

# HELPING HAND

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## Warning Signs of Suicidal Tendencies in Children

**A**lthough many suicidal children and adolescents do not self-refer, they do show warning signs to their peers, parents or trusted school personnel. **Never ignore these signs.** Suicide can be prevented with proper intervention. Parents and school personnel must be good listeners and observers. Below are some guidelines for intervening with a suicidal student.

### Warning Signs of Youth Suicide

**Suicide notes.** These are a very real sign of danger and should be taken seriously.

**Threats.** Threats may be direct ("I want to die." "I am going to kill myself.") or, unfortunately, indirect ("The world would be better without me." "Nobody will miss me anyway.")

**Previous attempts.** Often the best predictor of future behavior is past behavior, which can indicate a coping style.

**Depression.** When symptoms of depression include pervasive thoughts of helplessness and hopelessness, a child or adolescent is conceivably at greater risk for suicide.

**Masked depression.** Risk-taking behaviors can include acts of aggression, gunplay, and alcohol/substance abuse.

**Final arrangements.** This behavior may take many forms. In adolescents, it might be giving away prized possessions such as jewelry, clothing, journals or pictures.

**Efforts to hurt oneself.** Self-mutilating behaviors occur among children as young as elementary school-age. Common self-destructive behaviors include running into traffic, jumping from heights, and scratching/cutting/markings the body.

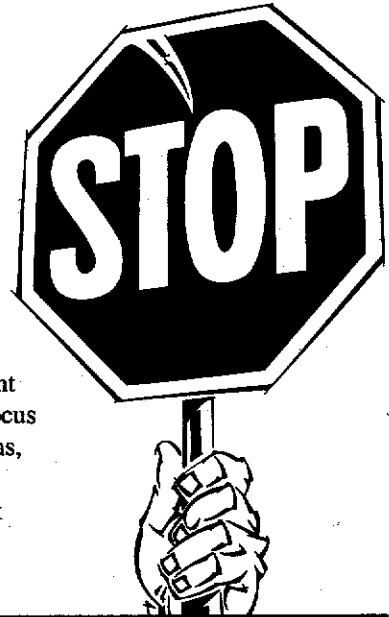
**Inability to concentrate or think rationally.** Such problems may be reflected in children's classroom behavior, homework habits, academic performance, household chores, even conversation.

**Changes in physical habits and appearance.** Changes include inability to sleep or sleeping all the time, sudden weight gain or loss, disinterest in appearance, hygiene, etc.

**Sudden changes in personality, friends, behaviors.** Parents, teachers and peers are often the best observers of sudden changes in suicidal students.

**Death and suicidal themes.** These might appear in classroom drawings, work samples, journals or homework.

**Plan/method/access.** A suicidal child or adolescent may show an increased focus on guns and other weapons, increased access to guns, pills, etc., and/or may talk about or allude to a suicide plan.



### Tips for Teachers

**Know the school's responsibilities.** Schools have been held liable in the courts for not warning the parents in a timely fashion or adequately supervising the suicidal student.

**Encourage students to confide in you.** Let students know that you are there to help, that you care. Encourage them to come to you if they or someone they know is considering suicide.

**Refer student immediately.** Do not "send" a student to the school psychologist or counselor.

**Escort the child yourself to a member of the school's crisis team.** If a team has not been identified, notify the principal, psychologist, counselor, nurse or social worker. (And as soon as possible, request that your school organize a crisis team!)

**Join the crisis team.** You have valuable information to contribute so that the school crisis team can make an accurate assessment of risk.

**Advocate for the child.** Sometimes administrators may minimize risk factors and warning signs in a particular student. Advocate for the child until you are certain the child is safe.

# Young Adulthood: A Time to Make or Break Bad Habits

By the time they reach early adulthood, a large proportion of American youth have begun the poor practices contributing to three leading causes of preventable death in the United States: smoking, overweight and obesity, and alcohol abuse. This finding is according to a National Institutes of Health (NIH)-funded analysis of the most comprehensive survey of adolescent health behavior undertaken to date.

The analysis also found that Americans are less likely to have access to health care when they reach adulthood than they did during the teenage years.

The analysis appears in the January 2006 *Archives of Pediatrics and Adolescent Medicine* and was conducted by researchers at the Carolina Population Center and the University of North Carolina at Chapel Hill.

"Smoking, obesity, and alcohol abuse are leading contributors to preventable

death in the United States," says Duane Alexander, MD, director of the National Institute of Child Health and Human Development, the NIH institute that funded the analysis. "By early adulthood, a large proportion of Americans smoke, are overweight, and drink alcohol to excess."

The survey participants responded to questions on diet, inactivity, obesity, tobacco use, substance use, binge drinking, violence, reproductive health, mental health, and access to health care.

For nearly all groups surveyed, diet, activity level, obesity, health care access, tobacco, alcohol and illicit drug use, and likelihood of acquiring a sexually-transmitted disease worsened as the youth reached adulthood.

By the time they had reached adulthood, the participants were more likely to be obese, to frequently eat fast food, and to be sedentary. They were also

less likely to have health insurance, to receive health care when they needed it, or to receive regular dental and physical health examinations.

The authors reported "dramatic" increases in behaviors related to three leading contributors to preventable deaths. These findings underscore the importance of ongoing preventive efforts related to smoking; poor diet and physical inactivity; and alcohol consumption, early in the life course.

The researchers added that the decline in health care coverage resulted from young adults leaving their parents' health insurance or Medicaid coverage as they reached legal age. On the positive side, participants were less likely to experience feelings of depression at adulthood than when they were adolescents, less likely to have suicidal thoughts, and less likely to be victims or perpetrators of violence.

## An Estimated 2.7 Million Children Have Emotional and Behavioral Problems

A special feature in the report, *America's Children: Key National Indicators of Well-Being 2005* shows that nearly 5% — or an estimated 2.7 million children — are reported by their parents to suffer from definite or severe emotional or behavioral difficulties, problems that may interfere with their family life, their ability to learn, and their formation of friendships.

This special child mental health indicator is based on responses from a sample of parents of children ages 4-17. They were asked to rate their child's difficulty with emotions, concentration, behavior, and ability to get along with other people.

"Parents are usually the first to notice emotional and behavioral difficulties in their children," said Thomas R. Insel, M.D., Director of the National Institute of Mental Health of the National Institutes of Health. "We encourage them to talk to

a health care or mental health professional if they are concerned about their child's mental, behavioral or emotional health."

Parents also reported:

- Boys were more likely than girls to have definite or severe emotional and behavioral difficulties.
- Children ages 8 and over were more likely than younger children to have emotional or behavioral difficulties.
- Children from poor families were more likely to have emotional or behavioral difficulties than other children.

The information for this special feature, Parental Reports of Emotional and Behavioral Difficulties, was contributed by experts from the National Institute of Mental Health, the Center for Mental Health Services in the Substance Abuse and Mental Health Services

Administration, the National Center for Health Statistics, the National Center for Birth Defects and Developmental Disabilities, and an international panel.

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# When Does a Student Need a Referral to the Student Assistance Program?

When symptoms persist several months and/or are disruptive to the student's academic, social, mental or physical functioning, you may need to recommend professional help. Counseling may be recommended as a preventive measure.

## How should the referral be made?

In making such a referral, it is important to stress that it is not a sign of failure from parents if they find they are not able to help their child by themselves. It is also important to note that early action will help the child return to normal and to avoid more severe problems later.

## When should a referral be made for a preschool or elementary school student?

### Consider referring the family for help if the child:

- seems excessively withdrawn and depressed.
- does not respond to special attention and attempts to draw him/her out.
- exhibits extreme signs of anxiety, such as excessive clinging, irritability, eating or sleeping problems for more than one month.

## When should a referral be made for a junior high or high school student?

### Consider referral if the student:

- is disoriented; that is, if he/she is unable to give own name, town and the date.
- complains of significant memory gaps.
- is despondent and shows agitation, restlessness and pacing.
- is severely depressed and withdrawn.
- mutilates self.
- uses drugs or alcohol excessively.
- is unable to care for self, e.g., doesn't eat, drink, bathe or change clothes.
- repeats ritualistic acts.
- hallucinates, hears voices or sees visions.
- states his or her body feels "unreal" and expresses fears that he/she is "going crazy."
- is excessively preoccupied with one idea or thought.
- has a delusion that someone or something is out to get him and his family.
- is afraid he or she will kill self or another.
- is unable to make simple decisions or carry out everyday functions.
- shows extreme pressure of speech — talk overflows.

For more information on responding to mental health needs in times of crises, or to find out about local mental health services, contact 1-800-789-2647, or visit <http://www.mentalhealth.samhsa.gov> (click on "Crisis Counseling").

## Searching for Solutions to Eating Disorders

Eating is controlled by many factors, including appetite, food availability, family, peer, and cultural practices, and attempts at voluntary control. *Eating disorders* involve serious disturbances in eating behavior, such as extreme and unhealthy reduction of food intake or severe overeating, as well as feelings of distress or extreme concern about body shape or weight. Researchers are investigating how and why initially voluntary behaviors, such as eating smaller or larger amounts of food than usual, at some point move beyond control in some people and develop into an eating disorder.

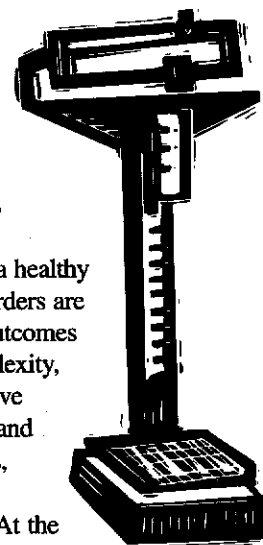
Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which certain maladaptive patterns of eating take on a life of their own. The main types of eating disorders are anorexia nervosa and bulimia nervosa. A third type, binge-eating disorder, has been suggested but has not yet been approved as a formal psychiatric diagnosis. Eating disorders frequently develop during adolescence or early adulthood, but some reports indicate their onset can occur during

childhood or later in adulthood.

Recognition of eating disorders as real and treatable diseases, therefore, is critically important.

Eating disorders can be treated and a healthy weight restored. The sooner these disorders are diagnosed and treated, the better the outcomes are likely to be. Because of their complexity, eating disorders require a comprehensive treatment plan involving medical care and monitoring, psychosocial interventions, nutritional counseling and, when appropriate, medication management. At the time of diagnosis, the clinician must determine whether the person is in immediate danger and requires hospitalization.

People with eating disorders often do not recognize or admit that they are ill. As a result, they may strongly resist getting and staying in treatment. Family members or other trusted individuals can be helpful in ensuring that the person with an eating disorder receives needed care and rehabilitation. For some people, treatment may be long term.





## I'm Human, Too

### Objectives

Students will identify offensive beliefs and/or remarks said about "their group" and share positive ways to counter them. Students will explore ways to increase people's sensitivity to cultural differences.

### Description

Students identify groups they belong to and, working with others of that same group, identify offensive images, remarks or viewpoints held about their group. Each group shares its list of offenses with the entire class. Through role-playing, students examine alternate ways of responding when offended, whether the offense is directed to them personally or to another person or group.

### Procedure

1. Have students help decide what types of groupings could be used that would divide the class into four to six groups. (Possible groupings are by race, ethnicity, gender, religious affiliation, extracurricular activities, musical tastes, etc.)
2. Have each student choose one group in which he or she is a member and meet with this group. There should be at least two students in every group. In each group, students list things that they "never want said again" about their group. After the groups have developed their lists, each is asked to come up before the class and have one member read its findings.

### Ground Rules for Activities and Discussions

- Listen carefully and patiently to each person who speaks.
- Express yourself openly and honestly.
- Search for truth from each person's perspective.
- Avoid belittling or blaming.
- Maintain each person's confidentiality.

### Follow-Up

1. After all groups share their lists, ask students the following questions:

- What are some effective ways you have responded to offensive remarks or biased views?
  - What types of responses are not helpful and cause further misunderstanding and/or anger?
2. Ask students to share personal experiences in which they were offended or when they have offended someone and learned from the experience.
  3. Have students form groups of two to six people. Have the groups develop a scenario in which they encounter someone who is offensive and confront that person. Stress the importance of being positive and assertive — not aggressive.
  4. After each role-play, discuss the strategy used and its effectiveness. When all groups are finished, have a discussion on the importance of standing up for others as well as for oneself.

### Remember:

- At some point, either now or in the future, each of us could find ourselves in a position of being ridiculed or stereotyped and in need of support from others. If we do not stand up for others, we risk not receiving their support when we are in need.
- Justice, safety and a sense of community are everyone's issues.
- We can agree to disagree. Opinions can and will clash, but people should not.
- When we are confronted with different perspectives, many of us have been taught to support and defend a position or belief, rather than to seek the truth.
- We all have differing perspectives based on our different backgrounds.

*This activity originally appeared in the Fall 1998 issue of Teaching Tolerance magazine and was adapted with permission from the Building Cultural Bridges curriculum (\$97; grades 7-12, available from: National Education Service, 1-800-733-6786)*

**For more information, contact:**

**For more information about Chippewa Valley Schools' Student Assistance (drug and violence prevention) programming, please call 586/723-2360.**