PUBLIC SCHOOL PROFESSIONALS' UNDERSTANDING, PERCEPTIONS, AND AWARENESS OF YOUTH SUICIDE

By

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A Research Paper

Submitted in Partial Fulfillment of the
Requirements for the
Master of Science Degree
With a Major in

Guidance and Counseling

Approved: (2) Semester Credits

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ABSTRACT

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Public School Professionals' Understanding, Perceptions, and Awareness of Youth Suicide
(Title)

Guidance and Counseling	Dr. Amy Gillett	May 2004	1-61
(Graduate Major)	**(Research Advisor)**	**(Month/Year)**	**(No. of Pages)**

American Psychological Association (APA) Publication Manuel 5th edition
(Name of Style Manuel Used in this Study)

Many suicides among teenagers can be prevented if appropriate help is available to students. Since early detection is an important means of hindering suicide attempts, school professionals continue to play a crucial role in preventing suicide among students.

The purpose of this study was to measure public school professionals' understanding, perceptions, and awareness of youth suicide in a metro suburban high school in Minnesota. Data was collected through a survey distributed to school professionals in the Minnesota high school in December of 2003 and January of 2004.

This study attempted to answer the following research questions: are secondary school professionals' aware of youth suicide; what are the school professionals'

perceptions of youth suicide; and do the school professionals' understand suicide among the youth population?

Overall, the findings of this study seem to suggest that school professionals are knowledgeable and aware of youth suicide. While this is reassuring, the fact is that not all participants indicated awareness of these important indicators of youth suicide. Education is the key to decreasing the prevalence of suicide thoughts, attempts, and completions among students.

ACKNOWLEDGMENTS

I would like to take the time to acknowledge the contributions of, and to deeply thank the following for their help and inspiration throughout my educational path:

My family for your love and support throughout college and your belief in my passion to help children and youth. My mom and dad for your financial support. I wouldn't have made it through without your help. I hope you know how truly thankful I am for everything you've done for me. Thank you for encouraging me to be the most successful that I can be!

My sister, Kelly, for your advice, guidance and support. Thank you for your expertise in writing resumes and help with my graduate school essay. You have always been someone I've looked up to, a great role model and the best big sister anyone could ask for. Thank you for being you!

My boyfriend and bestfriend, Jesse, for your encouragement, support and dedication during the 6 years of our long distance relationship while I completed my Bachelors and Masters Degree. You make me want to be a better person and I couldn't imagine my life without you. Thank you for being there for me for all these years.

My friend and roommate, Becky, for being there for me throughout our college experiences. We met as classmates freshmen year and 6 years later we're friends, roommates, workout buddies and colleagues. It was comforting going through college with a friend who had similar interests in counseling and sharing stressors and accomplishments that go along with graduate school, practicum and thesis. Thank you for being so supportive and listening when I needed you most.

My Death Education and Counseling Families Education professor, Jan Hare, and classmates during my senior year in the HDFS program. Thank you for giving me the opportunity to grieve the loss of a friend to suicide. Your support and empathy gave me the strength to work through my grief and complete a thesis on a sensitive topic that was so close to my heart.

My thesis advisor, Amy Gillett, for your interest and expertise in research foundations and data analysis. I wouldn't have been able to write this thesis without your direction, support and advice. Your patience and sense of humor made this process so much easier. Thank you Amy!

Thank you to all others who helped make my thesis study possible: my aunt, Joan; my high school Spanish teacher, Ms. Clark-Miles; and the participating school district and staff.

DEDICATIONS

I dedicate this thesis to Rachel Renae Dauwalter, who took her own life at age 19. Rachel, you gave me the inspiration to learn more about youth suicide. I wish I would have known what you were going through so I could have helped you when you needed someone the most. Since I couldn't help you then, I now dedicate my counseling career to identifying those at risk for suicide, teach alternatives to suicide and hopefully save lives. Your smile and laughter will always live on in my heart and memories. I love you and miss you D!

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CHAPTER ONE

Introduction

Suicide is a complex behavior that is usually caused by a combination of risk factors and stressful life events. According to King (2000, p. 1), "suicide is the second leading cause of death among youths 15 to 19 years of age and the third leading cause of death among youths 15 to 24 years of age." Although there are no official statistics, it is estimated that there were over 700,000 attempted suicides in the United States during the year 2000 (Poland & Lieberman, 2003).

In 1999, the National Institute of Mental Health (2000, n.p.) reported that "more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, and chronic lung disease combined."

Although the overall suicide rate has declined over the past twenty years, youth suicide continues to be a major problem in the United States. There is no one single pattern or risk factor that indicates suicide. Experts in the field (Poland & Lieberman, 2003, n.p.) stated that "approximately 90% of suicides are associated with mental or addictive disorders…affective disorders…conduct disorders and substance abuse are common among those youth who display suicidal behaviors. Sixty percent of those youth who die by suicide have been identified as suffering from depression."

Family stress, dysfunction, and situational crisis can also lead to a serious risk of adolescent suicide. Situational crisis and particular precipitating events account for approximately 40% of all adolescent suicides (Poland & Lieberman, 2003). Crisis situations that are mostly associated with suicidal behavior usually include traumatic events caused by physical or sexual abuse, death of a loved one, parental divorce, or

family violence. Extreme feelings of sadness and hopelessness are the most common indicators of depression among teenagers and increase their risk of contemplating or carrying out suicide.

King (2000, p. 255) found “nearly 86% of all suicides are by individuals between the ages 15 and 19 years old and for every youth suicide, there are approximately 100 to 200 youth suicide attempts.” In the United States, girls attempt suicide more often and report higher rates of depression, while more than four times as many male youth die by suicide (Center of Disease Control, 2002). For every male suicide attempt, there are three female suicide attempts. Suicide attempts to suicide completions are 4:1 for the elderly population, whereas adolescents are as high as 200:1 (Poland & Lieberman, 2003).

Society influences how males and females should act when it comes to expressing feelings. Males are generally taught to suppress their feelings or else they are perceived as weak. Females on the other hand, are encouraged to express their feelings. Crying and asking others for help is more acceptable for girls, while boys grow up learning to keep their emotions inside (Portes, Sandhu, & Longwell-Grice, 2002).

According to Poland and Lieberman (2003, n.p.), “while white males continue to figure predominately in suicide statistics across all ages, there is some concern that rates are increasing for minority youth.” Among the minority youth population, American Indian males have the highest rate of youth suicide. In 1997, Poland and Lieberman (2003, n.p.) found that “Mexican American students had the highest rates of suicidal ideation and behaviors and were more likely to attempt suicide than any other minority groups. Overall, African American male adolescents, aged 15 to 24, have shown the greatest increase in suicide completion rates.”

As stated by the Center of Disease Control (2002, n.p.), “a national survey of high school students in 1999 found that Hispanic students, both male and female, were significantly more likely than white students to have reported a suicide attempt.”

According to Lewis (1994, p.19), “the suicide rate for Native Americans is as much as 10 times the national average.” There are several factors such as alcoholism, depression, unemployment, racism, lack of association to spiritual traditions, and the accessibility of guns that account for discrepancy in the rate between different tribes. The Center of Disease Control (2002, n.p.) concluded that “the most likely explanation for ethnic rate differences are variations in cultural factors that promote or inhibit suicide.”

As reported by Poland and Lieberman (2003, n.p.), “gay and lesbian youth are 200-300% more likely to attempt suicide than other young people and may account for up to 30% of completed youth suicide annually.” Homosexual or bisexual activity among high school students is associated with higher rates of suicide thoughts and attempts compared to youth with heterosexual experience (Center of Disease Control, 2002).

> Experts in the field (Portes, Sandhu, & Longwell-Grice, 2002, p. 808) stated that most people who attempt suicide threaten to do so beforehand, with over 80% of those contemplating suicide verbalizing their thoughts. Seventy-seven percent of adolescents state that if they were contemplating suicide they would first turn to a friend for help. Every suicide attempt has an underlying message, and suicide completion indicates that sometimes the message was not received.

Suicide attempts are difficult to count because many may not be treated in a hospital or may not be recorded as self-inflicted injury (Center of Disease Control, 2002). Youth risk behavior surveillance 2001 data, as reported by Poland and Lieberman (2003,

n.p.) indicated that, “for every three youths who attempted suicide, only one reported actually receiving medical attention for injury.”

Accurate data for death by suicide continues to be unavailable. According to Corr, Nabe, and Corr (1997, p. 100-101), “perhaps only 50 to 85% of actual cases are reported.” A variety of factors are the result of this statistic. To protect family members from guilt and the social stigma often attached to suicide, authorities may be reluctant to call a death a suicide. Death by suicide is not always easy to determine. Some suicides may be ruled as an accident. The death may not be recorded as a suicide if there was no suicide note and/or no evidence of depression or other factors commonly associated with suicide (Corr, Nabe, & Corr, 1997).

There are a variety of means to committing suicide. The most frequently used methods include: firearms and explosives; hanging, strangulation, suffocation; and solid, liquid, and gas poisons. The use of firearms is the most common method of suicide among youth. According to Portes, Sandhu, and Longwell-Grice (2002, p. 808), “in the United States, suicide by firearm is currently the third leading cause of death for adolescents and young adults. Whether a suicide attempt is successful often depends upon the method chosen. When someone uses a firearm, death is almost certain.”

Males, compared to females, are more likely to use firearms to kill themselves. This is attributed to the socialization of males in American society (Portes, Sandhu, & Longwell-Grice, 2002). Portes, Sandhu, and Longwell-Grice (2002, p. 808) expressed that the “adolescent male often acts quickly using more violent means. Females, for the most part, use passive means of self-destruction: poison, gas, or pills. They have a greater access to prescribed drugs through more frequent use of medical services.”

Many suicides among teenagers can be prevented if appropriate help is available to students. If adolescents have a sense of "connectedness" to parents, family or other caregiving adults, they are much less likely to attempt suicide (Mozes, 2001).

Statement of the Problem

Since early detection is an important means of hindering suicide attempts, school professionals continue to play a crucial role in preventing suicide among students. The purpose of this study is to measure public school professionals' understanding, perceptions, and awareness of youth suicide in a metro suburban high school in Minnesota. Data was collected through a survey distributed to the high school professionals in December of 2003. The results of the survey will provide a basis on what school professionals know about suicide among youth today. This study will be helpful in determining if additional professional development on youth suicide awareness is needed in the high school.

Research Questions

This study attempted to answer the following research questions:

1. Are high school professionals' aware of youth suicide?
2. What are the school professionals' perceptions of youth suicide?
3. Do school professionals understand suicide among the youth population?

Definition of Terms

For the purposes of this study, the following terms are defined:

Adolescents - student's ages 15 to 19 years old, unless otherwise stated.

Metro suburban high school - one high school for grades 10 through 12.

School professionals - principal, assistant principal, dean of students, teacher, counselor, psychologist, speech/language, paraprofessional, coordinator, liaison officer, nurse, secretarial, reception, registrar, media and technology, custodial, and food service.

Suicide attempt - incident in which one tries to end one's own life and the act does not result in death.

Suicide completion - incident in which one deliberately ends one's own life.

Assumptions and Limitations

Due to the sensitive nature of the topic, some school professionals might be influenced in their participation, which may introduce some discrepancy in the data collected. Because participation is voluntary, it is possible that the results may not represent the entire sample of school professionals invited to participate in the study.

This study was limited to school professionals working in one school district, in a metro suburban high school in Minnesota. Consequently, the results should not be generalized to communities elsewhere in Minnesota. The sample was relatively small (100 to 145), and should not be considered representative of the total population of school professionals.

All of the staff members working in the Minnesota high school were surveyed. It is possible that certain school professionals haven't had any education or training on youth suicide. As a result, the data analysis may misrepresent the school professionals overall understanding, perceptions, and awareness of youth suicide. They may also have chosen not to participate in the survey if they felt the topic didn't pertain to them.

CHAPTER TWO

Literature Review

Introduction

This chapter will include a substantial amount of literature on the issue of adolescent suicide. It will outline adolescent development and stressors, risk factors, and the signs and symptoms of youth suicide. The researcher will also discuss common myths of suicide and how schools can educate students and school professionals regarding a comprehensive school suicide prevention program.

Adolescent Development and Stressors

Adolescence is a difficult time for most teenagers. It is a time of psychological, social, emotional, physical, and sexual changes. While growing up, adolescents experience strong feelings of confusion, self-doubt, pressure to succeed, future uncertainty, stress and other fears (Facts for Families, 1998). A combination of stress, cognitive immaturity, and lack of emotional bonding interact and overwhelm adolescents ability to cope and think clearly (Portes, Sandhu, & Longwell-Grice, 2002).

According to Erikson (cited in Portes, Sandhu, & Longwell-Grice, 2002, p. 806), "individuals attempt to resolve the issue of identity versus role confusion during the teenage years. Adolescents try to answer the question "Who am I?" so as to establish an identity in the sexual, social, ideological, and career domains." These experiences put considerable pressure on an adolescent's search for identity.

The conflict of intimacy versus isolation is the predominant developmental issue in the early adult years. Teenagers are in search of friendship and love, which puts them at risk for rejection. The clinical literature, as stated by Portes, Sandhu, and Longwell-

Grice (2002, p. 807), “supports the view that the less successful adolescents and young adults are in establishing healthy identities and intimacy, the more at risk they are for self-destructive behaviors.

Portes, Sandhu, and Longwell-Grice (2002, p. 806) reported that “adolescents who had attempted suicide reported significantly more stress related to parents, lack of adult support outside the home, and sexual identity than did control groups.”

Rigid families with unrealistic expectations repeatedly placed adolescents at-risk for developing difficulties with problem-solving skills and the ability to reason their way out of a crisis. Experts in the field (Portes, Sandhu, & Longwell-Grice, 2002, p. 807) found that “depression, hopelessness, helplessness, and loneliness were usually present in students who attempted suicide, with hopelessness the best predictor of more lethal behavior.”

Risk Factors

Guetzloe (1991, n.p.) made an attempt “to identify situations, experiences, or characteristics that contributed to the likelihood that a student would complete suicide.” The risk of suicide increases when a student has more than one of these factors. In addition to mental illness and behavior disorders, Guetzloe (1991, n.p.), reported that “suicide has been associated with demographic factors such as being between the ages of 15 and 24, being white or male, or having a history of attempted suicide.”

The researcher grouped risk factors into the following categories: previous suicide attempts; mental disorders or co-occurring mental and alcohol or substance abuse disorder; families at risk; family history of suicide; stressful life event or loss; easy access

to lethal methods, especially guns; exposure to the suicidal behavior of others; and biological conditions.

Previous Suicide Attempts

If youth have attempted suicide in the past, they are much more likely than other youth to attempt suicide again. According to the Center of Disease Control (2002, n.p.), "approximately a third of teenage suicide victims have made a previous suicide attempt." Teens in this high-risk group may remain at risk for about a year (Nelson & Galas, 1994).

Mental Disorders and Alcohol and Drug Abuse

The Center of Disease Control (2002, n.p.) confirmed that "over 90% of young people who complete suicide have a diagnosable mental or substance abuse disorder or both, and that the majority have a depressive illness. Almost half of teenagers who complete suicide have had a previous contact with a mental health professional." Among those who complete suicide, aggressive, disruptive, and impulsive behaviors are common in youth of both sexes.

Many adolescents attempt to reduce tension by getting involved in drugs or alcohol. Adolescents who are heavy users of alcohol or drugs will more likely complete the suicidal act (Portes, Sandhu, & Longwell-Grice, 2002). Drugs and alcohol impair a person's judgment and can cause them to lose control. Drugs cause depression after the initial high (Lewis, 1994).

Families at Risk

While some families that experience a suicide are close and caring, many others are not. Many families with members at-risk for suicide show specific and similar characteristics. There is usually a lack of communication, a poor relationship between

parents, long-standing patterns of alcoholism or drug abuse, high parent expectations, and a family history of depression and suicide (Lewis, 1994).

Family History of Suicide

A high percentage of suicides and suicide attempters have had a family member who attempted or completed suicide. Imitation or genetics may be the cause of familial suicide. A genetic factor to suicide risk appears to be contributed by mental illnesses (Center of Disease Control, 2002). Such illnesses include major depression, bipolar disorder, schizophrenia, alcoholism, and substance abuse.

St*ressful Life Events or Loss*

A suicide and/or suicide attempt is often preceded by stressful life events. Such stressful life events include: getting into trouble at school or with law enforcement; fighting or breaking up with a boyfriend or girlfriend; and fighting with friends (Center of Disease Control, 2002).

Some psychological conditions, such as parental loss, family disruption, exposure to suicide, and unwanted pregnancy are additional factors (Guetzloe, 1991). Family stress often contributes to adolescent suicide. Divorce, a separation, and unemployment in a family increases the likelihood of a teenager having suicidal behaviors (Hahn, 1999).

Easy Access to Lethal Methods

As mentioned earlier, firearms are the most common method of suicide by youth. The Center of Disease Control (2002, n.p.) reported that “the most common location for the occurrence of firearm suicide by youth is in their own home, and there is a positive association between the accessibility and availability of firearms in the home and the risk for youth suicide.”

Exposure to Suicidal Behaviors of Others

Vulnerable teens may be introduced to the idea of suicide by exposure to real or fictional accounts of suicide, including media coverage, such as the extensive reporting of a celebrity suicide, or the fictional representation of a suicide in a popular movie or television show.

According to The Center of Disease Control (2002, n.p.), "there is evidence of suicide clusters, that is, local epidemics of suicide that have a contagious influence." One person's death by suicide leads other young people to mimic suicides. This is for the most part an adolescent trend, and it occurs because teenagers are not only dramatic, but are very sensitive to actions by their peers (Lewis, 1994).

Biological Conditions

Certain biological conditions have also been associated with suicide. These conditions include perinatal factors, decreases in levels of serotonin, and decreases in the secretion of growth hormone, among others (Guetzloe, 1991). The National Institute of Mental Health (2000, n.p.) has "learned that serotonin receptors in the brain increase their activity in persons with major depression and suicidality."

Signs and Symptoms

Suicidal thoughts, threats, and attempts often lead to a suicide. The most frequently observed warnings of potential suicide include: extreme changes in behavior; a previous suicide attempt; a suicidal threat or statement; and signs of depression (Guetzloe, 1991).

Adolescents may demonstrate school difficulties, may withdraw from social events, have negative or antisocial behavior, or may use alcohol or other drugs that

contribute to suicidal behavior. They may express increased emotionality, and their moods may be impatient, irritable, hostile, or sullen. Personal appearance may not be given any attention. Refuse to cooperate in family events or wanting to leave home is often displayed in these teenagers. They may suffer from feeling misunderstood or not being accepted, or act very sensitive to rejection in love relationships (Guetzloe, 1991).

According to Poland and Lieberman (2003, n.p.), “depression (especially when combined with hopelessness), sudden happiness (especially when preceded by significant depression), a move toward social isolation, giving away personal possessions, and reduced interest in previously important activities are among the changes considered to be suicide warning signs.” Previous behavior is a significant indicator of future behavior. Anyone with a history of suicidal behavior should be carefully observed for potential suicidal behavior (Poland & Lieberman, 2003).

According to Poland and Lieberman (2003, n.p.), “it has been estimated that up to 80% of all suicide victims have given some clues regarding their intentions. Both direct (“I want to kill myself”) and indirect (“I wish I could fall asleep and never wake up”) threats need to be taken seriously.”

The more detailed the individual is about suicide, the greater the risk of suicidal behavior. The presence of a suicide note is a very significant sign of danger. As reported by Poland and Lieberman (2003, n.p.), “making funeral arrangements, writing a will, and/or giving away prized possessions may be warning signs of impending suicidal behavior. Excessive talking, drawing, reading and/or writing about death may suggest suicidal thinking.”

Nelson and Galas (1994, p. 41) believed that “while we cannot pinpoint specific types of people who are suicidal, we do know that some young people are at higher risk for suicide because of the particular situations or problems they face.” Following is a list of serious emotional indicators that a suicidal individual may display (Williams, 2002, n.p.):

- unusual, improbable, bizarre beliefs;
- vague, abstract, rambling, disconnected or tangential ideas, incoherent;
- grand, over inflated ideas about self: think they are a powerful person;
- wide range of quickly changing extreme moods, contradictory, erratic, unpredictable, inconsistent;
- distorted, scattered;
- preoccupied, poor concentration;
- sees, hears or smells things others do not sense;
- use of persistent repetitive words or phrases;
- inappropriate silliness;
- lethargic;
- confused, indecisive
- magical, superstitious, bizarre thinking;
- believes thoughts are being “broadcast” aloud;
- hears voices commanding that something be done;
- thinks they are being watched, talked about, followed, plotted against, poisoned;
- believes thoughts are placed “in their head,” or being controlled;

- extreme jealousy, possessiveness;
- not leave their room, withdrawn, uncommunicative;
- find special, symbolic or ritualistic meaning in common things or events, or hidden motives in people;
- greatly distressed or bizarre body image or physical complaints.

According to Nelson and Galas (1994, p. 38), “teens who want to kill themselves often are angry with parents, teachers, or friends who have hurt or disappointed them.” Normally their anger they feel towards others and oneself manifests itself into aggressive, rebellious, or disobedient ways (Nelson & Galas, 1994). The following list includes impulsiveness and manipulation indicators of suicidal individuals (Williams, 2002, n.p.):

- impulsive, not consider consequences;
- inconsiderate of others rights or feelings;
- alcohol/chemical abuse;
- superficial in relationships, “uses” others;
- fire setting;
- lying;
- stealing and shoplifting;
- broken promises;
- promiscuous, casual sex;
- threatened/actual injury to others;
- vandalism, damage to property, senseless destruction;
- charming, likeable;
- resentful of authorities;

- blames others;
- avoids authorities;
- repetition of problems and issues;
- takes “dares”;
- untrustworthy, unreliable, undependable;
- little shame, guilt, remorse;
- little insight into self or responsibility;
- temper outbursts;
- extremely self-centered.

The majority of youth who are at high-risk can manage their every day stress if the rest of their lives are in order. All the stress and hardships combined may become too much to handle and can bring about suicidal thoughts (Nelson & Galas, 1994). The following list includes indicators of anxiety and tension in suicidal individuals (Williams, 2002, n.p.):

- excessive/compulsive (repeated” behaviors such as cleaning, hand washing, etc.);
- extreme, unrealistic fears (germs, being alone”);
- worry, preoccupied thinking;
- recurrent thoughts they cannot get out of their minds;
- physical complaints;
- poor/distorted body image;
- possessive, jealous, demanding;
- confused, indecisive;

- overly sensitive, fragile;
- asks many people for advice but unwilling to do anything to solve a problem;
- withdrawn, isolated, shy;
- helpless, dependent, few friends, passive;
- does not complete tasks, homework, not follow through;
- makes more promises than they can keep;
- overly responsible and overwhelmed;
- self-critical;
- threats to harm self;
- overly moralistic and rigid;
- over controlled, constricted, holding things in, inhibited;
- early morning waking, trouble sleeping;
- severe physical symptoms: weight loss/gain, fainting, etc;
- trembling, nervousness;
- self-induced vomiting, binge eating;
- over-exercise;
- abuse of laxatives, diuretics or other medication.

Adolescents under the influence of drugs account for approximately one-third of individuals who commit suicide. Most teens that have completed suicide or are likely to commit suicide are affected in some way by alcohol or other drugs (Nelson & Galas, 1994). The following list includes chemical abuse indicators in suicidal individuals (Williams, 2002, n.p.):

- hangovers, feel bad, “shakes”;
- missed work, classes, appointments;
- black-outs and poor memory;
- hiding drugs/alcohol;
- denial of use or extent of problems despite clear evidence to the contrary;
- use in spite of related physical problems;
- violent or labile (swinging) mood changes;
- legal problems related to use;
- accidents/driving/ operating machinery under the influence;
- talking exclusively and enthusiastically about chemicals and their benefits;
- indecision, illogical thinking;
- use throughout the day;
- binge use;
- unable to stop or reduce use;
- interference with relationships, loss of friends;
- broken promises not to use again.

Myths

There are many universally held misconceptions about suicide. Providing assistance for those who are at-risk is often halted by these myths. According to Americas Continuing Education Network (2003, n.p.), “by dispelling the myths, school professionals will be in a better position to identify those who are at-risk and to provide the help that is needed.”

Talking about suicide won't give teenagers ideas. Educators are often concerned that talking about suicide may fabricate the very behaviors education is designed to minimize. Experts in the field (Corr, Nabe, & Corr, 1997, p. 368) found that

> it is not the exposure to knowledge about suicide or even the suicidal behavior of others that is crucial in itself, but actions that are perceived to legitimize life-threatening behavior. Especially for adolescents, such education insists that suicide is a permanent solution to a temporary problem.

Exposure to suicide education creates resources for resolving problems in other ways and directs attention to the suffering that is common after an adolescent suicide. Corr, Nabe, and Corr (1997, p. 369) felt that "talking about suicide in a constructive educational format is far more likely to clear the air and minimize suicidal behavior than to suggest or encourage such behavior."

People who talk about suicide commit suicide. According to Williams (2002, n.p.), "90% of all final attempters talk about it to at least one person. Adolescents who are ambivalent about ending their lives often attempt to communicate their need for help in some way or other." For example, individuals contemplating suicide may begin to give away prized possessions or verbalize vaguely about how their life would be better if they were no longer around. This implication is often overlooked because their message isn't recognized due to poor communication skills (Corr, Nabe, & Corr, 1997).

No special types of people commit suicide. According to Americas Continuing Education Network (2003, n.p.), "everyone has the potential for suicide. The evidence is that predisposing conditions may lead to either attempted or completed suicides." It is unlikely that those who do not have depression, conduct disorder, substance abuse,

emotional pain, or anger will complete suicide (Americas Continuing Education Network, 2003).

People are not suicidal most of their lives and it can be prevented. A suicidal crisis is very often temporary. If a person can get help, the desire to commit suicide may disappear. According to Williams (2002, n.p.), “80% of suicidal people ask for help and can be helped. Only 10% of suicides are people who mean to kill themselves and can’t be stopped.” Most young people are suicidal only once in their lives. As said by Nelson and Galas (1994, p. 25), “the truth is that most people are hazardous to themselves only for a brief period of time--24 to 72 hours.” It is possible that they won’t make another attempt on their lives if someone stops them from carrying out their plans and explains how to get help (Nelson & Galas, 1994).

Suicide is not just a way to get attention. According to Americas Continuing Education Network (2003, n.p.), “all suicide attempts should be treated as though the person has the intent to die. Do not dismiss a suicide attempt as simply being an attention-gaining device.” The individual may have previously tried to get attention and, therefore, this attention is desired. The attention that they get might save their life (Americas Continuing Education Network, 2003).

Comprehensive School Suicide Prevention Program

Adolescents spend one-third of their day in a school setting. Therefore, schools are the ideal places for suicide prevention. Educators can offer consistent, direct contact opportunities with large populations of adolescents (King, 2001).

As indicated by Guetzloe (1991), a comprehensive school suicide prevention program should include procedures related to the three components: prevention for the

aftermath of a suicide crisis, intervention for dealing with suicide attempts, threats, and ideation, and postvention to minimize trauma and reduce copycat suicides. This approach focuses on preventing suicide by describing and monitoring the problem, understanding the risk factors and causes of suicidal behavior, and implementing interventions and prevention strategies (King, 2001).

Prevention

The goal of suicide prevention programs is to decrease student suicide thoughts, attempts, and completions. School programs and activities should focus on increasing staff and student awareness of suicide warning signs, risk factors, and the proper referral procedures. According to King (2001, p. 133), "prevention offers the most direct method for saving student lives from suicide and, therefore, should receive the most attention. All school staff should share responsibility for identifying and helping students in need."

An essential component of an effective school-based suicide prevention program identifies students at-risk for suicide. Therefore, school professionals' ability to recognize suicide warning signs and risk factors is crucial in the prevention phase. According to Guetzloe (1991, n.p.),

> the primary role of all school personnel is to detect the signs of depression and potential suicide, to make immediate referrals to the contact person within the school, to notify parents, to secure assistance from school and community resources, and to assist as members of the support team in follow-up activity after a suicide threat or attempt.

While teachers and other staff members are not qualified to diagnose and treat suicidal adolescents, they should assist in recognizing students at risk and conveying that

information to school counselors or school psychologists. Suicide prevention training for school professionals can increase their awareness of suicide warning signs, knowledge of resources, and ability to make referrals (King, 2001).

According to King (2001, n.p.) “more than one-half of high school students report they would not feel comfortable talking to a school professional about a personal problem. Three out of four adolescents would first turn to a friend for help if they were contemplating suicide.” Peer assistance programs should be implemented for that reason alone. Educating students about the warning signs of suicide and how to refer suicidal friends to school counselors is essential (King, 2001).

Parent involvement in their children’s education is encouraged. When schools promote healthy relationships with parents, parents are more likely to support and cooperate with the programs schools offer. Consequently, it is the responsibility of the school to notify parents of all suicide prevention programs and inquire about their assistance in determining particular prevention activities (King, 2001).

Consistent with reviewed literature (Portes, Sandhu, & Longwell-Grice, 2002, p. 809), “awareness of the signs and symptoms of suicidal ideation should be priority in the schools and in the community. Teachers and family members can work in partnership with schools to intervene.”

A complete suicide prevention program cannot completely operate without external support and resources. Schools should strive to form and sustain positive relationships with other community agencies. Providing school professionals readily available agencies and services to contact is most beneficial when a student suicide threat

or attempt is made. Such contacts should include hospital emergency, law enforcement, youth health services, and psychiatric facilities (King, 2001).

Every school should have a crisis intervention team implemented. This team should consist of a diverse group of school professionals such as the principal, counselor, teacher, and school nurse. A designated person and a backup leader are needed to ensure the presence of at least one team leader in the building at all times. This team should develop an organized school suicide intervention plan that specifically recognizes the procedures to be followed when a student threatens or attempts suicide (King, 2001).

According to Portes, Sandhu, and Longwell-Grice (2002, p. 809), "a family approach to intervention is especially important in light of recent evidence suggesting that parents may actually precipitate a child's suicide." Prevention programs work to help connect people and improve an individual's self-worth to reduce potential suicides. This support can be implemented in a supportive social setting, such as the school (Portes, Sandhu, & Longwell-Grice (2002).

Intervention

As indicated by Portes, Sandhu, and Longwell-Grice (2002, p. 809), "intervention, including screening, should begin early. Suicide intervention should begin at preadolescence." School suicide intervention refers to school professionals following specific procedures outlined in the suicide intervention plan. The crisis intervention plan should designate a team leader to supervise the situation and make certain that appropriate actions are taken. The goal of the intervention phase is to secure the surrounding area, maintain student safety, and refer the suicidal student to further appropriate services (King, 2001).

According to King (2001, p. 135), “when a school professional encounters an adolescent who has expressed suicidal thoughts, the main objective is to prevent the act.” A school professional should stay with the suicidal student at all times. King (2001, p. 135) stated that “at this time the school professionals should actively listen, ask questions for clarity, encourage the open expression of feelings, remain calm, be positive about life in general, help the youth gradually accept reality, and refrain from promising confidentiality or secrecy.”

The school professional should accompany the youth to a prearranged, nonthreatening area away from others. A prearranged signal should be used to inform another adult about the situation. The signal will alert the crisis intervention team. The suicidal student should be asked if they have a specific plan, when the plan is to take place, and if they have access to lethal means to complete the plan (King, 2001).

According to King (2001, n.p.), “the school’s suicide intervention program should anticipate three levels of risk: extreme risk situation, severe risk situation, and moderate risk situation.” In the extreme risk situation, the student has a plan to harm him/herself and he/she know how he/she is going to actually complete the act of suicide (Poland & Lieberman, 2003).

In the severe risk situation, the student has a detailed suicidal plan, but has no dangerous means of carrying out the act. However, the youth may have access to lethal means at home (King, 2001). At this level of risk, students should also be asked if they have ever tried to hurt themselves before (Poland & Lieberman, 2003).

In the moderate risk situation, the student has verbalized suicidal thoughts, but has no specific suicidal plan or dangerous instrument. Since the level of risk is so crucial in

determining the proper services the student needs, appropriate assessments are required (King, 2001). As indicated by King (2001, p. 136), “the school should determine whether emergency or short-term procedures were followed and whether long-term services were arranged. If not, the school should contact a child-protection agency or a community mental health agency for assistance.”

Follow up on the intervention procedures should be debriefed by all staff involved in the incident. This process allows those involved an opportunity to sort out their feelings and concerns. The crisis intervention team should assess whether the prearranged strategies actually made the situation better or worse. Procedures can be upheld or modified based on their perceived effectiveness (King, 2001).

Postvention

Suicide postvention refers to strategies occurring after a student has threatened, attempted, or completed suicide. A completed suicide is a traumatic event for the survivors. According to King (2001, p. 136), “suicide clusters are well established among adolescents, so the school response to an actual suicide is crucial. The goal of postvention is to minimize the trauma to students and reduce the likelihood of copycat or further suicides.” Postvention procedures are most effective and easily carried out when planned well in advance of any actual emergency (King, 2001).

Suicide postvention steps should include: responding promptly after the event (within 24 hours of the suicide); acting in a concerned and conservative manner; informing all staff and school board members of the event and action steps; having teachers announce the death of the student to their first class of the day; making counseling sites available throughout the school; avoiding any glorification of the

suicide; assigning a school liaison to handle media inquiries, monitoring the school's ongoing emotional climate; and evaluating all postvention activities. As stated earlier, all school professionals should be aware of the school's postvention plan in managing the days following a student suicide or attempt (King, 2001).

All school professionals have a duty to report to parents, mental health agencies, or law enforcement. It's the school responsibility to anticipate that a student who is exhibiting the warning signs of suicide is at risk to take his/her own life. According to Poland and Lieberman (2003, n.p.) "courts have found school districts negligent in failing to notify parents that their child is known to be suicidal and in failing to take the appropriate steps to get help for the student."

Summary

Comprehensive school suicide prevention programs should include prevention, intervention, and postvention components. This chapter outlined practical steps for incorporating each component within a school system. School professionals should know the specific components, benefits, and anticipated effects associated with a comprehensive school suicide prevention program. Ongoing training and evaluation of the suicide prevention plan is needed. In so doing, school professionals can remain aware of suicide prevention efforts, and crisis intervention team members can accurately assess effectiveness of the school's overall program (King, 2001).

CHAPTER THREE

Methodology

Introduction

This chapter will describe the subjects in this study and how they were selected. The researcher will discuss the instrument used and how it was designed, how the data was collected and analyzed, and limitations apparent in the methodology.

Subject Selection

School professionals working in a metro suburban Minnesota high school during December of 2003 and January of 2004, were chosen to participate in this survey. A total of 145 school professionals were asked to participate in the research study and 39 filled out the survey for this study.

Instrumentation

This survey was specifically designed for this study. The information for the survey came from examining literature and determining the critical aspects the researcher wanted to investigate. No measures of validity and reliability had been established on this instrument because it was designed for this specific study.

The three-page survey consisted of nineteen statements and/or questions. The first five items addressed demographics in order to gain insight about the subjects' background information. The demographic items addressed in this survey included the subject's age, gender, highest educational level attained, job title, and the number of years working in the profession.

Questions six through nine addressed the subjects' level of suicide prevention and intervention awareness in the school setting. These questions addressed the following

questions: how much education or training on suicide prevention and/or intervention the subject had received; if the school had a crisis intervention team and if so, could they list who was on the team; if their school addressed suicide prevention in the curriculum and if so, what subject areas addressed the issue; and if they ever had a student address suicide issues to them.

Items ten through eighteen were statements used to measure the subject's opinions on a Likert scale of strongly disagree (1), disagree (2), neutral (3), agree (4), or strongly agree (5). The statements were designed to measure school professionals' understanding, perceptions, and awareness of youth suicide. The statements addressed risk factors, warning signs, and common myths about adolescent suicide.

The last question was an open-ended question about what the subjects thought the role of the school was in suicide prevention. The subjects had the opportunity at the end of the survey to include any additional comments if they felt it was necessary.

Data Collection

Data was collected through a survey distributed to metro suburban high school professionals in one school district in Minnesota. The surveys were brought to the staff lounge of the high school. The researcher then distributed surveys into each staff member's mailbox. The subjects were asked to return the surveys into a box located in the school staff lounge within two weeks from which they received the survey. The researcher then went back to the school to pick up the box of completed surveys. Out of the 145 surveys distributed in the Minnesota high school, 15 surveys were filled out and returned.

The researcher then distributed a reminder note in each school professionals' mailbox to prompt them to fill out a survey if they hadn't yet done so. An all staff email was also sent out to remind staff members to pick up a survey and fill it out. Extra surveys were placed in the staff lounge if subject's had misplaced their survey. Participants were asked to return the surveys into a box located in the staff lounge of the high school.

The researcher went back to the high school to pick up the box of completed surveys. Twenty-four more surveys were filled out the second time they were collected. A total of 39 surveys were used to measure public school professionals' understanding, perceptions, and awareness of youth suicide in a metro suburban high school in Minnesota.

Data Analysis

Ordinal, nominal, and ratio scales of measurement were used in the survey. The researcher completed the data analysis on the survey. Frequencies, percentages, and valid percentages were used on all scales. A crosstabulation of frequencies and percentages were determined for research questions two and three. The mode and range of scores were used for all items.

Limitations

Because of the sensitive nature of the topic, some school professionals might have been influenced in their participation. All of the staff members working in the Minnesota high school had the opportunity to fill out the survey. Because participation was voluntary, the researcher had a low return rate. The results do not represent the entire sample of school professionals invited to participate in the study. This study was limited

to school professionals working in one school district, in a metro suburban high school in Minnesota. Consequently, the results can not be generalized to communities elsewhere in Minnesota.

CHAPTER FOUR

Results

Introduction

The purpose of this study was to measure public school professionals understanding, perceptions, and awareness of youth suicide in a metro suburban high school in Minnesota. Data was collected through a survey distributed to the high school professionals.

This chapter will include demographic information about the subjects who participated in the study and will answer the research questions: do the school professionals' understand suicide among the youth population; what are the school professionals' perceptions of youth suicide; and are secondary school professionals' aware of youth suicide?

Demographic Information

There were 145 surveys distributed to school professionals' in a metro suburban high school in Minnesota during December of 2003 and January of 2004. There were 39 returned surveys. This resulted in a return rate of 26.9%.

The three-page survey consisted of nineteen statements and/or questions. The first five items addressed demographic information in order to gain insight about the subjects' background information. The demographic items addressed in this survey included the subject's age, gender, highest educational level attained, job title, and the number of years working in the profession.

Item 1 asked participant's to respond to an age category that pertained to them. Of the 39 participants, 10 were aged 20 to 30 years old (25.6%), 5 were 31 to 40 (12.8%), 11

were 41 to50 (28.2%), 12 were 51 to 60 (30.8%), and 1 was 61 or older (2.6%). Participants' ages were well distributed. The most frequent age group was 51 to 60 years old. Table 1 presents the ages of the participants.

Table 1

Age	20-30	31-40	41-50	51-60	61+	Total
Frequency	10	5	11	12	1	39
Percent	25.6	12.8	28.2	30.8	2.6	100

Item 2 asked participants to indicate their gender. Of the 39 participants, 27 were female (69.2%) and 12 were male (30.8%). Table 2 presents the gender of the participants.

Table 2

Gender	Female	Male	Total
Frequency	27	12	39
Percent	69.2	30.8	100

Item 3 asked participants to indicate their highest educational level attained. Of the 39 participants, 3 received some postsecondary education (7.7%), 9 received a Bachelor's Degree (23.1%), 22 received a Master's Degree (56.4%), 4 received a Doctorate Degree (10.3%), and 1 indicated other (2.6%). Table 3 presents the highest educational level attained by participants.

Table 3

Education	Some Post HS	Bachelors	Masters	Doctorate	Other	Total
Frequency	3	9	22	4	1	39
Percent	7.7	23.1	56.4	10.3	2.6	100

Item 4 asked participants to indicate their job title based on subcategories given. Of the 39 participants, 3 participants were administration (7.7%). Administration included principals, assistant principals and dean of students. Twenty-nine were teachers (74.4%). Two were student services (5.1%). Student services included counselor, psychologist, speech/language, paraprofessional, coordinator, and liaison officer. Five were support staff (12.8%). Support staff included nurse, secretarial, reception, registrar, media and technology, custodial, and food service. The majority of the participants were teachers. Table 4 presents the participant's job title.

Table 4

Job Title	Admin.	Teachers	Student Services	Support Staff	Total
Frequency	3	29	2	5	39
Percent	7.7	74.4	5.1	12.8	100

Item 5 asked participants to indicate the number of years working in the profession. The number of years working in the profession ranged from 1 to 35 years. The most frequent number of years working in the profession was 4 and the mean was 19 years. Table 5 presents the participants number of years working in the profession.

Table 5

Years Working	
Mode	4
Mean	19
Minimum	1
Maximum	35

Research Questions

This section will include analysis of the research questions.

Research Question 1-Are the high school professionals' aware of youth suicide?

Questions 6 through 9 addressed the subjects' level of suicide prevention and intervention awareness in the school setting. These questions addressed the following questions: how much education or training on suicide prevention and/or intervention the subject had received; if the school had a crisis intervention team and if so, could they list who was on the team; if their school addressed suicide prevention in the curriculum and if so, what subject areas addressed the issue; and if they ever had a student address suicide issues to them.

Items 6 through 9 were used to indicate whether high school professionals were aware of youth suicide. Item 6 asked participants to indicate whether they have received any education or training on suicide prevention and/or training. Of the 39 participants, 14 have not received any education or training on suicide prevention and/or intervention and 25 have received education on the subject. Of the 25 participants who received suicide education or training, 13 received suicide training from college, 15 from workshops or conferences, 8 from on-the-job training, 17 from in-service training, 4 from professional journals, 3 from the media, and 1 from another source. Table 6 presents if and where participants received education or training on suicide prevention and/or intervention.

Table 6

Received Education	Yes	No	College	Work-Shop	On the Job	In-service	Prof. Journal	Media	Other
Frequency	25	14	13	15	8	17	4	3	1
Percent	64.1	35.9	33.3	38.5	20.5	43.6	10.3	7.7	2.6

Item 7 asked participants if their school had a crisis intervention team. Of the 39 participants, 27 answered yes (69.2%), 6 said no (15.4%), and 6 didn't respond to the

question (10.3%). Table 7 presents participants' awareness of a crisis intervention team in their school.

Table 7

Crisis Team	Yes	No	No Response	Total
Frequency	27	6	6	39
Percent	69.2	15.4	15.4	100

Participants were also asked to indicate who was on the crisis intervention team. Various answers included deans, administration, school psychologist, nurse, police resource officer, chemical dependency educator, and teacher.

Of the 27 who answered yes, 25.6% (n=10) indicated deans and administration; 7.7% (n=3) said deans; 7.7% (n=3) said deans, administration and school psychologist; 7.7% (n=3) said deans, administration and nurse; 5.1% (n=2) said deans, administration, school psychologist and nurse; 2.6% (n=1) said deans, administration, nurse and teacher; 2.6% (n=1) said deans, administration, police resource officer and chemical dependency educator; 2.6% (n=1) said deans, administration, police resource officer, chemical dependency educator, school psychologist, and nurse; 2.6% (n=1) said deans, administration, chemical dependency educator, and teacher; 2.6% (n=1) said deans, administration, school psychologist, nurse, and teacher; and 2.6% (n=1) said chemical dependency educator.

Item 8 asked participants if their school addressed suicide prevention in the curriculum. Of the 39 participants, 13 responded no, 24 indicated yes, and 2 didn't respond to the question. If participants indicated yes, they were asked to list the subject area that addressed suicide issues in the curriculum. Of the 24 participants who responded yes, 22 said in health class, 1 said in family and consumer science class, 1 said in

communication in a small group class, and 2 said in teen issues class. Table 8 presents if and where suicide prevention is addressed in the school curriculum.

Table 8

Address in Curriculum	Yes	No	No Response	Health	FACS	Small Group	Teen Issues
Frequency	24	13	2	22	1	1	2
Percent	61.5	33.3	5.1	56.4	2.6	2.6	5.1

Item 9 asked participants if they ever had a student express suicidal thoughts or intents to them. Of the 39 participants, 20 said no (51.3%) and 19 said yes (48.7%). Table 9 presents student expression of suicidal thoughts or intents to participants.

Table 9

Express Suicide	No	Yes	Total
Frequency	20	19	39
Percent	51.3	48.7	100

Research Question 2-What are the school professionals' perceptions of youth suicide?

Items ten through eighteen were general statements used to measure the subjects' perceptions on a Likert scale of strongly disagree (1), disagree (2), neutral (3), agree (4), or strongly agree (5). The statements were designed to measure school professionals' understanding, perceptions, and awareness of youth suicide. The statements addressed risk factors, warning signs, and common myths about adolescent suicide.

Item 10 on the survey stated “youth suicide is a serious issue.” Of the 39 participants, 1 was neutral (2.6%), 12 agreed (30.8%), and 26 strongly agreed (66.7%). Table 10 presents participants’ perceptions of the seriousness of youth suicide.

Table 10

Serious Issue	Neutral	Agree	Strongly Agree	Total
Frequency	1	12	26	39
Percent	2.6	30.8	66.7	100

Item 11 on the survey stated “it’s the role of the school to identify students at risk of suicide.” Of the 39 participants, 15 were neutral (38.5%), 18 agreed (46.2%), and 6 strongly agreed (15.4%). Table 11 presents participants’ perceptions of the schools role.

Table 11

School’s Role	Neutral	Agree	Strongly Agree	Total
Frequency	15	18	6	39
Percent	38.5	46.2	15.4	100

Item 12 on the survey stated “I am aware of the risk factors of youth suicide.” Of the 39 participants, 2 disagreed (5.1%), 5 were neutral (12.8%), 24 agreed (61.5%), and 8 strongly agreed (20.5%). Table 12 presents participants’ awareness of risk factors.

Table 12

Risk Factors	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	2	5	24	8	39
Percent	5.1	12.8	61.5	20.5	100

Item 13 on the survey stated “I am aware of the warning signs and symptoms of youth suicide.” Of the 39 participants, 2 disagreed (5.1%), 8 were neutral (20.5%), 21 agreed (53.8%), and 8 strongly agreed (20.5%). Table 13 presents participants’ awareness of warning signs and symptoms.

Table 13

Signs and Symptoms	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	2	8	21	8	39
Percent	5.1	20.5	53.8	20.5	100

Item 14 on the survey stated "I feel I could intervene with potentially suicidal students. Of the 39 participants, 2 strongly disagreed (5.1%), 6 disagreed (15.4%), 9 were neutral (23.1%), 16 agreed (41%), and 6 strongly agreed (15.4%). Table 14 presents participants' comfort level with intervening with suicidal students.

Table 14

Intervene	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	2	6	9	16	6	39
Percent	5.1	15.4	23.1	41	15.4	100

Item 15 on the survey stated "few suicides happen without some warning." Of the 39 participants, 1 strongly disagreed (2.6%), 1 disagreed (2.6%), 8 were neutral (20.5%), 22 agreed (56.4%), 6 strongly agreed (15.4%), and 1 didn't respond. Table 14 presents participants' understanding of suicide warnings.

Table 15

No Warning	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	No Response	Total
Frequency	1	1	8	22	6	1	39
Percent	2.6	2.6	20.5	56.4	15.4	2.6	100

Item 16 on the survey stated "suicidal attempts are merely attention-seeking mechanisms." Of the 39 participants, 14 strongly disagreed (35.9%), 15 disagreed (38.5%), 8 were neutral (20.5%), and 2 agreed (5.1%). Table 16 presents participants' understanding of attention-seeking mechanisms among suicidal youth.

Table 16

Attention-Seeking	Strongly Disagree	Disagree	Neutral	Agree	Total
Frequency	14	15	8	2	39
Percent	35.9	38.5	20.5	5.1	100

Item 17 on the survey stated "suicide is preventable." Of the 39 participants, 5 were neutral (12.8%), 24 agreed (61.5%), and 10 strongly agreed (25.6%). Table 17 presents participants' perception of suicide prevention.

Table 17

Prevention	Neutral	Agree	Strongly Agree	Total
Frequency	5	24	10	39
Percent	12.8	61.5	25.6	100

Item 18 on the survey stated "talking about suicide causes students to think about or commit suicide." Of the 39 participants, 16 strongly disagreed (41%), 18 disagreed (46.2%), 4 were neutral (10.3%), and 1 strongly agreed (2.6%). Table 18 presents participants' perception of the causes of suicide.

Table 18

Talking Causes	Strongly Disagree	Disagree	Neutral	Strongly Agree	Total
Frequency	16	18	4	1	39
Percent	41	46.2	10.3	2.6	100

Research Question 3-Do school professionals' understand suicide among the youth population?

The majority of the participants were aware of the warning signs, signs and symptoms, and risk factors of youth suicide. Questions 10 through 18 were statements regarding many universal misconceptions of youth suicide and opinion statements related

to suicide. Overall, the participating school professionals consistently responded with agree or strongly agree to statements 10 through 18.

Thirty-eight of the 39 participants felt that youth suicide was a serious issue. Twenty-four believed it was the school's role to help identify students at risk for suicide. Thirty-six participants were aware of the risk factors and 29 were aware of the signs and symptoms of youth suicide. Twenty-eight felt that few suicides happened without some warning. Fifteen disagreed and 14 strongly disagreed that suicide was an attention-seeking mechanism. Eighteen participants disagreed and 16 strongly disagreed with the statement that talking about suicide caused students to think about or commit suicide and 34 felt that suicide was preventable.

Summary

Overall, the findings of this study seem to suggest that school professionals are knowledgeable and aware of youth suicide. While this is reassuring, the fact is that not all participants indicated awareness of suicide warning signs, symptoms, and risk factors. Not all participants had consistently identified the suicide misconceptions.

CHAPTER FIVE

Discussions, Conclusions, and Recommendations

Introduction

This chapter will include a discussion of the findings in this study, a summary of important results, and recommendations for the surveyed high school, school professionals, and for further research.

Discussion

Education and awareness is the key to helping school professionals identify students at risk and getting them the proper help they need. According to King (2001), suicide prevention training for school professionals can increase their awareness of suicide warning signs, knowledge of resources, and ability to make referrals. The researcher's results concurred with these findings. The more education participants had on youth suicide, the more they were able to identify students at risk and were better able to intervene with these students.

There are many universally held misconceptions about suicide. Providing assistance for those who are at-risk is often halted by these myths. According to Americas Continuing Education Network (2003, n.p.), “by dispelling the myths, school professionals will be in a better position to identify those who are at-risk and to provide the help that is needed.” The results of this study indicated that some participants agreed with common misconceptions about youth suicide. Further assistance and education can help school professionals dispel these myths and better their position to help students at risk.

Every school should have a crisis intervention team implemented. A crisis team should consist of a diverse group of school professionals, such as the principal, counselors, teachers, and school nurse (King, 2001). Results showed that not all of the high school staff professionals' know about a crisis team and there was some confusion as to who was on the team. Participants indicated that their crisis team possibly included deans, administration, school psychologist, nurse, police resource officer, chemical dependency educator, and teacher.

Conclusions

Overall, the findings of this study seem to suggest that school professionals are knowledgeable and aware of youth suicide. While this is reassuring, the fact is that not all participants indicated awareness of these important indicators of youth suicide. Approximately 50% of the school professionals had students express suicidal thoughts or intent. Only 56% of all participants felt they could intervene with potentially suicidal students.

Approximately 77% (n=30) were aware of a crisis intervention team. Only 70% (n=27) could list school professionals on the crisis team. Of those 27 participants who listed staff members on the crisis team, there were 11 different responses. These results indicate that the school's crisis intervention team and plan is not well known in the building.

School programs and activities should focus on increasing staff and student awareness of suicide warning signs, risk factors, and the proper referral procedures. Approximately 61.5% of school professionals suggested that suicide issues were

addressed within the curriculum. Participants indicated that health, family and consumer science courses, teen issues, and small group communication addressed suicide issues.

Recommendations for the Surveyed High School

The results seem to indicate that more education is needed to increase school professionals' awareness of suicide risk factors and warning signs and symptoms. Perhaps the school should have school-based suicide prevention and intervention training for all school professionals working in the building.

Results also indicate that the majority of participants were not accurately aware of who served on the crisis intervention team. All staff in the building should be made aware of crisis intervention procedures and appropriate school professionals to contact and refer at-risk students. While teachers and other staff members are not qualified to diagnose and treat suicidal students, they should assist in recognizing students at-risk and conveying that information to school counselors and school psychologists. This procedure could possibly be explained in a mandatory staff meeting at the beginning of the school year. Everyone should be educated on how to intervene with suicidal students and the proper referral procedures to follow.

Recommendations for School Professionals

Because suicide is of such a serious and important nature, school professionals should take it upon themselves to increase their awareness of youth suicide and crisis intervention procedures within their school. Find out who is on your crisis intervention team, what procedures to follow and who to contact when a student expresses potential suicidal thoughts or intent.

There are many universally held misconceptions about suicide. According to Americas Continuing Education Network (2003, n.p.), “by dispelling the myths, school professionals will be in a better position to identify those who are at-risk and to provide the help that is needed.”

In order to refer at risk students, educators need to be aware of the risk factors, warning signs, and symptoms of youth suicide. Workshops, conferences, on-the-job-training, in-service training, professional journals, and media coverage are just a few resources out there for professional development on youth suicide. Ongoing training and evaluation of suicide prevention is needed.

A complete suicide prevention program cannot entirely operate without external support and resources. Schools should strive to form and sustain positive relationships with other community resources. Providing school professionals readily available agencies and services to contact is most beneficial when a student suicide threat or attempt is made.

Parent involvement in children’s education is encouraged. When schools promote healthy relationships with parents, parents are more likely to support and cooperate with programs schools offer. Perhaps the school could offer a parent class on recognizing signs and symptoms of depression, suicide risk factors, and warning signs of youth suicide. Teachers and parents can work together with schools to intervene.

Participants were given the opportunity to express how schools play a role in suicide prevention. The following ideas came from school professionals surveyed: schools need to educate students about alternatives to suicide, as well as where and who to ask for help; schools should educate peers to understand and recognize the warning

signs and how to intervene; teach students about depression; collaborate with the community (parents, churches, police, social workers, etc,.); destigmatize mental illnesses; educate parents about available help and resources within the community; and educate parents to notice subtle changes in their children's behavior.

Recommendations for Further Research

One of the limitations of this study was the low participation rate. It would have been more effective to attend a school staff meeting to announce the researcher's study so all staff members were aware of it before surveys were distributed in their mailbox. A higher return rate would have better represented the metro suburban high school.

The researcher distributed the surveys 2 weeks before Christmas break. When the return rate was low at the first deadline, the researcher used the 2 weeks after Christmas break to get more surveys. These were very busy times in the school and it is suggested that surveying be done at a different time in the semester. The researcher was aware of the bad timing and needed to collect data in order to reach thesis deadlines. It is suggested that the thesis process and pace of progress be considered well in advance so timing of data collection gives participants more time to fill out the survey and so the researcher will have the best return rate for more representative results.

The survey itself was created by the researcher and may have had its own limitations. The survey inquired about the schools' role in suicide prevention and didn't mention help from parents or the community.

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APPENDIX A

Project Title: Public School Professionals' Understanding, Knowledge, and Awareness of Youth Suicide

Rachel Bachmann of the Guidance and Counseling Program at the University of Wisconsin-Stout is conducting a research project titled, "Public school professionals' understanding, knowledge, and awareness of youth suicide." She would appreciate your participation in this study.

It is not anticipated that this study will present any medical or social risk to you. The information gathered will be kept strictly confidential and any reports of the findings of this research will not contain your name or any other identifying information.

Your participation in this project is completely voluntary. If at any time you wish to stop participating in this research, you may do so, without coercion or prejudice.

When you have completed this survey, please fold it and drop it in the return box located in the main office of your school building. The last day to return the survey is Thursday, January 23, 2004. Once the study is completed, the analyzed findings would be available for your information.

Questions or concerns about the research study should be addressed to Rachel Bachmann, the researcher, phone (952) 250-8206 or Dr. Amy Gillett, the research advisor (715) 232-2680. Questions about the rights of research subjects can be addressed to Sue Foxwell, Human Protections Administrator, UW-Stout Institutional Review Board for the Protection of Human Subjects in Research, 152 Voc Rehab Bldg, Menomonie, WI, 54751, phone (715) 232-1126.

APPENDIX B

Public School Professionals' Understanding, Perceptions, and Awareness of Youth Suicide

Please mark an "X" next to the response that pertains to you.

1. What is your age?
   ___20-30
   ___31-40
   ___41-50
   ___51-60
   ___61+

2. Gender:
   ___Female
   ___Male

3. Highest educational level attained:
   ___High school degree
   ___Some postsecondary
   ___Bachelors degree
   ___Masters Degree
   ___Doctorate
   ___Other, please explain_____

4. Job title:
   ___Administration: principal, assistant principal, dean of students
   ___Teacher
   ___Student services: counselor, psychologist, speech/language, paraprofessional, coordinator, liaison officer
   ___Support staff: nurse, secretarial, reception, registrar, media and technology, custodial, food service

5. Numbers of years working in the profession
   ___

6. Have you received any education or training on suicide prevention and/or intervention?
   ___Yes ___No
   If so, please mark an "X" for all that apply:
   ___College education
   ___Workshops/conferences
   ___On-the-job training
   ___In-service programs
   ___Professional journals
   ___Media

___Other, please explain:_____

7. Does your school have a crisis intervention team?
   ___Yes
   ___No

   If so, please list, by title, who is on the crisis intervention team:_____

   _____

8. Does your school address suicide prevention in the curriculum?
   ___Yes
   ___No

   If so, please list subject areas where suicide issues are addressed in the curriculum:_____

   _____

9. Have you ever had a student express to you suicidal thoughts or intent?
   ___Yes
   ___No

Please circle the number that best represents your opinion on each item using the scale provided.

1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5 =Strongly Agree

10. Youth suicide is a serious issue. 1 2 3 4 5

11. It's the role of the school to identify students at risk of suicide. 1 2 3 4 5

12. I am aware of the risk factors of youth suicide. 1 2 3 4 5

13. I am aware of the warning signs and symptoms of youth suicide. 1 2 3 4 5

14. I feel I could intervene with potentially suicidal students. 1 2 3 4 5

15. Few suicides happen without some warning. 1 2 3 4 5

16. Suicidal attempts are merely attention-seeking mechanisms. 1 2 3 4 5

17. Suicide is preventable. 1 2 3 4 5

18. Talking about suicide causes students to think about or commit suicide. 1 2 3 4 5

Please answer this item to the best of your knowledge.

19. In your opinion, what is the role of schools in suicide prevention?

Any additional comments are welcome and would be appreciated.

Thank you for your participation