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PUBLIC SCHOOL COUNSELORS' ATTITUDES
TO SUICIDE/SUICIDE INTERVENTION

by
Robert S. Felloney

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree
of
The Graduate School
at
Rowan University
May 6, 2003

Approved by _____

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Abstract

Robert S. Felloney
PUBLIC SCHOOL COUNSELORS' ATTITUDES
TO SUICIDE/SUICIDE INTERVENTION
2002/03
Dr. John Klanderman & Dr. Roberta Dihoff
Master of Arts Degree

Most of the research on suicide/suicide intervention has focused upon client characteristics and attitudes. Little research, especially in the school setting, has been done on counselor characteristics and attitudes as key variables in these situations. This study was done, at least partially, to help overcome the lack of research in this critical area. This study involved fifteen school counselors (school psychologists and school social workers) who were selected nonrandomly. Based upon interviews, a key finding was that school counselors who prioritize the role of suicide intervention and were more comfortable in doing this, perceived themselves as being more successful in conducting these interventions than school counselors who place less priority on this role and were less comfortable with it. Other more specific findings were: male counselors and school social workers were more comfortable and perceived themselves as being more competent than female

counselors and school psychologists, respectively, in conducting these interventions. More years of experience and number of suicidal students seen were only mildly to moderately related to higher perceived performance. And interestingly, those counselors with more years of education had lower perceived performance than those counselors with less education. Another key finding was that the vast majority of school counselors interviewed thought they had a significant positive impact on the most serious suicide interventions they were involved in. Schema, at both, the global and more specific levels, and the defense mechanisms of repression and suppression, relating to past personal experiences, were found to have some suggestive explanatory power with respect to some of the key variables in this study.

Acknowledgments

I would like to acknowledge the cooperation of the fifteen school psychologists and school social workers who participated in this study. Without their willing participation, the study could not have been completed. Their identities will remain anonymous, because I promised them this would be done.

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Chapter 1

Introduction

- Need

The need for this study on suicide intervention and counselor characteristics was precipitated by a couple of factors. First, this researcher is a crisis counselor in a large public school district in Gloucester County, New Jersey. As a result, he was interested in obtaining information which will enable him to do his job more effectively. Second, this researcher from his previous experience and reading on the topic of suicide intervention has seen and read, respectively, how critical some counselor characteristics can be in this process.

- Purpose

The purpose of this study was to determine whether or not, in some suicide interventions in a public school setting, counselor characteristics can be just as critical as student variables in determining how successful the outcome of the intervention will be. These characteristics relate to the role conception and comfort level of the counselor in working with students who are contemplating suicide. These were deemed to be most critical in

borderline situations; in other words, where it could go either way, the student choosing life or death. In such situations, the counselor's input is likely to be most important.

- Research Questions

The main research question, as suggested, related to counselors' characteristics as being critical to effective suicide intervention in the public school setting, especially in those borderline cases noted. This broader question was examined by looking at two characteristics of counselors, who conduct suicide interventions that raise more specific questions.

The first question was whether or not counselors who do conceive of suicide intervention as one of their primary roles perceived themselves to be more successful in conducting suicide interventions. The second question was whether or not counselors who were more comfortable doing suicide interventions perceived themselves as being more successful in conducting such interventions than those who were not as comfortable. And there was presumed to be a consistent relationship between these factors, as well.

For example, a counselor who does view suicide intervention as one of his or her primary role responsibilities was presumed to be more likely to be comfortable with this aspect of his/her role.

- Theory

Interest in researching these topics was stimulated by previous "theories" on the topic, especially Shea's (1999). This was true as they specifically relate to effective suicide interventions. More general theoretical underpinnings of this research are briefly discussed now. The central unifying concept that this researcher proposed as underlying this research was schema, specifically as it relates to the self. Schemas are defined as ordering of experience, which people engage in to make sense of their world. This is a conscious mental process, as delineated by one school of thought in personality theory: the cognitive self-regulation perspective. The schema we form about ourselves is a self-schema. This is similar to the idea of self-concept. The self-schema, as is true for the self-concept, is both global as well as being composed of component parts. One of the component parts of the self-schema involves the various roles a person engages in.

Schemas related to specific social roles are role schemas. This concept of role schema has been investigated in sociology and social psychology, as it encompasses social expectations of role specific behavior. These schemas also entail information about how people engaging in particular roles actually perform these roles. This researcher examined various aspects of the roles school psychologists and school social workers perform. The focus was upon, as suggested, how they viewed themselves in their crisis counselor role in relation to other roles they must also perform. Inter-role and intra-role conflicts lead to incompatible expectations of appropriate behaviors between various positions and a single role, respectively. The implication being that a person focuses upon and puts more effort into that role or aspect of a role which is most highly valued.

Another general theoretical underpinning of this thesis involved the Freudian "theory" of defense mechanisms. Freud (1996) and his daughter (1974) elaborated on these. Defense mechanisms were described by Freud and his daughter as serving to protect the ego or self-concept. As noted, they tend to be unconscious. However, on occasion they can

operate at a conscious level. A key defense mechanism they both discussed was repression. This involved the ego's attempt to keep unpleasant and anxiety producing information from consciousness. This is an unconscious process. When it is consciously done, it is called suppression. In the context of terms being employed in this thesis, repression and suppression were proposed as being employed by the counselors doing suicide crisis intervention to protect both their global and more specific components of their self-schemas. These defense mechanisms are utilized by crisis counselors, according to Freudian theory, to protect their egos (self-concepts/self-schemas) from uncomfortable, anxiety producing information. It was presumed that for several counselors these processes relate to suicide and suicide intervention, and that it negatively impacted their performance in dealing with suicidal students.

- Definitions

Following are a list of terms and their definitions as used in this thesis. These terms are central to this analysis. One clear indication of this is their appearance and/or recurrence throughout this thesis.

1. Suicide - death resulting from self-inflicted injury where there is evidence the deceased intended to kill him or herself.
2. Parasuicide - someone who has attempted or seriously considered suicide.
3. Suicidal intent - a student who has thought about, planned, and/or actually attempted to take his or her life.
4. Suicide intervention - the process whereby a counselor tries to prevent a student from following through with his or her suicidal intent.
5. Comfort level with suicide/suicide intervention - the degree to which a counselor can openly discuss and actively intervene with a suicidal student.
6. Role conception - how the counselor views his or her job in terms of what is most central to it. Such aspects of the job could include, in addition to suicidal crisis intervention, assessment, consultation, general counseling, or administrative duties.
7. Defense mechanisms - an often unconscious operation whereby an individual protects his or her self-concept

from threatening or anxiety producing situations. They tend to be irrational.

8. Self-schemas - similar to self-concept that involves ordering the way they (counselors) think about themselves. These schemas have both global and more specific component parts.
9. School counselors - school psychologists and school social workers who work in the public school setting.
10. Mental health link - school counselors serving as facilitators in connecting students, who are seriously distressed and in need of services that go beyond the capacity of the school to provide with outside mental health agencies.

- Assumptions

There were several assumptions that were made in this study. First of all, the counselors (school psychologists and social workers) were not randomly selected. However, it was thought they represented a fairly typical sample of suicide crisis interveners in the public school setting, who hold degrees in school psychology or school social work. Secondly, there was an assumption that a counselor's perceived effectiveness related to actual effectiveness as

reflected in job performance. Thirdly, it was assumed that the semi-structured questionnaire developed for the interviews to be conducted in this study, accurately pinpointed key elements in effective suicide intervention.

- Limitations

There were several limitations of this study. A couple of them were associated with the assumptions previously noted. First, since there was neither a random nor a stratified sample of counselors, this limited the generalizability of the results obtained. Second, a counselor's perceived effectiveness may or may not coincide with his or her actual effectiveness with respect to various aspects of job performance. This is a problem with all self-report measures, as the respondent can fake good or bad. There were no independent measures of the counselor's self-assessment to confirm or deny the accuracy of their self-reports. Although several indirect measures of this obtained from the counselor's self-reports, such as outside reading, conference workshops attended, and conferring with peers, were examined. Third, no causal relationships can be discussed nor can levels of statistical significance of the results be obtained. Causality cannot be discussed because

no experimental controls were employed. Significance cannot be discussed because relating to the first limitation randomness was not employed in sample selection. Also, terms employed in this study were not defined with sufficient precision so as to enable formal operationalization. This would have allowed for statistical analysis.

- Overview

In the second chapter, research was reviewed as it related to suicide and suicide intervention in general. And more specifically, research on counselor attitudes and characteristics was examined to determine what impact they had on suicidal intervention in the public school setting. With respect to the design of the study, it was based on semi-structured interviews of school psychologists and social workers who conduct suicide interventions in the public school setting. This questionnaire was developed by this researcher, based upon his analysis of previous research and questionnaires on the topic of suicide intervention. The sample consisted of fifteen school psychologists or social workers who worked in the public school setting and who had experience with suicide

intervention. This sample was nonrandom and unstratified. There were three criteria this researcher used to select the sample. First, as noted, the counselor had to have previous experience with suicide intervention in the schools. Second, the counselor had to be a school psychologist or social worker, the reason being, it was assumed these professionals would have the best training of those employed in the school setting to conduct such interventions. Third, this researcher personally knew and respected all of the counselors selected for inclusion in the study.

Following this, key themes were singled out in the results obtained, along with certain patterns in the responses of some groups/categories of the participants. Finally, the results were discussed and analyzed with suggestions for further research, in light of the specific results and questions raised by this study.

Chapter 2

Review of Literature

Introduction

The study and treatment of those contemplating or attempting suicide is complicated by the stigma that is attached to it. One of the pathbreaking researchers on suicide, Shneidman (1970e), commented on the taboos associated with suicide involving "hostility, censure, and condemnation," which increased the difficulty of studying and obtaining accurate information about it. Even though he made these comments over 30 years ago, some of the same prejudices still exist, although they are breaking down somewhat over this time period. Stigma is also attached to mental illness, including depression, which can lead to suicide. However, there are other reasons, besides stigma, which can interfere with the study and treatment of mental illness. A recent Newsweek article (Wingert & Kantrowitz, 2002) indicated that only one in five depressed teens who needs treatment gets it. In this same article (Wingert & Kantrowitz, 2002), Dr. Madelyn Gould, a professor of child psychiatry at Columbia University, suggested that depression may be mistaken as teen turmoil among those living and

working with adolescents. Yet another barrier to its study and treatment cited in this article by Phil Lazarus who runs the school psychology training program at Florida International University and is Chairman of the National Association of School Psychologists (NASP) emergency-response team, is that many of these depressed kids are quiet and do not get the attention that the disruptive, acting out kids get (Wingert & Kantrowitz, 2002).

All of these factors add to the difficulty of studying a topic such as suicide and suicide intervention. In addition to the "client and disorder" variables just discussed that have contributed to this problem, there are "therapist" variables which come into play here, as well. Few therapists receive specific training in working with suicidal clients (Berman & Jobes, 1991). This may be changing some in the past 10 years. However, what this researcher has found is there has been little specific research done on counselor attitudes, including school counselors, on suicide and suicide intervention. Before examining the literature on this topic, a more general analysis of the literature on suicide and suicide intervention was conducted first.

First of all, an examination of suicide in general, including a definition of it and viewing it in historical and theoretical context, follows. The Centers for Disease Control and Prevention defines suicide as a "death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) that the injury was self-inflicted and that the decedent intended to kill himself/herself (cited in Jamison, 1999, p. 27)." Another definition or classification includes those who "attempt or seriously consider" suicide (Harry, 1983). This categorization is more generally known as "parasuicide" (Harry, 1983). These people represent the vast majority of those whom therapists and counselors come into contact with. For example, regarding the population that is the focus of this study, school aged youth, researchers have estimated for every completed suicide there are 200 attempts (Marcus, 1996). This does not include those who have only contemplated suicide. The ratio would be even greater for this category of youth.

Various Historical and Theoretical Views of Suicide

Views of suicide have varied historically and across cultures. The oldest documented reference to suicide comes

from the Egyptians over 4,000 years ago (Stone, 1999). The Greeks and Romans both displayed some ambivalence in how they viewed suicide. On the one hand, both cultures believed in dying with dignity, such as Socrates in Greece and the gladiators in Rome (Jamison, 1999). However, there were also strains of opposition to suicide in both societies, as well. Aristotle regarded it as being cowardly, and Roman law prohibited it (Jamison, 1999). Interestingly, Christianity and Judaism have been ambivalent about it too, when viewed in historical perspective. On the one hand, neither the Old nor the New Testament directly prohibits suicide (Marcus, 1996). Also, early Christianity was attracted to suicide perhaps due to its association with martyrdom (Stone, 1999). However, when Christianity became the dominant religion in the Roman Empire, its view of suicide gradually changed until it became a sin and a crime in the 6th Century (Stone, 1999). Jewish custom over the centuries was strict in its renouncing of suicide (Jamison, 1999). There has been some easing of these attitudes in Jewish custom over time for suicides committed when one was of "an unsound mind" (Jamison, 1999). There has been a more understanding attitude that has gradually developed in the

West, although there have been some ups and downs in this process. With the rediscovery of Greek and Roman thought in the 16th century and the Age of Reason in the 18th century, theological arguments against suicide were challenged (Stone, 1999). Shakespeare portrayed fourteen suicides in eight of his tragedies without morally condemning them (Stone, 1999). However, the early Puritans and other American colonists treated suicide not only as a sin, but as a crime as well (Jamison, 1999).

Most European countries decriminalized suicide in the 18th and 19th centuries, although it was still a crime in England and Wales until 1961 and in Ireland until 1993 (Jamison, 1999). In the United States, state after state has taken it off the statute books as being a crime (Shneidman, 1970e; Litman, 1970x). Since the emergence of antipsychotic drugs in the 1950s laid the basis for biochemical determinants of behavior, suicide has been viewed less as a moral crime and more as a manifestation of a psychological disturbance (Stone, 1999).

In non-Christian societies, views about suicide vary. Buddhist, Confucian, and Shintoist beliefs accept suicide and euthanasia for the incurably ill (Stone, 1999). Also,

Shintoist Japan during World War II elevated suicide in the case of the Kamikaze pilots to an heroic act. In Islamic countries, on the other hand, suicide is viewed as a crime even more serious than homicide (Jamison, 1999). Although there seems to be some difference of opinion here, as the Palestinian suicide bombers in Israel and the Al-Queda terrorists who demolished the World Trade Center claim to be following Islamic beliefs as justification for their actions.

In terms of theoretical perspectives, there are several that are briefly touched upon. Durkheim introduced one of the first rigorous analyses of suicide from a sociological point of view. He viewed suicide as resulting from society's strength or weakness in controlling the individual (Berman & Jobes, 1991). Freud, writing early in the 20th century, presented a psychoanalytic version of the causes of suicide. He claimed suicide was one of the costs of civilization. More specifically, he indicated, "In civilized man, extra aggression is channeled into the superego and turned against the ego (cited in Litman, 1970y, p. 580)." In other words, he viewed suicide as aggression directed against the self. The so-called grandfather of

American suicidology, Karl Menninger, who also wrote early in the 20th century, wrote about unconscious, subintentional elements in covert human self-destructiveness in *Man Against Himself* (Shneidman, 1996). Although he did propose his own distinct view of the causes of suicide, Menninger did borrow from Freud. He incorporated unconscious motivation into his theory, and he viewed risky, reckless behavior as a subtle substitute for classic suicide for some people (Shneidman, 1996). Several theorists have portrayed suicide from a social-psychological viewpoint. For example, some theorists view adolescent suicide as an interaction between multiple social and psychological factors (Berman & Jobes, 1991). Another analyst views suicide from a developmental, social/psychological perspective. Borrowing from Erikson's ideas according to this theory, adolescent suicide is related to developmental regression in identity formation that can lead to depression and/or suicide (Berman & Jobes, 1991).

Shneidman, Faberow, & Litman did research on suicide beginning in the early 1950s. Their studies in suicidology, as it came to be known, were pioneering. Shneidman has been the most prolific of these three researchers on suicide. He

views suicide as stemming from frustrated needs (Shneidman, 1996). Needs are central to his view of suicide and the human condition. He follows in Murray's steps by employing a need based motivational view of suicide. He conceives of suicide as precipitated by unbearable psychological pain, which he calls "psychache," that prompts an individual to seek relief by taking their lives (Shneidman, 1996).

Shneidman, along with his colleagues, conducted "psychological autopsies" of those who committed suicide to determine what common features they exhibited (Shneidman, 1970d); (Shneidman, 1996). Shneidman (1996) proposed a set of ten common features that those who are suicidal display, such as a common purpose - seeking a solution, a common goal - cessation of the pain, and a common emotion - a hopeless and helpless feeling, for example. They contended since there were clues to most suicides prior to their completion, intervention strategies could be developed to help prevent it. As a result of their research and empirical investigations, they set up the Los Angeles Suicide Prevention Center in the 1950s to do just this (Shneidman, 1970b; Shneidman, 1996).

Finally, regarding theoretical perspectives on suicide, a few comments on Beck's contributions. Beck is a cognitive psychologist who has developed a depression rating inventory. Based on his research on depression, he has found that hopelessness is strongly associated with completed suicides for both depressed inpatients and outpatients (Jamison, 1999). Beck's views on hopelessness and its relationship to depression and suicide have gained increasing acceptance. The theoretical perspectives reviewed on suicide were not meant to be exhaustive, but rather were intended to focus upon seminal and cutting edge theories in this area.

Statistics on Suicide and Parasuicide

One of the factors that make suicide a human behavior that is difficult to study is it is a relatively low incidence behavior, especially with respect to completed suicides. In 1996, just over 30,000 people committed suicide in the United States (Shea, 1999). This seemingly large number might appear to contradict the prior assertion. However, when viewed in larger context, this represents only 12 of 100,000 people committing suicide on average in the United States per year (Marcus, 1996). Suicide is the ninth

leading cause of death by adults in the United States (Shea, 1999). Suicide ranks third as the cause of death for 15 to 24 year olds, and it is the fourth leading cause of death among 10 to 14 year olds (NASP Communique Insert, 2001). Males are at a much greater risk in the 15 to 24 year old category of killing themselves. The ratio of completed suicides of males to females is four to seven times greater among males than females (Peters, 1985 and NASP Communique Insert, 2001), although girls attempt suicide three to four times more often (Marcus, 1996; Peters, 1985). This discrepancy is based upon the fact that young males tend to use more lethal means to kill themselves than young females. Also, it has been suggested that for young females it may represent more of an act of communication, a crying out for help, than it does for young males (Shea, 1999; Marcus, 1996; Shneidman, 1970d). In the United States in 1995, 330 children in the 10 to 14 age group killed themselves and seven children aged 5 to 9 did (Shea, 1999). From 1952 to 1992, the suicide rate among adolescents and young adults tripled (Shea, 1999). Possible reasons for this dramatic proportional increase are examined in the next section of the literature review. In absolute terms, the numbers of

youth reported to take their lives each year is in the 5,000 range (Gibson, 1994), although the number is believed to be much higher than this, because it is so under-reported in cases such as "deliberate auto accidents, victim precipitated homicides, and inconclusive coroner reports" (Gibson, 1994, p. 17).

These numbers viewed in isolation are not very encouraging. However, there are some other statistics that offer hope with respect to those who are contemplating and/or attempted suicide and to those who are working with them. Less than one percent of those people who have suicidal thoughts eventually go on to kill themselves, according to Shea (1999). As noted previously, young people make 200 attempts for every completed suicide, although not as encouraging is a 1997 high school survey of students in which 1 in 5 students considered and 1 in 10 actually attempted suicide the previous year (Jamison, 1999). On the other hand, 80% of those who are considering suicide give clues, which can be verbal, behavioral, or situational in nature (Shneidman, 1987). Another figure that provides hope is roughly 50% of those who commit suicide have been seen by their primary care doctor within the month prior to their

suicide (Shea, 1999). A study cited in Berman & Jobes (1991) found that about one-half of those who committed suicide had had previous contact with a mental health professional. This piece of information can be looked at in two ways. Either it can be viewed negatively, because even after seeing a mental health provider they still killed themselves, or it can be viewed positively in the sense they were reaching out for help. Possibly with further training and knowledge on the subject of suicide, these mental health professionals could do a better job in the future. A survey of 120 high school students found that if they were considering suicide, 91% would first tell a friend of their intentions (Ross, 1985). Finally, one study of people hospitalized for depression or a suicide attempt found that within the highest risk subgroup, based on certain factors within this high risk group, only one of five committed suicide in the two years following their hospitalization (Stone, 1999).

People who are contemplating suicide are often ambivalent about living or dying. For most people in the throes of depression and despair, who have thought of killing themselves, they come down in the end in choosing

life over death, as the statistics have shown. This is especially true for young people, as previously noted, by their frequent attempt to completion ratio. For the elderly, the prospects for life, when they are considering suicide, are not nearly as good. This is due to the fact that they make only two to four attempts for every completed suicide (Marcus, 1996). These figures should provide hope for youth and those who deal with them; there is something that can be done to help them even when they are down and in despair. Even more can be done to help them if family, friends, teachers, counselors, primary care doctors, and mental health professionals become more knowledgeable and comfortable in dealing with a youth who is considering suicide as an option to his or her life's problems.

Risk Factors Associated with Suicide

There are several general risk factors which are associated with greater suicidal risk. There are specific precipitating stressors that can lead a person to attempt to take his or her life. The risk factors that predispose an individual to be suicidal, targeted here, primarily involve psychiatric disorders. Shea (1999) has indicated that reviews of completed suicides have shown as many as 95% of

all suicides, and this includes both adolescent and adult populations, have been committed by people with a psychiatric disturbance. Before examining what the most prominent psychiatric disturbances are, some other general risk factors will be mentioned. As noted, males are more likely to kill themselves, while females are more likely to attempt to do so. This holds true across age categories. With respect to age, the elderly and young males are high risk groups (Marcus, 1996). Certain racial/ethnic groups are high risk. Native Americans are at the highest risk to kill themselves in the United States (Marcus, 1996). Whites kill themselves more often than blacks do, although the numbers of black suicides are increasing (Marcus, 1996). Regarding physical illness, Jamison (1999) stated that virtually everyone who has a physical illness and then eventually commits suicide also had a psychiatric illness. She goes on to say these physical illnesses, which can lead to suicide, are typically those that adversely affect brain functioning (Jamison, 1999). Although Shea (1999) points out that physical illnesses, which result in chronic pain, loss of function, and disfigurement, also can lead an individual to commit suicide. Jamison (1999) notes that a

previous history of suicide attempts is the most powerful predictor of subsequent suicide. These individuals have a 38 times greater than expected risk of killing themselves. Finally, geographically speaking, some countries and states in the United States are more prone to higher suicide risk. Hungary has a very high rate of 40 per 100,000 (Marcus, 1996) and in the United States, New Jersey has the lowest rate of 6.5 per 100,000, while Nevada has the highest at 25 per 100,000 of any state (Marcus, 1996). Reasons for why a person is more likely to kill him or herself are obvious for some of the categories listed above and not so obvious for others.

When one thinks of a suicidal person, the first thought that comes to mind is that he or she must have been depressed. In rank ordering the prevalence of psychiatric disorders among suicidal individuals Shea (1999) ranks them from more prominent to less prominent as follows: major depression, alcoholism, schizophrenia, bipolar disorder, and borderline personality disorder. He goes on to mention that, at times, individuals with an anxiety based disorder will hide their symptoms by presenting with depressive complaints (Shea, 1999). People suffering from obsessive

compulsive disorder represent almost 2% of the suicides committed in the United States (Shea, 1999). More specifically, depression as a risk factor in adolescent suicidal behavior can be seen, as one study reported, that 83% of young people who contemplated suicide were also depressed (Kirk, 1993). Of those adolescents who develop major depression, around 7% may eventually take their own lives (Cash, 2002). Kirk (1993) suggests acting out, impulsive behaviors among children and adolescents may mask underlying depressive symptoms. Jamison (1999) points to a hereditary, biological component in impulsive, aggressive acts (including suicide) where research has shown that low serotonin levels can lead to such behaviors. One study cited by Stone (1999) indicated that the greatest risk factors for teen suicide were in decreasing importance: prior attempt, major depression, substance abuse, antisocial behavior, and family history of suicide. Chronic alcohol or drug abuse can lead to suicide by decreasing impulse control or by precipitating psychotic process, which entails impaired, irrational thinking (Shea, 1999). Adolescent boys typically are more impulsive and engage in more acting out types of behavior, such as alcohol and drug abuse, than

adolescent girls do. Between 15% and 25% of all completed suicides are committed by the chemically dependent (Daley & Moss, 2002).

Some other predisposing factors to youth suicide that are not necessarily related to psychiatric disturbances are briefly reviewed now. One study of youth who had committed suicide found up to 50% of them had some type of learning disability (Berman & Jobes, 1991). Other studies have shown homosexual youth to be at much greater risk for committing suicide. Homosexual youth, it has been estimated, are two to six times more likely than other youth to commit suicide, especially just after coming out (Berman & Jobes, 1991). Social factors, more specifically, verbal/physical abuse and general intolerance, are cited as the key factors leading to suicide among this population (Remafedi, 1994; Gibson, 1994). In other words, psychological factors, such as ego dystonic homosexuality, are reported by these researchers to be less critical than social discrimination and prejudice in leading to such high rates of suicide among gay youth. It has been estimated that gay youth suicide may represent up to 30% of youth suicide (Remafredi, 1994). However, it should be noted that social and psychological factors are

not acting in isolation here, but rather interact (Shneidman, 1970a). Another characteristic of suicidal youth, which is not necessarily psychiatric in nature, is their perfectionism (Slaby & Garfinkel, 1994). Adolescents who display this type of thought process engage in all or nothing thinking, which can make them more prone to extreme solutions, such as suicide, to life's everyday problems.

Some adolescent observers (Slaby & Garfinkel, 1994; Kreisman & Straus, 1989) emphasize that typical teen emotional turmoil must not be confused with the depressive and/or impulsive, acting out symptomology characteristic of suicidal youth. They acknowledge that this is not always easy to do. There are several specific precipitating stressors that typically have been found to lead to suicide attempts among adolescents. These include: breakup with a boyfriend or girlfriend, arguments with siblings and friends, loss of a friend or family member (including divorce), personal injury or illness, and school problems such as failing grades, harassment, and changing schools (Kirk, 1993 & Berman & Jobes, 1991).

Skills and Attitudes Essential for Effective Suicide Intervention

Attention is now turned to a review of the literature with respect to skills and attitudes that have been discussed and/or documented as being essential for effective suicide intervention. The focus in this section is not on the school setting. That setting is examined later. Rather here these skills and attitudes are examined in a broader therapeutic context, which encompasses all age levels of suicidal individuals.

Two key factors are frequently cited by commentators on the subject as being necessary for counselors to possess or demonstrate to intervene effectively with individuals contemplating suicide. They are competence and a caring attitude (Shea, 1999; Jamison, 1999; Faberow et.al., 1970; Berman & Jobes, 1991; Kirk, 1993; Slaby & Garfinkel, 1994; Hinson, 1982). One study involving nursing students found that these factors are not necessarily related (Inman et al., 1984). Other studies have demonstrated that training and experience in suicide intervention skills, as well as in the area of providing a warm, caring environment can improve

counselor competence in both of these areas (Neimeyer et al., 2001; Neimeyer & Pfeiffer, 1994).

Several areas of counselor competence have been pinpointed as being critical in dissuading an individual from carrying through with his or her suicidal plans. First, there is simply the area of technical competence. Knowledge of risk factors is important (Shea, 1999). These risk factors can fall into the chronic and immediate risk categories (Shea, 1999). Chronic risk factors relate to such identifying characteristics of the person as follows: age, sex, family background (history of suicide in the family), mental state (depressed, agitated, anxious, psychotic process, all being danger signs), and social relationships (social isolation, rejection, or recent loss) (Shea, 1999). Other risk factors are cited by several suicide intervention experts as being more important than these chronic factors in determining whether or not an individual is in immediate risk of committing suicide. Key factors here include: 1) the presence of suicidal intent, 2) a concrete, detailed plan for carrying out this intention, and 3) the availability of lethal means for doing this (Kirk, 1993; Shea, 1999; and Faberow, et. al., 1970).

Interviewing skills are most important in eliciting this information. Shea (1999) states open-ended versus close-ended questions are much more productive in this process. Domino and Swain (1985-86) conducted a study of 280 mental health professionals examining the relationship between knowledge of suicide lethality and attitudes toward suicide. In their study, they found the following professional groups to be most knowledgeable to least knowledgeable of suicide lethality in descending order: psychiatrists, psychologists, crisis interventionists, physicians, social workers, psychiatric nurses, counselors, and clergy (Domino & Swain, 1985-86). Lethality factors in this study included both more immediate and more chronic risk factors. Regarding attitudes, the mental health professionals who recognized a greater number of suicide signs tended to perceive suicide as acceptable and as a reaction to difficult circumstances rather than as it being manipulative and self destructive in nature (Domino & Swain, 1985-86). Also, they believe the elderly, and to a lesser degree the deviant, are more prone to suicide, and they do recognize that suicide can represent a cry for help (Domino & Swain, 1985-86). Others have also discussed the possibility of suicide as being a rational,

acceptable choice for some people, for example, those with chronic, debilitating mental and physical illnesses (Rogers et. al., 2001; Nelson, 1984).

This viewpoint towards suicide is a controversial one. As Nelson (1984), one of the proponents of this position acknowledges, the general assumption in our society is that suicide should be prevented, and "life is preferable to death" (Nelson, 1984, p. 1328). Other suicide commentators, who take a pro-life, anti-suicide position focus upon the transient nature of the suicidal intent for most people (Shea, 1999; Jamison, 1999; Kirk, 1993; Berman & Jobes, 1991; Shneidman, 1985). Kirk (1993), in discussing suicide intervention with adolescents, states that the suicide "assessor" must not be ambivalent about suicide. He or she must be firmly opposed to it as an acceptable option, otherwise that ambivalence may be communicated to the at risk adolescent (Kirk, 1993). Shea (1999), in discussing a more varied, in terms of age, suicidal population states that the "interviewer" must come to terms with his or her own biases toward suicide, as well as any personal history relating to suicide, in order to make him or herself more psychologically available to the suicidal client. Neimeyer,

et. al. (2001), in a study of undergraduate psychology students, suicide hotline volunteers, and graduate students in clinical/counseling psychology, found several personal and professional factors related to effective suicide intervention. On a personal level, a personal history of suicidality, viewing suicide as an acceptable option, and a view of death as something to be feared rather than as a natural part of life, were all associated with less effective responses to suicidal verbalizations (Neimeyer, et. al., 2001). On a professional level, a higher level of training and having seen a greater number of suicidal clients, was correlated with higher suicide counseling competence (Neimeyer, et. al., 2001).

There is no firm and hard line between so-called technical competencies and creating a caring environment in which the suicidal person will share his thoughts and feelings, according to several of the sources this researcher reviewed on suicide counseling (Shea, 1999; Kirk, 1993; Jamison, 1999; Shneidman, 1985; Hinson, 1982). The main reason for this is because suicide intervention entails a relationship between a counselor and a client. Anything that can further this relationship, whether it relates to

technical, authoritative competence or the perception thereof by the client, warmth and self-disclosure where relevant, or humor, is viewed as fostering a greater probability of an effective suicide intervention (Berman & Jobes, 1991). In a research study dealing with therapist self-disclosure in general counseling situations, it was found that clients in the increased self-disclosure condition reported "less symptom distress and also mentioned they liked their therapists more" (Barrett & Berman, 2001). Hinson (1982), in discussing strategies for suicide intervention over the phone, indicates that an authoritative role, as seen in a parent-child relationship, can help to elicit suicidal intent and plans. She also states that direct, realistic, noneuphemistic questions are more helpful, for example, saying "killing yourself" rather than "doing yourself in" (Hinson, 1982). Several commentators have called for a tolerant, nonjudgmental attitude on the counselor's part to elicit maximum information (Hinson, 1982; Shea, 1999; Kirk, 1993; and Shneidman, 1970c). Open-ended, specific questions are also reported to be most productive (Shea, 1999). The importance of repeatedly questioning as to the person's lack of suicidal intent has

been emphasized by a few commentators as being the safest course of action (Shea, 1999; Daley & Moss, 2002).

Creating a warm, empathic environment is emphasized more than technical competence in leading to effective suicide intervention in the literature. Berman & Jobes (1991) refer to a study on counseling in general, which found more than 60% of the variance of treatment outcome appeared to be the result of a therapist-client match in terms of compatibility. Berman & Jobes (1991) and Kirk (1993) state that such compatibility is also critical in effectively intervening with suicidal adolescents. The establishment of a warm, calm, relaxed, and unhurried climate is deemed to be critical in facilitating the development of trust between the counselor and the suicidal individual (Shea, 1999; Slaby & Garfinkel, 1994). Development of trust is central to disclosure of suicidal intent, because the suicidal individual is being asked to reveal very deep, personal, often times unflattering, information about him or herself. Shea (1999) describes the best atmosphere for intimate sharing as one fostered by the counselor in which the patient feels "maximally comfortable with the interviewer while being maximally uncomfortable

with his or her own pain" (Shea, 1999, p. 145). For Shea (1999), the development of such a relationship can lead to the "window" which enables the therapist to enter the private world of the suicidal individual. Unless this is done, effective help will not be forthcoming, according to Shea (1999). Slaby & Garfinkel (1994) state it a bit differently, but they still emphasize the importance of the relationship when they indicate it is central to understand the crisis from the suicidal person's point of view.

If a warm, trusting relationship develops between the counselor and the suicidal person, there are dependency needs that may be satisfied in the suicidal person, which can lead to transference (Litman, 1970z). Such dependence and transference can lead to discomfort, undue pressure, and feelings of rejection by the counselor in relation to the client (Shea, 1999; Litman, 1970z). It is important for the counselor to be aware of these countertransference feelings so that he or she can work through them, so that a positive, optimistic, hopeful attitude, as opposed to a negative, pessimistic, rejecting attitude, can be conveyed to the client (Litman, 1970z; Richards, 2000).

Suicide Intervention in the School Setting

Scott Poland, past president of NASP, is one of the leading authorities on crisis intervention, including dealing with suicidal students, in the public schools. He has written extensively on the subject. In *Best Practices III* (1995), he has written on suicide intervention where he pinpoints the need for schools to develop a suicide intervention program which includes the following: 1) detection of suicidal students, 2) assessing the severity of their symptoms, 3) notifying parents, 4) securing needed mental health services for the student, and 5) providing follow-up at school. Poland (1995) emphasizes that school psychologists need to be knowledgeable about community resources that are available to assist suicidal students. Slaby et. al. (1990) also discuss the mental health link that school counselors can take a leading role with in the school setting. This is the link between the schools and other institutions in the community, which can help suicidal students. Related to the mental health link and the associated suicide intervention services provided in the schools, there is a recent movement in school psychology to put more emphasis on the psychology (mental health aspect of

school psychology) than on the school or assessment component. There has been extensive coverage of this movement in the *School Psychology Review* and the *Communique*, two publications of NASP. See the following for further discussion of this issue (Nastasi, et. al., 1998; Dwyer & Bernstein, 1998; Reeder, et. al, 1997; Feinberg, 2001; Dwyer, 1995; Nichol, 1993; Talley & Short, 1994; Kuffner, 2001; Allen, 2000; Wrobel, 1999; Position Statement - *Communique* Insert, 1998).

Peters (1985) also discusses the mental health link aspect of suicide intervention in the schools, and she also touches upon key identification and prevention issues. She notes that suicide is part of a process, and she views counselor intervention with suicidal youth in the schools as basically providing psychological "first aid" (1995). Thompson (1990) writes about crisis management in the schools, involving suicide and sudden loss, from a more detailed step-by-step approach. Shamoo & Patros (1985) provide an interesting framework, not limited to the school setting, with respect to suicide intervention strategies for the adolescent. They present eight strategies that deal with affective, cognitive, and behavioral aspects which

suicidal adolescents typically present with (Shamoo & Patros, 1985).

School Counselors' Attitudes Toward Suicide Intervention

Very little research has been done on school counselors' attitudes regarding their perceived effectiveness and comfort level in working with suicidal students. As a matter of fact, one such study, conducted in 1999, indicated there had been no published study at that time that investigated the perceived self-efficacy of high school counselors in recognizing students who might be at risk for committing suicide (King, et. al, 1999). This survey study of almost 2,000 high school counselors, who were randomly selected, found that only one-third of them believed they could recognize a student who was at risk for suicide (King, et. al, 1999). A previous study, conducted in a suburban high school in a major Midwestern metropolitan area, found students were most comfortable talking to their school counselors than any other school professional about personal problems (Armacost, 1990). The counselors in the King, et. al., (1999) study recognized by an overwhelming majority (87%) that it was part of their role to identify students who are a suicidal risk. An even greater number of

this sample (89%) reported that they had dealt with a student who had expressed suicidal thoughts to them (King, et. al, 1990). A key finding of the study was that counselors who worked at high schools which had crisis intervention teams, were significantly more likely to have high perceived effectiveness in dealing with suicidal students (King, et. al., 1999). Besides recommending greater use of crisis intervention teams, these researchers also recommended counselor training programs to increase their training on suicide intervention, as well as calling for greater collaboration between professionals, including community mental health professionals, in this area.

Another study of high school counselors in Dallas assessed the perceived effectiveness of counselors in determining the level of risk of suicidal students (King & Smith, 2000). They found that counselors who received Project SOAR (Suicide Options Awareness & Relief) training most recently were significantly more knowledgeable about suicide intervention steps than counselors who had received this training longer ago (King & Smith, 2000). The person who conducted this periodic training was "a suicidologist and crisis specialist employed by the Dallas School

District" (King & Smith, 2000). There were a couple of other significant findings in this study. Counselors who had assessed six or more suicidal students in their career perceived themselves as being significantly more effective (knowledgeable) than counselors who had not assessed this many suicidal students (King & Smith, 2000). Finally, counselors with five years or less experience were found to be significantly more knowledgeable about suicide intervention procedures than those who were employed longer than this (King & Smith, 2000). They propose two possible reasons for this seeming contradiction. First of all, more recent graduates among counselors are closer to their course work on suicide intervention than older graduates. Secondly, the newer counselors were possibly more exposed to suicide crisis intervention instruction in their graduate college curriculums than the older, more experienced counselors (King & Smith, 2000).

Gora, et. al, (1992) conducted a study of 30 school based counselors at the elementary, junior high, and high school levels in an urban school district in the province of Alberta, Canada. This study examined school counselors' perceived effectiveness in several aspects of their job,

including suicide crisis counseling (Gora, et. al., 1992). Interestingly, the overall results were ambivalent. The areas in which they felt they had the greatest impact - school problems, family problems, suicide and sexual abuse, were almost exactly the same as the problems for which they felt they had the least impact (Gora, et. al., 1992). The lone exception to this was sexual abuse, which was not included on their list of problems for which they felt they had little impact (Gora, et. al., 1992). The counselors in this study indicated there were several factors that helped to lead to positive outcomes in dealing with several problem areas. They included: developing a trusting counseling relationship with the student, being a good listener, and bringing up and focusing on the students' strengths and not their weaknesses (Gora, et. al., 1992). Several counselors mentioned teamwork, involving consulting with other staff members, had been important in dealing with difficult cases, such as counseling a suicidal student (Gora, et. al., 1992). Several factors were cited by the school counselors as hampering their ability to have more of an impact on the students they counseled. Overall these included: lack of parental support, low student motivation, and a lack of time

(Gora, et. al., 1992). Several counselors also cited some areas in which they felt they needed further training in order to have more of a positive impact. One of these was crisis counseling (Gora, et. al., 1992). In an effort to overcome some of the deficiencies cited, these researchers suggested that this school district could possibly turn to the community, including mental health services, to help them in assisting students with their problems (Gora, et. al., 1992).

In an anecdotal account, an elementary school counselor from Essex, Connecticut, supports some of the points made and recommendations offered in the previously reviewed study. This counselor discusses a successful suicide intervention with a sixth grade student, which she thinks was based upon the following factors: suicide intervention training, dissemination of this information to the school staff, and the ability to develop a trusting relationship with this student as a result of previous ongoing guidance lessons in his classroom (Andreozzi, 1988). In other words, regarding the last point, she needed time in her estimation to build this trust so that at a later time she could successfully counsel this student, when he was feeling

suicidal. As a result of her training and successful intervention in this case, this school counselor appeared to be more confident in herself and comfortable with working with suicidal students.

In another foreign study (Dissertation Abstract, 2002), over 400 Irish guidance counselors were randomly selected to examine their self-efficacy in identifying and assessing students who are at risk for suicide. There were two key findings of this study. First of all, guidance counselors who had dealt with a suicidal student before were three times more confident in their abilities to intervene successfully with a suicidal student than those who had not had such exposure (Dissertation Abstract, 2002). Male guidance counselors were almost three times more likely than female guidance counselors to have high suicide intervention self-efficacy (Dissertation Abstract, 2002).

Kush & Malley (1991) conducted a descriptive study of adolescent suicide prevention/intervention programs. Their study involved guidance counselors who were randomly selected nationwide to complete a questionnaire (Kush & Malley, 1991). There were several key findings in this study. First of all, almost half of the schools in this

study did not have a formal prevention/intervention program (Kush & Malley, 1991). Secondly, 41% indicated they had no training in assessing lethality with respect to suicide risk (Kush & Malley, 1991). And thirdly, and most important in relation to the research topic of this study, 51% of the respondents lacked confidence in their ability in school as a prevention agent of adolescent suicide, even though virtually all of these respondents reported they had received suicide prevention/intervention training (Kush & Malley, 1991).

Finally, Siehl and Moomaw (1991) conducted a study of over 200 school counselors, randomly selected, who work at the elementary, junior high, and high school levels with respect to their "attitudes, knowledge, comfort, and referral levels" in working with adolescents who are contemplating suicide (Siehl & Moomaw, 1991). There were several key findings of their study. Virtually all of them were more comfortable in assessing suicide risk if a team approach was used, and similar numbers of them were comfortable in referring suicidal students to other professional and outside agencies (Siehl & Moomaw, 1991). Two-thirds responded that their skills were not strong

enough to help a suicidal student, and a similar number of them felt it was preferable to refer such students to other professionals or outside agencies at the mere mention of suicide (Siehl & Moomaw, 1991). They concluded that school counselors refer out suicidal adolescent students at a very high rate, given their discomfort in working with this population, despite the fact that the level of their knowledge, training, and experience is high (Siehl & Moomaw, 1991).

Summary

Suicide is a problem that is increasingly confronting the youth in our country. The rate of suicide has tripled among this population over the past half century, and the age at which it is being committed is getting younger and younger. The topic of suicide has tended to be taboo. This is gradually changing. There have been increasing efforts in intervention and prevention, as well as research on suicide. This study was conducted, at least in part, to further these efforts.

The public schools are increasingly being asked to provide more services to their student populations. There are several reasons for this. Today's youth are facing more

and more problems, such as substance abuse, child abuse, teen pregnancy, divorced parents, depression, and other stressors. Other institutions in our society, such as the family and the church, which have helped to address the problems of youth and other societal problems, no longer do so as effectively as they have in the past. Therefore, public schools are being asked to pick up the slack, so to speak, left by the decline in the effectiveness of these institutions in dealing with the problems of youth.

Counseling services, including crisis counseling of suicidal students, has become a greater part of a school counselor's duties, as a result. The research reviewed in this study has found that school counselors are often uncomfortable with, and lack confidence in, their abilities to perform what might be a life saving role, even in some cases in which they have been trained to do this. More encouraging are other results obtained from some of these studies that, with increased training and experience working with suicidal students, as well as collegial support in this endeavor, school counselors can become more confident and comfortable with this role.

There have been only a few studies on school counselors' attitudes and feelings towards working with suicidal students. They have tended to be survey questionnaire in nature. This type of study, in this researcher's estimation, is good at providing salient factors in need of further, in-depth analysis. So in one way they are useful by pointing out areas in need of further research. However, in another way they are deficient because they are too superficial. That was the intent of this research study - to flesh out and examine in greater detail how school counselors view this critical role they are being increasingly asked to perform.

The general literature on suicide intervention suggests that technical counseling competence, and relationship building skills, and resultant higher levels of confidence, are critical in dealing effectively with suicidal individuals.

The focus in this study was on school psychologists and school social workers and their counseling of suicidal students. This represents a key difference with most of the studies which were reviewed here about counselor attitudes in that most of the counselors surveyed appeared to be

guidance counselors, although this was not always clear in reading these studies. This study focused on these two professional groups, because it was thought they are the most highly trained mental health professionals in the school setting. In those borderline cases that could go either way in terms of the suicidal student choosing life or death, school counselor skills, it is the contention here, are just as important as student variables in determining whether or not there will be a successful outcome to the suicide intervention. This researcher thinks in the most serious cases school psychologists and social workers are typically most knowledgeable and competent in linking up the suicidal student and his family with outside counseling services. This area was examined in this study, as well.

Chapter 3

Design of the Study

Sample

The participants in this study were fifteen school psychologists and school social workers. Most of the participants work in the public school setting. Of the fifteen people interviewed, fourteen work or have worked* in the public school setting. One of the participants works at a private school. Ten school psychologists and five social workers were interviewed. All of these school professionals work or have worked in schools in New Jersey. All of these schools were in the southern New Jersey area. Fourteen of the respondents work or worked in school systems in Gloucester County. One works in Camden county and one works in Burlington county. The respondent from Burlington county, it should be noted, worked for fourteen years in Gloucester county before moving to a new position in Burlington county two years ago. The average level of experience of the sample was 17 years with a range of 3½ years to 33 years in the school setting.

*One of the respondents retired in November 2001.

Nine of the participants were male, and six were female. Of the ten school psychologists, seven were male and three were female. And of the five school social workers interviewed, three were female and two were male. The educational level of the participants ranged from the bachelor's to the doctoral level. The educational breakdown of the participants was as follows: one at the bachelor's level, four at the master's level, five at the **master's +30 credit level, two at the ***Ed.S. level, and three at the doctoral level. In further breaking down the sample in terms of educational level, four of the five school social workers interviewed had master's degrees and one had a bachelor's degree. And of the ten school psychologists, five were certified, two had Ed.S. degrees, and three had doctorates.

This researcher nonrandomly selected this sample based on the facts that he either had worked with the respondents or knew them from participation in school psychologist

**This level of education is minimally required for certification in New Jersey to be able to function as a school psychologist. Certification is conferred by the state.

***Ed.S. is an Educational Specialist's degree in school psychology. It falls between the certification and doctoral levels. Like doctoral or master's degrees, it is conferred by the educational institution attended.

associations. They were selected not only because he had known them, but also respected their skills. In addition, each of the participants was also selected on the basis of having conducted at least five suicidal interventions over the course of their counseling careers in the schools.

Measures

The measurement device employed in this research study was a semi-structured interview. This instrument was constructed by this researcher. Data obtained was basically either demographic or attitudinal in nature. In other words, the respondents were asked a series of questions about their education and experience. They were then asked a series of questions about their attitudes toward suicide and suicide intervention. Several of the questions involved an expanded Likert scale format. On these questions, the respondents had to rate themselves from 1 to 10 with 1 being the lowest level of functioning and 10 the highest. The semi-structured nature of the interview format came into play in the 1) the respondents were asked a series of standard questions, and 2) depending upon their responses to these questions, further probing by this researcher in the form of follow-up questions followed. And at the end of the

interview, the participants were asked to respond to certain terms or questions in projective fashion with the first thought that came to their mind.

Design

The research design employed in this master's thesis was descriptive in nature. In order words, commonalities and themes in the participants' responses were pinpointed. This entailed the depiction of the respondents' answers in percentage terms and verbal descriptions of some of their responses. The latter are utilized in this thesis to flesh out some of the common themes that emerge.

Research Questions

The research questions in this thesis centered around counselor characteristics, and how they impacted suicide intervention in the schools. More specifically, it was proposed that 1) counselors who viewed suicide intervention as one of their primary roles, and 2) were more comfortable in doing suicide interventions would perceive themselves as being more effective in conducting suicide interventions than those counselors who did not. And there was presumed to be a positive relationship between these two variables. Respondents were asked to rank order the various roles they

performed in their jobs as school psychologists and social workers from most important to least important as they perceived them. They were questioned about their comfort level in doing suicide intervention on a scale of 1 to 10 with 1 being least comfortable and 10 being most comfortable. They were then asked how they perceived their performance in conducting these interventions on a scale of 1 to 10 with 1 being least competent and 10 being most competent.

Analysis

The research questions were tested in this study in the following manner. First of all, only those respondents who rated suicide intervention as either the most important or second most important role they performed in their job were viewed as conceiving of suicide intervention as one of their primary role responsibilities. This dividing line between primary and secondary role responsibilities was arbitrarily selected by this researcher. However, it was not without basis, in that for most people who have multiple task jobs, such as school psychologists and social workers, who typically have five or six responsibilities, role responsibilities assessed as being below the first two are

seldom viewed as being primary in this researcher's opinion. Secondly, the comfort level and performance level questions, administered using an expanded Likert scale, were rated as follows: only those responses of 7 or above were viewed as indicating high comfort level and high performance level. This dividing line was also somewhat arbitrary, but not without basis, as well. And that basis was 70% is often viewed as a passing grade in schools. Consequently, it was viewed as a "passing" grade, so to speak, on these two questions. Some might argue that 70% is a bit low to designate something as existing at a high comfort or performance level. It could be argued 80% or higher could legitimately be claimed as a more appropriate dividing line between high and low performance. This is a point well taken. However, since any dividing line is arbitrary, and since it could also be argued by some that performance on a variable in the 70% to 80% range being designated as low is questionable, 70% seems a fair enough percentage.

Summary

This study attempted to find out whether or not school counselors (school psychologists and social workers) who viewed suicide intervention as one of their primary role

responsibilities, and who were more comfortable in doing this, perceived themselves as being more effective in conducting suicide interventions than counselors who did not. This study employed semi-structured interviews. It was qualitative and descriptive in nature, although some quantification in the form of rank ordering of role responsibilities and expanded Likert scale ratings on several questions allowed for specification and categorization of the key research questions. And this enabled the results to be portrayed in percentage terms, which facilitated discussion of whether or not the research questions were supported.

Chapter 4

Analysis of Results

General Findings

It was originally proposed that school counselors who perceived suicide intervention as one of their primary roles would perceive themselves as being more successful in conducting these interventions than counselors who did not. Nine of the fifteen school psychologists and school social workers who were interviewed, based on the results obtained in this study, supported this hypothesis. Another proposition was that school counselors, who were more comfortable in doing suicide interventions, would perceive themselves as being more successful in conducting such interventions than counselors who were not as comfortable in these situations. Nine of the fifteen school counselors interviewed, based on this study, supported this hypothesis. And finally, there was proposed to be a positive relationship between these two factors. In other words, school counselors who viewed suicide intervention as one of their primary roles were more likely to be more comfortable in doing this and were hypothesized as perceiving themselves as being more successful in these situations than counselors

who did not support both of these views. Eight of the fifteen school counselors interviewed, given the findings, supported this proposition.

This discussion of the results obtained in this study represents an analysis at the most general level. In order to more accurately assess whether or not the research questions were supported in this study, an analysis of the results in a comparative context is necessary. For example, how did the perceived performance of those school counselors who ranked suicide intervention as one of their primary responsibilities compare with those counselors who did not. Ten of the counselors rank ordered suicide intervention as one of their primary responsibilities, as defined in this thesis. And of these ten counselors, nine of them perceived their performance as being high, as defined in this study, in these situations. Whereas, for those five school counselors who rank ordered suicide intervention not as a primary responsibility, their perceived performance level was low in three of five cases. Another way of stating this is 90% of those who rank ordered suicide intervention as a primary role responsibility saw themselves as being more successful at doing this. And only 40% of those who rank

ordered suicide intervention as a secondary role perceived themselves as being successful.

Now turning to comfort level, nine of the school counselors were more comfortable, as defined in this study, in conducting suicide interventions. Six of the counselors were less comfortable in doing this. Of those nine who were more comfortable in doing this, all nine, or 100%, perceived their performance in these situations to be at a high level. And of those six counselors who were less comfortable in these situations, only two of six, or 33%, perceived their performance to be at a high level in conducting suicide interventions.

In looking at the relationship of these two factors, rank order and comfort level, there was proposed to be a positive relationship between these two variables and perceived performance. In other words, if one of them was high, such as rank order, then the other factor, comfort level, should have been high as well. And perceived performance should be high, too. This was the case for eight of the fifteen school counselors in this study. This represented 53% of the counselors who were interviewed. Although not stated in negative terms in the introduction to

this thesis, a positive relationship between the two factors would also occur if rank order and comfort level were perceived to be lower in conjunction with a lower perceived performance level. Three of the fifteen counselors interviewed, or 20% of them, fit into this category. So eleven of the fifteen respondents showed a positive relationship between the variables in question. Eight of the participants' results in this study were in the proposed direction that was specifically hypothesized. Three of the participants' results were in the opposite direction, showing low comfort level, rank order, and perceived performance. This proposition was not specifically stated in the introduction, as noted. However, it too conversely supports the research question. As a result, 73% of the participants in this study support, in one way or another, the research questions posed in the introduction. Four of the fifteen respondents, or 27% of them, did not support the research questions in one way or another. These four school counselors had varying reasons for not supporting the research questions. One of them had a lower comfort level, but rank ordered suicide intervention as a primary role to go with lower perceived performance. Another counselor had

lower comfort level to go with a lower rank order of suicide intervention as a role responsibility in conjunction with higher perceived performance. One of the school counselors had a lower comfort level, but rank ordered suicide intervention as a primary role responsibility to go along with a higher perceived performance level. And finally, one of the counselors in this group had a higher comfort level with a view of suicide intervention as not being a primary role responsibility in conjunction with a higher perceived performance level.

Still at a general level of analysis, the school counselors were asked to rate the outcomes, also on a scale of 1 to 10, of the suicide interventions they participated in. The intent of this question was to gain some measure of the effectiveness of the suicide interventions these counselors were involved in without totally focusing on their performance in them. This researcher thought this was justified, because there were other key participants, counselors, in most of the suicide interventions conducted by the school counselors interviewed. These participants included other counselors in the schools, such as other child study team members and guidance counselors. And for

some respondents, they mentioned involvement of the school nurse. In many cases, these school counselors referred suicidal students to crisis centers. The vast majority (13 of 15) of the participants in this study preferred a team over an individual approach to suicide intervention. And a large majority (12 of 15) of them used a team approach almost exclusively or a majority of the time. There was presumed to be a positive relationship between the perceived performance and outcome variables. For ten of the fifteen counselors they co-varied in a positive direction. In other words, if perceived performance was seen as being higher, so was the outcome for them. Two of the respondents consistently rated their perceived performance and the outcomes at lower levels, while three of the participants had mixed results. Two of these three counselors rated their perceived performance lower, while the outcome was rated higher. And one of the participants in the study rated his perceived performance higher and the outcome lower.

One would think that those school counselors who had ranked suicide intervention as a primary role responsibility and were more comfortable in doing this, would be most

likely of the three groups discussed above to consistently rate their perceived performance and the outcomes of the interventions higher. This was, in fact, what occurred. Seven out of eight of the counselors, or 88%, of them in this grouping did so. On the other hand, one would think that those counselors who did not rank order suicide intervention as a primary role and had a lower comfort level with it, would be least likely of the three groups to consistently rate higher their perceived performance and the outcomes of the interventions they participated in. This, too, was true, as only one out of four, or 25%, of these counselors consistently rated these two factors higher. And finally, for the group of counselors who had mixed results, in terms their ratings of comfort level and rank order of suicide intervention as a primary role (one is higher and the other one is lower), one would suppose they would fall between the two other groups in terms of the consistency of their ratings of perceived performance and outcome. Two out of three of these counselors, or 67%, consistently ranked their perceived performance and outcomes of the interventions they conducted as higher.

A table with the results of this study is presented below. The respondents' initials are presented on the horizontal axis with initials to preserve anonymity, as they were told would be done. On the vertical axis are listed O for outcome, PP for perceived performance, and CL for comfort level. These numbers are the ratings each participant gave in these categories on the extended Likert scale (ranging from 1 to 10). The last category, RO, is for rank order.

	NF	DM	MP	RH	AL	BZ	JD	KK	JF	JB	NS	DG	TM	CT	KM
O	8	8	10	7	8	5	7	8.5	6	7	8.5	8	6.5	8.5	8
PP	6	9	8.5	6	10	7	7.5	8	5	8	10	7	6.5	8	8
CL	4	8	7.5	6	5	7	7	7	5	8	10	5	6.5	9	9
RO	3 rd	1 st	1 st	1 st	2 nd	1 st	2 nd	1 st	5 th	1 st	2 nd	3 rd	4 th	3 rd	1 st

General Findings - Perceived Counselor

Impact in Most Serious Cases

One of the key areas this study examined was what impact school counselors thought they had upon the most serious suicide interventions they were involved in. Most of the school counselors interviewed thought they had made a

significant, positive contribution in the most serious suicide interventions they were involved in. Eleven of the fifteen counselors, or 73% of them, were unambiguous in their belief they had played a positive role in these situations, although one of these counselors was disappointed with the performance of "outside agencies" in one of these situations. He thought that the crisis center, to which one particular student was sent, did not see the level of severity he did in this case. One counselor was both positive and negative in assessing her contribution in these most serious interventions. On the one hand, she said she did not have "much experience" in working in this type of situation, as she had few of these interventions at the elementary level. On the other hand, she implied she was feeling better about her skills in this area due to doctoral "course work" she was taking that relates to the topic.

Two of the participants in the study were either ambivalent and/or did not directly address how they felt about their perceived performance in these most difficult cases. One of the counselors expressed the thought she did "so-so" in these situations, due to the limited resources in the school district and the community in which she works.

And another counselor did not really address his level of performance in these situations. Rather, he focused upon the frustration he feels in these situations. He said that it was not "a sense of doing good or bad" in these cases, but recognizing "things aren't going to change" due to factors beyond his control. These factors included the families of the students in question and the lack of coordination and services of outside agencies. One of the counselor's answer to this question was negative in an indirect sort of way about her contribution in these most serious cases. She felt that these students had been assessed "pretty accurately" for risk level. However, she went on to say that, in the more serious cases, it was the "master level social workers (who) took over." She was the one participant in this study whose highest degree was at the bachelor's level.

Interestingly, two of the school counselors who had rated their perceived performance level as lower in most of the suicide interventions they had been involved in, felt better about their performance in the most serious interventions. One of them indicated he felt "better" in one case that was very serious, because the "nurse was

involved," and the student was sent to "Underwood Crisis Center." One other counselor also mentioned he felt "confident, especially with other people involved" in these critical cases. And the other counselor who rated her performance higher in these serious cases, compared to the less serious cases, said that she thought her input was "extremely important" in these cases. She did not give a reason for the difference in her estimate of her levels of performance in these two situations, although the implication was that she really geared up, so to speak, to rise to the challenge in the most difficult, serious cases.

Finally, with respect to these most serious cases, one counselor suggested they were easier to deal with than less serious cases. His words were they were "lockstep, no brainers," because in these cases there were certain procedures you had to follow, such as referral to the Crisis Center. Another counselor also expressed confidence in herself in these situations, because of referring these suicidal students to a crisis center. As a matter of fact, this counselor expressed a lot of confidence in herself in all suicide interventions. She said she referred all students to the crisis center at the mere mention of the

word suicide, because she did not feel it was her job to make a determination of whether or not a student was truly suicidal. Also, she indicated she used a particular "format" in the form of a letter in which all people, who needed to know, were informed of the actions she had taken in a suicide intervention. This often included parents, teachers, administrators, and guidance counselors. She said this had had the effect of cutting down somewhat, she thought, on the number of suicide interventions she conducted, if the students in question were not really serious about it. She also thought these students may have had second thoughts in the future about expressing suicidal intent, because they, and their parent(s), may have been put off about having to go to the crisis center.

More Specific Findings Related to Experience,

Education, Profession, and Gender

Experience, for the purposes of this study, was viewed in two ways. It involved years of service in doing the job of school psychologist or school social worker. And it also entailed experience in working with suicidal students. Years of service is examined first in relation to the research questions. The average level of experience the

school psychologists and social workers in this study had working in the school setting was 17 years. The range of experience was 3½ years by one social worker to 33 years by a school psychologist. The average level of experience of those counselors who were more comfortable in doing suicide interventions was 17.4 years with a range of 3½ to 33 years. For the school counselors who were less comfortable in these situations, their average years of experience were 16.3 with a range of 7 to 27 years. Those counselors who felt more comfortable in doing suicide interventions with students had an average comfort level and perceived performance level of 8.3 and 8.2, respectively, on the extended Likert scale. For those less comfortable, these numbers were 5.3 and 6.8, respectively. The average perceived performance rating numbers of 8.2 and 6.8, as well as the average comfort level numbers, will obviously remain the same for all the other categories (i.e., education, gender) discussed in terms of those more comfortable and those less comfortable, respectively, in doing this.

With respect to rank ordering of suicide intervention as a role responsibility, those counselors who ranked it high had average service in their counseling job in the

schools of 17.5 years with a range of 3½ to 33 years. And for those counselors who did not rank order it as a primary role responsibility, they had 16 years of experience with a range of 7 to 27 years. These numbers are very similar to those noted in the comfort level groupings, because there is a lot of overlap between the two groups. Counselors who rank order suicide intervention as a primary role responsibility have an average perceived performance level of 8.2, while those who rank order it lower have an average perceived performance level of 6.5. These numbers, too, will hold, as noted, for comfort levels in discussing future categories. The respondents can also be broken down into two groups with respect to experience: those at or above the average level of experience (17 years) and those below this. In terms of perceived performance, those in the greater experience group perceived their performance highly in six of eight cases (75%), and those in the lesser experience group did this in five of seven cases (71%).

Now the analysis turns to an examination of experience in terms of numbers of suicide interventions conducted by the school counselors in this study. This was examined in terms of the estimated number of interventions each

counselor had in the past year and for their career in the school setting. Both of these numbers were obviously estimates, particularly the number of suicide interventions the respondents gave as a career number. Those counselors who were more comfortable in doing suicide interventions had conducted an average of 44.4 interventions in their school careers. However, one counselor in this group far exceeded the number of interventions in a career of any other counselor. She had conducted 200 suicide interventions in her estimation over the years. This was more than triple the next highest number in her group and double the highest number of the counselor, who conducted the most interventions, in the less comfortable grouping. If her total is eliminated in figuring the average number of interventions in a career for the more comfortable group, the average goes down to 26.3, with a range of 7 to 60. For those counselors who were less comfortable in these situations, the average number of suicide interventions they had been involved in over the years was 32.5, with a range of 10 to 30. And looking at interventions over the past year, the average number for the more comfortable group was 4.9. However, once again there is the counselor who

conducted many more suicide interventions (20) over the past year or, in her case, the last year she worked, since she is retired. She conducted more than three times as many interventions in her last year than any other counselor had done in the past year. If her last yearly total is not considered in figuring this group's average, the average of the group falls to 3 with a range of 0 to 6. For the grouping of counselors who were less comfortable with their role in suicide intervention, the average number of suicidal students they had counseled in the past year was 2.7, with a range of 1 to 5.

With respect to rank order of suicide intervention as a role responsibility and career number of suicide interventions, the numbers are comparable to the previous groupings. Once again, this is to be expected, due to the fact there is much overlap in the composition of these groups. The grouping which rank ordered suicide intervention highly saw 50 suicidal students on average in their career. Without considering the one school counselor's numbers in the average, given their preponderance over any other counselor's numbers, the average is reduced to 33.3, with a range of 7 to 60. For

the grouping of counselors who did not view suicide counseling as one of their primary responsibilities, the average number of students they had seen in their years in the school setting was 21, with a range of 10 to 30. And over the past year, the group which rank ordered suicide intervention highly, the average number of students seen was 4.5. However, once again eliminating the most prolific counselor from consideration, the average declines to 2.8, with a range of 0 to 6. And for the group that rank ordered suicide intervention lower, the average number of suicide students seen over the past year was 3, with a range of 1 to 5.

Four groups of counselors can also be created in looking at experience in conducting suicide interventions. Two groups involve those counselors who have conducted an average number or above (among the participants in this study) of suicide interventions in a career and those below this number. And another two groupings entail those counselors who have conducted an average number or above (among the participants in this study) of suicidal interventions in the past year and those below the average. The average number of interventions conducted by the

counselors in a career in this study was 40.3. Four school counselors saw more than this number of suicidal students in their careers. And all four of these counselors (100%) viewed themselves as being more successful in conducting these interventions. Eleven counselors had seen less than this number of suicidal students in a career. Of these eleven, seven (64%) perceived their performance to be more successful in these situations. The average number of suicidal students counseled by the participants in this study in the past year was four students. Seven counselors had seen this many or more suicidal students in the past year. Six of seven of them (83%) perceived their performance to be more successful in counseling them. Eight counselors had seen three suicidal students or less in the past year. Five of eight of them (63%) perceived themselves as being more successful in performing these interventions.

An analysis of the results was also done by looking at educational level with respect to the groupings of the counselors on the rank order and comfort level variables. It was thought to be particularly appropriate to look at this variable in this study because it could relate to training in suicide intervention skills. However, as it

turned out, most of the participants did not have course work on this topic, but virtually all of them attended workshops and/or did outside reading on suicide. It should be noted the educational levels of the participants in this study are estimates of their years of schooling, based on the highest degrees they had received. The average educational level of all of the participants in this study was 18.4 years. Those who ranked suicide intervention as a primary role responsibility had 18.6 years of education on average. Those who did not rank it as highly had 18.1 years of schooling on average. While those counselors who were more comfortable in conducting suicide interventions had an average 18.3 years of schooling. And those counselors who were less comfortable in these situations had 18.6 years of education on average. In looking at the perceived performance of those eight counselors who had more than the average number of years of education in this study, only four of them (50%) perceived their performance as being high. While those counselors who had less than the average number of years of education perceived their performance to be high in 7 of 7 cases (100%).

The results of this study are analyzed now by looking at the professions of the participants, school psychologist and school social worker, to see whether or not there was any difference in their perceptions. Seven of the ten, or 70%, of the school psychologists ranked suicide intervention as one of the most important things they did in their job. Three of the five, or 60%, of the school social workers in this study ranked suicide intervention highly in terms of role responsibilities, while three of ten, or 30% of the school psychologists ranked suicide intervention as not one of their primary roles. And two of five, or 40%, of school social workers ranked suicide intervention lower with respect to role responsibilities. Regarding comfort level, five of ten (50%) of the school psychologists indicated they were more comfortable in doing suicide counseling. Four of five (80%) of the school social workers interviewed in this study viewed themselves as being more comfortable in conducting suicide interventions. Five of ten (50%) of the psychologists were less comfortable in doing this, while only one of five (20%) of the social workers fell into this category. With respect to perceived performance, only six of ten (60%) of the school psychologists viewed this as

high, whereas, all five (100%) of the school social workers saw themselves as being more successful in these situations.

Now turning to gender in analyzing the results, male counselors expressed more comfort and less discomfort than female counselors in working with suicidal students. Seven of the nine (78%) male counselors rated themselves as being more comfortable in conducting suicide interventions. Two of the six (33%) female counselors rated themselves as being comfortable in doing this. On the other hand, only two of the nine (22%) of the male counselors were uncomfortable in working with suicidal students, while four of six (67%) female counselors were in this category. The percentages were similar with respect to gender breakdown, when it came to the proportions of male and female counselors who ranked suicide intervention as a primary or not as a primary role. Eight of nine (89%) of the male counselors viewed it as one of their primary responsibilities. Only two of six (33%) female counselors saw suicide intervention in this way. Only one of nine (11%) male counselors did not view it as a primary role, while four of six (67%) female counselors viewed suicidal counseling as one of their lesser role responsibilities. In terms of perceived performance,

only three of six (50%) of the women rated themselves highly, whereas, eight of the nine (89%) of the men did.

Specific Findings Relating to Counselors' Personal
Experiences and Projective Responses

One of the theoretical underpinnings of this research study was proposed to be Freudian defense mechanisms. More specifically, it was suggested that repression and suppression might be employed by crisis counselors to protect their self-concepts from uncomfortable, anxiety producing information. With repression, this process operates at an unconscious level. And with suppression, it is on a conscious level. This anxiety producing information was thought to be related to personal experiences of the crisis counselors, which would make them uncomfortable in dealing with suicidal students. It was also suggested this would adversely affect their performance in dealing with suicidal students.

Six of the counselors were less comfortable (using the cutoff point of a 7.0 scaled score) in counseling suicidal students. Nine counselors were more comfortable in doing this. Five of the six counselors who were less comfortable in doing this mentioned personal experiences or deficiencies

suggestive of why they did not like to work with this population. Two of them mentioned previous experiences they had with people who had committed suicide. One was a counselor 25 years ago at a mental health center at which one of her clients killed themselves. And the other counselor dated a girl briefly who tried to kill herself. He said he saved her life. He went on to say he "cannot relate to somebody who wants to take their life." Another counselor who was previously employed in a school system as a crisis counselor indicated he "dreaded" his last six weeks on this job for fear a student might kill themselves. Two other counselors in this group made critical remarks about their suicide counseling skills, one based on the fact she did not have a master's degree and the other relating to her not having used suicidal surveys with these students in the past. Also, two of these six counselors admitted to being either "very self-critical" or "not a very confident person." Also, five of these six counselors answered the projective questions with at least one response, which could be interpreted as suggesting that suicide intervention might have been something they would have liked to avoid. Examples were "dread," "scary," and "yuk, no." The overall

perceived performance level of these six counselors was 6.8. Only two of the six counselors in this group had a perceived performance above 7.0.

In the group of counselors who were more comfortable in doing suicide interventions in the schools, not one of them had a perceived performance level below 7.0. Their average perceived performance score was 8.2, significantly higher than the other groups' score. Only two of these nine counselors mentioned negative personal experiences relating to suicide. One of them said he got out of private practice because he did not want to work with suicidal clients. And another counselor said that two of the students he had seen when he was a counselor at a vocational school years ago later killed themselves following graduation. He also mentioned his best friend's brother, whom he did not know, killed himself. None of these nine counselors made self-deprecatory remarks about their skills. Only two of the nine made comments in their projective responses that might have been suggestive of a desire to avoid the topics of suicide/ suicide intervention with students. One described suicide as "scary," and the other counselor described suicide ideation in similar terms as being a "little scary."

Five of the seven remaining counselors in this group described suicide/suicide intervention in more clinical, academic terms.

Summary

Some of the key findings in this study are summarized below in bulleted format. The findings are presented starting with more general results and then moves on to various categories (i.e., experience, education, gender) in looking at them.

- 9 of 10 (90%) counselors who ranked suicide intervention as a primary role responsibility perceived their performance to be high, whereas, those counselors who saw it as a secondary role perceived their performance to be high in only 2 of five cases (40%),
- 9 of 9 (100%) counselors who were comfortable in counseling suicidal students, perceived their performance to be high in these situations, whereas, for those counselors who were less comfortable in these situations, only 2 of 6 (33%) perceived their performance to be high,
- 8 of 15 (53%) counselors ranked suicide intervention both as a primary responsibility and were more

comfortable in doing it in conjunction with high perceived performance, whereas, 3 of 15 (20%) counselors rated themselves lower on all of these measures - combining both of these totals, resulting in 73% of the respondents, provides both direct and indirect support for a key research question in this study,

- 5 of 6 (83%) counselors who were less comfortable in doing suicide intervention cited personal experiences and had projective responses suggesting they wanted to avoid the topic of suicide, whereas only 2 of 9 (22%) counselors who were more comfortable in these situations had these types of responses,
- 11 of 15 (73%) counselors thought they had a significant impact on the outcome of the most serious suicide interventions they were involved in,
- more years of experience on the job was only slightly to somewhat positively related to the measures in this study: rank order of suicide intervention, comfort level, and perceived performance,
- there was some positive relationship between the greater number of suicidal students a school counselor

had seen in his/her career and over the past year with the key measures in this study compared to school counselors who had seen lesser numbers of these students,

- there were mixed results with respect to years of education and the key measures in this study; those counselors with more than the average education of the sample (18.4 years) were more likely to view suicide intervention as a primary role responsibility than those below the average; however, the reverse was true for comfort level and perceived performance, in other words, those with less education felt more comfortable and perceived their performance to be higher than those with more education.
- profession of the participants in this study, school psychologist and school social worker, resulted in significant differences on two of the three key measures; social workers were much more likely to feel comfortable and more successful in conducting suicide interventions than school psychologists; there was little difference in how they rank ordered suicide intervention.

- there were significant gender differences on all three measures with male counselors scoring higher than female counselors on all three.

Chapter 5

Summary and Conclusions

The focus of this study has been on school counselors' attitudes and how they affect their performance in conducting suicide interventions in the school setting. It was proposed that those counselors who ranked suicide intervention as one of their primary role responsibilities and/or felt more comfortable in doing this were more likely to have perceived their performance to be more successful in counseling suicidal students than those counselors who did not feel this way. The results of this study clearly confirmed these propositions. It was assumed that school counselors' comfort levels in conducting suicide interventions with students would be adversely affected by negative past personal experiences cited by the respondents. There was definite evidence of this. And it was also presumed at the outset of this investigation that school counselor characteristics and attitudes would be critically important in the most serious interventions involving suicidal students. The results of this thesis also confirmed this.

A major premise of this study was that school counselor variables could be just as important as student variables in certain situations involving suicidal students, particularly in those cases in which the students were most at risk for hurting themselves. School counselors, thought to be most adept in providing competent counseling to suicidal students, were school psychologists and school social workers. This was by virtue of their more extensive training in childhood/adolescent development and social/emotional problems than any other professionals in the school setting in this researcher's opinion. It was also thought that they would be the most competent school professionals with respect to knowledge of outside referral sources in serious cases in linking up students in need of further counseling due to underlying emotional problems with mental health professionals. Fifteen school psychologists and school social workers, known and respected by this researcher, who had conducted at least five suicide interventions in their school careers, were interviewed. There were ten school psychologists and five school social workers in this study. Nine of the respondents were male and six female. The range of experience of these counselors

in the school setting was from 3½ to 33 years, with the average years of experience being 17 years. The average number of suicide interventions these counselors had done in the school setting in their careers was just over 40 with a range of 7 to 200. And the average number of suicide interventions they had done in the past year was 4, with a range of 0 to 20. The average level of education of the participants in this study was almost 18½ years of schooling with a range from 16⅔ years to 20 years.

There were no independent measures of the key variables in this study. Rank ordering of suicide intervention as a role responsibility, and estimating the comfort level, and performance level in doing this, were also based on the participants' perceptions. If the respondent ranked suicide intervention either first or second among their several roles, this was deemed to be a primary role responsibility. If the respondent rated their comfort level and perceived performance 7 or higher on an extended Likert scale of 1 to 10, they were considered as seeing themselves as more comfortable and more successful in doing this, respectively, than those who rated themselves lower than 7.

Most of the studies this researcher reviewed on suicide examined the topic from the suicidal individual's point of view. These results were typically obtained by interviews or surveys. More often than not, the populations, which were the focus of the studies, were not students. There has been very little research done on counselor attitudes, let alone school counselor attitudes, in relation to the topics of suicide/suicide intervention. This study represented an attempt to develop some information in this important area, specifically as it related to the school setting. On a personal note, this researcher had an interest in this area because he is a crisis counselor in a public school system.

Conclusions

Some of the more important findings are listed below:

1. School counselors who ranked suicide intervention as one of their primary roles were almost twice as likely to view their performance in these interventions as being more successful than counselors who did not view it as one of their primary roles.
2. School counselors who were more comfortable in counseling suicidal students were three times as likely to perceive their performance as being more successful.

in these situations than counselors who were not as comfortable in doing this.

3. A little more than half of the school counselors in this study perceived suicide intervention as a primary role, were comfortable in doing this, and saw their performance in successful terms. One-fifth of the respondents, on the other hand, consistently rated all three of these variables lower. As a result, almost 3/4 of the participants in this study demonstrated a relationship (covarying in the same direction-either positive or negative) of the variables examined.
4. Respondents who were uncomfortable in doing suicide counseling in the schools were almost four times as likely to mention negative personal experiences or give negative, avoidant projective responses than respondents who were more comfortable in working with suicidal students.
5. Almost 3/4 of the school counselors interviewed thought they made a significant contribution to the outcome of those suicide interventions which were most serious in nature.

6. There was a modest positive relationship between greater years of experience as a school counselor and the greater number of suicidal students seen in the past year/career with respect to all three measures: rank order, comfort level, and perceived performance. It should be pointed out again the numbers of students seen, especially over a school career, are only estimations.
7. There were mixed results with regard to years of education and the three key variables in this study. More education resulted in greater prioritizing of suicide intervention as a primary role. Lesser education resulted in feeling more comfortable and perceiving oneself as being more successful in intervening with these students, although on two of these three measures, rank ordering and comfort level, the differences in the educational levels is less than a half year of schooling. However, on perceived performance, the difference is more significant with 1½ years of education separating the more educated and the less educated group. Keep in mind though these years

of education are only approximations, based upon highest degree attained.

8. School social workers were almost twice as likely as school psychologists to perceive themselves as being more successful in conducting suicide interventions. They were also almost 1½ times as likely to be more comfortable in conducting suicide interventions than school psychologists were. There were only modest differences between these two groups of professionals in terms of how they prioritized suicide intervention.
9. There were significant differences between male and female counselors on all three key measures in this study. Male counselors were almost three times as likely as female counselors to view suicide counseling of students as one of their primary roles. Males were over twice as likely to feel comfortable than females in this study in conducting suicide interventions. Males in this study of school counselor attitudes were almost twice as likely as females to perceive themselves as being more successful in counseling suicidal students. It should be noted that male counselors in this study averaged almost six more years

of experience than female counselors. However, as noted earlier, this difference may not be so meaningful, since there was only a modest relationship between greater years of experience and higher scores of the respondents on all three measures.

10. An outcome measure was also obtained in this study.

The reason for this measure was due to the fact that it was presumed at the outset most of the school counselors would work in a group context (with another school professional) in conducting suicide interventions. This was, in fact, the case for 80% of the counselors in most of these situations. Perceived performance was viewed, by this researcher, as teasing out, so to speak, more of the individual counselor's contribution in the intervention than the outcome measure, although it was also presumed there would be a positive relationship between these two variables. Sixty-seven percent of the school counselors viewed themselves as being more successful on both of these measures. While 13% of the counselors viewed themselves as being less successful on these two measures. Combining these two measures to show

consistency of the findings in either direction results in 80% of the respondents answering consistently.

Discussion

One of the theories underpinning this study involved schema, more specifically self-schema. Schema, as noted, helps people to make order or sense of their experience. The self-schema is global, which is similar to the conception of general self-concept, and it has its component parts, for example, relating to the various roles a person performs. Regarding the latter, it has been suggested a person will focus on and work harder in those roles or aspects of a role which they value most. By logical extension, those who value a role or aspect of a role more highly are more likely to perceive their performance in that role or aspect of a role as being superior to those who value it less highly. The results of this study confirmed this with respect to school counselors, and how they viewed that aspect of their role as suicide counselors. Those counselors who valued this aspect of their role more highly were almost twice as likely to view their performance as being more successful than counselors who did not. At the global level of self-concept, there was even some support

for the relationship between a good self-concept and job performance (in this study, suicide intervention skills). Three counselors tended to be critical of themselves overall and their job performance. They represented three of the four school counselors who viewed their perceived performance as being less successful. This, although not a focus of this study, was not surprising, because general self-concept does relate to job performance, in general, as well as specific aspects of it. It should be noted all three of the counselors who made self-deprecatory remarks about themselves were female. No male counselors did this. More will be said about gender differences later.

Now turning to the other general theory underlying this research study, defense mechanisms, more specifically repression and suppression, it was suggested these mechanisms are used by crisis counselors to protect their self-concept or schema from anxiety producing situations. One of these situations for school crisis counselors obviously is suicide intervention. It was proposed this could adversely affect their performance in these situations. The evidence for the use of the defense mechanisms of repression and/or suppression by school

counselors in this study was only suggestive. Suggestive of this was that those counselors who were more uncomfortable in performing suicide interventions were four times more likely than those counselors who were more comfortable in doing this to mention negative personal experiences relating to suicide (including their intervention skills), as well as giving projective responses suggesting discomfort with the topic. This, combined with the fact that counselors who were more comfortable working with suicidal students perceived their performance to be three times more successful than those counselors who were less comfortable in doing this. Combining the results of the research questions in this manner provides, in this researcher's opinion, some support for this undergirding theory of defense mechanisms, and how it could negatively impact suicide intervention effectiveness by school counselors.

A review of several of the findings in this study provided firm support, some support, and no support, respectively, for some of the findings, discussed in the literature review, on school counselor attitudes toward suicide intervention. In the firm support category, almost all of the counselors in this study preferred to use a team

approach when conducting suicide interventions. The reasons most often cited for this were for support and having another professional's opinion in these most trying circumstances. Several counselors in the Gora et. al. (1992) study of school counselors' attitudes toward several aspects of their job, including suicidal intervention, also mentioned teamwork as being critical in difficult cases, such as those relating to counseling suicidal students. Agreement on this aspect of suicide intervention between the current study and the study cited was not surprising, since the difficult or trying nature of the intervention in these cases has been emphasized. Such circumstances have elicited in both studies the need for assistance, which is a common human response in extreme situations.

An Irish study of over 400 guidance counselors was also clearly supported in one respect in this current study. The Irish study found that male guidance counselors were almost three times as likely to have a high feeling of competence in conducting suicide interventions compared to female guidance counselors (Dissertation Abstract, 2002). In this current study, male counselors were over twice as likely as female counselors to have perceived themselves as being more

successful in counseling suicidal students. No definitive reason was put forth in the Irish study to account for this difference in perceived competency levels between the genders. Possible reasons for this difference could relate to education and experience. However, in the current study, there was minimal difference in the educational levels of the genders. There was an almost six year difference between males and females in experience on the job with males being more experienced. However, the overall results of the study indicated there was only a modest relationship between years of experience and perceived performance levels. The female counselors, with respect to experience in working with suicidal students, roughly average twice as many students seen in their career and over the past year as male counselors. Even by not considering the one female counselor's totals, who was prolific in her numbers of suicidal students seen, the totals of students seen by both genders were comparable over a career and were in favor of females in the past year. Female counselors have seen one and one-half times the number of suicidal students seen by male counselors in this time even after having manipulated the data in this way. However, what does separate the

genders in this study is that female counselors were twice as likely as male counselors to have mentioned negative personal experiences and projective responses relating to suicide/suicide intervention. Also, as noted earlier, three female counselors made self-deprecatory remarks about themselves and their skills, while male counselors did not do this at all. Two of three of these female counselors mentioned deficiencies in their training or education, when citing negative personal experiences. This suggests that the reason females had less self-efficacy in this study than males was because they tended to be more self-critical.

There was only some support with the results in this study with a couple of studies cited in the literature review relating to numbers of suicidal students seen and perceived self-efficacy. The current study found modest to moderate support for the proposition that the more suicidal students a counselor has seen, the more self-efficacious he or she feels. However, the Irish study of guidance counselors (Dissertation Abstract, 2002) found that counselors who had dealt with a suicidal student before were three times more confident in their abilities than those who had not. The King and Smith (2000) study of high school

counselors in Dallas found that those counselors who had assessed six or more suicidal students in their career perceived themselves as being significantly more effective than those counselors who did not. The reason for the difference in the level of support for experience, defined in these terms, relating to perceived competence level would appear to center around the number of students seen among the three studies. In this current study, all of the school counselors had seen at least seven suicidal students in their career. While the studies cited in the literature review involved lesser number of students seen, at least for some of the participants in the studies. Apparently a law of diminishing returns was reached beyond a certain number of students seen by a counselor in terms of the effect it had upon his or her perceived competence. Increases in numbers of suicidal students seen at very low numbers of such students assessed, would logically lend themselves to greater incremental increases in self-confidence in dealing with them than higher numbers, such as in this study. However, this tendency to have more confidence in one's skills, given the greater number of suicidal students a school counselor has seen, did not hold true for female, as

compared to male, counselors in this study. Evidently the gender variable had a greater impact on competence feelings than the experience factor. Sample size of this study and the manner in which it was selected most likely had something to do with these findings. More will be said about this later.

The results of three studies cited in the literature review were not supported by the results obtained in this study. And a fourth study had differences in findings, which were more apparent than real compared to this study. All of these studies involved, in some way, training as a key factor. Kush and Malley (1991), in a nationwide study of guidance counselors, found that just over half of the respondents lacked confidence in their ability to effectively deal with suicidal students, even though virtually all of them had indicated they had received training in this area. Another study done by Siehl and Moomaw (1991) of over 200 counselors, found that two-thirds responded that their skills were not strong enough to help a suicidal student. A similar proportion of them in this study thought that it was preferable to refer such students to other professionals or outside agencies at the mere

mention of suicide. They concluded that these counselors refer out suicidal adolescent students at a very high rate, because of their discomfort in working with these students, even though they had high levels of knowledge, training, and experience in doing this. Finally, King et. al. (1999), in a survey of almost 2,000 high school counselors, only one-third of them believed they could recognize a student who was at risk for suicide. None of these findings were, in any way, supported by the results of this study. In this study, almost three-fourths of the respondents indicated they perceived their performance to be high in dealing with suicidal students in general. This same proportion reported they felt they had a significant influence on the outcome of their most serious interventions. Only one of the fifteen respondents in this study referred students to an outside agency at the mere mention of suicide. She said she did this because she did not feel qualified to assess the level of risk of these students. No other counselor in this study mentioned they did this.

So what accounts for the startling differences in the perceived competence levels in the literature review cited studies and this study? Two key factors come to mind.

First, all of the counselors in this study were either school psychologists or school social workers with an average estimated educational level of almost 18½ years of schooling. One of the studies cited in the literature review noted the sample was composed of guidance counselors, and another study hinted their sample was composed of guidance counselors. The third study did not specify one way or another what the professional training of their sample was. Therefore, the difference in the perceived competence levels between the counselors in those studies and this one, it is suggested here, related to the different professional training between the two groups: predominantly guidance counselors in those studies and school psychologists and social workers in this one. As noted earlier, these school professionals were deliberately selected for this study because of their high levels of training in the areas of social/emotional development and problems of children and adolescents and how to deal with them. A second reason for the better perceived competence of the school counselors in this study compared to those cited, probably relates to the greater number of suicidal students seen by counselors in this study than those in the

cited studies. Although this was not directly stated in any of the studies, it was alluded to in all three.

Another study, consulted in the literature review (Neimeyer et. al. 2001), examined professional training more specifically. This study examined differences in perceived competence levels in conducting suicide interventions among nonprofessionals, paraprofessionals, and professionals. Nonprofessionals were defined as undergraduate psychology students, who were part of the survey in this study (Neimeyer et. al. 2001). Paraprofessionals were defined as being local suicide hotline volunteers, who had some training in crisis counseling (Neimeyer et. al., 2001). And professionals in this study were defined as graduate students in a clinical and counseling psychology program (Neimeyer et. al., 2001). The students, who were surveyed in this study, were from a southern university. And the hotline volunteers worked at a crisis hotline center in the town in which the university was located. The results of this study indicated that those counselors who had more education and/or training in dealing with suicidal individuals perceived themselves as being more competent in

choosing "appropriate therapeutic responses to suicidal individuals" (Neimeyer et. al., 2001).

Suicide intervention training was not examined in detail in this current study. The respondents were asked whether or not they had course work, done outside reading or attended workshops, on the topic. Most had done the last two. Few had course work on suicide/suicide intervention. However, the current study did look into, in more detail, the level of education and perceived competence in conducting suicide interventions. The findings obtained here did not support the results obtained in the Neimeyer et. al. (2001) study. Interestingly, as previously noted, those school counselors who had more education in this study perceived themselves as being less competent than those who had less education in performing suicide intervention with students. The difference in educational levels between the higher and lower groups was about one and one-half years of graduate schooling. On the surface, this finding does not make sense. It could be a quirk in the results related to the small sample size. The Neimeyer et. al. (2001) study had almost ten times the number of participants as this current study. However, there is another more logical

reason that may account for this difference. School social workers perceived themselves as being almost twice as likely as school psychologists in being successful in conducting suicide interventions in this current study. On average, they had one and one-half years less schooling than school psychologists in the study.

This researcher asked one of the school social workers, who he has worked with and who participated in this study, what he thought the reason for the difference in perceived competency levels of school psychologists and school social workers was. He said that he thought school social workers, and social workers in general, are trained more in crisis intervention, not just restricted to suicide intervention, during their years of schooling at the graduate level compared to school psychologists. And he believed this gives them a "better handle" on how to deal with all types of crisis situations, including suicide. Described as such, the greater number of years of education of counselors in this study did not result in greater perceived suicide intervention competence as it did for the participants in the Neimeyer et. al. (2001) study. However, one group, the hotline counselors , in the Neimeyer et. al. (2001) study

received specific crisis intervention training, and the graduate students in this study, it is probably reasonable to presume, received more instruction than the undergraduate students in crisis intervention. Looking at the results of the two studies in this way, there is more congruity between the findings in them, as it apparently is the type of training or education, which is critical here and not the total years of education. Although it should be noted in this current study all of the participants had conducted suicide interventions, while in the Neimeyer et. al. (2001) study only the hotline volunteers had done this. In this sense, this current study is more realistic and less theoretical than the Neimeyer et. al. (2001) study.

Implications for Future Research

The research questions have been confirmed in this study, relating to prioritizing of suicide intervention, high comfort level with it, and resultant high perceived level of competence of school counselors in working with this population. Other more specific findings have clearly been established, as well, in this study. For example, there were significant professional and gender differences in perceived competence level, as school social workers and

male counselors saw themselves as being much more competent in working with suicidal students than school psychologists and female counselors, respectively. However, the small number of school counselors interviewed, the nonrandom and unstratified nature of their selection, and the extreme geographic restriction of the sample prevents generalization of the results obtained. Obviously that was not the intent of this study. Rather, since there has been so little research done on school counselors' attitudes toward suicide intervention, this study was intended as an exploratory analysis of the question.

Also, future research on this topic should delineate in greater detail what exactly provides a school counselor with a sense of competence and feeling of comfort in working with suicidal students. These factors were examined at a very general level in this study in that the respondents were only asked to broadly assess their comfort levels and perceived performance in working with these students. Studies cited in the literature review, several of which were not restricted to a student population, made mention of two key competencies that are critical for effective suicide intervention (See Shea, 199; Berman and Jobes, 1991; Kirk,

1993; Hinson, 1982; Shneidman, 1985). They included technical competence involving skill in knowing suicide risk factors, step-by-step procedures to follow, and interviewing skills. The other key competency entailed creating a warm, caring environment so the person in crisis feels comfortable to share their deepest thoughts and feelings. It had also been suggested there was not necessarily a clear demarcation between these two skill areas, as suggested by the studies just previously noted. For example, interviewing skill surely overlaps and relates to creating a supportive environment. By looking at comfort level, one could assume, probably with some justification, that it would be much more difficult for a counselor to create a warm, caring environment if he or she was not comfortable in working with this population. Perceived performance could be specified with respect to certain competencies, as just noted. This would represent looking at perceived performance more in process terms. In more outcome terms, later student adjustment, follow-up, and knowledge of outside counselors could be examined. The concepts of perceived performance and comfort level were kept open ended in this study in that respondents were told they could define them in any way they

felt comfortable. A more rigorous analysis, specifying and defining these concepts, would allow for detailed findings as to what exactly might be helpful and productive in working with these students.

To be more objective, further research on this topic requires independent measures of the variables assessed, and not just the respondents' perceptions of where they rate themselves on them. This would be much more difficult to accomplish. One way this could be attempted is by asking by way of interviews or surveys how other professionals or students assess school counselors' competence levels. Anonymity would have to be assured to obtain the desired level of objectivity. Also, performance reviews of the counselor's performance might be able to tap certain areas of competence pinpointed in this study. This would be more objective, as would the surveys and interviews with others, because they are not self-serving, as self-reports are much more likely to be. In some cases they might even be more objective by being less critical, for example, for those counselors who are extremely self-critical.

Some comments about the underlying theoretical constructs of schemas, relating to self-concept and roles,

and defense mechanisms, such as repression and suppression are in order now. One-to-one interviewing, as this study was based upon, did not allow for deep probing questioning, such as personal experiences with suicide or suicide ideation. These types of questions were not asked, because they were thought to be inappropriately personal. Anonymous surveying allows for probing in this area. This researcher attempted to get at some of these "buried" feelings by asking if there were any personal reasons for the respondent's interest or disinterest in the topic(s) of suicide/suicide intervention. The respondents were free to answer in any manner. In most cases, there were no follow-up questions to their initial responses to this question, as their answers were usually to the point. They were asked, as well, to respond projectively to a few terms, the majority of which were associated with suicide. This did elicit, what appeared to be in some cases, deeper feelings about the topic(s) of suicide/suicide intervention. However, to truly probe more deeply, more rigorous projective testing, such as the Rorschach or human figure drawing, would appear to be necessary. Also, more objective personality measures, such as the California Personality

Inventory, would be able to elicit more information about respondents' personality dynamics. These are all alternative ways of exploring the personality, including self-concept and, in some cases, defense mechanisms of the respondents they are administered to. That is the good feature about them. The downside is considerable though. They can be very tedious and time consuming, as well as invasive of a person's privacy. The return on them may not be worth the cost.

Finally, with respect to role prioritizing, three of the participants in this study had primarily administrative responsibilities and counseling for them, such as suicide intervention, was only done on an as needed basis. Two of these counselors have had long careers, prior to their administrative roles, in which they had done much counseling. As a matter of fact, one of them was a crisis counselor for seven and one-half years. The point being made here is that if this study had been strictly limited to participants who functioned primarily in a nonadministrative counseling role, the results might have been "cleaner" in that they would be focused more on school "counselors," although analysis of their results does not indicate they

stood out from the results of the other respondents. Their results were similar to those of the other participants. It should also be noted four of the respondents were employed in out-of-district schools, primarily for acting out and disaffected, classified students. One of the respondents worked at a private school. This also might have tainted, so to speak, the results somewhat. However, in looking at their results, they, too, did not differ much at all from other respondents who were employed at in-district public schools. The one factor that might have affected the results more than the others cited here was the fact that three respondents worked primarily at the elementary level. The number of interventions tended to be lower there. Maybe as a result, two of these three counselors felt less comfortable and competent in working with this population.

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Appendix

Appendix

Suicide Intervention Interview

1. Male_____ Female_____
2. How many years of experience do you have in the school setting?
3. School Psychologist_____ School Social Worker
4. What is your highest degree attained?
5. How many suicide interventions have you conducted?_____
How many in the past year?_____
6. How were these interventions primarily conducted (individual or team approach)? Which method are you more comfortable with? Why?
7. Have you collaborated or consulted with colleagues who were not involved in the suicide interventions you conducted? How often did you do this? Why did you do this?
8. Have you attended in-service training, workshops, done outside reading or course work regarding suicide and/or suicide intervention? Specify.
9. What would you say is the average length of the suicide interventions you have conducted? The shortest? The longest? Did any extend beyond school hours in terms of your involvement? Specify.
10. How would you generally assess the outcomes of the suicide interventions you have conducted? (On a scale of 1 to 10, with 1 being least successful and 10 being most successful.) Explain.
11. How would you rate your overall performance in the suicide interventions you have been involved in? (On a scale of 1 to 10 with 1 being least competent and 10 being most competent.) Explain.

12. What are some other roles besides suicide intervention you perform in your job as a school psychologist or a school social worker? How would you rank order them in terms of importance or what you most value doing in your job? (From most important to least important.) Explain.
13. How comfortable are you in doing suicide interventions? (On a scale of 1 to 10 with 1 being least comfortable and 10 most comfortable.) Explain.
14. How would you assess your performance in the most serious cases you have handled?
15. Are there any reasons for your interest or disinterest in working in the area of suicide/suicide intervention? What do you like least about counseling suicidal students? And what do you like most?
16. Have any suicide interventions you have been involved in been so serious that you had to refer the student and his parents/guardians to mental health professionals outside of the school setting? How often have you done this? Do you have a list of outside professionals you can refer seriously suicidal students to? Please discuss further.
17. Please respond to the following terms or questions with the first thing that comes to your mind.
 - a. Suicide
 - b. School Psychologist (if the respondent is one)
School Social Worker (if the respondent is one)
 - c. Suicide intervention
 - d. Like most about your job?
Like least about your job?
 - e. Suicide ideation