

STARTING YOUNG, STARTING EARLY

CRY FOR HELP: Can Children Elementary-Age and Younger Really Be Suicidal?

Well Aware



WEBINAR #1 of 3

**CRY FOR HELP:**  
Can Children Elementary-Age and Younger Really Be Suicidal?

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STARTING YOUNG, STARTING EARLY PROLOGUE




CRY FOR HELP: Can Children Elementary-Age and Younger Really Be Suicidal?

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Welcome to the 1<sup>st</sup> in our series of webinars for Fall 2011

WELL AWARE WEBINARS

UPCOMING WEBINAR

<p>TUESDAY, SEPTEMBER 27th 3-4:30 PM Eastern</p>  <p><b>CRY FOR HELP:</b> Can Children Elementary-Age and Younger Really Be Suicidal? WITH CYNTHIA R. PEPPER, M.D.</p>	<p>TUESDAY, OCTOBER 18th 3-4:30 PM Eastern</p>  <p><b>BUILDING LIGHT:</b> Using Positive Coping Skills for Parents for Children in Their Charge WITH CYNTHIA R. PEPPER, M.D. AND MARLENE CALVERT, M.S.</p>	<p>WEDNESDAY, NOVEMBER 2nd 3-4:30 PM Eastern</p>  <p><b>HOW YOUNG IS TOO YOUNG?</b> An Intervention Program for Parent-Child Relationships in Children WITH DENISE ENEMY, Ph.D.</p>
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**WHY**

a 3-part  
webinar series  
on young children  
and suicide




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PROLOGUE



"Most males who completed suicide and/or made serious suicide attempts in adolescence or early adulthood had

**PSYCHIATRIC PROBLEMS BY THE AGE OF 8 YEARS,**

indicating a trajectory that persists throughout their lives."

FINNLS 1981 BIRTH COHORT STUDY, ARCH GEN PSYCHIATRY 2009 APR

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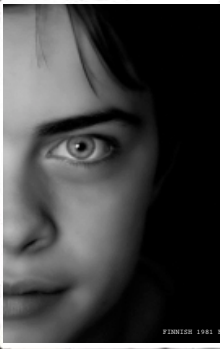
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PROLOGUE



"The connection between self-reported **depressive symptoms at age 8** and ideation and acts of deliberate **self-harm at age 18** is a good reason to already pay special attention to children's own intimations of distress **IN ELEMENTARY SCHOOL.**"

FINNLS 1981 BIRTH COHORT STUDY, ARCH GEN PSYCHIATRY 2009 APR

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STARTING YOUNG, STARTING EARLY PROLOGUE


**CRY FOR HELP:**  
Can Children Elementary-Age and Younger Really Be Suicidal?



**TODAY'S PRESENTER: CYNTHIA R. PFEFFER, M.D.**



- Among the world's most distinguished authorities on suicide in children
- Author of groundbreaking books "The Suicidal Child" and "Severe Stress and Mental Disturbance in Children"
- 30-year researcher and clinician whose seminal work has shaped understanding of suicidal preadolescent children
- Life Fellow and past Councilor-at-Large of the American Academy of Child and Adolescent Psychiatry
- Distinguished Life Fellow of the American Psychiatric Association
- Past President of Amer Association of Suicidology




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**CRY FOR HELP:**  
Can Children Elementary-Age and Younger Really Be Suicidal?



**What We'll Cover Today**

- PART I—SCOPE AND SIGNIFICANCE: Defining the issue and its magnitude
- PART II—WHAT CAUSES IT: How do young children become suicidal?
- PART III—WHAT TO LOOK FOR: How to recognize potential for suicide in young children
- PART IV—HOW TO RESPOND: What to do safeguard young children

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**PART I SCOPE AND SIGNIFICANCE:**  
Defining the issue and its magnitude

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PART I—SCOPE AND SIGNIFICANCE

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PART I—SCOPE AND SIGNIFICANCE

**Suicidal thoughts, attempts and completions in young children**  
**Not a "NEW POINT OF VIEW"**  
 50 YEARS OF SCIENTIFIC LITERATURE SUBSTANTIATES THIS

<p>1962: SUICIDE AND SUICIDAL ATTEMPTS IN CHILDREN AND ADOLESCENCE, Tostan JM</p> <p>1974: SUICIDE IN CHILDHOOD AND EARLY ADOLESCENCE, Shaffer D.</p> <p>1976: SUICIDE POTENTIAL AND BEHAVIOR IN CHILDREN AGES 3 TO 10, Fawcett MJ et al.</p> <p>1978: PSYCHIATRIC HOSPITAL TREATMENT OF SUICIDAL CHILDREN, Pfeiffer CR</p> <p>1981: SUICIDAL BEHAVIOR IN CHILDREN: A REVIEW WITH IMPLICATIONS FOR RESEARCH AND PRACTICE, Pfeiffer CR</p> <p>1982: LIFE STRESS AND SYMPTOMATOLOGY: DETERMINANTS OF SUICIDAL BEHAVIOR IN CHILDREN, Cohen-Sandler R, Berman AL, King RA</p> <p>1982: INTERVENTIONS FOR SUICIDAL CHILDREN AND THEIR PARENTS, Pfeiffer CR</p>	<p>1983: SUICIDAL AND ASSAULTIVE BEHAVIOR IN CHILDREN: CLASSIFICATION, MEASUREMENT AND INTERRELATIONS, Pfeiffer CR et al.</p> <p>1984: SUICIDAL BEHAVIOR IN PRESCHOOL CHILDREN, Rosenthal &amp; Rosenthal</p> <p>1986: PSYCHOPATHOLOGY AND ITS RELATIONSHIP TO SUICIDAL IDEATION IN CHILDHOOD AND ADOLESCENCE, Swartz LR et al.</p> <p>1989: THE SUICIDAL CHILD, Pfeiffer CR</p> <p>1989: SADNESS AND SUICIDAL TENDENCIES IN PRESCHOOL CHILDREN, Pfeiffer CR, Tostan JM</p> <p>1991, 1992, 1993, 1994, 1996: SUICIDAL CHILDREN GROW UP, Pfeiffer CR et al.</p> <p>1994: INTERVIEWING PREPUBERTAL CHILDREN ABOUT SUICIDAL IDEATION AND BEHAVIOR, Jacobson LK et al.</p>
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**YOUR TALKBACK**

What has research revealed ... (regarding) this new point of view that children have suicidal thoughts and are making suicide attempts?

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PART I—SCOPE AND SIGNIFICANCE

**DEFINING WHAT WE ARE TALKING ABOUT:**

D DEFINE

Most child development specialists now agree that the essential quality of SUICIDALITY is the intent to cause self-injury or death, regardless of a child's cognitive ability to understand finality, lethality or outcomes

**YOUR TALKBACK**

I truthfully wouldn't have thought for a minute that elementary kids and younger even know what suicide is. I just don't think there is any way a child can understand what suicide means!

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PART I—SCOPE AND SIGNIFICANCE

Scientific literature suggests that  
**CHILDREN AS YOUNG AS PRESCHOOL AGE**  
can display suicidal behavior and thinking



**YOUR TALKBACK**  
What is the youngest age that you have seen a suicidal person?

ROSEN L, SCHILDER P. SUICIDAL PRE-OCCUPATIONS AND ATTEMPTS IN CHILDREN. AM J ORTHOPSYCHIATRY.1997  
PEREYRE CB, COHEN BA, RIVKINEK B, JEREMY S. SUICIDAL BEHAVIOR IN LATEST AGE CHILDREN.1980  
TISLER CL. INTENTIONAL SELF-HARMFUL BEHAVIOR IN CHILDREN UNDER AGE TEN.1982  
CARSON SA AND CAMPBELL DP. SUICIDAL BEHAVIOR AND TENDENCIES IN CHILDREN AND ADOLESCENTS.1982  
HEIST DA, KALAS H, ROZENDRICK C, CORVELLO AJ, BOLGAN M, CORVINE M. PSYTOPATHOLOGY AND ITS RELATIONSHIP TO SUICIDAL IDEATION IN CHILDHOOD AND ADOLESCENCE.1986  
COMBLES S. SUICIDAL BEHAVIOR: DOES IT BEGIN IN PRESCHOOL AGED CHILDREN? 1999  
PEREYRE CB. DIAGNOSIS OF CHILDHOOD AND ADOLESCENT SUICIDAL BEHAVIOR: UNMET NEEDS FOR SUICIDE PREVENTION.2001

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PART I—SCOPE AND SIGNIFICANCE


**Suicide  
DEATH in children:  
HOW  
COMMON?**

**COMPLETED suicide in children:**

>> **9<sup>th</sup> leading cause of death  
for 5-9 year olds**

>> **3<sup>rd</sup> leading cause of death  
for 10-14 year olds and  
for 15-19 year olds**

SOURCE: 2008 DATA (MOST CURRENT YEAR AVAILABLE)  
CDC NATIONAL CENTER FOR SUICIDE  
PREVENTION AND CONTROL.



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PART I—SCOPE AND SIGNIFICANCE

**Suicide  
DEATH in children:  
HOW  
COMMON?**




age	suicides	# of males
age 5	1	1
age 6	1	1
age 7	1	0
age 8	5	5
age 9	9	8
age 10	44	39
age 11	97	78
age 12	169	132
}		
age 13	327	227
age 14	556	378
age 15	876	622
age 16	1192	899
age 17	1466	1192
age 18	1947	1640
age 19	2355	2000
}		

**5-12 years old**

**13-19 years old**

SOURCE: CDC SUICIDE DEATHS AMONG CHILDREN AND ADOLESCENTS, CDC DATA BY AGE FOR YEARS 2003-2007 COMBINED



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PART II—WHAT CAUSES IT

### CHILD SUICIDAL BEHAVIOR:

- >> A complex, multi-determined phenomenon
- >> Associated with a variety of factors that elevate risk for a suicidal episode
- >> Includes AFFECT regulation, early developmental EXPERIENCES, CONSTITUTIONAL factors, EGO functioning, INTERPERSONAL relations

**PROTECTIVE FACTORS:** Decrease the likelihood of a suicidal episode

**RISK FACTORS:** Increase the likelihood of a suicidal episode

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PART II—WHAT CAUSES IT

**PROTECTIVE FACTORS:** Decrease the likelihood of a suicidal episode

**RISK FACTORS:** Increase the likelihood of a suicidal episode

### The EQUILIBRIUM

between **RISK AND PROTECTIVE** factors determines whether a suicidal episode will occur

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PART II—WHAT CAUSES IT

### A SUICIDAL EPISODE:

- >> A discrete entity
- >> Has an onset and a specific duration

SOME EPISODES MAY OCCUR SUDDENLY, BE BRIEF, AND APPEAR TO HAVE AN IMPULSIVE QUALITY

OTHER EPISODES MAY HAVE A LONG DURATION THAT INCLUDES REPETITIOUS PREOCCUPATIONS ABOUT AND PREPARATIONS FOR A SUICIDAL ACT

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PART II—WHAT CAUSES IT

### SUICIDE METHODS IN YOUNG CHILDREN

**YOUR TALKBACK**  
What method does a young child use to complete suicide?

- >> hanging (most common method in young children)
- >> self-immolation
- >> jumping from a high place or down stairs
- >> stepping in front of a moving vehicle
- >> intentional drowning
- >> stabbing/cutting
- >> banging head with deadly intent
- >> strangling/suffocating
- >> medication overdose
- >> electrocution
- >> gunshot wound

METHODS YOUNG CHILDREN USE ARE TYPICALLY LESS COMPLEX AND MORE EASILY AVAILABLE THAN THOSE METHODS USED BY OLDER YOUTHS AND ADULTS

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PART II—WHAT CAUSES IT

### SUICIDE TRIGGERS IN YOUNG CHILDREN

**YOUR TALKBACK**  
I would like to know more about what is really important to this age group SOCIALLY and how that can affect their thoughts, etc.




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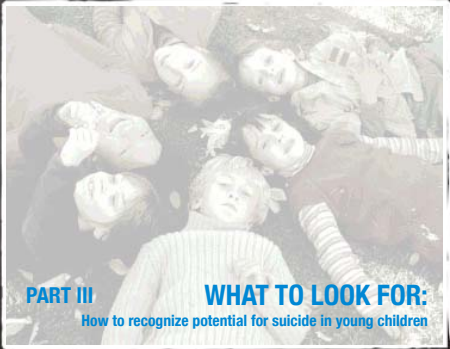
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**PART III** **WHAT TO LOOK FOR:**  
How to recognize potential for suicide in young children

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PART III—WHAT TO LOOK FOR

**ROBERT**

THE STORY  
OF A SUICIDAL  
10-YEAR OLD

**YOUR TALKBACK**

What kinds of things happen to an elementary-age child that would cause the kind of mental pressure for them to even consider suicidal thoughts?

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PART III—WHAT TO LOOK FOR

NOTE: ALL IMAGES USED IN THIS CASE STUDY ARE STOCK PHOTOGRAPHY OF MODELS ONLY.



**AGE 4**

Physically healthy and intellectually advanced.

Parents reported he was always a sensitive and difficult child.

Since Robert was 4 years old, he experienced numerous environmental stresses.

At this time his mother was hospitalized for four months with a fever of unknown origin.

SOURCE OF THIS CASE STUDY: REDUCING ENVIRONMENTAL STRESS FOR A SUICIDAL TEN-YEAR-OLD, PFEFFER CR. TREATMENT PLANNING, HOSPITAL AND COMMUNITY PSYCHIATRY, JANUARY 1987.

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PART III—WHAT TO LOOK FOR



**AGE 6**

His parents separated after a great deal of animosity, including numerous physical altercations.

Robert witnessed this family violence—a risk factor for childhood suicidal behavior.

Robert's father had been unemployed for a year and drank excessively.

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PART III—WHAT TO LOOK FOR



**AGE 7**

Robert reacted to changes and criticism with anger.

For example, he became enraged when a male teacher disciplined him, and he hit the teacher.

This even precipitated the beginning of Robert attending outpatient psychotherapy.

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PART III—WHAT TO LOOK FOR



**AGE 8**

Robert attended a nearby child psychiatry clinic twice a week from age 7 to 8, until his therapist left the clinic.

Thereafter, Robert refused to see a new therapist, saying no one else could help him.

Robert's parents divorced when he was almost 8 years old. His father remarried shortly after, began to work again, and controlled his drinking.

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PART III—WHAT TO LOOK FOR



**AGE 9**

Robert's mother remarried when he was 9.

Robert's stepfather found it very difficult to cope with Robert's willfulness and anger.

When verbal efforts at discipline failed, his stepfather resorted to harsh corporal punishment, often with a belt.

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PART III—WHAT TO LOOK FOR



**AGE 9**

When his mother talked moving to another town with her husband, Robert became increasingly despondent and began thinking about suicide as "the best way out" if his family moved.

CHILDREN MAY BE THINKING ABOUT OR PLANNING SUICIDE, YET NOT REVEAL THIS TO OTHERS UNTIL A CRISIS OCCURS. A SMILE ON THE OUTSIDE MAY BELIE WHAT AN AT-RISK CHILD IS CONTEMPLATING INSIDE.

He planned to see if things would work, but if not, he would "take pills, get run over by a car, or jump out the school window."

He felt that he was isolated and that no one in the family could understand his feelings.

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PART III—WHAT TO LOOK FOR

**AGE 10:** Robert attempts to jump off the 20<sup>th</sup> floor balcony of his home



Please, mother,  
let me go and jump.

It will be better if I'm dead.

I won't have to think.  
I won't have to worry.

There's a better place.  
Maybe it's pretty there.

It'll be beautiful.

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PART III—WHAT TO LOOK FOR

**6 WEEKS EARLIER:** His mother noticed a marked change in his behavior

- FAMILY MOVED AWAY FROM HIS DAD
- RELUCTANT TO ATTEND HIS NEW SCHOOL
- WAS ALARMED WHEN MOM TOOK PILLS
- NUMEROUS AGGRESSIVE OUTBURSTS, TEARFUL
- TROUBLE STAYING ASLEEP
- VIOLENT FIGHT WITH BROTHER, HIT ON HEAD
- TOLD HIS DAD HE'S HIT WITH BELT BY STEPDAD

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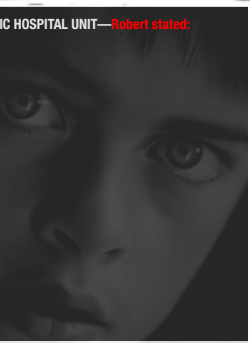
PART III—WHAT TO LOOK FOR

**IN A CHILD PSYCHIATRIC HOSPITAL UNIT—Robert stated:**

I wanted to jump off the balcony because my mom and I were fighting so much, and I wanted to stop this.

I went too far, I guess.

I was very sad for several days, and angry since we moved.




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PART III—WHAT TO LOOK FOR




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PART III—WHAT TO LOOK FOR



**YOUR TALKBACK**

How do providers (ER/CPFPs, parents) distinguish between the child who is actively suicidal and needs hospitalization, and one who is just in need of treatment in an outpatient setting?

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PART III—WHAT TO LOOK FOR

Robert had been **seriously depressed** for at least a year before his hospitalization.

His diagnosis:

- >> MAJOR DEPRESSIVE DISORDER
- >> OPPOSITIONAL DISORDER (single episode)
- >> Psychosocial stressors: **SEVERE**
- >> Highest level of adaptive functioning in past year: **FAIR**

**YOUR TALKBACK**

When young children are at risk for suicide, is it environmental or genetic? Can they be helped or cured? If so, how? And how do we convince parents their children need help?

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PART III—WHAT TO LOOK FOR

Robert's case illustrates that:

- >> children can be **preoccupied with thoughts** of suicide for a long time
- >> children have **distinct plans** for carrying out their suicidal wishes

**YOUR TALKBACK**

Are there specific signs to look for and what should be done about it? Often hospitals will send parents away as the individual child hasn't formed a plan. What can be done?

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PART III—WHAT TO LOOK FOR

**MORE RED FLAGS IN YOUNG CHILDREN**

**PREVIOUS EXPERIENCES** of suicidal behavior

- >> Once a child has made a suicide attempt, the risk that he or she will eventually complete **suicide increases significantly**.
- >> Suicidal ideation and suicide attempts among prepubertal children both predict suicide attempts in adolescence (Pfeffer et al., 1993).
- >> Prepubertal children who have attempted suicide may be up to 6 times more likely to attempt suicide in adolescence, as such behavior "may begin with relatively low intent and lethality and increase in crescendo-like fashion with age (Brent 2004)




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PART III—WHAT TO LOOK FOR

### MORE RED FLAGS IN YOUNG CHILDREN



- >> **mood disorder** (depression and other affects)
- >> **anxiety disorders**
- >> **disruptive/conduct disorders**
- >> **bipolar** (extremely high risk of suicidal ideation and behavior for young children with this diagnosis)
- >> **psychotic disorders**

**DEPRESSIVE SYMPTOMS CAN INCLUDE**  
SLEEP, APPETITE, CONCENTRATION, ENERGY LEVEL, FATIGUE, FEELINGS OF WORTHLESSNESS, SELF-REPROACH, GUILT

**CHILDREN WHO ARE DEPRESSED CAN ALSO PRESENT WITH ANGER, IRRITABILITY AND AGITATION, SUDDEN UNEXPLAINED BEHAVIOR OR ATTITUDE CHANGES, OR FEELING BORED**

**YOUR TALKBACK**  
How can a young child be able to demonstrate signs of depression, and what present day modalities are used for diagnosis and treatment?

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PART III—WHAT TO LOOK FOR

### MORE RED FLAGS IN YOUNG CHILDREN

- >> **COMORBID PSYCHIATRIC ILLNESSES** are a red flag
- >> young children with **conduct disorders AND concomitant depression** are at high risk for suicidal behavior
- >> **depression coexisting WITH anxiety OR alcohol or drug use/abuse** are at high risk for suicidal behavior

**YOUR TALKBACK**  
What are signs or behaviors that would alert us to children who are suicidal or depressed? Anxiety? Anger? How do these signs differ from other child behaviors that may be similar?

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PART III—WHAT TO LOOK FOR

### MORE TO LOOK FOR WITH YOUNG CHILDREN

- >> Negative home environment
- >> Witnessing family/domestic violence
- >> Experiencing violence (physical, sexual, verbal), history of maltreatment
- >> Family dysfunction: disturbed intrafamilial relationships
- >> Poor family cohesion
- >> Divorce or death; loss of emotionally important people through death, separation or termination of relationship

**YOUR TALKBACK**  
What are potential reasons these children may be overlooked for assessment or services?

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PART III—WHAT TO LOOK FOR

**MORE TO LOOK FOR WITH YOUNG CHILDREN**

- >> Parent psychiatric disorder; family history of psychopathology, suicidal behavior
- >> Addiction in parents or caregivers
- >> Experiencing multiple transitions in the living situation
- >> Firearms in the home
- >> Addictive disorders

**YOUR TALKBACK**

I had a 10-year-old who said he was suicidal. I could not believe it and looked for ways to support my theory. What are key areas in behavior to know if it is a serious threat or not?

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PART III—WHAT TO LOOK FOR



**MORE TO LOOK FOR WITH YOUNG CHILDREN**



- >> Inappropriate coping styles (such as impulsivity or catastrophizing)
- >> Lack of social supports, loneliness
- >> Negative peer pressure
- >> Poor performance
- >> Experiencing bullying, cyberbullying or other peer-driven violent behavior
- >> Recent significant losses

**YOUR TALKBACK**

Are risk factors and warning signs with young children similar or different than those for adolescents? How does suicidal ideation in young children differ from that of adolescents?

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PART III—WHAT TO LOOK FOR

**WHAT ABOUT VERY YOUNG CHILDREN?**

**YOUR TALKBACK**

We work with children from birth to five years old and their parents. What are some key signs or "red flags" to watch for in these age groups?

**YOUR TALKBACK**

With an early childhood age student (3-5 years old), how do we know that they are not just being 3 or moody, but that there is actually a problem that needs intervention?

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STARTING YOUNG, STARTING EARLY



PART IV

**HOW TO RESPOND:**  
What to do to safeguard young children

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PART IV—WHAT TO DO

WHAT TO DO: Dr. Pfeffer weighs in

YOUR TALKBACK **1. How not to overreact?**



I recently had a 6-year-old boy make a statement about wishing he was dead ... I was not informed about this situation until two days later ... After further discussion, it did not appear he actually meant what he said, but rather he reacted to not getting his way, which is challenging for him. I am concerned about his mother's reaction that he may use similar statements as a way to manipulate her to get his way. How to assess suicidality without overreacting?

— VOCATIONAL REHABILITATION COUNSELOR, STATE DIVISION OF VOCATIONAL REHABILITATION SERVICES

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PART IV—WHAT TO DO

WHAT TO DO: Dr. Pfeffer weighs in

YOUR TALKBACK **2. When to take seriously?**

How do we know when to take elementary children seriously? What are the signs? When they make comments like, "My life is awful. I just want to die." Or "I'm going to kill myself. There isn't anything else for me to do." Or "Please just kill me. My life sucks." These are first, second, third graders! Then there are the comments that become "I'll kill him," or "I'm going to murder you," when talking to or about kids they don't like or who have offended them in some way. As school counselors we address these, and yet I always feel as though "the addressing" is inadequate because I want to convince them they don't mean what they are saying. Still I know at the moment their statements are said with real feeling. They do mean what they are saying!



— ELEMENTARY SCHOOL COUNSELOR

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PART IV—WHAT TO DO

**WHAT TO DO: Dr. Pfeffer weighs in**

**YOUR TALKBACK**

### 3. Parent barrier?



I would like to know how best to inform parents about their children who are crying for help. Too many times I have had a parent and child in my office and the child bravely states they want to die and the parents do not believe them and invalidate what the child is telling them. How can we get parents to take this seriously?

—SUPERVISING LMHC, COUNTY MENTAL HEALTH



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PART IV—WHAT TO DO

**WHAT TO DO: Dr. Pfeffer weighs in**

**YOUR TALKBACK**

### 4. Pervasive hopelessness?



I work with more than 150 different American Indian/Alaska Native Head Start programs around the country. Various directors of those programs have shared with me the extremely high rates of suicide in their communities (i.e., upwards of 3-4 times the national average) ... with some children (as young as 8-9 years old) taking their lives. What advice might Dr. Pfeffer have for communities where a sense of hopelessness among young people seems to be pervasive?

—DIRECTOR OF A NATIONAL AMERICAN INDIAN/ALASKA NATIVE HEAD START COLLABORATION OFFICE



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PART IV—WHAT TO DO

**WHAT TO DO:**  
Dr. Pfeffer weighs in



### 5. Best assessment tools and methods?

**YOUR TALKBACK**


I would be interested in knowing about assessing children for suicide risk. The assessments I am familiar with are directed toward adults.

**YOUR TALKBACK**

Risk assessment with young children whose verbal skills are not well developed, please.

**YOUR TALKBACK**

How to best ask child about suicidal ideation without being leading, to get a good assessment?



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**WHAT TO DO:**  
Dr. Pfeffer weighs in



### 8. How to question?

**YOUR TALKBACK**

I know how to talk to adults and teens, but what different words and phrases might help a child? They're developmentally so different, how do I communicate to them that this, too, shall pass? Is early childhood depression usually physical (chemical imbalance?) or situational?

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**WHAT TO DO:**  
Dr. Pfeffer weighs in



### 9. School role?

**YOUR TALKBACK**

At what age should we begin to address suicide as a topic when educating students about social emotional issues? What are developmental issues that should be taken into account in addressing suicide in schools?

**YOUR TALKBACK**

What precautions should a parent/caregiver put into place if a young child makes a suicidal statement? I'd like to know how to better help parents respond to their at-risk child.

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**WHAT TO DO:**  
Dr. Pfeffer weighs in



### 10. Community role?

**YOUR TALKBACK**

How can we get communities more involved in preventing suicide among children and youth?

**YOUR TALKBACK**

I am interested in knowing how best to promote awareness among community members and even healthcare providers that young children can and do experience mental health problems.

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### IN SUMMARY

- >> Suicidal behavior in preadolescents is a **REAL PROBLEM; IT DOES EXIST**
  - >> **ANY SUICIDAL COMMUNICATION** by a child should be taken very seriously and responded to immediately
- >> Early recognition of **DEPRESSIVE SYMPTOMS** and **FAMILY PROBLEMS** are vital to successfully treat and prevent these life-threatening behaviors
- >> **MANY INTERVENTIONS** are possible, in a range from the least intrusive to a the child's daily life to the most extensive approaches that dramatically alter the child's environment
- >> The basis for assessment, prevention and treatment is **APPLICATION OF PRACTICAL MEASURES TO DECREASE THE RISK**

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- >> Attention should focus on risk factors such as child's **INTENSITY OF DEPRESSION, PREOCCUPATIONS WITH DEATH, PARENTAL DEPRESSION AND SUICIDAL BEHAVIOR**
- >> Parents, public and professional people **MUST RECOGNIZE THE SIGNS** of suicidal risk early in children, and take appropriate steps to provide treatment. **It is essential to REFER such children to WELL-TRAINED mental health professionals** who can administer specialized treatments as indicated—these can include individual, family, and group therapy, and medication
- >> Treatment must involve a **NETWORK OF PEOPLE** with clearly defined goals: first, to keep the child alive; then, to provide the environment and stimulation needed for optimal development

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Next on tap! Parts 2 and 3 in our Fall 2011 webinar series

WELL AWARE WEBINARS

SESSION #2  
SCISSORS LIGHT  
How can parents understand the potential for suicide in their children?

SESSION #3  
HOW YOUNG IS TOO YOUNG?  
Are educational programs to foster suicide prevention in children?

Register at [www.wellaware.org/webinars.php](http://www.wellaware.org/webinars.php)

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WEBINAR #1 OF 3

**CRY FOR HELP:**  
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THANK YOU FOR JOINING US TODAY!

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