I DEATION – Threatened or communicated

S UBSTANCE ABUSE – Excessive or increased

P URPOSELESSNESS – No reason for living

A NXIETY – Agitation/insomnia

T RAPPED – Feeling there is no way out

H OPELESSNESS

W ITHDRAWING – From friends, family, society

A NGER (uncontrolled) – Rage, seeking revenge

R ECKLESSNESS – Risky acts, unthinking

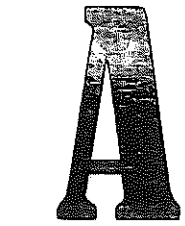
M OOD CHANGES (dramatic)

IS PATH WARM

NATIONAL SUICIDE PREVENTION LIFELINE

1-800-273-TALK (8255)

suicidepreventionlifeline.org



A SK your friend

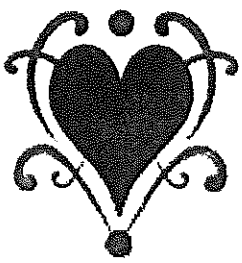
- Have the courage to ask the question, but stay calm.
- Ask your question directly.
- Have you been really unhappy lately?
- Have you had thoughts, feelings, or plans of suicide?
- Will you go with me to get help?

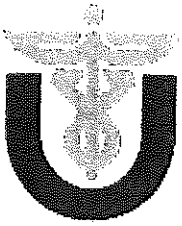
C ARE for your friend

- Show COMPASSION
- Take ACTION
- REASSURE your friend
- EMPOWER your friend

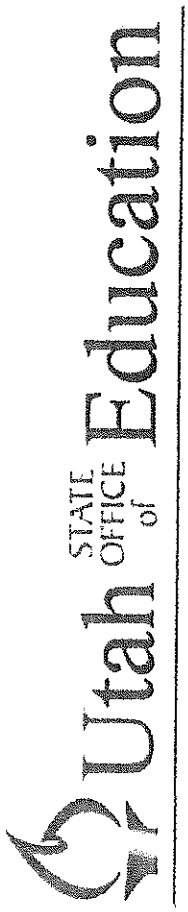
E SCORT your friend

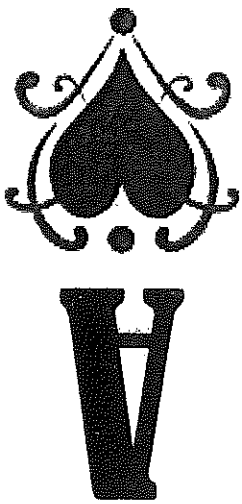
- Never leave your friend alone.
- Contact the nearest adult or parent.





Crisis Line & Mobile Outreach Team University Neuropsychiatric Institute (801) 587-3000





Coping with Trauma

Physical and emotional reactions to trauma are normal following tragic events.

Normal Reactions may include:

Numbness or Shock
Sleep Disturbances
Recurring thoughts and images
Guilt
Fear
Mood Swings
Grief, Sadness, Despair
Renewal of emotions related to past events

Suggestions for Coping:

Share feelings with family, friends
Don't dwell on fears or What if's?
Care for yourself physically
Avoid turning to drugs or alcohol
Establish a sense of control by reestablishing daily routines
Help others
Take a break from media coverage

Special Considerations for Children:

Be honest, open and clear
Listen to your child
Provide reassurance and physical comfort
Limit the exposure; be mindful of TV and radio
Maintain family rules, expectations and routine

Remember that crisis is temporary. While lives are forever changed by traumatic experiences, we can face life with new understanding and meaning. Overcoming even the greatest tragedies is possible.

Help is Available

If you or someone you know experiences difficulty or is overwhelmed, you may contact the SLCo/UNI 24-hour CrisisLine at 801-587-3000 for assistance.

SLCo/UNI Crisis Services

YOUR STRESS

TIP: Self Injury

Harming yourself in any way to relieve pain is like a drug addict shooting up to get high. However, with a drug, you can make the commitment to avoid it at all costs. You can refuse to be in its presence. With self-injury, there will always be an opportunity to fall back into poor coping skills.

Maybe you only harm yourself occasionally when things are really bad, maybe you're just trying it for the first time, or maybe you have escalated to the point where your life is in danger. No matter what degree of injury you inflict on yourself, there's a problem that needs to be admitted. You're not handling things in a healthy way, and you owe it to yourself to get help.

It's difficult to say what brings a someone to the injure themselves, but poor coping skills can be developed during almost any crisis in your life. You might have tried it for the first time after failing a class, maybe you're trying to process the physical or sexual abuse you've suffered in the past, or maybe the love of your life just decided that they don't want to be in a relationship with you anymore. Regardless of how it began, self injuring is about taking some kind of control over your emotions. Since you can't control how you feel inside, you're going to control how you feel and how you appear on the outside. For those that cut, there is some kind of satisfaction from the blood that trickles down. What you find eventually find is that more and more is necessary to be satisfied. The greater the satisfaction, the closer you are to ruining your life.

So before things get any more dangerous, you must learn not only how to be courageous but also how to truly let go. Let go of the absolute need to be in control, let go so the true issues can surface, let go so the people who love you can help you out of the darkness, and let go so that you can be free to actually live this life. Do it now so you don't bury your problems so deep that you lose the perspective that what your problems are now, probably won't be that way forever.

Don't be afraid to get help. Take all the support you can get and don't be ashamed. Get help from friends, family, and professionals that have seen people survive this. Just as drug addicts need rehabs, counseling, and support groups, so do the self injurers to overcome their addiction. This is going to take courage, commitment, and time, but the reward is having the opportunity to become the person you deserve to be.

Make it one day. Then wake up and make it another day. Then get up and try to make it again. You deserve a chance at a better life.

http://www.yourlifeyourvoice.org/Pages/tip-self-injury.aspx

RESOURCES FOR TEXT COUNSELING WITH NON-SUICIDAL SELF-INJURY

INFORMATION

Emotion and Emotion Regulation Lab: http://www.ocf.berkeley.edu/~eerlab/

- By EERLAB Researcher Tchiki Davis, PhD:
www.ocf.berkeley.edu/~eerlab/pdf/papers/Davis_etal_Emotional_Reactivity_Selfharm.pdf

Safe Alternatives: http://www.selfinjury.com/

Self-Injury Outreach and Support: http://www.sioutreach.org/

Cornell University Research Program on Self Injury and Recovery:
http://www.selfinjury.bctr.cornell.edu

RESOURCES FOR TEXTERS

ReachOut: us.reachout.com

- ReachOut has moderated forums with peer supporters, including threads by youth struggling with NSSI. It also has youth written fact sheets
- ReachOut Video: *My Green Box - Coping with Wanting to Hurt Yourself*
https://www.youtube.com/watch?v=_FYxHZmMo84

Teen Line: teenlineonline.org

- Teenline, many ways to interface, well moderated message board with a Self-Injury thread

Your Life Your Voice: www.yourlifeyourvoice.org

- Your Life Your Voice, many ways for youth to interface
- NSSI tip sheet: http://www.yourlifeyourvoice.org/Pages/tip-self-injury.aspx

SELF-INJURY CONTAGION

Contagion refers to the rapid spread of an idea or behaviour. Studies have shown that self-injury contagion is particularly prevalent amongst adolescents. There is a rising trend for youth to discuss self-injury online and to form cutting clubs within their schools, thereby triggering the behaviour in each other. In some cases, youth self-injure in one another's presence, may share tools or even take turns injuring one another.

Why Does Contagion Occur?

- Many youth are introduced to self-injury through peers.
- Self-injury may be encouraged, admired and thereby reinforced within a social context.
- Self-injury may produce feelings of cohesiveness within a group.
- The behaviour may be inadvertently reinforced by the adult response.
- Self-injury is a powerful form of communication.

Preventing / Responding to Contagion

- Caregivers must strive to react to self-injury behaviour in a calm manner, recognizing the seriousness of the issue but not inadvertently increasing its appeal through reactions of hysteria or an outpouring of empathy.

- Within a given community, self-injury should generally be treated through individualized methods, rather than in groups.

- Reduce the display of recent self-injury wounds by requiring that appropriate, covering clothing be worn while wounds are healing.

- Research has shown that single-shot awareness raising strategies (such as school assemblies) are linked to increases in the behaviour they intend to stop (*Levine and Smolak, 2005*). The literature regarding self-injury suggests that schools should rather discuss this issue in the context of a health class or group regarding positive and negative coping strategies.

- Parents should talk openly about self-injury with their children and monitor their online involvement (What do they know about it? Do they have friends who self-injure? What have they seen online?). Parents have the opportunity to educate regarding the issues with self-injury while encouraging the use of healthy emotion regulation skills.

SPECIAL CONSIDERATIONS FOR SCHOOLS

SCHOOL RESPONSE PROTOCOL

A self-injury school protocol is important for helping staff to respond to this often complicated issue in a calm and strategic manner. A protocol helps to ensure that a school's legal responsibilities and liabilities are addressed. Though policies vary considerably from school to school, the following is adapted from the Cornell Research Program on Self-Injury and Recovery (*www.selfinjury.bctr.cornell.edu*) and provides an overview of best practices for responding to self-injury within school settings.

IDENTIFYING SELF-INJURY

School staff may learn that a student is self-injuring as a result of:

- Noticing warning signs.
- The student self-disclosing.
- The student being seen in the act.
- A peer disclosing.

It is important for all staff within a school to be educated about the prevalence of self-injury among adolescents, the common methods utilized, warning signs and possible functions served. Staff should inform the school counsellor if they suspect self-injury may be occurring, but also be trained to comfortably respond to students who disclose self-injury to them (including letting them know that the disclosure will need to be passed on to the school counsellor).

ASSESSING SELF-INJURY

Appointed staff member (typically school counsellor) meets with the student to assess their self-injury, maintaining a calm, compassionate and non-judgemental demeanor (*see "Assessment", p.23-25, for more information*).

- Do they need medical attention? (Open wounds should be treated)
- Is this a one-time incident or have they self-injured before?
- What do they use to self-injure?
- What triggers their self-injury?
- How does it help them?

- How often do they self-injure?
- Do they know others who self-injure?
- Do they ever have thoughts of suicide? (if so, suicide protocols should be followed)

Lower-risk students:

- Little history of self-injury, a manageable amount of external stress, some positive coping strategies and the presence of some supports.
- These students are more likely to be managed through school and family support.

Higher-risk students:

- Chronic, long-standing self-injury, high-lethality methods, few positive supports or coping strategies, suicidal ideation.
- Should be referred to more intensive outside counselling services.

ENGAGING PARENTS/GUARDIANS

Though policies regarding student confidentiality and parent disclosure differ from one school to the next, confidentiality between counsellors and students generally no longer applies when a student is at risk of harm. The literature surrounding self-injury suggests that school staff should inform parents about their child's self-injuring behaviour even if the child is not deemed an immediate threat to himself/herself.

Talk to the student about informing their parents

- Individuals who self-injure may not want their parents to know, but well-informed parents can be an important part of the recovery process.
- Explore student's fears regarding disclosing to parents. If there is a high likelihood that informing parents will pose an additional risk to the student, this process needs to be very carefully navigated and in some cases child protection involvement may be warranted.
- The adolescent should be part of determining how parents will be told (e.g., student tells parent themselves, counsellor tells parent while student listens, counsellor tells parent and provides education before student talks with them).

School counsellor meets with the student and parents to talk about the next steps

- Educate parents regarding the function of self-injury and provide written and web-based resources.
- Discuss how to create a supportive environment for the student.
- Encourage parents to have appropriate expectations for change.
- Refer family to outside counselling services, if deemed necessary, and create a plan for ongoing communication between parties.

What's Typical for Adolescents and What's Cause for Concern?

Typical	Not Typical: Cause for Concern
1. Increased moodiness	Intense, painful, long-lasting moods; risky mood-dependent behavior, major depression, or panic attacks; self-injury or suicidal thinking
2. Increased self-consciousness, of feeling "on stage," increased focus on body image	Social phobia or withdrawal; perfectionism and unrealistic standards; bingeing, purging, or restricted eating; obsessive about or neglectful of hygiene
3. Increased dawdling	Multiple distractions to point of not being able to complete homework or projects, lack of focus that interferes with daily work or tasks, regularly late for appointments
4. Increased parent–adolescent conflict	Verbal or physical aggression, running away
5. Experimentation with drugs, alcohol, or cigarettes	Substance abuse, selling drugs, substance-using peer group
6. Increased sense of invulnerability (may lead to increased sensation seeking or risk taking)	Multiple accidents; encounters with firearms; excessive risk taking (e.g., subway surfing, driving drunk or texting while driving), getting arrested
7. Stressful transitions to middle and high school	School refusal; bullying or being bullied; lack of connection to school or peers; school truancy, failure, or dropout
8. Increased argumentativeness, idealism, and criticism; being opinionated	Rebellious questioning of social rules and conventions; causing trouble with family members, teachers, or others who attempt to assert authority over the adolescent

(continued)

Typical	Not Typical: Cause for Concern
9. Increased sexual maturation; sexual interest or experimentation	Sexual promiscuity, multiple partners, unsafe sexual practices, pregnancy
10. Becoming stressed by everyday decision making	Becoming paralyzed with indecision
11. Increased desire for privacy	Isolation from family; breakdown of communication, routine lying, and hiding things
12. Strong interest in technology; social media	Many hours per day spent on computer, on high-risk or triggering websites; casually meeting partners online; revealing too much (e.g., "sexting," overly personal posts on Facebook, Tumblr, Instagram, in blog)
13. Messy room	Old, rotting food; teen not able to find basic necessities; dirty clothes covering floor chronically
14. Sleep cycle shifts later (urge to be a "night owl" and to sleep late on weekends)	Often up nearly all night; sleeps almost all day on weekends; routinely late (or missing school) because of sleep schedule

MENTAL HEALTH DIAGNOSES ASSOCIATED WITH SELF-INJURY

Self-Injury itself is not a mental health diagnosis, but in some cases may co-occur with or be one of the diagnostic criteria for a mental health diagnosis. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (2013) has listed Nonsuicidal Self-injury in the section, "Conditions for Further Study". Future research and developments may therefore create shifts in how self-injury is viewed in the mental health sphere.

There is no medication for self-injury itself, but medication is sometimes prescribed to treat accompanying symptoms, such as depression or anxiety, which may reduce urges to self-injure.

Borderline Personality Disorder

- Borderline Personality Disorder (BPD) is the most frequent diagnosis linked to individuals who self-injure, as this behaviour is one of the diagnostic criteria.
- BPD is characterized by a pattern of unstable and intense relationships, emotion dysregulation, feelings of emptiness, intense anger and fear of abandonment.
- Individuals with BPD often self-injure in an attempt to regulate mood.
- Diagnosing an adolescent with a personality disorder remains a controversial issue in the mental health field.

Depression

- Self-injury may be seen in those diagnosed with depression or bipolar disorder.
- There is a link between these diagnoses and deficiencies in serotonin levels.
- Individuals who are depressed struggle with emotional distress and upsetting thoughts; self-injury may be used to cope with this.
- Self-injury that occurs in the context of bipolar disorder is likely an attempt at mood regulation and tends to be more dangerous and potentially life threatening during a manic episode.

Anxiety Disorders

- There are several different forms of anxiety disorders, which are characterized by excessive rumination, worrying, uneasiness and fear about uncertainties, either based on real or imagined events.
- Self-injury has been linked to those suffering from anxiety as a means to managing emotional distress.

Post-Traumatic Stress Disorder

- Many people who harm themselves have experienced physical, sexual or emotional abuse, or another trauma which may result in a diagnosis of Post-Traumatic Stress Disorder.
- Self-injury as a result of PTSD is typically engaged in to escape painful memories, cope with feelings of numbness, regulate emotions or return to reality if dissociation is occurring.

Substance-Use Disorders

- There is a strong correlation between self-injury and substance abuse.
- Use of drugs or alcohol may be an alternative coping mechanism to self-injury, as all are powerful means to feeling better emotionally in the moment.
- The risk of lethal self-injury increases when substances are present.

Eating Disorders

- A number of studies indicate that eating disorders increase the risk for self-injury. (*Nixon & Heath, Eds. 2009*)
- A significant percentage of individuals with eating disorders have a history of sexual abuse, which is also a risk factor for self-injury.
- Both populations have difficulty managing emotions, are often dissatisfied with their bodies and are desperate for a sense of control.
- Disordered eating has a negative effect on the bio-chemicals in the brain that control mood.

Hope & Healing: How Teachers can Help Teens Deal with Suicide Grief

Terri Erbacher, PhD

The teen years are already tumultuous, and the bereaved teen needs special attention. Under ordinary circumstances, teenagers go through many changes in their body image, behavior, attachments and feelings. While people of all ages struggle with loss, teenagers face particularly painful adjustments following the death of a peer, friend, or loved one.

Do teens grieve like adults?

Teens grieve deeply but often work very hard to hide their feelings. Fearing the vulnerability that comes with expression, they look for distractions rather than stay with the grief process long enough to find real relief. Feelings can be turned off quickly, much like flipping a light switch. Teens can act as if nothing has happened while they are breaking up inside. You may observe teens who take on the role of caregiver to family members or friends, in effect denying their own grief.

Gender makes no distinctions when it comes to experiencing grief, but the outward signs may be different. Young men of this age may have a particularly hard time when they have been taught that showing emotion is something that girls do - but macho guys don't.

Do grief support groups work?

Yes, by sharing feelings with one another, teens find out they are not alone and that others are also struggling to rebuild shattered lives. Grief groups help teens feel understood, accepted and supported.

Common Grief Symptoms/Behaviors a teen may experience:

Emotional Effects
Shock & Disbelief
Anger & Irritability
Depression/Sadness
Despair or Helplessness
Terror/Fear
Guilt or Self-Blame
Anxiousness or Worry
Loss of pleasure in activities
Confusion

Physical Effects
Fatigue
Insomnia or Disturbed Sleep
Stomach/Headaches
Decreased Appetite
Hyperarousal or Easily Startled

Cognitive Effects
Difficulty Concentrating
Trouble Making Decisions
Trouble Remembering
Impaired Self-Esteem
Intrusive Thoughts or Memories
Nightmares

Social/Behavioral Effects
Social Withdrawal or Isolation
Increased Relationship Conflict
Refusal to go to School or Activities
Crying Easily
Change in Daily Patterns
Regression in Behavior
Risk Taking Behaviors (substance use)
Aggression or Oppositional Behaviors

If adults are open, honest and loving, experiencing the loss of someone loved can be a chance for young people to learn about both the joy and pain that comes from caring deeply.

Some things teachers can do:

How adults respond when someone loved dies has a major effect on the way teens react
Be available if a teen approaches you to talk, but realize many teens may not come to you
Teens often need caring adults to confirm that it is okay to be sad
Remind teens that there is no "right" way to grieve and they may feel varied emotions
Listen without judgment and share your own feelings and concerns honestly
It is okay to tell a teen that you don't know answers to some difficult questions
Try to re-establish a routine, with appropriate expectations, as soon as possible
Try not to take anger or irritability personally as it may be directed toward adults
Remember that telling teens to "be strong" discourages them from sharing feelings
Help teens understand that the hurt they feel now won't last forever
Help teens realize that ignoring their own grief may make them feel *more* alone and sad
Emphasize the importance of them seeking help when needed
Help teens realize the importance of looking out for each other
Help the child find a grief group if they are interested as to not help them feel so alone
Be gentle and compassionate in all of your helping efforts

When should a referral to professionals be made?

Some of the indicators that let you know when a teen needs more support are:

- **Dramatic behavior changes at home, school or socially**
- **Feeling extraordinary pressure, overwhelmed, or burdensome**
- **Teen is beginning to isolate themselves from peers and school**
- **Depression that lasts more than 2 weeks after the death of a loved one**
- **Talk about dying or wishing they were dead**
- **Extreme anger that causes problems at home, school or with friendships**
- **Feelings of guilt that leave the teen feeling isolated and alone**
- **Substance abuse – teens sometimes turn to drugs or alcohol to rid pain**
- **Acting out or risk taking behaviors (acting out sexually, driving fast)**
- **Skipping school or dropping grades**

If a child mentions suicide, do take it seriously. Do not leave the child alone at any time. Get them help immediately by having them escorted to the guidance department.

*****Remember that the NUMBER ONE protective factor in the life of a child is a caring adult who listens to a child without judgment. This is often a teacher!*****

Source: Erbacher, T.A. (2013). Lending a Helping Hand: Suicide in Schools: Empowering School Districts. Booklet published by the Delaware County Intermediate Unit, Morton, PA.

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(continued)

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Promoting Healing – Caring for the Caregiver

Self-care is important at all times, and even more so when going through difficult and tragic times. There are many things students (and adults!) can do to care for themselves.

Remember that as everyone grieves differently, strategies for healing are unique for each individual. Some of these will work for you and some will not. When we are feeling stressed and overwhelmed, it can be difficult to think of what to do, so here are some suggestions to ease the burden of having to think about what to do next:

Be Healthy
- Drink plenty of water and eat well
- Limit alcohol and caffeine
- Exercise to release endorphins and decrease stress: try yoga, take a walk, hike or bike ride

Mental Escapes/Take a Break
- Do things you enjoy: If you can't think of anything right now, ask someone what you used to enjoy. Do it even if it sounds like too much right now
- What are your guilty pleasures? Do them.
- Enjoy all that nature has to offer
- Rest & Relaxation: light a candle, take a bubble bath, get a massage
- Swim: water can be therapeutic
- Play with your favorite pet
- Hold a baby (then give him/her back to the parent if he/she isn't yours!)
- Play with a child
- Meditate
- Watch a funny TV show (but not too much and not right before bed)
- Laughter is the best medicine: hang out with your funniest friend
- Watch a pleasurable/funny movie
- Read a page turner

Internal Coping
- Write lists of gratitude
- Be easy on yourself
- Give yourself permission to feel/grieve
- Accept yourself
- Remember that this is hard and takes time
- Don't blame yourself

External Coping
- Reach out to others to talk: professionals, colleagues, friends, family, clergy (make sure these are people you trust!)
- Attend a religious service
- Ask for a hug

Expressive Activities
- Communication is 90% nonverbal: dance, sing, cry, perform, draw
- Listen to (or create) relaxing/soothing music
- Write in a journal
- Write poetry

Maintain Structure
- Eat, sleep, pray at regular times
- Plan your day
- Keep as normal a routine as possible (though this may be a *new* normal)

What to Expect: Developmental Responses to Grief
A Primer for Parents & Caregivers

Developmental Perspectives

Infants (0-2 years): Infants do not cognitively understand death, but can sense uneasiness in a grieving household. And, in the event a caregiver dies, the infant may exhibit repeated protests (crying). If the caregiver does not return, the infant may develop despair, followed by detachment. Infants may feel intense abandonment and exhibit intense separation anxiety. A detached child does not readily form healthy new attachments to new caregivers. Grief may also be exhibited as physical manifestations and behavioral and developmental regression may occur. Infants may model the distress exhibited by their caregiver.

Suggestions: Providing abundant love and a warm, caring environment are essential. To provide stability, keep routines and schedules as normal as possible. Avoid separation from surviving significant others as much as possible.

Preschool (2-6 years): Toddlers may view death as temporary and reversible and they interpret he world in concrete and literal manner. They may express grief by regressing to thumb-sucking and toileting accidents, fear of the dark and may have nightmares or trouble sleeping. This is often due to their limited cognitive understanding at this age. Grief may be expressed via irritability, stomachaches and repetitious questions. They may experience intense separation anxiety and express feelings and fears through their play. Hostile play is sometimes observed as toddlers may have trouble verbalizing their feeligns. Asking for a replacement parent is also typical. As children tend to sense grief in caregivers, a surviving parent hiding their grief may make toddlers feel unsafe. Be clear with toddlers that their loved one 'died' as euphemisms such as they are 'sleeping' could make the child fearful of going to bed.

Suggestions: Toddlers who lose a parent need consistent caregiving. It is important to be honest with the toddler if they see a surviving parent tearful. It is important to ensure toddlers that they did not cause the death or grief as they often feel it is their fault or that they behaved badly, which caused their parent to leave them. Toddlers might also need reassurance that others in their lives will not die and will be there to take care

of them. Meet toddlers at their cognitive level by encouraging expression of emotions through play, by drawing pictures of their loved one, making up stories about he person or enjoying things they used to do together. Help toddlers feel safe to talk, make it acceptable for them to cry or be angry, and continue to talk about their loved one and share favorite memories. Provide straightforward explanations to toddlers and answer questions repeatedly as needed as toddlers may be seeking consistency. Remind them that their loved one will not return and correct misperceptions. Bibliotherapy can be helpful. When culturally appropriate, share spiritual or religious comforts to instill hope. Go back to structure and routine as soon as plausible to provide safety and security. Physical comfort, hugs, and touch may be calming to these young children.

School-Aged Children (7-11 years): a school age child may demonstrate appropriate emotions when grieving such as anxiety, depression or anger and often experiences physical symptoms such as stomachaches. Separation anxiety may be heightened and children at this age may think they caused the death or were somehow responsible for it. Or, they may exhibit anger toward the deceased or towards those they perceive should have been able to save the deceased. A child of this age may maintain a relationship with the deceased in a fantasized way or may find a place for their deceased parent such as heaven whereupon their loved one can watch over them. Children at this age may retreat socially and academically, losing interest in friends or scholastic activities. Some may disguise their pain with a facade of coping, while other children may act out with angry outbursts, irritability, sleeping and eating problems, fear of their own frailty, hypochondria, shock, and persistent questioning about the death. School-aged children may have fears about death and be concerned about the safety of other loved ones.

Suggestions: The use of books and age appropriate literature is an excellent intervention at this age as characters in stories can provide role-modeling for bereaved children. It is important to support children at this age in their desire to remain close to the surviving caregiver, while fostering independence. Ongoing discussions are helpful to address the child's concerns, fears, emotions and questions and model identification of your own feelings. Provide clear, realistic information. Some children may benefit more from other expressions of emotions, such as creating artwork or symbolic play. Modeling healthy coping is

important, such as participating in memorial activities, rituals of mourning, and sharing memories of their loved one. Spending time with family may be of utmost importance to rebuild feelings of safety, security and stability. For the same reasons, it is important to return to typical routines and schedules as quickly as possible. Offer to involve school-aged children in funeral activities, but do not require it.

Adolescents (12-18 years): Adults often shield adolescents by limiting discussions about death, but this may isolate the teen and delay the recovery process. Adolescents have an adult understanding of death, are often able to think abstractly and may be curious of the existential realities of death. Teens often have strong emotional reactions including feeling guilt or responsibility for a loved one's death, anger, sadness, shock and disbelief, a sense of unreality and numbness. An adolescent's self-perception may also change as they may feel 'different' from peers after losing a loved one. Teens often feel that no one understands them.

While adolescent perceptions of death are more mature, mourning is complicated by their developmental tasks. Adolescence is already a time of change as teenagers struggle with issues of independence, are undergoing awkward physical changes, and are encouraged to begin thinking of their futures. Teens may engage in high-risk activities in order to challenge their own mortality. Adolescents may experience conflict over how to handle the grief and may feel as if they need to act as grown ups either for younger siblings or to care for a surviving parent.

Suggestions: Allow for a shared social response to the death with family members by discussing it openly. It is important that schools provide a safe a nurturing environment where support services are offered for adolescents to express their grief. Supportive interventions can also involve "open discussions with trusted adults and peers, explorations of questions of life and death, permission to mourn, appropriate assignment of role responsibilities for the age, models of healthy coping behaviors, and toleration of some acting out behavior" (Schoen, Burgoyne & Schoen,). It is important that adults are available to offer emotional support when needed.

The above is adapted from D'Antonio, 2011, Schoen, Burgoyne & Schoen, 2004, & Himebauch, Arnold, May, 2008.