2004

School counselors' perceptions of effective components in adolescent suicide prevention programs

Janet Marlene Jackson

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SCHOOL COUNSELORS' PERCEPTIONS OF EFFECTIVE COMPONENTS IN ADOLESCENT SUICIDE PREVENTION PROGRAMS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Janet Marlene Jackson

June 2004
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Janet Marlene Jackson
June 2004

Approved by:

Dr. Rosemary McCaslin, Faculty Supervisor Social Work

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Dr. Rosemary McCaslin, M.S.W. Research Coordinator
ABSTRACT

This study explored effective components in adolescent suicide prevention programs. School counselors were interviewed face-to-face concerning their perceptions of effective components. Two models were presented in the current study, the stress model and the mental health model. The importance of social workers in the school setting was also explored. Data analysis was conducted on narrative data that was coded to find common thematic patterns. It was hypothesized that effective components according to school counselors consisted of components from both the stress model and the mental health model. School counselors identified four effective themes as effective components and one theme as an ineffective component of adolescent suicide prevention. The findings of the current study confirmed the hypothesis that counselors would identify effective components from both the stress and mental health model. The findings of this study confirm the importance of school social workers implementing both models in school-based suicide prevention programs.
ACKNOWLEDGMENTS

I wish to express thanks to my family and friends who have supported me throughout the MSW program. Without their understanding, I may not have succeeded. I would like to thank my children Amanda, Christian, and Drew, who are the joy of my life and if I have neglected you during this long process, please forgive me. I only hope to serve as an example in that you will also continue your education after high school. I would also like to thank my boyfriend Fred who has been neglected the most. Now we can enjoy life together as a couple.

Finally, I would like to thank my research supervisor Dr. McCaslin for all her guidance and assistance.
DEDICATION

This proposal is dedicated to my son Derek who passed away on November 22, 1994 as a result of suicide. At that time, his high school did not participate in an adolescent suicide prevention program. My goal as a social worker specializing in school social work, is to implement an effective suicide prevention program throughout the State of California. Derek has been the motivation to continue my education in order to complete this goal.
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CHAPTER ONE
INTRODUCTION

Problem Statement

Adolescent suicide is growing at an alarming rate. It is considered a leading cause of death among teenagers. It is the third leading cause of adolescent death and accounts for 13.5% of all deaths in the United States (Zametkin, Alter, & Yeminin, 2001).

Approximately, 8 percent of all high school students have moderate to high levels of suicidal thoughts (Mazza, 1997). According to Lyon et al. (2000), in a twelve month period, 20.5% of students in grades nine through twelve, seriously considered suicide and 7.7 percent attempted suicide one or more times. More than likely, these figures are conservative due to underreporting. Factors such as religious beliefs, insurance benefits, and social stigmas affect the actual percentage of reported completed suicides (Mazza, 1997).

In the past, suicidal behavior was usually addressed within the immediate family with a referral from the family physician recommending individual and/or family counseling. Currently, adolescent suicidal behavior is also addressed through community prevention and
intervention with programs such as suicide crisis hotlines and school-based programs. During the past decade, high schools across the nation have been implementing programs bringing suicidal behavior to high levels of awareness by educating both students and teachers in the classroom setting. These curriculum-based programs consist of primary and secondary prevention programs.

Primary prevention programs consist of components such as education on risk factors, referrals to community resources, firearm management, and media education. Risk factors are considered an important component because students and school staff are informed of signs of suicidal behavior. Community resources are another important element of primary prevention programs. If outside resources are made available, students are more aware of services that could address their needs.

Treatment agencies such as centers for abuse (physical, emotional, and sexual) are considered important factors since these are high risk factors for suicide behavior. Treatments for alcohol and drug abuse are also included because they are considered high risk factors for suicide. Suicide crisis hotlines are another component in primary prevention programs. Students are made aware of these hotlines for crisis situations that may arise. Firearm
management is another important element included in primary programs. Research indicates two-thirds of all adolescent suicides are the result of firearm use (Miller & DePaul, 1996). Media education is another approach that heightens suicide awareness. Publicized suicides have been proven to lead to suicide contagion and suicide clusters (Miller & DePaul, 1996).

School-based prevention programs also consist of secondary prevention programs. Secondary prevention programs directly assess students in order to identify high-risk students through the use of a self-report questionnaire. Individuals identified as high risk are administered a structured clinical interview as a means of intervention (Miller & DePaul, 1996).

These primary and secondary prevention programs are based on the stress model of suicide prevention. This model assumes that students display suicidal behavior as a reaction to severe psychosocial or interpersonal stress (Garland & Zigler, 1993). It does not include the mental health model, consisting of psychological components contributing to suicidal behavior (Garland & Zigler, 1993).

The mental health model focuses on psychopathology and is generally not applied in school-based prevention
programs. This model helps students understand that suicide attempts and completions are usually the result of a treatable psychiatric disorder (Cliffone, 1993).

According to Mazza (1997), approximately 95% of adolescents who commit suicide suffer from some form of psychopathology such as depression. Recent research indicates that the majority of school-based prevention programs are ineffective due to the exclusion of the mental health model and that if both models were implemented, the effectiveness would be greatly improved (Garland & Zigler, 1993; Mazza, 1997; Miller & DuPaul, 1996; Ward, 1995; Zametkin et al., 2001).

Purpose of the Study

The purpose of the present study is to identify school counselors’ perceptions of effective components in adolescent suicide prevention programs. This study also identified the attitudes of school counselors toward the stress model and the mental health model. Although there is substantial literature supporting the need for components of both models, this study investigates school counselors’ point of view towards both models in an effort to determine their perception of effective components in adolescent suicide prevention programs. School counselors
are the population that helps students in crisis situations that arise during school hours and offer the experience of handling emergency situations students encounter. It is crucial that school suicide prevention programs are successful in heightening suicide awareness in order to reduce the high rate of adolescent suicide.

School counselors, social workers, and teachers are individuals who are involved with adolescents on a daily basis. This exposure enables them to address this social problem on an educational level during school hours. These individuals are in a position to serve as strong support systems for students at risk of suicidal behavior. If a strong effective program is enforced, these individuals can make a difference in the welfare of suicidal adolescents. School counselors may already possess the necessary knowledge to help enforce such a program.

Qualitative data from this study were collected and recorded from school counselors in high schools regarding their options about effective components of adolescent suicide prevention programs. This study sought to identify whether effective components of the stress model and/or the mental health model are included in counselors’ perceptions. The school counselor population was the best
source due to their close relationship and expertise with the adolescent population.

Significance of the Project for Social Work

School counselors consisted of individuals holding a Master degree in Education, Social Work, Marriage and Family Therapy, and individuals in these master programs serving internships. School social workers and other school counselors are major contributors to mental health services within the school setting. Working collaboratively, school social workers, who may already hold special expertise, and other school counselors can provide the necessary and critical implementation of adolescent suicide prevention programs. By promoting awareness among students and school staff, social workers will help identify those students at risk before suicidality becomes deadly, which is why it is critical for schools to employ social workers as counselors. There are few school social workers employed in California. Most are employed in the larger metropolitan cities. Currently, San Bernardino County does not employ social workers in this capacity. Social workers make an important contribution and should be increased in the schools throughout California.
Acting as a strong support system, social workers may act as a liaison between the school, parents, and various community resources. Community resources include suicide crisis hotlines, mental health agencies, and treatment facilities for substance abuse. Research indicates abuse (sexual, physical, and emotional) and substance abuse are high risk factors for suicide behavior (Ward, 1995). If these social problems are addressed appropriately, adolescent suicide would be reduced (Ward, 1995).

Social workers in the school setting are able to provide this vulnerable adolescent population social justice by addressing the social problems leading to adolescent suicide. Social workers are also able to provide this population dignity and self-worth since society attaches a stigma to suicidal behavior. By addressing this stigma with dignity, social workers are mindful of this vulnerable population's differences.

To improve the quality of treatment for suicidal adolescents, social workers must also consider society as a whole. Suicidal behavior not only affects the individual, it also affects family, friends, and other community members. Social workers also provide these students empowerment. By heightening students' awareness, individuals have a higher rate of recovery than those
individuals who are not exposed to an effective school-based suicide prevention program (Ward, 1995). Utilizing the generalist model for social work practice, the current study is at the evaluation stage. School counselors' perceptions are evaluated as to whether they are effective components in adolescent suicide prevention.
CHAPTER TWO
LITERATURE REVIEW

Introduction

Adolescent suicide is not only a family concern, it is also a concern of the community. Therefore, community efforts are needed to heighten awareness on a national level. In the past, discussing suicide was considered taboo. At the present time, society has made great strides concerning this social problem by addressing suicide through the implementation of prevention programs in the schools throughout the United States.

The stress model and the mental health model are the two models implemented in suicide prevention programs. This chapter will discusses effective components in both models and will also address theoretical perspectives guiding this study.

Effective Components of the Stress Model

The majority of curriculum-based suicide prevention programs employ the stress model. This model educates students and teachers about the signs of and risk factors for suicidal behavior. The stress model also addresses the availability of community resources, firearm management,
and media education. The model consists of primary and secondary prevention programs.

Primary prevention programs within the stress model offer suicide awareness for students and teachers. They are curriculum-based and are presented in a classroom setting. Students and school staff are presented the signs and risk factors of suicide behavior. Risk factors include previous suicide attempts, substance abuse, sexual or physical abuse, neglect, and suicide ideation (Zametkin et al., 2001). Other risk factors include poor self-esteem, sexual orientation, and negative life situations such as parental separation or divorce and loss of a loved one (Dube et al., 2001).

According to Dube et al. (2001), if an adolescent experiences several negative life events concurrently, the risk of suicide increases. According to Garland and Zigler (1993), these negative life experiences increase social instability; therefore, it is vital that primary programs offer students strength-based coping skills to increase their beliefs in self-efficacy. By increasing adolescents' coping and problem-solving skills, relationships between hopelessness and suicidality can be mediated (Garland & Zigler, 1993).
Another effective component in primary programs is educating students and staff about the availability of various community resources. In order to increase teenage suicide awareness, students and teachers are exposed to the availability of various community resources. These resources address drug and alcohol abuse, sexual and physical abuse, and mental health problems. These social problems, which are risk factors for suicidal behavior, are addressed through specialized prevention programs in order to reduce suicidal tendencies (Ward, 1997).

Primary prevention programs also consist of firearm management. The most frequent method of adolescent suicide is the use of firearms (Garland & Zigler, 1993). The emphasis for students is to reduce suicide by limiting the availability of firearms (Garland & Zigler, 1993). Research shows that increased availability of firearms is associated with increased adolescent suicide rates (Garland & Zigler, 1993). As a measure of prevention, Garland & Zigler (1993) suggest stricter gun control laws. Although this is a long-term goal, a more immediate and less controversial step can be taken by informing students of the importance of storing guns and ammunition in separate locked areas (Garland & Zigler, 1993).
Media education is also an important component in primary programs. Not only is it important for the media to be educated concerning social imitation effects of suicide, students and teachers should also be aware of these media effects. According to Miller & DuPaul (1996), adolescents ages 15 to 19, following a publicized suicide, were found to engage in suicide behavior more frequently than would be expected by chance alone. Social workers and counselors present this information in a nonthreatening and nonaccusatory manner to adolescents since it is unrealistic to expect the media to censor suicide coverage (Garland & Zigler, 1993). It is also important for reporters to downplay suicide and the method used in a suicide the media publicizes (Miller & DuPaul, 1996). It is suggested that the media emphasize prevention actions after publicly addressing suicide to heighten awareness (Miller & DuPaul, 1996).

The stress model also consists of secondary prevention programs. Secondary prevention programs offer students assessment, screening, and the availability of suicide crisis telephone hotlines. The goal of these programs is to prevent existing conditions from progressing into a severe form of psychopathology (Miller & DuPaul, 1996). Secondary prevention programs directly
assess and screen students who are at risk for suicidal behavior. This is accomplished by administering a self-report questionnaire such as the Suicidal Ideation Questionnaire (Miller & DuPaul, 1996). Students who score high on the questionnaire are then administered a structured clinical interview as a means of intervention (Miller & DuPaul, 1996). Garland & Zigler (1993), suggest assessment and screening techniques are best if used integratively with other health related programs such as substance abuse treatment in order to reduce suicidal behavior as the sole focus. This will help limit labeling those identified as showing suicidal behavior (Garland & Zigler, 1993).

Telephone crisis hotlines are another effective component in secondary programs. Hotline services are shown to reach a population not served by other mental health interventions (Garland & Zigler, 1993). These services are more appealing to adolescents due to their anonymous nature and adolescents’ perceived control of being able to hang up the telephone at any given time (Garland & Zigler, 1993). Evidence indicates hotline service reduce suicide rates among the population that most uses these them, for example, young white women (Garland & Zigler, 1993). Since teenage males are the
highest risk population, Garland & Zigler (1993), suggest promoting and emphasizing hotline services geared towards male adolescents.

Effective Components of the Mental Health Model

The mental health model emphasizes psychopathology and is generally not implemented in school-based suicide prevention programs. This model consists of educating students and teachers about symptoms of mental disorders. Many students who display suicidal behavior have psychiatric conditions such as affective, conduct, antisocial or bipolar disorders, and depression (Garland & Zigler, 1993). Many of these adolescents also suffer from psychological anxiety, displaying perfectionism with rigid behavior and inflexibility concerning environmental changes (Garland & Zigler, 1993). According to Mazza (1997), approximately 95% of adolescents who commit suicide have some psychopathology such as depression. With the knowledge of psychopathological symptoms, students and teachers are able to help identify high-risk students in order to reduce suicidal behavior (Garland & Zigler, 1993).

The mental health model helps students understand that suicide attempts and completions are usually symptoms
of treatable psychiatric illnesses, and when proposed in this manner, students are more likely to self-disclose (Cliffone, 1993). When teenagers self-disclose their feelings and intentions, there is a higher likelihood other students and teachers will identify symptoms of suicidal behavior and intervene (Cliffone, 1993).

This model also targets only the high-risk student population. An effective mental health model includes assessment instruments that examine actual suicidal behavior at the beginning of the program, identifying students who are high risk (Mazza, 1997). By targeting high-risk students, counselors and social workers are able to provide immediate intervention to those in need instead of the entire student body, creating a more efficient program (Mazza, 1997). Instruments used at the beginning of the program can identify students who have engaged in previous suicidal behavior and capture any family history of suicidal behavior (Mazza, 1997).

Another effective component in the mental health model is increasing awareness of various community resources. Like the stress model, the mental health model also addresses the availability of various community resources. If students are aware of treatment and mental
health agencies, there is a greater likelihood they will use these facilities (Zametkin et al., 2001).

Another important component in this model is educating students and staff about pharmacological treatments for mental disorders. It is important that students are aware of successful pharmacological treatments for various mental disorders and the importance of continuation of medication such as antidepressants, due to the relationship between depression and suicidal behavior (Zametkin et al., 2001). Students are informed of the danger of discontinuing effective treatments that can send a depressed adolescent on a downward spiral of hopelessness and despair leading to suicide attempts and completions (Zametkin et al., 2001). Research shows that antidepressants have reduced suicide attempts in adolescents over the past ten years (Zametkin et al., 2001).

Theories of Suicide Guiding Conceptualization

There are several theories explaining suicidal behavior. This study utilized the sociocultural theory of suicide, which is associated with the stress model and the escape theory of suicide, and contains components of both the stress and mental health models. Sociocultural theory
emphasizes social and cultural stressors as causes of suicidal behavior. Escape theory emphasizes social stressors and psychopathology as causes of suicidal behavior.

The Sociocultural Theory of Suicide

The sociocultural theory of suicide views suicidal behavior as a result of social and cultural forces. This theory explains adolescent suicidal behavior as the result of family conflict and breakups and individualism due to increased expectations and changes in teenage transitions (Eckersley & Dear, 2002). Changes in adolescent transition occur when youth are isolated from adults, which increases peer-group influence and creates tension between dependence and autonomy (Eckersley & Dear, 2002).

Cultural changes such as increased individualism not only apply to Western society youth, but also affects all youths on a global level contributing to the increase of psychosocial disorders such as drug abuse, crime, depression, and suicidal behavior (Eckersley & Dear, 2002). This shift towards individualism places youths at the center of a system of values, behavioral choices, and convictions emphasizing personal autonomy and independence (Eckersley & Dear, 2002). According to research,
socioculture changes in Western societies have adversely affected men more than women due to the changing role and status of women and the gender difference in how the self is seen (Eckersley & Dear, 2002). This may be due to the fact that men in the West construct the self as independent and separate from others, while women perceive the self as interdependent (Cross & Madson, 1997). As a result, individualism is less isolating for women than men (Cross & Madson, 1997).

This theory posits that individualism in Western societies has reached the point of broad-spread dysfunction, and if taken too far, results in isolation and social fragmentation (Eckersley & Dear, 2002). These societies are taking autonomy to unrealistic and unattainable heights resulting in a gap or tension between youths' expectations and realities (Eckersley & Dear, 2002). This tension is making autonomy and freedom excessive and increasingly dissatisfying and depressing (Eckersley & Dear, 2002). Individualism is also undermining the human need to belong and form lasting relationships (Eckersley & Dear, 2002). Autonomy also creates conflict among the formal constraints of society's laws, regulations, and rules resulting in criminal behavior and substance abuse (Eckersley & Dear, 2002).
Generally, individualism is seen as better for most individuals, but there is a cost to a small minority by society’s failure to provide appropriate sources of social identity and attachments by promoting false expectations to youths (Eckersley & Dear, 2002). This may be especially problematic for adolescents since society’s expectations of individualism are premature. Suicide is regarded as an ultimate expression of individual freedom of choice and control over one’s life and the greater the sense of personal autonomy, the more likely youths will make the choice to die (Eckersley & Dear, 2002).

The Escape Theory of Suicide

The escape theory of suicide points to suicide risk factors such as negative life stressors, perfectionism, anxiety, and depression. These are factors contained in both the stress model and the mental health model. This theory posits a six-step process leading to suicide behavior.

The first step is the occurrence of current circumstances that fall short of or below an individual’s standards (Dean & Range, 1996). This is usually the result of an individual’s self-oriented socially prescribed perfectionism (Dean & Range, 1996). Self-oriented
perfectionism arises when an individual self-imposes unrealistically high standards and expectations on the self (Dean & Range, 1996). Socially prescribed perfectionism arises when an individual believes that others expect and place high standards on the individual (Dean & Range, 1996).

The second step of the process consists of internal attributions. Internal attributions cause an individual to self-blame for disappointing and negative outcomes resulting in low self-esteem and a high risk factor for adolescent suicidal behavior (Dean & Range, 1996).

The third step involves increased self-focus. In a state of high self-awareness, the individual focuses the self as inadequate, incompetent, unattractive, and guilty (Dean & Range, 1996). In order to detect these imperfections, the individual monitors his/her behavior against perceived standards the individual has placed on the self or others have placed on the individual (Dean & Range, 1996).

The fourth step in the process involves negative affect. Depression and anxiety, which are psychopathological symptoms of suicidal behavior, arise when the individual places unrealistic standards on the
self based on the self's perceptions of perfectionism (Dean & Range, 1996).

Now, the individual shifts to a state of cognitive deconstruction. The fifth step occurs when the individual's cognitive deconstruction of hopelessness shifts from long-term to short-term and the individual focuses on immediate ideas and emotions (Dean & Range, 1996).

The sixth and last step occurs when the individual experiences a reduction in inhibition. The reduction in an individual's inhibition eliminates reasons for the individual to continue living and creates the reason for committing suicide (Dean & Range, 1996). At this time, the individual is depressed or anxious, leaving an open pathway to suicidal behavior.

Summary

The models and theories discussed in this study relate to environmental and psychological stressors in the lives of American youths. Both the stress model and the mental health model contain effective components to help prevent adolescent suicidal behavior. Most research indicates that school-based prevention programs would be much more effective if both models were included in the
curriculum (Cliffone, 1993; Garland & Zigler, 1993; Mazza, 1997; Miller & DuPaul, 1996).
CHAPTER THREE

METHODS

Introduction

This research project was a qualitative, exploratory, single group design of school counselors’ perceptions of effective components in adolescent suicide prevention programs. Face-to-face interviews with school counselors were conducted posing the following three core questions: 1) Which components in adolescent suicide prevention programs do you think are most effective? 2) Which components in adolescent suicide prevention programs do you think are least effective? 3) Do you feel there are high-risk students who fall outside the established prevention zone? Why or why not?

Study Design

The purpose of the current study was to explore perceptions of effective components in adolescent suicide prevention programs among San Bernardino County school counselors. Not only did this study explore effective components from the stress model and the mental health model, but also included any other additional effective components described during interviews. This design was selected because school counselors hold essential
knowledge about what works in adolescent suicide prevention. It is hoped that the use of open-ended questions allowed for comments by the respondents to reveal their true feelings, overriding any limitations of the study’s design. School counselors’ perceptions of effective components of adolescent suicide prevention may offer a deeper understanding of the issues than standardized instruments.

Limitations of this design included reliance on counselor reports. In addition, school counselors may have misrepresented their own views if they viewed the interviewer negatively. Also, school counselors may have displayed social desirability in their responses in order to please the interviewer.

**Sampling**

The population of interest for this study consisted of school counselors in San Bernardino County. School counselors were defined as individuals holding a Master degree in either Educational Counseling, Social Work, or Marriage and Family Therapy. School counselors were also defined as those in the above Masters programs serving their internship in the capacity of school counselor. The sample was purposive because this population would yield a
considerable amount of important knowledge concerning teenage suicide. School counselors were the key informants due to expert qualifications such as education, experience, and daily exposure to the adolescent population. School counselors interact and observe teenagers on a daily basis concerning various personal issues and crisis situations.

The sample for the current study included ten school counselors from nine high schools in San Bernardino County. Demographics of the respondents were noted concerning diversity, gender, age, and educational level to achieve greater representation of the population sample.

Data Collection and Instruments

Data collection consisted of face-to-face interviews. A qualitative design was chosen since research on school counselors’ perceptions of effective components in adolescent suicide prevention programs is limited. Each interview took approximately thirty to forty minutes. The interviewer asked respondents various open-ended questions. Three core questions along with seven prompt questions were used for respondents who needed additional clarification (Appendix A). The prompt questions addressed
components in both the stress and mental health models. Program components of firearm safety, coping strategies, and community resources addressed the stress model. Awareness of mental disorders addressed components included in the mental health model. Awareness and risk factors, which address both models, were also included in the prompt questions. The final prompt question addressed counselors' experience with adolescents displaying suicidal behavior to determine if school counselors' approaches consisted of the stress model and the mental health model. Resulting data was analyzed on a categorical level to determine common themes concerning suicide prevention.

Procedures

The data source of the present study consisted of school counselors in San Bernardino County. Respondents were contacted via telephone or electronic mail by the interviewer for an appointment and invited to participate. The interviewer contacted nine San Bernardino County high schools and spoke with the counselors directly and made an appointment for an interview. At that time, counselors were also informed of the nature of the study and the approximate length of the interview. Interviews were held
off school grounds and after school hours. Interviews took place where respondents and interviewer were free from interruptions and disturbances.

Interviews took place after special permission was granted by the Superintendent of San Bernardino County Schools. An interview limitation occurred when one school counselor forgot about the interview and was not available to reschedule.

All information was transcribed by hand and noted carefully including relevant verbatim statements offered by the school counselors.

Protection of Human Subjects

To ensure confidentiality of the respondents, names and identifying data for each respondent were not recorded. Each respondent was assigned a random research number during the data collection process. Additionally, the number of individuals reviewing the data was limited to the researcher and the faculty supervisor of the study. All data gathered from the interviews were safeguarded at the interviewer's home during the study. All respondents were informed that any information offered to the interviewer was completely confidential. Each respondent received an informed consent form prior to the interview.
briefing school counselors on confidentiality and that participation in this study was voluntary and that they could stop participation at any time (Appendix B). Respondents were provided with the telephone number of the faculty supervisor to answer any additional questions. After the interviews were completed, each respondent received a debriefing statement explaining the purpose of the study (Appendix C).

This research project was approved for protection of human subjects by the Department of Social Work Sub-Committee of the Institutional Review Board of California State University, San Bernardino.

Data Analysis

The interviewer’s notes were transcribed and evaluated. Key words and terms from the interviewer’s notes were transcribed onto index cards and evaluated for similarity. The narrative data were also coded and entered into a matrix table of thematic codes. Qualitative analysis was used to examine the strength of the relationships between narrative data points.

Summary

This study explored effective components in adolescent suicide prevention programs. A qualitative
study was used to determine common thematic patterns in the narrative data. All respondents in this study were insured of confidentiality at all times. It is hoped that this study provided information that may generate further studies of this nature. Additionally, it is hoped that school counselors are able to identify and practice effective components of adolescent suicide prevention.
CHAPTER FOUR

RESULTS

Introduction

This study included ten counselors from nine San Bernardino County High Schools. They ranged in age from 25 to 55 years old. The ethnic make-up consisted of 60% Caucasian, 30% Mexican-American, and 10% African-American. Ninety percent of the respondents were females and 10% were male. For further demographic information, refer to table 1 below.

Table 1. Demographic

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30
Presentation of Findings

Each core question in the face-to-face interviews was used to gather statements and relevant factors that were then summarized as responses that pertained to the questions asked. These responses were then used to form themes that pertained to effective and ineffective components of adolescent suicide prevention. The following reports core and prompt questions, sample responses, and how these responses were used to establish main themes and important factors.

The first core question asked school counselors to identify effective components in adolescent suicide prevention programs. Counselors identified four themes as effective components. These include the importance of coping strategies, suicide awareness education, the importance of crisis hotlines, and understanding depression. One theme counselors identified as an ineffective component to suicide prevention was firearm safety. Factors were identified to support these themes as effective or ineffective components of suicide prevention.

Coping strategies were identified by 70% of counselors’ responses as an effective theme or component. For example, respondent 8 stated, “Coping strategies are essential in preventing suicide ideation, but not only for
addressing suicide, but all life’s stresses and crisis situations.” Respondent 8 also emphasized the importance of implementing coping skills, but at an earlier age. Other respondents indicated that coping strategies affect decision making. Respondent 2 stated, “Coping strategies help adolescents remain calmer in their decision making when in a crisis situation, therefore, he/she is able to avoid making an emotional decision that may lead to a suicide attempt.”

Three factors were extracted from the above responses supporting the importance of coping strategies. Forty percent indicated developing coping skills at an earlier age as an important factor. Forty percent also identified coping strategies for all crisis situations as an important factor. Effective decision making was also noted by 30 percent of the counselors as an important factor in coping strategies.

Another theme that was established by school counselors was suicide awareness education. All respondents stated that this was an effective component in suicide prevention. Factors included identifying risk factors and normalization. All respondents emphasized the importance of identifying risk factors as the major factor for suicide awareness education. Forty percent stated that
suicide awareness helped students normalize their feelings.

Respondent 6 stated, "Educating students about suicide awareness normalizes what students may be feeling and identifying risk factors helps students talk about suicide." Respondent 2 stated, "Educating students helps them know they are not alone and that others feel the same way too." This respondent also indicated that if students know the risk factors, they are able to help identify other students who may be at risk for suicidal behavior."

A third theme identified by school counselors was the importance of crisis hotlines. Forty percent identified crisis hotlines as an important component to suicide prevention. Three factors arose concerning crisis hotlines and included providing someone to listen to, confidentiality, and trust.

Respondent 5 stated, "Crisis hotlines are very effective in helping to prevent suicide behavior. They provide students someone to talk to and listen to them and it is easier to trust hotlines because of their anonymity." Both respondents 1 and 2 expressed that crisis hotlines provide adolescents the opportunity for someone to listen to them. Respondent 6 claimed that confidentiality is a great concern for the adolescent
population. Thirty percent of counselors' responses identified as a factor that crisis hotlines provide adolescents someone to listen to them. Confidentiality was identified by 20% of respondents and trust was also identified by 20% of respondents.

The fourth theme school counselors expressed was the importance of students understanding depression. Ninety percent expressed that addressing depression is an important component in reducing suicidal behavior. The two major factors for this theme were students identifying what is wrong and medicine compliance. Symptom identification was declared as a factor by 90% of the respondents and medicine compliance by 30% of counselors' responses.

Respondent 2 declared, "Depression helps students identify what may be wrong and lets them know about the appropriate ways they can deal with depression." This respondent also stressed the importance of students complying with their medication. Respondents 6 and 10 indicated that understanding depression helps students identify what is wrong when they display these symptoms. Respondent 9 stated, "Adolescents need to understand depression in order for them to admit they need help,"
which makes it easier for them to receive the appropriate help."

A component that was discovered as being least effective was firearm safety. When counselors were asked the prompt question, "Do you think firearm safety is an important component in suicide prevention," eighty percent answered "no." One factor supported this ineffective theme in suicide prevention. The counselors felt that if an individual was going to commit suicide, the knowledge of firearm safety would not prevent them from committing the act. For example, respondent 3 stated, "Anyone who knows how to use a gun would consider using one in a suicide attempt." Respondent 2 declared, "If students want to commit suicide, they will find a way to do it even if firearm safety is a part of their knowledge base." All respondents agreed that firearm safety is an important component for accident prevention, not suicide prevention.

When school counselors were asked the third core question, "Do you feel there are other high-risk students who fall outside the established prevention zone," all respondents answered "Yes." All respondents felt that there are always a few individuals who are not identified as being at-risk students. For example, respondent 4 stated, "Identifying risk factors helps other students
identify students at-risk, therefore, preventing them from falling through the cracks."

Summary

The summary of responses and the percentages of responses were obtained from 36 pages of transcripts, which were derived from approximately six hours of face-to-face interviews. If additional information on responses is desired, they may be found in the "Summary of Responses" in Appendix E. The responses of school counselors in this study showed common themes and factors as effective and ineffective components in adolescent suicide prevention.
CHAPTER FIVE

DISCUSSION

Introduction

After analyzing school counselors’ responses in the current study, five themes emerged. Four themes were found as effective components to adolescent suicide prevention and one theme was found as an ineffective component to suicide prevention. Themes as effective components consisted of coping strategies, suicide awareness education, crisis hotlines, and understanding depression. Surprisingly, counselors did not consider firearm safety as an effective component to suicide prevention.

Discussion

The current study’s findings supported the hypothesis that school counselors’ perceptions of effective components consist of elements of both the stress model and the mental health model.

Coping strategies were a major theme counselors found as an effective component of suicide prevention. Although not listed as an actual component for either model, coping strategies are mentioned as useful tools in the stress model. According to the stress model, coping skills increase students’ self-efficacy which lowers suicidality.
Garland & Zigler, 1993). Developing coping strategies at an earlier age was a major factor claimed by counselors in the current study. If adolescents were taught appropriate coping skills earlier in life, it may have an impact on their decision making and help them choose options that are not life threatening. Counselors also identified decision-making as a factor in coping strategies. School counselors indicated that coping skills are also important for all of life’s crisis situations, not just for suicidal behavior. If children learn appropriate coping skills at a young age, they should be able to apply positive cognitive decisions in all emotional situations that arise in their lives (Dube et al., 2001).

Suicide awareness education was the strongest component school counselors found to be effective. According to Laux (2002), if risk factors are identified, then appropriate counseling can be offered and behavior can be monitored in future sessions. Identifying risk factors was a factor all respondents agreed upon. According to the stress model, identifying risk factors is crucial in reducing suicidal behavior (Zametkin et al., 2001). Garland and Zigler (1993), allege that the identification of risk factors enables counselors to encourage coping skills mediating suicidal behavior.
School counselors also addressed normalization as a factor for suicide awareness education. Several counselors indicated that normalization made the students feel they were not the only ones feeling the way they did. Counselors also indicated that if students know what is wrong it helps them understand the normalcy of what they are feeling. Although counselors identified risk factors and normalization as factors contributing to suicide awareness education, they did not go into depth as to what the risk factors may be. For example, the stress model includes risk factors in suicide awareness education and identifies many risk factors such as substance abuse, sexual and physical abuse, sexual orientation, and negative life stressors such as divorce (Dube et al., 2001).

School counselors identified crisis hotlines as an effective component in suicide prevention. Crisis hotlines are included in both the stress and mental health model as a major component in reducing suicidal behavior. Counselors described benefits crisis hotlines offer such as providing adolescents someone to listen to, confidentiality, and trust. Several counselors indicated that hotlines may be a last resort for adolescents in crisis and may be the one thing that keeps him/her alive.
According to Garland & Zigler (1993), hotlines help those in crisis decide that suicide is not an option. As stated before, crisis hotlines appeal to the adolescent population due to the anonymous nature (Garland & Zigler, 1993).

Understanding depression was a theme the majority of counselors interviewed identified as an effective component to suicide prevention, which is contained in the mental health model. School counselors did not feel that the description "mental disorders" was appropriate. They thought this term was too harsh and contained stigma implications. Depression was considered a milder more acceptable term by school counselors. Counselors also agreed with Zametkin et al. (2001), that medicine compliance is a factor in preventing suicidal behavior.

Surprisingly, school counselors did not find firearm safety as an effective component to suicide prevention. The majority indicated that this knowledge would not prevent an adolescent from a suicide attempt. This component is included in both the stress and mental health model and is seen as an important component in reducing suicidal behavior. Counselors viewed firearm safety as a measure of preventing firearm accidents rather than preventing suicide.
There were several components in the stress and mental health model that counselors did not identify as either effective or ineffective components. The counselors interviewed in this study did not include media education as an important component in suicide prevention.

Research indicates that adolescents engage in suicidal behavior more frequently after a publicized suicide which is a component in the stress model (Garland & Zigler, 1993; Miller & DuPaul, 1996). Another effective component that is described in the mental health model is the importance of assessment instruments examining suicidal behavior for students at-risk. Counselors interviewed did not give any indication that they used assessment instruments to help identify risk factors and mental health symptoms.

Overall, school counselors’ perceptions of effective components did coincide with the sociocultural and escape theory in that they were able to identify risk factors that contribute to adolescent suicidal behavior (Dean & Range, 1996; Eckersley & Dear, 2002).

Limitations

This study was limited in several ways. One was that the gender composition of the respondent did not give a
wide enough sample of males due to the unavailability of males in the school counselor population. Because the sample was almost entirely female, caution should be made in generalizing to males. Another limitation was the small sample size. This small sample size restricts its generalizability to the counselor population. Another limitation was that the counselor population sample was absent school social workers with a Masters in Social Work due to their nonexistence in San Bernardino County serving as school counselors.

Recommendations for Social Work Practice, Policy and Research

The current study interviewed school counselors as the best population for assessing perceptions of effective components in adolescent suicide prevention programs. As the demographic data indicates, none of the counselors interviewed were school social workers. Currently, San Bernardino County does not employ school social workers in the capacity of school counselors. Other counties in California do employ school social workers in some of the major metropolitan cities, but the numbers are few. School social workers are the ideal population to address adolescents' issues and problems.
The practice of social work on a micro level addresses family issues along with client issues. School social workers would be in a position to make home visits to students and their families. On a macro level, social work practice addresses policy proposal and policy change. According to current research and the findings of the present study, school social workers are able to approach both policy proposal and policy change. To best serve the adolescent population, school social workers can implement the stress model and the mental health model in school-based suicide prevention programs. With this implementation, adolescent suicidal behavior can be reduced.

Conclusion

The current study confirmed the importance of effective components from both the stress and mental health models of adolescent suicide prevention and supported the study’s hypothesis. Since the majority of prevention programs across the nation only include the stress model, this study’s findings support the need to include components from both models in suicide prevention programs in the school curricula. Additional studies will
help program developers and policymakers enhance their programs to reduce adolescent suicidal behavior.
APPENDIX A

CORE QUESTIONS AND PROMPT QUESTIONS
CORE QUESTIONS

1. Which components in adolescent suicide prevention programs do you think are most effective?

2. Which components in adolescent suicide prevention programs do you think are the least effect?

3. Do you feel there are high-risk students who fall outside the established prevention zone?

PROMPT QUESTIONS

1. Do you feel that student’s knowledge of risk factors helps identify at-risk students for suicide behavior? Why or why not?

2. Do you think it is a good idea to include suicide as a result of mental disorders to students’ knowledge base? Why or why not?

3. Do you think the development of coping strategies for crisis situations benefits students if such an emotional situation should occur? Why or why not?

4. Do you think that firearm safety is an important component in suicide prevention? Why or why not?

5. Do you feel that community resources such as crisis hotlines are effective in changing adolescent suicide behavior? Why or why not?

6. Do you feel that educating students suicide awareness helps prevent suicide behavior? Why or why not?

7. In your experience as a counselor, how often and what strategies did you use for suicide prevention?
APPENDIX B

INFORMED CONSENT
INFORMED CONSENT

This study is being conducted by Janet M. Jackson under the supervision of Dr. McCaslin, Professor of Social Work, at California State University, San Bernardino. The research is designed to explore perceptions of school counselors in San Bernardino County concerning effective components of adolescent suicide prevention programs.

This study involves answering questions in an interview format and should take approximately 30 to 40 minutes to complete.

Any information you provide will be confidential. At no time will your name be recorded with your responses. All data will be reported in group form only. You may receive the group results of this study upon completion in the Fall Quarter of 2004 at the John M. Pfau Library located at California State University San Bernardino, 5500 University Parkway, San Bernardino, California 92407.

Your participation in this research is voluntary. You are free not to answer any questions at any time during this study without penalty or remove any data you have provided at any time during the study. There are no foreseeable risks to you for participating in the study. After completion of the interview, you will receive a debriefing statement describing the study in more detail. In order to ensure validity of the study, we ask that you not discuss this study with other counselors in the San Bernardino School District.

This research has been approved by the Department of Social Work Sub-Committee of the Institutional Review Board at California State University, San Bernardino. If you have any questions or concerns regarding the study, please contact Dr. R. McCaslin at (909) 880-5507.

By placing a mark in the space below, I acknowledge that I have been informed of and understand the nature and purpose of this study, and I freely consent to participate.

By this mark, I also further acknowledge that I am at least 18 years of age.

Give your consent to participate by marking an X here

Today’s date is ________________
APPENDIX C

DEBRIEFING STATEMENT
DEBRIEFING STATEMENT

This study you have just completed was designed to explore effective components in adolescent suicide prevention programs. In this study two models were investigated; the stress model and the mental health model. The stress model includes components such as student and teacher awareness through education about risk factors and symptoms, firearm safety, and the availability of community resources. This model states that adolescent suicide is due to the impact of major environmental stressors. The second model, the mental health model, includes student and teacher awareness through education about psychopathology and the availability of community resources. This model explains suicide as the result of psychopathology such as depression. We are particularly interested in the perceptions and beliefs of school counselors as to which components of these models they think are effective in teenage suicide prevention programs.

Thank you for your participation and for not discussing the contents of the interview with other school counselors in the San Bernardino County School District. If you have any questions or concerns, please feel free to contact Dr. Rosemary McCaslin at (909) 880-5507. If you would like to obtain a copy of the results of this study, please contact Pfau Library at California State University, San Bernardino, 5500 University Parkway, San Bernardino, California 92407.

If you would like a source on school-based suicide prevention programs, please refer to http://wonder.cdc.gov/wonder/prevguid/pooooo24/pooooo24.asp.
APPENDIX D

SUMMARY OF RESPONSES
### Table 2. Summary of Responses

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<tr>
<th>Effective Component Themes</th>
<th>Number</th>
<th>Percentage</th>
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<tr>
<td>Coping Strategies</td>
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<td>70</td>
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<td>Factors</td>
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<td>Develop at an earlier age</td>
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<td>40</td>
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<td>For all crisis situations</td>
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<td>40</td>
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<tr>
<td>Affects decision-making</td>
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<td>30</td>
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<tr>
<td>Suicide Awareness Education</td>
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<td>100</td>
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<tr>
<td>Factors</td>
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<td></td>
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<tr>
<td>Identification of risk factors</td>
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<td>100</td>
</tr>
<tr>
<td>Normalization</td>
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<td>40</td>
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<tr>
<td>Crisis Hotlines</td>
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<tr>
<td>Factors</td>
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<td></td>
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<tr>
<td>Someone to listen</td>
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<td>Confidentiality</td>
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<td>Trust</td>
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<tr>
<td>Understanding Depression</td>
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<tr>
<td>Symptom identification</td>
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<td>Medicine compliance</td>
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<tr>
<th>Ineffective Component Theme</th>
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<tr>
<td>Firearm Safety</td>
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<td>80</td>
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<tr>
<td>Factors</td>
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<tr>
<td>Would not prevent suicide attempt</td>
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<td>80</td>
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<th>High Risk Students Who Fall Outside The Prevention Zone</th>
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<td>Factors</td>
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<td>Identifying risk factors</td>
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REFERENCES


