High School Counselors Perception of Preparedness in Implementing Prevention and Postvention of a Student Suicide

by

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ABSTRACT

Suicide is a deadly act that can easily be prevented with the proper knowledge and help from an educated adult. Since youth spend a majority of their time at school, it seems obvious that school counselors should play a vital role in youth suicide prevention.

The purpose of this study was to measure high school counselors perception of preparedness in implementing prevention and postvention of a student suicide. Data was collected through surveys mailed to school districts with 50-500 high school students between the months of March 2007 and April 2007.

The study attempted to answer the following questions: do school counselors have suicide prevention programs offered in their school; do school counselors feel prepared to implement prevention programs to students about suicide; do school counselors feel prepared to implement postvention after a student suicide occurs; do school counselors feel they need to receive additional

education on issues relating to youth suicide; and are school counselors aware of risk factors and warning signs of suicide?

Overall, the findings suggested that most school counselors are aware of the risk factors and warning signs of suicide as well as felt prepared to implement prevention and postvention to students. While this is reassuring, it was also discovered that not all school counselors have the confidence to assist youth in suicide prevention or postvention and some school counselors are not at all aware of the risk factors and warning signs of suicide. It is apparent that continued education would assist all school counselors to gain or continue to gain confidence in assisting students in reducing suicide.

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Dedication

I dedicate my thesis to my friend Melissa Sue Cole, who took her own life on October 4, 1999 at the young age of 14. The loss of her precious life has given me the determination to assist those individuals who NEED help, to let them know someone cares, and to prevent the preventable from occurring to any other family or friends. Melissa's sweet smile and spirited personality is what made her loved by everyone. Her loss was sudden and unexpected, but has taught me to seek out those who need help, no matter who they are. I will always miss you and always love you M.C.

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"Don't blame yourselves, Mom and Dad, I love you. It was signed Mike 11:45 p.m. In a move that totally stunned all who know him, Mike shot himself at a time of deepest despair. At 11:52 pm his parents pulled into the driveway behind that bright yellow Mustang, *seven minutes too late*" (Light for Life Foundation, n.d. n.p.). This is a story that is all too often heard about in our society, affecting young teens around the United States. The question that is debated over and over is WHY, but the question we should be asking is how can we help?

Suicide is prevailing as one of the leading causes of death among Americans, and is even more prevalent among our youth and children. Suicide, also known as "self-murder," is the third leading cause of death among teenagers and children following only accidents and homicides. "In 2002, an estimated 790,000 people in the United States attempted suicide" (American Association of Suicidology [AAS], 2006, n.p.) Of those 790,000 people "approximately 10 youth per every 100,000 commit suicide, each day approximately 11 youth commit suicide, and every two hours and eleven minutes, a person under the age of 25 completes suicide" (AAS, 2006, n.p.). In the following year, 2003, "244 children ages 10-14 completed suicide in the United States, a rate of 1.12 per 1,000 children" (AAS, 2006, n.p.). The National Institute of Mental Health (2003) explained that "suicide was the 8th leading cause of death for males and the 19th leading cause of death for females in 2000" (n.p.) as "females are three times more likely than males to attempt suicide, but males are five times more likely than females to complete suicide" (King, cited in King, 2000, ¶ 6). The reason for this difference is due to the means in which they choose to end their life. "Boys tend to use more lethal methods such as firearms or hangings in order to keep their emotions hidden because they are ashamed

of their feelings and feel they would be better off dead. Girls, on the other hand, choose more survivable methods such as overdosing on pills in an attempt to communicate their need for help" (Portner, 2001, p. 5).

> According to The Wisconsin Suicide Prevention Strategy,
>
> suicide is a major public health issue as it is the second leading cause of death for young people aged 15-34 and the 10th leading cause of death for individuals overall. Also, in the year 2000, 588 lives were lost to suicide and the state suicide rate was three times greater than the state homicide rate. (2002, p. 4)

This is a statistic that is much too high and very preventable. According to the Department of Public Instructions 2000 Youth Behavioral Risk Survey, "one in five Wisconsin high school students reported seriously considering suicide" (The Wisconsin Suicide Prevention Strategy, 2002, p. 8), which proves that suicide truly is a serious public health issue and needs to be managed.

Nationally, "a recent survey of high school students found that almost 1 in 5 had seriously considered attempting suicide; more than 1 in 6 made plans to attempt suicide; and more than 1 in 12 had made a suicide attempt in the past year" (National Youth Violence Prevention Resource Center, 2002, n.p.). These statistics provide the three general categories of suicide, which are necessary to understand in order to help individuals who are having the ideations of suicide. The categories are: thinking about attempting suicide, attempting suicide, and committing suicide. Robbins, author of

> some researchers view the three categories as points on a continuum. Thinking about suicide occurs at the beginning of the process. The person who attempts suicide usually has thought about it extensively and reacts to those thoughts and finally the person completes the suicide because he/she is acting on an overpowering despair. (1998, p. 7).

When this continuum is recognized, we can attempt to reduce the final step from occurring, but if and when the individual reaches the third category, it is very important that proper action is taken to reduce a potential wave of copycat suicides. It is noted, "for every completed suicide by youth, an estimated 100-200 attempts are made" (AAS, 2006, n.p.). When a suicide is completed, "the impact of suicide sends a wave across communities and if suicide occurs in a community, there is a 300% chance that another one will occur" (Yates, 2001, n.p.). With this increased risk, it is necessary that communities are prepared to deal with this crisis and understand suicidal behavior.

In gaining insight on suicide, individuals need to realize that suicide is a disease of the mind. It is noted that 90% of individuals who complete suicide suffer from some form of mental illness, 60% of those individuals suffering from depression, the most common form (Yates, 2001, n.p.). The American Psychiatric Association (2005) stated, "over half of all kids who suffer from depression will eventually attempt suicide at least once, and more than seven percent will die as a result" (n.p.). According to the National Strategy for Suicide Prevention, "suicide is an outcome of complex interactions among neurobiological, genetic, psychological, social, cultural, and environmental factors" (cited in The Wisconsin Suicide Prevention Strategy, 2002, p. 7). Teens can be at greater risk for suicide due to their:

> biochemical makeup or life experiences which could include: previous suicide attempt; depression and/or alcohol or substance abuse; family history of mental disorder, substance abuse, or suicide; stressful situations or loss; easy access to guns; exposure to other teenagers who have committed suicide; history of physical and/or sexual abuse, poor communication with parents; incarcerations; and lack of access. (National Youth Violence Prevention Resource Center, 2002, n.p.)

With all this information, it is apparent suicide prevention is needed in the schools, where our youth spend a majority of their time, as well as postvention to deal with the immediate impact a student suicide has on a school district. School counselors play a tremendous role in assisting in the prevention or, if needed, postvention of a student suicide. School counselors often "address student mental health issues and help other school professionals such as teachers, nurses, and administrators to effectively deal with mental health concerns as they are the school professionals strongly encouraged to lead school crisis prevention and intervention programs" (King, 2000, ¶ 2). With this in mind, it is essential for school counselors to feel prepared to implement the prevention strategies and postvention plans when dealing with a suicidal student or a completed suicide. But do school counselors feel prepared to address this sensitive topic? In a study conducted by Peach and Reddick, it was found that

> two out of three counselors were aware of warning signs of youth suicide; but only one in two reported that they had received some special training on youth suicide, and only one in five reported working in a school that had formed a suicide prevention or intervention program. (cited in King, 2000, ¶ 3)

This is a disturbing ratio because school counselors are supposed to play a major role in the success in overcoming these tragedies. If appropriate help is available and school counselors feel prepared to implement such programs, they can watch the statistics on suicide decrease and help prevent the preventable from occurring.

Statement of the problem

Since school counselors play a vital role in the prevention programs and postvention plans of a student suicide, it is crucial to determine if these individuals are capable of providing the necessary programs. The purpose of this study was to determine if high school counselors in Wisconsin school districts of 50-500 high school students felt prepared to implement prevention or postvention of a student suicide. Data was collected through a mailed survey during the months of March and April 2007. The results of the study assisted in discovering if school counselors felt prepared to counsel suicidal students or felt prepared to overcome the crisis of a student suicide in their school district. The study will be useful to determine if additional education is needed in order to prepare school counselors for the issues related to student suicides.

Research Questions

There are five research questions this study attempted to answer. They include:

1. Do schools have suicide prevention programs offered in their schools?
2. Do school counselors feel prepared to implement prevention programs to students about suicide?
3. Do school counselors feel prepared to implement postvention after a student suicide occurs?
4. Do school counselors feel they need to receive additional education on issues relating to youth suicide?

5. Are school counselors aware of risk factors and warning signs of suicide?

Definition of Terms

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

Attempted Suicide: when a person tries to end ones own life, but doesn't succeed.

Completed Suicide: when a person ends ones own life.

Postvention: a plan provided by school counselors or other school professionals which aids in assisting students in coping with the death of a student by suicide.

Prevention: programs provided by school counselors or other school professionals, which aid in reducing or stopping a student suicide from occurring.

Assumptions and Limitations

There are a number of assumptions and limitations of this study. There may be a bias from the school counselor participants due to the sensitivity of the topic, which could influence their participation and may misrepresent the results.

The researcher created the survey; therefore, the survey has no documented measurement of validity or reliability.

Finally, the study was limited to Wisconsin schools with 50-500 high school students and those who receive the survey may choose not to participate or may not complete the survey correctly. This indicates the results should not be generalized to all school counselors or considered a total representation of the population.

Chapter Two: Literature Review

Introduction

This chapter will begin with a discussion of misconceptions of suicide, including the fact to the misconception. Next, will be necessary information regarding risk factors of youth suicide, followed by the signs, symptoms, and motives of a suicidal student. Concluding will be a discussion of prevention, an eleven-step intervention that school counselors can provide, as well as postvention within the school.

Misconceptions and the Facts

Suicide is a very sensitive topic that many are unwilling to discuss and even unwilling to think about. With the lack of education and knowledge, many misconceptions can and will develop in regards to truly understanding suicide. Steele (2001) provided common "fictitious" information regarding suicide followed by the fact to the fiction, which should be used to help uneducated individuals become educated about suicide.

Fiction: if people talk about killing themselves, they will not really do it.

Fact: Talking about suicide often is a clue to or warning of a person's intent. Always take any mention of suicide serious.

Fiction: suicidal tendencies are inherited.

Fact: although several suicides can happen in one family, it appears to be a response to previous suicides rather than genetically transmitted.

Fiction: people who are suicidal want to die, believing there is no turning back.

Fact: people who are suicidal want to get rid of their problems more than they do their lives.

Fiction: all people who are suicidal are deeply depressed.

Fact: people contemplating suicide frequently are depressed. However, a more positive demeanor may be observed because they have decided to resolve their problems through suicide.

Fiction: there is a low correlation between alcoholism and suicide.

Fact: alcohol may trigger a suicide attempt and is often ingested before suicide by both alcoholics and non-drinkers. (p. 93)

Risk Factors of a Suicidal Student

A commonly asked question in regards to suicide is *why are a greater number of our youth committing suicide*? There is no exact answer to this question, but there are a number of factors that may contribute to their fatal act. Portner (2001) stated:

> no single group of children is exempt. Suicide does not discriminate by race, class, religion, or gender. Upper-class urbanites, poor rural farm children, and middle-class kids crammed into minivans who become class presidents and get scholarships to Ivy League schools have all been victims of suicide. (p. 3)

This means that any person is susceptible to suicide, which is why it is necessary to learn what factors could lead an individual to commit such an act.

The National Youth Violence Prevention Resource Center (2002) said there are a number of risk factors that could lead a teen to suicide. The first risk factor discussed of a teen suicide is a previous suicide attempt. When adolescents attempt suicide, they are not just doing the act to get attention; there is a motive behind their attempt. "Teens who have attempted suicide in the past are much more likely than other teens to attempt suicide again in the future and approximately one third of teen suicide victims have made a previous suicide attempt" (n.p.). It is often stated that teens who attempted suicide are just crying for help and they don't really want to die; that is all too true, these individuals

are crying for help, but if they don't get the help they need, they will try to commit suicide again. It is necessary to take students seriously when they attempt suicide because if they do not get the help needed, they may attempt again and this time succeed.

Another risk factor is depression. As noted, "over 90% of teen suicide victims have a mental disorder, such as depression...." (National Youth Violence Prevention Resource Center, 2002, n.p.). Wanda Johnson, author of *Youth Suicide* (1999), discussed that adolescents will show their depression differently than adults and this may lead individuals to overlook the adolescents' feelings. "A depressed youth may develop bodily complaints—headaches, muscle aches—or behave in ways that are referred to as 'acting out,' such as skipping classes, failing to do homework, or simply doing poorly in school" (p. 7). Depression alone is a very serious health factor for students and is necessary to be detected; therefore, school counselors must become aware of their students' lifestyle, especially when they are at risk for suicide.

A third risk factor is family history of mental disorders or suicide. Many of the mental illnesses that an adolescent develops could be genetic. Also, teens who take their own lives have often had family members who attempted or committed suicide. While this is not a genetic trait, when exposed to the suicide, the young individual sees suicide as an escape for him/herself.

A fourth risk factor of a youth suicide is a history of alcohol or substance abuse. William Steele, author of *A Handbook of Interventions Following Suicide or Trauma in Schools*, stated that there is a 50% correlation between drugs and alcohol and suicide. It is noted that in some individuals, there is a similarity with drugs, alcohol, and suicide as all three are used as an escape. "Alcohol, and at least some drugs, provide a temporary state of relaxation....although alcohol and drugs provide a relief and escape from

problems, frustrations, and boredom, the effects are temporary, but the relief offered by suicide is, of course permanent" (Robbins, 1998, p. 55). When adolescents are using and abusing drugs and alcohol, it truly affects their brain development. These youth are clearly in an altered state of mind and much more "sensitive" to their problems, which is why their risk of suicide is so high.

A fifth risk factor is a stressful situation or loss in a teen's life. Often, serious problems, such as depression or substance abuse, are visible in teens who commit suicide and when they experience losses or certain stressful situations, a suicide attempt can be triggered. "Some of these stressful situations can include a breakup with a girlfriend or boyfriend; the loss of a family member, friend, and sometimes even a pet; or even fighting with friends" (National Youth Violence Prevention Resource Center, 2002, n.p.). Richard Liberman, a counselor at the suicide prevention unit in Los Angeles said that the "reasons for increase in youth suicide in the last 30 years is because today we have a greater number of kids under greater stressors than ever before with less parental support and supervision" (Yates, 2001, n.p.). Our youth today place high expectations on themselves to achieve as much as they can in a short period of time. When situations don't turn out the way they expected and their goals (for life) are not being met, the ideation of suicide develops.

Easy access to guns is another risk factor that could lead to a suicide attempt or completion. It has been noted, "approximately 52% of suicides occur with a firearm" (AAS, 2006, n.p.) It is more likely that teens will kill themselves if they have easy access to a loaded gun; if they find the gun in their home, they will most likely complete the act in their home. Other commonly used methods of suicide include: "hanging/suffocation, poison, and falling/jumping"(Portner, 2001, p. 101).

Sexual orientation is another risk factor of suicide. Gay, lesbian, bisexual, and transgender (GLBT) students are at a greater risk for suicide than heterosexual students. "Gay and lesbian youth are three times more likely than heterosexual youth to engage in suicidal behavior" (McFarland, cited in King, 2000, ¶ 6). Johnson (1999) explained the reason for this high statistic is because "gay teens, whether they conceal their sexual orientation or are open about it, tend to experience greater social discrimination, depression, isolation, low self-esteem, and violence than their non-gay peers" (Proctor & Groze, cited in Johnson, 1999, p. 11).

Another risk factor is exposure to other teenage suicides. If adolescents are exposed to a recent suicide, there is a greater chance that they will want to commit suicide as well. If these teens experience the loss of a friend or family member to suicide, the exposure "plants the seed," which increases their chance of potentially using the same means to end their pain and loss.

Lastly, a risk factor of a student suicide is impulsivity. Johnson (1999) stated that "adolescence is an impulsive age, and suicide is often an impulsive act" (p. 7). Obviously a child who has a history of impulsivity is at greater risk for suicide, but impulsivity alone rarely leads to suicide. If in conjunction with other life events, the destructive behavior may occur. Portner (2001) indicated:

> impetuousness alone doesn't make a teenager suicidal, or virtually every teenage in the country would be a suicidal risk. Things turn fatal when an adolescent's natural impulsivity is combined with environmental hazards such as abusive parents, vicious classmates, or a loaded gun under the bed. (p. 7)

Along with the impulsivity, Portner (2001) recited "young people are more vulnerable than adults to thoughts of suicide, experts say, because they often don't comprehend in a

rational sense that death is final" (p. 7). It has been noted that young children fantasize about their funeral after they commit suicide, as they can look on it and see all the people mourning their death. The reality though, is that these children don't realize the finality of taking their own lives. They see suicide as the easy way out, an easy way to end their pain and a quick fix. They become impulsive and attempt to end the pain, not realizing that if they succeed, they are gone forever and there is not another life they can live. They don't realize that they are never coming back.

Individuals who have attempted suicide stated as soon as they made the attempt, they wanted to take it back and they really didn't want to die. This is a scary fact when thinking about suicidal individuals and proves how necessary it is to help them realize, at their weakest moment, to not be impulsive, and to realize that with the right help, things can and will look better.

"Other risk factors discussed that could also contribute to a student suicide include a history of physical and/or sexual abuse, poor communication with parents, incarceration, and lack of access or an unwillingness to seek mental health treatment" (National Youth Violence Prevention Resource Center, 2002, n.p.). The risk factors discussed are only some risk factors to think about when working with a potentially suicidal student. It is important to remember that each suicide case is very different and any combination of the above risk factors along with other factors, not discussed, could lead to suicide. We must take each student serious and take a look at their whole life to assist in preventing them from taking their own life.

Johnson (1999), along with many other researchers, agreed, "no single indicator is a sure sign of a teen at risk of suicide. But when a cluster of indicators can be checked,

educators and parents should be alert to heightened risk" (p. 6). She provided the following checklist in which individuals can use to assess a suicidal student.

- Poor school work, failing grades
- Family instability such as divorce
- Death or illness of a loved one (including a pet)
- Lack of communication and inability or unwillingness to talk about feelings
- Illness, chronic illness, or disability
- Major disappointment or humiliation
- Problems at home including lack of parent communication
- Anger; feelings or expressions of a desired revenge
- Family history of suicide or suicide attempts. (p. 6)

With this information, an individual can begin to gain the knowledge of students' lifestyles and discover if the students' history and behaviors may lead to a suicide.

Along with all of the risk factors mentioned, Marion Crook, author of *Suicide: Teens talk to teens* (1997), has added six indicators that could lead students to kill themselves. These indicators include: rejection, loneliness, low self-esteem, confusion about sexuality, outside influences, and finally self-blaming. The previously discussed risk factors are noticeable externally, but these particular indicators occur internally, which is why communication is so important in suicide prevention. If someone is indicating he/she is feeling any of these ways, a red flag should go up in the mind of the person he/she is telling and proper help should be sought out. When we can come to gain an understanding of all of these risk factors, we "will begin to look at the boy or girl in the seat in front of us, in the house next door, or in the room next to ours in a new and

hopefully more connected way. We can make a difference between life and death and the time is now" (Portner, 2001, p. xii).

Signs, Symptoms, and Motives of a Suicidal Student

Perhaps the greatest way to prevent student suicide is to become aware of the signs and symptoms that could lead to the self-destructive act. With all the research on suicide, there are enormous amounts of signs and symptoms to look for, but there is not one exact indicator that an individual is suicidal, therefore it is important to take each individual case seriously. The American Association of Suicidology (2006) provided some signs that someone may be suicidal and if these are observed in an individual, it is necessary that he/she seek out professional help. The signs include:

- Presence of psychiatric disorder
- The expression/communication of thoughts of suicide, death, dying or the afterlife (in a context of sadness, boredom, hopelessness, or negative feelings)
- Impulsive and aggressive behavior, frequent expressions of rage
- Increasing use of alcohol or drugs
- Exposure to another's suicidal behavior
- Recent severe stressor (e.g., difficulties in dealing with sexual orientation; unplanned pregnancy; significant real or anticipated loss) and/or
- Family instability, significant family conflict. (n.p.)

Additional suicidal clues provided by Steele (2001) include:

- Sudden changes in behavior
- Drinking and/or taking drugs
- Decline in school performance
- Withdrawing from others

- Studying all the time to the exclusion of outside activities and friends or involvement with one activity to the exclusion of other activities and friends, fighting physically with family members
- Running away and giving away possessions. (p 20)

Some verbal clues that can help identify individual's suicidal thoughts include statements such as:

"I feel like killing myself"

"Sometimes she makes me so mad I feel like hanging (shooting, etc) myself"

"Everyone would be better off without me"

"If this happens again...."

"I just can't take it anymore"

"It's always....It's never...." (Steele, 2001, p. 21)

Another important symptom that contributes to a student suicide and often goes unnoticed is the thoughts that individuals have throughout their day. These thoughts are not recognizable unless the individuals express them to someone close to them. Lisa Firstone (1998), an expert in the field of suicide, discussed eleven steps in a continuum of negative thoughts, which contribute to suicide or self-destructive behavior. These eleven steps are what people are thinking which can eventually lead to the thoughts of completing suicide. By understanding these steps, we may be able to break the cycle before the self-destruction occurs. The first thought the individual will have is self-depreciating thoughts of everyday life. The individual will think common negative thoughts everyday, such as "your stupid" or "your not very attractive." Next, the individual will have rationalizing self-denial thoughts. This is where the individual will deny him/herself pleasure or things that make him/her happy by telling him/herself things

that will encourage him/herself to not do what he/she wants such as "you are too shy to make friends so don't go to that party tonight." The third step includes the individual having cynical attitudes towards others. The individual thoughts about others will be negative which will lead him/herself to distance him/herself from other people and out of relationships. During the fourth step the individual will have thoughts influencing isolation. During this step the individual will rationalize reasons why he/she is alone, such as "I can't make friends" and then during this time he/she will begin to think more negatively about him/herself. Step five is when the individual will have vicious self-abusive thoughts, which mentally break them down. During this stage the individual thinks "you are too fat" or "to skinny," and these thoughts lead to psychological pain. The next step is thoughts urging use of substance abuse. First the individual will lure him/herself into using the alcohol or drugs and once he/she begins/continues drinking he/she runs him/herself down by saying "you wimp you said you weren't going to drink anymore." The seventh step is when the individual develops thoughts leading to hopelessness. The number one feeling a suicidal individual feels is hopelessness. The individual feels like he/she is never going to get any better and he/she is doing his/her friends and family a favor by committing suicide. The eighth step includes thoughts influencing a person to give up his/herself priorities and activities. During this step the person no longer cares about his/her personal possessions anymore and is willing to give them up. During step nine the individual will develop injunctions to inflict self-harm. At this point the person is angry and will think, "you are so stupid, why don't you just cut yourself." Once the individual reaches the tenth step, he/she has thoughts pertaining to the details of suicide. The individual will begin to think about when, how, and where he/she will commit suicide and begin thinking he/she is really going to end his/her life.

The final step is when the individual has actual injunctions to commit suicide. Once the individual reaches this step, if proper help is not attained the individual will carry through with the thought and actually commit suicide.

If and when we can come to understand what a suicidal individual is experiencing, we are more able to recognize what is happening and understand what he/she is truly feeling. Recognizing the signs and symptoms is one important way in preventing a student suicide from occurring and another way is in understanding the motives of a student suicide. Gretchen Gush, a speaker on suicide, provided numerous motives behind suicide, which can include:

- Crying for help which is an implicit call for counseling, nurturance, or control by others
- Threatening suicide as a means of manipulating and controlling others through anxiety
- A neglectful accident (e.g. stimulus seeking, sexual arousal)
- Avoiding pain and suffering from degenerating disease
- Experiencing depression, despair, hopelessness, helplessness, and there is nothing to live for
- Creating revenge in order to make others feel sorry
- Impulsivity following crisis/trauma
- Feeling loss of face, shame, embarrassment
- Experiencing delusional behavior under drug/alcohol influence, mental illness
- Feeling atonement, guilt, self-punishment
- Joining deceased lover, parent
- Exercising of only control possible, that suicide is one's "right"

- Need to have "blaze of glory" by having others kill them (e.g. hostage shoot-out)
- Killing "part of self" that is disliked or disowned
- Believing that symbolically that the death already occurred

(Available: Gretchen Kush, 105 Washington Ave Suite 381, Oshkosh, WI 54901)

As discussed previously, too often individuals don't understand why someone would commit such an act, therefore learning the motives of such an act can help someone move his/her focus away from why has this occurred to how can we prevent this from happening (again or in the future).

Prevention

Children and adolescents spend a majority of their time at school, so it seems appropriate to implement a comprehensive suicide prevention program at school. Also, landmark court cases have assisted in requiring that schools are more proactive with student suicide:

> Wyke v. Polk County School Board 11th Federal Circuit Court, 1997 found the school district liable for not offering suicide prevention programs, providing inadequate supervision of a suicidal student, and failing to notify parents when their children were suicidal. Parents elected not to seek punitive damages from the district, but wanted a policy shift to include provisions for suicide prevention, intervention and postvention; the school district complied. (Landmark Court Cases, 2007, n.p.)

In addition, schools are to respond appropriately if a student speaks of his/her intention of suicide, especially in notifying the parents.

> "Eisel v. Board of Montgomery County 2nd Federal Circuit Court, 1991 determined that even when a student denies suicidal intent, (as can often occur), a

> collaborative school team has an obligation to notify parents if the team suspects a child to be suicidal (Landmark Court Cases, 2007, n.p.).

Suicide prevention is essential to incorporate into the middle and high school guidance curriculum because it serves to educate students about suicide. The main purpose of a suicide prevention program is to decrease students' suicidal thoughts, attempts, or completions through increasing their self-esteem. Also necessary in a suicide prevention program is educating students and staff about the warning signs and risk factors of suicidal students and provide correct procedures on referring suicidal students. It has been found that students will turn to their friends, before an adult, when facing suicidal ideations, so educating peers about the risk factors could effectively assist in the prevention of a student suicide. Roggenbaum and Lazear (2003), authors of the *Youth Suicide Prevention School-Based Guide*, indicated that "the rationale behind programs that utilize the curriculum component is that by educating students on suicide, students should feel more comfortable about self-disclosing suicidal thoughts and students who know the risk factors for suicide may be more likely to identify and refer at-risk peers to an appropriate adult" (p. 1). Further discussed was that

> research has shown that a curriculum approach intended to raise awareness about suicide can lead to a significant improvement in students' knowledge gain, particularly how to seek help for oneself and for others as well as shows gains in positive attitudes and a reduction in suicidal feelings (p. 1-2).

It is apparent that a school-based suicide prevention program is needed, but in order to be effective, collaboration among staff, parents, and community resources must also occur. Not all staff members are able to identify at risk students to suicide, this is why staff members need to become educated of the risk factors and warning signs of

suicidal students. When they become educated, they can identify and refer the student to the school counselor or psychologist for proper procedures in reducing the suicidal ideation. Also important is parental support and communication with parents about having an effective prevention program. This is because parents have the most contact with their child and parents obtain the most control in allowing their child to participate in educational curriculum. By communicating with the parents about the programs implemented, a school counselor is gaining the parents' trust and building effective relationships to prevent a tragedy from occurring. Lastly, schools need to collaborate with community resources, seeking out help in the prevention of student suicides, the intervention of student suicides, or the immediate postvention of student suicides.

Counselor Intervention

As noted, the school counselor plays a vital role in the prevention of student suicides. In a study done by King (2000) the school counselor was found to be the person students are most comfortable talking to, but only one in three students indicated they would talk to the school counselor about their problems. Due to this, King (2000) stated, "most students with personal problems do not approach the school counselor, thus school counselors must be aware of the warning signs of adolescent suicides as means to identify those at risk" (¶2). King (2000) also indicated, "students feel that the most comfortable school professional to talk with about personal problems is the school counselor, thus school counselors must be prepared to appropriately and effectively help students contemplating suicide (¶ 2). It is important that school counselors not only know the risk factors, signs, and symptoms of a suicidal student, but it is necessary that they are prepared to "handle" suicidal students and can help them change their thoughts of dying to thoughts of living. Steele (2001) indicated that when suicidal students confide in their

school counselor their intents, they realize they don't have the answers and hope that the school counselor can help (p. 37). Steele (2001) said, once the intent of the suicide is identified in a student, proper procedures needs to come into action. He discussed an eleven-step intervention, which includes the following:

Calling For Help.

It is important to call a team member for assistance. The responsibility for this student should not be solely one person's responsibility and it is important to have assistance if needed. Having a colleague assist in the intervention indicates that the student who is suicidal always has someone to trust, especially if you are not available and also lets the student know that you are acting on the seriousness by developing a "safety net" for the student.

Expressing Seriousness.

It is important to assure the student that he/she is being taken seriously. Statements such as "I didn't realize how bad it was for you until now;" or "Now that I know how serious your situation is, this is what we are going to do today..." will assure the person that you care and want to help. It is also necessary to let the student know "I don't want you to die," which will help the individual cognitively refocus his/her thoughts from suicide to living.

Cognitive Reframing.

It is necessary to reframe the finality of suicide. The student is not focused on the finality of death, but on ending the hurt, the pain, the sense of helplessness, and haplessness; it is important to explain that if he/she chooses suicide, his/her life will be over forever. He/she needs to change his/her focus from ending the hurt and pain to realizing that death is final and although the hurt and pain may be gone, so will he/she.

Ambivalence.

This is the inner dialogue that is telling the student, "yes I want to die" against "no I don't want to die, I want to live and I want someone to help me with my struggle to live." It is very important to redirect the student at this point and help the student see his/her situation differently with hope instead of despair.

Problem Solving.

While the student is in a suicidal state, it is necessary that someone actively help solve his/her current situation. The problem solving needs to be "doable" actions that are likely to be successful, which will give the student hope, hope which is related to the future.

Future Orientation.

It is essential to redirect the suicidal thoughts to the future, even if it is short lived. Connecting, even the smallest thing, to the future will give the student hope and give him/her a new beginning to his/her life.

Assessment.

This begins with the above steps because the information on the plan will be collected in the verbalization of intent. You then continue finding out the details of the suicidal intent such as when, where, how, and method availability.

No Suicide Contract.

This is a contract the student signs indicating he/she will do no harm to self. If the student refuses to sign a contract it may indicate that he/she is no longer able to respond to help and is in need of psychiatric intervention.

Consultation.

When working with suicidal students, it is important to speak with the team member to decide what level of action needs to be done with the student, so the sole responsibility is not on one person. It is also important to discuss concerns with parents and keep in contact with the child or child's parents for 24 hours until further evaluation is done and the student is out of immediate danger.

Inform/ Refer/Follow up.

It is a legal responsibility to inform proper individuals of the child's intents, refer the child to outside resources if needed, and follow up with the child and parents to assure that proper procedures were done.

Attending to the Student.

Keep in touch with the student through the following weeks to assure that this act NEVER gets carried through. (p. 37-45).

By following these intervention steps correctly, school counselors can most likely guarantee that their actions will aid in saving the life of their suicidal student. Interventions for suicidal students are very important, but just as important are preventing these ideations from occurring and providing assistance if a suicidal act occurs.

Postvention

A student death is a tragic event for everyone involved, but when the student death is a suicide, the immediacy of postvention is necessary to prevent further suicides from occurring, as well as assist those affected by the student's death to cope with the loss. Postvention refers to strategies necessary to implement in order to help students (and staff) limit the shock and cope with the loss. An important aspect of postvention is the schools' crisis team, which puts a created plan into action if a crisis occurs. When

schools have these teams implemented and a crisis occurs, the "clean-up" happens much more smoothly. The crisis team should consist of "the school principal, selected teachers, a guidance counselor, a school nurse, a secretary, and a custodian; all these individuals should be trained in grief management and human relations" (Johnson, 1999, p. 66). The responsibility of the crisis team is both proactive and reactive. Johnson (1999) indicated that the proactive responsibilities include preparing a protocol in dealing with a crisis, preparing training for staff on adolescent suicide, contacting the community resources including developing relationships with outside agencies and monitoring the students at risk of suicide. Further discussed, the reactive responsibilities include providing organized assistance in the aftermath of a suicide, facilitating communication between outside resources and within the school, and creating follow up reports and debriefing after the crisis has occurred. As discussed, postvention is very important to implement in schools as it reduces the wave of copy cat-suicides, as well as assists in helping the school get back to the normalcy of the school day as soon as possible.

Summary

Suicide is an issue no school counselor wants to experience, but that is not enough to prevent it from occurring. In order for a school counselor to be prepared for this type of crisis, it is necessary the proper knowledge (and possibly education) is achieved to assist in all three categories: prevention, intervention, and postvention. In understanding a student suicide, school counselors need to know the risk factors, signs, symptoms, and motives of these individuals. Likewise school counselors and other school personnel need to provide a comprehensive school-based suicide program, which includes prevention, intervention, and postvention to help everyone understand that suicide is a tragedy that can be prevented.

Chapter Three: Methodology

Introduction

This chapter will include a description of the subjects in this study and how the sample was selected. The researcher will then discuss the instrument and how it was created, along with the data collection and data analysis. The chapter will conclude with limitations in the methodology.

Subject Selection and Description of Sample

School counselors in Wisconsin school districts with 50-500 high school students were chosen to participate in this study, which was then limited to those school districts with only one high school counselor. A total of 278 schools were chosen to participate in this study.

Instrumentation

The instrument used was created specifically for this study by the researcher. The information for the survey was inspired by a previous thesis created by Rachel Bachman (2004), University of Wisconsin-Stout, as well as from examining literature to determine the appropriate aspects the researcher wanted to investigate. No measurements of reliability or validity had been established on this instrument because is created specifically for this study.

The four-page survey consisted of 20 questions and/or statements. The first three questions addressed demographic information in order to gain insight about the subjects' background. The demographic information included the subjects' age, gender, and number of years working as a school counselor. Question number four determined if the subjects' would complete the whole survey or conclude the survey as it determined if there was more than one school counselor in the high school. Question five determined

whether the counselor had a mentor to utilize, if so needed. Questions six through ten addressed the subjects' knowledge of prevention, intervention, and postvention awareness in the schools' setting. The questions in the survey addressed the following: how much education the subjects' had received on suicide prevention and/or intervention; if the subjects' school district have a crisis intervention team and if so, who was on the crisis team; if the schools addressed suicide prevention in the curriculum and if so, which school subjects they provided the curriculum; if the subjects' has had a student express suicidal intent and if they were prepared or felt prepared to provide assistance; and if they had a student commit suicide and if they were prepared or felt prepared to provide the necessary postvention. Question eleven determined if the subjects' felt additional education on suicide prevention or postvention was necessary. Items twelve through twenty were statements used to measure the subjects' opinion on a Likert scale of (1) strongly disagree, (2) disagree, (3) neutral, (4) agree, or (5) strongly agree. These statements were designed to measure the school counselors' awareness of the risk factors and warning signs of youth suicide. In the final question, the subjects had to opportunity to end the survey by adding any additional comments.

Data Collection

Data was collected through a mailed survey to Wisconsin School Counselors with 50-500 high school students. The researcher utilized the 2003-2004 Wisconsin Interscholastic Athletic Association directory of member high schools to determine which school districts in the state of Wisconsin had 50-500 high school students. The surveys were sent out on March 12, 2007 and the school counselors receiving the surveys were expected to return the survey in a pre-paid envelope to the researcher by April 13, 2007 if they wanted to participate.

Data Analysis

All appropriate descriptive statistics were run on the data. The researcher assisted in the data analysis of this study. Mean and mode were used for all the items in the survey. Frequencies and percentages were performed on all questions.

Limitations

There are some limitations to this study regarding the sample and procedures of this study. One limitation was the sample size and selection as the participants were limited to school districts with 50-500 high school students. This made the study not generalizable to all school counselors, but to school counselors in small school districts. Also, the researcher created the instrument and therefore no reliability or validity have been documented on the instrument. Lastly, the book utilized to determine who received surveys may not have been up to date and therefore the researcher may not have reached all the counselors possible.

Chapter Four: Results

Introduction

The purpose of this study was to measure school counselors perception of preparedness to implement prevention and postvention of a student suicide. Data was collected through a survey sent to school counselors in the state of Wisconsin with 50-500 high school students.

This chapter will discuss the demographic information about the subjects who participated in the study and answer the five questions. Out of the 278 surveys, 151 were filled out correctly (137 used and 14 not used due to multiple counselors' in the high school), 11 were filled out incorrectly, and 3 were returned to the researcher by the postal service. A total of 137 surveys were used to measure school counselors perception of preparedness to implement prevention and postvention of a student suicide.

Demographic Information

Out of the 278 surveys, there were 162 surveys returned at a return rate of 58.3%. Of the 162 surveys returned, 137 were used for the study indicating a useable return rate of 49.3%.

The survey consisted of 20 questions pertaining to youth suicide. The first 4 questions addressed demographic information in order to gain insight about the subjects' background. The demographic information addressed the subjects' age, gender, years working as a school counselor, and level at which the school counselors work.

The first item asked participants to indicate the age range that pertained to them. Of the 137 participants, 18 were aged 20-30 years (13.1%), 35 were aged 31-40 years (25.5%), 36 were aged 41-50 years (26.3%), 44 were aged 51-60 years (32.1%), and 4

were aged 61 and older (2.9%). The most frequent age group was 51 to 60 years old. Table 1 represents the ages of the participants.

Table 1: Age of Subjects

AGE	20-30	31-40	41-50	51-60	61 +	Total
Frequency	18	35	36	44	4	137
Percentage	13.1	25.5	26.3	32.1	2.9	100.0

The second question asked the participants to indicate their gender. Of the 137 subjects, 89 were female (65.0%) and 48 were male (35.0%). Table 2 represents the gender of the participants.

Table 2: Gender of Subjects

Gender	Female	Male
Frequency	89	65.0
Percentage	48	35.0

The third question asked the participants to indicate the number of years working as a school counselor. The number of years working ranged from 1 to 35 years. The number of years that was most frequent was 8 (8.0%). Following closely behind, the number of years that tied for second was 1 year and 2 years (7.3%). Table 3 represents the subjects' number of years working in the profession.

Table 3: Number of Years

Number of Years Working	
Mode	8
Minimum	1
Maximum	35

The fourth question asked the participants to indicate at which level are they a school counselor. Of the 137 surveys, 137 subjects (100%) responded they were school counselors for the high school level.

Additional Information

The fifth through seventh questions provided evidence to the researcher on any additional assistance the subjects have acquired or have within their school district.

Question five asked the participants to identify if they had a mentor. There were 34 subjects who didn't respond to this question. Of the 103 who responded, 84 subjects (81.6%) indicated they did not have a mentor in their school district, while 19 subjects (18.4%) had a mentor within their school district. Table 4 represents the subjects who responded to this question and if they had a mentor.

Table 4: Mentor for Subjects

Mentor	Yes	No	Total
Frequency	19	84	103
Percentage	81.6	18.4	100

Question six asked the participants to indicate if they had received any additional education on suicide prevention and/or intervention. The number of subjects who had not received additional education was 12 of 137 (8.8%). This indicates that many of the participants had received additional education. The number of subjects who had received additional education was 125 of 137 (91.2%). Under question six, the subjects were also asked to indicate what kinds of additional education they had received. The choices were: college education, workshop/conference, on-the-job training, in-service programs, professional journals, media, or other (with an explanation). The subjects were to

indicate all of the areas in which they had received additional education. Of the 125 subjects who had received additional education the most common form was workshop/conference at 84.0% (105 subjects). Following was college education, 60.0% (75 subjects); on the job training, 46.4% (58 subjects); in-service training, 43.2% (54 subjects); professional journals, 41.6% (52 subjects); media, 18.4% (23 subjects); and other 13.6% (17 subjects). Table 5 presents if and where subjects received additional education on suicide prevention an/or intervention.

Table 5: Additional Education

Additional Education	Yes	No	Workshop	College	On-job	In-service	Professional	Media	Other
Frequency	125	12	105	75	58	54	52	23	17
Percentage	91.2	8.8	84.0	60.0	46.4	43.2	41.6	18.4	13.6

Question 7 asked the participants to indicate if their school district had a crisis intervention team. Of the 137 participants, 2 did not respond to this question, 111 (81.0%) indicated they had a crisis intervention team, and 24 (17.5%) indicated they did not have a crisis intervention team. The participants were also asked to list who was on their school districts crisis intervention team. A majority of the respondents indicated that the following individuals were on their crisis intervention team: principal, superintendent, dean of student, school counselor, school psychologist, school nurse, teachers in the district, school liaison, local clergy, and the school social worker.

Research Questions

This section will include an analysis of the research questions.

Question 1: Do school counselors have suicide prevention programs offered in their schools?

Question 8 addressed whether school counselors had suicide prevention programs in their schools. The question asked: do you address suicide prevention in your curriculum; if the subjects responded yes, they were asked to list the subject areas in which they addressed suicide in their curriculum. There were 4 participants (2.9%) who did not respond. Of the 133 subjects who responded to the question, 39 (29.3%) indicated they did not address suicide in their curriculum and 94 (70.7%) indicated they addressed suicide in their curriculum. Table 6 presents the subjects who addressed and did not address suicide in their curriculum.

Table 6: Addressed Suicide Prevention

Suicide Prevention	Yes	No	Total
Frequency	94	39	133
Percentage	70.7	29.3	100.0

The 94 subjects who addressed suicide in their curriculum was then asked to list which subject areas they addressed suicide. The majority stated health and psychology were the subject areas where suicide was addressed. Other subject areas included: literature, religion, decision making, developmental guidance class, social problems, life skills, family consumer science, skills for living, skills for success, English, homeroom, family relations, western civics, physical education, science, wellness, sociology, and theology.

Question 2: Do school counselors feel prepared to implement prevention programs to students about suicide?

Question 9 represents whether school counselors felt prepared to implement prevention programs to students. The question asked if the school counselor had a

student express suicidal thoughts or intent to them; if answered yes the subject was asked to indicate if they felt prepared to provide assistance to the student; if answered no to the first question, the subject was asked if they believed they would feel prepared to provide the assistance needed; if answer yes that they felt prepared to provide assistance they were asked to indicate how they felt prepared.

Of the 137 subjects who responded, 8 subjects (5.8%) had not had a student express suicidal thoughts or intent. The 8 subjects who indicated they had not had a student express to them suicidal thoughts or intent were then asked to indicate if they believed they were prepared to provide the assistance if needed. Of the 8 who answered, 2 subjects (25.0%) believed they were not prepared and 6 subjects (75.0%) believed they were prepared. The 6 participants who believed they were prepared were then asked to state how they were prepared. The responses were as follows: 3 subjects stated their faith would assist in their preparation, 1 subject stated he/she would follow the proper protocol, 1 subject stated it would depend on the level of severity, and 1 subject would refer the student to counselors. Table 7 represents those participants who had not had a student express to them suicidal thoughts or intent and whether they believed they were prepared or not prepared to provide necessary assistance.

Table 7: Believed Prepared to Provide Assistance

Believe Prepared to Provide Assistance	Yes	No	Total
Frequency	6	2	8
Percentage	75.0	25.0	100.0

Of the 137 subjects who answered question 9, 129 subjects (94.2%) had a student express to them suicidal thoughts or intent. The 129 participants who had a student

express to them suicidal thoughts or intent were then asked if they were prepared to provide the assistance needed. Only 2 participants (1.6%) indicated they were not prepared and 127 participants (98.4%) indicated they were prepared to provide the assistance needed. Table 8 represents the participants who had a student express to them suicidal thought or intents and whether they were prepared to provide the necessary assistance.

Table 8: Prepared to Provide Assistance

Prepared to Provide Assistance	Yes	No	Total
Frequency	127	2	129
Percentage	98.4	1.6	100.0

Question 3: Do school counselors feel prepared to implement postvention after a student suicide occurs?

Question number 10 represents if school counselors felt prepared to implement postvention after a student suicide occurred. The question asked if the school counselor had a student commit suicide; if the subject answered yes they were asked to indicate if they were prepared to implement postvention to the school district; if the subject answered no to the question they were asked to indicate if they believed they would be prepared to implement postvention to the school district; if they indicated they would be prepared they were asked to state how they felt they were prepared.

Of the 137 subjects who responded, 100 subjects (73.0%) indicated they had not had a student commit suicide. The participants were then asked to indicate if they believed they were prepared to implement postvention to their school district. Of the 100 subjects who had not had a student commit suicide, 87 subjects answered the question

indicating if they felt prepared or didn't feel prepared to implement postvention to their school district. There were 63 subjects (72.4%) who indicated that they believe they are prepared to implement postvention to their school district and 24 subjects (27.6%) believed they are not prepared to provide postvention to their school district. Table 9 represents the subjects who had not had a student commit suicide and if they believed they were or were not prepared to provide postvention to their school district.

Table 9: Believed Prepared for Postvention

Believe Prepared for Postvention	Yes	No	Total
Frequency	63	24	87
Percentage	72.4	27.6	100.0

Of the 137 subjects who responded to question 10, 37 subjects (27.0%) had a student commit suicide. The 37 subjects were then asked to indicate if they were prepared to provide postvention to their school district. One individual did not respond to this question. Of the 36 subjects who responded, 3 subjects (8.3%) indicated they were not prepared to provide postvention to their school district and 33 subjects (91.7%) felt they were prepared to provide postvention to their school district. Table 10 represents the participants who have had a student commit suicide and if they were prepared or if they were not prepared to provide postvention to their school district.

Table 10: Prepared to Provide Postvention

Prepared to Provide Postvention	Yes	No	Total
Frequency	33	3	36
Percentage	91.7	8.3	100.0

Question 4: Do school counselors feel they need to receive additional education on issues relating to youth suicide?

Question 11 on the survey represents if school counselors felt they needed additional education on suicide prevention or postvention. Of the 137 subjects who responded, 88 subjects (64.2%) felt they needed additional education on suicide prevention or postvention and 49 subjects (35.8%) felt they did not need additional education on suicide prevention or postvention. Table 11 represents the participants who felt they needed or did not need additional education.

Table 11: Additional Education

Additional Education	Yes	No	Total
Frequency	88	49	137
Percentage	64.2	35.8	100.0

Question 5: Are school counselors aware of the risk factors and warning signs of suicide?

Questions 12 through 20 were general statements used to measure school counselors awareness on a Likert scale of (1) strongly disagree, (2) disagree, (3) neutral, (4) agree, and (5) strongly agree. The statements were used to measure school counselors awareness of the risk factors and warning signs of suicide.

Item 12 stated: "A prior suicide attempt would lead me to believe that a student may attempt suicide again." Of the 137 participants, 55 agreed (40.1%), and 71 strongly agreed (51.8%). Table 12 presents the participants perception of a prior attempt leads to another attempt.

Table 12: Prior Suicide Attempt

Prior Attempt/Another	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	4	0	7	55	71	137
Percentage	2.9	0.0	5.1	40.1	51.8	100.0

Item 13 stated: "If a student has a family history of a mental disorder or suicide, he or she will not likely commit suicide." Of the 137 participants, 66 strongly disagreed (48.2%), and 47 disagreed (34.3%). Table 13 presents the participants perception of family history of a mental disorder will not lead to suicide.

Table 13: Family History and Suicide

Family History	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	66	47	14	5	5	137
Percentage	48.2	34.3	10.2	3.6	3.6	100.0

Item 14 stated: "If a student has a firearm in the house, he/she are less likely to commit suicide." There were 4 individuals who did not respond to this question. Of the 133 who participated, 57 strongly disagreed (42.9%), 44 disagreed (33.1%), and 25 were neutral (18.8%). Table 14 presents the participants' perception that if there is a firearm in the house, the student is less likely to commit suicide.

Table 14: Firearm and Suicide

Firearm in Home	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	57	44	25	3	4	133
Percentage	42.9	33.1	18.8	2.3	3.0	100.0

Item 15 stated: "A student who suddenly seems withdrawn from school and hobbies is not potentially suicidal." Of the 137 participants, 59 strongly disagreed (43.1%), and 62 disagreed (45.3%). Table 15 presents the participants perception that a

student who suddenly seems withdrawn from school and hobbies is not potentially suicidal.

Table 15: Suddenly Withdrawn and Suicide

Suddenly Withdrawn	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	59	62	6	4	6	137
Percentage	43.1	45.3	4.4	2.9	4.4	100.0

Item 16 stated: "A student who gives away his/her possessions and prepares for arrangements for death may be suicidal." Of the 137 participants, 34 agreed (24.8%) and 90 strongly agreed (65.7%). Table 16 presents the participants' perception that if a student gives away his/her possessions and prepares for arrangement for death, he/she may be suicidal.

Table 16: Gives Away Possessions and Suicide

Gives Away Possessions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	11	1	1	34	90	137
Percentage	8.0	0.7	0.7	24.8	65.7	100.0

Item 17 stated: "A warning sign of suicide is trouble eating or sleeping." There were 3 participants who did not participate in this study. Of the 134 participants, 30 were neutral (22.4%), 60 agreed (44.8%), and 32 strongly agreed (23.9%). Table 17 presents the participants' awareness that a warning sign of suicide is trouble eating or sleeping.

Table 17: Trouble Eating/Sleeping and Suicide

Trouble Eating/Sleeping	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	2	10	30	60	32	134
Percentage	1.5	7.5	22.4	44.8	23.9	100.0

Item 18 stated: "One who talks about committing suicide will not actually attempt or commit suicide." Of the 137 participants, 76 strongly disagreed (55.5%), and 46 disagreed (33.6%). Table 18 presents the participants awareness that if an individuals talks about committing suicide he/she will not actually attempt or commit suicide.

Table 18: Talking about Suicide

Talk About Suicide	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	76	46	8	3	4	137
Percentage	55.5	33.6	5.8	2.2	2.9	100.0

Item 19 stated: "A stressful life event, such as death or divorce, is a risk factor of suicide." Of the 137 participants, 57 agreed (41.6%), and 55 strongly agreed (40.1%). Table 19 presents the participants awareness that a stressful life event is a risk factor of suicide.

Table 19: Stressful Life Event and Suicide

Stressful Life Event	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	8	8	9	57	55	137
Percentage	5.8	5.8	6.6	41.6	40.1	100.0

Item 20 stated: "A student who appears to suddenly be happier or calmer may be suicide." There were 2 participants who did not respond to this question. Of the 135 participants, 24 were neutral (17.8%), 62 agreed (45.9%), and 38 strongly agreed (28.1%). Table 20 presents the participants awareness that a student who appears to suddenly be happier or calmer may be suicidal.

Table 20: Appearing Happier/Calmer and suicide

Appears Happier/Calmer	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Frequency	2	9	24	62	38	135
Percentage	1.5	6.7	17.8	45.9	28.1	100.0

Summary

Overall, it appeared from this study that school counselors in school districts with 50-500 high school students are prepared to implement prevention and postvention to students. Also, the school counselors appeared to be aware of the risk factors and warning signs of a student suicide. It is reassuring that a majority of the school counselors are prepared and aware, but not all school counselors indicated this preparedness. Not all school counselors indicated they were prepared to implement the prevention or postvention to their school district as well as not all school counselors were aware of the suicidal risk factors and warning signs of a student suicide, as they were unable to correctly identify the misconceptions.

Chapter Five: Discussions, Conclusions, and Recommendations

Introduction

This chapter will include a discussion of the findings of this study, a summary of the important results, followed by recommendations for school counselors, as well as recommendations for further research.

Discussion

For school counselors, becoming educated and aware of the risk factors and warning signs of suicide will only decrease the amount of suicides they experience in the school district. Steele (2001) noted, "the more information you have, the easier it is to determine who may be potentially suicidal and how serious the person may be, who is thinking about or threatening to commit suicide" (p. 14). Additionally, the more education individuals receive, the more prepared they are to handle suicidal ideations, as well as postvention when a student suicide occurs. It appears that when the school counselor participants receive additional education, he/she is more prepared to provide the necessary assistance to a suicidal student or to their school district after a suicide occurred.

Too often individuals are not educated about suicide and misconceptions can develop when someone has not received proper education on the myths and facts of suicide. When an individual is unable to determine what is fact versus fiction or warning signs and risk factors of suicide, the chance of that individual providing complete and accurate assistance is reduced. Kalafat (1990) and Remley and Sparkman (1993) stated, "school counselors should be knowledgeable about the extent of adolescent suicide, the risk factors for adolescent suicide, at-risk student profiles, appropriate intervention techniques, and the mental health resources available in the community" (cited in King,

2000, ¶ 4). Peach and Reddick (1991) stated, "their overall knowledge regarding suicide may determine the school's success in providing assistance to at-risk students (cited in King, 2000, ¶ 4). It appeared that a majority of the participants were knowledgeable about the risk factors and warning signs of suicide, some were unsure, while others were completely wrong.

An important aspect of suicide is to implement prevention programs, which will assist all individuals in understanding how to identify and help an individual who is suicidal. Johnson (1999) indicated that educators play an important role in the prevention of suicide. This prevention is done through providing a developmental suicide curriculum. Roggenbaum and Lazear (2003) stated that research indicated when a curriculum is used to raise awareness about suicide, there is a significant improvement in knowledge gained, especially how to seek help for oneself or to others. Also, Roggenbaum and Lazear (2003) discussed that studies have shown that students who are exposed to a suicide curriculum have improved attitudes about suicide and they hold more accurate and positive attitudes about suicide. Suicide prevention was dominant in the school districts that participated, but was not dominant in all schools that participated in the study.

Every school should have a crisis team who can provide the necessary assistance in the aftermath of a suicide. A crisis team should consist of trained staff who are educated on how to assist those who need assistance and are knowledgeable of the school district's plans and procedures when a crisis occurs. While a majority of the participants indicated their school district had a crisis team, not all were aware of who was on the team. Also, as indicated, all school should have a crisis team in their school district and this was not the case for all school districts that participated in the study.

Conclusions

Overall, the findings of this study indicated that school counselors were aware of the warning signs and risk factors of student suicides. Regardless, not all school counselors indicated this knowledge and some were completely inaccurate about the warning signs and risk factors. Of the participants who answered the questions regarding risk factors and warning signs of suicide, on average 2-5% were completely inaccurate on the answers and another 5-12% of the participants were neutral about some of the questions, indicating they may not be sure. While these percentages are low, they should be eliminated, because it is necessary that school counselors are aware of these signs and symptoms in order to prevent suicides from occurring.

Approximately 91% of the participants (n=137) indicated they have received additional education on suicide prevention and intervention. This education has apparently assisted in helping the school counselors feel prepared for assisting students who have expressed suicidal thought or intent. Of the 137 participants, 94.2% have had a student express to them suicidal thoughts or intent. Of those 94.2% of participants, 92.7% (n=137) were prepared to provide necessary assistance to those students. This indicates that education on suicide has helped those counselors gain confidence in their capabilities to help their students. Likewise, of the 8.8% of participants (n=137) who had not received additional education, 25% (n=8) did not feel prepared to provide assistance when a student expressed suicidal thoughts or intent. Interestingly, of the 91.2% who had received additional education, 64.2% (n=137) still felt they needed additional education, which proves that continuous education on suicide can be beneficial for school counselors.

In regards to postvention, of the 27.0% of participants (n=137) who had a student commit suicide, 91.7% of participants (n=36) were prepared to provide necessary postvention for their school district. Again, indicating the importance of education about suicide to school counselors.

Approximately 71% of participants (n=133) provided a suicide prevention curriculum in their school. This number appears to be high, but as indicated earlier, suicide prevention is necessary to provide in school districts to help school personnel, students, and parents become more aware of suicide and how to reduce the risk of losing a loved one to "self-murder."

Finally, approximately 82% of participants indicated their school district had a crisis intervention team. Although this large number has indicated they had a team, not everyone was aware of who was on their team. Also, approximately 17% of the schools indicated they did not have a crisis team, which shows that not all schools had a crisis team or were not aware of their team, indicating their school may not be able to provide the necessary assistance in the aftermath of a suicide.

Recommendations for School Counselors

As implied, education is incredibly important in assisting to reduce suicide from occurring or re-occurring in schools. School counselors should take it upon themselves to receive additional education. Numerous colleges and workshops provide up to date education on suicide and school counselors should attend these informational meetings on a regular basis. Once additional education is received, school counselors should then educate staff and parents about suicide because just as it is important for school counselors to assist in suicide prevention, it is also important for parents and school

personnel to understand the warning signs and risk factors which will help reduce suicides from occurring.

Additionally important is for all schools to have in place a crisis intervention team and for all staff to understand who is on the team and those individuals' role on the team. If a school district does not have a crisis intervention team, it is necessary for someone to take charge and create a team, a job a school counselor is capable of completing. This could be initiated through a mandatory meeting at the beginning of the school year to inform everyone of what is expected.

Another necessary role for the school counselor is to provide a developmental suicide curriculum within the school. Suicide curriculum provides students and staff with the necessary information regarding suicide and how to prevent it from occurring.

Involvement of parents is also a vital aspect of implementing suicide education. Parents are ultimately the final say in their child's education and by creating a positive environment for students and allowing parents to partake in decision-making, a collaboration will likely be successful. Perhaps the school counselor could invite the parents to an informational meeting about suicide awareness and prevention and have the parents participate in the creating of a curriculum or continuation of the curriculum.

Finally, the school counselor should seek outside resources to assist in the suicide prevention or postvention programs the school provides. The school counselor may need to contact area agencies that would be able to assist in either being a part of the crisis team or in implementing the necessary programs to reduce and possibly eliminate student suicides.

Recommendations for Further Research

A limitation of this study was the technique in which the researcher used to find participants for the study. Particularly, the book used could have been outdated and the researcher could have found a more recent book to utilize. It would have been even more effective for the researcher to discuss ideas on how to find participants with other individuals who have more knowledge and utilize a web based program to determine participants for the study.

Also, after receiving comments about the surveys, the researcher would recommend changing or eliminating some of the questions in the survey, to reduce confusion. The researcher would change question 4 to state: how many school counselors are in your high school? Followed by the statement, if there are more than one school counselor in your high school, stop the survey now and return in the pre-paid envelope. Additionally, the researcher would have eliminated question 5 which had the participant indicate if he/she had a mentor in his/her school district. This question caused confusion as well as was not important to the research. In regards to the Likert scale about warning signs and risk factors of suicide, the researcher recommends eliminating negatively stated questions. For example, changing statements from less likely to more likely. Finally, the researcher would recommend re-wording question 14 to state: if a suicidal student has a firearm in his/her home, he/she is more likely to commit suicide.

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Appendix A

Project Title: High School Counselors' Perception of Preparedness in Implementing prevention and Postvention of a Student Suicide

Morgan Mitchell, a guidance and counseling student at the University of Wisconsin-Stout, is conducting a research project titled: High School Counselors Perception of Preparedness in Implementing Prevention and Postvention of a Student Suicide. The research will be useful in identifying if School Counselors feel educated and prepared in helping a suicidal student or assisting with postvention of a student suicide. She would greatly appreciate your participation in this study.

It is not anticipated that this study will present any medical or social risks to you. The benefits will be to assist in determining whether school counselors feel prepared in handling student suicides and whether additional education is needed in providing preparedness for school counselors in handling student suicides.

This 20-question survey should take you no more than twenty minutes to complete. Your participation in this study is completely voluntary. If at any time you wish to withdraw from this study, you may do so with no penalty. The information you provide will be kept confidential and any reports or findings of this research will not contain your name or other identifying information.

When you have completed the survey, please return it in the pre-paid envelope provided. The last postmarked day to return the survey is Friday, April 13, 2007. Once the study is completed, the analyzed findings would be available for your information.

This study has been reviewed and approved by the University of Wisconsin-Stout's Institutional Review Board (IRB). The IRB has determined that this study meets the ethical obligations required by federal law and university policies. If you have any questions or concerns regarding this study please contact Morgan Mitchell, the researcher, at (715) 556-3262 or Dr. Amy Gillett, the research advisor at (715) 232-2680. Any questions, concerns, or reports regarding your rights as a research subject can be directed to Sue Foxwell, Director Research Services, 152 Vocational Rehabilitation Bldg., UW-Stout, Menomonie, WI 54751, phone (715) 232-2477 or email, foxwells@uwstout.edu.

By completing the following survey, you agree to participate in the project entitled High School Counselors Perception of Preparedness in Implementing Prevention and Postvention of a Student Suicide.

Appendix B

This research has been approved by the UW-Stout IRB as required by the Code of Federal Regulations Title 45 Part 46.

High School Counselors' Perceptions and Awareness of a Student Suicide

Please indicate the correct answer with an "X" next to the response that pertains to you.
please make sure you answer all the questions pertaining to you

1. What is your age?
   ____ 20-30
   ____ 31-40
   ____ 41-50
   ____ 51-60
   ____ 61 +

2. Gender
   ____ Female
   ____ Male

3. Number of years working as a school counselor?
   _____

4. Mark the level(s) in which your district has a school counselor?
   ____ Elementary school
   ____ Middle School
   ____ High School
   ****if there is more than one counselor in your high school, (middle or elementary) please STOP here and return in the envelope provided****

5. If you are the only counselor in your district, do you have a mentor?
   ____ Yes
   ____ No

6. Have you received any education or training on suicide prevention and/or intervention?
   ____ Yes
   ____ No

If yes, please mark an X for all that apply
____ College education
____ Workshop/Conference
____ On-the-job training
____ In-service program
____ Professional journals
____ Media
____ Other, please explain:
_____

7. Does your school have a crisis intervention team?
____ Yes
____ No

If yes, please list by title, who is on your team
_____
_____

8. Do you address suicide prevention in your curriculum?
____ Yes
____ No

If yes, please list the subject areas in which you address suicide in your curriculum:
_____
_____

9. Have you had a student express to you suicidal thoughts or intent?
____ Yes
____ No

If yes to question 9, were you prepared to provide the assistance needed?
____ Yes
____ No

If no to question 9, do you believe you would be prepared to provide the assistance needed?
____ Yes
____ No

If yes, how so?
_____
_____

10. Have you had a student commit suicide?
    ____ Yes
    ____ No

    If yes to question 10, were you prepared to implement postvention to your school district?
    ____ Yes
    ____ No

    If no to question 10, do you feel you are prepared to implement postvention to your school district?
    ____ Yes
    ____ No

    If yes, how so?

    _____

    _____

11. Do you feel you need additional education on suicide prevention or postvention?
    ____ 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

12. A prior suicide attempt would lead me to believe that a student may attempt suicide again

    1 2 3 4 5

13. If a student has a family history of a mental disorder or suicide he or she will not likely commit suicide

    1 2 3 4 5

14. If a student has a firearm in the house in which he/she lives, he/she are less likely to commit suicide

    1 2 3 4 5

15. A student who suddenly seems withdrawn from school and hobbies is not potentially suicidal

    1 2 3 4 5

16. A student who gives away his/her possessions and prepares arrangements for death may be suicidal

    1 2 3 4 5

17. A warning sign of suicide is trouble eating or sleeping

    1 2 3 4 5

18. One who talks about committing suicide will not actually attempt or commit suicide
    1 2 3 4 5

19. A stressful life event, such as death or divorce, is a risk factor of suicide

    1 2 3 4 5

20. A student who appears to suddenly be happier or calmer may be suicidal

    1 2 3 4 5

Any additional comments are welcome and would be greatly appreciated!!!
Thank you for your participation!