AN ASSESSMENT OF TEACHERS' AWARENESS OF THE INDICATORS OF SUICIDE AMONG ADOLESCENTS

BY

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A Thesis

Submitted to the Faculty of Graduate Studies

in Partial Fulfillment of the Requirements

for the Degree of

Master of Education

Department of Educational Psychology

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Winnipeg, Manitoba

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ABSTRACT

A survey was administered to 159 high school teachers in a Winnipeg School Division to assess their awareness of the indicators of suicide among adolescents. Frequency counts and percentages were calculated for each of the questions in this descriptive study. Ninety-two percent of the teachers had taken no courses on suicide. The majority of teachers were not aware of: ethnic groups at greatest risk in Manitoba, method of suicide used by males, suicides in their school, or a school plan to deal with suicidal students. Teachers were somewhat aware of suicide signs, factors, myths and resources. The teachers strongly agreed it was their role to help a suicidal student and would inform someone. However, 87.7% of the teachers did not feel adequately prepared to work with suicidal adolescents. The majority of teachers, 95.5%, felt staffs should receive training and 66.6% felt students should be taught a unit/course on suicide. Therefore, the Department of Education and school divisions, in Manitoba, need to develop workshops and course outlines which meet the needs of teachers and students.

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Introduction

Suicide is the second leading cause of death among adolescents in Canada (Statistics Canada, 1989). Many accidents, which are the leading cause of death, are considered by experts to be unreported or misclassified suicides (Holinger, 1978; Peck, 1982). In the United States, an estimated 13 adolescents per day or 5,000 per year end their own lives (Bensley & Bertsch, 1987). These statistics have prompted experts to declare adolescent suicide as being a major epidemic problem in the United States (McKenry, Tishler, & Christman, 1980). In order to address this problem, we must establish whether teachers are aware of the warning signs or indicators of suicide. If teachers are aware of these indicators, then they might be able to identify and refer high risk students for counselling which, in turn, might decrease the number of adolescent suicides.

Background of the Study

Shulman and Margalit (1985) described suicide as "the expression of a total sense of rejection and distress being turned upon the self" (p. 263). They viewed suicide attempts as an effort to achieve control and to cope with one's feelings of helplessness. In the past two decades, there has been a 300% increase in the number of adolescent suicides (National Task Force on Suicide in Canada, 1987). Subsequently, the rate of suicidal attempts is

estimated as ranging from 9 to 50 attempts for every completed suicide (Hipple & Cimbolic, 1979; Peck, 1982). Due to the stigma attached to suicide, by society, the rate of suicidal ideation in the adolescent population is difficult to determine.

The pace of society has increased so drastically that adolescents are experiencing difficulties in coping with their constantly changing world. There are many economical, familial, educational, and social factors which are applying additional stress on today's teenagers' lives (Peck, 1982). Adolescence is a period of rapid and dramatic biological, psychological, and emotional changes (Anderson, 1982). A time of transition - moving from parental dependence to independence. All these changes and transitions create stress which can lead to depression (Ishisaka, 1987). The threat of nuclear war reinforces the helplessness and hopelessness of society's future. Family disorganization, relationship breakups, alcohol abuse and depression have been identified as major suicide risk factors (Hoberman & Garfinkel, 1988). These external and internal factors compounded with students' inexperience to deal with stressful situations, may encourage them to consider suicide (Baechler, 1980).

Rich and Bonner (1987) believe that suicide ideation is the entry point into the suicidal process. Seibel and Murray (1988) believe that the decision to commit suicide develops over time -

caused by the adolescent's emotional vulnerability, family and social pressures. Smith and Crawford (1986) found that 62% of students reported some degree of current suicidal ideation and over 8% had made a suicide attempt. Only a small fraction of these attempters received any medical or therapeutic assistance. Bailey et al. (1986) found that 52% of their adolescent follow-up subjects reported having thought about suicide. Moscicki (1989) cited Ramsey and Bagley's (1985) Calgary results, where 38% of the students reported some form of suicidal ideation with 6% reporting a suicidal attempt. Seventy-five percent of college students surveyed reported having contemplated suicide as an adolescent (Bolger, Downery, Walker & Steininger, 1989). Thompson (1987) found that in Manitoba, males committed suicide 5 times more often than females; native males were the highest risk group with rural, caucasian males being the second highest risk group.

Seibel and Murray (1988) cited Schneideman's (1985) description of suicide as a coping pattern - "habitually dysfunctional patterns of reacting to threat, pain, stress and failure make dire predictions of a tragic suicidal outcome" (p. 49). Schneideman felt that suicide can often be predicted. Tishler, McKenry and Morgan (1981), as cited by Nelson (1988), suggested that the adolescent suicide rate could be significantly decreased by training persons to perform "psychological first aid" in the

identification of and response to suicide danger signals. Today, schools act as a liaison and meeting ground for the adolescent, family and outside social agencies (Grob, Klein & Eisen, 1983). Teachers are in the position to observe changes in behavior, academic performance or interpersonal relationships, which are important indicators of their students' moods and coping abilities. Legally, teachers have been mandated to report any child they suspect or know is being abused; neglected; out of control or in need of protection (Manitoba Teachers' Society, 1988). With the higher incidence of suicidal behaviors in teenagers, educators have been forced to assume a new and difficult role (Deykin, 1984).

Teachers and counsellors play significant roles in assisting their students in developing into capable, fully functioning adults. Seibel and Murray (1988) believed that early childhood teachers are the first people to identify students with dysfunctional coping behaviors. They also felt that teachers have the greatest opportunity to break these patterns of self-destruction. Bensley and Bertsch (1987) stated that teachers and classmates generally are the first to identify suicidal behaviors, but do not report these observations for fear of overreacting. Safran's (in press) survey found that teachers felt inadequately prepared to work with socially withdrawn students compared to those students who were acting out socially (Csapo, 1988). By ignoring the early warning signs of

suicide, we are further isolating the student and increasing the risk of suicide (Deykin, 1984).

To date, the majority of the research has dealt primarily with the identification of the incidence rates, causes, factors, and indicators of suicidal adolescents. Recently, there has been some research on the role of schools and teachers in preventing adolescent suicides. Ray and Johnson (1983) found that parents, friends, and teachers are generally the first to notice behavioral changes that may be indicative of a potential suicide. Unfortunately, a large portion of this population cannot recognize these behavioral changes as indicators of potential suicidal victims (Duraj, 1984; McKenry et al., 1980) or is afraid to approach a student for fear of precipitating a crisis (Deykin, 1984). Nelson (1988) found that 34% of the student population had contact with a suicidal peer. However, only 9% said they would go to a teacher or counsellor for help.

The literature assessing high school counsellors' knowledge and abilities to identify suicidal gestures indicates that they are not properly prepared to work with potential suicides (Domino & Swain, 1986; Duraj, 1984; Schnacke, 1972). Two-thirds of the teachers studied reported a need for further professional development in the areas of adolescent suicide and depression; 40% felt that there was a need for support, supervision and

collaboration among staff members; and 20% advocated early referral of high risk adolescents to trained professionals (Grob et al., 1983).

Clearly, the needs of adolescents and teachers are not being met. Universities and school boards are not training counsellors and teachers to recognize, intervene or prevent suicidal ideation in their students. Teachers should be able to:

- identify high risk students;
- provide emotional support to socially isolated students;
- provide opportunities for success in school;
- teach relevant curricula and;
- mobilize community resources and services (Csapo, 1988).

Society has a responsibility to be cognizant of adolescents' suicidal thoughts; to educate parents and teachers about teen suicide; and to provide educational and counselling programs for students to learn how to resolve their suicidal thoughts in a more positive and healthy manner. Adolescent suicide is present in all societies and cultures. Early identification and treatment of high risk groups are essential elements of effective intervention and prevention of suicides (Csapo, 1988). Therefore, it seems appropriate to assess teachers' understanding and awareness of adolescent suicide.

Through this study the author hopes to assess teachers' current awareness of adolescent suicide and to identify specific areas where teachers require further training. School divisions can use the findings of this study to develop programs to meet the needs of the staffs and students in the area of youth suicide.

Statement of the Problem

Adolescent suicide is considered a major health problem. However, present studies focus primarily on completed and attempted suicide rates, causes of adolescent suicide, and high risk factors in adolescents. The literature regarding the ability of individuals, who influence adolescents, to recognize and identify the signs of a suicidal adolescent is almost negligible. Ideally, valuable information could be obtained from a study assessing teachers' awareness of the indicators of suicide among adolescents. If the results indicate that teachers are cognizant of the indicators of suicide, then we could conclude that teachers are knowledgeable and capable of identifying and referring high risk adolescents for counselling. However, contrary results would suggest that there is a need to educate teachers to enable them to identify potential suicidal students. By educating teachers, we may be taking the first step in reducing the incidence of suicide in adolescents.

The purpose of this study is to assess teachers' awareness of the indicators of suicide among adolescents. The results of this study will be compared to the published statistics to determine whether teachers are aware of the signs of suicidal youth.

Significance of the Study

This study will identify educators' awareness level regarding their knowledge of the indicators of a potentially suicidal student. Local dissemination of the findings of this study may encourage parents and school boards to provide teachers and counsellors with the opportunity to increase their knowledge and competency in recognizing suicidal behaviors. Through teacher education, there is a greater probability that suicidal adolescents will be identified at an earlier stage and given appropriate treatment. Finally, informed teachers may advocate for improved counselling services and educational programs for their students.

Current statistical information indicates that a significant portion of adolescents are contemplating suicide. The question remains - what are parents, schools and communities doing to resolve this situation? The National Task Force on Suicide in Canada (1987) recommended that the provinces provide suicide prevention training to correctional workers, health care professionals and teachers. Presently, teachers are not being adequately prepared at university to identify high risk students (those students who are abusing

drugs, victims of child abuse, sufferers of depression or contemplating suicide).

This is an unfortunate situation as this group of professionals spends a great deal of time with adolescents. Teachers are in the position to observe behavior changes which may indicate that a student is under some kind of pressure or experiencing some form of trauma (Wellman, 1984). Teachers are cognizant of adolescent development and empathize with their students, therefore, they appear to be a target group to educate in the area of adolescent suicide.

This study's results could have far reaching implications on schools, teachers, parents, communities, and society. First, they could indicate that teachers are not aware of the indicators of suicide among students. Secondly, it could identify specific areas where teachers require further training. Thirdly, it could reinforce the need for schools to develop a plan of action to meet the needs of their students. Finally, school divisions may use the findings of this study to:

1. provide training for their teachers on how to identify high risk students;
2. implement the concept of team meetings where teachers are provided with the opportunity to discuss high risk

students with their counsellor, administration and resource personnel;

3. promote a positive and successful school experience for all students;
4. develop school action plans for crisis situations;
5. develop preventive programs for students, and;
6. identify community resources and services available for their adolescent population.

Research Questions

This study was designed to address the following research questions:

1. Are teachers aware of the incidence rate of attempted and completed suicides, by sex and age, in Canada?
2. Are teachers aware of the incidence of completed suicides, in Manitoba, according to ethnic origin?
3. Are teachers aware of the most common methods used by males and females, in Manitoba, to commit suicide?
4. What percentage of their school's student population do teachers feel have contemplated, attempted or committed suicide in the past 12 months?
5. Are teachers aware of the behaviors or warning signs of a suicidal adolescent?

6. Are teachers aware of the main factors for adolescent suicide?
7. Are teachers aware of community resources available for suicidal adolescents?
8. Do schools have a specific plan for dealing with suicidal students?
9. Do teachers feel that they would inform someone else if a student had indicated to them that they were suicidal?
10. Are teachers aware of the facts and myths about suicide?
11. Do teachers believe it is their role to help suicidal students?
12. Do teachers feel that staffs and students should receive further training on the topic of suicide?
13. What areas do teachers feel they require further information on regarding adolescent suicide?

Definition of Terms

The following terms have been operationally defined to assist the reader in understanding the meaning of these terms in relation to the present study:

Completed Suicide - "includes all the situations in which the circumstance surrounding the death lead to the conclusion that the individual took a positive action with the primary purpose of ending his (or her) life" (Freese, 1979, p. 5).

Suicide Attempt - "includes those situations in which a person performs a life-threatening behavior with the intent of jeopardizing his (or her) life or (giving) the appearance of such an intent" (Freese, 1979, p. 5).

Suicide Gesture - "self-inflicted injuries without stated suicidal intent including small ingestions or superficial cuts to the throats and wrists" (Deykin, Perlow, and McNamara, 1985, p. 90).

Suicidal Ideation - "includes behaviors which might be directly observed or inferred and which are concerned with or move in the direction of a possible threat to the individual's life. However, the potentially lethal act is not actually performed" (Freese, 1979, p. 5).

Organization of the Study

Four chapters follow this introduction to the study. Chapter two is a review of the literature pertaining to the trends and factors relating to the increase in adolescent suicides and the extent that counsellors and teachers are knowledgeable and capable of predicting a potential suicide. Chapter three describes the methodology including the sample research design, instrument, and procedures utilized for this study. Chapter four presents the results of the study. Chapter five is a discussion of the results

and conclusions of the study. It also identifies the limitations of the study, and makes recommendations for future consideration.

Review of Literature

Adolescent suicide has been classified as a major health problem, which has reached epidemic proportions (McKenry et al., 1980). Consequently, the literature and research pertaining to adolescent suicide has increased in the last two decades. This chapter will review the literature for the following areas: 1) historical overview 2) current trends 3) theories of suicide 4) factors influencing the increase in adolescent suicide 5) assessment, prevention and treatment of suicidal behavior 6) role of teachers and schools and 7) ability of educators to assess suicidal ideation.

Historical Overview

Suicidal acts have existed in all known human societies (Freese, 1979). During the Roman Empire, suicide was perceived as an elegant, noble act. This attitude of martyrdom provoked an increase in suicides. Alarmed by these results, the Church adopted a position which condemned suicide as a "sinful act", which would result in ex-communication (Shneidman, 1981). During the Middle Ages, the mortal sin of suicide further denied the victim from the rights of a Christian burial (Freese, 1979).

In Shneidman's (1981) overview of theoretical development of suicide, he highlighted three major trends. In the 1700's, Rousseau theorized that society, not its members, was responsible for their

suicidal acts. Durkheim, in the twentieth century, further postulated that suicide depended on society's ability to have control over its members. Freud proposed his psychoanalytical theory of suicide, which stated that the individual's unconscious mind was responsible for one's suicidal ideation (Shneidman, 1981). These two latter theories represent the extremes in which suicide has been and is being viewed by society.

Since the 1900's, the highest recorded rate of suicide was in 1932, a direct result of the Stock Market Crash (Frederick, 1978). By 1954, suicide was the fifth leading cause of death in the 15 to 19 year old age group (Bakwin, 1957). Seiden (1969) found that in the decade, from 1952 to 1962, the rate of suicide in this age bracket increased by 8 to 10 fold. He also found a significant increase in the percentage of female and non-white suicides. Frederick (1978) found from 1955 to 1975 there was a 200% increase in suicides for 10 - 24 year old males, and a 128% increase for females. Hagen and Frandsen (1986) stated that in the last 25 years, the suicide rate for 15 to 24 year olds has increased 200% for girls and 300% for boys (Neiger & Hopkins, 1988).

Prior to 1950, suicide was not viewed as a mental health problem (Frederick, 1978). In 1958, the National Institute of Mental Health funded the first suicide prevention centre in Los

Angeles. This stimulated an increase in research, training and services.

Current Trends

Youth suicides have increased with the increase in drug and alcohol abuse, delinquency, sexual assault, pregnancy and crime (Hendin, 1987; Hoberman & Garfinkel, 1988). The suicide rate for 10 - 19 year olds has tripled since 1950, and for the 15 - 19 year olds alone it has doubled since 1960 (Blumenthal & Kupfer, 1988; Freese, 1979; Smith & Crawford, 1986). From 1960 to 1980, Marcs (1985), as cited by Lester (1988), found a 287% increase in youth suicides. Lester (1988) noted that in Canada, there was a 50% increase in the number of male adolescent suicides from 1970 to 1980. He also found that nations with a higher quality of life, generally, had a higher rate of suicide.

The 1989 Health Reports Supplement for Statistics Canada stated that in 1987, suicide represented the eighth leading cause of death for the total population. In Canada, there were 3,594 suicides for an overall rate of 14.0 / 100,000. In the 15 - 19 age bracket, suicide was the second leading cause of death - after accidents. However, there is some speculation that a high percentage of these accidents may in actuality be disguised suicides (Peck, 1982). In 1987, Canada had 244 suicides for 15 - 19 year olds. There were 201 male suicides for a suicide rate of 20.5 /

100,000. Forty-three of these suicides were females which is a rate of 4.5 / 100,000.

Rates of suicide attempts and threats are difficult to assess. Weissman (1974), in his New Haven study, reported a 1,104% increase in the number of suicide attempts brought into emergency rooms from 1955 to 1970. The rate of completed suicides to attempted suicides has been estimated to vary from 1:9 (Hipple & Cimbolic, 1979) to as high as 1:120 (Tuckman & Connon, 1962). Smith and Crawford (1986) found that 1/8 to 1/12 of high school students have made a suicide attempt.

Suicide ideation presents even greater problems for measurement. Studies estimate that between 10 - 75% of high school students have contemplated suicide (Bolger et al., 1989; Garrison, 1989). Suicidal thoughts are found to be very common in "normal adolescent development" (Ladame & Jeannert, 1982). Smith and Crawford (1986) estimated that 62% of their high school sample had contemplated suicide at one point in their life. Davis (1985) estimated that between 25 and 30% of their school sample population contemplated suicide.

American Natives have the highest rate of suicide (Neiger & Hopkins, 1988; Csapo, 1988, Thompson, 1987). There has been a significant increase in suicides for all color groups and both sexes (Seidan & Freitas 1980; Petzel & Cline 1978. However, the highest

increase has been in white, young males. The rate of whites to blacks who commit suicide is estimated at 3:1. The number of suicides for males to females varies from 3:1 (Frederick, 1978) to 5:1 (Blumenthal & Kupfer, 1988; Csapo, 1988; Shaffer, Garland, Gould, Fisher & Trautman, 1988). The ratio for males to females for attempted suicide also varies from 1:3 (Neiger & Hopkins, 1988; Weissman, 1974) to 1:7 (Trautman & Shaffer, 1984 as cited by Rotheram-Borus & Trautman, 1988).

Thompson (1987) studied the 190 completed suicides for ages 20 years and younger in Manitoba from 1971 to 1982. Males committed suicide 5 times more often than females. Three-quarters of all suicides were committed by firearms, (white males), or hanging, (native males). Overdose was the number one method of suicide for females. Native males had the highest rate of suicide with rural, white males comprising the second highest population group. Alcohol abuse, relationship breakup and recent marital or family dispute were the leading risk factors. Statistically, there was an increase of suicides for males during the months of September and October; on the victims birthday; and for native males weekends, especially Sundays.

> Neiger and Hopkins (1988) described suicidal adolescents as: usually dependent, accident prone, restless or bored, obnoxious (to receive attention), easily fatigued, experience

> notable changes in sleeping habits, are pessimistic, angry, guilty, have difficulty concentrating, have poor peer relationships, experience frequent mood swings, and feel rejected, lonely, isolated, or restricted (p. 474).

Factors which increase risk include: absence of natural parent, remarriage, family member seriously ill, previous attempt, parent, relative or close family friend had attempted suicide (Bensley & Bertsch, 1987). A marked decline in academic performance was evident in 76% of adolescent suicides (Hoberman & Garfinkel, 1988). A profile of a high risk suicide victim, in Manitoba, would be a rural, native, single male between the ages of 12 - 19. There would be a history of alcohol abuse; adoptive or foster status; recent loss of significant other; or a family or marital dispute (Thompson, 1987).

Firearms are the leading cause of death for males (Frederick, 1978; National Task Force on Suicide in Canada, 1987). However, overdoses are the most common method selected by females (Hoberman & Garfinkel, 1988; Cheiftez, 1987; Thompson, 1987). Over 50% of the attempts were made at home with intervention probable in the majority of attempts (Rotheram-Borus & Trautman, 1988; Gispert, Wheeler, Marsh & Davis, 1985). Several trends which are noteworthy are:

(1) The use of firearms has increased significantly for both sexes (Petzel & Cline, 1978), which suggest that the level of intent to die is greater.

(2) The increased availability of drugs is speculated to be significantly related to the increase in completed and attempted suicides (Weissman, 1974).

(3) There has been a significant increase in the number of white professional women who are committing suicide (Weissman, 1974).

Theories of Suicide

In the review of the literature, there are seven theories which represent the full spectrum of adolescent suicide. The first one is Durkheim's sociological theory of suicide. Durkheim believed in the social causes of suicide, basically because the rate of suicide was relatively stable across time but varied amongst nations across time (Bakwin, 1957). He felt the "suicide potential of a given society varied inversely to the degree of cohesion existing within that society" (Seiden, 1969, p. 26). Shneidman (1981) summarized Durkheim's three classifications of suicides. First, the altruistic group consisted of individuals who committed suicide because the customs or rules of their society demanded it. Second, the egoistic group was comprised of those individuals who had too few ties with their community. This group is considered

characteristic of the majority of the suicides in the United States. Finally, there was the anomic group, where the accustomed relationship between the individual and society has been shattered by a major crisis. Based on Durkheim's theory, Bakwin (1957) felt adolescent causes of suicide were largely related to external factors.

Freud proposed a psychodynamic theory of suicide. He felt suicidal behavior was an outcome of a person's ambivalence of loving and hating a lost object. These dichotomous feelings initiate feelings of hostility, which precipitate feelings of guilt. In order to satiate these feelings, the individual turns their aggression inward. At some point, these aggressive feelings need to be released. Often, the individual will resort to suicidal behaviors to appease his unconscious hostility toward the introjected love object (Gould, 1965).

In 1980, Baechler proposed a strategic theory for suicide. He viewed individuals as being in a constant state of struggle. Initially, their struggle is within themselves. However, as they develop, their struggle extends to their parents and eventually others. These struggles provide the foundation for the individual's decision-making and coping skills. Baechler believes there are five basic solutions to every problem, with suicide being one of the possible options. Society and social groups dictate the typical

solutions to problems, which tends to limit the individual's creativity and options. If an individual is incapable of responding in a typical manner, then he/she may elect to commit suicide. This theory suggests that every individual is susceptible to suicidal behavior, which intimates that the incidence of suicidal ideation is even greater than the statistics report.

Shulman and Margalit (1985) used a family systems model to explain their theory of adolescent suicides. They described suicide as a sense of total rejection and disgust turned against one's self. The child's impulsive self-destructive behavior is motivated by their desire to attain control over their chaotic situation and sense of helplessness. The parents respond by giving the child more attention which reinforces this pathological coping style.

Developmental theorists describe adolescence as a time of changes, crises, pressures and impulsiveness (Neiger & Hopkins, 1988). Wellman (1984) summarized Jacobs' five stage model of suicidal behavior, which is based exclusively on adolescents. The first stage represents an adolescent who has had a history of long standing problems. They perceive their parents as rejecting and unloving, which produce feelings of powerlessness and loneliness. During the second stage, there is an escalation of the problems with the onset of adolescence. This is a period of dramatic biological, psychological and affective changes which drastically reduces the

adolescent's coping resources. The third stage is typified by the inability to cope with these life stressors which promotes social isolation. During the fourth stage, a series of events occurs which eliminates any existing social relationships. The adolescent at this stage feels totally hopeless. In the final stage, just prior to the attempt, there is a period of justifying the suicidal action. This justification process is a result of the escalation of problems and their inability to effectively resolve them.

The cognitive theory is based in Piaget's stages of cognitive development (Davis, 1985). Adolescents view death with a sense of immortality - that death is reversible and is not final. Their perception is limited by their egocentric view of the world, their limited intellectual development, cultural attitudes and the media which supports the remoteness of death (Neiger & Hopkins, 1988).

Finally, there has been biological evidence that suicide and violence are closely related (Hendin, 1987). Recent studies suggest a deficiency in serotonin metabolite, 5-hydroxyindoleacetic acid (5-HIAA) is present in the cerebrospinal fluids in people who attempt suicide (Neiger & Hopkins, 1988). This deficiency alters the brain chemistry which makes the individual prone to depression when a stressful situation arises (Ishisaka, 1987).

Although these theories represent different perspectives on the concept of suicide, they all appear to agree that the

"individual's actions result from forces over which he has little or no control" (McKenry et al., p. 131). Finally, these theories reinforce the significance of regarding suicide as a multidisciplinary problem. One that should be viewed from a medical, psychological, social and educational perspective.

Facts and Fallacies

Adolescents who commit suicide have generally expressed their intention either verbally or behaviorally (Barrett, 1989). However, these clues are missed because suicide is a taboo topic and there are many popularly believed misconceptions (Martin et al., 1987). To effectively prevent suicides we must identify and dispel these fallacies.

Below are some of the key myths and facts about adolescent suicide:

1. Myth: Suicide happens without warning.

   Fact: 80% of suicidal people display many clues about their intention (Martin et al., 1987).

2. Myth: Suicidal people want to die.

   Fact: Generally they are ambivalent about dying and are often crying out for help (Barrett, 1989).

3. Myth: He isn't the suicidal type.

Fact: There is no "suicidal type". People of all races, religions, classes, ages and sexes commit suicide (Martin et al., 1987).

4. Myth: Suicide is inherited.

   Fact: Suicide is not transmitted genetically, it is a learned coping mechanism (Martin et al., 1987).

5. Myth: Someone who threatens suicide will not do it.

   Fact: Many adolescents who commit suicide have verbalized or hinted at their intent. All threats must be taken seriously (Barrett, 1989).

6. Myth: Once suicidal, always suicidal.

   Fact: Adolescents who receive proper treatment may lead a healthy life (Barrett, 1989).

7. Myth: Suicidal people are mentally ill.

   Fact: They may be depressed or suffering from a loss but cannot be diagnosed as mentally ill (Barrett, 1989).

8. Myth: Talking about suicide will encourage people to do it.

   Fact: The opposite is often true. By asking, the individual will feel free to discuss their feelings and problems which will deter the suicidal attempt (Barrett, 1989).

9. Myth: When the depression lifts, there is no longer any danger of suicide.

   Fact: The first three months after the recover from a deep depression are the most dangerous period for a suicidal individual (Barrett, 1989).

Suicide statistics are underreported (Martin et al., 1987). Often, suicides are not reported because it is "taboo". Through discussions and awareness of the facts and myths of suicide, we can begin to impact on youth suicides.

Factors Influencing the Increase in Adolescent Suicide

> suicidal teenagers in the United States come from all economic backgrounds, from all levels of education and every social class from every ethnic and racial background (Freese, 1979, p. 1).

Adolescent suicide is represented in all facets of society, however, there are certain factors which augment the risk of a suicidal attempt. First, the adolescent population has increased since the baby boom era. This increase in adolescents served to isolate them as a unique sector of the population. This factor alone is considered to have contributed to the increase in suicides (Weissman, 1974).

Secondly, adolescence is a period of many firsts. Physically, their bodies are undergoing rapid and dramatic biochemical changes

(Miller, 1981). Their cognitive development is making the transition from Piaget's concrete level of development to his abstract level of formal operations (McCandless, 1970). Adolescents often perceive death as a temporary state (Csapo, 1988). Socially, their center of support is shifting from their parents to their peer group. Teens who do not belong to a peer support group are at a greater risk (Allen, 1987; Bolger et al., 1989). The onset of sexual maturity produces feelings of ambivalence and anxiety regarding the individual's sexuality and their ability to interact with members of the opposite sex (McKenry et al., 1980). Adolescence is also the beginning of Kohlberg's formal stage of moral development, where the individual internalizes their own value system (McCandless, 1970).

All these factors contribute to Erickson's "identity crisis", where the individual is in a constant state of confusion regarding their self-concept (Grob et al., 1983; McCandless, 1970). Throughout their struggle with their identity, adolescents may encounter some of these problems:

- family breakdown (divorce, abuse, violence, non-communication, etc.)
- sexuality (teen pregnancy, AIDS, prostitution)
- body image (anorexia nervosa, obesity, acne)

- achievement in school (pressure to succeed, drop-outs, truancy, etc.)
- substance abuse (alcohol and drugs)
- peer pressure and romantic relationships
- pressures of the media's image of adolescents
- moral and spiritual confusion (Martin et al., 1987)

Other individual risk factors which may contribute to the increase in adolescent suicides are: impulsivity and impaired social skills (Brent et al., 1986); previous suicide attempt (Allen, 1987); Davis, 1985); psychiatric history (Thompson, 1987); sense of worthlessness (Posener, LaHaye & Cheifetz, 1989); poor problem-solving skills (Garrison, 1989) and traumatic birth history (Shaffer et al., 1988). With their limited life experiences in surviving painful experiences, adolescents tend to envision a problem as hopeless - and may see suicide as the only possible alternative (Konopka, 1983). Adolescents may also perceive suicide as a means to gain control of their lives or of their significant others (Hendin, 1987).

A third major factor is family disorganization (Garrison, 1989). Adolescents from single parent families consider suicide 3 times more often than teens from two parent families (Csapo, 1988). Gispert et al. (1985) found that at the time of their subjects' attempts, 80% were from broken families. Family violence, loss of

a parent and marital discord increase an adolescent's risk of suicide (Neiger & Hopkins, 1988). In today's society, the family nucleus has been rapidly disintegrating. A number of factors have attributed to this decentralization of the family: increased divorce rate; increased mobility; changing values; and the increase in both parents working (Weissman, 1974). The end product is that the adolescents perceive their parents as indifferent and unloving. Tuckman and Connon (1962) found that twice as many adolescents reported the fear of being unloved as their reason for attempting suicide, as compared to the parents' speculation of intent. Suicidal behaviors may run in families and may be a form of communication (Martin et al., 1987). Adolescents whose parents have attempted or completed suicide are at greater risk (Bolger et al., 1989; Neiger & Hopkins, 1988).

Social changes play a predominate role in the development of the adolescent. Interpersonal relationships become a crucial part of their existence. Tuckman and Connon (1962) reported difficulties with a member of the opposite sex to be the reason for attempting suicide in one out of five adolescents. The increase in adolescent pregnancy is often cited as a precipitating event for an attempted suicide (Sudak et al., 1984). The increase of substance abuse (Neiger & Hopkins, 1988); physical and sexual abuse, and the lack of religious supports and moral values are also associated with the

increase in suicidal behavior (Simons & Murphy, 1985; Sudak et al., 1984). These factors tend to produce a negative self-concept which reduces one's coping skills and develops feelings of hopelessness. Generally, this culminates in a state of isolation and loneliness which increases one's risk of suicide (Allen, 1987).

The media has a powerful influence on this video generation of adolescents. Movies and videos are influxed with violence and self-destructive acts. More subtly, actors are continuously being brutally murdered but only to reappear on the screen next week. To the immature adolescent, this may reinforce their egocentric concept of immortality (Shaffer & Fisher, 1981) and their perception of suicide as a temporary escape from an unpleasant reality (Allen, 1987). School and academic failure is another contributing factor to the increase in adolescent suicides (Connell, 1972; Stanley & Barter, 1970). For some students, the structured setting and the pressure to perform is overwhelming. Older adolescents preparing to enter the work force may be disillusioned by the high unemployment rate, the threat of nuclear war and the high crime rate. Facing such a bleak future, some may feel that suicide is a more realistic alternative (Sudak et al., 1984). Some experts believe the easy accessibility of guns and drugs are responsible for the increase in suicidal attempts (Seidan & Freitas, 1980).

Depression is a fifth major factor which has contributed to the increase in adolescent suicides (Cole, 1989; Neiger & Hopkins, 1988; Rotheram, 1987). Weiner (1974), as cited by Lee (1978), concluded depression was the most frequent psychopathology present in adolescent suicides. Sixty-five percent of suicidal children were depressed (Davis, 1985). However, depression is often masked in adolescents in such acting out behaviors as alcohol or drug abuse; sexual promiscuity; academic failure or significant behavior changes - loss of appetite; sleep disturbances; social isolation, etc. Friederick, Reams, and Jacobs (1982) found depression was related to a recent life crisis, low family cohesion, and low parental income. Beck and Albert (1975), as cited by Lee (1978), found that 33% of their subjects experienced moderate to severe depression, while 35% acknowledged having contemplated suicide. Shaffer and Fisher (1981) found that psychiatric illness often resulted in suicidal gestures.

Hawton (1986), cited by Perron (1987), highlighted the following reasons adolescents commit suicide:

1. fear of school failure
2. loss of status among friends and family
3. feel they have let someone down
4. angry because they have been publicly reprimanded or humiliated

5. loss of a love relationship.

Barrett (1989) summarized an adolescent's motives for suicide as a potential relief from a stressful situation; an opportunity to show people how desperate they are - a cry for help; as revenge against a lost object directed inward; a means of gaining love and control by manipulating others; an effort to stabilize relationships; an atonement for one's sins; a means of coping with the death of a parent and finally an opportunity to escape from an intolerable situation (e.g., abuse). There are numerous motives and factors which may precipitate a suicidal attempt. The above discussion summarized the factors, which are cited in the review of literature, as contributing to the increase in adolescent suicides.

Assessment, Prevention and Treatment of Suicidal Behavior

> School counselors and teachers need to know the various ways in which adolescents communicate their suicidal ideation and strategies in intervention to prevent further escalation of the incidence of adolescent suicide (Wellman, 1984, p. 109).

Assessment. The purpose of the assessment is to determine the degree to which the student is at risk of committing suicide (Martin et al., 1987). Ray and Johnson (1983) summarized Shneidman's four areas of suicidal signs. The first area is any verbalization of a threat of suicide. It is estimated that 75% of suicide victims

voice their intent to die (Freese, 1979). The development of a suicide plan; writing of notes or assignments about suicide; or the expressed desire to join a lost loved one are clues of a potential suicidal student (Martin et al., 1987).

The second major group consists of behavioral signs. Forty-five percent of victims have made a previous suicidal gesture or threat (Rotheram-Borus & Trautman, 1988; Shaffer, 1974). Other significant behaviors teachers and counsellors should be attuned to are: giving away of prized possessions; increased sexual promiscuity and substance abuse; running away; decline in academic performance; and accident proneness (Shaffer, 1974). Any sudden change in attitude or behavior are critical patterns to observe especially if the adolescent suddenly appears calm. This may be a signal that they have made the decision to commit suicide (Martin et al., 1987). Frederick (1978) described the suicidal adolescent as helpless, hapless, and hopeless.

Shneidman's third area is that of situational signs. Family disharmony and disorganization are significantly related to the incidence of suicide (Martin et al., 1987; Stanley & Barter, 1970). Specifically, the loss of a parent at an early age; the constant threat of a parental divorce; the loss of a loved object; socially isolated individuals or those with a chronic illness.

Syndromatic signs, or characteristic conditions of specific illnesses, are the basis for Shneidman's fourth group. Ray and Johnson (1983) and Cole (1989) stated the most prevalent syndrome was that of depression. Fifty-four percent of attempters demonstrated moderate to severe signs of depression (Rotheram-Borus & Trautman, 1988). Teachers and counsellors should be conscious of any sudden changes in behavior - disruptive behavior in the classroom; restlessness; boredom; noticeable somatic signs (i.e. fatigue, change in eating habits); or the student who appears to be emotionally void and alienated from their peer group (Martin et al., 1987; Wellman, 1984).

In order to successfully assess or prevent suicidal behaviors, teachers should also be aware of the following facts: females attempt suicide more often than males, but males succeed more frequently (Hawton, 1982); a high level of stress, a loss or an upsetting event may trigger a suicide attempt (Frederick, 1978); the more detailed and lethal the plan is the greater the risk (Fitchette, 1982); and individuals with limited personal resources, coping skills, are at risk (Anderson, 1980).

Patterson, Dohn, Bird and Patterson (1983) proposed a model, the SAD PERSONS scale, for assessing a potential suicidal victim. This model can be easily adapted for teachers and counsellors. Briefly, the scale summarizes the following ten risk factors.

Sex - males are more successful; females attempt more often

Age - those under 19 demonstrate a higher incidence of suicide

Depression - suicide rate for depressed individuals is 30 times greater than for normal individuals

Previous Suicidal Attempts - significant predictors of future suicidal behavior

Ethanol abusers - more susceptible to suicidal actions

Rational thinking loss - psychotics, high risk population

Social support systems - if absent, individual is in greater danger

Organized plan - chances of success increase when the plan is lethal, detailed and well-organized

No spouse - single individuals are more apt to commit suicide; for adolescents, family disorganization or teen pregnancy may be factors to consider

Sickness - especially if terminal

Teachers who utilize this model will be more apt to identify potential suicidal victims in their school population.

Suicide risk may be determined in an assessment interview. First, the caregiver must establish a rapport with the adolescent. Secondly, ask questions which focus on the student's observable behaviors when the client is having difficulty responding. Thirdly, explore the client's thoughts and feelings. Try to determine the

lethality, availability and sophistication of their suicide plan (Davis, 1985). Also, ascertain the adolescent's concept of death. The fourth step is to identify and prioritize the adolescent's immediate stressors - family problems, precipitating events, history of abuse or emotional instability (Davis, 1985). Finally, throughout the process monitor the client's internal state and the overall interaction between the two of you (Martin et al., 1987).

Rotheram (1987) proposed a two-tiered model to assist lay people in assessing those individuals in imminent danger of suicide. In the first stage, Rotheram used two criteria to assess the extent of suicidal risk. First, the current level of suicidal ideation and plan. Secondly, a positive response to five or more suicide related factors, such as those previously reviewed. During the second phase, the counsellor evaluates the following four areas to determine the student's ability to respond in a non-suicidal manner:

(1) ability to promise to abstain from suicidal behavior for a specific period of time

(2) ability to compliment self and others

(3) ability to identify and assess one's feelings by developing a Feelings Thermometer

(4) ability to identify potential suicidal situations and develop specific plans of action.

Prevention. The school environment provides an opportunity for teachers and counsellors to detect suicidal behaviors before it becomes a serious problem (Ray & Johnson, 1983). Seiden (1969) recommends that the school staff become more actively involved with the welfare of their individual students, by encouraging them to participate in extracurricular activities; providing successful learning experiences for all students; and by showing a personal interest in each student. Schools must also encourage the development of the individual's creativity and uniqueness (Konopoka, 1983). Teachers must assume the role of advocate for the introduction of Peer Counselling Programs (Ross, 1980); increased community services and resources (Shneidman, 1981); better use of the media for educational purposes (Hawton, 1982); and by applying pressure to legislatures to enforce stricter controls on guns and the prescribing of drugs (Shaffer et al., 1988; Sudak et al., 1984).

Duraj (1984) believes that in order to decrease the number of suicides, teachers should take all suicide threats seriously. Toolan (1975) and Hawton (1982) recommend immediate psychiatric evaluation, following the victim's recovery from the attempt. Ray and Johnson (1983) classified treatment for suicide attempt/ideation under three perspectives: biophysical - medical consultation; psychological - individual therapy; or sociological - where environmental causes suggest the inclusion of the family in therapy.

Ideally, schools should have a referral system developed to provide for immediate access to resource people who deal specifically with the suicidal adolescent.

In order to prevent an escalation of adolescent suicides, teachers and parents must be able to identify depressive illnesses and signs of alienation and mounting anger (Hoberman & Garfinkel, 1988; Ladame & Jeannert, 1982). Davis (1985) recommends five approaches to achieve this goal:

(1) educational workshops for students, staffs and parents on the indicators of suicide

(2) guidance programs which allow students to discuss their fears and develop positive, healthy coping skills

(3) in-services to develop teachers' assessment skills for recognizing high risk students

(4) consultation with outside resources and agencies

(5) further research.

Shaffer et al. (1988) felt students and staffs should be aware of the mental health resources, hot lines and crises centres in their community. Education and awareness are the keys to decreasing the youth suicide rate in Canada.

Treatment. Every suicide threat must be taken seriously (Csapo, 1988). After assessing the student's degree of risk, students should be referred for treatment - in-patient day treatment

or outpatient programs, psychiatric or counselling services (Csapo, 1988).

Treatment goals should include:

(1) enhance client's self-esteem by empowering the client to make positive things happen

(2) lower client's high expectations of self by teaching art of compromise

(3) destroy client's romanticized concept of death (Perron, 1987).

(4) modify client's aggressive responses to frustration and disappointment

(5) reduce depression and hopelessness while increasing self-esteem (Davis, 1985).

Role of the School

Teachers are the first on line professionals to identify students at risk (Grob et al., 1982). Bolger et al. (1989) found the risk of considering suicide increases at about age 9. Therefore, schools must develop teachers' skills to identify children at risk; monitor high risk students; recognize potential suicide attempters; practise crisis management and counselling skills; increase students' awareness and utilize community resources (Csapo, 1988).

First, schools must assess the mental health climate of their school (Martin et al., 1987). Schools must look at their classroom atmosphere and motivational techniques; teachers' belief systems and their expectations for high risk students; teachers' level of stress; the overall school climate and the teachers' level of understanding of the thinking process of adolescents' functioning at different mood levels (Mills, Dunham & Alpert, 1988). We need to create an environment for successful learning for all students (Csapo, 1988; Martin et al., 1987). This means that the curriculum must be relevant. Teachers must attempt to make an emotional connection with each student and provide co-operative rather than competitive learning experiences. Often, high risk students feel they cannot learn or that they are alienated at school (Mills et al., 1988).

Secondly, schools must use a consultative/collaborative approach (Martin et al., 1987). Siebel and Murray (1988) described a team approach where administrators, counsellor, nurse, social worker and psychologist meet on a regular basis to determine students at risk; develop plans of action; refer students for counselling; and develop curriculum activities which focus on self-concept, communication skills, decision-making and community resources. Besides an in-school team approach, there needs to be a

community support network which functions in an emergency (Martin et al., 1987).

The third component is to in-service all teachers and support personnel (Barrett, 1989; Downing, 1988; Martin et al., 1987; Shaffer et al., 1988). Hamilton's Board of Education has developed a series of four workshops for their staffs which covers the following topics: suicide overview, assessment, intervention and postvention (Martin et al., 1987). Subsequently, teachers can deliver a suicide prevention curriculum to their students (Barrett, 1989; Bensley & Bertsch, 1987). Hamilton's program is developed around five fundamental ideas: it is okay to talk about suicide; there are different legal, cultural and religious views on suicide; there are clues to watch for; what we can do to help; and how to cope with a loss (Martin et al., 1987).

Finally, schools must develop postvention programs. Schools should develop a plan of action in the event of a suicide or an attempted suicide (Martin et al., 1987). Bensley and Bertsch (1987) proposed the following plan:

(1) school confirm with family/police/hospital

(2) call a staff meeting giving information and allowing staff to vent their feelings

(3) set up discussion areas for students

(4) identify close friends and offer individual counselling - to avoid a clustering of suicides

(5) provide opportunity for staff and students to attend funeral

Manitoba Education (1987) also recommends the inclusion of outside resource people and peer helpers; class discussions focusing on factual information, support services, allaying of guilt feelings, de-romanticizing the act of suicide, and alternatives to suicide; and the development of seminars to enhance public awareness.

Education is one of the best means we have to prevent suicides (Martin et al., 1987). By utilizing a team approach comprised of school and community personnel, schools can develop plans to educate teachers, students and parents; deal with a suicide or attempt; develop community resources and promote the research of suicidal behavior in their community.

Ability of Educators to Assess Suicidal Ideations

The majority of the research regarding the recognition of suicidal behavior or ideation has been restricted to the medical profession. A recent study found that people's knowledge about suicide is more extensive than previously thought (Durocher, Leenaars & Balance, 1989). Also, people who had attempted suicide knew more than those who had not. Lee (1978) found that parents, friends and teaching personnel are most likely to notice any

behavior changes which may be related to depression or feelings of inadequacy. Therefore, it seems appropriate to assess their knowledge and ability to recognize the presence of suicidal ideation in adolescents. Since the research in this area is basically limited to counsellors, this discussion will focus primarily on studies in this areas.

Schools are one of the primary social environments for teenagers. Therefore, schools provide a natural setting for counsellors and teachers to observe adolescents. One of the few studies done on teachers was done in Ottawa, in 1981 (Duraj, 1984). They found that teachers were an important link in the relationship network of teenagers. The results also indicated that counsellor knowledge of suicide was "no greater than that of the majority of the teachers" (Duraj, 1984, p. 45). Previously, Ross (1980) had found from her interviews with surviving families, friends and teachers of suicidal victims, that there had been numerous clues to the victim's suicidal intent which had gone undetected.

Two studies have examined counsellors' knowledge and their ability to recognize suicidal behavior. Holmes and Wurtz (1981) scored counsellors on the Suicide Potential Rating Scale (Holmes & Howard, 1980) and compared their results to Holmes and Howard's study of professional groups and college students. The 1981 sample consisted of college professors, post-secondary, secondary and

elementary school counsellors. This latter study found that the professors scored significantly higher than high school and elementary counsellors. This was attributed to their more extensive psychological training. However, when compared to the results of the 1980 study, counsellors were equally able to recognize suicidal behaviors as social workers, while physicians and psychiatrists were ranked significantly higher.

Although, counsellors scored comparable to social workers, the authors did not stipulate the criteria for a "good" score. Subsequently, these scores do not tell us if the counsellors would actually be able to identify a potential suicide. Since there is no description of the population the test items were designed to assess, it is difficult to ascertain whether or not the counsellors were able to identify potential suicidal behaviors in their specific sites.

One serious limitation of this study was its lack of randomization in its sample selection. All counsellors were solicited at a conference, which could significantly limit the representativeness of the counsellor population. A further criticism of this study is that it does not report the reliability or validity of the instrument administered to its subjects. Therefore, the results of this study may be questionable.

In 1972, Schnacke did an extensive investigation of high school counsellors' knowledge and training regarding adolescent suicides. Fifty-eight percent of the counsellors responded. Of the 139 verified suicides, for 10 to 20 year olds between 1961 to 1970, 48% of the counsellors reported one or more suicide or attempt. Only 30% stated they had been confronted with a suicidal victim. Approximately, 62% of the respondents felt suicide was not a problem in today's high schools, and that there was no possibility of a suicide occuring in their school. Only 22% of the respondents felt they were adequately prepared to deal with a suicidal adolescent. An alarming 92% had no form of training (i.e. workshops, seminars, or courses) in suicide prevention or detection.

Schnacke's (1972) results suggest that counsellors are unaware of the factors related to adolescent suicide. Secondly, significant inconsistencies were apparent in the study's results in relation to the verified data. Since the counsellors only reported one-third of the verified suicides, this suggested that they were unaware of the level of suicidal intent present in their area. The counsellors also felt females were more apt to commit suicide, which is contrary to national statistics. This may suggest that counsellors overlook suicidal clues demonstrated by their male population. In Schnacke's study, 10% of the counsellors reported a student suicide and 48% an attempt, but 61% did not see suicide as a problem in their school -

then what do they define as a problem? Finally, the results found that counsellors had received little or no training in suicidal prevention during their university programs or through in-services offered by their school divisions.

Schnacke's study is significant for the purposes of this present study because it was the first to address the area of counsellor's knowledge of suicide. The need to educate counsellors in what is considered a major epidemic health problem is quite apparent from these results. This triggers a question - if counsellors are not being trained to assess potential suicides, what training are teachers, the major referral source for counsellors, receiving?

There are several noteworthy limitations to this study. There was no student assessment of their present or past suicidal attempts. Most experts feel that suicide is grossly underreported (Peck, 1982). Therefore, there is a need to ascertain information, not just from public sources, but also from the actual population being studied. Secondly, there was no assessment of the degree of competency, approachability or effectiveness of the counsellors. If the students do not view the counsellor as accessible, they will not feel they can approach them regarding a personal issue. Thirdly, there was no discussion regarding the method in which counsellors identified potential suicidal behaviors. The study addressed their

knowledge of suicidal trends rather than their ability to isolate specific behaviors as being possible suicidal gestures. Fourth, there may have been some problems pertaining to the definition of a suicidal attempt. Also, it would have been interesting to have the counsellors speculate on the extent of suicidal ideation in their school population.

Finally, the experimental design and procedures of this study were quite thorough but they could have increased their response rate through a second mailing of the survey. Schnacke pretested his instrument on a smaller counsellor sample but neglected to report the validity and reliability of his instrument. Therefore, the results of this study should be interpreted in light of their possible limitations. However, both of these studies reinforced the need for further research.

Summary

The review of the literature supports the concept that suicide is a problem amongst today's adolescents. This chapter reviewed the history; current trends; theories; influencing factors; assessment, prevention and treatment; the role of schools and educators and their ability to assess suicidal ideation amongst adolescents. Current research suggests that the incidence of suicidal ideation and behavior is severely underestimated by the general public. There appears to be a definite need for further research and the

development of programs and services to help curtail the increase in adolescent suicides.

This present study is designed to add to the present body of literature regarding adolescent suicide. More specifically, it is hoped to identify to what extent teachers' are aware of the indicators of suicide among adolescents.

Method

Subjects

The high school teachers of a Greater Winnipeg School Division comprised the sample surveyed for this descriptive study. Twenty-six teachers from a middle years school, within this division, were asked to pilot this study. This school was selected because of the teachers' committment to complete the survey and willingness to comment on the survey's format. The survey was then administered to 159 high school teachers (including administrative staffs and counsellors). The teachers were asked to indicate their position in the school so that comparisons could be made between two groups (i.e., academic teachers vs. counsellors).

The particular division was selected because it is comprised of two urban high schools and one rural high school. Within the three high schools, there is a cross-section of programs offered - academic, vocational, industrial arts, business education, work education and french immersion which represents the larger population of teachers in Manitoba high schools.

Design and Instrument

This is a descriptive study. A questionnaire was developed and was administered to assess teachers' awareness of the indicators of suicide amongst adolescents (see Appendix A). The format of the

survey consists of multiple choice questions, Likert scaled items and open-ended questions.

The items were primarily selected to provide a measure or an indication of teachers' awareness of the indicators of adolescent suicide. The items were based on the key indicators discussed in the current review of the literature. Part I of the survey asked the teachers to provide background information regarding their sex, grade taught, teaching experience, school setting and coursework in the area of suicide.

The items in Part II were designed to determine the teachers' awareness of the following areas: incidence of completed, attempted and contemplated suicides amongst adolescents in general and their student population; high risk groups; method of suicide used by gender; warning signs or indicators; factors related to suicide; community resources; and school procedures. The items consisted of multiple choice and open-ended questions. For example, they were asked, "In Manitoba, which of the following adolescent groups has the highest rate of completed suicides?" and "Does your school have a specific plan for dealing with suicidal adolescents? If you answered yes, please outline your school plan."

Part III items used a 5-point Likert Scale. The teachers were asked to select a response from one of these five choices - strongly disagree, disagree, no opinion, agree or strongly agree. The items

were based on the "Myths and Facts" Sheet provided by the Suicide Prevention Intervention Network (S.P.I.N.) at a local workshop on suicide (Manitoba Education, 1987). For example, they were asked to respond to the following statements: "Persons who talk about suicide do not commit suicide", "Suicide happens without warning" and "Suicidal people want to die". Statements 28 and 29 were taken from the Suicide Opinion Questionnaire (SOQ) developed by Domino, Moore, Westlake and Gibson (1982).

The last section asked teachers for feedback regarding their role; competency; need for training; support for school-based curriculum for students; and their areas of concern regarding the topic of adolescent suicide. The teachers were asked to respond to each of the statements using a 5-point Likert response scale. For example, "I feel adequately prepared/trained to work with suicidal adolescents". The final item asked the teachers for any additional suggestions or comments that they may have regarding the survey or the topic of adolescent suicide.

This instrument was designed specifically for this study, information on reliability and validity for most items of this instrument are not available. Items 28 and 19 had test-retest reliabilities of above .68 (Domino et al., 1982). This survey was first administered as a pilot to a group of Winnipeg teachers. The pilot study served as a means to test the content reliability and

validity of the survey items. Finally, the survey was administered to all high schools teachers in a Greater Winnipeg School Division.

Procedures

Permission was obtained to administer a questionnaire to all high school teachers, in a Greater Winnipeg School Division, by the Ethics Committee of the University of Manitoba; the Superintendent of the school division; the President of the local Teachers' Association and each high school principal. For the pilot study, the researcher attended a staff meeting and requested the staff to complete the survey. The teachers were asked to make any comments they may have regarding the survey's questions or format. They were asked to note, on the survey, the amount of time it took them to complete the survey. All forms were completed anonymously, sealed in an envelope and placed in the researcher's mailbox located in the pilot school's staff room. The researcher collected the forms on Friday, March 23, 1990, for calculation and possible revisions to the survey, prior to administering the survey to the high school teachers.

The researcher attended a staff meeting at each high school to present this survey. Teachers were requested to complete the form anonymously, seal it in the envelope provided and return by inter-school mail to the address of the researcher's school which was marked on the front of the envelope. The surveys were

distributed at the beginning of the week and were to be returned by that Friday, May 4, 1990. A reminder was sent out to all high school teachers, at the beginning of the following week, requesting that teachers please forward their surveys if they had not done so. The surveys were collected to calculate and report the findings of this study.

In order to conduct a descriptive analysis of the data from this survey, frequency distributions and percentages were calculated for each item of the survey. A five point scale was developed to interpret the teachers' awareness date for each of the 13 research questions.

Results

In this chapter, the results will be presented for each survey question. This is a descriptive study, accordingly, descriptive statistics (e.g., frequency counts and percents) were calculated for each question. The percentages were based on the number of people who responded to each question. For question 4, the means and standard deviations were computed. In order to interpret the teachers' awareness data for each question, the following scale was developed:

0 - 20% responded - very unaware

21 - 40% responded - unaware

41 - 60% responded - somewhat aware

61 - 80% responded - aware

81 - 100% responded - very aware

This scale will be used to interpret the results of this study.

This survey was administered to 159 high school teachers. A total of 99 surveys were returned for a response rate of 62.2%. Seven, or 4.4%, of the forms were returned unanswered. For the purpose of this study, calculations were made on the 92 complete surveys for a response rate of 58.8%.

Part I asked for the following demographic information: sex, years of experience, teaching position, courses and workshops respondents have attended on suicide, and their place of employment.

Table 1 summarizes this data. Fifty-three or 57.6% of the respondents were male with 69 or 75% of the teachers having 11 years or more teaching experience. The majority of teachers, 46.2%, taught the academic program for grades 10 - 12. Only four of the counsellors and four of the administrators completed this survey, therefore, it was not possible to do any comparative analysis between different groups. The majority of respondents, 92.4% and 70.3%, respectively, had not attended a course or a workshop on suicide. One quarter, or 23, of the teachers responded that they had attended one workshop. Sixty-four, or 69.6%, of the respondents were from an urban school while 28, or 30.4%, were from a rural school.

Part II asked questions about the current statistical facts and information regarding adolescent suicide. The majority of respondents, 80.2%, correctly identified the 15 - 19 years old group as the group with a 300% increase in the incidence of suicides in the past 20 years. Table 2 summarizes these findings.

Table 3 presents the findings of the rate of attempted and completed suicides, respectively. Sixty-three, or 69.2%, of the respondents knew that women attempted suicide more often than men. Sixty-nine or 75.8%, of the teachers knew that males completed suicide more often than females.

Table 1

Demographic Information

	Frequency (N)	Percent (%)
Sex		
Males	53	57.6
Females	39	42.4
Years of Experience		
0 - 5	14	15.2
6 - 10	9	9.8
11 - 20	29	31.5
21 +	40	43.5
Teaching Position		
Gr. 9 Academics	4	4.4
Gr. 10 - 12 Academics	42	46.2
Gr. 10 - 12 Vocational	8	8.8
Industrial Arts (9 - 12)	2	2.2
Resource	2	2.2
Counsellor	4	4.4
Administrator	4	4.4
Physical Education	4	4.4

(table continues)

Table 1 (cont'd)

	Frequency (N)	Percent (%)
Paraprofessional	3	3.3
Home Economics	4	4.4
Art	1	1.1
Work Education	1	1.1
Academics (9 - 12)	7	7.7
Business Education	2	2.2
Special Needs	1	1.1
Library Clerk	1	1.1
Mall Work Program	1	1.1
No response	1	0.0
No. Suicide Courses		
0	85	92.4
1	5	5.4
2	1	1.1
3	0	0.0
4	0	0.0
5 or more	1	1.1

(table continues)

Table 1 (cont'd)

	Frequency (N)	Percent (%)
No. Suicide Workshops		
0	64	70.3
1	23	25.3
2	3	3.3
3	0	0.0
4	0	0.0
5 or more	1	1.1
No response	1	0.0
Work Setting		
Rural	28	30.4
Urban	64	69.6

Table 2

Age Group with a 300% Increase in Suicides in last 20 Years

	Frequency (N)	Percent (%)
Age Group		
0 - 14 yrs.	11	12.1
15 - 19 yrs.	73*	80.1*
20 - 24 yrs.	2	2.2
25 - 29 yrs.	2	2.2
30 - 40 yrs.	0	0.0
41 - 50 yrs.	0	0.0
51 - 60 yrs.	0	0.0
61 - 70 yrs.	0	0.0
Undecided	3	3.3
No response	1	0.0

Note. * denotes correct response.

Table 3

Attempted and Completed Suicides by Sex

Sex	Attempted		Completed	
	No.	%	No.	%
Males	23	25.3	69	75.8*
Females	63	69.2*	14	15.4
Undecided	5	5.5	8	8.8
No response	1	0.0	1	0.0

Note. * denotes correct response.

Table 4 summarizes the findings of what the female:male ratio of attempted and completed suicides were in Canada, respectively. A large percentage of the population was undecided, 33.3% and 36.3% respectively. Thirty-nine, or 43.3%, knew that the ratio was 5:1 for attempted suicides. While 31.9%, or 29 respondents, knew that the ratio was 1:5 for completed suicides.

The next two questions asked which ethnic adolescent groups had the highest and second highest rates of suicide, in Manitoba. Half of the respondents knew that the male aboriginal group had the highest incidence of suicide. Only 11 teachers, or 12.4%, knew that white, rural males had the second highest rate of suicide, while 23 teachers, or 25.8%, thought it was the white, urban male group. These findings are presented in Table 5.

Questions 13 and 14 asked what was the most common method of suicide used by males and females, respectively, in Manitoba. Thirty-four respondents, or 38.2% correctly identified firearms for males and 79 teachers, or 88.8%, correctly identified drug overdose for females. The results are presented in Table 6.

The next three questions asked the respondents what percentage of their school population, did they think, had contemplated, attempted or committed suicide in the past 12 months? These findings are summarized in Tables 7 and 8. One-third of the respondents thought that 0 - 15% of their student population had

Table 4

Female:Male Suicide Ratios

Ratio	Attempted		Completed	
	No.	%	No.	%
1:5	12	13.3	29	31.9*
5:1	39	43.3*	14	15.4
1:10	4	4.4	7	7.7
10:1	4	4.4	1	1.1
1:1	1	1.1	7	7.7
Undecided	30	33.3	33	36.3
No Response	2	0.0	1	0.0

Note. * denotes correct response.

Table 5

Ethnic Suicides in Manitoba

	1st		2nd	
Ethnic Group	No.	%	No.	%
White rural male	2	2.2	11	12.4*
White rural female	2	2.2	0	0.0
Aboriginal male	45	50.0*	12	13.5
Aboriginal female	8	8.9	16	18.0
White urban male	22	24.4	23	25.8
White urban female	3	3.3	13	14.6
Other minority male	0	0.0	1	1.1
Other minority female	1	1.1	0	0.0
Undecided	7	7.8	13	14.6
No response	2	0.0	3	0.0

Note. * denotes correct response.

Table 6

Suicide Methods in Manitoba by Sex

	Males		Females	
Method	No.	%	No.	%
Hanging	21	23.6	0	0.0
Firearms	34	38.2*	1	1.1
Drug Overdose	21	23.6	79	88.8*
Gas Poisoning	2	2.2	1	1.1
Undecided	11	12.4	8	9.0
No response	3	0.0	3	0.0

Note. * denotes correct response.

Table 7

Teachers' Awareness of Contemplated or

Attempted Suicide in the Past 12 Months

	Contemplated		Attempted	
School Pop. (%)	No.	%	No.	%
0 - 15	29	33.0	70	88.8
16 - 30	28	31.8	7	7.9
31 - 45	7	8.0	0	0.0
46 - 60	8	9.1	1	1.1
61 - 75	3	3.4	0	0.0
76 - 90	0	0.0	0	0.0
91 - 100	1	1.1	0	0.0
Undecided	12	13.6	11	12.4
No Response	4	0.0	3	0.0

Table 8

Teachers' Awareness of Completed Suicide in the Past 12 Months

No. of Suicides	Frequency (N)	Percent (%)
0	55	61.8
1	11	12.4
2	2	2.2
3	0	0.0
4	0	0.0
5	0	0.0
More than 5	0	0.0
Undecided	21	23.6
No Response	3	0.0

contemplated suicide. Twenty-eight, or 31.8%, thought that 16 - 30% had contemplated suicide. One person felt that 90 - 100% had considered suicide. Seventy out of the 89, or 88.8%, felt that 0 - 15% of their students had attempted suicide. Fifty-five teachers, or 61.8%, stated that none of their students had committed suicide while two teachers responded that two students had died of suicide. Twenty-four of the respondents, or 23.6%, did not know if any students had committed suicide.

Question 18 asked teachers if they felt they were aware of the signs or behaviors which may indicate that a student was suicidal and to list three of these behaviors or signs. Tables 9 and 10 summarized these findings. Fifty-eight percent, or 51 of the teachers, felt they were aware of the possible indicators of suicide. Thirty-seven respondents, or 42%, stated that they were not aware or were undecided. When the teachers were asked to list three of these signs, 40, or 43.5%, did not complete this section. Of the people who responded, the following signs or behaviors were identified, in Table 10, as being indicative of a suicidal student: loner/withdrawn/socially isolated; mood/behavior changes; verbal threats; depression; and the giving away of personal items.

Question 19 asked the teachers if they were "aware of some of the main factors why an adolescent may attempt or commit suicide". Seventy-one, or 81.6%, felt they were aware of some of the main

Table 9

Teachers' Awareness of the Signs, Factors, Resources, School Plan, and Need to Inform Someone

	Yes		No		Undecided		No Response	
	(N)	(%)	(N)	(%)	(N)	(%)	(N)	(%)
Signs	51	58.0	23	26.1	14	15.9	4	0
Factors	71	81.6	7	8.0	9	10.3	5	0
Resources	54	63.5	19	22.4	12	14.1	7	0
School Plan	14	15.9	33	37.4	41	46.6	4	0
Inform Someone	90	98.9	0	0.0	1	1.1	1	0

Table 10

Suicidal Signs and Behaviors

Sign/Behavior	Frequency (N)	Percent (%)
Lonely/withdrawn/isolated	23	44.2
Mood/behavior changes	22	42.3
Depressed	20	38.5
Verbal threats of suicide	20	38.5
Giving away personal items	14	26.9
Decline in school	10	19.2
Interest/writing about death	9	17.3
Apathy	5	9.6
Increased school absenteeism	4	7.7
Improvement after being depressed	4	7.7
Low self esteem	3	5.8
Acting out/attention seeking	3	5.8
Loss of weight	2	3.8
Feeling helpless/hopeless	2	3.8
Self-abuse/mutilation	1	1.9
High strung	1	1.9
Getting life into order	1	1.9
No religious base in life	1	1.9
No response	40	0.0

factors, as summarized in Table 9. When they were asked to list three factors, 21 teachers, 22.8% of the population, did not complete this part. Of those who responded, they identified the following factors as critical motivators for suicidal behavior: family problems/divorce; boy/girlfriend break up; poor self-esteem/self-worth; feel like a failure and peer pressure/unacceptance by peers. Table 11 summarizes these findings.

When the teachers were asked if they were aware of any community services or resources for referring suicidal students, 63.5%, or 54 of the teachers, felt they were aware of possible resources or services, as presented in Table 9. Thirty-nine of the teachers did not or were not able to list three of these resources. The five resources or services which they would most frequently refer a suicidal student to were: Child and Family Services; Suicide Hot Line; school counsellor; Child Guidance Clinic and Klinic. These results are summarized in Table 12.

Question 21 asked if their school had a specific plan for dealing with a suicidal student. Seventy-four, or 84.1% of those who responded, as outlined in Table 9, stated they did not have a plan or were undecided about this question. Whey they were asked to outline their school plan, less then 20% of the teachers responded. Thirteen, or 72.2% of the respondents, stated they would contact their principal or counsellor first and follow this up by referring

Table 11

Suicide

Factor	Frequency (N)	Percent (%)
Family problems/divorce	42	59.2
Boy/girlfriend break-up	34	47.9
Low self-esteem/self-worth	19	26.8
Feel like a failure	18	25.4
Peer pressure/unaccepted by peers	18	25.4
Unable to cope with pressures/stress	14	19.7
Feel unloved/rejected	12	16.9
Isolated/lonely	8	11.3
Feel helpless/no control	8	11.3
Alcohol/drug abuse	7	9.9
Depression	6	8.5
Future hopeless (war, unemployment)	5	7.0
Suffered a loss/change/move	3	4.2
Unwanted pregnancy	3	4.2
Abuse (sexual, physical)	2	2.8
Perfectionist	1	1.4
Ashamed	1	1.4

(table continues)

Table 11 (cont'd)

Factor	Frequency (N)	Percent (%)
Revenge	1	1.4
New experience/adventure	1	1.4
Illusion vs. Reality	1	1.4
Puberty (hormonal changes)	1	1.4
Interest in death	1	1.4
No religious base	1	1.4
No response	1	1.4

Table 12

Community Resources and Services

Resource/Service	Frequency (N)	Percent (%)
Child & Family Agency	30	56.6
Suicide Hot Line	21	39.6
School Counsellor	20	37.7
Child Guidance Clinic (CGC)	15	28.3
Klinic	14	26.4
Church	8	15.1
Salvation Army Suicide Center	5	9.4
Family doctor	4	7.5
Natural/Peer Helpers	4	7.5
Teen Touch	2	3.8
Psychologist	2	3.8
Man. Adolescent Treatment Center	2	3.8
Hospital	1	1.9
Police	1	1.9
McEwen Center	1	1.9
MHS	1	1.9
Youth Suicide Information Center	1	1.9
Mount Carmel Clinic	1	1.9
No response	39	0.0

Table 13

School's Suicide Plan of Action

Steps Followed	Frequency (N)	Percent (%)
Notify counsellor/principal	13	72.2
Refer to CGC	8	44.4
Refer to a professional/agency	4	22.2
Unaware of one, if we have one	3	16.7
Contact Child and Family agency	2	11.1
Follow-up with Student	2	11.1
Contact Natural Helpers	2	11.1
Contact parents	1	5.6
No Response	74	0.0

the student to the Child Guidance Clinic or to an outside agency for professional help. Table 13 summarizes these findings.

Almost all of the teachers, 98.9%, as stated in Table 9, indicated that they would inform someone if a student displayed signs that he/she were suicidal. The majority, 64%, stated they would inform their school counsellor. No one indicated a reason for why they would not tell. Table 14 refers to these latter results.

Part III of the survey consisted of eight Likert statements, which asked the respondents to react to various statements pertaining to the facts and myths of suicide. These results are summarized in Table 15. The following percentages are a summation of similar categories (e.g., strongly agree and agree). Statements 23 - 29 represented common myths about suicide. Eighty percent or more of the teachers, who strongly disagreed or disagreed, recognized these as false statements. After examining the data, it appeared that the younger teachers (0 - 5 years of experience), Table 1, knew that these statements were myths, Table 15, while a few of the older teachers (21 + years of experience) thought the myths were true. Eighty-one percent of the respondents knew that suicide was the second leading cause of death for the 15 - 24 year old age group.

Part IV of the survey was designed to get teachers' perceptions of their role; the need for student programs and their

Table 14

Person Teachers Would Inform First About a Suicidal Student

Person	Frequency (N)	Percentage (%)
School Counsellor	57	64.0
Principal	13	14.6
Child Guidance Personnel	8	9.0
Parent	5	5.6
Another Teacher	4	4.5
Child and Family Agency	1	1.1
Team Leader	1	1.1
Friend of the student	0	0.0
No Response	3	0.0

Table 15

<u>Teachers' Awareness of the Myths and Facts of Suicide</u>

Myths/Facts	SD N (%)		D N (%)	NO N (%)	A N (%)	SA N (%)
People who talk about suicide do not commit suicide	32(32.5)	*	41(45.1)	7(7.7)	10(11.0)	1(1.1)
Suicide happens without warning	30(33.3)	*	50(55.6)	3(3.3)	5(5.6)	2(2.2)
Only depressed individuals commit suicide	18(20.2)	*	53(59.6)	7(7.9)	9(10.1)	2(2.2)
If you talk to someone about suicide you may be giving them the idea	33(36.7)	*	43(47.8)	7(7.8)	6(6.7)	1(1.1)

(table continues)

Table 15 (cont'd)

Myths/Facts	SD N (%)	D N (%)	NO N (%)	A N (%)	SA N (%)
Suicidal people want to die	28(30.8) *	51(56.0)	8(8.8)	4(4.4)	0(0.0)
Once a person is suicidal he/she is suicidal forever	35(38.9) *	44(48.9)	7(7.8)	4(4.4)	0(0.0)
Improvement following a suicidal crisis indicates that the risk is over	20(22.0) *	67(73.6)	2(2.2)	2(2.2)	0(0.0)
Adolescent suicide is the second leading cause of death for 15 - 24 yr.	1(1.1)	3(3.3)	13(14.3)	57(62.6)*	17(18.7)

Note. * denotes correct response. SD = strongly disagree, D = disagree, NO = no opinion, A = agree, SA = strongly agree.

Table 16

Teachers' Perceptions of Suicide

Perceptions	SD N (%)	D N (%)	NO N (%)	A N (%)	SA N (%)
I feel adequately prepared to work with suicidal adolescents.	31(34.4)	48(53.3)	4(4.4)	3(3.3)	4(4.4)
I feel there is a need for in-servicing	1(1.1)	1(1.1)	2(2.2)	56(62.2)	30(33.3)
I feel that students should be taught a course/unit	0(0.0)	10(11.5)	19(21.8)	39(44.8)	19(21.8)
As a teacher, I feel it is my role to help suicidal adolescents	3(3.4)	2(2.2)	9(10.1)	56(62.9)	19(21.3)

Note. SD = strongly disagree, D = disagree, NO = no opinion, A = agree, SA = strongly agree.

need for further training and information. Table 16 summarizes these findings. The following percentages represent the summation of similar responses (e.g., strongly disagree and disagree). Of those teachers who responded, 86 or 87.7%, did not feel adequately prepared/trained to work with suicidal students. The majority of teachers, 95.5%, felt there was a need to train teachers in the area of suicide and prevention. Two-thirds of the respondents felt that students should be taught a unit/course in suicide prevention. Seventy-five teachers, or 84.2%, felt it was their role to help suicidal adolescents. Table 17 summarizes the steps teachers would take to help a student. Of the 57%, or 52 teachers, who responded to this question, the steps they would take to help a student would be: talk to the student and help identify the problem; refer student to a professional person; consult with their counsellor and/or principal; and be available/follow-up with the student. Almost 10%, or 9 of the teachers, did not feel it was their role to help suicidal students. The reasons they gave are outlined in Table 18. Two-thirds of them did not feel adequately prepared to work with suicidal students.

Table 19 summarizes the areas teachers felt they would like further information on regarding adolescent suicides. The major areas cited were: warning signs; intervention/counselling techniques; resources available and the referral procedure;

Table 17

Steps to Help a Suicidal Student

Steps	Frequency (N)	Percent (%)
Identify problem/talk	42	62.7
Refer to professional/CGC	30	44.8
Consult with counsellor/principal	24	35.8
Be available/follow-up with student	14	20.9
Identify alternatives	8	11.9
Encourage student to talk to someone	7	10.4
Develop student's self-image	7	10.4
Communicate with parents	4	6.0
Let student know others care	4	6.0
Teacher take further training	3	4.5
Get student involved in activities	2	3.0
Tell student I'm not trained	2	3.0
Teach a unit on suicide	2	3.0
Be aware of signs of suicide	2	3.0
Develop crisis handling strategies	1	1.5
Don't leave student alone	1	1.5
Hospitalize student	1	1.5

(table continues)

Table 17 (cont'd)

Steps	Frequency (N)	Percent (%)
Consult with team leader	1	1.5
Pray for student	1	1.5
No response	25	0.0

Table 18

<u>Reasons Why it is Not Teachers' Role to Help Suicidal Students</u>

Reason	Frequency (N)	Percent (%)
Do not feel adequately trained	6	66.7
Do more harm than good	2	22.2
Small contact time with students	1	11.1
No response	83	0.0

Table 19

Areas Teachers Requested Information on Regarding Suicide

Areas	Frequency (N)	Percent (%)
Warning Signs	45	65.2
Intervention/counselling skills	23	33.3
Resources/referral procedure	23	33.3
Procedure teachers should follow	14	20.3
Causes/Reasons	13	18.8
How to prevent suicide/clusters	12	17.4
Legal and moral liability	3	4.3
Education about Adolescence	3	4.3
How to cope after a suicide	2	2.9
In-servicing/training for teachers	2	2.9
All areas	2	2.9
Our division compared to others	2	2.9
How to deal with attemptee/friends after an attempt	2	2.9
Case studies with responses	2	2.9
School policy	2	2.9
Procedure for monitoring	1	1.4

(table continues)

Table 19 (cont'd)

Areas	Frequency (N)	Percent (%)
How to build student's self-esteem	1	1.4
A course to teach	1	1.4
Coping strategies	1	1.4
Satanic symbols indicative of suicide	1	1.4
No response	23	0.0

steps/procedures teachers should follow with a suicidal student; causes/reasons for suicide and how to prevent suicides. Table 20 itemizes the comments made regarding this survey or the topic of adolescent suicide.

Table 20

Comments Regarding Suicide Survey

Comment	Frequency (N)	Percent (%)
Need a school in-service	3	16.7
Important Issue	3	16.7
Judaeo-Christian philosophy not emphasized - root of problem	2	11.1
Good luck	2	11.1
It's time teachers are better equipped/trained	1	5.6
Good People die because signs go unrecognized	1	5.6
General public not aware of problem	1	5.6
Teachers can't be all encompassing entity for students	1	5.6
Hope you find results that will help us deal with kids better	1	5.6
How extensive is the problem?	1	5.6
I'd like to see the results and correct answers	1	5.6
No Response	74	0.0

Summary

Discussion of the Results

This study was designed to address several research questions. This section will interpret the findings of this study as they relate to each of these questions. In order to make a statement regarding teachers' awareness level of adolescent suicide, the scale presented in the results section will be used for comparative purposes. The first 10 research questions, excluding question #4, pertain to knowledge whereas the last 3 questions and question #4 focus on teachers' perceptions and attitudes.

Research question 1: "Are teachers aware of the incidence rate of attempted and completed suicides, by sex and age, in Canada?". Questions 6 to 10 of the survey provided the answers to this question. The respondents were very aware that the 15 to 19 year old age group has shown a 300% increase in the rate of completed suicides (National Task Force on Suicide in Canada, 1987). The teachers, were aware that more females attempted suicide while more males completed suicide (Hawton, 1982). However, 29 or almost 1 out of every 3 teachers did not know that females attempt suicide more often than males. One out of 4 teachers surveyed did not know that males completed suicide more often than females (Frederick, 1978). The teachers were somewhat aware that the female:male ratio for attempted suicides was 5:1 but were unaware that the ratio was

1:5 for completed suicides. Part of the difficulty with this question is that the body of research varies in its findings (Csapo, 1988; Frederick, 1978; Rotheram-Borus, 1988).

These findings suggest that teachers are at greater risk of completing suicide than females and that 15 - 19 year olds have shown a dramatic increase in the rate of suicide. However, teachers appear to be unaware to what extent females and males attempt or complete suicide. Is this because teachers do not think suicide ideation is prevalent amongst their student population? This question should have been asked directly to the respondents in this survey.

<u>Research question 2: "Are teachers aware of the incidence of completed suicides, in Manitoba, according to ethnic origin?"</u>. Thompson (1987) found that aboriginal males had the highest rate of suicide in Manitoba with rural, white males having the second highest rate. Half of the respondents correctly identified aboriginal males as the highest risk group but only 11 of the teachers, 12.4%, identified white, rural males as being the second highest risk group. Almost 26% of the teachers identified white, urban males as the second highest group. Thompson (1987) cited the following reasons to account for these groups being at risk. Poverty, loss of their traditions and culture, death of a loved one, limited access to resources, alcohol abuse and availability of

firearms place rural, caucasian males at greater risk than their urban counterparts.

Reserves and rural settings appear to be at the greatest risk for a completed suicide. Based on the findings of this survey, it would be fair to conclude that the majority of teachers are somewhat aware of the risk for native males but are very unaware of the risk for white, rural males. These results reiterate the need to train teachers and hire qualified counsellors in the rural communities and reserves.

Research question 3: "Are teachers aware of the most common methods used by males and females, in Manitoba to commit suicide?". Three out of every five teachers surveyed were unaware that firearms were the most common method used by males to commit suicide (Thompson, 1987). However, teachers were very aware that drug overdose was the most common method used by females (Thompson, 1987). These findings imply that rural males with their access to firearms for hunting are at an even greater risk of going undetected.

Research question 4: "What percentage of their school's student population, do teachers feel, have contemplated, attempted or committed suicide in the past 12 months?". Since the students were not surveyed to determine their level of suicide behavior, these results were compared to current studies reviewed in the body

of literature. Bolger et al. (1989) found that 75% of his college undergraduates had considered suicide during their adolescence. Compared to the lower percentage reported by Davis (1985) and Ramsey and Bagley (1985), as cited by Moscicki (1989), these higher results are attributed to the greater openness about suicide and the confidentiality and anonymity guaranteed in the survey. One-third of the teachers surveyed thought less that 15% of their students had contemplated suicide. Twenty-eight teachers, or 31.8%, thought that 16 - 30% of their students had thought of suicide which supports the more conservative findings of Davis (1985).

Smith Crawford (1986) found that 8 - 12% of students surveyed had attempted suicide. The majority of teachers felt that less that 15% of their school had attempted suicide which concurs with Smith and Crawford's findings. One problem with these questions was that 0% was not identified as a separate category. This may have given a clearer indication of how many teachers actually do not feel that suicidal behaviors are present amongst their school population. In total, 13 teachers indicated they were aware of one or two suicides. The majority, 85.8% were very unaware of any suicides occuring in their schools.

These findings suggest that the teachers surveyed are not aware of the number of students who are contemplating, attempting and especially those committing suicide. This would concur with the

findings in the first research question. In order to verify these results, the students of these schools would have to be surveyed. One concern raised by these findings is that if there have been known suicides in these schools, what has been done to support the victim's friends, family, classmates and teachers? Since the majority of teachers were not aware of any suicides, there could be a number of students and staff members who have still not been allowed to deal with their feelings and may be at risk. These results would suggest that schools do not have a plan of action to deal with suicides which is further supported by the findings of research question #8.

Research question 5: "Are teachers aware of the behaviors or warning signs of a suicidal adolescent?". Fifty-one or 58% of the teachers, responded affirmatively to this question. This means that 2 out of every 5 teachers surveyed were unaware of the signs of behaviors of a suicidal student. Therefore, we could conclude that the teachers were somewhat aware of the signs of adolescent suicide. The 52 teachers who listed three signs or behaviors were able to identify the key indicators of suicide, as reviewed in the literature. Forty-four percent of the teachers felt lonely, socially isolated and withdrawn students would be at the greatest risk. The fact that this question was open-ended may account for

the fact that no one sign or behavior was identified by more than 44% of the teachers.

Three out of the 10 key indicators proposed by Patterson et al. (1983) were not identified. These were a previous attempt, alcohol abuse and level of lethality of plan. Some explanations may be that teachers may not know if there has been a previous attempt; how to measure the lethality of a plan or that alcohol abuse is a suicide risk factor. Due to the extent of alcohol abuse in reserves and rural communities, this latter point reiterates the fact that native and white, rural males are at further risk of going undetected.

Research question 6: "Are teachers aware of the main factors for adolescent suicides?". The majority of teachers felt they were aware of these factors which means 1 out of every 5 teachers surveyed was not aware of them. The teachers were able to identify the main factors presented in the review of the literature. Family problems or divorce were identified by the teachers as the number one factor. The open-ended format of this question may account for the lower percentages. However, teachers did not cite an attempted or completed suicide by parent (Bolger et al., 1989) or psychiatric illness (Davis, 1985; Shaffer & Fisher, 1981) as risk factors.

Earlier, we noted that school staffs have not been informed if students have committed suicide. Therefore, it is probable that

schools are not informed when parents commit or attempt suicide. These children are at risk and are not being given the support, understanding or counselling they require. Only 6 teachers identified depression as a risk factor. This may suggest that teachers are very unaware of the signs of depression or psychiatric illnesses. In order to identify high risk students, teachers, our key source of referrals, need to be educated in the signs and symptoms of depression and other psychiatric illnesses.

Based on these findings, we could conclude that teachers felt they were very aware of the risk factors for adolescent suicide. However, when they were asked to identify these factors they were only somewhat aware of the range of factors which contribute to adolescent suicides.

Research question 7: "Are teachers aware of community resources available for suicidal adolescents?". Fifty-four teachers, felt they were aware of these resources. However, 38 or 41.3% of all the teachers surveyed were unaware or undecided about the resources available. This means that 2 out of every 5 teachers surveyed did not know where to refer suicidal students. The number one resource, a Child and Family agency, was identified by 56.6% of the respondents. This open-ended question elicited a number of resources but it may also account for the minimal awareness for each of these resources. The 53 teachers who listed resources were able

to identify the crisis services listed in the Winnipeg Suicide Prevention/Intervention Network pamphlet (see Appendix C). There was also a limited number of community resources listed for rural Manitoba. It is interesting to note that no one identified Winnipeg's Youth Suicide Information Centre or Child and Mental Health Services which operates in rural and northern communities in Manitoba. Only 20 of the teachers, or 37.7%, acknowledged their school counsellors as possible resources. This may have been because the teachers focused on the word "community" in this question. These findings suggest that the majority of teachers surveyed are somewhat aware of the community resources and services available for suicidal youth.

Although the majority of teachers were aware or somewhat aware of the resources, signs, factors and risk groups, there was not a 100% correct response rate - which it should be. These questions referred to factual information which teachers can easily learn through school or community workshops. However, 92% and 70% of the teachers, respectively, have not taken a course or workshop on suicide. School divisions and universities must begin to educate teachers and the general public. This appears to be a small price to pay to save even one life.

Research question 8: "Do schools have a specific plan for dealing with suicidal students?". Teachers were very unaware of a

specific plan for dealing with suicidal adolescents. Thirteen of the 18 teachers who identified a plan stated they would contact their counsellor or principal first. Next, they would refer the student to the Child Guidance Clinic or an outside agency. It is obvious that there is not a specific plan for dealing with suicidal students although some teachers have definite ideas as to how they would handle the situation.

Research question 9: "Do teachers feel that they would inform someone else if a student had indicated that they were suicidal?". The majority of teachers responded affirmatively to this question. Therefore, we could assume that although schools may not have a specific plan, teachers are very aware that they would take the initiative to seek help. Fifty-seven of the teachers stated they would inform their school counsellor first. Therefore, it appears that teachers do recognize their counsellors as potential resources. One teacher stated she would inform her team leader first which promotes the team consultative/collaborative approach. The team meeting concept creates an ideal avenue to discuss students at risk with other teachers and support staff (counsellor, resource teacher, etc.).

Research question 10: "Are teachers aware of the facts and myths about suicide?". Based on this study's findings the respondents were very aware of the difference between the myths and

facts of suicide. However, there is still roughly 1 in every 5 teachers surveyed who believe that people who talk about suicide do not commit suicide; suicide happens without warning; only depressed individuals commit suicide; if you talk about suicide you may give the person the idea to commit suicide; once suicidal you are always suicidal and improvement after a suicidal crisis indicates that the risk is over. Due to the lack of education and knowledge, these teachers may not be able to identify high risk students. It is also noted that teachers with less years of experience were aware that the myths were not true whereas there were a few more experienced teachers who believed the myths. This finding may suggest a need for further research.

The last three research questions focus on teachers' perceptions and attitudes. The five point scale being used to interpret these results was slightly modified for these questions. The scale used was:

0 - 20% responded - strongly disagree

21 - 40% responded - disagree

41 - 60% responded - somewhat agree

61 - 80% responded - agree

81 - 100% responded - strongly agree

Research question 11: "Do teachers believe it is their role to help suicidal students?". The survey results indicate that the

teachers strongly agree it is their role to help suicidal students which supports the earlier findings of Grob et al. (1983). Nine of the fourteen teachers felt it was not their role because they do not feel adequately trained; are afraid to do more harm than good; and have limited contact time with their students. These reasons do not reflect an uncaring attitude rather a feeling of inadequacy. Through education, we can reduce teachers' level of anxiety and provide them with a sense of competency and a plan of action. Based on current studies (Bolger et al., 1989; Smith & Crawford, 1986), chances are most teachers will encounter a suicidal student during their career, therefore, they need to know how to handle the situation. Teachers may not feel competent enough to counsel a suicidal student but they do need to be able to provide students with the resources and supports they need.

Research question 12: "Do teachers feel that staff and students should receive further training on the topic of suicide?". The teachers strongly agree there is a definite need for staff training in the area of suicide. Most teachers feel it is their role to assist suicidal students but an overwhelming number of teachers, 87.7%, do not feel adequately prepared. These findings support those of Grob et al. (1983). The Department of Education, universities, and school boards need to develop a means in which to meet the needs of Manitoba teachers.

Two-thirds of all teachers surveyed agree students should be taught a unit or course on suicide. One-fifth of the teachers were undecided. Often teachers feel they do not have the time to complete their curriculum as it is and can not envision adding additional units to their programs. Some teachers may not feel qualified enough to teach such a course. Finally, there are still some teachers, 7 in this survey, who believe the myth that by talking about suicide you may be giving the student the idea to commit suicide. It seems apparent that we need to look at the stress levels of teachers, the curriculum presently being taught and determine if the needs of staff and students are being met.

One avenue that could have been explored further is teachers' level of committment to the topic of adolescent suicide. The survey could have asked teachers if they would attend a workshop or teach a unit on suicide if they were given the opportunity. This may have given us an indication of the extent to which teachers are committed to preventing the incidence of adolescent suicides.

<u>Research question 13: "What areas do teachers feel they require further information regarding adolescent suicide?"</u>. The majority of teachers agree they would like further information on the topic of adolescent suicide. Most of them requested practical information they could use to identify, intervene, counsel or refer a suicidal student. A number asked for a plan of action they could

follow which would ensure that the student receives proper treatment. Based on the requests of the teachers, it is obvious that workshops must be developed which will increase the teachers' knowledge base and their comfort level so they feel adequately prepared to identify, approach, support and refer suicidal students.

In summary, the major findings of this study are:

(1) Overall, teachers are somewhat aware of the signs, factors, resources and facts of suicide.

(2) 92.4% of teachers surveyed have taken no courses or workshops on suicide.

(3) Teachers were unaware of the female:male ratios for attempted and completed suicides.

(5) The majority of teachers, 50% and 89.6% respectively, were unaware that, in Manitoba, native males and white, rural males were at the greatest risk of committing suicide.

(6) 61.8% of teachers were unaware that the method most commonly used by males to commit suicide, in Manitoba, was firearms. However, they were very aware that females use drug overdoses to commit suicide.

(7) The majority of teachers, 64.8%, thought that less than 30% of their students have contemplated suicide.

(8) 88.8% of the teachers thought that less than 15% of their students have attempted suicide.

(9) 85.4% of teachers were very unaware that there had been a suicide in their school in the past 12 months.

(10) Teachers, 84.1%, were very unaware of a school plan to deal with suicidal students.

(11) 98.9% of the respondents stated they would inform someone else if a student indicated he/she were suicidal.

(12) Teachers, approximately 80%, were very aware of the myths and facts about suicide.

(13) Teachers, 84.2%, strongly agreed it was their role to help a suicidal student.

(14) 87.7% of teachers strongly agreed they were not adequately prepared to work with suicidal adolescents.

(15) 95.5% strongly agreed there was a need for teacher in-services on the topic of suicide.

(16) Two-thirds of the teachers agreed students should be taught a unit or course on suicide.

It appears that teachers feel it is their responsibility to assist suicidal students. However, the teachers do not feel adequately prepared to deal with these students. Therefore, school divisions, universities and the Department of Education must acknowledge

teachers' interest and need for further information on adolescent suicides.

Limitations of this Study

This study has several noteworthy limitations, which may prevent the generalizability of these results. First, there was only a 58.8% response rate. One may assume that teachers who did not complete the survey were too busy, not interested, or did not feel comfortable with the survey or topic. This low response rate made it difficult to compare groups of teachers to determine if there was a difference in teachers' knowledge based on their university training. Secondly, these results may not be indicative of teachers across Manitoba. Although a rural school was surveyed, the close proximity to Winnipeg would suggest that this school would not be representative of most rural communities in Manitoba.

Thirdly, the students were not surveyed, therefore, it is not possible to measure the accuracy of the teachers' responses regarding the level of suicidal ideation and gestures amongst their student population. The range used to select the percentage of students teachers felt have contemplated or attempted suicide did not accurately measure the extent to which teachers feel suicidal behaviors are present within their school. Teachers should have been given the opportunity to select 0% as a response to these questions. Teachers should also have been asked whether or not they

felt that suicide behaviors were a concern at their school. Finally, to determine teachers' committment level to preventing adolescent suicides they should have been asked if they would agree to attend a workshop or teach a unit on suicide if they were given the opportunity.

Recommendations for Further Study

The results from this study suggest the need for further research. First, in order that these results are generalizable, the parameters of the sample surveyed should be expanded to provide a more representative sample of the high schools across the province or nation. The confined limits of this study may not reflect the perceptions and awareness of teachers in isolated communities with limited community and school supports. By surveying a wider population, comparisons could be made amongst different groups of teachers using gender, school setting, teaching subject or years of teaching experience as the independent variable. These comparisons may indicate that certain teaching streams better prepare their teachers to identify students at risk of committing suicide. Therefore, a better method for surveying the teachers should be selected to ensure a higher response rate from teachers. This would ensure that the results were truly indicative of the entire teacher population.

Secondly, there is a need to survey students and elicit their perceptions of the extent to which suicidal ideation is present in their school population. Through the use of self-reports, researchers could measure the level of adolescent suicidal behaviors; the factors which trigger suicidal ideation and the steps teachers and parents could take to help adolescents cope with their problems. These student self-reports could then be compared to the perceptions of teachers and parents to assist in delineating the magnitude of adolescent suicide.

Thirdly, various controlled studies could be designed to examine the different aspects presented in this descriptive story. For instance, a study could be designed to measure the difference between teachers who receive a training session on the topic of suicide and those who do not. Another comparative study could be done between new university graduates and teachers with 20 years or more teaching experience. These studies could compare the different groups of teachers and their ability to identify, intervene and refer suicidal students for proper treatment.

Conclusions

Adolescent suicide is becoming a major health concern in today's world. The dimensions of this issue are multi-faceted. The complexity and misconceptions behind suicide need to be clarified before methods of preventing and treating suicide can be implemented

effectively. The results of this study indicate that teachers are somewhat aware of the indicators of suicide. It also identified areas for further research and programming. For instance, the majority of teachers felt it was their role to help a suicidal student but they did not feel adequately prepared to fulfill this role. Furthermore, this study acknowledged that teachers are aware that some of their students are contemplating, attempting or committing suicide. Hopefully, this study will provide the incentive to further research in this area, which would curtail the incidence of suicidal behaviors and ideation amongst adolescents.

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APPENDICES

APPENDIX A

SURVEY OF TEACHERS' AWARENESS OF THE INDICATORS OF SUICIDE AMONG ADOLESCENTS

INSTRUCTIONS: Please circle the number which you believe best describes your answer.

PART I: BACKGROUND INFORMATION:
Please complete the following demographic information as it is necessary in order to analyze the data collected from this survey.

1. Sex:

(1) male (2) female

2. Years of teaching experience:

(1) 0 - 5 yrs. (3) 11 - 20 yrs.
(2) 6 - 10 yrs. (4) 21 + years

3. My position at school can best be described as a/an:

(1) Grade 9 teacher
(2) academic teacher (Gr. 10 - 12)
(3) vocational teacher (Gr. 10 - 12)
(4) industrial arts teacher (Gr. 9 - 12)
(5) resource teacher
(6) counsellor
(7) administrator
(8) physical education teacher
(9) paraprofessional
(10) Other (please specify) ____________________________

4. (a) How many university courses (full or half-time) have you taken on suicide?

(1) 0 (2) 1 (3) 2 (4) 3 (5) 4 (6) 5 or more

(b) How many in-services (put on by a school, division, local organization) have you received in suicide?

(1) 0 (2) 1 (3) 2 (4) 3 (5) 4 (6) 5 or more

5. I work in:

(a) rural Manitoba (b) urban Manitoba

PART II: STATISTICAL FACTS AND INFORMATION

The following questions are designed to measure teachers' awareness of the current statistics and risk factors regarding adolescent suicides. For the purpose of this study, please use the following definitions for these terms:

completed suicide - death resulting from an action taken by an individual with the intention of ending his/her life

attempted suicide - person unsuccessfully performs a life-threatening behavior with the intent of jeopardizing his/her life

contemplated suicide - person has thought or verbalized a threat to his/her life (Freese, 1979).

Please circle the number which you believe best describes your answer.

6. In Canada, what age group has shown a 300% increase in the incidence of completed suicides in the last 20 years?

(1) 0 - 14 (4) 25 - 29 (7) 51 - 60
(2) 15 - 19 (5) 30 - 40 (8) 61 - 70
(3) 20 - 24 (6) 41 - 50 (9) undecided

7. In Canada, which sex has the highest rate of attempted suicides?

(1) males (2) females (3) undecided

8. In Canada, which sex has the highest rate of completed suicides?

(1) males (2) females (3) undecided

9. In Canada, what is the female:male ratio for attempted suicides?

(1) 1:5 (3) 1:10 (5) 1:1
(2) 5:1 (4) 10:1 (6) Undecided

10. In Canada, what is the female:male ratio for completed suicides?

(1) 1:5 (3) 1:10 (5) 1:1
(2) 5:1 (4) 10:1 (6) Undecided

11. In Manitoba, which of the following adolescent groups has the highest rate of completed suicides?

(1)	white, rural, male	(5)	white, urban male
(2)	white, rural, female	(6)	white, urban female
(3)	aboriginal, male	(7)	other minority groups, male
(4)	aboriginal, female	(8)	other minority groups, female
		(9)	undecided

12. Which of the groups below has the second highest rate of completed suicides in Manitoba?

(1)	white, rural, male	(5)	white, urban male
(2)	white, rural, female	(6)	white, urban female
(3)	aboriginal, male	(7)	other minority groups, male
(4)	aboriginal, female	(8)	other minority groups, female
		(9)	undecided

13. In Manitoba, what is the most common method used by adolescent males to commit suicide?

(1)	hanging	(3)	drug overdose	(5)	undecided
(2)	firearms	(4)	gas poisoning		

14. In Manitoba, what is the most common method used by adolescent females to commit suicide?

(1)	hanging	(3)	drug overdose	(5)	undecided
(2)	firearms	(4)	gas poisoning		

15. What percentage of your school's student population, do you think have <u>contemplated</u> suicide in the past 12 months?

(1)	0 - 15%	(4)	46 - 60%	(7)	90 - 100%
(2)	16 - 30%	(5)	61 - 75%	(8)	undecided
(3)	31 - 45%	(6)	76 - 90%		

16. What percentage of your school's student population, do you think, have <u>attempted</u> suicide in the past 12 months?

(1)	0 - 15%	(4)	46 - 60%	(7)	90 - 100%
(2)	16 - 30%	(5)	61 - 75%	(8)	undecided
(3)	31 - 45%	(6)	76 - 90%		

17. How many of your school's students have committed suicide in the past 12 months?

(1) 0	(3) 2	(5) 4	(7) more than 5
(2) 1	(4) 3	(6) 5	(8) unknown

18. Do you feel you are aware of some of the behaviors or signs to look for in a student which would indicate that he/she was suicidal?

(1) yes (2) no (3) undecided

If you answered yes, please list 3 behaviors or signs which may indicate that a student is suicidal.

1. ____________________

2. ____________________

3. ____________________

19. Do you feel you are aware of some of the main factors why an adolescent may attempt or commit suicide?

(1) yes (2) no (3) undecided

If you answered yes, please list 3 of these factors.

1. ____________________

2. ____________________

3. ____________________

20. Do you feel you are aware of any community resources or services which are available for referring suicidal adolescents?

    (1) yes (2) no (3) undecided

    If you answered yes, please list 3 of these resources/services.

    1. ____________________

    2. ____________________

    3. ____________________

21. Does your school have a specific plan for dealing with suicidal adolescents?

    (1) yes (2) no (3) undecided

    If you answered yes, please outline your school plan.

    ____

    ____

    ____

    ____

22. (a) If a student indicated that he/she were suicidal would you inform someone else?

(1) yes (2) no (3) undecided

(b) If you answered yes, who would be the first person that you would inform?

(1)	parent	(5)	principal
(2)	another teacher	(6)	Child and Family agency
(3)	school counsellor	(7)	Child Guidance Personnel
(4)	a friend of the student	(8)	Other (please specify) ______________

(c) If you answered no, why not?

____

____

____

PART III: SUICIDE FACTS AND MYTHS:

This section is designed to measure your awareness of the myths and facts pertaining to suicide. Please circle the response which best represents your answer to each of the following statements.

Strongly Disagree (SD)	Disagree (D)	No Opinion (NO)	Agree (A)	Strongly Agree (SA)

23.	Persons who talk about suicide do not commit suicide.	SD	D	NO	A	SA
24.	Suicide happens without warning.	SD	D	NO	A	SA
25.	Only depressed individual commit suicide.	SD	D	NO	A	SA
26.	If you talk to someone about suicide you may be giving them the idea to commit suicide.	SD	D	NO	A	SA
27.	Suicidal people want to die.	SD	D	NO	A	SA

28. Once a person is suicidal, he/she is suicidal forever. SD D NO A SA

29. Improvement following a suicidal crisis indicates that the risk is over. SD D NO A SA

30. Adolescent suicide is the second leading cause of death in the 15 - 24 year old age group. SD D NO A SA

PART IV: TEACHER PERCEPTIONS

This section is designed to get teachers' perceptions of their role; the need for student programs and their need for further training and information. Please circle the answer which best represents your answer. Choose one of the following responses.

Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
(SD)	(D)	(NO)	(A)	(SA)

31. I feel adequately prepared/trained to work with suicidal adolescents.

SD D NO A SA

32. I feel there is a need to provide teachers in your school with some further training in the area of suicide and prevention.

SD D NO A SA

33. I feel that all students should be taught a course/unit in suicide prevention.

SD D NO A SA

34. (a) As a teacher, I feel it is my role to help suicidal adolescents.

SD D NO A SA

(b) If you are in agreement, what steps would you take to help the student?

1. ______________________________

2. ______________________________

3. ______________________________

(c) If you do not agree, why not?

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35. What are 3 areas you would like more information about regarding adolescent suicide?

1. ______________________________

2. ______________________________

3. ______________________________

<u>SUGGESTIONS OR COMMENTS</u>

If you have any comments regarding this survey or the topic of adolescent suicide please comment in the space provided.

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If this questionnaire has raised any concerns or questions for you, please feel free to contact the researcher at 224-4231 (work) or 222-5498 (home).
THANK-YOU FOR YOUR ASSISTANCE AND CO-OPERATION!

APPENDIX B

75 Blairmore Gardens
Winnipeg, MB R2C 4S6

TO ALL PARTICIPANTS OF THIS SURVEY

I am a graduate student at the University of Manitoba. As part of my thesis, I am surveying all high school teachers in your division on the topic of adolescent suicide. The purpose of this survey is to determine teachers' awareness of the indicators of suicide among adolescents. This survey has been approved by my committee members: Richard Carreiro, Associate Professor, Faculty of Education; Dr. J. Keselman, Professor, Associate Dean, Faculty of Education; and Dr. M. Kral, Assistant Professor, Department of Psychiatry, Faculty of Medicine.

I would appreciate if you would complete this form anonymously, to ensure confidentiality, and to the best of your knowledge. Your support will make my results much more valid. Any staff member has the right to choose not to complete this form if they wish to. Please put your form (complete or blank) in the envelope provided, marked Lorraine Laporte, Arthur Day School. Then place this sealed envelope in the green interschool mail bag in your main office.

This survey should take approximately 15 minutes to complete. Please mail your survey by Friday, May 4, 1990. Each school will be provided with a copy of the results of this study.

Your co-operation would be greatly appreciated. If you have any questions or concerns about the survey or the results, please feel free to contact me at 224-4231 (work); 222-5498 (home); or at the above address.

THANK YOU FOR YOUR TIME AND EFFORT!!

Lorraine Laporte

A REMINDER TO ALL SURVEY PARTICIPANTS

Last week each staff member was asked to complete a survey on teachers' awareness of the indicators of suicide among adolescents. If you have not returned your survey, I would appreciate if you would take a few minutes to complete my survey. Your co-operation will help make the results of my study much more valid.

If you have misplaced your survey, please ask your principal for an extra copy. Please return this survey by the end of the week.

If you have already returned your survey, please ignore this reminder. I would also like to thank you for your assistance and co-operation.

Thank you for your time and effort! If you have any questions, please feel free to contact me at 224-4231 (work) or 222-5498 (home).

Lorraine Laporte

Graduate Student

University of Manitoba

75 Blairmore Gardens
Winnipeg, MB R2C 4S6
January 2, 1990

Transcona-Springfield School Division
769 Kildaire Avenue East
Winnipeg, MB R2C 3Z4

Dear Mr. Fiorentino,

This fall I started working on my master's thesis in Educational Psychology. My original proposal was not accepted by the Ethic Committee at the University of Manitoba. My new proposal still focuses on the issue of adolescent suicide. However, the purpose for my new study is to assess teachers' awareness of the indicators of suicidal adolescents.

I am writing to request your permission to conduct a survey of all high school teachers in the division. The teachers will be asked to complete an anonymous survey which would take approximately fifteen minutes. The teachers are under no obligation to complete the survey. I would like to administer this survey during the school's staff meeting.

After, I have compiled my results I would be more than willing to share my results with yourself, the school board and schools.

I have enclosed a copy of the teachers' survey. If you have any further questions regarding my survey, please feel free to contact me at 224-4231 (work) or 222-5498 (home). Thank you for your assistance and co-operation.

Yours truly,

Lorraine Laporte

75 Blairmore Gardens
Winnipeg, MB R2C 4S6
January 7, 1990

T.S.T.A.
Murdoch MacKay
260 Redonda Street
Winnipeg, MB R2C 1L6

Dear Lana:

This fall I started working on my master's thesis in Educational Psychology. My proposal focuses on the issue of adolescent suicide. The purpose of my study is to assess teachers' awareness of the indicators of suicidal adolescents.

As President of the Transcona-Springfield Teachers' Association, I am writing to request your approval for me to survey all high school teachers in the division. I have also contacted the Superintendent's office for their approval of this survey. The teachers will be asked to complete an anonymous survey which would take approximately fifteen minutes. The teachers are under no obligation to complete the survey. I would like to administer this survey during the schools' staff meetings.

After, I have compiled my results I would be more than willing to share my results with yourself, the school board and schools.

I have enclosed a copy of my teachers' survey. If you have any further questions regarding my survey, please feel free to contact me at 224-4231 (work) or 222-5498 (home). Thank you for your assistance and co-operation.

Yours truly,

APPENDIX C

A HOSPITALS

1) Health Sciences Centre - Child and Adolescent Psychiatry

a) 3 West Crisis and Community Intervention Unit
Age Serviced: 5 - 16 years
Services Provided: Short-term admission for assessment and/or crisis intervention with community reintegration as soon as possible.
Area Served: Manitoba
For Suicide attempt emergencies contact: Children's Hospital Emergency Department - 787-2306
For Inpatient or Day Treatment assessments contact: Intake Coordinator - 787-2483, Dr. Selzer 787-2626 or 787-2625

b) Child and Adolescent Psychiatry Outpatient Department
Age Serviced: 0 - 18 years
Services Provided: Outpatient multidisciplinary mental health diagnostic and treatment services to children and their families.
Area Served: Winnipeg and close surrounding area
Contact: Intake Secretary - 787-3873

2) St. Boniface Hospital

a) Adolescent Day Hospital Programme
Age Serviced: 15 - 17 years
Services Provided: Intensive therapeutic and educational programming for adolescents while maintaining them in the community.
Area Served: Manitoba
Contact: Intake Secretary - 237-2690

b) Adolescent Inpatient Assessment Unit
Age Serviced: 13 - 17 years
Services Provided: Intermediate care facility providing assessment and treatment with a family/child/community orientation.
Area Served: Manitoba
Contact: Intake Secretary - 237-2690

B TREATMENT CENTRES

1) Manitoba Adolescent Treatment Centre

a) Short-term Acute and Consultation Programmes
Age Serviced: 12 - 18 years
Services Provided: Short-term treatment adolescents in acute episodes of a psychiatric nature. Limited consultation services are available on adolescent psychiatric issues.
Area Served: Manitoba
Contact: Liaison and Admissions coordinator - 477-6391

C CLINICS

1) Child Guidance Clinic of Greater Winnipeg (Psychiatric Component) or Educational Support Services (St. James)

Age Serviced: 5 - 17
Services Provided: Preventative, consultative, diagnostic and direct treatment programmes (on an outpatient basis) to students of the Greater Winnipeg School Divisions and St. James School Division during the school year.
Area Served: Greater Winnipeg
Contact: (C.G.C.) Area Service Director - 786-7841 or (E.S.S.) 885-1334

2) Klinic Community Health Centre

Age Serviced: Any age
Services Provided: Crisis intervention and/or short-term counselling 24 hours/day; 7 days per week.
Area Served: Winnipeg and surrounding area
Contact: 786-8686

D COMMUNITY MENTAL HEALTH SERVICES

1) Child and Adolescent Mental Health Services

Age Serviced: 0 - 18 years
Services Provided: Identification, assessment, treatment and crisis services for psychiatrically disturbed children, adolescents and their families.
Area Served: Rural/northern Manitoba
Contact: Regional Government Community Mental Health Office or Directorate at 945-5040.

E CRISIS LINES

1) Klinic

Age Serviced: Any age
Services Provided: Crisis intervention and/or short-term counselling 24 hours/day; 7 days per week.
Area Served: Winnipeg and surrounding area
Contact: 786-8686

2) Salvation Army Suicide Prevention Bureau

Age Serviced: Any age
Services Provided: Suicide prevention and intervention counselling available 24 hours/day for those in a suicidal crisis or needing services after an attempt
Area Served: Winnipeg and surrounding area
Contact: 943-4300

3) Teen Touch T.M.

Age Serviced: Youth
Services Provided: Provide a listening ear and pass on information relevant to the callers situation 24 hours/day
Area Served: Manitoba
Contact: 233-0914 (collect calls accepted)

F SUICIDE BEREAVEMENT

1) Winnipeg Suicide Bereaved Group

Age served: Any age
Services provided: A supportive environment in which the bereaved can talk and share their feelings with others.
Area served: Winnipeg and surrounding area
Contact: 943-0381

G INFORMATION SERVICES

1) Canadian Mental Health Association (Winnipeg and Manitoba Regions)

Age Serviced: Any age
Services Provided: Referral and information service, advocacy, public education, supportive housing, volunteers, and service development for mental health issues
Area Served: Winnipeg and Manitoba
Contact: Winnipeg Region - 775-8655
Manitoba Region - 775-8888

S.P.I.N.
Suicide Prevention/Intervention Network

WINNIPEG INDEX OF CRISIS SERVICES FOR CHILDREN AND ADOLESCENTS

This Index has been compiles for the use of the Suicide Prevention/Intervention Network. These services are intended for children, adolescents and their families who are facing a crisis as a result of a suicidal concern. This Index is not to be considered as a comprehensive list of services available to children/adolescents/families.

For information/services on other problems of children/adolescents/families please phone Contact Community Information - 944-8555, or consult the Social Services Manual of Manitoba (available from the Social Planning Council of Winnipeg - 943-2361).

NOTE: In case of a suicide attempt (medical emergency) dial 911.