Appendix One
Situational Conditions that are associated with increased risk of suicide

- The death of a family member or close friend.
- Anniversary dates of painful life events such as the death of a parent or loved one.
- Tough transition times (e.g., parental divorce, breakup of a romantic relationship, anxiety over graduation, rejection by valued friend or social group, school transfer).
- Being socially isolated and lonely—lack of close personal relationships
- Problems with blended family relationships (stepparents or siblings).
- Chronic and intensifying conflict with parents, teachers, employers, peers.
- Severely dysfunctional family situations (substance abuse, sexual abuse, violence)
- Onset of serious illness in youth or family member with little hope for improvement.
- Experience or anticipation of significant failure or embarrassment
- Loss of job or valued role.
- Incarceration or pending incarceration, trouble with the law.
- Serious alcohol or drug abuse, with either primary or secondary depression
- Confirmation of an unwanted pregnancy
- Being forced to take on what seem like overwhelming responsibilities
- Intense pressure for achievement coupled with fear of disapproval or failure
- Conflicts over one's emerging sexual identity or preference.

(Taken from Preventing Youth Suicide)

Appendix Two
Personal conditions that may be associated with suicidal thinking

- Marked changes in behavior. These may include changes in sleeping patterns, onset of eating disorders, extreme promiscuity, dramatic emotional outbursts, uncharacteristic acts of rebellion, dramatic decline in school performance
- Voluntary isolation from friends and withdrawal from normally sociable activities
- Significant increase in the use of alcohol and/or drugs
- Neglect of personal appearance
- Senseless risk taking or clear lack of concern for personal welfare
- Exaggeration of health complaints or the emergence of psychosomatic illnesses
- Pronounced difficulty in being able to concentrate on tasks (often coupled with dramatic mood changes).
- Preoccupation with death, with morbid thoughts or themes of destruction
- Expressions of pervasive and enduring sadness, or expressions of emotion that seem not at all to fit in with the social context.
- Inability to make even the most minor decisions.
- Low self esteem
- Preoccupation with escape fantasies
- Intense anger or desire for revenge against real or imagined enemies.
- Behavior that is characterized as putting one's life in order (giving away possessions, settling accounts)
- Constant seeking of attention through inappropriate behaviors
- Suicide threats or attempts to commit suicide

(Taken from Preventing Youth Suicide)

Appendix Five
Screening or Suicide

Red flag questions
During the course of the assessment, a positive response to any of these three questions would usually be an indication the youth should be referred for a more detailed assessment. They are:

- **Are you thinking seriously about killing yourself?**
- **Do you have a plan for killing yourself?**
- **If you have been considering suicide, do you have the means to take your life?**

Additional indicator questions
These questions are often useful in a preliminary assessment of risk. The McEvoys consider three or more positives grounds for further referral, but they acknowledge the arbitrary nature of this count. The evaluator's judgment and sense of the youth are important.. These questions serve to get a sense of risk by discussing serious issues.

- Have you made a previous suicide attempt?
- Do any adults who can help you know about this?
- Did you receive any help following your attempt?
- Do you still want to die? (See red flag questions above.)
- Have any of your family or close friends attempted suicide or taken their own lives?
- Are you having serious trouble at school, at home, or with the law?
- Can you see any way to solve the problems other than suicide?
- Do you have anyone to turn to for help or support right now?
- Do you get drunk or "high" at least twice a week?
- Do you feel deeply guilty or extremely angry about things that have happened?
- Do you have any hope that the future will be better?

(Adapted from Preventing Youth Suicide)

Appendix Four
General Interviewing Principals

Establish Rapport

- Speak calmly and slowly. The more confident and in control you appear, the more security the youth will feel.
- Use basic terms about feelings, such as "sad, unhappy, hurt, angry, discouraged." Avoid using technical or therapeutic jargon.
- Label and reflect the student's feelings by using phrases that reflect interactive listening, such as "It sounds as if you are feeling..., I'm hearing you say that you are...I wonder if you..." Feeling "heard and understood" is a very important part of connection.
- Don't minimize or maximize a student's problems or don't dismiss a student's thoughts as ridiculous or exaggerated. Try to encourage an honest expression of feelings.
- Try not to act judgmental. Expressions of anger, irritation, disapproval or moralizing about the student's deficiencies only make the youth feel more isolated and vulnerable.
- Resist the urge to begin problem solving during the initial part of the interview. Sometimes the first problem you hear is not the full issue. Also, people need time to feel emotionally connected before they can switch from a process of disclosure to a process of problem solving.

If you don't know the student:

- In a straightforward way, identify that someone has indicated that the youth has not seemed to be themselves, seemed more unhappy, seemed to not look well, or whatever. Try to cite facts and not inferences.
- Indicate that people are concerned and have asked that you speak with the youth. Approach the student from a viewpoint of caring and concern.
- Ask whether there is something bothering the student that the youth could talk about. Ask what has been going on recently in the student's life.
- Listen carefully to the answer.

If you know the student:

- Indicate your observations that the student seems to be having some difficulty, not doing well, appears unhappy or seems to be getting into trouble often. Try to cite facts and not inferences.
- Indicate your concern for the student. Approach the youth from a viewpoint of caring and concern.
- Ask whether there is something bothering the student that the youth could talk about. Ask what has been going on recently in the student's life.
- Listen carefully to the answer.

Appendix Six
Advanced Risk Assessment

The goal of conducting a more comprehensive assessment of suicide risk is to answer three basic questions:

- Accuracy—is the youth truly at risk?
- Magnitude—How great is the risk? Is the student in imminent danger?
- Source—What is the cause of the crisis?

All of this information the goal is to formulate an appropriate intervention.

Assess suicidal thoughts
It is critical to assess the frequency, duration and intensity of a person's thoughts about suicide as a way of dealing with whatever the youth faces. The more time and energy spent thinking about death, the likely the higher the risk. Questions can be asked very directly about suicidal thoughts—do they occur, how often do they occur, how long do they last, how close the student has come to acting on the thoughts—as a means of getting a sense of risk.

Assess suicidal plans
Generally, the more specific the suicide plan, the higher the risk. A detailed, specific and thought out suicide plan is of great concern and indicates immediate danger. However, since adolescents tend to be more impulsive than adults, the limited capability of some impulsive youths needs to be factored into the assessment of risk. Also, the use of alcohol is associated with much higher risk since it tends to reduce inhibitions.

Most suicide-prone youths will respond honestly if asked straightforward questions. If a student says nothing about having suicidal thoughts or seems deliberately evasive, it may be necessary to either have another interviewer reevaluate the child, or proceed as if there is risk.

Examine behavioral history
Previous episodes of suicidal behavior are of concern, particularly if they were serious attempts, or if the child shows a pattern of increasing seriousness of attempts. A person with a history of a suicide attempt in the last year or a completed suicide within the family has a forty times higher risk than the general population. Multiple poorly defined physical complaints (which are likely indicators of stress) are also of concern. Family members or friends who have committed suicide are a serious indicator, both because of the modeling behavior and because of the desire to be reunited with the dead person.

Assess social relationships
States of depression, anger, guilt and estrangement in the context of hopelessness are consistently associated with suicidal students. We know that if students who face serious problems feel isolat4ed, rejected, or cut-off from significant others, they are at high risk of risk of developing a depressed condition that could provoke suicide. Some are also likely to fee a deep anger which they may direct towards others or which they turn inward. This is particularly true in cases where there is serious family dysfunction. It is important to get a sense of how the student characterizes the dysfunction, and whether the student sees other means of support as being available and usable.

Appendix Three
Range of Suicidal Behaviors

- **Suicidal ideation** refers to conscious thoughts of suicide. These cognitions may range from fleeting thoughts to a chronic preoccupation. Although some consideration may have been given to means of suicide, no overtly self-destructive behaviors are displayed.
- **Suicidal gestures** are mild self-destructive behaviors displayed by individuals with thoughts of suicide. However, these behaviors do not cause physical harm (e.g. pointing an unloaded gun at one's head). Gestures range in purpose from a way to express distress to a rehearsal for a suicide attempt. They may or may not be a part of a suicide plan.
- **Parasuicide** is more severe planned self-destructive behavior that has resulted in significant, nonfatal physical harm. Parasuicide is often referred to as attempted suicide, but sometimes the term is used when the intent to die is low. Obviously there is a fine line between low-intent-to-die parasuicide and high-intent-to-die attempted suicide. Parasuicide can be lethal and may result in "accidental suicides." Sometimes if you walk along the edge of a cliff, the ground gives way out from under you.
- **Attempted suicide** refers to serious, planned, self-destructive acts that result in significant but nonfatal physical harm. Unlike parasuicidal behavior, the individual's intent to die is high. The means employed in attempted suicide are typically more lethal than those in parasuicide. The use of lethal means is highly correlated with high intent to die.

Taken from Brock and Sandoval, Suicidal Ideation and Behaviors, in Crisis Intervention and Response: A Collection of National Association of School Psychologists Resources, in the Sunnyvale School District Pupil Personnel Crisis Intervention Manual

The Centre For Living With Dying
Healing Heart Program
Age related behaviors and perceptions about significant loss and death

Children ages 5 thru 8

Children ages 5-8 are able to accept the idea of death or dying, but also believe that not eveyone will die, especially them.

- Agression (hitting)
- Less social interaction (joining in play with others)
- Regrassive behavior (bed wetting, thumb sucking)
- Possessiveness of living parent
- Physical aliments such as stomach aches, head aches
- Not wanting to go to day care or school
- Irritable
- Separation anxiety (tantrums, nagging, whining)
- Moody
- Magical thinking or unrealistic fantasies
- Fears - of the dark, for example
- Anger
- Scared about the future
- Responsiblilty for the death - blames self
- Lower self esteem
- Confusion
- Decline in school work
- Forgotful, distracted or distant
- Apathy- not much desire to do anything

Age 9 thru 12

At ages 9-12, children begin to realize that death is final and that everyone will die, including them. Children this age may also believe in an afterlife.

- Distancing in relationships with their peers
- Acting out aggressive behavior
- Bossiness
- Possessiveness of remaining family members
- Physical complaints (headaches, stomache aches, chest pains)
- Loneliness / longing for person who died
- Depression / anxiety
- Fear of life or the world (no control over anything)
- Scared other family member or friend will die too
- Gulit
- Feeling rejected by people who are close (or friends)
- Inability to concentrate
- Fear of "going crazy"
- Unorganized (both time and life)
- Drop in school performance
- Afraid it will always be this way
- Distracted
- Forgetful

HANDLING A CLASS AFTER A STUDENT DIES

Nearly every teacher involved with a death in the classroom or the school community needs help in handling his or her class. The following strategies, which involve many sharing experiences, will help.

1. Don't be impassive about a student's death. Share reactions with the class.

2. Let the children talk and write about their feelings.

3. Listen to whatever students have to say. Never shut off discussion.

4. Make sure the class knows the details of the student's illness. Especially for younger children, separate the illness of the child who dies from any medical problems his or her classmates experience.

5. Never tell young children, "God took Sally always because He loves her," because children will wonder if it's a good idea to be loved by God. Likewise, don't say " Sally went to sleep"; you may create a class of insomniacs.

6. Don't force a "regular day" upon grieving students, but at the same time, don't allow the class to be totally unstructured. Offer choices of activities such as letters, journals, and discussions.

7. Ask the students to write personal sympathy notes either to the parents or to a student who has suffered a loss. Give an address for these notes or offer to deliver them yourself.

8. Older students may want to plan more concrete expressions of concern. Allow them to arrange a schedule for making food for the family. Help them raise money for a memorial scholarship fund, medical research donations, or a cause especially commemorative of the deceased student through functions such as car washes, dances, or basketball games.

9. Make sure that visitation times are well publicized, perhaps with a tactful lesson on funeral etiquette.

10. Explain how students should treat a bereaved student who is returning to school. Emphasize that trying to avoid or being overly solicitous to the student will not help. Point out the need to resume normal relationships.

11. Remember that your class may remain quiet and depressed for some time afterward (perhaps even a month), and that some students may begin to act out noisily and physically as a way of affirming that they are still alive.

No Self-Harm Contract

Client Name_____ Phone_____

Address_____ City_____ State_____ Zip_____

Person to Contact in an Emergency.

Relation to Cient_____

Address_____ City_____ State_____ Zip_____

In the event that I, _____, am feeling badly:
Client Name

1. I promise that I will not attempt to hurt or harm myself in any way.
2. I promise not to hurt or harm myself accidentally or on purpose.
3. I promise that any time I feel badly and/or begin to have thoughts about hurting or harming myself, I will call_____ and come in for a face-to face meeting as soon as reasonably possible.
4. I promise that if I am unable to reach my therapist, I will call the
   Suicide and Crisis Service at 408-279-3312
5. If I am not able to contact my therapist or the Suicide and Crisis Service, I promise to immediately :
   A. Call 911
   B. Report my Status
   C. Wait for help to arrive
   D. Not take any action to hurt or harm myself accidentally or on purpose.

I have read and understand the terms and conditions stated above. All my questions have been answered, and I agree to fully comply with this No Self-Harm Contract.

_____

Date and Time Signature of Client Printed Name

In my presence, the client has read the provisions of this No Self-Harm Contact out loud tome, and in my judgement appears to have demonstrated a clear understanding of all its terms and conditions.

_____

Date and Time Signature of Therapist Printed Name