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A DESCRIPTIVE STUDY OF THE USE OF
AN EDUCATION-SPONSORED
SUICIDE RISKLINE

by
R. Kelly Haws

A thesis submitted in partial fulfillment
of the requirements for the degree

of
MASTER OF SCIENCE
in
Family and Human Development

Approved:

Thomas R. Lee
Major Professor

Joan A. Kleinke
Committee Member

Glen O. Jensen
Committee Member

Lawrence H. Piette
Dean of Graduate Studies

UTAH STATE UNIVERSITY
Logan, Utah

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R. Kelly Haws

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ABSTRACT

A Descriptive Study of the Use of
An Education-Sponsored
Suicide Riskline

by

R. Kelly Haws, Master of Science
Utah State University, 1991

Major Professor: Dr. Thomas R. Lee
Department: Family and Human Development

The purpose of this study is to provide a descriptive evaluation of Jordan School District's riskline as a step toward assessing the effectiveness of education-sponsored suicide risklines. The riskline received over 1000 calls from mid 1988 to mid 1989 for a variety of problem areas. Demographics and risk assessment for the calls relating to suicide are presented and evaluated. The findings indicate that risk assessment is independent of all variables considered except the age of the counselor and the grade of the caller. The number of calls is independent of every variable considered except the grade level of the caller, the sex of the caller, and the person in whose behalf the caller is calling. Approximately 59% of the calls with the grade recorded came from people beyond high school age, 75% of the calls came from females, and 55% of the calls came from people

stating that they were calling for someone other than themselves.

Risk assessment was found to be related to the age of the counselor and the grade of the caller with the calls assessed as "high risk" coming from those beyond high school age and assessed by older counselors. The number of calls was found to be related to the grade and sex of the caller, as well as the person in whose behalf the caller was calling. Higher numbers of calls came from those beyond high school age, from females, and from people stating that they were calling in behalf of someone other than themselves.

(91 Pages)

INTRODUCTION

Suicide - An Overview

Some Statistics

The rate of suicide among our nation's youth has tripled in the last 30 years (Blumenthal & Kupfer, 1988), an increase that has been termed "epidemic" (Renfro, 1984). The number of suicides between the ages of 15 and 24 has been around 5,000 for the past several years (Peck, 1982), and these figures represent just those who complete the act. The statistics are far more staggering if we consider those who attempt to commit suicide. In the general population it is at least as high as five to 10 attempts for every actual suicide, and among adolescents it may be as high as 25 to even 50 attempts for each reported case (Peck, 1982). McGuire (1983) quoted statistics estimating that the number of attempts may have been as high as 420,000.

Why such staggering statistics? Konopka (1983) suggests some general reasons that incorporate much of what is to follow. Our society lacks warm, genuine, and loving, friendships; a myth suggests that adolescents do not want to be a part of families; our morals are disintegrating; youth are not satisfied with the old, pacifying answers, they are seeking more; more and higher expectations are being placed on youth; we have not learned how to help people with their

emotional pain; in addition to the problems of adolescence, an increasing "doomsday" attitude about adulthood pervades society; and some prejudice still exists against people from different backgrounds and races. The research about to be explored bears out each of these reasons with the themes of families, relationships, pain, and expectations as predominant themes in the literature.

An At-Risk Profile

Suicidal adolescents seem to fall into several categories which include the loner, those who act out depression, the crisis suicide, and those whose suicidal behavior is a form of communication (Peck, 1982). They generally have four characteristics in common: (1) they feel impotent and powerless; (2) they feel unable to control or improve their situation (external locus of control); (3) they feel unappreciated; and (4) they feel unable to contribute (Renfro, 1984). A person who is suicidal feels as if there are no other alternatives, as if the emotional pain is unending.

Families play a major role. The family background of adolescents at-risk for suicide often includes divorce or dysfunctional marriage. The level of risk increases if a family member has previously committed suicide. Julia Weinstein (1982) has argued that the greatest deterrent to

suicide is a father who is present, strong, and loving.

The adolescent's life and feelings are characterized by feelings of rejection, depression, maladjustment, unworthiness, and lack of love. Drastic, persistent changes in things such as sleep patterns, relationships, personal grooming, and academics are signs that might indicate risk. Some precipitating events might include family problems, loss of something of perceived importance, problems with the opposite sex, and school difficulties (Tishler, McKenry, & Morgan, 1981). The decision to commit suicide is often characterized in the literature by an extended pattern of problems in the areas mentioned above, combined with a recent dramatic increase in one or more problem areas.

Predisposing Determinants, Precipitating Causes, and Signs

There are two types of risk factors, which are best termed predisposing determinants and precipitating causes. In the lives of those who attempt or commit suicide, **predisposing determinants** are broad, long-term kinds of patterns. **Precipitating causes** are events that occur immediately prior to the suicide and which serve to increase risk and precipitate the suicide. These events are often major crises which stand out in addition to the life's

general pattern. However, signs of suicide can be detected. These signs are not determinants or causes per se; rather they are indicators, external evidences, things to look for that suggest suicidal risk. The broad, predisposing determinants cover areas which include family dysfunction, personal factors, and peer relationships (Allen, 1987; Blumenthal & Kupfer, 1988; Duraj, 1984; Fish & Waldhart-Letzell, 1981; Gispert, Wheeler, Marsh, & Davis, 1985; Grob, Klein, & Eisen, 1983; Hals, 1985; Hawton, 1982; McGuire, 1983; Robinson, 1984).

The precipitating causes listed in the literature include any of the broad determinants previously listed, if such an event had not been characteristic of a life and/or if the event were to begin occurring with increased frequency or intensity than before. In addition, a sudden loss of anything important might precipitate suicide. These causes are perceived to be crisis events and stand out in contrast with or in addition to the life's pattern in general.

As for signs, The American Association of Suicidology has synthesized them into five general warning signs: (1) a suicide threat or other statement indicating a desire or intention to die; (2) a previous suicide attempt, as well as a recent suicide of a friend or relative; (3) depression; (4) marked changes in behavior, including eating and sleeping patterns, acting out, hyperactivity, substance

abuse, or high risk-taking behavior; and (5) making final arrangements or saying good-bye to possessions or individuals.

Prevention and Intervention

Suicide prevention and intervention can occur in a variety of ways. A number of educational approaches include such things as classroom education, parent/family education and counseling, and peer counseling programs. Professional mental health consultation including competence enhancement is also available, and counseling services are offered through schools or community based clinics.

Statement of the Problem

The State of Utah requires each school district to maintain a suicide prevention program. Jordan School District has chosen to operate a riskline. The line is open to callers in any category of risk; however, it was implemented to comply with the law requiring a suicide prevention program. Currently, few (if any) other school district-based suicide risklines exist around the country. Therefore, information regarding these risklines and their operation is needed.

Purpose of the Study

The purpose of this study was primarily to provide a descriptive evaluation of Jordan School District's riskline as an elementary step toward assessing the effectiveness of education-sponsored suicide risklines. The questions considered included:

1. Who uses the riskline?
2. How serious is the need for this type of line?
3. How often is the line used as a referral source?
4. Is the risk assessment assigned to each call related to any particular characteristic of the counselor or the caller?

REVIEW OF THE LITERATURE

Suicide - Profile of a Problem

Numbers and Trends

Suicide has been on the increase in the United States. Since 1960 the number of suicides in the United States has gone from 10 per 100,000 to just over 12 per 100,000. The rate for adolescents has increased even more, going from four per 100,000 to 12 per 100,000 (Simons & Murphy, 1985). In fact, from 1950 through the mid 1980's, the rate of adolescent suicide has increased 300%! In other words, the rate of suicide among our nation's youth has tripled in the last 30 years (Davis, Sandoval, & Wilson, 1988; Blumenthal & Kupfer, 1988; Fish & Waldhart-Letzell, 1981).

In the year 1977-78, 4800 adolescents in America were known to have committed suicide and, it is estimated that 420,000 attempted it (McGuire, 1983). Between 1970 and 1980, 49,496 youth between 15 and 24 years of age committed suicide, an increase of 40% over the previous decade (Duraj, 1984). That is an average of 5,000 adolescents each year; in fact, the number of adolescent suicides each year for the past several years has been around 5,000 (Peck, 1982). Viewed in other terms, in the United States, 14 adolescents commit suicide every day; and this includes only those who

complete the act. The statistics are far more staggering when considering those who attempt suicide. Statistics for attempted suicides are much greater. In the general population, it is at least as high as five to 10 attempts for every actual suicide; among adolescents it is perhaps as high as 25 to even 50 attempts for each reported case (Peck, 1982).

As of 1985, the Center for Disease Control indicated that suicide was the tenth leading cause of death for individuals of all ages in this country. During the late 1970's and the early 1980's, suicide was the third leading cause of death among adolescents; as of 1987, it was the second leading cause (Nelson, 1987).

Few cases of suicide in young children are reported. However, the incidence rises steadily after the age of 12 and continues into the twenties; it is especially high among married teenagers (Hawton, 1982).

With suicides there seems to be what has been termed a "Werther" effect (Alexander & Harman, 1988). This modeling or the tendency toward imitation is referred to as clustering (Allen, 1987). It is clear that people who know someone who has committed suicide or hear of another person who has committed suicide can be influenced to complete the act that they have been considering for themselves (Lester, 1988).

Predisposing Determinants, Precipitating Causes, and
Signs

An extensive effort has been made to identify the factors that may be commonly found in the lives of those who attempt or commit suicide. These factors are complicated and multidimensional (Bernard & Bernard, 1980). They include **broad, predisposing determinants**, which are general, long-term patterns in the lives of those at risk for suicide and, **immediate precipitating causes**, which are events that occur immediately prior to the suicide and which serve to increase risk and precipitate the suicide. These events are often major crises, or at least they are perceived to be such, that stand out in addition to the life's pattern in general. In contrast, **signs** are distinct from determinants or causes in that signs are indicators, external evidences, "red flags" that a danger of suicide exists.

Tishler, et al. (1981) suggest a three-stage progression leading to suicide

1. A long standing history of problems, from childhood to early adolescence. This stage might be termed "predisposing determinants."

2. A period of escalation during which new problems associated with achieving adolescence are introduced. This stage might be termed "precipitating causes."

3. A final stage, the weeks and days immediately

preceding an attempt, characterized by a chain-reaction dissolution of the adolescent's few remaining primary associations and an escalation of signs.

Predisposing Determinants

The broad, predisposing determinants mentioned in the literature cover a multitude of areas. The most common general areas include family dysfunction, personal factors, and peer relationships (Allen, 1987; Blumenthal & Kupfer, 1988; Duraj, 1984; Fish & Waldhart-Letzel, 1981; Gispert et al., 1985; Grob et al., 1983; Hals, 1985; Hawton, 1982; McGuire, 1983; Robinson, 1984).

Family Dysfunction

In a society characterized by a disintegrating family, it should be noted that family stress plays a central role in the lives of adolescents and that they depend a great deal on their families. Adolescents are, however surprising as it may be, extremely sensitive to family processes and the quality of their family life (Siddique & D'Arcy, 1984). It is a popular perception that adolescents are not influenced by their families, but only by the peer group. In reality, the family is crucial to suicide prevention and intervention. Often families are critical problem points. If youth do indeed "depend a great deal on their families"

and are genuinely concerned about the "quality of intrafamily life," then it becomes very important to evaluate the modern family along with when, where, and why dysfunctions occur in families, thus providing a beginning point for prevention and intervention.

Families of adolescents with suicidal tendencies are characterized by interpersonal dysfunctions including such things as divorce, poor communication, conflict, neglect, selfishness, and low cohesiveness. Parenting styles which include extremely high expectations and achievement orientation, coupled with low support, little flexibility and unavailable parents, contribute to suicidal ideation. Other common elements of the pattern are mental illness, job loss, other suicides, alcoholism and drug abuse, and low organization (Allen, 1987; Peck 1982, Asarnow, Carlson, & Guthrie, 1987; Friedrich, Reams, & Jacobs, 1982; Garbarino, Seves, & Schellenbach, 1984; Wright, 1982).

Specifically, the fathers of suicidal adolescents have been found to be more depressed and have lower self-esteem. The mothers have been found to be more anxious and have more suicidal ideation (McKenry, Tishler, & Kelley, 1983).

The divorce of parents and the pain and unhappiness that is part of the negative family process preceding divorce have consequences for children. Children who experience these things have more negative evaluations of self and parents than do children who come from homes

characterized by positive, happy family processes (Parish & Wigle, 1985). In addition to divorce, a general obsession with self exists within these families. This attitude teaches children that parents take care of themselves first and that the children's needs will be attended to in relation to remaining time and energy (Peck, 1982).

Deficient rearing, absence of the mother, neglect, and abuse are recurrent themes in the literature describing family dysfunction. These circumstances have been found to lead to depression which is probably the most mentioned precursor of suicide in the literature and which, if prolonged, can eventually lead to suicide (Blumberg, 1981). As part of this deficient rearing, families of suicidal adolescents have been found to have one or both parents on the same level of authority as the suicidal adolescent. Adolescents, in one way or another, communicate a need to have someone set limits on them (Madden & Harbin, 1983).

Young people who do not learn how to express feelings, and who are denied affection and approval, appear to have difficulty developing the inner reservoirs and coping mechanisms necessary to solve difficult problems (Fish & Waldhart-Letzel, 1981). Suicide attempters have expressed the belief that their feelings are unacceptable to their parents and that their parents are unresponsive to their needs, both of which are indicative of a lack of listening in the home (Peck, 1982). Drug abuse has been found to be a

precursor of suicide, and families that are high in conflict or structure or both have a higher incidence of drug abuse (Levine, 1985). Parents who abuse drugs themselves are modeling self-destructive behavior, and this may be an indicator for self-destructive behavior in the adolescents themselves (McKenry et al., 1983).

Family Systems Theory is a critical theory to consider and apply when considering the role of family dysfunctioning in adolescent suicide. The family is a complex system. It is not a series of individuals sharing a roof and floor and walls who have no influence on each other. Family members influence and are influenced constantly by each other. Adolescence can be a time of disruption even for healthy families.

The source of the individual's psychic pain lies in the structure and dynamics of his or her family system...a family conflicted in important ways will engender in the child a sense of powerlessness, worthlessness, and subjective distress, anxiety, depression, numbness, and confusion. (Levine, 1985, p. 11,12).

Personal Factors

The personal factors that are repeated in the literature (Garbarino et al., 1984) can be most easily grouped into categories of (a) emotional, (b) physical, and

(c) intellectual.

Emotional factors. Personal emotional factors include depression, low self-esteem, manipulativenss, hopelessness, sadness, isolation, inadequate ego-defenses, mental disorders, impulsivity, revenge, and external locus of control.

Depression is one of the most commonly spoken of precursors of suicide. Findings are evident to indicate that depression is not an infallable determinant of suicide, and it should be noted that none of the precursors or patterns spoken of are infallable determinants. Not all depressed people are suicidal, and not all suicidal people are depressed. However, depression remains one of the most consistent determinants of suicidal ideation (Allen, 1987; Asarnow et al., 1987; Goldring & Fieve, 1984). In addition to depression, external locus of control, the belief that the controlling factors in one's life are environmental and beyond one's ability to control, has been shown to be present in suicidal people (Seeman, Widrow, & Yesavage, 1984).

In psychoanalytic theory it has been hypothesized and found that adolescents in earlier stages of ego development are less capable of working through stress, anxiety and troubled relationships. An adolescent who is in the lower stages of ego development might have increased trouble working through the turbulence that often characterizes

adolescence (Noam, Hauser, Santostefano, Garrison, Jacobson, Powers, & Mead, 1984). The family and personal dysfunction that characterizes adolescents at-risk might also affect their progress through the stages of ego development.

Physical factors. Personal physical factors include drug and alcohol consumption, physical illness, physical and sexual abuse, and pregnancy. In addition, sex differences exist in the rate of those who attempt suicide and those who complete the act.

Adolescent males are two to three times more likely to actually commit suicide, while in attempted suicides among adolescent females, the ratios are reversed (Peck, 1982). Females also have been found to be significantly more external in their locus of control than are males, which might be a partial reason for female's greater stress levels (Siddique & D'Arcy, 1984). Females also exhibit a higher reported incidence of perceived problems with self-esteem, parental support and emotional problems than males, and they also reflect a higher incidence of suicide ideation. The best predictors of suicide ideation for adolescent males are employment problems and emotional problems, and parental support has a strong impact on the extent of emotional problems. The best indicators of suicide ideation for females include emotional problems, delinquent behavior, and lack of parental support (Simons & Murphy, 1985). Currently there is little evidence to indicate any obvious differences

between gay and straight males who commit suicide. To determine whether homosexuality itself was a risk factor would require a longitudinal study to be done among a group of homosexuals (Rich, Fowler, & Blenkush, 1986).

Drug and alcohol abuse are factors that increase risk for suicide (Rich et al., 1986). Alcohol abuse, in tandem with many of these other factors, increases the risk for suicide (Motto, 1980).

Intellectual factors. School problems do indeed factor into the potential for adolescent suicide (Tishler et al., 1981). Intellectual factors include poor problem-solving skills, poor academic performance, learning disabilities, and high expectations. These factors can lead to depression and despair which are highly related to adolescent suicide (Duraj, 1984). Suicidal adolescents have been found to be truancy prone, and they are often a grade behind in school (Gispert et al., 1985).

It must be understood that children who are suicidal are less able to cognitively develop coping strategies for life's stresses than children who are not suicidal (Asarnow et al., 1987). Further, it has been shown that adolescent problem solving skills can be taught, improved, and retained (Hains & Hains, 1987).

Peer Relationships

The third area that characterizes adolescents at risk

for suicide is peer relationships, both absence of relationships with peers and relationships that are characterized by conflict. Social stress does have an influence on adolescent suicide (Siddique & D'Arcy, 1984). Social factors include poor social skills, racial or ethnic prejudice, blurred sexual roles, and low communication. Adolescents who are suicidal often feel isolated, unwanted, and unloved with poor interrelationships. Social withdrawal and/or acting-out is often how the adolescent displays his feelings of abandonment (McGuire, 1983; Peck, 1982). It has also been found that suicidal adolescents have poor ego development (Noam et al., 1984). The social dysfunction of these adolescents has been shown to include aggression against society in terms of criminal activities (Peck, 1982).

The establishment of sexual identity during adolescence creates a delicate, push-pull kind of situation (Wodarski & Harris, 1987). Part of adolescents' potential for difficulty lies in the need to begin establishing an independence from parents, combined with sexual maturing (Wodarski & Harris, 1987). The blurring of sexual roles leads to identity confusion (Ray & Johnson, 1983) which is often a major contributing cause of suicide.

One of the first elements of suicide in the realm of peers and their relationships is what has been termed "modeling" (Hawton, 1982) and "clustering" (Morrison, 1987).

This is the phenomenon that when one suicide occurs, the tendency for other suicides to occur within a short period of time often follows.

David Lester (1987) theorizes that a subculture of adolescents at risk for suicide exists. He suggests that those at risk for suicide have similarities across the lines of drug involvement, music, interpersonal (particularly family) relationships, self-image, personal loss, and suicidal ideation.

Precipitating Causes or Life Crises

There are some precipitating causes (Tishler et al., 1981) that occur immediately before a suicide attempt which increase the risk of suicide to the point where thought becomes action (Gispert et al., 1985). The precipitating causes listed in the literature include any of the broad determinants previously listed, if such an event was not characteristic of the life of the adolescent, and begins occurring or has occurred with increased frequency or intensity than before. In addition, such things as losses of: a boyfriend or girlfriend, confidant, or anything important - from a job (Jackson, Stafford, Banks, & Warr, 1983) to a body part (Hals, 1985) to self-respect - increase the adolescent's risk. These causes can also include: a sudden economic setback, the recent suicide of a friend or

relative, and a recent disappointment or loss in general. These causes are perceived to be crisis events and stand out in contrast with, or addition to, the life's pattern in general.

Signs

In the context of considering adolescent prevention and intervention, it is important to consider not only the causes of suicide but also some of the signs that one might watch for to indicate risk. A genuine danger of denial exists because of the stigma attached to suicide. Consciously or unconsciously, the signs may be overlooked because of this stigma. There is also the danger of simply missing the warning signs because of myths or lack of correct information (Allen, 1987). Some signs act as "red-flags" if they can be recognized. This, however, requires a familiarity with those signs (Allen, 1987; Blumenthal & Kupfer, 1988; Fish & Waldhart-Letzell, 1981; Gispert et al., 1985; Greuling & DeBlassie, 1980; Hals, 1985).

The American Association of Suicidology (Johnson, 1985) has synthesized all of these signs to just 5 warning signals. First, there is a **suicide threat** or other statement indicating a desire or intention to die. This includes such things as stories or poems that the adolescent might write. Adolescents who are preoccupied with and

discuss death and suicide might be exhibiting this sign. This sign might also be exhibited by physical communications such as provoking fights with parents or peers or the occurrence of frequent injuries. The second signal is a **previous suicide attempt** as well as a recent suicide of a friend or relative. Third, the individual becomes **depressed**. This sign would include such things as guilt, hopelessness, self-reproach, social isolation, sadness, and withdrawal. These states are often brought about as a result of a recent disappointment or loss. The loss could be anything from a job to a girl or boyfriend, and while the loss might seem insignificant to the observer, it might be very significant to the adolescent at-risk. Fourth, there are **marked changes** in behavior, including eating and sleeping patterns, acting out, hyperactivity, substance abuse, or high-risk taking behavior. This sign includes sudden and marked changes in such things as weight, appearance, grades, and school attendance, as well as personality and sociality changes such as dropping out of activities and withdrawal from friends and family. Fifth, the adolescent begins **making final arrangements** or saying good-bye to possessions or individuals. This could be accomplished by such things as making a will or giving away prized belongings. It might also be accomplished by verbal cues or outright statements of "goodbye." Other studies have recently added **major substance abuse** as a sixth sign

(Davis et al., 1988), including both drugs and alcohol (McKenry et al., 1983; Motto, 1980).

Myths

In relation to suicide, a number of myths exist (McGuire, 1983; Ray & Johnson, 1983). These myths can be synthesized into three general misconceptions: 1) discussion increases the risk of suicide; 2) "normal" people never commit suicide; and 3) suicidal risk and its changes.

Discussion Increases the Risk of Suicide

It is a misconception that discussing suicide increases the risk of suicide. A feeling exists that the discussion of suicide will increase the incidence of suicide ideation and thus the possibility of increased incidence of suicide. According to the research, this statement is false. It is very helpful to discuss the reasons for suicide ideation which then opens up the avenue for dialogue and providing access to the principles and skills that will provide help for adolescents who are at risk (Johnson, 1985).

It is also a misconception that discussing negative feelings increases the risk of suicide. A myth exists that to allow the at-risk adolescent to express negative feelings in words serves to heighten the likelihood of physical expression of those feelings by suicidal actions. That is

not true. Verbal expression of feelings lends tangibility to those feelings, thus increasing the person's ability to deal with and conquer them (Johnson, 1985). By the same token, it is just as much a myth that children who talk about suicide won't commit suicide. They can, and this is one of the signs discussed earlier.

"Normal" People Never Commit Suicide

Some of the misunderstandings surrounding this myth are that suicide and depression are synonymous, that all suicidal individuals are mentally ill, and that suicide always is the act of a psychotic person. Some people think that there is a specific profile for suicidal people, including economic level, age, and sex, and that suicide is inherited. Each of these statements is false. Not all depressed persons are suicidal, nor are all suicidal persons psychotic. While there may be some general determinants that increase the risk of suicide, it is impossible to pinpoint the specific profile of those at risk. Suicide has not been found to have a biological or genetic correlate. Mental illness has been shown to relate to suicide, but genetics per se have not been shown to be a factor (Motto, 1986; Rainer, 1984). The risks increase because of family history factors, but suicide has not been shown to be genetic.

How Suicidal Risk Changes

There are several misunderstandings about how suicidal risk changes. One is that improvement after a suicidal crisis means the suicide risk is over, or that once a person attempts suicide and fails, a decreased likelihood of another attempt will prevail. The opposite is the case, however. "...Once the barrier between thought and action is crossed, subsequent attempts are easier." In fact, the majority of those who commit suicide have attempted to do so earlier (Johnson, 1985, p. 116).

Another myth is that once a person is suicidal, he is suicidal forever. That, too, is incorrect. A person can find help and overcome the desire or thoughts of committing suicide and go on to lead a normal life (McGuire, 1983).

One last myth is that suicidal people are fully intent on dying. In fact, most suicidal people do not truly want to kill themselves (Shneidman, 1984) and are hoping someone else will save them. Almost no one commits suicide without attempting to communicate his/her feelings to someone first (Dryden & Jones, 1986).

Prevention and Intervention

The adolescent is in a period of time in his/her life when support networks including parents, peers and other external resources are greatly needed. It is, however, the very time when those systems begin breaking down (Miller & Miller, 1983). There is a need, therefore, for heightened sensitivity on the part of those who are able to offer help, as well as the need for increased efficiency on the part of those already in a position to help. Any efforts made in this regard are not wasted. Intervention does have a deterrent effect on adolescents who are at-risk for suicide (Morrison, 1987).

If a solution is to be found for adolescent suicide, then the societal forces capable of effecting change must put forth maximum effort. Those with the influence necessary to eradicate this problem include families, schools, peers, communities, businesses and the media (Wodarski & Harris, 1987). Families must reevaluate their role at the basis of society, deal with and resolve their dysfunctions. Schools and peers must take advantage of opportunities that come from rubbing shoulders with those at risk for suicide and expend the effort to become informed and involved. Communities, businesses, and media must begin to invest their assets in today's adolescent to help educate, train, and prepare them to function successfully as

tomorrow's adults.

Suicide prevention is difficult to measure. How does one know if a suicide has been prevented? Regardless, with careful diagnosis and treatment, prevention can occur, (Murphy, 1984) and there are ways to evaluate the effectiveness of suicide prevention programs (Streiner & Adam, 1987).

Suicide prevention and intervention can occur in a number of ways, using different approaches in a variety of settings. The first thing that must occur in any setting is some type of screening. Screening allows needs to be assessed and a course of action to be determined. At that point there are a number of prevention and intervention options. These options include educational approaches, professional mental health consultation, and school district and community programs.

Screening

Blumenthal and Kupfer (1988) suggest a model for prevention, based upon three different levels of detection with appropriate levels of assessment and treatment.

Level 1 is simply detection awareness and consists of red-flagging kids who fall into a high-risk group by virtue of environmental stressors. Prevention at this level might consist of being aware of warning signs, red-flagging kids

who exhibit these signs, and educating them.

Level 2 is detection of a major environmental or behavioral problem such as severe changes in behavior, grades, concentration, etc., suicide of a friend, presence of personality issues, running away from home, or any of the other signs discussed earlier in this paper. This level may require assessment and intervention.

Level 3 is the detection of a psychiatric disorder and may require intervention by mental health professionals. Screening in this area might include the use of any one of a number of available instruments, as well as peer screening which consists of simply asking kids about their peers, since this may be the most highly informed group about those at risk for suicide.

Educational Approaches

Educational approaches include programs in the arenas of student/classroom, peer counseling, school personnel, and parent/family. The types of educational programs available are summarized below.

Classroom Programs

In regard to classroom programs, the school system is in a particularly good position to provide accurate information to facilitate effective intervention on behalf

of adolescents who are at risk. Educators are known (Johnson, 1985) to have substantial influence on the behavior of adolescents. One reason (Renfro, 1984) educators' opportunities may be unique is that for students coming from backgrounds characterized by turmoil, the school may be the only constant in the at-risk adolescent's life.

The people who have the most contact with adolescents would be the first to notice signs of suicide, but the possibility also exists that parents and friends are so close they have more difficulty with objectivity than do teachers and counselors. Because of this, teachers and counselors need to be aware of the signs of suicide and behavior pattern changes (Ray & Johnson, 1983). On the other hand, although parents and friends may have difficulty being objective, they also have the greatest potential for influence. There is an absolutely fundamental need, therefore, for families to have positive, nurturing, intact family processes.

Another issue facing concerned individuals and organizations is that if prevention and intervention are to take place, the person at risk must be identified. This is not so much an issue with hotlines because the person finds the hotline and initiates the intervention process. In the community or educational system, however, identification is an issue. Identification is difficult because not every person who shows the signs or whose life is characterized by

the patterns of those at risk is actually considering suicide. Change marks adolescence in general. The thing to monitor is prolonged or persistent change (Renfro, 1984). Even though difficult, identification is of critical importance if a connection is to be made with the adolescents at risk and someone who can help (Peck, 1982).

For the teacher, an effective measure of prevention is simply and honestly listening and developing trust. In addition, a willingness to get involved and to seek professional help or to help the student seek professional help is also important.

A great majority of students want to learn about suicide so they can help their friends in crisis (Wodarski & Harris, 1987). This means that if teachers are interested enough to become informed and care enough to get involved, they are in a position of opportunity with respect to training and ultimately helping to prevent adolescent suicide.

Teachers can perform a significant role in suicide intervention and prevention by holding classroom discussions. This role automatically suggests the need for teachers to have in place a personal prevention priority which helps them become aware of and recognize predictors and signs (Alexander & Harman, 1988). Teachers also need to be aware of causes, be familiar with common myths, and have some fluency with some basic prevention and intervention

principles and skills (Johnson, 1985).

Another role that teachers could fill is that suggested by Sharlin and Shenhar (1986). Students' creations, like poetry or art, are often used as a means of expressing their feelings and thoughts. Teachers could look for more than just literary or artistic excellence. Teachers could be informed and look for themes that would indicate risk for suicide. This would require sensitizing the teachers to this opportunity. The poetry and art of suicidal adolescents is different from that of nonsuicidal adolescents in the usage of loaded words and images, particularly those where death and negative situations are a common reference.

Peer Counseling Programs

In addition to teacher/classroom programs, peer counseling programs are effective in suicide prevention. Davis et al. (1988) cite research indicating that fellow students are the most aware of students who are at risk for suicide; young people turn to their peers for help. Thus it is an important resource in suicide prevention.

Peer involvement ought to be of the highest priority (Wodarski & Harris, 1987) because an adolescent at risk for committing suicide will often give signs and in some way communicate something to their peers. Thus, by virtue of peers' influence, availability, and accessibility training

should be undertaken to help them be aware of suicidal signs, their meanings, and what they can do about them.

School Personnel Programs

Another approach to suicide prevention/intervention is school personnel programs. This could consist of familiarizing school personnel with signs and available resources, sensitizing them to the reality of the problem. This education process could take place at faculty in-service meetings with the help of trained professionals. This, however, has been noted as one of the least effective means of intervention and prevention (Morrison, 1987) since school professionals don't know their students well enough and don't have the time to get to know their students well enough, particularly in larger schools. The potential for prevention and intervention does exist because when educators do get concerned and involved, they are known (Johnson, 1985) to have substantial influence on the behavior of adolescents.

It has been suggested that suicidal adolescents do not consult with a family physician or clinical psychologist. School counselors need to provide this help. Teenagers are more likely to consult with a peer than with parents or teachers. If a school counselor can produce a feeling of friendship and nonauthority, trustworthiness, openness, and a sense of common values, and language compatibility with

the students, he/she can perform a most critical and helpful role in suicide prevention and intervention (Greuling & DeBlasie, 1980). The school counselor has access to both the student at risk and the peers, who are a primary information system.

School counselors, social workers, psychologists, teachers, and administrators have some experience-based feelings and perceptions about the development, warning signs, and risk factors of adolescent suicide. According to Grob et al. (1983), these experience-based conclusions are generally in harmony with theoretical and empirical research. Not only do these school professionals have some ability and background that can be helpful to at-risk youth, they also have the opportunity as well as access to one of the primary information systems. Again, there is some indication that kids will talk to kids before they will talk to family or outside professionals, and the school professional is in the middle of that information system - hence the increased opportunity. So, how can this reservoir of experience, knowledge, and opportunity be used and accepted in the intervention and prevention of adolescent suicide? Heightened awareness on the part of school professionals is a beginning point (Grob et al., 1983). If these school professionals can become aware of the potential for suicidality and then use their resources carefully, there is great potential for early intervention. Other

training and inservice might include (Grob et al., 1983) recognition of depression, assessment of its degree and risk, knowledge of local treatment facilities, and skill in the delicate task of engaging a student and making an appropriate referral.

Parent and Family Programs

Adults who are tuned in and who are willing to listen, constitute the greatest potential deterrent to suicide in youth (McGuire & Ely, 1984). The most important adults to adolescents are still parents. To work toward suicide prevention and intervention, adults should sincerely listen. Adolescents want to communicate with adults but often feel pushed away (Konopka, 1983).

A majority of the predictors and reasons for adolescent suicide are related to troubled and dysfunctional families. The family members often have little ability to empathize with the suicidal family member (Clements, Sider, & Perlmutter, 1983).

Family systems theory would assert that there are familial processes that precurse suicidal acts in one or more of its members. Attempted adolescent suicide is, in reality, a symptom of a process involving the entire family, thus necessitating intervention with the family. A person's family system can be credited with being the source of the individual's internal pain and serves to heighten risk for

suicide.

A family with conflicted family processes will promote in the child a sense of powerlessness, worthlessness, distress, anxiety, depression, numbness, and confusion. (Levine, 1985). Therefore, one of the suggestions that Simons and Murphy (1985) make is that those concerned with adolescent suicide should concentrate on strengthening family processes, particularly the nurturing, supportive functions of the family. In a crisis it is consequently necessary for the therapist to work in harmony with the family (Walker & Mehr 1983).

Walker and Mehr (1983) suggest some procedures and goals for implementation of crisis intervention. The family and the adolescent should be brought together by the counselor as quickly as possible after the suicide attempt. In this first session the therapist's goals are to assess the strengths and weaknesses of the family and to provide assurance, concern, and support. The family's suggested goals are to share perceptions and feelings regarding the suicide attempt and to share responsibility for the adolescent's behavior. In the intervention sessions that follow, the therapist's goals are to begin problem solving with the family, to support new behaviors, to establish appropriate family goals that help the family to understand their dysfunctional problems, and to begin to solve family problems. In the final session, the therapist's goals are

to withdraw from the family and to provide direction to them for the future. Important family goals at this stage are to trust the adolescent and to continue to support change within the family. Each of these findings leads to the conclusion and points to the importance of prevention and intervention (Robinson, 1984) occurring on the level of the whole family unit.

Mental Health Consultation

As counselors proceed through the process of prevention and intervention, it should be recognized that suicide is often a result of psychological phenomena. Suicide is the product of both conscious and unconscious psychological processes (Bernard & Bernard, 1980). There is a need, therefore, for psychotherapy and professional mental health counseling. Shneidman (1984) proposed twenty aphorisms about suicide which looked at: (a) the unmet psychological needs of people at risk for suicide; (b) the rights of the person at risk for suicide; and (c) our responsibility in relationship to people at risk for suicide. He then suggested some implications and notions pertinent to psychoanalysis. Shneidman (1984) suggests that:

1. Suicide is best understood not so much as a movement toward death as it is a movement away from something like pain or anguish which must be reduced to provide reason and

incentive for living.

2. Suicide is best understood not so much in terms of some sets of defined compartments (i.e., depression) but rather in terms of two continua of general personality functioning: perturbation and lethality. Perturbation is the extent of inner turmoil, and lethality is the risk of inflicting harm. To deal with a person's lethality might best be done by reducing his/her level of perturbation, thus reducing his/her level of lethality.

3. Suicide is best understood not so much as a psychosis, a neurosis or a character disorder, but rather as a more-or-less transient psychological constriction of emotions and feelings in combination with other elements such as intellect.

4. Suicide is best understood not so much as an unreasonable act, but as a reaction to frustrated psychological needs.

5. Suicide is best understood not so much in relation to the idea of a death as it is in terms of the idea of "cessation of life." Specifically, when cessation is seen by the suffering individual as the solution, suicide seems to become the perfect solution to life's painful and pressing problems.

Some resulting implications for psychotherapy are evident, necessitating a day-to-day ascertainment of and monitoring of the patient's perturbation and lethality

levels. The therapist should be willing and anxious to consult with other professionals in this life-or-death situation and even use hospital facilities if needed. The therapist might even need to carefully modify the usual canons of confidentiality.

The main goal with a suicidal person is to reduce the lethality level. This might best be accomplished by reducing the perturbation level. Counter the suicidal person's constriction-of-thought by attempting to widen the mental blinders and explore other viable alternatives. Identify and help with patient's unmet needs. This process should include "significant others" of the patient such as parents, friends, etc.

In general, the categories of preventive methods might include open communication, loving respect, provision of creative outlets, acceptance of strong emotions, and allowance for laughter and tears (Konopka, 1983). The skills needed by counselors might fall into four categories: (1) active listening, (2) focusing complaints, (3) showing involvement, and (4) exploring suicidality (Neimeyer & Hartley, 1986).

Prevention through Competence Enhancement

At whatever level the counseling takes place, it must be understood that young people who are suicidal are less able to cognitively develop coping strategies for life's

stresses than are young people who are not suicidal (Asarnow et al., 1987). Those at risk for suicide are less vigorous with their imaginations and therefore less able to project into the future (Santostefano, Reider, & Berk, 1984). Recognizing a need to assist in (a) the development of coping strategies, as well as, (b) the ability to develop coping strategies may have an effect on how we approach suicidal adolescents. Independence and self-reliance should be fostered.

One of the personal factors of adolescent's at risk for suicide is poor problem solving skills. It has been shown that adolescent problem solving skills can be taught, improved, and retained (Hains & Hains, 1987).

It also seems that sometimes a misperception exists on the part of suicidal youth that death may not be final. They have a cartoonish, wild west, or sit-com attitude toward problems as well as toward life and death (Bernhardt & Praeger, 1985). In prevention and intervention there is a need to discuss and teach the finality of death, that it is more than just sleeping.

Competence enhancement occurs whenever problem solving skills, stress reduction, and critical thinking are discussed. This can be done with the youth directly or with the parents. Any program aimed at problem solving or skills enhancement can be thought of as suicide prevention.

As intervention is considered, regardless of the level

at which it occurs--be it family or peer or professional-- crisis intervention theory can be very helpful. Crisis intervention theory suggests that intervention might include these four simple steps (Spero, 1980-81):

Step 1. An understanding of the crisis.

Step 2. A ventilation of feelings. This step will most likely occur along with step one, but it can also occur following step one and will set the stage for step three.

Step 3. An exploration of the various coping mechanisms and options, "taking off the blinders," so to speak.

Step 4. A re-opening, a re-establishment, a restoration of equilibrium in the client's social world.

With crisis intervention theory some of the elements of counseling in an ideal situation, such as building rapport and trust, are of necessity laid aside because of the imminent need to defuse a crisis. Spero (1980-81) suggests two additional interventative steps for the counselor: bracketing and stabilization. Bracketing consists of what might be called freezing the frame. This allows the counselor to get the patient outside of the panic with the chance to look at the crisis and explore feelings and options. It can also buy the counselor some time and help the patient gain a feeling of reason so that both can begin the process of reestablishing hope and trust. Stabilization is the reestablishment of equilibrium in the patient's

feeling and thinking processes by helping him/her ventilate feelings and helping the client locate some feelings of self-confidence and the will-to-achieve.

School District and Community Approaches

School Districts, as well as individual schools, have the opportunity to address the needs of adolescents at risk for suicide. Once the need is recognized, methods of meeting the need can be established. The state of California passed a legislative mandate in 1983 (Davis et al., 1988) requiring all schools to have a school based suicide prevention program. Apparently the program included a four-hour training of high school students, school personnel, and parents to recognize suicidal behavior and signs, and taught them how to act in a manner most likely to prevent suicide (Nelson, 1987). The majority said that the information most valued was the practical "how to's" that would help them respond to a suicide crisis. The findings of this study also indicate that students who participated in the program had a significantly higher knowledge about and awareness of suicidal risk signs and prevention. Ninety-six percent of the students and ninety-five percent of the school staff who participated in the program felt like it would be helpful in suicide prevention. It was also noted that even though family problems seemed to be a good

predictor of youth suicide, very few parents attended and participated in the program. The need for families to be more involved in suicide prevention and intervention was carefully underscored.

As of 1987, (Kyman, Berger, & Perez, 1987) most communities across this country did not offer adolescents general health care clinics. However, a trend now exists for communities and schools to begin to offer these kinds of intervention facilities to adolescents. By 1977 (Bonneson & Hartsough, 1987) there were 600 suicide and crisis hotlines with about 12 million people using these services annually. The act of using a suicide hotline by someone who is at risk for suicide is essentially one last cry for help on the part of that person. He or she is giving society one final opportunity to care or is making his/her last cry for help (Glatt, 1987).

In studies that have looked at the effectiveness of suicide prevention centers it has been found that they do attract people who are at risk for suicide. It was found that clients of suicide prevention centers were more likely to commit suicide than were general members of the community and that individuals who had committed suicide were more likely to have been center clients than were members of the general population (Dew, Bromet, Brent, & Greenhouse, 1987; Dryden & Jones, 1986).

In an attempt to facilitate this integration, the

Mental Health Center of Crow Wing County, Minnesota suggested the following elements of intervention: liaison with school counselors, peer counseling, support groups, faculty in-services, suicide education inclusion in some curriculum, and community forums (Morrison, 1987).

Suicide Counseling Skills

In concrete terms, how can school professionals and riskline counselors help? Counseling is not a simple process. It is not the intent of this section to present counseling as a simple, 1-2-3, kind of process. For the sake of brevity, a very simple description of preventive counseling has been termed the "ABC method" and will be used to outline the literature in this area. In step A, the counselor **acquires** information and establishes rapport with the adolescent. In step B the counselor **boils** the situation down to the causes and feelings. Step C is the **coping** stage in which the counselor helps the adolescent explore the best ways of coping with feelings and the situations (Ray & Johnson, 1983).

Acquiring Information

As information is acquired, it is important for the counselor to show involvement and actively listen (Neimeyer & Hartley, 1986) while facilitating open communication and expressing loving respect and care. There is a need throughout this whole process for the counselor to be accepting of strong emotions and to allow for the expression of laughter and tears (Konopka, 1983). While listening and acquiring information, there are some specific things that professionals can do. According to Hals (1985), the professional can: (a) be aware of and look for warning signs; (b) be aware of and ask for help from the outside professional resources if needed; (c) let the person know he/she is being taken seriously; (d) not make judgements or make the person feel guilty or stupid, be accepting; (e) let the person know they care; (f) make sure the person gets to help even if they need to accompany them there; (g) help the person understand the reality and finality of death; and (h) help the person with his/her coping skills.

When a counselor or other school professional is confronted with a student who might be suicidal and begins this step of acquiring information, the first question needs to be something like, "Are you thinking of killing yourself?" It is important to understand that asking the question will not increase the likelihood of suicide, and it

is important for the interviewer to act in a calm and confident manner. Subsequent questions might include such questions as (McBrien, 1983): Have you ever attempted suicide? Do you have a plan? This will reveal the level of risk. How much do you want to die, or what is the probability that you will kill yourself? The answer will send a clear signal as to the need for intervention and referral. How much do you want to live? This forces the person to focus on living, and would provide a great opportunity to help the person pursue reasons for living. How often do you have these thoughts and how long do the thoughts stay with you? This will indicate whether or not the person has the thoughts in control. Is there anyone or anything to stop you? If there is, a connection should be made between this person and that element of the person's support system.

Boil Down the Situation

Perhaps questions could be asked like, What has happened that makes life not worth living? Are there any other alternatives? Questions like these will provide a forum for the person to express feelings and help the counselor boil down the situation, as well as provide an opportunity to deal with those feelings and discuss problem solving and coping.

Linehan, Goodstein, Nielsen, and Chiles (1983) have put together a Reasons for Living Inventory. They tested and retested their inventory, having settled on six subscales with 48 reasons on the whole inventory. The subscales are survival and coping beliefs, responsibility for family, child-related concerns, fear of suicide, fear of social disapproval, and moral objections. The researchers concluded that although it is more difficult for suicidal people to generate and believe in reasons for living, reasons for living can be generated by both suicidal and nonsuicidal individuals.

Develop Coping Skills

The professional can help the adolescent do some things also. Renfro (1984) indicates that counselors should help the student begin to identify with viable role models and family processes. They should help the student begin taking some responsibility for family processes or whatever the source of the suicidality is and then set some realistic goals. The counselors should also help the student begin developing an internal locus of control, self-discipline and control, communication and cooperation skills, problem-solving and decision-making skills, and the ability to judge and apply this knowledge.

It is also recommended that counselors and school

professionals use a "no-suicide contract" when necessary. This approach increases the counselors' involvement with the adolescent and is known to have positive results (McBrien, 1983). Because suicidal actions can be impulsive, suicidal contracts help to give the adolescent some control over those impulses.

Lists and lists exist showing factors that research indicates are related to incidence of suicide. The problem is a result of complex and interdisciplinary problems. To approach suicide prevention and intervention from the vantage point of a single discipline such as sociology or psychology would be to ignore, or at least underestimate, the impact of problems from other disciplines. Suicide prevention and intervention must be an interdisciplinary approach (Sudak, Ford, & Rushforth, 1984).

Summary of Literature

Adolescent suicide is currently triple what it was forty years ago. Currently nearly 5000 adolescents who commit suicide each year, with 25 to even 50 attempts for each reported suicide. As of 1987, suicide was the second leading cause of death among adolescents (Nelson, 1987).

Long-term determinants were found to predispose adolescents to increased levels of risk for suicide. Family dysfunction was found to be a common determinant. Personal

factors, such as depression and hopelessness, and troubled peer relationships were also common in the literature.

In addition to these long-term patterns in the lives of those at risk for suicide, often events that occurred immediately prior to a suicide attempt precipitated the suicide. These precipitating events included two general categories. The first category is the predisposing determinants listed above if such an event: (a) were not characteristic of a life, (b) were to begin occurring, or (c) were to occur with increased frequency. The second category is the loss of anything important such as a boyfriend, a girlfriend, a job, or an article of importance.

In addition to causes, signs also existed that concerned persons could monitor that indicated a person might be suicidal. The list of warning signs was distilled to just six signs: (1) a suicide threat, (2) a previous suicide attempt, (3) depression, (4) marked changes in behavior, (5) making final arrangements, and (6) major substance abuse.

In relation to suicide, a number of myths also existed. These myths were synthesized into just three general areas of misconception: (1) discussion increases the risk of suicide, (2) normal people never commit suicide, and (3) suicidal risk and its changes.

Prevention and intervention was the next area of literature reviewed. Prevention included the development of

strategies and supports that helped one to overcome self-destructive feelings and thoughts (McGuire & Ely, 1984). Prevention and intervention were found to benefit those at risk. Therefore, these became potentially life-saving areas of consideration. Areas of possible prevention and intervention were reviewed.

Purpose of the Study

The purpose of this study was primarily to provide a descriptive evaluation of Jordan School District's riskline as a step toward assessing the effectiveness of education-sponsored suicide risklines. The questions considered included:

1. Who uses the riskline?
2. How serious is the need for this type of line?
3. How often is the line used as a referral source?
4. Is the risk assessment assigned each call related to any particular characteristic of the counselor or the caller?

Hypotheses

1. The sex of the counselor and the risk assessment are independent of each other.
2. The age of the counselor and the risk assessment are independent of each other.

3. The amount of education of the counselor and the risk assessment are independent of each other.
4. The educational discipline of the counselor and the risk assessment are independent of each other.
5. The amount of counseling experience of the counselor and the risk assessment are independent of each other.
6. Whether or not the call was received on a weekend is independent of the risk assessment.
7. The age of the caller and the risk assessment are independent of each other.
8. The sex of the caller and the risk assessment are independent of each other.
9. The grade of the caller and the risk assessment are independent of each other.
10. Whether or not the caller gave his or her name and risk assessment are independent of each other.
11. Whether or not the caller gave his or her address and risk assessment are independent of each other.
12. Whether or not the caller gave his or her phone number and risk assessment are independent of each other.
13. The length of the call and risk assessment are independent of each other.
14. Whether or not the caller was calling for himself or for another person and risk assessment are independent of each other.
15. Whether or not there had been a previous suicide attempt and risk assessment are independent of each other.
16. The month the call was received and the risk assessment are independent of each other.
17. The number of calls will be independent of the age levels of the callers.
18. The number of calls will be independent of the sex of the caller.
19. The number of calls will be independent of the callers source of concern, himself or another person.

In addition to the consideration of these hypotheses, this study provided some descriptive information about those who call the line. This information included: (a) some demographics about the callers, (b) some descriptive information about the calls themselves, and (c) the frequency of associated problems.

Limitations

In the cross tabulations that were run to assess the Chi-Square test for independence between risk assessment and each of the other variables, the samples were relatively small, and there were several empty cells. This limits the results to approximations of levels of significance.

The riskline is used by callers in a number of different areas of risk. The descriptive information presented in this paper is limited to those who used the line for suicide. Each call is described on an information sheet which is filled out by the riskline counselor. This study is limited to the information recorded on the data sheets. That information is limited because when reviewing the riskline information sheets, some information was missing.

Last, there was no access to the adolescents who have used the riskline. It is therefore impossible to do any

kind of follow-up study to determine before and after kinds of effectiveness of the riskline.

METHODS

Jordan School District's Riskline

Utah's State Legislature passed a law requiring school districts to have a suicide prevention program in place. To comply with this requirement, Jordan School District planned and implemented a riskline. Although one of the primary purposes of the line is to comply with the law requiring a suicide prevention program, the line is advertised as a general riskline for students and is not limited to those at risk for suicide. Rather, it is also used by those at risk for areas such as abuse, depression, family problems, peer problems, dating, as well as suicide and a number of other areas. The line is used by teachers, parents, and students in Jordan School District, as well as by people outside of the district.

Population

The population for this study was comprised of the students in the Jordan School District, their parents, teachers, counselors, and other professionals employed by the Jordan School District, and anyone outside of the district who knew about the line.

Sample

The sample consists of the 130 phone calls received regarding suicide risk between June, 1988 and May 1989.

Data Collection

Nine people staffed the riskline 24 hours a day during the time that data was collected for this study, June 1988 through May 1989. These counselors would meet monthly to generate a schedule of who would staff the line on which days during the month. During the day shift the calls would be transferred to the riskline office at the Jordan School Administration building. During the evening and night shift the calls would be transferred to the homes of the counselors. The school district designed a caller information sheet for the counselors to use in recording calls (See Appendix A). This sheet covers some basic demographics, the areas of risk for the caller, the level of lethality or problem complexity of the caller, and the actions discussed and suggested. It also provides some room for comments. When a counselor answers a call that comes into the riskline, the information sheet is filled out as the counselor works through the problem with the caller. This sheet is then turned in for compilation and evaluation

of the data. The information sheets from each suicidal caller will constitute the data for this evaluation.

Data Coding

For a consideration of the procedure for data coding, see Appendix B.

Data Analysis

Each piece of information on the data sheets was considered a separate variable. The data analysis for this study consisted of (a) running frequencies for each separate variable, and (b) comparing each of these variables with risk assessment using cross tabulations. This has been done in order to assess whether or not risk assessment can be predicted knowing any of the caller characteristics or the counselor characteristics. This has also been done in order to assess whether or not the number of calls can be predicted by knowing any other variables.

RESULTS

In the results section, two kinds of results are presented: (1) descriptive information regarding the callers who used the riskline and the calls themselves, and (2) the testing of each of the hypotheses. The descriptive information will be presented first.

Descriptive Statistics

The riskline operates 24 hours every day of the year. Each time a call comes in, an information sheet is filled out on that call. Some 130 suicide calls were recieved by the line during the year in consideration, and some of the information sheets have information missing. Obviously, only the information that is recorded can be considered. Forty-nine (68%) out of a recorded 72 callers called during the week with 58 information sheets missing this information. The age of the callers ranged from 10 to 41. The most common ages were 14 and 18 followed by 13, 15 and 17 (See Table 1).

Table 1

Age of the Caller

<u>Age of the Caller</u>	<u>Frequency</u>	<u>Percent of Total</u>
10	1	.8
11	0	0
12	1	.8
13	4	3.1
14	6	4.6
15	5	3.8
16	2	1.5
17	5	3.8
18	6	4.6
24	1	.8
41	1	.8
Missing	98	75.4
Total	130	100.0

Ninety-one (75%) out of 122 recorded calls were female with eight information sheets missing this information. The grade of the caller ranged from those in sixth grade to those who were out of high school. More than half (59%) of the recorded calls of those who called the riskline for suicide were already beyond high school age. Of those still in school, callers were most frequently from the ninth grade, followed by the twelfth grade (See Table 2).

Table 2

Grade of the Caller

<u>Grade of the Caller</u>	<u>Frequency</u>	<u>Percent of Total</u>
6	1	.8
7	3	2.3
8	6	4.6
9	14	10.8
10	4	3.1
11	2	1.5
12	5	3.8
Out of School	51	39.2
Missing	44	33.9
Total	130	100.0

Callers represented 19 different schools within the district with 13 calls representing schools outside of Jordan School District (See Table 3).

Table 3

School Attended by the Person At-Risk

<u>School Name</u>	<u>Frequency</u>	<u>Percent of Total</u>
Albion Middle	3	2.3
Alta High	13	10.0
Bingham High	2	1.5
Bingham Middle	1	.8
Brighton High	3	2.3
Butler Middle	5	3.8
Butler Elementary	1	.8
Crescent View Middle	3	2.3
Eastmont Middle	2	1.5
Hillcrest High	10	7.7
Joel P. Jensen Middle	4	3.1
Jordan High	7	5.4
Midvale Middle	2	1.5
Mount Jordan Middle	1	.8
Oquirrh Hills Middle	1	.8
Union Middle	2	1.5
Valley High	1	.8
West Jordan High	4	3.1
West Jordan Middle	5	3.8
Out of District	13	10.0
Missing	47	36.2
Total	130	100

The length of the calls ranged from just a few moments to over an hour. About one third of the calls lasted from 11 - 20 minutes with the next most common lengths being 6 - 10 minutes and 21 - 30 minutes (See Table 4).

Table 4

Length of the Call

<u>Length in Minutes</u>	<u>Frequency</u>	<u>Percent of Total</u>
0- 5	17	13.1
6-10	19	14.6
11-20	31	23.8
21-30	19	14.6
31-60	9	6.9
60+	1	.8
Missing	34	26.2
Total	130	100

Forty-seven (36.1%) of the callers were calling for themselves with 71 (55%) of them calling for someone else. There were 12 (8.9%) calls with this information missing. Of the 71 callers calling for someone other than themselves, 30 were calling for a child and 27 were calling for a friend, with the rest split between calling for a parent, a student, or other.

Thirty-one (24%) callers had previously attempted suicide, eight (6%) had not previously attempted suicide, with 87 (70%) of the caller information sheets not having this information recorded.

When a call comes into the riskline, the counselor assigns a risk assessment to the call. This risk assessment indicates the suicidal person's level of lethality according to the perceptions of the counselor and the descriptions of the caller. Thirty-seven (28%) of the calls were assigned a risk assessment of low, 16 (12%) medium, 10 (8%) high, and six (5%) imminent. There were 61 (47%) calls that had no

risk assessment assigned to them.

In most cases, the counselor suggested some action to the caller. These suggested actions ranged from seeing the school counselor, to going to a hospital or mental health facility, to calling the county sheriff (See Table 5).

Table 5

Action Suggested by the Counselor

<u>Action</u>	<u>Frequency</u>	<u>Percent of Total</u>
School Counselor	28	21.5
Multiple Action Suggested	15	11.5
No Action Suggested	14	10.8
Jordan Valley Mental Health	4	3.1
Private Counselor	3	2.3
Parents	2	1.5
Hospital	2	1.5
Jordan Family Ed. Center	1	.8
County Sheriff	1	.8
Missing	60	46.2
Total	130	100

Suicide was not the only problem that callers mentioned. Suicide was often one problem in a constellation of problems that the person at risk was experiencing. Part of the data that has been gathered indicates how frequently other problem areas were mentioned by callers (See Table 6).

Table 6

Associated Problems Mentioned by the Caller

<u>Problem</u>	<u>Frequency</u>
Family	24
Suicide of Others	18
Suicide Attempts of Others	16
Depression	15
Friends	15
Drugs/Alcohol	12
Sexuality/Dating	11
School	8
Abuse	6
Pregnancy/Abortion	6
Death of Friends/Family	4
Stress	2
Sexual Identity (Homosexuality)	1
Satanism	1

NOTE: The totals do not equal 130 because a number of callers mentioned more than one associated problem. Of the information sheets with this variable missing it is impossible to detect if that is because the counselor failed to mark the sheet or because the problem did not exist.

Testing of Hypotheses

The second area to be covered in the results section is the statistical results on each hypothesis. The data were collected by having the riskline counselors fill out an information sheet on each caller as the call was received. Each piece of information on these data sheets has been considered a separate variable, and each of these variables has been compared to risk assessment. This has been done in order to study whether or not risk assessment can be predicted by knowing any of the other variables.

Table 7 presents the statistical findings for the first five hypotheses. These hypotheses were to test whether or

not risk assessment was independent of the counselor variables. These findings indicate that risk assessment was independent of every counselor variable except counselor age. The counselors between the ages of 41 and 45 assessed 14 calls as being of either high or imminent risk, the counselors between the ages of 36 and 40 assigned zero calls to these risk levels, and the counselors between 31 and 35 assigned a single call to these risk levels (See Table 7).

Table 7

Counselor Characteristics and Risk Assessment

<u>Variable</u>	<u>Chi-Square Value</u>	<u>Df</u>
Counselor Sex	3.00390	2
Counselor Age	12.90114*	4
Counselor Years of Ed.	2.96421	2
Counselor Field of Study	3.09358	4
Counselor Experience	7.02300	4

Note: * p is less than .05

Table 8 presents the statistical findings for the hypotheses that relate to the characteristics of the caller. These hypotheses were to test whether or not risk assessment was independent of the caller characteristic variables. The findings indicate that risk assessment was independent of every variable except the grade of the caller. Between the grades of six and nine there were zero calls assessed as being of either high or imminent risk, between the grades of 10 and 12 there was one call assessed as being of either high or imminent risk, and for callers beyond high school

there were 12 calls that were assessed as being of either high or imminent risk (See Table 8).

Table 8

Caller Characteristics and Risk Assessment

<u>Variable</u>	<u>Chi-Square Value</u>	<u>Df</u>
Age of Caller	4.90774	6
Sex of Caller	.67744	2
Grade of Caller	13.75129**	4
Name Given	3.87071	4
Address Given	1.12118	2
Phone Given	2.31136	2
Call For Self or Other	1.01823	2
Previous Attempt	1.65079	2

Note: ** p is less than .01

Timing variables include month of the call, day of the call, and the duration of the call. The hypotheses relating to these variables were to test whether or not risk assessment was independent of the timing variables. The findings indicated that risk assessment was independent of each of these variables.

Hypothesis #17 was that the number of calls would be independent of the age levels of the callers. The grades were divided into categories: sixth grade through ninth grade, tenth through twelfth grade, and everything beyond high school. The Chi-Square test for independence was used to test the probability of this null hypothesis. There was less than a .000005 probability that these variables were independent; therefore, hypothesis #17 is rejected. The two

variables are not independent. Descriptively, of the calls that had this piece of information recorded on the information sheet, 60% were from callers of post high school age, 27% were from callers in the sixth through ninth grades, and 13% from callers in the tenth through twelfth grades (See Table 10).

Hypothesis #18 stated that the number of calls would be independent of the sex of the callers. The Chi-Square test of independence indicated that there was less than a .000005 probability that these two variables were independent. Hypothesis #18 is rejected; the two variables are not independent. In this case far more callers were female (75%) than male (25%) (See Table 10).

Hypothesis #19 was that the number of calls would be independent of the caller's source of concern, himself or another person. The Chi-Square test of independence showed less than a .02717 probability that these two variables are independent. Again the hypothesis is rejected and the variables are not independent. In this case there were 71 (60%) calls made where the caller was calling for another person, and there were 47 (40%) calls made where the caller was calling for himself or herself (See Table 9).

Table 9

Caller Characteristics and the Number of Calls

<u>Variable</u>	<u>Chi-Square Value</u>	<u>Df</u>
Grade Level of Callers	29.7415**	2
Sex of Callers	5.4343**	1
Caller for Self or Other	4.88*	1

Notes:

Grade level of callers is the variable: grade of caller categorized into three levels. Level 1: grades 7-9; Level 2: grades 10-12; Level 3: Post High School.

* p is less than .05

** p is less than .01

Overall, risk assessment is found to be independent of every variable except the age of the counselor and the grade of the caller. The number of calls is found to be independent of every variable except the the grade level of the caller, the sex of the caller, and for whom the caller was calling. More calls came from people beyond high school age than people still in school, more calls came from females than from males, and more calls came from people calling for someone else than from people calling for themselves.

DISCUSSION

One of the goals of this research was to provide a profile of those who use the riskline, together with when and how the line was used. During the formation of the riskline, it was anticipated that the line would be used more on the weekend than during the week. The opposite actually happened. There were approximately two calls during the week for every call on the weekend. This is likely due to the fact that a majority of those who called the line were beyond high school age and were calling for someone other than themselves; often these were parents calling for their children.

Of those still in school, the majority of the calls came from young people in the ninth through the twelfth grade. In addition, there were approximately three calls made by females for every call made by a male. The adolescent years are the years that are often most afflicted by turbulence. Males perhaps are less likely to admit their need for help.

The majority of the calls were made by people who were beyond high school age. There were more calls made by people stating that they were calling for somebody else than by people calling for themselves. About one in three callers gave their full name, but few phone numbers or addresses were given. That was probably because acquiring

that information was not a priority. Over 90% of the calls were less than 30 minutes in length.

Very few of the calls were from someone who had attempted suicide previously, with 85% of the calls being assessed as low or medium risk; therefore, when a referral was made, it was most often to the school counselor. Even if a parent were calling for a child, the referral was often to have the child see the school counselor.

The associated problems reported by callers coincide closely with the research reviewed in literature review. The categorical problem most frequently cited by riskline callers was "family," followed closely by the "suicide" or "suicide attempt" of another person which was followed closely by "depression" and "friends." The other most commonly cited problems were "drugs and alcohol," "sexuality and dating," "school," "abuse," and "pregnancy." The problems cited least commonly were "death," "homosexuality," and "satanism." It seems that on the whole, the constellation of callers' problems would not be unique to Jordan School District, although the intensity may differ from place to place.

Testing the hypotheses indicated that risk assessment was independent of all of the variables except two: the age of the counselor and the grade of the caller. The older counselors tended to more frequently assess the calls as being of high or imminent risk. This might be partially due

to the fact that most callers were beyond high school age and would call during the week, probably during the day. The calls were, therefore, directed to the district office and were all answered by the same two riskline counselors. This is one possible explanation for the finding that the age of the counselor and the risk assessment were related; these two counselors may have been in a position to talk to more high risk callers.

Risk assessment was also found to be independent of each variable except the grade of the caller. Most of the calls that fell into the high or imminent risk categories involved adolescents between ninth and twelfth grade. This means that the school district's efforts for intervention might benefit by focusing on the ninth through the twelfth grades. It also means that any prevention efforts need to start before the ninth grade since ninth grade is when the incidence of suicidal problems begins to escalate. One school district organized an elementary school death education puppet show (Bernhardt & Praeger, 1985). This kind of effort could fit into the Peer Leadership Team programs that are already being conducted in Jordan School District and could be an important tool in teaching children.

To summarize, the profile of those who used the line most indicates that they were more prone to be females. Most were beyond high school age, stated they were calling

for someone other than themselves, and called during the week. Parents and friends used the line slightly more often than the person who was suicidal. This can be very important because it means that suicide prevention and intervention programs can be very valuable and reach an important target audience by focusing on the families and the friends of those who are at risk.

Jordan School District has some peer programs in place like PLT ("Peer Leadership Team," an intraschool organization of peers that leads out in important issues like drug abuse) and PRIDE ("Peers Responsible In Drug Education," an interschool organization that travels throughout the district and the country presenting programs primarily on the avoidance of drugs) that might be utilized to provide some of this kind of peer teaching and support. Peer involvement in this process should be given a very high priority (Wodarski & Harris, 1987) because an adolescent who is at risk for committing suicide will give signs and communications, and most often their peers are the ones around to pick up on the signs. Thus, by virtue of peers' availability and accessibility to the signs, they need to be trained and knowledgeable about the signs and their meanings and what to do about them.

The constellation of contributing problems reported by those who used the riskline is congruent with the research presented earlier, most frequently involving family, others'

suicides, depression, and social life. Drugs and alcohol and school were also frequently mentioned. These findings are important because they mean that suicide is not a problem independent of other problems, nor is it a problem that suddenly occurs in people. Warning signs can indeed be monitored in an attempt to help those who are at risk. Some of the most common warning signs have been covered in some detail in this paper. Providing a knowledge of these warning signs to teachers, counselors, other school professionals, peers, and families would be a valuable prevention technique.

The findings support the literature reviewed that dysfunctional families are a critical problem point. If the problem of suicide is to be approached from anything more than a superficial level, steps need to be taken to heal, educate, and help families as family units. In addition, suicidal people have associated problems that lead to depression, poor social skills, and suicidality. This is important because it means that problem solving skills, coping skills, and internal locus of control are things that the educational world needs to be conscious of and help young people to develop.

Suicide is often a symptom of other problems. If we define the problem as suicide and leave out the problems that precipitate suicide, then our prevention and intervention efforts will be limited to building more

suicide prevention centers and implementing more suicide risklines. While a need exists for these facilities, limiting prevention and intervention efforts to crisis intervention must fall short because the causative problems still exist. Prevention and intervention efforts need to include (a) a focus on facilitating the growth of stronger families, and (b) helping young people to develop decision making, coping, and problem solving skills along with internal locus of control.

One of the questions being asked by Jordan School District is whether or not the riskline is meeting the needs of those at risk for suicide. That is a difficult question to answer. During the year for which data was collected and evaluated for this study, there were 130 suicide calls. How many of those would have resulted in suicide without the riskline is impossible to know. Murphy (1984) states that it is difficult to determine if we are preventing suicides because the lack of a suicide generates no data. If a person calls the riskline and the counselor helps that person, a problem might have been addressed and a suicide may have been avoided and "we rarely have the luxury of knowing that our efforts have actually prevented a suicide...if suicide is difficult to predict, its prevention is even more difficult to detect" (Murphy, 1984, p. 348).

Recommendations

The following recommendations are made to assist Jordan School District, as well as future researchers and teachers who may be studying the impact of suicide risk lines.

1. Recognize the critical role that troubled families play in the problem of adolescent suicide and seek ways to educate and strengthen families as family units.

2. Recognize the role that youth play in helping other youth. Troubled youth will talk to other youth, and healthy youth have been shown to be anxious to help. Seek ways to have healthy, strong youth teach and help youth at risk.

3. Recognize that suicide is symptomatic of other problems and that prevention and intervention is, therefore, long term. Prevention kinds of education done in the early grades through things like PRIDE, the Peer Leadership Team, puppet shows, or any of a multitude of things can be just as important as emergency intervention kinds of procedures done through risklines. Seek ways to implement prevention principles in all grades, especially the earlier ones, in addition to intervention programs in the later grades. The prevention principles taught need to grow out of the problems from which suicide grows, including such things as dysfunctional families, problem solving, and depression, as well as drugs and alcohol.

4. Encourage follow-up after referrals have been made. If a referral has been made to a school counselor, encourage

the riskline counselor who made the referral to follow up with that counselor to make sure that some contact is made with the student. Perhaps a place on the caller information sheet could be used to indicate whether this kind of follow up has taken place.

5. If there is indeed a need to more closely assess the effectiveness of the riskline, there is a "Crisis Call Outcome Rating Scale" (Bonneson & Hartsough, 1987) that could be employed to follow a sample of calls, or all calls if resources permitted it.

6. Encourage the riskline counselors to fill out the riskline information sheets as completely as possible. This will provide more accurate data with which to study the riskline in the future and then make adjustments as needed.

7. In future analysis, separate out the parents and friends of those who are suicidal and consider just the sample of suicidal callers themselves.

8. Continue to monitor the associated problems mentioned by suicidal callers so that future preventative educational programs can be structured to meet the needs that exist.

The problems that lead an adolescent to need a riskline are fairly easily outlined; they are less easily solved and even less easily prevented. A need exists for some kind of crisis intervention for those experiencing the crisis, as well as for those who have friends or family experiencing

crisis. The need for intervention bespeaks the need for prevention. It appears that the work being done is meeting a need and helping. Much more remains to be done.

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APPENDIXES

Appendix A

DATE: _____

COUNSELOR: _____

RISK LINE INFORMATION

ABUSE _____ FRIENDS _____ SEXUALITY/DATING _____
 DRUGS/ALCOHOL _____ PREGNANCY _____ SUICIDE/DEPRESSION _____
 FAMILY _____ SCHOOL _____ OTHER _____

AGE: _____ SEX: _____ OUT OF DISTRICT _____

SCHOOL: _____ GRADE: _____

NAME OF CALLER: _____

ADDRESS: _____ PHONE: _____

CALL BEGAN: _____ CALL ENDED: _____ TOTAL MIN.
 OF CALL: _____

COMMENTS: _____

RISK LINE CHECKLISTLow Risk

- ___ Call Completed, no action
 ___ Referral to school counselor: _____

Medium Risk

- ___ Referral to school counselor: _____
 ___ Referral to Jordan Family Ed. - 565-7442
 ___ Notification to parents

High Risk

- ___ Referral to So. Valley Mental Health - 566-2455
 ___ Notification to parents

Imminent Risk

- ___ Referral to So. Valley Mental Health - 566-2455
 ___ Referral to SLC County Sheriff - 535-5055

Appendix B

The data were coded as follows:

	<u>Variable</u>	<u>Variable Name</u>	<u>Column</u>	<u>Code</u>
1	ID number	ID	1-4	ID #
5	Date- Month/Year	Date	5-8	Mo/Yr 01-12/88-90 Missing = 0*
9	Weekend	Weekend	9	Fri-Sun = 1 Mon-Thu = 2
10	Age	Age	10-11	#
12	Sex	Sex	12	F = 1 M = 2
13	Grade	Grade	13-14	#
15	School Name	School	15-16	Albion = 01 to Out of Dist. = 99
17	Name Given	Name	17	First = 1 Both = 2
18	Address	Address	18	Given = 1
19	Phone Number	Phone	19	Given = 1
20	Length of Call	Lngh	20	0-5 = 1 6-10 = 2 11-20 = 3 21-30 = 4 31-60 = 5 60+ = 6
21	Caller - For Self of For Other	Caller	21	For Self = 1 For Parent = 2 For Child = 3 For Friend = 4 For Student = 5 For Other = 6
22	Previous Attempt	Prev Att	22	Yes = 1 No = 2
23	Risk Assessment	Risk	23	Low = 1 Med = 2 High = 3 Imminent = 4

24	Action Suggested	Action	24	School Coun = 1 Family Ed = 2 Parents = 3 Mental Health = 4 Sheriff = 5 Private Coun = 6 Hospital = 7 Multiple = 8 No Action = 9 Yes = 1
25	Abuse from Parent	Abuse	25	
26	Drugs/Alcohol	DrugAlc	26	
27	Family Problems	Family	27	
28	Problems with Friends	Friends	28	
29	Pregnant/Abortion	Preg	29	
30	Problems with School	School	30	
31	Sexuality/Dating	Sex	31	
32	Depression	Depress	32	
33	Others' Suicides	Suicide	33	
34	Others' Attempts	Attempt	34	
35	Stress	Stress	35	
36	Deaths of Friends/Family	Death	36	
37	Sexuality Identity	Sex ID	37	
38	Satanism	Satan	38	
39	Counselor Sex	CSex	39	Fem = 1 Male = 2
40	Counselor Age	CAge	40	31-35 = 1 36-40 = 2 41-45 = 3 46-50 = 4
41	Counselor Education	CEd	41	Bach = 1 Mast = 2 PhD = 3

42	Counselor Educational Discipline	CDeg	42	MSW = 1 Ed Psych = 2 Ed Admin = 3 Ed = 4 Health Ed = 5 Business = 6
43	Counselor Experience	CExp	43	1-5 = 1 6-10 = 2 11-15 = 3 16-20 = 4

* - For each variable if the information was missing from the information sheet, the variable was coded "0".