Increasing suicide awareness through inservice training

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INCREASING SUICIDE AWARENESS
THROUGH INSERVICE TRAINING

MASTER'S THESIS

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Abstract

Although practitioners recognize the alarming increase in suicidal behavior among students, few have formal training in identifying symptoms often associated with suicidal ideation and behavior. Twenty-seven educators in a metropolitan school district in the Northeast attended an informative inservice training on suicide and, using a pretest-posttest design, completed a questionnaire specifically designed to measure knowledge of suicidal ideation and gestures, personal comfort level with students exhibiting suicidal behavior, and level of personal depressive symptoms. Results suggested that participants increased their knowledge of suicidal ideation and gestures following the inservice training. These changes may affect the ability of school personnel to function appropriately and feel comfortable in crisis situations with students displaying suicidal ideation and gestures.
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Literature Review

Suicide is the second leading cause of death among adolescents (Berman & Jobes, 1995), and the sixth among children (Guetzloe, 1991a). Although the leading cause of death for adolescents is accidents (Poland, 1989), some suicides may be misinterpreted as accidents (Malley, Kush, & Bogo, 1994). In some cases, coroners will not classify a death as suicide without the presence of a suicide note (Poland, 1988). Suicidal ideation and behavior for students under ten years of age are usually undetected or underreported (Guetzloe, 1991a). This may be due to some people's belief that “young children do not understand the finality of death” (Guetzloe, 1991b) or the lack of a specific criterion for determination of death by suicide (Poland, 1989). Despite these possible inaccuracies, the adolescent suicide rate has reportedly increased over three hundred percent in the past three decades (Malley et al., 1994).

Although reasons for this increase have not been determined, a number of factors have been identified and appear to be present in a majority of cases (Berman & Jobes, 1995). There may be over twenty-five factors involved in any one suicide case (Siebel & Murray, 1988). The most common stressors that lead to a suicide ideation or attempt are the end of a relationship with a significant other (e.g., boyfriend or girlfriend), difficulty or arguments with siblings, parents, teachers, and friends, a change in household finances, a change in the marital status of the student's parents (e.g., separation or divorce), a change in school, a personal injury or illness, failing grades, and a loss of friends (Eyeman, 1987). One factor is the presence of psychopathology, such as major depressive disorder and other affective disorders (Berman & Jobes, 1995). Parental
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(Jackson, McCartt Hess, & vanDalen, 1995) and student (Poland, 1995) substance abuse have been cited as possible factors. The use of substances allows the student to detach from reality, resulting in a greater risk of inaccurate perception of life situations (Poland, 1989).

Students with physical, emotional, and cognitive learning disabilities are at greater risk for depression and suicide than are students without disabilities (Guetzloe, 1991b). However, few have examined depression and suicide in special education students (Guetzloe, 1991b). Females are twice as likely to attempt suicide than males. Males tend to use more lethal means, or act more impulsively than females (Guetzloe, 1991b). However, females may be increasing their use of more lethal means (Cappuzzi & Golden, 1988). Since most disabilities are more prevalent in males than females, this increases the likelihood of males with disabilities attempting suicide. It has also been hypothesized that males have a lower threshold of reactivity to stress than females (Martumen, 1991).

Other reasons for suicide risk include family structure, life changes, and financial status (Guetzloe, 1991a). Cohen-Sandler, Berman, and King (1982) found through a comparative study that one factor specific to suicide ideation was birth order. In this study, children who were first born had a higher incidence of suicidal behavior. Other significant factors precipitating suicidal behavior included exposure to divorce, and separation from significant others at an early age, and death or hospitalization of a parent during adolescence (Cohen-Sandler, Berman, & King, 1982). Another motive for suicidal behavior is to repair or alleviate an intolerable situation (Rosenthal & Rosenthal, 1984). A number of suicidal students experienced crisis situations within the family unit
and were required to assume responsibilities they are not capable of, and these demands supplanted the child’s own needs (Stefanowski-Harding, 1990). Cohen-Sandler, Berman, and King (1982) also found this trend, stating that children may use suicide as retaliation to control events or behaviors that they have no control over in the hopes that change will occur. Financial status can also play a role, although not as large, in suicidal behavior. Feelings of alienation and anonymity increase as childrens’ needs and wants are unable to be fulfilled due to the financial constraints of the caregivers (Stefanowski-Harding, 1990).

Sudden changes in social behavior, such as giving away prized possessions, breaking social ties, academic deterioration, truancy, and perfectionistic tendencies are some of the psychosocial predictors of suicide (Cappuzzi & Golden, 1988; Leenaars & Wenckstern, 1990). Another psychosocial indicator of suicidal behavior is underachievement or learned helplessness. This can occur when a student attributes failures to a lack of ability rather than a lack of effort (Cappuzzi & Golden, 1988). Internal indicators of suicide are the presence of depression, mental illness, emotional instability, poor self esteem, and poor problem solving abilities (Cappuzzi & Golden, 1988; Cotton & Range, 1993; Poland, 1989). As students with behavioral, emotional and cognitive disorders are at a greater risk for suicidal behavior than other students, the need to implement interventions for this population has arisen. A number of states have passed legislation mandating suicide prevention (Berman & Jobes, 1995; Guetzloe, 1991). The primary form of prevention is education of students and school personnel (Leenaars & Wenckstern, 1990). This education must reach teachers, administrators, and other school staff in order to
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ensure correct information and training of those who work with school-aged children. Some prevention programs also include student education in the community, and the use of mental health professionals (Leenaars & Wenckstern, 1990).

It has been hypothesized that fear, rather than a lack of concern, results in teachers and other school personnel not interacting with a potentially suicidal student (Peck, Farberow, & Litman, 1985). This, coupled with the “consensus” that school personnel prefer to implement early intervention rather than tertiary strategies (Sattem, 1990), may lead to a feeling of inadequacy and confusion among school professionals. Ignorance of behavioral or personality indicators and the proper way to handle a suicidal student may leave school personnel unwilling or unable to act effectively (Cappuzzi & Golden, 1988).

According to Berman and Jobes (1995), many school personnel and community training programs are structured to include information such as recognizing warning signs for suicide, examining referral sources, developing crisis plan policies, and increasing confidence regarding the participant’s helping skills. Evaluations of these programs have demonstrated that participants gain a better understanding of suicide and are more satisfied with their ability to handle suicidal behavior. Despite these positive findings, behavioral changes have not been documented (Berman & Jobes, 1995).

Programs providing direct education to students generally include information on suicide, statistics and myths, and local available resources. These programs are designed to change students’ attitudes toward seeking help. However, evaluation of student oriented programs thus far suggests they do not appear to be effective (Berman & Jobes, 1995). However, Nelson (1988) found that a number of programs implemented by school
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districts experiencing high suicide rates did experience success by encouraging problem solving skills development and rapport building between the suicidal and nonsuicidal student. These effective programs also succeeded in training educators in becoming "suicide interventionists" through structured training of warning signs, identifying students at-risk, and demonstrating how to make an appropriate referral (Nelson, 1988). It continues to be a well known problem, however, that more quantitative and qualitative information regarding suicide prevention programs and their effectiveness is needed. Characteristics of successful programs need to be identified and implemented (Celotta, Jacobs, Keys, & Cannon, 1988).

The purpose of this study was to determine if educational inservices are effective in educating school personnel about suicide. It was predicted that a suicide inservice would increase staff awareness and self confidence in dealing with suicidal ideation or behavior. It was also predicted that the staff member's own level of depression and his or her prior knowledge of suicide would help determine how effective the inservice would be for the individual staff member.

Method

Subjects

The subjects consisted of regular and special education teachers, teacher aides, support staff, and administrative personnel from a suburban special education school in the Metropolitan New York area. Out of fifty-six questionnaires distributed to subjects during a suicide inservice, twenty-seven were used in the analyses (41%). Subjects were excluded from the study if they chose not to complete the pretest, posttest, self
assessment, or demographic data. This low response rate may reflect the comfort level of participants with the inservice content. Demographic information was collected regarding participant age, gender, specialty area (e.g., special education teacher, regular education teacher, teacher aide, or other school professional), grade or grades taught, and number of years teaching.

The final sample consisted of six regular education classroom teachers, six special education classroom teachers, and ten teacher aides, while the remaining five classified themselves as “other”. Descriptors indicated that this group included such professionals as social workers, speech-language pathologists, fine arts teachers (e.g., art, music, industrial), psychologists, and school administrators. The majority of the respondents were female (81%), which is typical of educator populations. Many respondents taught students at the secondary level, grades nine to twelve (26%), and an equal percentage identified themselves as teaching all grades. The remainder of respondents taught at the upper primary level (grades 4-6; 22%), the lower primary level (grades K-3; 15%), and the middle level (grades 7-8; 11%). Anecdotally, the reported number of years teaching and age appeared to be related, with 41% of the sample between the ages of 40 to 49, and the majority of these teachers (26%) had taught 16 to 20 years. The next largest age and years teaching group was the ages 20 to 29 (30%), with 1 to 5 years of teaching experience (30%). An equal number of respondents were between the ages of 30 to 39 and 50 to 59 (15% each). For teaching experience, these groups reported 6 to 10 years (22%), and 11 to 15 years (15%).
Procedure

Inservice participants were informed that the purpose of the inservice was to increase staff awareness of suicide literature, signs and symptoms, and interventions. The Pre-Post Inservice Suicide Knowledge Questionnaires (PISK-Q) were administered to participants. The participants were told that the purpose of the questionnaires was to determine if the inservice was effective. Following this, a forty minute inservice was conducted. During the inservice, the author discussed current statistics, precipitating events, behavioral indicators, emotional indicators, assessment and intervention methods, and direct consultation guidelines (Suicide Inservice, Appendix A). Statistics regarding suicide prevalence, suicidal cognition among students, significant demographic factors, substance use, and other social factors regarding the student at risk were presented. The causes of suicide were then discussed, and included common stressors, behavioral indicators, and cognition and emotionality of suicidal students. Three types of intervention and examples of each were presented.

The participants were then taught three techniques for assessing student risk of suicidal ideation or behavior. The inservice included an examination of district policy on appropriate action and notification of school personnel. Guidelines for talking to the student in question were also discussed. Finally, participants were presented with a number of myths and facts regarding suicide, which were discussed and elaborated upon. This was determined by the participant needs as voiced to the presenter during the inservice. Participant questions were then entertained. Participants were also provided with informative suicide handouts (Suicide Inservice, Appendix A). At the conclusion of
the discussion period, participants were asked to complete the Pre-Post Inservice Suicide Knowledge Questionnaire (PISK-Q). The questionnaire was an exact replica of the pretest suicide knowledge questionnaire without the demographic questions included. They were then asked to complete a inservice evaluation form. Participants were given the opportunity to meet with the author and a psychologist at any time after the inservice to discuss any personal feelings or issues regarding the information presented in the inservice.

Instrumentation

The inservice questionnaire consisted of three parts. The suicide knowledge section (PISK-Q) was derived from suicide ideation, gestures and behavior literature (Berman & Jobes, 1995, Cappuzzi & Golden, 1988, Guetzloe, 1991b, Jackson et al, 1995, Leenaars & Wenckstern, 1990, Peck et al, 1985, Poland, 1989, & Poland, 1995). This section consisted of twenty-eight questions, scored on a Likert scale, with the number one representing “Never True”, and the number five, representing “Always True”. Following data collection, three factor scores were created from the twenty-eight questions. These factor scores are Self Attribution, Psychosocial Predictor, and Internal Student Predictor. Questions in the Self Attribution factor score specifically addressed the participant’s feelings of personal comfort and knowledge regarding suicide and suicidal students. The Psychosocial Predictor factor consisted of questions designed to assess trends in suicide directly related to psychosocial predictors, such as time of day or time of year when most attempts occur, substance abuse, and family dynamics. Questions in the Internal Student
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Predictor factor score specifically addressed participant beliefs and knowledge regarding suicidal student behavior before, during, and following a suicide attempt. Six demographic questions preceded the twenty-eight questions on the PISK-Q. This demographic information was included to examine the gender, age, teaching setting, and years teaching of the sample. It also included an anecdotal question regarding participant personal opinion about suicide.

The PISK-Q was used again for measuring posttest knowledge and consisted of the same questions in the same order original, without the inclusion of Demographic Information questions. This was done in order to observe differences in knowledge before and after presentation of the inservice.

The Depression Symptomology Questionnaire (Teacher Self Report Questionnaire, Appendix D) was derived from recent literature on suicide and depression, as well as the DSM-IV clinical definition of depression (American Psychiatric Association, 1994). This section consisted of fifteen questions, phrased to allow participants to evaluate their own level of depressive symptomology. Levels of depressive symptomology were determined by the mean participant responses. Values below 52.00 were categorized as low self reported depression, values between 53.00 and 66.00 were categorized as average self reported depression, while values of 67.00 and above were categorized as high self reported depression. This depression questionnaire was included to allow examination of the relationship between self reported level of depression and knowledge of suicide, as well as his or her knowledge growth between pre and post test data.
collections. Although standardization of the questionnaire was not established prior to the inservice, reliability information was calculated following data collection.

A reliability analysis was conducted for the Pre-Inservice and Post-Inservice, as well as for the Self Report Questionnaire. Coefficient alphas for these measures appeared to be adequate as evidenced by the Teacher Pre-Inservice Section (.78), the Teacher Post-Inservice Section (.73), and the Teacher Self Report Questionnaire (.75). These results indicate adequate reliability of the sections written to assess suicide knowledge and the section written to assess level of depression, especially considering the small sample size.

Results

To determine if the inservice resulted in significant gains in suicide knowledge, a repeated measures MANOVA was performed on the pretest and posttest data for the PISK-Q. There was one within subjects factor (Repeat) for repeated measurement of participants and one between subjects (Group) factor for low, moderate, and high depressive symptom groups. For the Self Report Questionnaire, written to assess the participant’s level of depression, three distinct levels of depression were established. These levels have been labeled low, average, and high, respectively. 18.5% of the participants fell into the low depression category, indicating that this percentage possessed little to no level of depression. 63% of the participants fell into the average depression category, indicating that this percentage possessed moderate levels of depression. The final 18.5% of participants scored in the high depression category, indicating that this percentage of participants possessed moderate to severe levels of depression.
Results revealed no main effect for Group \((F_{(2,24)} = .80, p = .462, \text{ power} = .17)\). However, the main effect for the Repeat factor was significant \((F_{(1,24)} = 26.58, p < .001, \text{ power} = 1.00)\). The interaction of the Repeat factor by Group factor was nonsignificant \((F_{(2,24)} = 1.48, p = .247, \text{ power} = .28)\). As indicated in Table 1, a positive 12.56 point gain in suicide knowledge was achieved.

**Table 1**

*Descriptive Statistics For Pre, Post, and Self Report Scales*

<table>
<thead>
<tr>
<th></th>
<th>PreTest</th>
<th>PostTest</th>
<th>Self Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M</strong></td>
<td>90.00</td>
<td>102.55</td>
<td>59.55</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>11.22</td>
<td>10.46</td>
<td>6.98</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>1.82</td>
<td>2.07</td>
<td>1.22</td>
</tr>
</tbody>
</table>

A doubly multivariate repeated measures MANOVA was performed on three factor scales described earlier (Self Attribution, Social and Student Internal). This analysis is necessary because there are two within subjects factors, one for pre and posttest, and one for the factor scales. The main effect for Group was nonsignificant \((F_{(6,42)} = .45, p = .844, \text{ power} = .16)\). As was the case for the total PISK-Q score, the main effect for Repeat factor was highly significant \((F_{(3,22)} = 8.31, p = .001, \text{ power} = .98)\), suggesting that significant gains were made on one or more of the factor scales. The interaction effect between Group and Repeat was nonsignificant \((F_{(6,42)} = .94, p = .478, \text{ power} = .33)\).

To determine which of the three factor scales were significantly different from pretesting to posttesting, three separate stepdown repeated measures analyses were
performed for each of the factor scales. For the Self Attribution repeated measures analysis, results were nonsignificant for Group \( (F_{(2,24)} = .18, p = .837, \text{power} = .08) \). The within subject effect, however, proved to be significant \( (F_{(1,24)} = 7.51, p = .011, \text{power} = .75) \). As was the case with the doubly multivariate analysis, the interaction effect was nonsignificant \( (F_{(2,24)} = .17, p = .845, \text{power} = .08) \). For the Social repeated measures analysis, results were once again nonsignificant for Group \( (F_{(2,24)} = .88, p = .428, \text{power} = .18) \). The participants demonstrated significant knowledge gains as indicated by the Repeat factor \( (F_{(1,24)} = 16.71, p < .001, \text{power} = .98) \), but the Group by Repeat interaction was again nonsignificant \( (F_{(2,24)} = .82, p = .451, \text{power} = .17) \). Finally, the Internal Student Predictor scale repeated measures analysis showed a similar pattern to the others, with no Group significant effect \( (F_{(2,24)} = .82, p = .452, \text{power} = .17) \). The Repeat factor was again significant \( (F_{(1,24)} = 24.15, p < .001, \text{power} = 1.00) \). The interaction between Group and Repeat again showed no significant effect \( (F_{(2,24)} = 2.29, p = .123, \text{power} = .42) \). As can be seen in Table 2, the gains from pretest to posttest were significant for all three scales. However, judging by the power and \( p \) values, the largest gains were made on the Internal Student Predictor scale.

The respondent answers to the anecdotal question on the Pre-Inservice Questionnaire indicated that the majority of participants possessed opinions of distress and desperation when asked about suicide. For example, some responses included "A desperate act", and "A subject I'm not willing to revisit". Other participants indicated that they felt that suicide is "a selfish act" and "a tragedy for those left behind". Still others felt that
suicide is “acceptable in some situations”.

Table 2

**StepDown Results For Factor Scale Scores**

<table>
<thead>
<tr>
<th>Factor Scale</th>
<th>Pretest</th>
<th>Posttest</th>
<th>F</th>
<th>p</th>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self Attribution</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>14.11</td>
<td>15.89</td>
<td>2.51</td>
<td>.011</td>
<td>.75</td>
</tr>
<tr>
<td>SD</td>
<td>3.20</td>
<td>3.55</td>
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<tr>
<td><strong>Psychosocial</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>14.85</td>
<td>18.19</td>
<td>16.71</td>
<td>&lt;.001</td>
<td>.98</td>
</tr>
<tr>
<td>SD</td>
<td>2.57</td>
<td>3.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Internal Student Predictor</strong></td>
<td></td>
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<tr>
<td>M</td>
<td>61.04</td>
<td>68.48</td>
<td>24.15</td>
<td>&lt;.001</td>
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<tr>
<td>SD</td>
<td>7.43</td>
<td>7.07</td>
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</table>

**Discussion**

This study has raised a number of important issues and points of discussion, as well as avenues for future research. While it is apparent from the data collected that inservice training is an effective means to advance the knowledge and understanding of suicide for teachers and other school personnel, participants’ personal comfort level with the topic did not appear to significantly improve in this study. This process may require an increased length of inservice time or multiple inservices performed before participant personal comfort level increases. However, gains were made for the PISK-Q total score and all factor scores. Regardless of level of depressive symptomatology, gains were made
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on the Self Attribution scale, which assessed participants’ level of suicide awareness.

Gains were also made on the Psychosocial Factor scale, suggesting increased awareness about stressors which may precipitate suicidal behavior in children. Finally, gains were made on the Internal Student Predictor scale, reflecting increased participant awareness of students’ suicidal cognitions and behaviors.

An area that future research could address is how inservices affect the participant’s ability to intervene during a crisis situation with a suicidal student. Collection of data after an inservice or series of inservices including description of the student in crisis, how the student was identified and handled by school personnel, and outcome of the situation should be analyzed for any significant results. The participant’s comfort level and satisfaction should also be obtained to determine if “time and practice” increase the significance of these areas. While this may appear to be a difficult feat, a study could help to determine if the use of teacher inservices is effective in long term behavioral change for participants. To determine whether knowledge is retained over time, a repeat post-inservice questionnaire at specified time intervals following inservice could be performed.

While it appears that all self reported depression groups did make gains in knowledge, there were different gains based on participant’s level of depression. This trend suggests that participants may draw different information from the inservice depending on their own personal needs. While it was hypothesized that those with high depression levels would retain the least amount of information from the inservice due to high personal needs and a decreased helping ability, those within the high depression
group gained the same overall amount of information as those within the low depression group. Further study with a larger sample size is needed with those within the average range for depressive symptomology to determine possible reasons for the significantly smaller gains in knowledge this group made as compared to the low and high depressive symptomology groups. This will help indicate whether Psychosocial and Internal Factor Scale gains are actually related to personal investment and interest, or other personal gains. This may lead to further information regarding the competency of school personnel and personal depressive symptomology levels that had not been previously expected within this study.
References


Increasing Suicide Awareness


APPENDIX A
APPENDIX A

SUICIDE INSERVICE OUTLINE
July 1996
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I. INTRODUCTION

STATISTICS

* Suicide is the second leading cause of death for adolescents and sixth for children (Cappuzzi & Golden, 1988).

* The first cause of death is accidents. More than 25% of these accidents may be unrevealed suicides (Single car accidents, etc.) (Poland, 1989).

* For every successful suicide there are an estimated 50 to 120 suicide attempts (Poland, 1989).

* The suicide rate has risen 300% in the last three decades (Guetlzloe, 1991).

* Numbers of suicides may be low, since some coroners will not label a death suicide unless there is a suicide letter present. There is no set classification system for suicide (Poland, 1989).

* Research on the effects of suicide suggests that there are a minimum of three people who are left devastated, with numbers typically running between six to ten (Cappuzzi & Golden, 1988).

* It has been estimated that a suicide results in a 300 percent increase in the likelihood that at least one other student at the school will commit suicide (Berman & Jobes, 1995).

* On a survey of over 11,000 8-10th graders from 217 schools in 20 states, 34% of them had seriously thought about suicide and 14% had tried it (Poland, 1995).

* Most successful suicides have a family history of suicide (Berman & Schwartz, 1990).

* The majority of successful suicides are first born children and may have experienced a form of abuse during their lifetime (Jackson, McCartt Hess, & vanDalen, 1995).
* One out of four families that have a history of both substance abuse and suicide have a firearm contained in the home (Berman & Schwartz, 1990).

* The use of firearms to complete suicide has risen 40% in the last 25 years (Berman & Jobes, 1995).

* Students with physical, emotional, and cognitive learning disabilities are at even higher risk for depression and suicide (Guetzloe, 1991).

II. CAUSATION

PRECIPITATING EVENTS

Children and adolescents commit or attempt suicide for a number of reasons. Some of these are:

- Generally responding to an acute crisis involving discipline incidents, loss of face with peers, or arguments with parents (Shaffer, 1985).
- Ineffectiveness of old coping skills on new problems.
- Person sees lack of alternatives
  Person feels that needed resources are not present or attainable
- Person is usually more willing to take risks. This can lead to better acceptance to outside support.
- Person has low serotonin levels.
  Person often rebels against authority, leads a dangerous or reckless lifestyle, and may have a history of drug and alcohol abuse.
- 55% have recently experienced death of a friend or relative (Porter, 1985)
- Recent death of celebrity suicide, especially if idolized by children or teens (i.e.: rock star)
- Eyeman (1987) Identified the most common stressors:
  (as cited by Poland, 1989)
  * Break up with boyfriend or girlfriend
  * Trouble with siblings
  * Change in parent’s finances
  * Divorce
  * Loss of friends
  * Trouble with teacher(s)
  * Change in school
  * Injury or Illness
  * Failing Grades
  * Increased arguments with friends
  * Problems with parents
**BEHAVIORAL INDICATORS**

- Problems Sleeping
- Loss or increase in appetite
- Isolation or withdrawal
- Dramatic changes in appearance
- Anxiety
- Accident proneness
- Drug and/or alcohol abuse
- Crying spells
- Sexual promiscuity
- Drop in grades
- Drop in school attendance or dropping out
- Art work depicting violence
- Extreme self criticism
- Excessive talk about death
- Running away
- Loss of interest in enjoyable activities
- Giving away personal possessions
- Euphoria following depression
- Writings with messages of self destruction
- Neglect of personal hygiene
- Inability to concentrate
- Inability to complete tasks once started

**FREQUENT FEELINGS**

OVERWHELMED
- by loneliness, problems, pain, despair

ISOLATED
- unloved, not understood, alone

UNWORTHY
- may be loved or respected, but not worthy of it

CONFUSED
- ambivalent about living or dying

DEPRESSED
- sad, tired of “fighting” despair and problems

HOPELESS
- tired of waiting for life to improve, sees situation as static
III. INTERVENTION

TYPES OF INTERVENTION
(Berman & Jobes, 1995)

1. Primary Prevention
   GOAL: reduce the likelihood of antecedent conditions, or those conditions which may predispose student to suicidal tendencies

   examples for:
   - Student: depression and anger management training, dropout prevention, problem solving training, surrogate role models
   - Parent: early detection of parental pathology, parent skills training
   - School: Suicide awareness training, firearms prevention training and education

2. Secondary Prevention
   GOAL: Target early identification, assessment and referral to outpatient treatment for at risk students and their families.

   Examples for:
   - Student: outpatient treatment, peer counseling, medication emetics
   - Parent: caregiver training, counseling
   - School: environmental safety, presence of crisis plan

3. Tertiary Prevention
   GOAL: reduce psychiatric disability and institutional dependency

   Examples for:
   - Student: psychiatric treatment, drug abuse treatment
   - Parent: juvenile justice programs, case management follow-ups
   - School: (student would not attend school at this point)
ASSESSMENT OF A POTENTIALLY SUICIDAL STUDENT
“Quick and Dirty” Diagnostic Tools

SLAP

S = Specific Details in the plan of action  
L = Lethality level of the proposed method  
A = Availability of the proposed method  
P = Proximity of help (Who is the student’s support? Do they have a plan for rescue?)

D I R T

D = Dangerousness of past plans (more or same)  
I = Impression of degree of risk  
R = Rescue - What are the chances of someone intervening?  
T = Timing - How long ago was the attempt made?

3 H’s

Helpless - coping skills have failed  
Hopeless - one of the best predictors of suicide  
Hapless - dysfunctional upbringing....only .1% of suicides are by students from loving, supportive, “healthy” families

*The use of a formal assessment tool, such as an interview guide, is the best plan of action to determine the student’s needs.

* Every school should have a crisis plan in place. No student should be evaluated in a crisis situation by only one professional - always have someone with you and work in teams. The school psychologist, school nurse, social worker, guidance counselor, or administrator are all capable of assisting.

* Referral to a psychiatrist or evaluation clinic should always be offered. Hot line numbers and community referrals are important.

DIRECT CONSULTATION

There are some guidelines to follow during this type of crisis intervention when counseling the student and talking with parents and colleagues.

* Accept what is said and treat it seriously

* Be Direct - asking the person if they are suicidal will not give them the idea to become that way.
* Be a supportive, caring and concerned listener.

* Focus on the problem. Attempt to break down the situation into manageable pieces, allowing the person to see these pieces separately.

* Explore feelings that these pieces bring up.

* Help to determine what needs to be done or changed.

* Identify resources needed to improve things.

* Be open and clear in communication. Do not talk "in code".

* If you are not trained to or comfortable with counseling the student, encourage them to seek out someone who is.

* Do not give advice.

* Do not say that everything will be all right. This can sound patronizing to a person in crisis, or may be perceived as a lack of understanding.

* Deal with the person and situation as quickly as possible. A person in this kind of crisis must become top priority.

* Do not encourage perceptions of others (How would you parents/friends/etc. Feel?)

* Do not leave the person alone at any time.

* Do not debate the issue of suicide. This may encourage feelings of guilt of worthlessness.

* Do not promise confidentiality.

* Trust your suspicions.

IV. CONCLUSION

MYTHS VERSUS FACTS

MYTH: Suicide happens without warning.

FACT: Most suicidal adolescents give many clues to their intentions, whether, verbally, in the form of gestures, or sometimes even becoming accident prone (Cappuzzi & Golden, 1988).
MYTH: Once a student is suicidal, he or she must always be considered suicidal.

FACT: Most students are only suicidal for a limited amount of time, usually 24 to 72 hours around the time of the crisis is most dangerous. The higher the identification of stressors for and the development of coping skills, the lower the risk of the second attempt.

MYTH: If a student attempts suicide and is not successful, he or she will not make additional attempts.

FACT: The student will most likely re-attempt, and the lethality of the attempt will increase each time.

MYTH: Most suicides occur late at night.

FACT: Most suicides occur during mid to late morning and mid to late afternoon.

MYTH: Suicidal students are always in crisis when they make attempts.

FACT: Many who commit suicide appear calm, and more content because they have found a solution to their problem.

MYTH: Improvement after a suicidal crisis means the risk is over.

FACT: Most suicides occur about three months after the beginning of improvement, when the individual has the energy to put suicidal thoughts and feelings into effect.

V. CLOSING

Question and Answer period.
I. INTRODUCTION

STATISTICS

* Suicide is the second leading cause of death for adolescents and sixth for children (Cappuzzi & Golden, 1988).

* The first cause of death is accidents. More than 25% of these accidents may be unrevealed suicides (Single car accidents, etc.) (Poland, 1989).

* For every successful suicide there are an estimated 50 to 120 suicide attempts (Poland, 1989).

* The suicide rate has risen 300% in the last three decades (Gueltzloe, 1991).

* Numbers of suicides may be low, since some coroners will not label a death suicide unless there is a suicide letter present. There is no set classification system for suicide (Poland, 1989).

II. CAUSATION

- Eyeman (1987) Identified the most common stressors:
  (as cited by Poland, 1989)
  * Break up with boyfriend or girlfriend
  * Trouble with siblings
  * Change in parent’s finances
  * Divorce
  * Loss of friends
  * Trouble with teacher(s)
  * Change in school
  * Injury or Illness
  * Failing Grades
  * Increased arguments with friends
  * Problems with parents
BEHAVIORAL INDICATORS

- Problems Sleeping
- Loss or increase in appetite
- Isolation or withdrawal
- Dramatic changes in appearance
- Anxiety
- Accident proneness
- Drug and/or alcohol abuse
- Crying spells
- Sexual promiscuity
- Drop in grades
- Drop in school attendance or dropping out
- Art work depicting violence
- Extreme self criticism
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V. CLOSING

Question and Answer period.
APPENDIX C
APPENDIX C

PRE-POST INSERVICE SUICIDE KNOWLEDGE QUESTIONNAIRE (PISK-O)

DIRECTIONS: Listed below are a number of statements regarding suicide. Based on your experience with this subject and your experience with students, please answer these questions as truthfully as possible. Please do not omit or leave any question blank.

Please Check off or fill in the following information as it relates to you:

1.  Class:  ______Classroom Teacher
        ______Special Education Teacher
        ______Teacher Aide
        ______Other (please specify) ____________________________

2.  What grade do you teach? ________________________________

3.  Age Bracket: ______20-29  ______30-39  ______40-49
    ______50-59  ______60-69

4.  Sex: ______Male  ______Female

5.  How long have you been teaching? _______________________

6.  What is your personal opinion on suicide?
    __________________________________________________________________________________
    __________________________________________________________________________________

Although situations may vary, please choose the number that best represents your perspective. You can answer these questions as follows:

    1 - Never True  to  5 - Always True

1.  Students who commit suicidal gestures do not really want to die, they just want attention.  1  2  3  4  5

2.  I am personally comfortable when dealing with a suicidal student.  1  2  3  4  5

3.  There is no connection between students who use drugs or alcohol and suicide.  1  2  3  4  5

4.  Only students who are mentally ill or crazy try to commit suicide.  1  2  3  4  5

5.  I feel that I am knowledgeable about suicide.  1  2  3  4  5
<table>
<thead>
<tr>
<th>1 - Never True</th>
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<td>6. Most students don't think about suicide.</td>
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<td>18. Suicidal students are the parent's responsibility rather than the schools.</td>
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1 - Never True  to  5 - Always True

21. Encouraging students to talk about their suicidal feelings will encourage them to act on those feelings.  1  2  3  4  5

22. Students who act out are less depressed than those who do not.  1  2  3  4  5

23. Students who commit suicide always leave a note explaining their intentions.  1  2  3  4  5

24. Depression is the leading cause of suicide.  1  2  3  4  5

25. A drop in a student's grades may indicate that he or she is contemplating suicide.  1  2  3  4  5

26. Once a student is suicidal they are always suicidal.  1  2  3  4  5

27. I am aware of my district's policy for dealing with suicidal students.  1  2  3  4  5

28. Students who are impulsive are at higher risk for attempting suicide.  1  2  3  4  5

Thank you for your participation.

This questionnaire was adapted from the current research and literature on suicide.
# Pre-Post Inservice Suicide Knowledge Questionnaire (PISK-O)

**DIRECTIONS:** Listed below are a number of statements regarding suicide. Based on your experience with this subject and your experience with students, please answer these questions as truthfully as possible. Please do not omit or leave any question blank.

Although situations may vary, please choose the number that best represents your perspective. You can answer these questions as follows:

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28. Students who are impulsive are at higher risk for attempting suicide.  1  2  3  4  5

Thank you for your participation.

This questionnaire was adapted from the current research and literature on suicide.

Number ___
DIRECTIONS: Now please answer these questions about yourself as truthfully as possible. Please do not omit or leave any question blank. You can answer these questions as follows:

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<td>1. I have thought about death and dying.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>2. At times, I have had thoughts of hurting or killing myself.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>3. I have difficulty focusing on work or work-related tasks.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4. I have difficulty sleeping at night.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>5. I often feel fatigued and &quot;run down&quot;.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>6. At times, it is hard for me to look forward to the future.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7. I am not interested in activities I once found pleasurable.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>8. I am often sad.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>9. I prefer to do things alone rather than in groups.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>10. I engage in social activities.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
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<td>1 2 3 4 5</td>
</tr>
<tr>
<td>12. I have gained or lost weight recently without dieting.</td>
<td>1 2 3 4 5</td>
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Thank you for your participation.

This questionnaire was adapted from the current research and literature on suicide, depression, and the DSM-IV.