Adolescence:
The Power of the Developmental History
Susan, CA: 15-6, Grade: 10, L1: English

- **Referring concerns**
  - Poor school attendance
  - Poor grades (failing all but one class)
  - Appears to have given up
- **Pregnancy and birth history**
  - Full term (mother not married at time of birth)
  - Uncomplicated delivery
  - Birth weight 7 pounds
  - Described as "very active" in the womb

- **Developmental history**
  - Walked early (exact age unknown)
  - Parent reports she was always on the go
  - First words late (exact age unknown)
- **Health history**
  - No problems during infancy or childhood
  - Frequent "accidents" since age 13 (hit by car, car crash, alcohol OD)
- **School history**
  - Has always had difficulty getting work done
  - Grades declined dramatically after middle school
  - Difficulty establishing/maintaining peer and adult relationships
- **Family history**
  - Family dysfunction (mother mentally ill, uncle attempted suicide, father unknown)

What initial hypothesis would you develop?
What additional questions should be asked?
Adolescence
Cognitive Development: Piaget

- Formal Operations
  - Able to reason about hypothetical events and hypothetical transformations of those events.
  - Able to go beyond concrete experiences.
  - Begins to emerge at about 11 years, should be well-developed by 15 years.
  - Development of requires specific learning opportunities.

- Instructional Implications?
Adolescence
Physical Development

- Growth Spurt
  - 10.5 years in girls
  - 12.5 years in boys

- Puberty
  - As early as 9 to 10 years
  - As late as 15 to 16 years

Adolescence
Eating Disorders

- Anorexia Nervosa
  - Intense preoccupation with food
  - Severe weight loss
  - Age at onset, 13-14, 17-18 years
  - 90-95% female
  - Family history of Anorexia
  - Severe food restrictions, possible binging and purging, and/or use of laxatives and diuretics.
  - Denial, withdrawal, depressed, asexual, suicidal.

- Bulimia
  - Intense preoccupation with food
  - Fluctuating weight loss
  - Age at onset, 17-25 years
  - 90-95% female
  - Family history of depression
  - Binging and purging with use of laxatives and diuretics.
  - Guilt or shame, outgoing, heterosexual, impulsive, substance abuse depressed, suicidal.
Adolescence
Erikson’s Stages

- Industry vs. Inferiority (6-12 years)
  - “I am what I learn.”
  - Teachers become more important
  - Success = industry
  - Failure = inferiority

- Identity vs. Role Confusion (12-18 years)
  - “Who am I?”
  - Peers become more important
  - Independence, self-reliance = Identity
  - Dependence = role confusion

Adolescence
Erikson’s Stages

- How would Erikson set up the elementary grade classroom?
- How would Erikson set up the high school classroom?

Adolescence
Erikson’s Stages

- Referring back to Erikson’s theory of personal-social development, why should a teacher be concerned about social isolates and unpopular children in the classroom?
- What can a teacher do to help a student become more socially integrated into the class?
- Give examples from your own experience of classroom situations where a teacher followed good practice to promote positive self-concepts
Adolescence

Suicide

- Third leading cause of death among 10 to 24 year olds.
- 20.5% of high school students report having seriously considered suicide in the prior 12 months.
- 15.7% report having made a suicide plan in the prior 12 months.
- 4.5% of high school students report having attempted suicide.
- 2.6% indicating that the attempt required medical attention.

Data from the Youth Risk Behavior Survey (Kann et al., 1998)

Adolescence

Suicide Risk Factors

- Psychopathology
  - Associated with 90% of suicides
  - Prior suicidal behavior the best predictor
  - Substance abuse increases vulnerability and can also act as a trigger

- Familial
  - History
  - Stressor
  - Functioning

Adolescence

Suicide Risk Factors

- Biological
  - Reduced serotogenic activity

- Situational
  - 40% have identifiable precipitants
  - A firearm in the home
  - By themselves are insufficient
  - Disciplinary crisis most common
### Adolescence: Suicide Intervention Warning Signs

- Suicide notes
- Direct & indirect suicide threats
- Making final arrangements
- Giving away prized possessions
- Talking about death
- Reading, writing, and/or art about death
- Hopelessness or helplessness
- Social Withdrawal and isolation
- Lost involvement in interests & activities
- Increased risk-taking
- Heavy use of alcohol or drugs

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### Adolescence: Suicide Intervention Warning Signs

- Abrupt changes in appearance
- Sudden weight or appetite change
- Sudden changes in personality or attitude
- Inability to concentrate/think rationally
- Sudden unexpected happiness
- Sleeplessness or sleepiness
- Increased irritability or crying easily

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### Adolescence: Suicide Intervention Warning Signs

- Increased irritability or crying easily
- Low self esteem
- Dwindling academic performance
- Abrupt changes in attendance
- Lack of interest and withdrawal
- Changed relationships
- Despairing attitude
Adolescence
Suicide Intervention General Staff Procedures

Responding to a Suicide Threat.

- A threat would include any statement or communication indicating a desire to cause physical harm to oneself. Such threats might include suicide notes, indirect threats, and direct threats.
- A potential place for students to write suicide notes and reveal suicidal thoughts is in their journals. Written assignments in general are often the sources of suicide notes as well as direct and indirect suicide threats. English teachers need to be especially sensitive to such communications.

- Indirect threats of suicide often take the form of wishes or desires. However, they clearly indicate that the student feels he or she would be better off if he or she were not alive. Such threats might include the following: "I wish I were dead.", "Everyone would be better off if I weren't around any more.", "If only I could go to sleep and never wake up again.", etc.

- Direct threats are clear unequivocal statements that the student is considering suicide as a solution to problems. A student making a direct suicide threat might say, "I'm going to kill myself".

- A student who has threatened suicide must be carefully observed at all times until a qualified staff member can conduct a risk assessment. The following procedures are to be followed whenever a student threatens to commit suicide.

1. Stay with the student or designate another staff member to supervise the youth constantly and without exception until help arrives.
2. Under no circumstances should you allow the student to leave the school.
3. Do not agree to keep a student's suicidal intentions a secret.
4. If the student has the means to carry out the threatened suicide on his or her person, determine if he or she will voluntarily relinquish it. Do not force the student to do so. Do not place yourself in danger.
5. Take the suicidal student to the prearranged room.
6. Notify the Crisis Intervention Coordinator immediately.
7. Notify the Crisis Response Coordinator immediately.
8. Inform the suicidal youth that outside help has been called and describe what the next steps will be.
Adolescence: Suicide Intervention

Exploration

Understanding

Action

NOTE: Developed by Ramsay, Tanney, Tierney, and Lang (1996) and very similar to the "Carkhuff Helping Model"

Adolescence: Suicide Intervention

- **Exploration**
  - Engagement
    - Empathy
      - Stressors (experiences)
      - Overwhelming/intolerable loss.
      - e.g., "My life will never be the same!"
    - Symptoms (feelings)
      - Helplessness and hopelessness.
      - e.g., "Things are bad and won't get better."
  - Respect
    - Pausing to listen
  - Warmth
    - Non-verbals and touch

Adolescence: Suicide Intervention

- **Exploration**
  - Identification of suicidal intent
    - Be direct when asking the "S" question.
      - BAD
        - You're not thinking of hurting yourself, are you?
      - Better
        - Are you thinking of harming yourself?
      - BEST
        - Sometimes when people have had your experiences and feelings they have thoughts of suicide. Is this something that you're
Adolescence: Suicide Intervention Understanding

**Understanding**

- **Suicide Indicators**
  - Inquire about stressors
  - Inquire about symptoms

Adolescence: Suicide Intervention Understanding

**Understanding**

- **Suicide Predictors (CPR++)**
  - Current plan (greater planning = greater risk).
  - How (method of attempt?)
  - How soon (timing of attempt?)
  - How prepared (access to means of attempt?)
  - Pain that is unbearable
  - Resources
    - Reasons for living
      - Can be very idiosyncratic
      - Person at-risk’s perceptions are key
    - Prior suicidal behavior
    - Mental health status

Adolescence: Suicide Intervention

**Action**

- Contracting to reduce risk.
  - Facilitative (when risk is low)
  - Directive (when risk is high)
    - Help the person to identify reasons for living (resources)
      - Objective knowledge of resources becomes important
      - Surface ambivalence
  - Implementing the contract.
Adolescence: Suicide Intervention Risk Assessment & Referral Procedures
1. Conduct a Risk Assessment.
2. Consult with fellow school staff members regarding the Risk Assessment.
3. Consult with County Mental Health.
4. Use risk assessment information and consultation guidance to develop an action plan. Action plan options are as follows:

   - **Extreme Risk**
     - If the student has the means of his or her threatened suicide at hand, and refuses to relinquish such then follow the Extreme Risk Procedures.

   - **Crisis Intervention Referral**
     - If the student's risk of harming him or herself is judged to be moderate to high then follow the Crisis Intervention Referral Procedures.

   - **Contracting**
     - If the student's risk of harming him or herself is judged to be low then follow the Contracting Procedures.

Next Week
- Turn in developmental and Health History Questionnaire.
- Present a Developmental and Health History Questionnaire Poster.
- Poster Session Development Resources
  - [www.csus.edu/atcs/poster_session.htm](http://www.csus.edu/atcs/poster_session.htm)