to get some. You have been experiencing many symptoms of depression and are frightened by suicidal thoughts. Your parents are not taking the problem seriously.

You ran away from home to call attention to the serious nature of your problems. You are very angry at your parents because they are not listening to your "cry for help." You think that a suicide attempt is needed to get your parents to listen. You do not want to kill yourself. Rather, you want help. In fact, you don't even want to attempt suicide, but think it is the only way to get attention.

When the counselor was doing the suicide risk assessment, a communication block surfaced because you felt that your confidence was betrayed by your roommate. You don't want the counselor to get involved because this could make matters worse. The counselor will need to get through these hostile and guarded feelings.

INTERVENTION ROLE PLAY #4
Counselor's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. The observer may be called upon for help as a consultant or as another staff member if you wish. Begin this role play by asking the resident, "Are you thinking of hurting yourself?"

Remember to use the following guidelines in your intervention:

___ Take Action

___ Provide Support and Control

___ Provide Hope

___ Expand Alternatives

___ Ease Confusion/Reduce Crisis

___ Clarify Concept of Death

___ Take Care of Yourself

___ Reinforce Coping Skills

___ Mobilize Resources

___ Establish a Contract

___ Formulate a Realistic Plan

___ Monitor Resident

___ Try to Reduce Pain

___ Key Into Ambivalence

* * *

A sixteen-year-old male was dropped off at the shelter by his father. He has been crying for hours. His world has been completely shattered ever since he confided to his friends that he thought he was gay. He was kicked off the varsity hockey team, lost his friends, and was disowned by his family. He is totally confused and feels that his life has ended. He is frightened both by his gay feelings and some fleeting thoughts about suicide.

The suicide risk assessment shows that the resident may be at high risk for suicide due to isolation and feelings of hopelessness, but isn't in imminent danger. This youth is totally confused about his emotions and situation. Focus on intervention.

INTERVENTION ROLE PLAY #4
Observer's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. You, the observer, will take a more active role in this situation: you may be called upon for help as observer or asked to act as another staff member. The counselor will begin this role play by asking the resident, "Are you thinking of hurting yourself?"

Help the counselor to use the following guidelines in the intervention:

___ Take Action	___ Reinforce Coping Skills
___ Provide Support and Control	___ Mobilize Resources
___ Provide Hope	___ Establish a Contract
___ Expand Alternatives	___ Formulate a Realistic Plan
___ Ease Confusion/Reduce Crisis	___ Monitor Resident
___ Clarify Concept of Death	___ Try to Reduce Pain
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* * *

A sixteen-year-old male was dropped off at the shelter by his father. He has been crying for hours. His world has been completely shattered ever since he confided to his friends that he thought he was gay. He was kicked off the varsity hockey team, lost his friends, and was disowned by his family. He is totally confused and feels that his life has ended. He is frightened both by his gay feelings and some fleeting thoughts about suicide.

The suicide risk assessment shows that the resident may be at high risk for suicide due to isolation and feelings of hopelessness, but isn't in imminent danger. This youth is totally confused about his emotions and situation. Focus on intervention.

INTERVENTION ROLE PLAY #4
Resident's Role

This role play is identical to the assessment role play. In this case, the counselor, observer and resident all have the same information. The counselor will begin this role play by asking the resident, "Are you thinking of hurting yourself?"

* * *

You are a sixteen-year-old male who was dropped off at the shelter by your father. You have been crying for hours. Your world has been completely shattered ever since you confided to your friends that you think you are gay. You were kicked off the varsity hockey team, lost your friends, and have been disowned by your family. You are totally confused and feel that your life has ended. You are frightened both by your gay feelings and your fleeting thoughts about suicide.

The suicide risk assessment done by the counselor shows that you may be at high risk for suicide due to isolation and feelings of hopelessness, but you aren't in imminent danger. You are totally confused about your emotions and the situation.

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