ANALYSIS OF INCIDENCE, KNOWLEDGE, AND EXPERIENCE OF WINNIPEG SECONDARY SCHOOL COUNSELLORS WITH SUICIDAL 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

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Abstract

Secondary school counsellors occupy a position which gives them an opportunity to observe and act on the signs of suicidal risk in students. Secondary school counsellors in the ten school divisions and the Manitoba Catholic School System schools that comprise the greater Winnipeg area (n = 88) were surveyed to determine the frequency of contact with suicidal adolescents, to document previous training and current knowledge about suicide, and to describe the means by which at-risk students come into contact with counsellors. In addition, the counsellors were asked to describe school and community resources that were helpful and to describe counselling methods used for suicidal students, families, other students, and for school staff after suicide attempts and completions. Counsellors were also asked for recommendations for helping deal with suicidal students. The return rate of the survey was 46.3%.

Results indicated that a large majority of counsellors are dealing with suicidal adolescents and that most view their contact with suicidal students as increasing over the previous two years (1987 & 1988). Most have received some form of specialized training in the schools but a majority had received no academic educational preparation in this specific area. Counsellor contact with suicidal students came most

frequently from self-referral, and then from friends of the students. Senior high counsellors dealt with significantly more suicidal students when compared to junior high counsellors. Most counsellors stated that there was a need for a policy and procedures regarding suicidal attempts and completions in the student population. Several recommendations were made including the need for more professional development, and classroom work on the topic of adolescent suicide for students.

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I hope you are alive and well.

CHAPTER 1

INTRODUCTION

Statement of the Problem

Suicide is the number one cause of unnecessary and preventable death in adolescents (Maris, 1985; Gordon, 1979; Winicoff & Resnik, 1971). Peck (1982) has estimated that 10% of youngsters in the classroom have suicide on their minds and are at risk. Ross (1987a) stated that approximately 60% of all adolescents were reported as having seriously considered suicide at least once. The increase in adolescent suicide over the past two decades has become both a cause for concern and major challenge for counsellors in secondary schools. Sabbath (1969) stated, "Suicide in adolescents is a particularly poignant challenge to those of us in the helping professions, for it points out far too clearly our inability to help a child who, by his own actions has made himself nonexistent. He is indeed a dropout from life - premature and permanent" (p.272).

Adolescent suicide rarely occurs without warning (Smith, 1976: Gordon, 1979) and numerous reliable indicators of adolescent suicidal risk have been identified through extensive research (National Task Force on Suicide,

1987; Thompson, 1987; Maris, 1985). The secondary school counsellor is among the individuals who have the earliest opportunity to both recognize these factors and to take positive action to deal with the suicidal adolescent (McNeely, Shaffi & Schwab, 1977; Gordon, 1979). The secondary school counsellor, because of the long term, recurring nature of contact with the student population, has the unique opportunity to observe various patterns and changes in student behavior as these occur within the social context as well as in isolation.

In spite of the school counsellor's proximity to a group that has shown dramatic increases in reported suicides, a number of studies have suggested a lack of training for mental health professionals in general and for counsellors in particular regarding information about suicide and in the recognition of the potential signs of suicide (Domino & Swain, 1985-86; Holmes & Howard, 1980; Holmes & Wurtz, 1981; Schnacke, 1972).

The secondary school counsellor is in a special position to save a life and to promote the reduction of self-destructive tendencies (Winickoff & Resnik, 1981). The need to ascertain the prospects for realizing the prevention, intervention, and postvention potential of this group is of great importance (Gordon, 1979). Greuling and DeBlassie (1980) stated, "Some professionals feel that school

counsellors can be effective preventive agents because adolescents who are genuinely suicidal usually do not consult directly with a family physician or a clinical psychologist. They also are not likely to consult with parents, clergymen, or anyone else they do not trust.... If the school counsellor can establish the image of a stable and trustworthy friend, then he or she can easily become one to whom a troubled youngster can turn in time of serious need. It is in this role of a true friend and counsellor that the school professional can render a unique, unmistakably gratifying and life-saving service to young people today" (p. 595).

The role played by secondary school counsellors in the detection and prevention of suicide in adolescents should not be underestimated. The National Task Force on Suicide in Canada (N.F.T.S. 1987) stated that, "as a result of close day-to-day contact, teachers, guidance counsellors, and other school personnel have a direct and powerful influence on the lives of potentially suicidal students. Students in distress frequently present teachers or guidance counsellors with overt suicidal ideation, or indirect indications through suicidal themes in their written assignments. Given the appropriate attitudes and level of expertise, school personnel could play a vital role in the prevention of suicide" (p. 43).

The N.T.F.S. (1987) stated, "It is generally acknowledged that suicide and self-destructive behavior need more study. As suicide prevention programs evolve and mature, one of many research needs will be for evaluative research to measure and improve these new programs. More urgently, there is a prior need to develop a comprehensive data base on suicide and self-destructive behavior" (p.79).

The N.T.F.S. does not state what would be appropriate attitudes and levels of expertise for school personnel and this gives rise to various questions. What are the current levels of expertise in guidance counsellors? What roles do counsellors currently play in the prevention of suicide? How often do counsellors deal with suicidal adolescents? These questions have yet to be asked directly to school counsellors.

Several computer assisted journal searches and personal conversations with suicide researchers have revealed to this author that at present there is not a researched knowledge base upon which to answer these questions. A study to determine the nature and incidence of secondary school counsellor involvement with suicidal adolescents could help in the creation of this knowledge base. This might provide additional information to help the secondary counsellor deal more effectively with this serious issue.

Purpose of the Study

The purpose of the current study was to survey the experience of secondary school counsellors with suicidal adolescents. This was accomplished by:

a) Documenting the levels of contact between counsellors and suicidal students.

b) Comparing relevant demographic counsellor and school variables with the levels of contact between counsellors and suicidal students.

c) Documenting counsellor training and knowledge in the area of adolescent suicide.

d) Detailing counsellor methods in dealing with suicidal students.

e) Describing recommendations and areas of support for these counsellors in dealing with suicidal students.

Definition of Terms

In order to minimize misinterpretation, the following terms are defined in an operational manner:

Adolescent in this study refers to those individuals not younger than 12 or older than 19 years of age.

Confidentiality is defined as the process of maintaining trust and secrecy.

Junior secondary school refers to those schools encompassing grades seven, eight and nine.

Parasuicide is defined as attempted suicide.

Secondary school refers to those programs encompassing grades 7-12 in the public school system.

Senior secondary school refers to those schools encompassing grades ten, eleven, and twelve.

Suicide is defined as "the human act of self-inflicted, self-intentioned cessation" (Shneidman, 1985, p.14). Therefore, to be suicidal is defined as being involved in the active process of suicide. This includes the serious consideration and planning of a suicide.

CHAPTER 2

A REVIEW OF RELATED RESEARCH

Despite the recent proliferation of studies and articles on adolescent suicide, several computer assisted searches have failed to turn up comprehensive research, or a conclusive data base dealing with secondary school counsellors and their direct experiences with suicidal adolescents. This chapter provides a review of relevant research regarding the nature, occurrence, and causes of adolescent suicides and suicidal behavior. The incidence of adolescent suicides, counsellor variables, school variables, counsellor knowledge, and techniques used by counsellors with suicidal adolescents are also reviewed.

Adolescent Suicide

A complete statistical understanding of adolescent suicide and suicidal tendencies is difficult due to the unreliability of the data (Miller, 1975; Winicoff & Resnik, 1971; Duraj, 1984; Kleck, 1988). Traditionally, the reporting of a suicide is dependent upon reports made by local medical examiners. Authorities agree that a large number of suicides have gone unreported because of social, religious, or legal taboos (Miller, 1975; Pollack, 1971;

Brown, 1975; Smith, 1976; Kleck, 1988). The statistics regarding the number of parasuicides versus suicides and the number of suicidal people given any population group are also unreliable because of the problems with various reporting methods used and because of the unique sub-populations reviewed (Smith & Crawford, 1986).

The trend of underreporting adolescent suicide has recently changed. This appears responsible for at least part of the recent rise in reported adolescent suicidal deaths. The N.T.F.S. (1987) stated, "current speculation is that the rate of adolescent suicide has not increased so much as the rate of under-reporting has decreased" (p. 30).

In spite of the problems inherent in the reliability of the statistics, it is this researcher's opinion that there has been an increase in the concern and involvement of secondary school counsellors with suicidal adolescents over the past two decades. This opinion is derived from the recent flood of journal articles regarding secondary schools and suicidal adolescents. The content of these articles has dealt with administrative concerns (Toepfer, 1986), myths surrounding suicide, lethality assessments (Smith, 1976), suggestions for preventative measures (Farberow, 1985; Fujimura, Weis & Cochran, 1985; Curran, 1988; Stillion, McDowell & May, 1989), as well as postvention strategies (Kelsch, Share, & Preyma, 1987; Lamb & Dunne-Maxim, 1987).

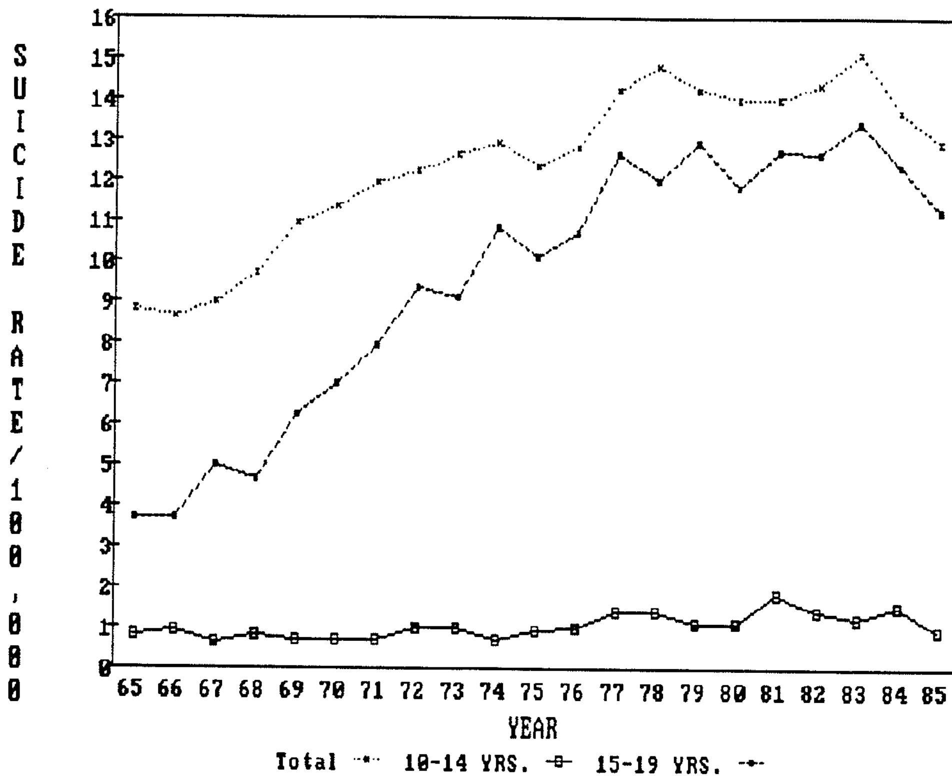
Adolescent Suicide Trends

Suicides constitute approximately 15 per cent of all fatalities in the 10-19 year old age group (Statistics Canada,1983). The number of reported suicides among young people has increased dramatically over the last twenty years. This increase in adolescent suicide is primarily due to the large number of male suicides. In 1983, the incidence of male suicides in the 15-20 year age group was five times greater than in 1963. Among females it was 2.5 times greater (N.T.F.S., 1987). This trend has been consistent with statistics from the United States (Maris, 1985; Mercy, Tolsma, Smith & Conn, 1984) where numerous authors have written of the adolescent suicide "epidemic" (Allen, 1987; Fitchette, 1982: Steele, 1985). This alarmist viewpoint has persisted in Canada also, despite recent figures which have shown a tapering off of the number of reported adolescent suicides since 1979 when 308 15-19 year old Canadians killed themselves. In 1980 there were 278 suicides in this age group followed by 293 in 1981, 289 in 1983 (N.T.F.S., 1987), 253 in 1984, 221 in 1985, 241 in 1986, 244 in 1987, and 242 in 1988 (personal conversation with Statistics Canada July 10, 1990).

The increase of reported suicide in the 10-14 age group has also risen over the last twenty years. The numbers

of suicides for this group reached a peak in 1981, declined to a low of 17 suicides in 1985, and have risen again to 30 suicides in 1987 and 27 in 1988 (personal conversation with Statistics Canada, July 10, 1990).

Figure 1. Canadian suicide rate per 100,000 population for 10-14 year olds, 15-19 year olds, and all ages 1965-1985.



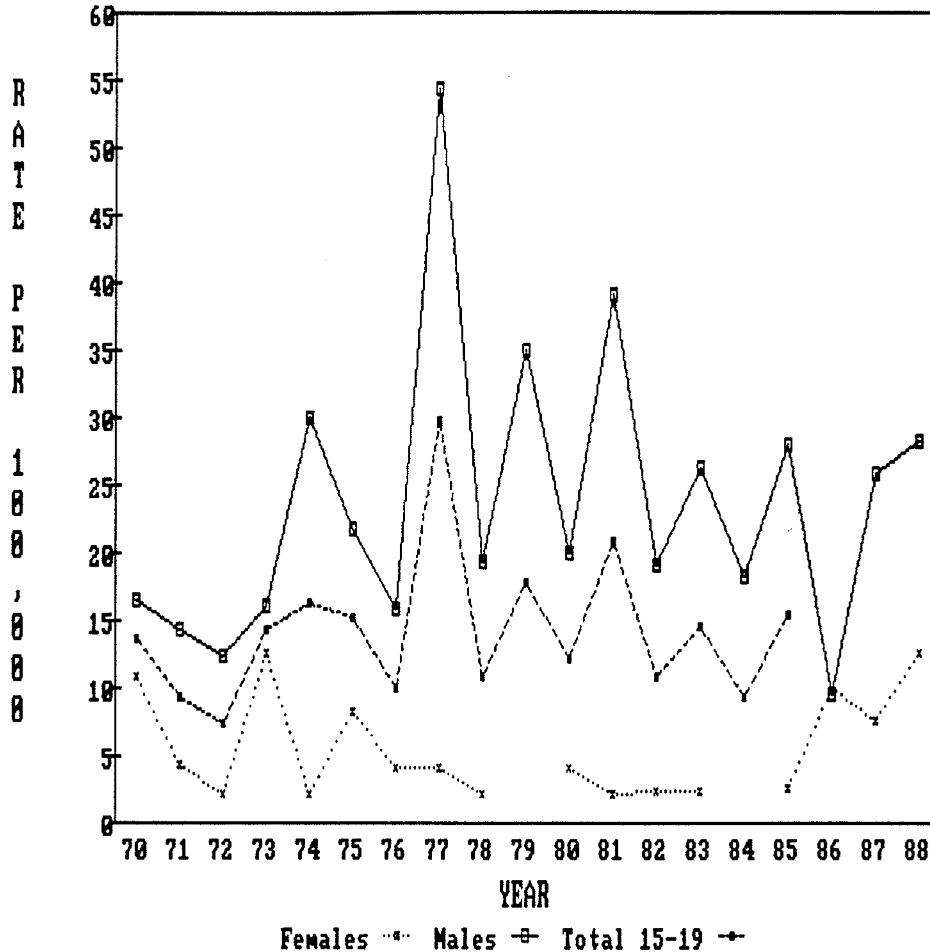
Note. Adapted from Suicide in Canada (p. 82) by The National Task Force on Suicide in Canada, 1987, Ottawa, Ministry of National Health and Welfare.

There is roughly a 5:1 male/female ratio of suicides in this group (Bagley, 1989). This matches figures from the United States (Shaffer, Garland, Gould, Fisher & Trautman, 1988). The reported suicide rates for youth in Canada have been lower than that of other age groups up to 1981, but the 15-19 and 10-14 year-old groups have shown the greatest degree of increase over the past twenty years (N.T.F.S., 1987). This is clearly shown in the comparison of age groups in Figure 1.

The suicide statistics for Manitoba adolescents show an overall increase over time combined with a levelling off around 1980. A comparison of the suicide rates for Manitoba males and females aged 15-19 over time is shown in figure 2. This figure clearly demonstrates a disturbing recent rise in female suicides for this age group.

The highest total of adolescent suicide deaths in Manitoba occurred in 1977 when 32 people between the age of 10-19 years killed themselves. Suicides for this group have tapered off to 14 in 1985 (personal conversation with Statistics Canada, April 1987), 11 in 1986, 21 in 1987, and 16 in 1988 (personal conversation with Chief Medical Examiner for Manitoba, July 1990).

Figure 2. Manitoba suicide rate for male and female 15 - 19 year olds from 1970-1988.



Note. Adapted from Suicide in Canada (pp. 92-93) by the National Task Force on Suicide in Canada, 1987, Ottawa, Ministry of National Health and Welfare, and a personal conversation with Statistics Canada, July 9, 1990.

In a recent study, Thompson (1987) found that young males in Manitoba were 7 times more likely to commit suicide when compared to their female counterparts. He also found a significant difference in the number of native males and rural white males compared to urban white males.

Adolescent Parasuicide

There have been several estimates of the number of adolescent parasuicides in relation to each suicidal death. The estimates vary from 50 attempts per death (Jacobziner, 1965) to 120 attempts per death (Tuckman & Connon, 1962). These estimates have been widely publicized despite the fact that these figures were derived from a unique sample of attempters who had been admitted to hospital. That sample may not be a true representation of the adolescent population at large (Smith & Crawford, 1986). This would suggest that parasuicide among adolescents is less prevalent than the former studies have documented.

Recent Canadian figures (N.T.F.S., 1987) showed a distinct difference in male and female parasuicide to suicide ratios. The males in the 15-19 year range had a parasuicide to suicide ratio of 38:1 and females in the same age range had a ratio of 216.6:1. These figures seem to imply that, while more females attempt, more males complete suicide. The discrepancy in these numbers also points to the fact that males tend to use more lethal means to kill themselves. A total of 31.9% of the male suicidal deaths in 1983 involved the use of firearms compared to only 9.4% of the female suicides (N.T.F.S., 1987). The method of choice among females was to overdose on drugs.

The Ontario Health Study (Joffe, Offord, & Boyle, 1988)

studied 3,294 children and indicated that 5% to 10% of the boys, and 10% to 20% of the girls between the ages of 12 to 16 had experienced suicidal ideation or made suicide attempts within the previous six months of the study.

Factors in the Increase of Adolescent Suicide

Numerous explanations have been given for the overall growth in adolescent suicide. Some experts have looked into demographic irregularities to try to understand this phenomenon. The N.T.F.S. (1987) speculated that because of the rapid growth in the number of young people reaching adolescence since the 1960's, the increase in suicide rates is actually much less than the actual number of suicides reported. As well as speculating about the previously mentioned reporting irregularities employed in suicidal documentation, they state that changing social attitudes towards suicide have made it a more appropriate classification of death for ambiguous adolescent deaths.

Maris (1985) also noted the youth population rise in the 1960's and the corresponding stress that this age group has had to deal with because of increased class sizes, economic and social competition among peers, and with older groups for a meaningful place in society. He suggests

that this closely matches the increase in youth suicide rates in the United States. He predicted that, because of the decrease in population in the 15-24 age group predicted until 1995, the suicide rates will drop throughout the next decade even if no preventative action is taken at all. His prediction was shared by Holinger and Offer (1982).

In spite of the statistical correlations and changes in suicidal reporting, numerous experts have written of other causes of the dramatic increase in adolescent suicide. Morgan (1981) suggested that the breakdown of the family structure, changing value systems, a sense of rootlessness, and a disillusionment with society's institutions are all direct causes. Duraj (1984) and Ross (1987a) mentioned the rise in malfunctioning or "broken" families and alienation from other family members as a major cause. The Ministry of Health of British Columbia (1986) stated that the major points of theories concerning the rapid increase in adolescent suicide include increased pressures, increased social and family disruption, decreased resources of extended families and neighbourhoods, increased isolation of family units, increased access to suicidal means, and the increased recognition that young people commit suicide (p.43).

Maris (1985) stated that the process of adolescence may be more difficult and stressful than in the past because

of changing economic and social standards. He describes the process of youth as a curious dilemma currently involving an earlier arrival into adolescence and a later transition to adulthood than in the past. He mentions that this stage has been extended by economic, biological, and social events and that the young have been freed from the responsibilities and rights of adulthood. This has effectively disenfranchised them from meaningful participation in society and rendered them relatively impotent. Maris combined this idea of being disenfranchised from society with that of a more stressful and difficult adolescent life stage and wonders why so few youths actually do suicide.

Risk Indicators

Many researchers have analyzed various groups of adolescents who have killed themselves in order to look for common factors involved. The N.T.F.S. (1987) has stated "it may be concluded that, despite the lack of an established model depicting the interplay of the various influences on the young person, the extensive research in the area of youth suicide has identified several predisposing and precipitating factors that may serve as reliable indicators of suicidal risk" (p.32).

Thompson (1987) in his demographic study of adolescent suicide in Manitoba points to such risk factors as

alcohol abuse, a recent breakup with a partner, and a recent marital or family dispute as common to all groups. Among females he found that previous psychiatric contact, medical illness, and a previous attempt were predisposing factors. Among native suicides he found a history of alcohol abuse, adoptive or foster care status, the recent death of a significant other, and a recent family or marital dispute as associated factors. He reported that drug abuse, unemployment, and legal problems were associated with young white males who killed themselves. School problems were found to be common in the 15-17 year old group.

The Ministry of Health in British Columbia (1986) stated that suicidal behavior has been associated with depressed mood, negative self-evaluation, anhedonia, insomnia, poor concentration, indecisiveness, lack of reactivity of mood, psychomotor disturbance, and alcohol and drug abuse.

Levy and Deykin (1989) reported findings regarding the connections between suicidality, depression and substance abuse in adolescence. They reported that more than a quarter of the surveyed students (424 college students) had experienced suicidal thoughts at one time or another. About half of the students who had made a suicide attempt did not meet the diagnostic criteria for major depression at any time in their lives. They suggested that

the association between depression and suicide is not as strong in community settings as previously thought. They also found that the presence of substance abuse elevated the risk of suicidal ideation or behavior. This also had the greatest impact on both the desire to be dead, and a suicide attempt. Substance abuse was also described as a secondary barometer of a disturbed life situation.

The role of drugs in adolescent suicide attempts was studied by McKenry, Tishler, and Kelley (1983). Although a small sample (N=48) was used, they stated that drug use and particularly abuse was a form of self-destructive behavior closely related to suicidal behaviors. They also stated that parental drug abuse can indicate an adolescent's potential for self-destructive behavior.

Neiger and Hopkins (1988) stated that the risk of suicide is increased with alcohol and drug abuse for several reasons. Suicidal adolescents typically exhibit low selfcontrol and are more easily frustrated and affected by distress. These teenagers while under the influence of drugs or alcohol are more apt to act on impulse and involve themselves in other self-destructive acts. The substance itself also can serve as a mechanism by which the person may choose to end life.

Bagley (1989) studied medical examiner reports in Alberta and found social and clinical characteristics of

youthful suicides. He stated that 43% of his sample (N=130) had been separated from their biological parents for over 6 months, 39% had quit school and were not working, 31% had communicated suicidal intent in the previous six months, 24% had serious drug and alcohol abuse issues, 24% had clinical treatment or indicators of clinical depression in the prior 12 months, 23% had separated from a spouse or partner in the previous month, and 21% had a history of mental illness or suicide in parent, sibling, aunt, uncle, or grandparent.

Grob et al. (1983) studied the role of high school professionals in identifying and managing adolescent suicidal behavior. Eighty school professionals including counsellors, teachers, nurses, administrators, social workers, and psychologists were interviewed. When asked about indicators of suicidal risk, they identified 30 signs from 11 major categories. Over 70% of the respondents identified manifestations of depression (sadness, despair, indifference) as well as vegetative signs (sleeping and eating disorders) as clues to suicidal potential. Sixty percent were alerted by an expression of a suicidal impulse manifested either as a direct acknowledgement of suicidal intent or, as indirect suicidal themes in art, written work, or conversation. Almost the same percentage found social

isolation, withdrawal, and the absence of peer support as a warning sign. Others in the sample noted declining academic performance and other school related problems, lateness, truancy, discipline problems, as well as self-destructive tendencies, and drug and alcohol abuse as risk factor

Suicide and the Secondary School

Secondary schools and their counsellors play a unique and strategic role in the identification and possible prevention of adolescent suicidality (Grob, Klien & Eisen, 1983; Ross, 1981). Since adolescents do not typically seek help voluntarily or utilize helping resources as would adults, and since they attend school for close to six hours a day for over 180 days of the year, school personnel may be the first to notice the behavioral signs of a suicidal youth (Shipman, 1987; Gordon, 1979; Jacobs, 1971).

Suicidal Students

Ross (1987b) reported that suicide attempters made up 13% of the California high school students that were surveyed. Klagsbrun (1976) found that 10% of 113 New York high school students had attempted suicide in his self-report study, and Mishara, Baker and Mishara (1976) found that 15% of 293 college students in Detroit reported having attempted suicide. Perhaps the most conclusive study to

date has been that of Smith and Crawford (1986) who reported that 10.5% of their sample of 313 high school students had made one or more suicide attempts. They found that 25.2% of the students surveyed reported feeling suicidal enough to either make a plan or an attempt. They stated, "... that suicide is a personal concern of most high school students and a serious concern of 1 of 4 of these students. From 1 out of 8 to 1 out of 12 high school students have actually made an attempt" (p.324).

If the most conservative estimate of one in twelve is used in conjunction with the approximately 52,000 secondary school students in the Winnipeg area (Manitoba Education, 1987), then it can be assumed that 4,333 of these students will attempt suicide in one form or another. It would seem inevitable that a secondary school counsellor would encounter numerous suicidal adolescents each year. It would seem imperative that each counsellor have adequate professional preparation and available resources to deal effectively with this.

Counsellor Knowledge and Training

One of the areas of preparation for counsellors in dealing with suicidal youth is the ability to recognize factors in the lethality of suicide. Holmes and Wurtz (1981) reported on the tested ability of counsellors, including 47 secondary level counsellors with Master's degrees selected

non-randomly at a counsellor education conference, to recognize the associated signs of suicide using the Suicide Potential Rating Scale (also known as the lethality scale). They compared the results with other groups as tested by Holmes and Howard (1980). They found that the amount of time spent counselling each day did not increase their recognition of suicidal signs but that there was a significant difference in the number of years in counselling and the recognition factors. Overall the secondary counsellors studied were more accurate observers than were ministers and college students but not as accurate as elementary school counsellors, professors of counsellor education, social workers, psychologists, psychiatrists, or physicians.

Schnacke (1972) reported on his research into the knowledge and training of Kentucky high school counsellors regarding adolescent suicide. A 28 item questionnaire was filled out by 290 Kentucky high school counsellors and analyzed. Specifically, the investigation was centered around four basic assumptions:

1. High school counsellors are unaware of the various factors related to suicide on a nation-wide basis.

2. High school counsellors are unaware of the various factors related to suicide among the adolescent population.

3. High school counsellors are unaware of the most

productive counselling techniques when confronted by a suicidal adolescent.

4. High school counsellors do not possess adequate academic training to work with the potentially suicidal adolescent (p.2).

Schnacke found that the counsellors sampled were not generally aware of factors related to suicide among adolescents. His results indicated that counsellors are prey to the myths and misconceptions surrounding suicide. He also found that they were both naive and resistive in the recognition of adolescent suicide as a problem confronting the school. It was discovered that a large percentage of adolescent suicides were not identified as such by their school counsellors, that 62% of the respondents were unwilling to recognize the existence of suicide as a problem in U.S. high schools, and that 61% felt that a suicide was unlikely to occur in their school.

His study further demonstrated that the counsellors sampled were ill prepared to deal with the suicidal adolescent by the documentation of an almost total lack of academic training in suicidology. Ninety-two percent of the respondents had never participated in formal classroom seminars, workshops, or training in suicidology.

Inman, Basque, Kahn, and Shaw (1984) studied the relationship between suicide knowledge and suicide

interviewing skill. They reported that the lack of association between the two variables studied suggested that they are independent of each other. The study was marred by using a sample that scored very low on both the suicide lethality scale and the Suicide Intervention Response Inventory (SIRI) showing that they had very little knowledge of suicide, and little training in suicide intervention.

School and Family Factors

Ross (1987) surveyed 120 high school students asking them whom they would tell if they should ever consider suicide. The questionnaire offered the choices of parent, other adult, teacher, school counsellor, school nurse, doctor, friend, minister, or other. Friend was selected as the first choice in 91% of the responses. Mishara (1979) reported in his study of college students that many peers wanted to help but did not know what constituted an appropriate response. That conclusion was consistent with the findings by Norton, Durlak, and Richards (1989), based on their work with high school students. This demonstrates the potential problem of having untrained gate keepers dealing directly with suicidal adolescents in the schools.

The Grob, Klien, and Eisen study (1983) included reactions by students, family, and school faculty to suicides and parasuicides. Students were seen primarily as

disbelieving, sobered, sad, and shocked. Beyond these reactions were those of trying to be helpful or ignoring the event. Respondents tended to view their colleagues as helpful or at least trying to be so, although some stated that the school staff tried to ignore the event. These helpful or empathic responses were contrasted to the perceived reactions by the family of denial and disbelief. Supportive reactions by the parents were noted in only 10% of the sample.

One conclusion that arose as a result of this study was that there was an area of ambiguity in the relationship of the school and the parents of the suicidal youth. Many school professionals sampled thought that the parents had to be informed of the school's concerns but there were doubts about how helpful some troubled families might be in the situation or whether they might make the existing situation worse. "Clearly, issues of confidentiality were raised here" (p.172). This also reflects upon the focus of individual counselling versus group or family counselling by the school professionals interviewed.

During the period of this study (October through December 1987), there was no requirement for either school boards or individual schools for the creation and maintenance of a suicide prevention or education plan. There was also no requirement for the academic training of

counsellors in adolescent suicide prevention in counsellor training programs at the university level. This runs contrary to a current trend in the United States where six states have passed legislation mandating the establishment of suicide prevention programs in the schools (Stillion, McDowell, & May, 1989). Recent court proceedings in the United States have involved parents of suicide victims suing school districts over the lack of suicide prevention training for teachers.

Although a manual on how to prevent and cope with suicide has been produced by Manitoba Education for both staff and students (Lucus, 1987), the only statement that is made regarding confidentiality is this: "Do not swear to keep it a secret; suicide information is one of the secrets you can not keep. It's not worth the risk. You must report a child who is in danger of harming him/herself" (p.8). This manual also informs the helper to encourage the person to go to a parent or other people for help but states nothing regarding the obligations of a school, school counsellor, or other school professional with respect to being in care of a youth, and the legal implications of not informing the appropriate agencies and legal guardians of suicidal concerns. This lack of clarity regarding responsibility, liability, and confidentiality surrounding a suicidal adolescent has been mirrored in other reports (Ross, 1980 & 1987a; Stillion,

McDowell & May, 1989) and in numerous conversations with secondary counsellors including Ms. Linda Dier, the 1987 president of the Manitoba School Counsellors' Association (M.S.C.A.), and Ms. Nadia Preyma, Coordinator of Pupil Services, Winnipeg School Division #1.

Summary

The rate of reported adolescent suicide has risen dramatically over the past twenty years in the United States, Canada, and Manitoba. Many students in the secondary schools seem to exhibit suicidal behaviors and to think actively about suicide. There seem to be many individual, family, and socio-cultural factors involved that make students at risk for suicide.

The school counsellor appears to be in a unique position to help the suicidal student. Current studies are inconclusive regarding the knowledge, abilities, and experience of counsellors in these situations. Many of the studies thus far reviewed were based on self-reports of students. Other studies originated in hospitals of medical situations and did not involve secondary schools or counsellors at all. Although these studies are useful and help to develop a large knowledge base on suicidal adolescence, they do not focus on the direct experience of

secondary school counsellors.

In spite of the recent wealth of information and studies being conducted on the subject of suicidal adolescents, an exhaustive computer search of sources through the Suicide Information and Education Centre failed to find information in certain key areas. The previous studies showed a lack of information obtained through directly addressing the experiences of the secondary school counsellor with suicidal adolescents. Currently, no information is available regarding the number of suicidal students that counsellors are dealing with and whether counsellors think this number is increasing or decreasing. No information is available on how these suicidal adolescents come into contact with secondary counsellors. No information is available on perceived counsellor needs, or areas of professional support for counsellors regarding this issue. No Canadian data exists on the time spent by counsellors in academic training and professional development on this topic.

CHAPTER 3

METHOD

This chapter will detail the method used to research the questions posed in the introduction. The sample population that was used, the instrument used, the procedure that was followed in the collection of data, and the process of data analysis that was employed will be described.

Research Population

All 190 secondary school guidance counsellors in the greater Winnipeg area were sent questionnaires. Of this number, 88 (46.3%) filled out and returned the survey form. There was representation from all ten school divisions as well as the Manitoba Catholic School system.

The sample was almost split evenly between male and female respondents. There were 50.6% male and 49.4% female respondents. The mean age of this group was 39.6 years with a range of 32 years. This is reviewed in Table 1.

There were 47.9% of the counsellors that worked in senior secondary schools, 40.6% that worked in junior secondary schools and 11.6% that worked in integrated schools. The total number of counsellors working in the schools ranged from one to five with a mean of 2.7

counsellors per school.

Length of employment in the school system had a range of 29 years with a mean of 15.1 years. The mean amount of time spent by the counsellors in their current counselling positions was 7.7 years. There were 60.5% that were full time counsellors and 39.5% were part time counsellors.

The vast majority of counsellors in the sample (88.4%) had completed graduate education beyond the bachelor's level. Two percent of the respondents stated that they had completed a doctorate degree, 5.8% had completed work beyond the master's level, 32.4% had received a master's degree, 48.8% had completed some master's courses beyond a bachelor's degree, and 11.6% had completed a bachelor's degree.

Table 1

Sample Population

Variables	n	M	R
Age	64	39.6	32
Years Employed in School	84	15.1	29
Years Employed in Position	84	7.7	22
Number of Counsellors in School	85	2.7	5

Table 1 (continued)

Variable	n	Percent of Total
Sex	85	
Male	43	50.6
Female	42	49.4
Worksite		
Junior High	35	40.6
Senior High	41	47.9
Integrated	10	11.6
Position		
Full Time	52	60.5
Part Time	34	39.5
Educational Background		
B.A.	10	11.6
B.A.+	42	48.8
M.A./M.Ed.	27	31.4
M.A./M.Ed.+	5	5.8
Doctorate	2	2.3

Instrumentation

A survey form consisting of 25 open and closed questions was developed for this study (see Appendix A). Numerous questions were developed to explore the nature and method of contact between the secondary counsellor and the suicidal student (#1, 2, 3, 4, 5, 9, 10, 11, & 12). Other questions were devised to enquire into the issue of school policies regarding suicidal students, agents of personal support and confidentiality (#15, 16, 17, 19, & 20).

Questions #6, 7, 8, 13, 14, 18, 19, 21, 22, 23, 24, and 25 of this survey were adapted by the researcher from the work of Grob, Klien and Eisen (1983) and rewritten to alter the measurement format from an in-person interview to that of a survey (personal conversation with Ms. M. Grob, May 6, 1988). All of the survey questions were included and revised with direct consultation and review by professional members of the Suicide Prevention/Intervention Network (SPIN), MSCA, Klinic Community Health Centre, and the University of Manitoba.

The survey form took approximately 15 minutes of time to complete. The package delivered to each counsellor included a self-mailer, introduction to the study, and instructions for completion and return of the questionnaire.

Procedure

The self-administered survey was delivered to the sample population late in the month of October 1988 via the inter-school mail system in each school division. Included with the survey was a short cover letter of support from Ms. Linda Dier, the 1987 president of the Manitoba Secondary Counsellors Association. The forms were completed and returned via the inter-school mail or through the enclosed mailer to the researcher. At the end of three weeks from the date of receipt of the surveys, the results were coded,

tabulated and analyzed.

Analysis of the Data

The resulting data from the completed surveys were analyzed in the following ways.

Contact with suicidal adolescents over the previous two months and the previous academic year (question 1) was analyzed in descriptive terms. Various comparisons were made using two sample t tests with numerous variables in conjunction with suicidal contacts over the previous academic year to see if any of these were related to change in the incidence of counsellor contact with suicidal students.

Question four related to how suicidal students came into contact with counsellors. The first choice of the methods of contact was selected for descriptive study and reported on in this manner.

The responses on questions #6, and 7 were organized into the descriptive categories utilized in the Grob et al. (1983) study and reported as percentages of the total counsellor response. These questions dealt with perceived suicidal behavior and underlying individual, family, and socio-cultural factors regarding suicide.

The responses for question eight regarding counselling methods or procedures used with suicidal adolescents were organized into descriptive categories and

reported as percentages of the total counsellor response.

Questions 13 and 14 dealt with positive steps taken with other students, family, and school staff after a suicide attempt and a suicide completion. The responses were organized into descriptive categories and reported as a percentage of the total counsellor response. This procedure was also followed for the responses to questions 17 and 18 regarding perceived areas of professional support for the counsellor as well as the staff, and students of the school.

Questions 21, 22, 23, and 24 dealt with academic and professional development on the topic of suicide and were reported by means of descriptive statistics. These two areas of training were also totaled to create a separate category of total training hours. This was described separately as well as compared to the other categories. The responses to all other questions were totaled and reported by means of descriptive data using percentage of total counsellor response to the question.

The following chapter will describe the results from this study.

CHAPTER 4

RESULTS

This chapter contains the results of the survey answered by the secondary counsellors in the Winnipeg area. All percentages are derived from the eighty-eight questionnaires that were returned from the 190 requested. Descriptive data and comparisons of specific variables will be described.

Counsellor Contact With Suicidal Students

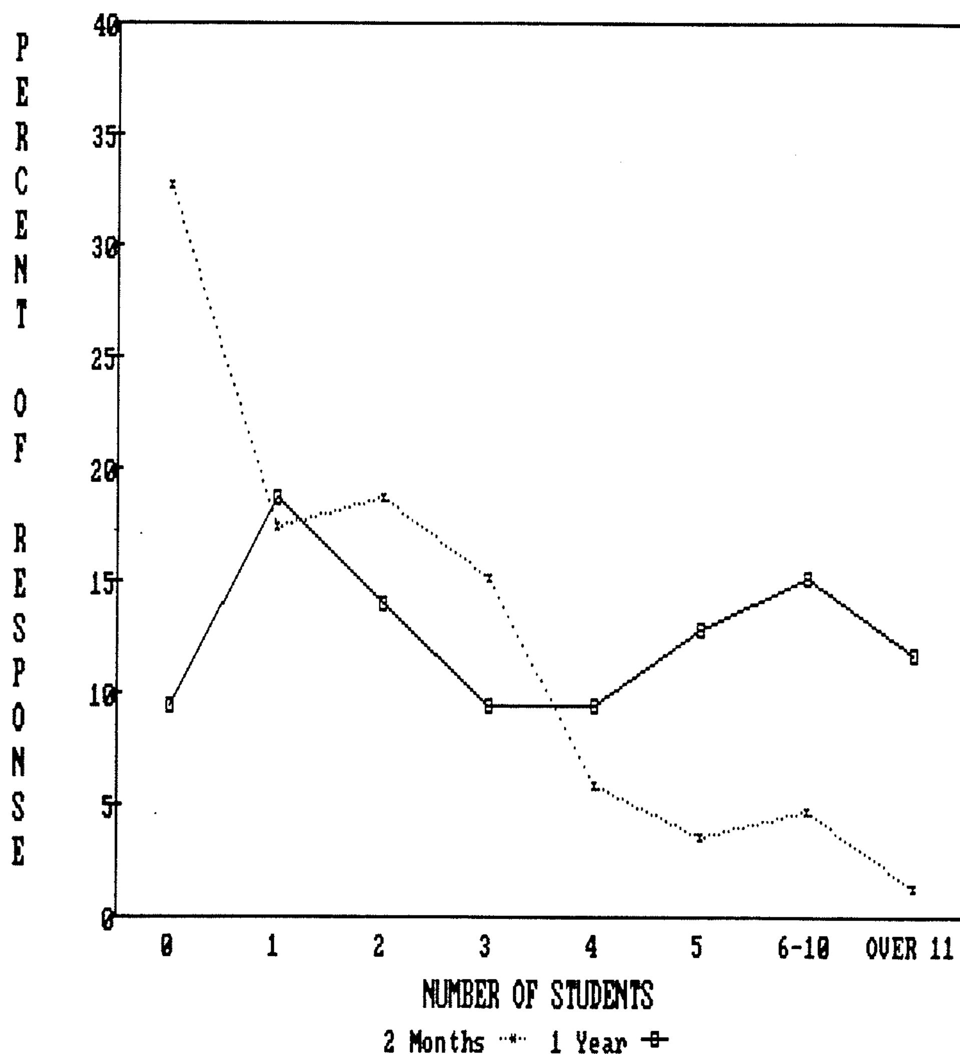
This section will document counsellor contact over the two months and previous academic year to the survey date, levels of contact estimated for other counsellors, level of suicidal contact over the previous two years, and the method of contact with suicidal students.

Previous Two Months

Slightly over two thirds (67.4%) of the counsellors had contact with at least one suicidal student over the previous two months (September and October, 1988). Fifty percent of the counsellors had encountered two or more suicidal students and 31.4% had contact with three or more suicidal students. There was a mean of 2.05 suicidal contacts, with a range of 25 contacts and a standard deviation of 3.07. Figure 3 shows the breakdown of number

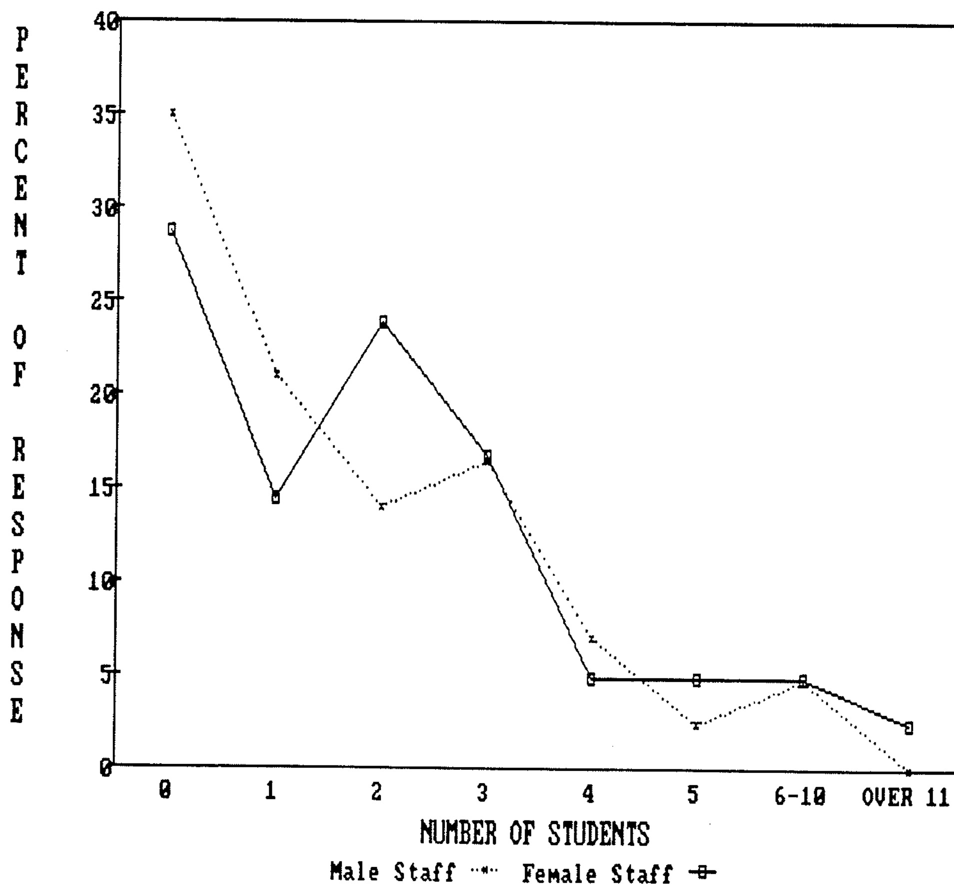
of suicidal contacts for both 2 months and the previous academic year.

Figure 3. Counsellor contact with suicidal students over two months and the previous academic year.



The female counsellors had a mean of 2.48 suicidal contacts, with a range of 25 contacts, a standard deviation of 4.01 and a median of 2 contacts. Male counsellors had a mean of 1.65 contacts, with a range of 6 contacts, standard deviation of 1.72 and median of one suicidal contact over two months. Figure 4 diagrams the differences between male and female counsellor contact with suicidal students over a two month period.

Figure 4. Male and female counsellor contact with suicidal students over 2 months.



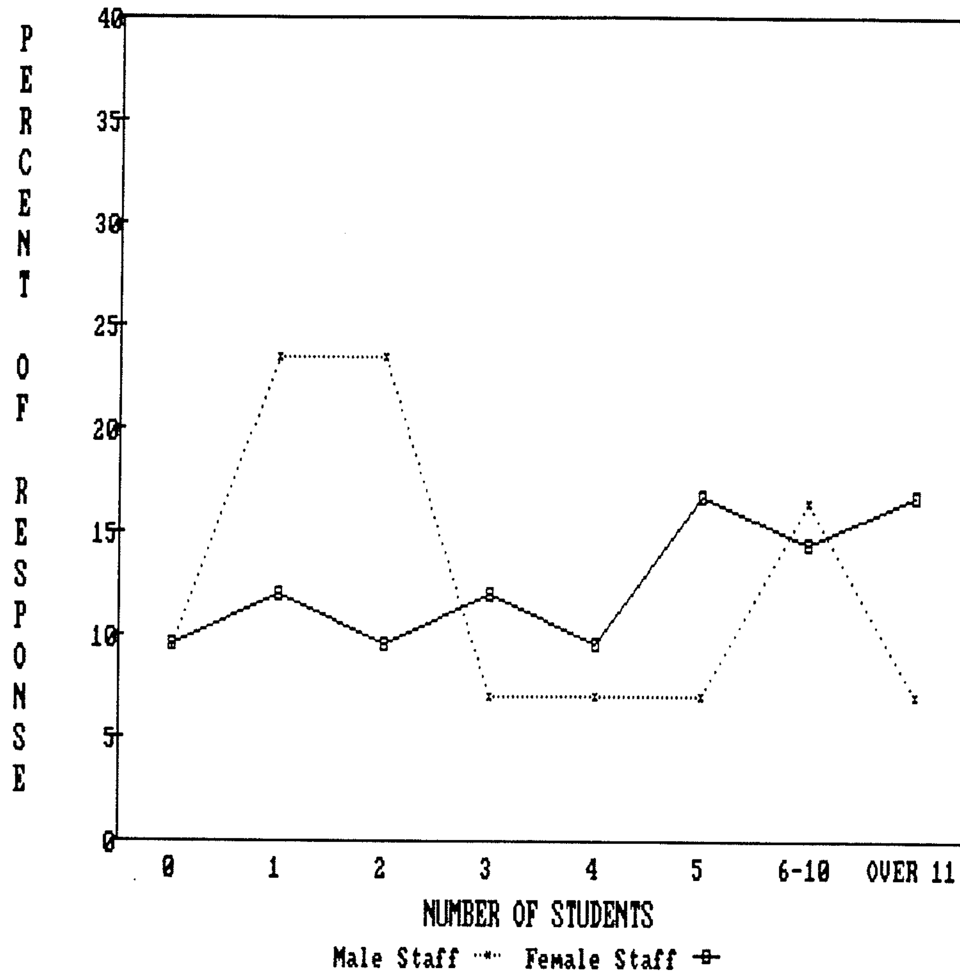
Previous Academic Year

A large majority of counsellors (90.7%) had contact with at least one suicidal student over the previous academic year. Only 9.3% stated that they had no contact, while 39.5% reported that they had contact with five or more suicidal students over this period. The mean number of suicidal contacts for all counsellors was 5.24, with a median of three.

Female counsellors reported a mean number of 6.62 suicidal contacts over the previous year. The range of contacts for female counsellors was 40 with a median of 4 contacts. The mean number of suicidal contacts for male counsellors was 4, with a range of 20 and a median of 2 suicidal contacts.

Figure 5 shows a comparison between the reported suicidal contacts of both male and female counsellors over the previous academic year. Male counsellors reported fewer contacts, while the female counsellors responded with an overall higher percentage of contact with a greater number of suicidal students (three and over).

Figure 5. Male and female counsellor contacts with suicidal students over the previous academic year 1986-1987



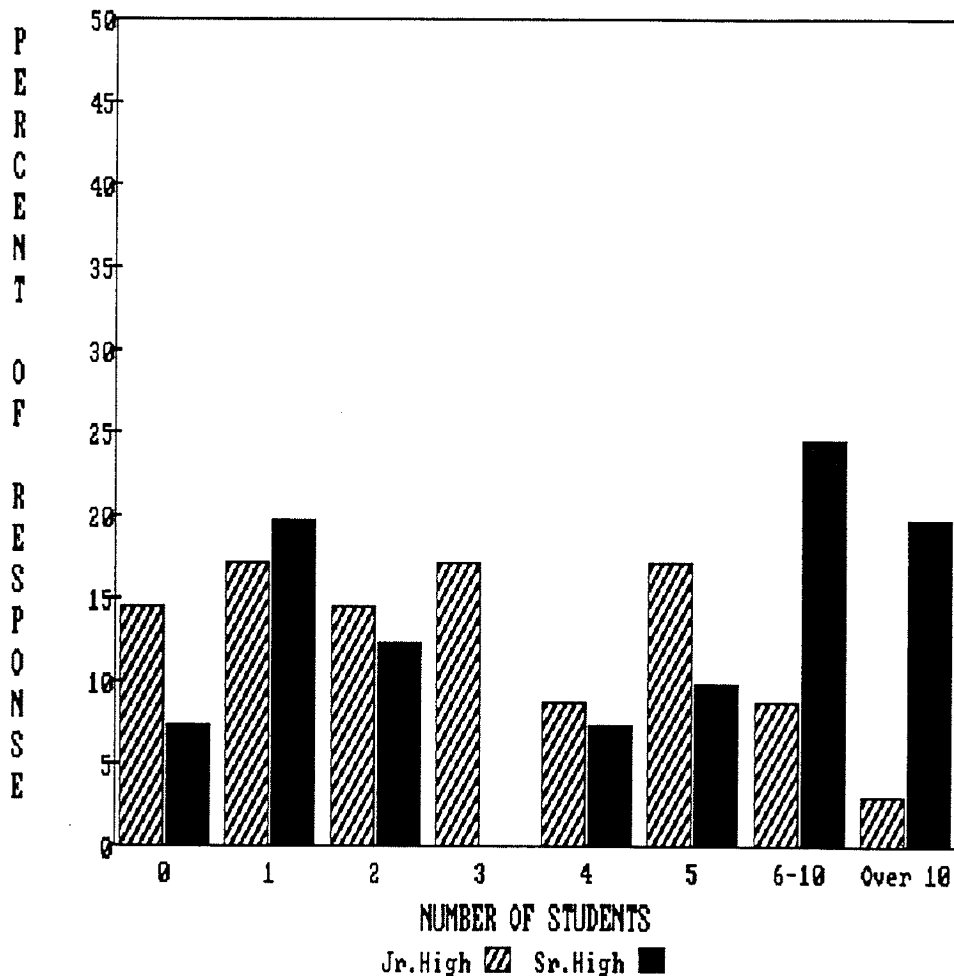
<u>Suicidal Contacts Over the Previous Academic Year and Counsellor Workplace</u>

Several comparisons of specific groups of counsellors were made in order to derive the true meaning of the data. It was found that only the "workplace of the counsellor" was related to change in the incidence of counsellor contact with

suicidal students.

Senior high counsellors dealt with significantly more suicidal students than junior high counsellors ($t = -2.71$, $p < .01$). The mean number of contacts for the senior high counsellors was 6.80 with a standard deviation of 7.511 compared with a mean for the junior high counsellors of 3.34 with a standard deviation of 3.009. Figure 6 shows the comparison of these groups.

Figure 6. Suicidal contact with junior and senior high counsellors over one year.



Senior high male counsellors dealt with significantly more suicidal students than junior high male counsellors (t = -3.02, $p < .005$). The mean number of contacts for senior high males was 5.4 compared to 2 for the junior high males.

Senior high male counsellors also dealt with significantly more suicidal students than had integrated school male counsellors (t = 2.83, $p < .008$). The mean number of contacts for integrated school males was 2.17.

Junior high female counsellors dealt with significantly more suicidal students than junior high male counsellors (t = -2.58, $p < .02$). The mean number of contacts for the females was 4.18 compared with a mean of 2 for the males.

Other comparisons showed no relationship to the level of incidence of counsellor contact with suicidal students. These included counsellor age (under 40 and 40 years and older), sex (male and female), years employed (under 16 years, and 16 years and over), educational background (less than a M.A./M.Ed., and M.A./M.Ed. or greater), years in current position (under 7 years, and 7 years or more), educational training (0, and 1 hour or more), professional development time (under 7 hours, and 7 hours or more), total training hours (under 9 hours, and 9 hours or more), number of counsellors in the school (under 3 and 3 or more counsellors), position (part time and full time), and policy (yes and no). The numeric variables were

grouped above and below the median.

Levels of Suicidal Contact for Other Counsellors

The counsellors estimated the number of suicidal contacts that other counselling professionals in their school had dealt with in the previous academic year (1987-1988). The mean estimate was 7.67 contacts, the median was 3, with a standard deviation of 14.94 and a range of 100. The largest estimated number of suicidal contacts by other counsellors in a Winnipeg secondary school was 100.

Involvement with Suicidal Students Over Time

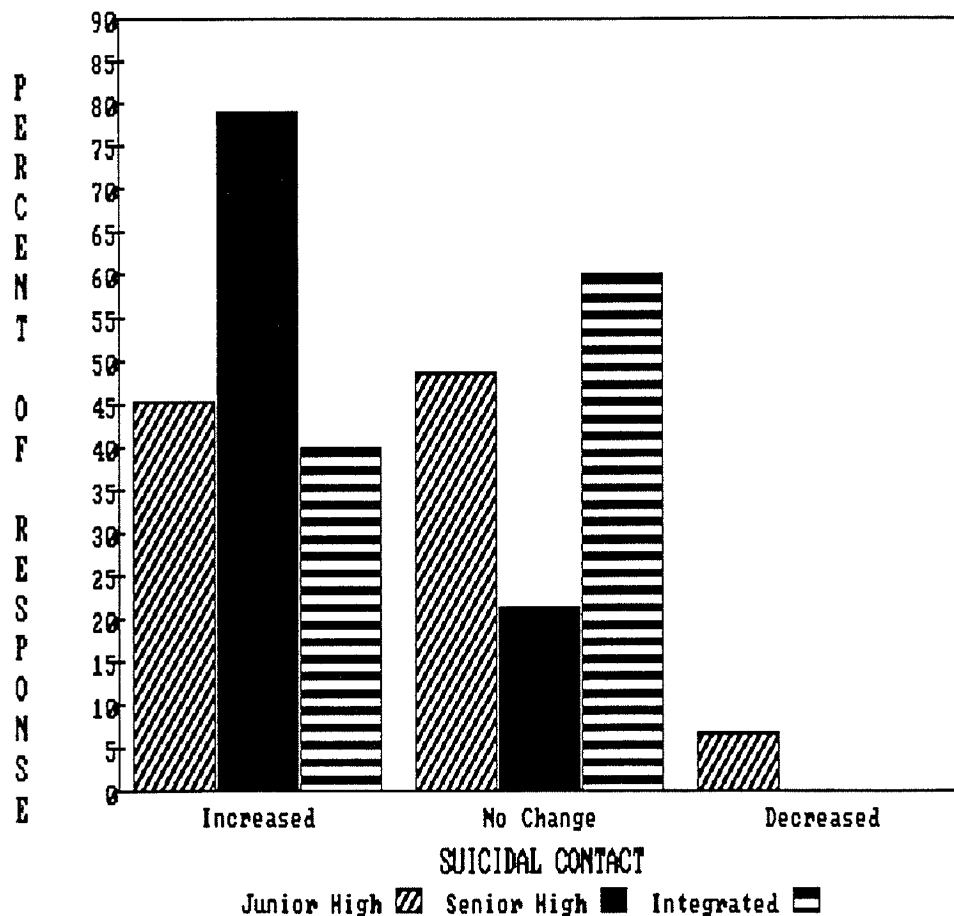
A majority of 60.7% of the counsellors stated that their involvement with suicidal adolescents had increased over the past two years (1986 - 1988). Thirty-seven percent stated that their involvement had been the same over this period and only 2.5% thought that there had been a decrease in personal involvement.

The junior high counsellors were almost evenly split between those who stated that their involvement with suicidal students had been the same over the previous two years (48.4%), and those who stated that their involvement with suicidal students had increased over the previous two years (40%). Figure 7 documents this.

The majority of senior high counsellors (78.9%) stated that they had experienced an increase regarding their involvement with suicidal students, while 21% stated that their involvement was the same.

Most integrated school counsellors (60%) stated their involvement with suicidal students had maintained the same level. The other integrated school counsellors (40%) stated their involvement had increased over the two years.

Figure 7. A comparison of suicidal contact over time for junior high, senior high and integrated school counsellors.

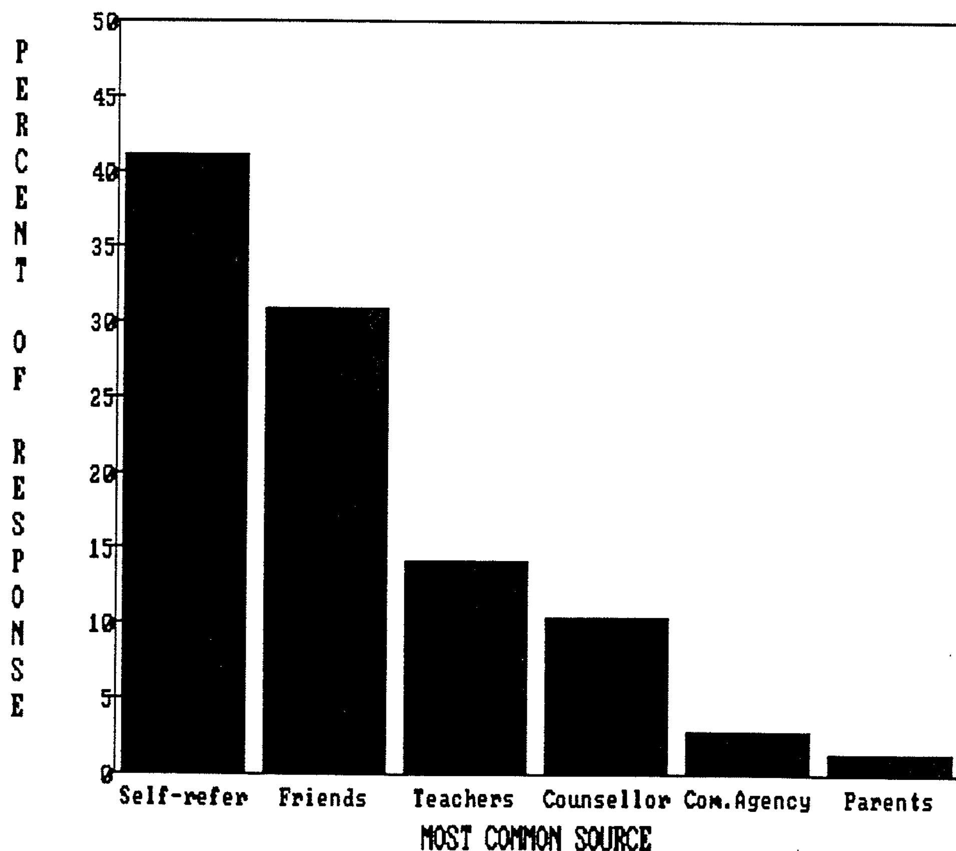


Method of Contact

The counsellors stated how suicidal students came in contact with them by ranking eight possible avenues of contact. The top six avenues of contact are documented in Figure 8.

Forty-one percent stated that self-referral was the most common form of contact. Thirty-one percent stated that friends of the student were the next most common form of referral, followed by 14.1% who chose teachers, 10.3% who chose counsellors, 2.6% selected outside professionals or community agencies, and 1.3% chose parents.

Figure 8. Most common form of referral of suicidal students to secondary counsellors



Counsellor Knowledge

This section will document counsellor training on the topic of suicide, counsellor knowledge of suicide attempts and completed suicides among their student population, knowledge of suicidal risk factors, individual factors, family factors, and socio-cultural factors. Abbreviated forms of certain terms will be used in the figures. These abbreviated terms will be shown in brackets following the full form of the term.

Training of the Topic of Suicide

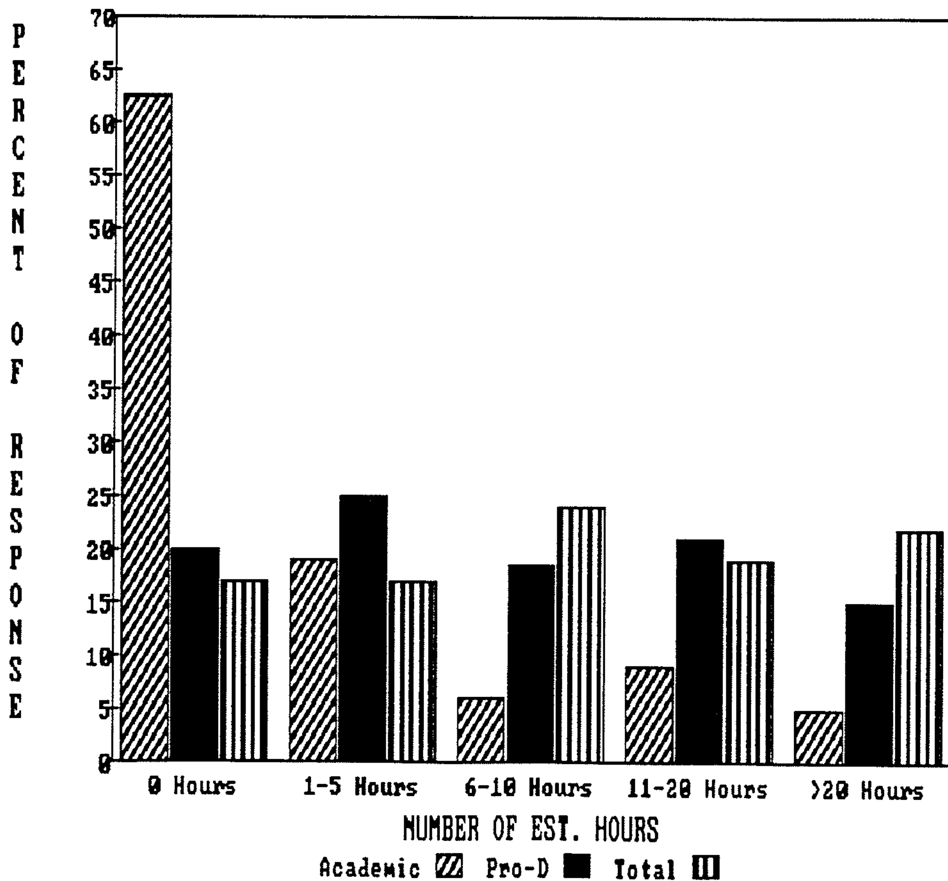
A majority of the counsellors surveyed (80%) had participated in some form of professional development (Pro-D) on the topic of adolescent suicide. The mean amount of time spent in professional development on the topic was 10.2 hours with a median of six hours. Twenty percent of the respondents stated that they had received no professional development on the topic.

Sixty-one percent of the counsellors stated that they had never received any courses or portions of courses in their professional academic training that had dealt specifically with the topic of suicide. This is shown in Figure 9. Of those who reported some professional academic training on the subject, fifty percent had received between one and five hours of instruction. The mean amount of time spent in academic training on this subject was 4.9 hours,

with a range of 64 hours.

The average total amount of time spent both in academic training and in professional development on the subject of suicidal adolescents was 14.6 hours with a median of 8.5 hours. Almost twenty percent (19.8%) reported that they had received no academic or professional development on the topic of suicidal adolescents.

Figure 9. Secondary counsellor training on the topic of adolescent suicide.

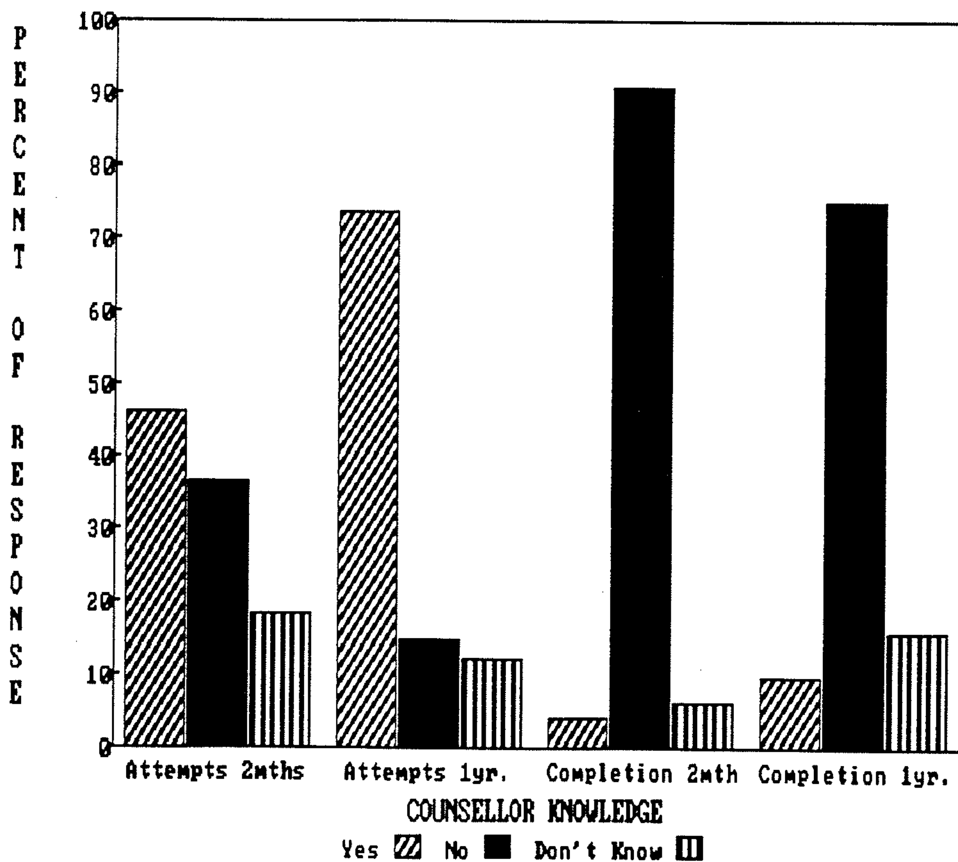


Knowledge of Suicide Attempts and Completions

The majority of the respondents (73.5%) knew of a suicidal attempt among their school population within the past year, while 45.8% knew of an attempt within the past two months (see Figure 10).

Very few counsellors (3.6%) stated that they knew of a suicidal completion among their student population within the previous two months before completing the survey. More counsellors (9.5%) had knowledge of a suicide among the same population over the previous academic year.

Figure 10. Counsellor knowledge of suicide attempts and completions in their school over time.

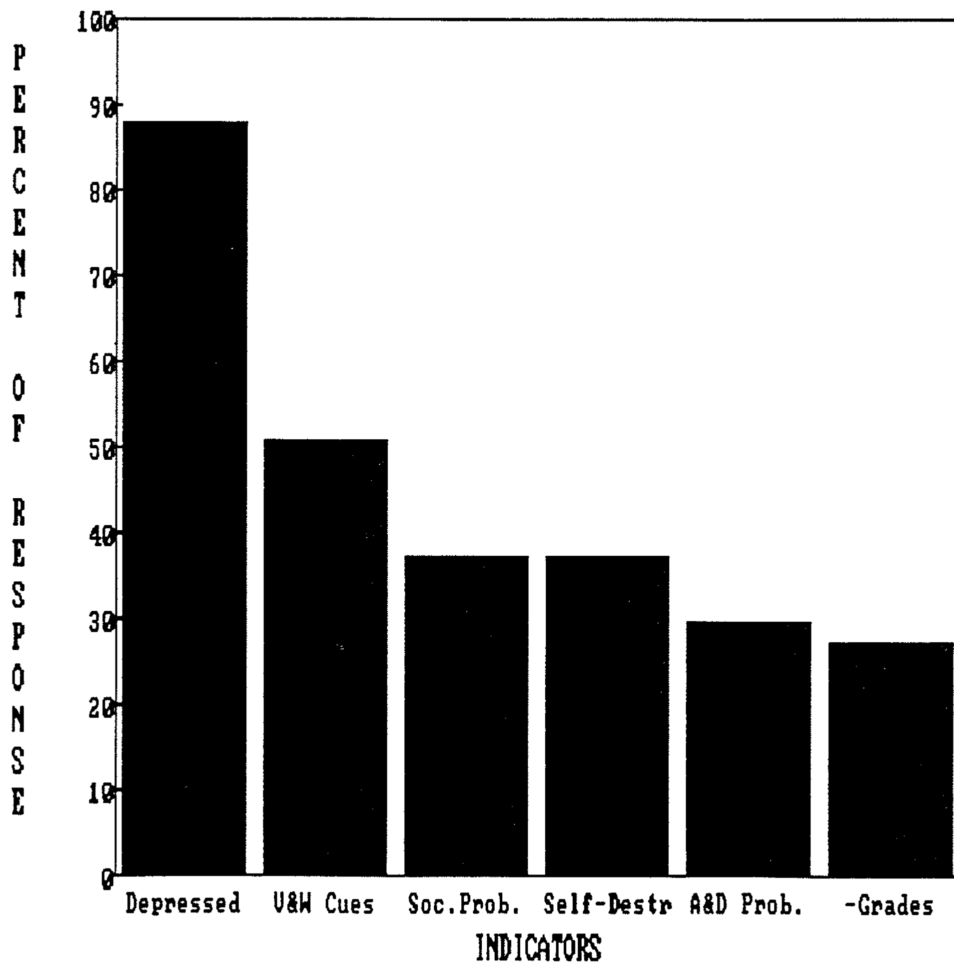


Suicidal Risk Factors

A vast majority (95.2%) of the counsellors stated that they had recognized suicidal warning signs, and 92.6% had approached a student directly regarding suicide.

Counsellors described behavior that would show that a student was at risk for suicide. There were a total of 270 responses which were grouped together. The top six categories are shown in Figure 11.

Figure 11. Indicators of student suicidal risk.



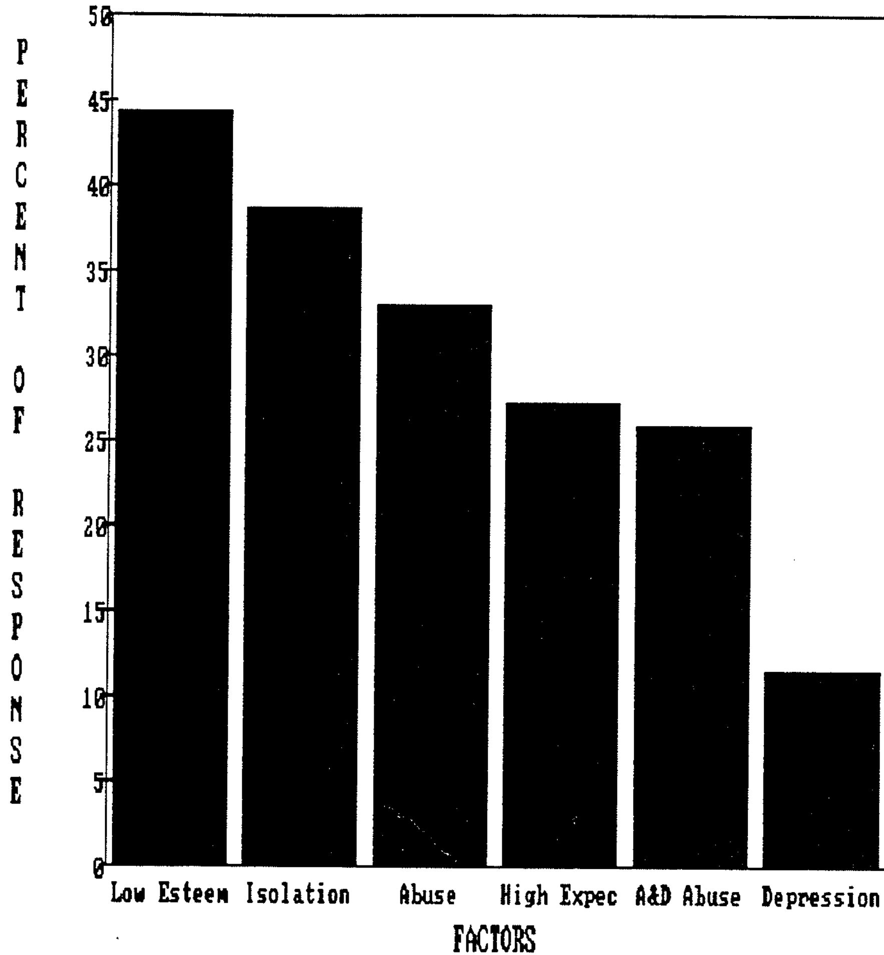
Eighty-eight percent of the counsellors stated that a depressed emotional state showed that a student was at risk for suicide. Half the counsellors (50.7%) stated that verbal or written cues (V&W Cues), 37% stated social problems (Soc. Prob.), and 37% also stated that self-destructive behavior (Self-Destr) showed suicidal risk. Alcohol or drug involvement (A&D Prob.) was selected by 29.6%, poor academics (-Grades) selected by 27.2%, change in appearance selected by 24.7%, acting out behavior selected by 24.7% and medical problems were also mentioned by 14.8% of the counsellors in answer to this question.

Underlying Individual Factors

The counsellors named underlying individual, family, and socio-cultural factors which seemed to make students more vulnerable to suicide. One hundred and forty responses regarding individual factors were categorized into groups and are shown in Figure 12.

Forty-four percent of the counsellors selected low self-esteem (Low Esteem), 38.6% stated social isolation (Isolation), and 32.9% mentioned physical or sexual abuse (Abuse) as underlying individual suicidal factors. Other factors included high expectations (High Expec)(27.1%), drug or alcohol abuse (25.7%), depression (11.4%), physical factors (5.7%), mental disorder (1.4%) and other (12.9%).

Figure 12. Underlying individual suicide factors.

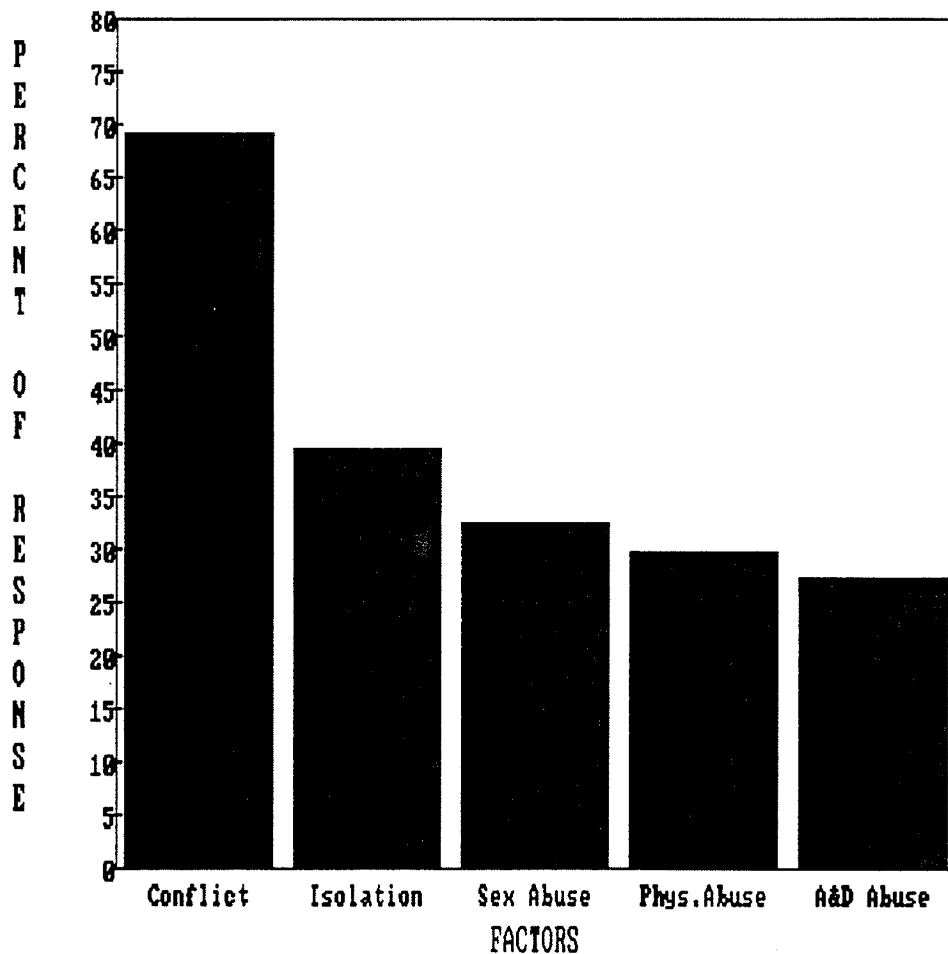


Underlying Family Factors

There were a total of 174 responses from counsellors regarding family factors that underlie student suicidal behavior (see Figure 13). A majority of the counsellors (68.9%) mentioned family conflict (Conflict). Many counsellors (39.2%) stated that disattachment or isolation in the family was a factor (Isolation), 32.4% mentioned sexual

abuse (Sex Abuse), 29.7% physical abuse (Phys. Abuse), and 27% mentioned alcohol or drug abuse (A&D Abuse). Other family factors mentioned included financial difficulties (14.9%), a recent loss or death (12.2%), and a history of suicide in the family (8.1%).

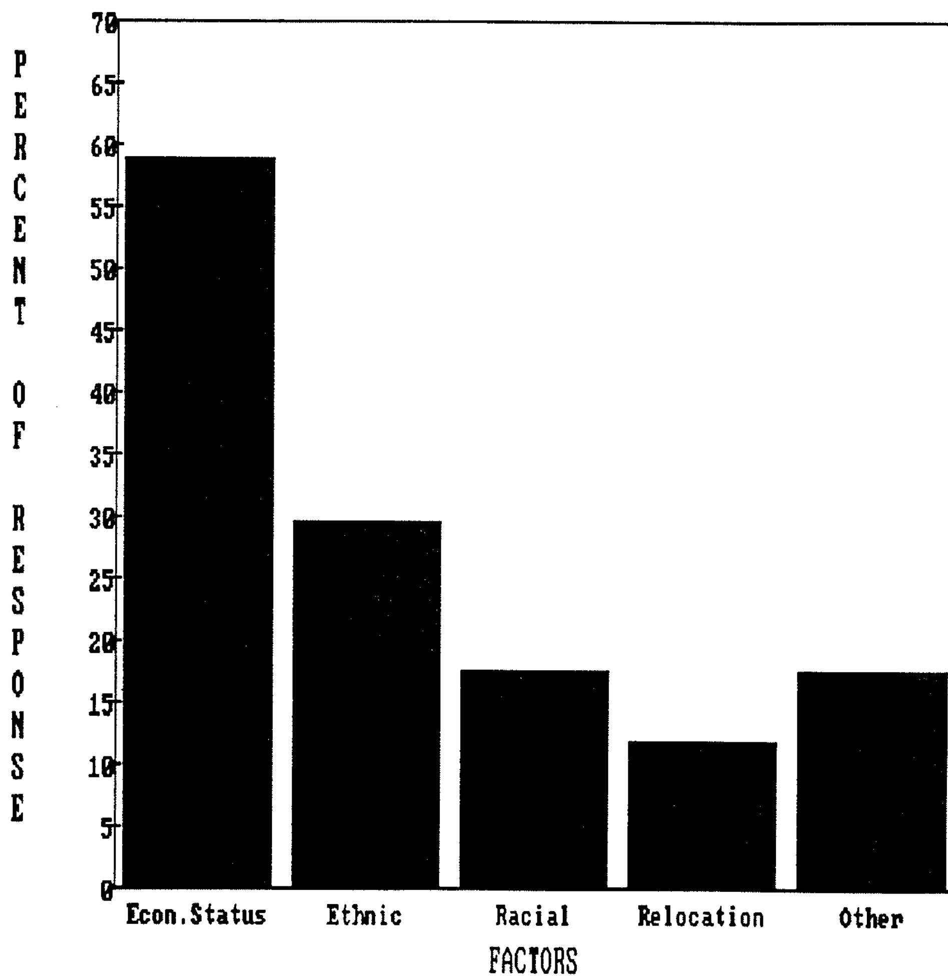
Figure 13. Underlying family suicide factors.



Underlying Socio-cultural Factors

Counsellors responded with 23 socio-cultural factors that underlie student suicidal behavior. These included economic status (58.8%) (Econ.Status), ethnic problems (29.4%) (Ethnic), racial problems (17.6%) (Racial), job relocation (11.8%) (Relocation), and other (17.6%). These factors are shown in Figure 14.

Figure 14. Underlying socio-cultural suicide factors.



Counselling Methods

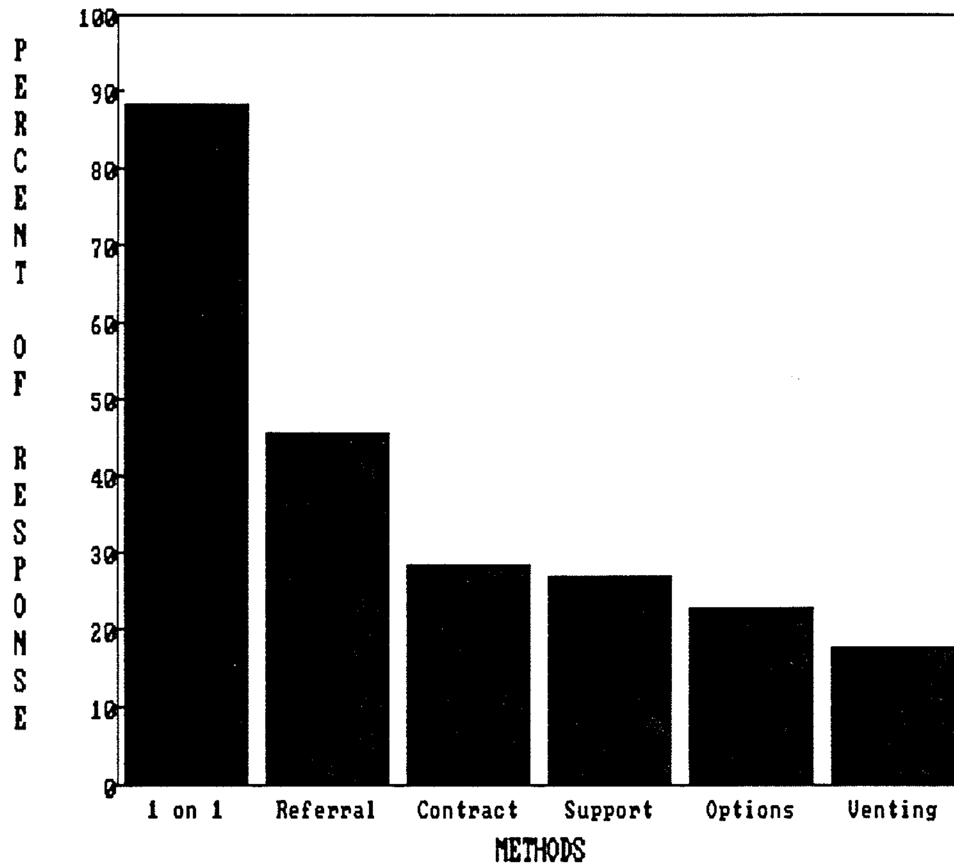
This section will document the counselling methods used with suicidal students, other students, the student's family, and with the school staff after both a suicide attempt and a suicide completion by a student.

With Suicidal Students

The counsellors replied with a wide variety of answers when asked what counselling methods or procedures they found helpful when in contact with suicidal students. A total of 189 responses to this question were grouped together. These answers are documented in Figure 15.

Individual counselling for the suicidal student (1 on 1) was mentioned by the majority of counsellors (88%), followed by 45.3% who referred the student to outside professionals (Referral), 28% who would utilize non-suicide contracting with the student (Contract), and 26.7% who preferred organizing support for the student (Support). Fewer counsellors found that organizing options and plans (22.7%) (Options), helping the student to vent feelings (17.3%) (Venting), assessing the lethality of the intent to suicide (9.3%), helping to define the issues (8%), and staying with the student (6.7%) were beneficial.

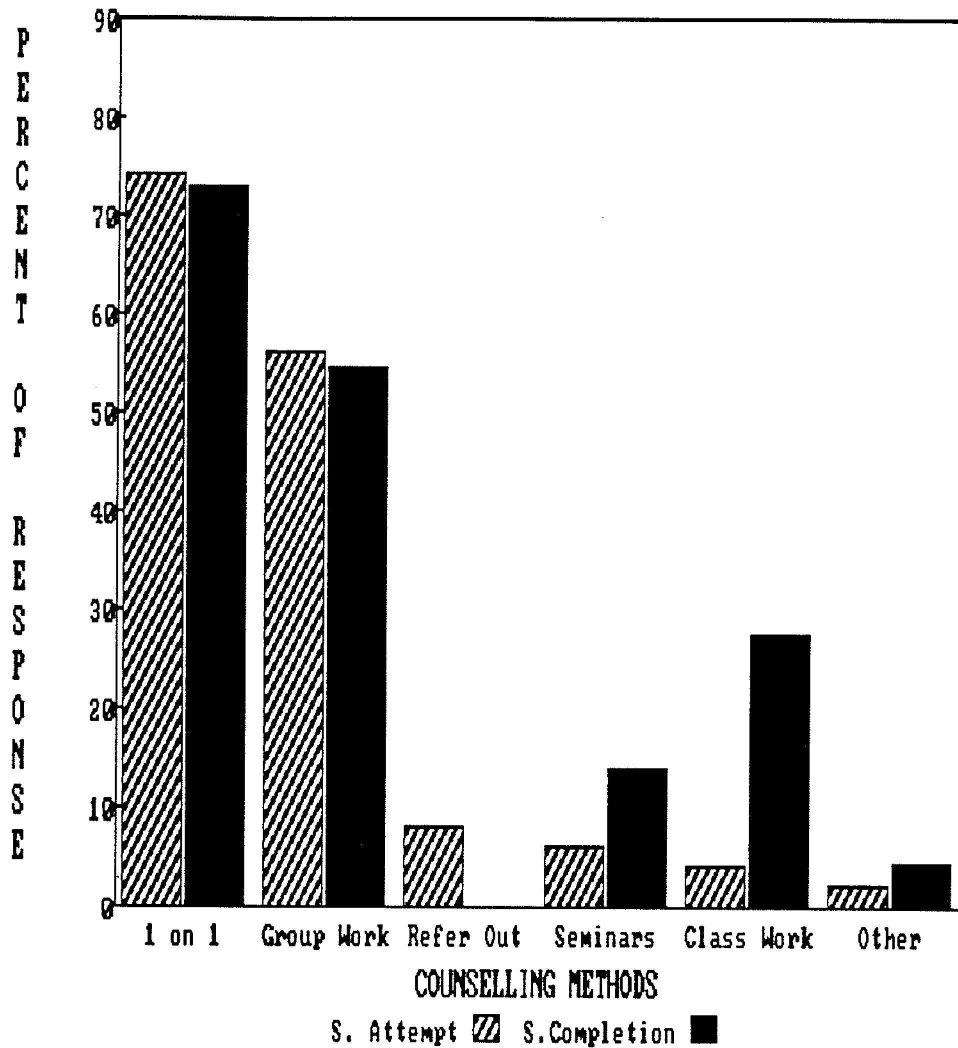
Figure 15. Counsellor methods for dealing with suicidal students.



With Other Students

Counsellors named seventy-one steps that were helpful in working with other students after a suicide attempt. These responses and those used by counsellors following a suicide completion are summarized in Figure 16.

Figure 16. Helpful steps taken by counsellors with other students after a suicide attempt and completion.



The majority of counsellors (74%) stated that individual counselling was helpful after a suicide attempt (1 on 1), while group work was mentioned by 56%, and referrals by 8% (Refer Out). School seminars were

mentioned as helpful by 6%, and classroom work was useful for 4% (Class Work).

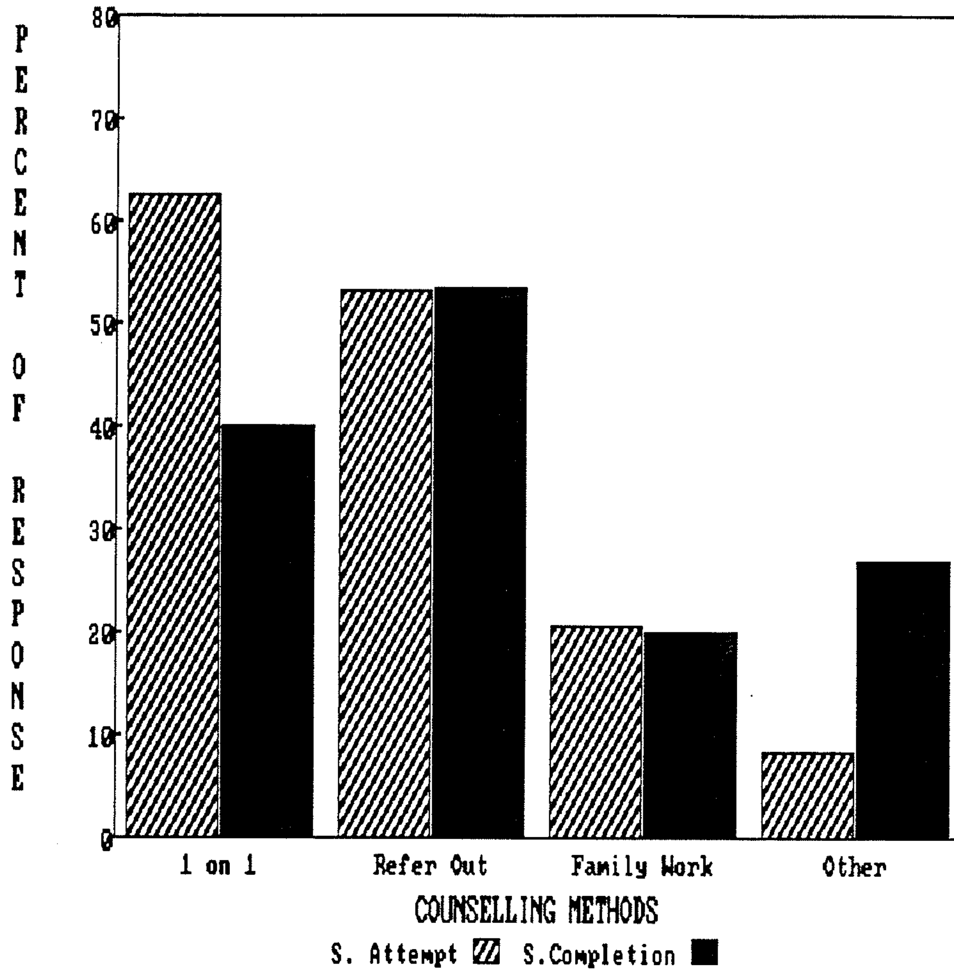
There were thirty-seven responses by counsellors regarding helpful methods for other students after a suicide completion. Seventy-two percent stated that individual counselling for students was helpful, while 54.5% used group counselling and 27.3% used classroom information sessions.

With a Student's Family

There were a total of sixty-nine steps listed by counsellors that were stated as helpful in dealing with the reactions of the family after a suicidal attempt. Sixty-two counsellors stated that individual counselling was used, 53.1% used referrals, and 20.4% utilized family counselling. Eight percent replied with other responses. All responses were coupled with those used after a completed suicide and shown in figure 17.

There were a total of twenty-one responses from the counsellors regarding helpful steps used with families following a completed suicide. Over half the counsellors (53.3%) stated that referrals to other agencies were used while individual counselling was mentioned by 40% and family counselling sessions were described as helpful by 20%.

Figure 17. Helpful steps taken by counsellors with families after a suicide attempt and completion.



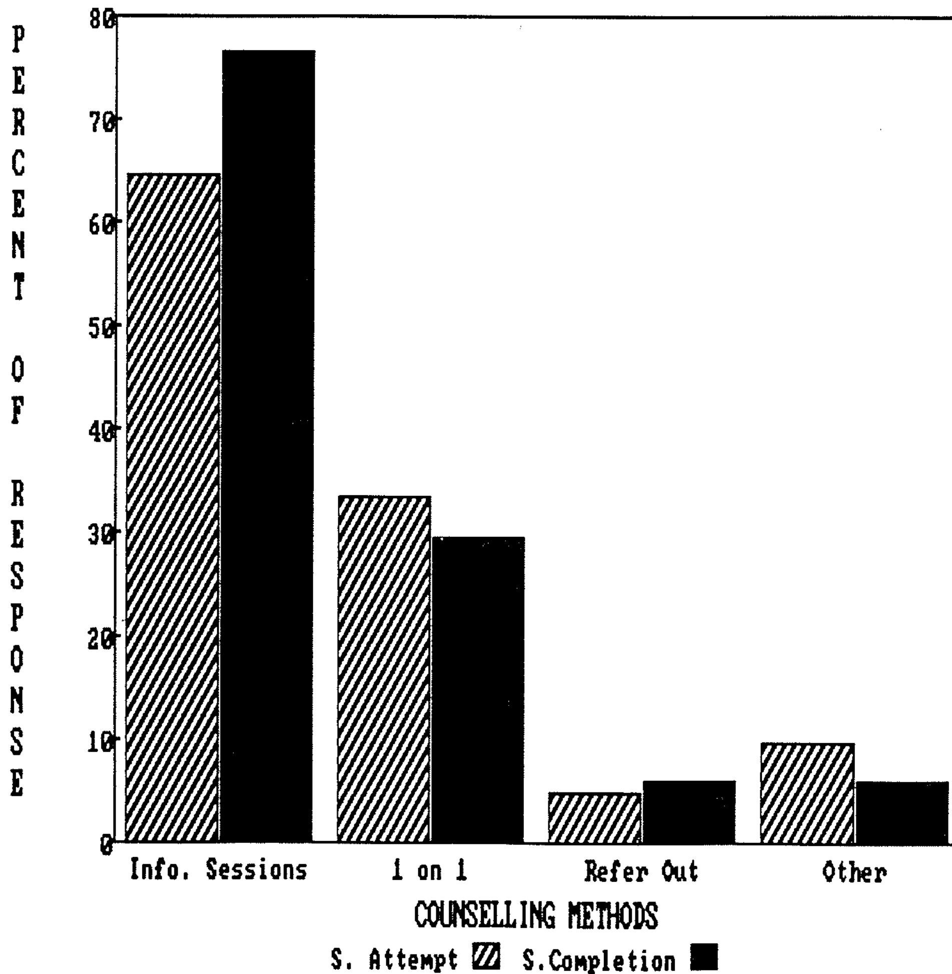
With School Staff

Forty-seven helpful steps for dealing with the reactions of the school staff after a suicidal attempt were described (see figure 18). Sixty-four percent mentioned information sessions were useful, while 33.3% utilized

individual counselling, and 4.8% used referrals to other counselling professionals.

Counsellors responded with twenty positive steps that they had taken with school staff following a suicidal completion by a student. A majority of 76.5% stated that information sessions were helpful, and 29.4% stated that individual counselling was used. Referral was seen as helpful by 5.9%.

Figure 18. Helpful steps taken by counsellors with school staff after a suicide attempt, and suicide completion.



School Variables

This section will document the counsellor perceptions on school policy regarding the topic of suicide, confidentiality, and the notification of the parents or legal guardian of a suicidal gesture revealed to them.

School Policy

Slightly over three quarters (76.2%) of the counsellors stated that their school did not have a set policy and procedure for dealing with suicide attempts or suicides. The majority (80.3%) of the counsellors responded that their school should have a set policy and procedure.

Confidentiality

The counsellors were asked if confidentiality had been a problem for them in dealing with suicidal adolescents. A majority of 72% stated that it had not been a problem while 28% stated that it had presented a problem.

Several counsellors also wrote responses to explain the choice that was used for this question. These responses ranged from concern for the safety needs of the student to those stating concern as to how much to tell teachers, parents and others involved with the student.

Notification of a Suicidal Gesture

The counsellors replied to a question asking them if they would notify the parents or guardians of a suicidal

gesture or comment revealed to them by a student. Thirty-nine percent responded that they would notify the parents, while 60% stated that they would notify the parents or legal guardian only sometimes, and 1% stated that there would be no notification.

Professional Support and Recommendations

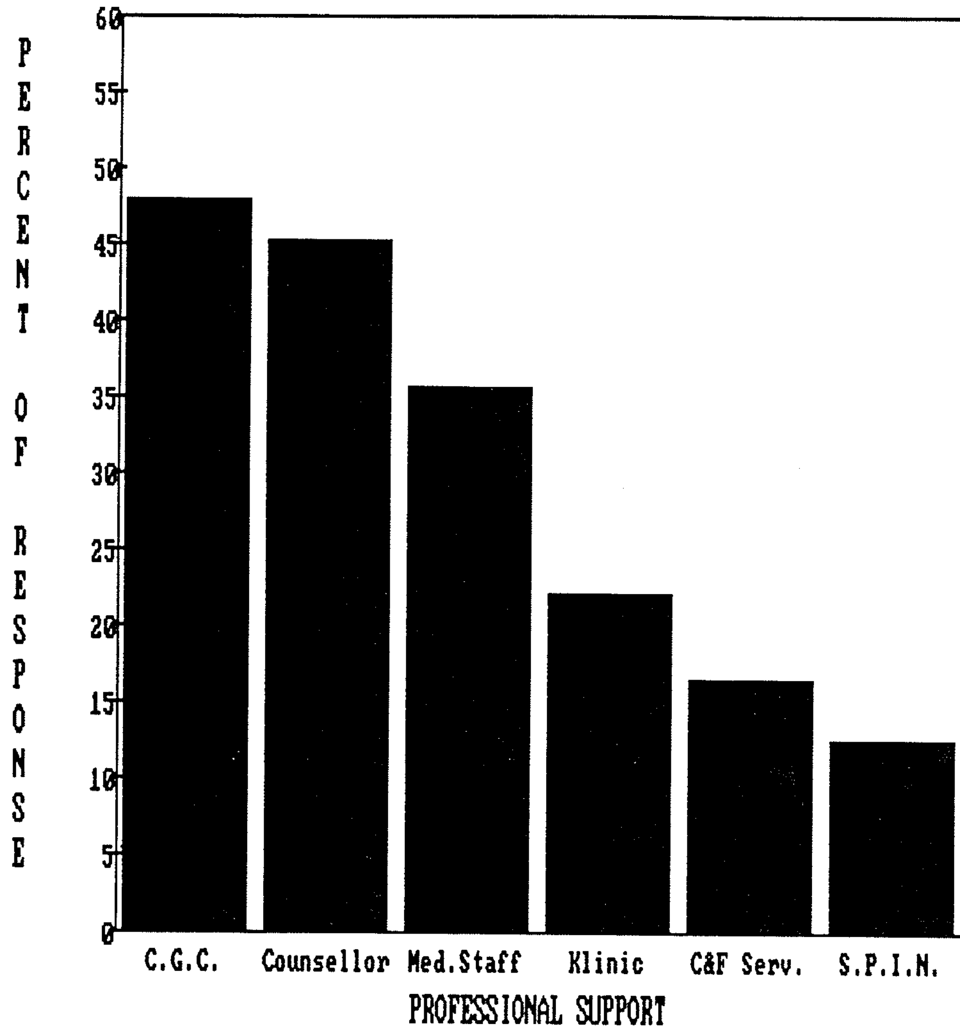
This section will document the perceived areas of professional support for the counsellors, the school staff, the students, and will review the recommendations made by the counsellors to assist themselves and others in dealing more effectively with suicidal adolescents.

Support for Counsellors

The counsellors replied with 143 responses regarding the kind of professional support that had been most helpful for themselves in dealing with suicidal adolescents. This is shown in Figure 19.

Forty-eight percent mentioned the Child Guidance Clinic (C.G.C.), 45.2% other school counsellors, 35.6% medical staff (Med.Staff), 21.9% Klinic, 16.4% Child and Family Services (C&F Serv.), 12.3% S.P.I.N., and 5.5% mentioned M.A.T.C., district staff, and other responses.

Figure 19. Areas of professional support for counsellors dealing with suicidal students

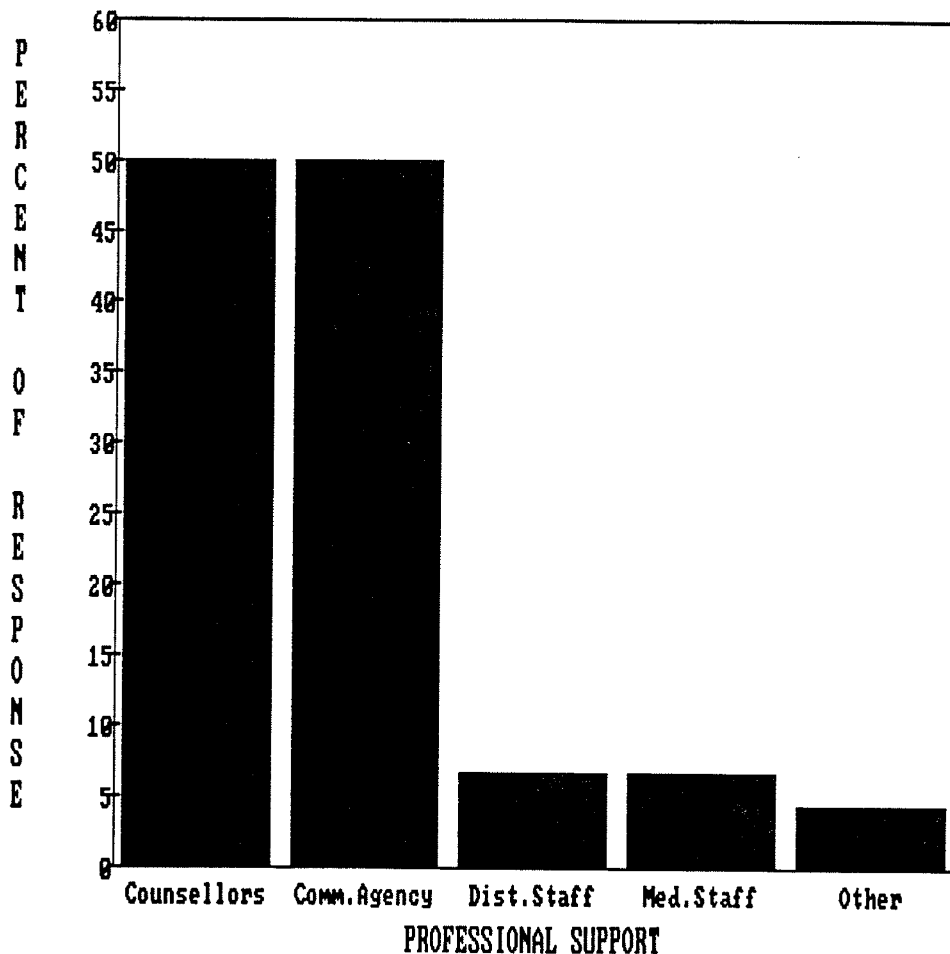


Support for School Staff

Figure 20 documents the responses of the counsellors regarding the most useful professional support for other school staff when dealing with the topic of suicide. Half of

the counsellors mentioned both school counsellors and outside agencies (Com.Agency), while district staff (Dist.Staff) and medical staff (Med.Staff) were mentioned by 6.5% and other responses by 4.3%.

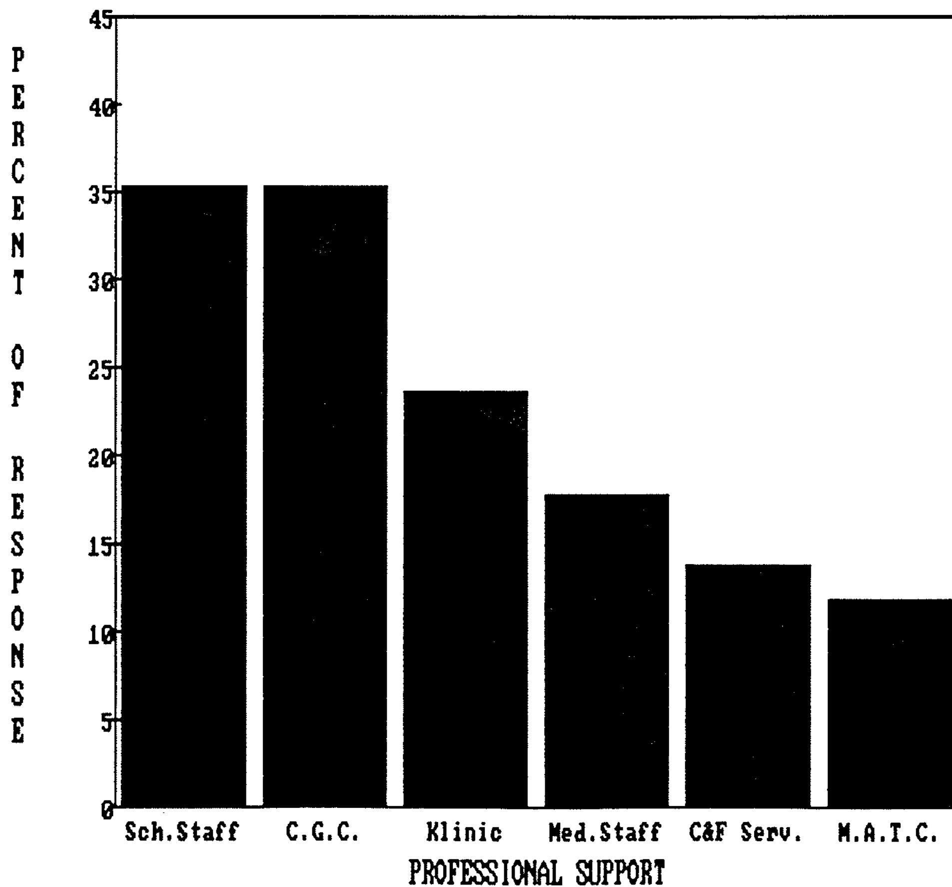
Figure 20. Areas of professional support for school staff when dealing with suicidal students.



Support for Students

The Child Guidance Clinic (C.G.C.) and the school staff (Sch.Sta) were both mentioned by 35.3% of the counsellors regarding the useful areas of professional support for students. Twenty-three percent mentioned Klinic, 17.6% medical staff (Med.Staff), 13.7% Child and Family Services (C&F Serv), and 11.8% M.A.T.C. This is documented in Figure 21.

Figure 21. Areas of professional support for students when dealing with suicide.

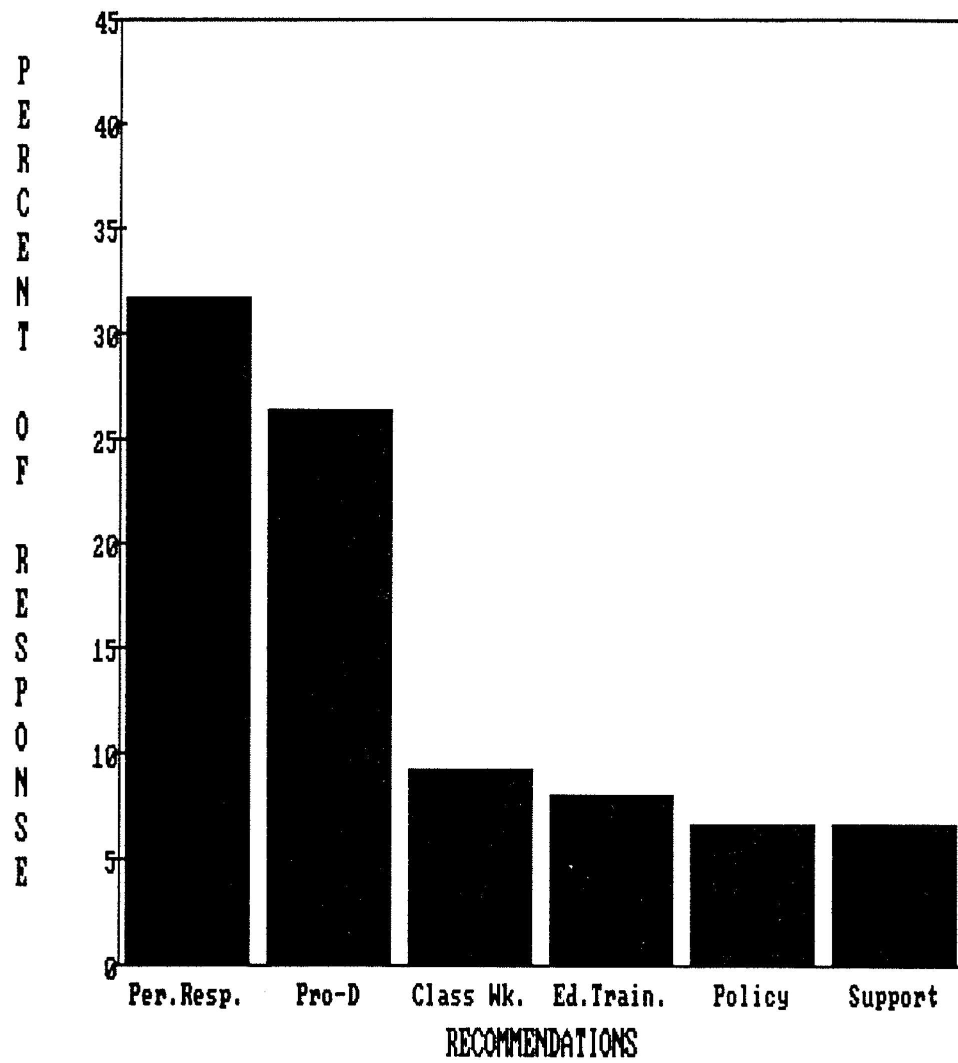


Counsellor Recommendations

The final question of the survey asked the counsellors to give one recommendation to assist themselves and others in dealing more effectively with suicidal adolescents. The top six responses are summarized in Figure 22.

Numerous counsellors responded with various recommendations (31.6%) which were classified as personal responses (Per.Resp). These responses included "listen to the student," "take all suicidal threats seriously," and "stay close to the student." Other responses included recommendations by 26.3% of the counsellors for more professional development on suicide (Pro-D), 9.2% of the counsellors recommended academic course content on suicide in the secondary schools (Class Wk.), 7.9% stated more educational training on suicide (Ed. Train), 6.6% recommended developing a school policy (Policy), and 6.6% recommended developing more support services and resources for suicidal adolescents (Support). A further 5.3% of the counsellors recommended improving the ease of referral for students to services, and 5.3% recommended improving counsellor communication on this topic.

Figure 22. Counsellor recommendations for dealing more effectively with suicidal adolescents.



CHAPTER 5

CONCLUSIONS

The purpose of this study was to survey the experience of Winnipeg secondary school counsellors with suicidal adolescents. This was accomplished through the documentation of levels of contact between counsellors and suicidal students; by comparing relevant demographic and school variables to the incidence of contact with suicidal students; by documenting counsellor training and knowledge in this area; by detailing counsellor methods for dealing with suicidal students; and by describing the recommendations and areas of support for these counsellors.

This chapter will offer some limitations and then state the conclusions that are drawn from this research.

Limitations

It is suggested that several limitations may be considered when reflecting on the conclusions from this study.

a) The response rate associated with surveys in general, and to this survey in particular (46.3%), makes it difficult to draw conclusions. The answers that might have been given by a majority of the underlying population are unknown.

b) The survey instrument itself, although based on a previous research instrument and reviewed by numerous professionals, may have included questions that were too open for interpretation by the sample and may not have measured the true responses that were intended. A small number of questions in the survey required a single response but numerous counsellors wrote in several responses. These additional responses tended to nullify the original intention of these questions.

c) All of the answers were reviewed and tabulated by a single researcher. This lead to high consistency, but it may have lead to a systematic bias in the interpretation of responses.

Conclusions

The conclusions that follow seem warranted based on the data.

Suicidal Contact

There was a wide range of reported contact with suicidal adolescents in the Winnipeg school system. Respondents reported up to 25 contacts with suicidal students in the previous two months, and up to 40 suicidal student contacts in the previous year. Although the majority

of respondents had contact with between one and five suicidal adolescents in the previous year (64%), a group of 9.3% reported no contact, and 26.7% reported over five suicidal contacts in the previous year. This may be due to the vast differences in school populations and school environments in the Winnipeg area. It may also be due to the unique characteristics of the individual counsellors themselves.

Most secondary counsellors in Winnipeg were dealing with suicidal adolescents on a regular basis. Of the counsellors surveyed, 67.4% had contact with one or more suicidal students in the prior two months. A large majority (90.7%) of the counsellors had contact with a least one suicidal student in the academic year.

The senior high respondents reported contact with significantly more suicidal students over the previous year than had junior high respondents. This finding may seem straightforward in that suicide for a 10 -14 year old is rare (Shaffer & Fisher, 1981), and therefore fewer 10 - 14 year olds should be suicidal. It has been stated that suicide is generally underreported in this age group (Hoberman & Garfinkel, 1988) and that suicides within this age group involve a greater degree of intentionality, or at least planning when compared with adults. This has a direct relation to the method most commonly used in this age

group (hanging and strangulation) and the need for secrecy (N.T.F.S., 1987). It would seem logical that fewer children suicide because they have less access to more lethal means to kill themselves (handguns and rifles). There is evidence to suggest a much smaller suicide/parasuicide ratio for those under 15 years of age. The rate for children during 1970-71 in Ontario was 25.6 to 1 compared to 38 to 1 for 15 - 19 year olds. When this ratio is combined with a suicide rate of one per 100,000 population for children under 15 during the same year, compared to the rate of 9.3 in the same year for 15 - 19 year olds, it appears that the actual number of suicidal children is less than the number of suicidal adolescents (N.T.F.S., 1987). This factor could explain the large difference in suicidal contacts between senior high and junior high counsellors.

Winnipeg secondary counsellor involvement with suicidal adolescents appears to be on the increase. Over 60% of the counsellors stated that their involvement with suicidal adolescents had increased over the previous two years. This reflects the increase in suicide rate as reported in Figure 2 on page 10 (personal conversation with Statistics Canada, July 9, 1990). This may be due to various factors which include more suicidal adolescents in the schools, a more open attitude by suicidal adolescents to seek help from counselling professionals in the schools, a greater

openness by the counsellors to discussing or dealing with suicidal students than in the past, or any number of other factors. This statistic does reflect the perceived increase in counsellor contact with suicidal students over the two years in question.

There appeared to be willingness and capability by counselling professionals to diagnose suicidal adolescents and to initiate contacts. This was demonstrated by the vast majority of counsellors who stated that they had both recognized suicidal warning signs and approached a student concerning suicide.

The counsellors stated that the most common form of referral of suicidal students to counsellors was directly from the student, followed by referral from friends, teachers, and then counsellor-initiated contact. This would tend to suggest that suicidal students, their friends, and their teachers have more initial awareness of the suicidal problems that students are facing than have the secondary counsellors. This matches the findings of a recent study (Pronovost, 1990) that a majority of suicidal students could not find anyone to confide in. The preferred confidants of the suicidal students were friends, boyfriend or girlfriend, parent, psychologist, sibling, social worker, other relative, nurse, teacher and grandparent. Although secondary counsellors were not mentioned in the study, it is clear that

there is great potential for peers to act as gatekeepers for referring suicidal friends to counselling professionals.

It also does not seem odd that parents were only mentioned by one counsellor in this survey as the prime source of referral for suicidal students. According to Pronovost (1990), 37.7% of the young people in her study mentioned family problems as events triggering their thoughts of suicide. Parents did, however, rank above teachers in this study as preferred confidants of suicidal adolescents. This does seem to suggest that there is a gatekeeper role for parents that is not being utilized.

Counsellor Knowledge

The survey results showed that a majority of the secondary counsellors (61.2%) had never taken any educational academic training on the topic of suicidal adolescents, and that 20% had not received professional development on the topic. The total training hours on this topic averaged 14.6. If this were contrasted to the 42 hours of direct training given to crisis line volunteers who deal with suicidal clients over the telephones at Klinic Crisis Centre, there appeared to be a lack of direct training to deal with the significant issues surrounding the prevention, intervention, and postvention of suicidal adolescents (personal conversation with Tim Wall, Klinic, April 14, 1988). However, if the level of training by the Winnipeg

counsellors were contrasted to the findings of the Schnacke study (1972), where 92% of his sample of school counsellors had never participated in formal classroom seminars, workshops, or training in suicidology, then the Winnipeg counsellors have had a considerable amount of training on suicide.

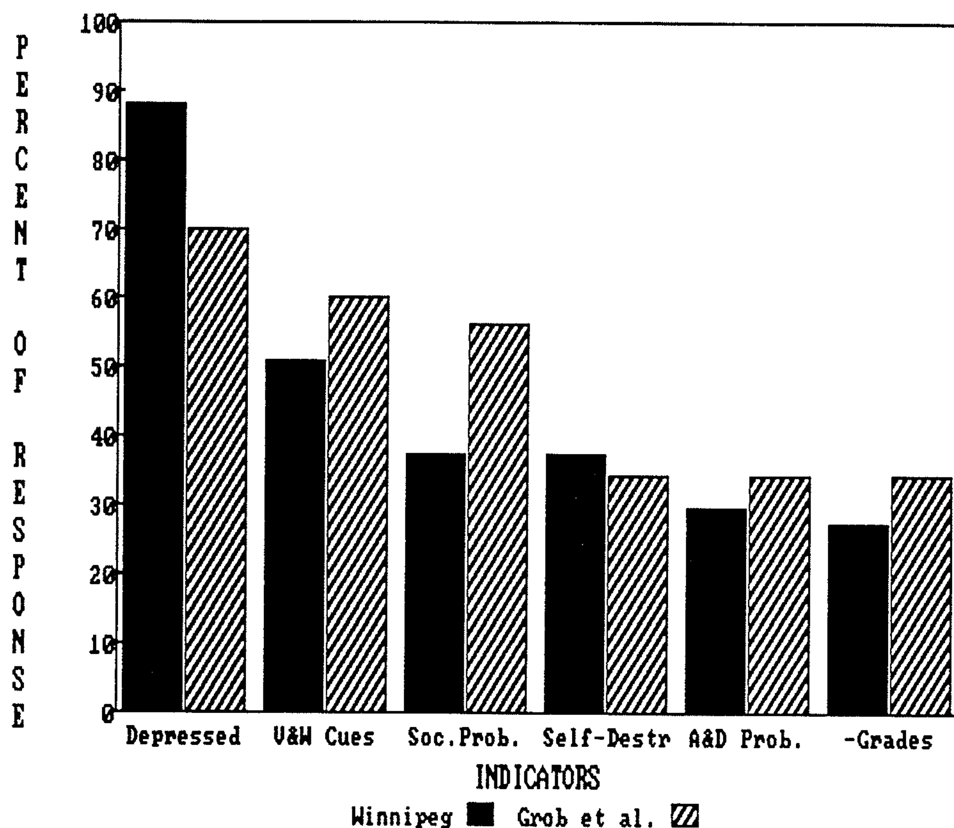
Counsellors were aware of suicidal attempts among their student population. The majority of counsellors knew of suicidal attempts among the student population within the last year, and close to half knew of attempts within the previous two months. A small number reported a suicide completion within two months, and 9.3% reported a completion within the last school year. These statistics were not surprising, given the number of suicidal students who had contact with the counsellors over the previous year.

The counsellors correctly described a wide variety of suicidal risk indicators that closely matched the order of indicators described by school professionals in a previous study (Grob et al. 1983). A comparison showing this close match between the two studies is displayed in Figure 21.

The top four selections of the Winnipeg counsellors matched the order of the Grob et al. (1983) study. The Winnipeg counsellors chose depression and self destructive behavior more often than the professionals in the other study, while the other professionals all other categories

more often than the Winnipeg counsellors. There is a strong consistency of choice between these two groups of school professionals.

Figure 23. A comparison of suicidal risk indicators listed by Winnipeg counsellors and Grob et al. (1983).



Note. Adapted from "The Role of the High School Professional in Identifying and Managing Adolescent Suicidal Behavior"by M. Grob, A. Klien and R. Eisen, 1983 Journal of Youth and Adolescence, 12, p. 166.

Underlying individual factors were also described, and the Winnipeg counsellors mentioned five of the top six categories of the Grob et al. (1983) study in their top six. The other category included by the Winnipeg counsellors in the top six was that of physical and sexual abuse. This was selected as the third most common factor but was not selected as a factor in the Grob et al. study. Peer pressure, although included in the Grob et al. study as the second most popular factor was not described as an underlying factor by any of the Winnipeg counsellors. The reason for the omission is unclear.

There was also general agreement among the two studies regarding underlying family factors. There were exceptions to this agreement, however. Physical abuse and sexual abuse were mentioned by the Winnipeg counsellors as separate underlying family factors. These were not included in the Grob et al. study. This inclusion of physical and sexual abuse by the Winnipeg counsellors would attest to the sensitivity of these counsellors to abuse issues in the family.

There is agreement between the Winnipeg counsellors and the sample used in the Grob et al. study about the order and importance of underlying socio-cultural factors leading to suicide. Both studies reported identical top four categories.

Some credibility of the knowledge of the secondary counsellors in this study is implied. This stems from their description of suicidal risk factors, underlying individual factors, and underlying sociocultural factors of suicide that mirrored so closely the findings of another study. This consistency of findings occurred, in spite of the differences in samples, places and dates of the studies.

Counselling Methods

Secondary counsellors in Winnipeg tended not to follow any pre-defined pattern or strategy when dealing with suicidal students, but, responded with a personal and idiosyncratic response. When asked what methods or approaches were used with suicidal adolescents the counsellors responded with a wide variety of combinations of responses. The most popular response to a suicidal student was individual counselling. This utilized a variety of counselling skills which included listening, making time for the student, taking the suicidal threat seriously, and being empathic with the student. Other responses included referrals, contracting, organizing support for the student, organizing options and plans, venting feelings, assessment of lethality of the suicidal intent, and helping the student to define issues concerning the intent. There were 14.6% of the respondents who chose not to answer this question.

Counsellors also utilized individual counselling most frequently for other students after a suicidal attempt and completion. It seemed odd that referral was not suggested by any counsellor after a suicide completion but was mentioned third overall (8%) after a suicide attempt. Individual counselling was also suggested most often for families after a suicide attempt but not for a suicide completion. In this case referral was the most commonly suggested step.

Information sessions were suggested as the most useful step to take with school staff following both an attempted and completed suicide. Individual counselling was suggested as the next most helpful step and a small minority stated that referral was appropriate.

School Variables

Although confidentiality was stated as not being a problem by a majority of the counsellors, there was a wide range of problems listed by the secondary counsellors concerning confidentiality. This included how much information, if any, to reveal to the teachers or to the other counsellors; what to do when the parents and students wanted to keep information "hushed up"; who and when to inform; what was the legal responsibility of the counsellor if in conflict with the client's demands; and how to inform the family without placing the student in a situation that would

not be beneficial to the needs of the student and how to act without losing the trust of the student. These comments formed the basis of the 28% of the counsellors who had issues with confidentiality.

A majority of the counsellors reported that they would sometimes notify the parents or legal guardian of a suicidal comment or gesture revealed to them by a student. Over a third stated that they would notify the parents. This appears to point out a lack of confidence that the counsellors have towards the ability of the parents or guardians to be helpful to the suicidal student. This finding also reflected reports in the Grob et al. (1983) study that the "potential split between the school and the family is troublesome and perhaps dangerous." (p.172)

Policy

Three quarters of the counsellors stated that their school currently had no set policy and procedure for dealing with suicide attempts or suicides, and over three quarters stated that they thought that their school should have a set policy and procedure for dealing with these events. This appears to be a straightforward request to the school administrators to come up with a workable policy statement on this issue.

Professional Support and Recommendations

The counsellors stated that the professional support most helpful for them personally in dealing with suicidal adolescents came from the Child Guidance Clinic; next most helpful came from other school counsellors. The professional support that was viewed as being the most helpful for the school staff came from other counsellors and various community agencies. The professional support that was viewed as being most helpful for the students came from school staff and the Child Guidance Clinic. This shows a strong reliance on the professional counsellors in the school system and at the Child Guidance Clinic to deal effectively with the majority of suicidal issues that arise within the school.

When asked to make one recommendation to assist other counsellors and themselves in dealing more effectively with suicidal adolescents, the largest response was that of receiving some form of professional development on the topic. Areas also mentioned, in order of preference, included courses for the students, more educational training, and development of a school policy.

Many counsellors answered this question by making personal statements imploring other counsellors to always take a suicide threat seriously, to listen to the suicidal student, to refer the student to specialists in the field, to

offer hope to the student, and to seek personal support for themselves also.

Recommendations for Further Research

There are numerous types and areas of research that seem necessary. These will be reviewed in this section.

Counsellor Contact

It needs to be determined whether Winnipeg counsellors are representative of Canadian counsellors regarding the number of suicidal contacts with students? Further study of secondary counsellors in various geographical, socioeconomic, and cultural regions of Canada could determine this. Various school districts could also be studied to detect differences in suicidal contact.

Has the level of contact continued to rise for Winnipeg counsellors since the collection of data? Another brief review of the Winnipeg counsellors at this time could help establish a current baseline and note possible changes in contact.

Counsellor Training

What type of pre-service training is needed for secondary counsellors on adolescent suicide? When the majority of counsellors state that they have received no academic training on this topic in their counsellor training

programs, and yet are dealing with suicidal students on a regular basis, it seems apparent that this needs to be addressed. Every secondary counsellor should have training in this area. All counsellors need to avail themselves of the currently existing suicide prevention courses and workshops available through numerous community agencies in Winnipeg. However, what would be the best training, and the best form to deliver this training?

School Factors

When one counsellor estimates that over 100 suicidal students are seen by counsellors at a secondary school in one year, it appears that some study should be directed at the possibility of some schools being more suicide prone than others. Is this due to unique student populations, geographic location, or are there other school based factors that promote this higher level of interaction between suicidal students and counsellors? Can schools be suicide proofed?

Policy

There are numerous areas that need to reviewed in terms of policy and procedures. There is the possibility of separate and distinct policies and procedures for numerous personnel in differing situations surrounding the topic of suicide. Examples of these different situations include the difference between how a counsellor deals directly with an

actively suicidal adolescent, and how a school deals effectively after a suicidal death. Who (if anyone) should inform the parents of a suicidal gesture or suspicion? Should counsellor consultation be mandated in the event of dealing with a suicidal student? A study into the effectiveness of school policies and procedures for dealing with suicidal students could help to understand which policies best meet the needs of both the students, and counselling professionals.

Counselling Methods

How effective are counselling techniques in the areas of prevention, intervention, and postvention of suicidal students? How effective are parents and peer helping programs at detecting and referring suicidal students? Another topic for study in this area would be the possible development of short term counselling techniques for counsellors to use with suicidal adolescents while awaiting service by outside professionals in the field.

Suicidal Students

One last area that needs to be thoroughly researched in Canada is the suicidal tendencies of students across the secondary age span. A definitive study could not only develop a baseline of number of suicidal students at the various ages, but could help target high risk suicidal ideators and attempters directly in the classroom.

Summary

The experience of secondary counsellors with suicidal students is unique. It involves regular contact with a variety of suicidal students in settings that require various areas of training, knowledge, organization, and expertise. This study has broken new ground by describing unique experiences of secondary counsellors in dealing with suicidal adolescents. It has provided a description of how secondary counsellors are dealing with suicidal adolescents and a baseline of data for comparison with future studies in Winnipeg and other parts of Canada.

This documentation now clearly indicates that secondary counsellors are dealing with a substantial number of suicidal students on a yearly basis. Data are available on the number of hours of training that secondary counsellors have received on this topic in both academic experience and professional development. Data clarifies counsellor recommendations and views regarding school policy on this topic. Canadian data on secondary counsellor knowledge of suicidal risk, and of the factors leading to suicidal behavior, now exists.

This information can provide the foundation for realistic and effective strategies to be used by secondary counsellors to reduce the number of youths who tragically and unnecessarily take their own lives each year.

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APPENDIX A:

COUNSELLOR EXPERIENCES WITH ADOLESCENT SUICIDE QUESTIONNAIRE

COUNSELLOR EXPERIENCES WITH ADOLESCENT SUICIDE

DEAR ______________________________,

This survey is part of a Master`s thesis involved with the phenomenon of suicide in the adolescent school population. You are asked to help explain the incidence, issues and problems currently facing counselling professionals who deal with this age group. The information gathered from this survey will help to create a profile of the student at risk, to document the occurrence of counselling with suicidal students, and to suggest improvements for effective counselling with these students.

Your responses to this survey will be pooled with others in the documentation and reporting of results. Confidentiality of individual replies is assured.

INSTRUCTIONS:

Please answer all of the following questions as accurately as possible. This should take approximately 15 minutes of your time. Return it in the mailer at your convenience.

If a reply has not been received from you after a short waiting period, I will contact you over the phone to make sure that you have received the survey. Your input is important and a high participation rate is necessary in order to draw the most valid conclusions.

If there are questions, concerns, or problems regarding this survey, please call me at (604) 535-1031.

If you would like a copy of the results of this survey, please give your name and address below and I will send you a summary of the findings.

NAME: ______________________________

ADDRESS: ______________________________

CITY: ______________________________

POSTAL CODE: ____________

Yours Sincerely,

Mr.Jamie Marshall (researcher)
Dr.Ray Henjum (supervisor)

COUNSELLOR EXPERIENCES WITH ADOLESCENT SUICIDE

BACKGROUND INFORMATION

Sex: Male ____ Female ____ Age: _____

Worksite: Junior High ____ or Senior High ____

Years employed in the school system: ________

Position in school: ____________________ Years in position: _____

Number of counsellors in your school: _____

Average amount of time spent by you counselling each day: ____

What is your highest level of academic education? (check one)

_____ Bachelor's Degree

_____ Graduate work beyond the Bachelor's Degree

_____ Master's Degree

_____ Graduate work beyond the Master`s Degree

_____ Doctorate

_____ Other (please specify) __________________________

SURVEY QUESTIONS

SUICIDE: 'The human act of self-inflicted, self-intentioned cessation' (Shneidman,1985,p.14). To be suicidal is to be involved in the active process of suicide. This includes the serious consideration and planning of a suicidal act.

1) Please estimate the number of students described as suicidal that you have dealt with directly in the:

last two months ______

previous academic year _____

2) Please estimate the number of students described as suicidal that the other counselling professionals in your school have dealt with directly in the last year. ________

3) Do you think that your involvment with suicidal adolescents has increased over the past two years? Please check one.

Increase ____ Same ____ Decrease ____

4) In your experience, how do suicidal students come in contact with school counsellors? Please rate the following sources of contact between suicidal adolescents and counsellors from 1 (for most common) to 8 (for least common).

____ self-referral
____ parents
____ counsellor initiated
____ outside professionals
____ other (please specify)________________________________
____ friends of the student
____ teachers
____ other staff

5) Have you ever, a) recognized suicidal warning signs, and
b) approached a student concerning suicide?

a) YES _____ NO _____
b) YES _____ NO _____

6) What kind of behavior would make you think that a student was at risk for suicide? (please list and use the back of this page if necessary)

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7) From your experience, what are some underlying individual, family and socio-cultural factors which seem to make students more vulnerable to suicide? (use additional space if needed)

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8) From your experience, what counselling methods or procedures have you used that work well when you come into contact with a suicidal student?

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9) To your knowledge, have there been any suicidal attempts among your student population within the last <u>two months?</u>

YES ______ NO ______ DON'T KNOW ______

10) To your knowledge, have there been any suicidal attempts among your student population within the last <u>academic year</u>?

YES ______ NO ______ DON'T KNOW ______

11) To your knowledge, have there been any suicidal completions among your student population within the last <u>two months</u>?

YES ______ NO ______ DON'T KNOW ______

12) To your knowledge, have there been any suicidal completions among your student population within the last <u>academic year</u>?

YES ______ NO ______ DON'T KNOW ______

13) An attempted suicide often brings about numerous reactions from other significant people. What positive steps did you take to help these people handle their reactions? Please use additional space if needed.

Other students: ______________________________

____

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Family: ______________________________

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School staff: ______________________________

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14) A completed suicide often brings about numerous reactions from other significant people. What positive steps did you take to help these people handle their reactions? Please use additional space if needed.

Other students: ______________________________

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Family: ______________________________

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School staff: ______________________________

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15) Has confidentiality been a problem for you in your dealings with suicidal students?

YES _____ NO _____ Please explain.

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16) Would you notify the parents or legal guardian of a suicidal gesture or comment revealed to you by a student?

YES _____ NO _____ SOMETIMES _____

Please explain.____

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17) What kinds of professional support have you found most helpful for you personally in dealing with suicidal adolescents?

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18) What kinds of professional support have you found most useful for both the, a) staff and
b) students in your school?

STAFF____

____

STUDENTS____

____

19) Does your school have a set policy and procedure for dealing with suicidal attempts or suicides?

YES _____ NO _____

20) Should your school have a set policy and procedure for dealing with suicidal attempts or suicides? Please explain.

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21) In your professional training, did you encounter courses, or portions of courses, that dealt specifically with the topic of adolescent suicide?

YES _____ NO _____

22) If yes, please estimate the total number of hours devoted to this subject.

# of Hours_______

23) Have you participated in professional development that has dealt specifically with the topic of adolescent suicide?

YES _____ NO _____

24) If yes, please estimate the total number of hours involved in this participation.

# of Hours _____

25) What one recommendation would you make to assist yourself and other counsellors in dealing more effectively with suicidal adolescents?

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PLEASE PLACE THE COMPLETED SURVEY IN THE ENCLOSED PREADDRESSED MAILER AND RETURN IT AS SOON AS POSSIBLE USING EITHER YOUR SCHOOL MAIL SYSTEM (IN WINNIPEG #1) OR REGULAR MAIL DELIVERY. ANY ADDITIONAL CORRESPONDENCE MAY BE SENT TO THE FOLLOWING ADDRESS:

Mr. J. Marshall
c/o Dr. R. Henjum,
Faculty of Education,
University of Manitoba,
Winnipeg, Manitoba.
R3T 2N2

THANK YOU FOR YOUR FEEDBACK, INSIGHT, AND TIME.