PREVENTION OF

ADOLESCENT SUICIDE

A Seminar Paper

Presented to

the Graduate Faculty

University of Wisconsin - La Crosse

In Partial Fulfillment

of the Requirements for the Degree

Master of Science in Education: Special Education

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May 1984

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Abstract

The purpose of this study was to review relevant literature
concerned with adolescent suicide. The incidence of adolescent
suicide was examined as well as literature dealing with causation,
depression, family relations, social relations, and school failure.
Overt warning signs were presented and discussed along with a review
of the lethality of the suicidal ideation and intent. An action
plan was proposed which consisted of a plan for a unified school
program to address the issue of adolescent suicide, an outline of
an inservice training program for concerned teachers, and a provision
for contacting consultants in the community when the problem of
suicide becomes too great for educators to handle effectively.
Included was a packet of material to be distributed for inservice
training of concerned teachers.

Chapter I

Introduction

Adolescent suicide is at an epidemic level today. Studies
have shown that from 1974-1975, the suicide rate of the 15-19 age
group increased 124% (McBrien, 1983). The New Jersey Education
Association Review (NJEAR) reported that in 1980, the teenager suicide
rate had increased 200% since 1950. In the United States alone,
suicide has become the third leading cause of death among adolescents
(Emery, 1983; Smith, E. J., 1981). In 1971, 3,479 youths between
the ages of 15-24 were reported to have committed suicide. In 1975,
4,870 youths in the same age group committed suicide (Hart, 1978;
Rosenkrantz, 1978). In 1978, 5,000 children and adolescents committed
suicide, or nearly three times the number that did so 20 years ago.
Within the last 10 years, the suicide rate for teenagers has almost
doubled; it is estimated that 57 teenagers attempt suicide every
hour (Smith, E. J., 1981). In 1979 the number of deaths by suicide
for the 15-24 age group of white males was 21.0%, or nearly 5,000
deaths per 100,000 deaths (Statistical Abstracts of the United States,
1982-1983).

The number of adolescent deaths caused by suicide may be
underestimated. Statistics become "meaningless" because of heavy
underreporting (Emery, 1982). A death is recorded statistically

as a suicide only when it is signed on the death certificate as
such (Hart, 1978). There is no uniform legal requirement for
reporting a death by suicide, which suggests that many deaths
may be attributed to other causes (Smith, D. F., 1976). Shaffer
and Fisher (1981) reported that in 1968 a new label for a cause
of death was introduced and incorporated in the International
Classification of Diseases: "'undetermined whether death is accidental
or purposefully inflicted'". The number of deaths of teenagers
attributed to suicide does not include children under 10, whose
deaths are classified as accidents. The numbers also do not include
drug overdoses, willful accidents, or even some homicides where the
suicidal person angers another person in the hope that this will
lead to a fight and ultimately to the teenager's death (Hart, 1978;
Smith, E. J., 1981; Toolan, 1962).

Taken all together, the number of actual completed suicides
by adolescents is much higher than statistics or authors report.
It is conservatively estimated that for every one completed suicide,
there are approximately 10 attempts (Emery, 1983). More liberal
estimates state that for every one successful suicide, there are
50-150 suicide attempts (McBrien, 1983).

Young people today are choosing suicide as a means of escaping
the many problems and frustrations they face. Many authors have
cited family problems such as parental pressure to succeed, parental
divorce and remarriage, transient families or death of one or both
parents as the major cause of adolescent suicide (Emery, 1983;
Greuling & DeBlassie, 1980; Klagsbrun, 1977; McBrien, 1983;

Pinkston, 1983; Smith, D. F., 1976; Smith, E. J., 1981). The
authors cited have listed other factors which have been reported
by teenagers as having the potential to lead them to contemplate
and attempt suicide. These factors included: depression; drug and
alcohol temptations; boy or girlfriend problems; fear of failure;
lack of love; rejections; the so-called alienation of youth; and
peer pressure and conflicts.

As educators who work with a special population of students
where school and home problems may be of greater intensity, teachers
must become aware of the causes and warning signs of adolescent
suicide, and be prepared to offer preventive strategies to reverse
the rising number of young people who take their own lives. In
order to insure that teachers can recognize causes of adolescent
suicide and suicidal signs, and offer positive interventions, this
paper attempted; (a) to identify variables that contribute to
adolescent suicide; (b) to identify overt warning signs of adolescent
suicide; (c) to examine assessment devices which are most successful
in identifying the potential of suicide; and (d) to propose an
intervention strategy to be implemented in school.

Chapter II

Review of Literature

The review of literature chapter served three purposes.
The first section of the chapter discussed identified variables
that contribute to adolescent suicide. The major subtopics in
this section were: depression; family relations; social relations;
and school failure. The second section of the chapter discussed
identified overt warning signs, ranging from low lethality signs
to high lethality signs. The third section reviewed four assessment
devices to determine lethality.

Variables that Contribute to Adolescent Suicide

Depression. To assess the correlation between depression and
suicide attempts, Carlson and Cantwell (1982) conducted a study
with 102 consenting adolescents, who were psychiatrically referred
because of suicidal ideation and depression, and their parents to
determine the relationship between suicide and depression. The
study examined:

(1) the extent to which psychiatrically referred children
who contemplate suicide are depressed; (2) if children who
actually attempt suicide are more depressed than those who
simply think about it; (3) which specific psychiatric diagnoses
are most associated with suicide behavior; (4) whether feelings

Shaffer (1982) reported that a study conducted at Children's Hospital National Medical Center in Washington showed that a group of 20 children with suicidal behavior were more often depressed than their nonsuicidal comparison group of 21 children.

A survey of high school professionals by Grob, Klein, and Eisen (1983) indicated that 70% of teachers surveyed felt that depression was an indicator of suicidal risk for adolescents. Smith, E. J. (1981) reported depression to be a major factor in adolescent suicides. In a study reported by McBrien (1983) with a group of 40 adolescents who had all attempted suicide, 82% of the group were severely depressed.

Family relations. Family problems have been identified by Konopka, McBrien, Pinkston (1983), and Smith, E. J. (1981) as being a predominant factor in suicide attempts by teenagers. McGuire (1982) cited that continual parent-child fighting resulted in a crippling environment that may lead to suicide by the child. Disruptions in family life due to divorce or death, alcoholism, or poverty because of the sudden loss of employment precipitated adolescent suicide.

Pfeffer, Solomon, Plutchik, Mizruchi, and Weiner (1982) isolated factors related to the number of children and the child's ordinal position in the family, parental violence, and divorce as variables that contributed to adolescent suicide. Also, the attempted suicides of parents influenced children to attempt suicide. Peck (1982) emphasized the destructiveness of divorce

on a teenager, which resulted in suicide. Pfeffer (1981) reported parental separation, marital discord, and abuse and neglect may be associated with suicidal behavior of children. Grueling and DeBlassie (1980) reported that a significantly high proportion of adolescents attempting suicide experienced the death of a parent. According to Lee (1978) the child may view a parental death as abandonment, and the result is that the child internalizes hostility toward the deceased parent and the culmination of the hostility is suicide by the teenager.

The ambivalence demonstrated by the family towards the child can push the child to suicide as an escape (Smith, E. J., 1981). Researchers have discovered that young people need a warm, loving family environment, need to be treated equally and be viewed as a significant family member. When this is lacking, the teenager may eventually commit suicide (Konopka, 1983; McAnarney, 1979).

Social relations. Adolescence is a time when a person's body is changing very rapidly; developing satisfactory relationships with other adolescents is very important. The failure to be accepted by a peer group may result in suicide (Hart, 1978; Konopka, 1983; Pinkston, 1983). Boy or girlfriend problems are also related to adolescent suicide, where one teenager is rejected by the other teenager (Pinkston, 1983).

In a study conducted by Wenz (1979) with 200 subjects who either had a history of previous suicide attempts or a history of calls to crisis-intervention centers, Wenz used Dean's Alienation Scale

to determine what variable(s) were associated with alienation.
The results indicated that the strongest variable associated with
alienation was lack of social contact with peers.

Peck (1982) reported the absence of a close friend, with
whom to share problems, may be the difference between living or
taking one's life. Peck stated, "if the history of the youngster
is one of progressive or continued isolation in early childhood,
the prognosis for suicide is more serious than if the history
indicates the ability to have some relationships" (p. 35).

School failure. Much pressure is placed on adolescents to
achieve in school today. Failure to achieve both intrapersonal
and interpersonal goals may effect some adolescents severely.
Regardless of one's age, failure can lead to suicidal attempts
and completion of the act (Pinkston, 1983; Smith, E. J., 1981).
School performance has been reported as almost uniformly poor in
adolescent suicides. These students had a tendency to be truant
more often, were more of a discipline problem, and were dropping
out of school at the time of suicidal attempts (Smith, D. F., 1976).

Warning Signs of Suicidal Ideation

Overt warning signs. Many authors and researchers have
identified certain behaviors which have become associated with
suicidal ideation of adolescents. McKenry, Tisher, and Christman (1980),
Morgan (1981), and Smith, D. F. (1976) provided information about
behavioral changes or cues which are indicators of suicidal thought.

This list included: (a) a drastic change in the students's personal

appearance, particularily from good to bad; (b) somatic complaints;

(c) inability to concentrate and problems in judgement and memory;

(d) a dramatic shift in quality of school work; and (e) changes in

daily behavior and living patterns, such as extreme fatigue, boredom,

stammering and/or decreased appetite. Social behavior changes included:

(a) behavioral disorders in class; (b) falling asleep in class;

(c) emotional outbursts compounded with crying or laughter; (d) inability

to sit still; (e) sudden bursts of energy followed by lethargy;

(f) excessive use of alcohol or drugs; (g) open signs of mental illness,

such as delusions and hallucinations; (h) a sense of overwhelming

guilt and shame; and (i) loss of friends.

The NJEAR (1982) and Smith, E. J. (1981) also identified signs

of suicide contemplation: (a) changes in sleeping or eating habits;

(b) a significant decline in school performance along with giving

away prized possessions; (c) having a preoccupation with death, and

(d) making statements about feeling worthless or being a burden to

the family. McBrien (1983) has identified four broad areas that

are signs that a teenager may be thinking about suicide:

1. verbal statements such as, "I want to die"; 2. behavioral

clues, the most serious being previous attempts or writing

a will; 3. situational clues, with family and relationship

problems being most common; and 4. syndromatic clues, with

the three developmental stages of the syndrome being (a) history

of previous problems, (b) additional problems being associated

with adolescense, (c) a recent intense period of problems

with significant social relationships. (p. 76)

McGuire (1982) listed the following as possible presuicidal

behaviors; (a) running away from home; (b) accident proneness;

(c) impulsive acting out; (d) temper tantrums; (e) self-deprecation;

(f) serious conflict; (g) loneliness; (h) aggressions, external

and inhibited; (i) changes in school performance; and (j) psychosomatic

illnesses. Behaviors such as excessive risk-taking, along with

acting irrationally where such behaviors had not been present in

the past, may be indicators of adolescent suicidal ideation (Emery,

1983; Grob, et al., 1983; Hart, 1978).

Besides being aware of behaviors in the school or classroom,

teachers must also be aware of problems that may be effecting teenagers

away from school, particularily at home. McKenry, Tisher, and

Christman (1980) provided a list of major causes of suicide away

from school which included: (a) the death of a family member, close

friend or relative; (b) the divorce or separation of parents, siblings

or relatives; (c) personal problems with the law or a family member

who is having present difficulty with the law; (d) the marriage

of a sibling or remarriage of a parent; (e) a change in residence;

(f) trouble with a teacher or teachers or a parent having trouble

with a boss at work; and (g) the death of a pet. The prescence of

these crises did not necessarily imply suicidal thoughts, but if

teachers were aware of these happenings away from school, along with

changes in behavioral patterns, teachers stood a better chance of

preventing an adolescent suicide if one was being contemplated.
A summarization of overt behaviors associated with impending suicide
can be found in Appendix A.

Lethality. Any expression of a suicide threat should be
taken seriously by teachers. The thought of suicide is recognized
as a cry for help. When a teenager displays one or more of the
warning signs of suicide, the first step a teacher must take is to
determine the lethality of the suicide intent. Smith, E. J. (1981)
has divided lethality into three groups:

1. high lethality - the person definitely wants to die and
anticipates that his or her actions will result in death;
2. medium lethality - the person is ambivalent, playing some
partial or unconscious role, as in drug abuse, foolhardiness,
carelessness or outright disregard of lifesaving medical care;
and 3. low lethality - the person has no conscious which to die
and yet is willing to take unknown risks, as in the case of
"inhalers". (p. 291)

Teachers determined which level of lethality the teenager was
experiencing by being aware of the teenager's suicidal history,
suicidal plan, resources that the adolescent had available to
prevent a suicide attempt, and communication avenues open to the youth.
Assessment of lethality helped the concerned teacher to judge as
accurately as possible how likely an identified student was to
attempt suicide in the immediate future. By assessing lethality
teachers had a basis for planning interventions, for discriminating

potential lethal adolescent suicide attempts from "non-serious"
adolescent suicide attempts, and to help the teacher deal with
anxieties regarding the potential suicide of another person
(Motto, 1978; Smith, E. J., 1981).

Assessment Devices

Once a student approaches a teacher about suicidal thoughts,
or has been identified as possibly committing suicide, the teacher
has available a number of devices to assess the lethality of the
suicidal thoughts, and devices which may help the teenager reflect
on what has been comtemplated, and change their thoughts. Nelson
and Chiles (1983) have developed a Reasons for Living Inventory (RFL)
(Appendix B). The RFL was tested on 197 Seattle shoppers and 175
psychiatric inpatients. Six categories containing statements to
which the subjects gave a yes or no answer were: (a) Survival and
Coping Beliefs; (b) Responsibility to Family; (c) Child-Related
Concerns; (d) Fear of Suicide; (e) Fear of Social Disapproval;
and (f) Moral Objections. After tallying the responses, those
with higher suicidal ideation had a lower amount of yes responses
to all statements. The RFL has been shown to be an effective tool
to assess the degree of lethality an adolescent has experienced.

The Hopelessness Scale (HS) (Appendix C) by Beck, Weissman,
Lester, and Trexler (1974), offered another assessment device to
educators. The HS consisted of 20 questions to assess a teenager's
outlook on the future. The HS was developed using 294 hospitalized

patients who had made past suicide attempts. A score of zero to one was assigned to each statement. The 11 true statements were assigned zero if the patient answered them negatively, and a one if the patient answered them positively. The nine false statements were assigned a zero if answered positively and a one if answered negatively. The closer to a score of 20, the greater the suicidal risk. Kazdin, French, Unis, Esveldt-Dawson, and Sherick (1983) conducted an experiment with the HS as assess the degree of hopelessness experienced by the subjects. The results indicated the HS was a satisfactory device for assessing hopelessness in children, which may be an indicator of suicide. Educators used the HS to assess the degree of hopelessness a teenager was experiencing and move to an intervention if one was necessary.

An assessment scale was used by First Call for Help (La Crosse Lutheran Hospital) (Appendix D) for incoming calls which were suicidal in nature. The scale consisted of 19 items where a zero, one, or two were assigned to the responses given by the caller. A score of 15 or higher was considered to be high lethality and called for an immediate intervention, such as calling the police and having them sent to the residence of the suicidal caller. Once again, the teacher used this scale to assess the degree of lethality a teenager was experiencing.

McBrien (1983) offered a list of 10 questions developed by researchers at the Center for Cognitive Therapy (Appendix E). Educators asked these questions of teenagers who are exhibiting

suicidal symptoms. Examples of the questions were: (a) how will

you commit suicide?; (b) do you have a plan?; (c) what has happened

that makes life not worth living?; and (d) when you are thinking

of suicide, how long do these thoughts stay with you?

Chapter III

Interpretation of Literature Review

The findings of the literature review were that a number of
researchers agree that depression was the major cause of adolescent
suicide. Studies cited showed that a majority of subjects had
severe depression at the time of serious suicide contemplation.
The reasons for depression were varied, but a number of researchers
agreed that severe problems in the home and with the family were
the major causes of severe depression in youths. The relatedness
of depression and family relations was a circular problem.

Other factors cited by researchers were poor social relations
and school failure. Researchers agreed that depression may be the
overriding cause for a youth to experience poor social relations
with peers and failure in school. The converse was also cited by
researchers. A teenager who was unable to make satisfactory social
relations, and who was not accepted in a peer group, may become
severely depressed, and think about suicide as an escape. Youths
who set unobtainable goals of academic success may experience
depression when these goals are not reached and contemplate suicide.

Educators working with a special population of students must
be aware of the possible problems a student may have had with school,
peer relations, and parental relations. Many researchers were in
complete agreement over observable behavior signs which may indicate

that a teenager might choose suicide as an escape. Researchers also cited events away from school which have influenced adolescents to attempt suicide.

Researchers were in agreement about the assessment of lethality. The use of the RFL, HS, and the First Call for Help assessment scales of lethality can help the teacher know if the youth has a plan, or access to a means of carrying out a suicide. This can help the teacher intervene and prevent a suicide immediately, or plan an intervention strategy if the degree of lethality is not very high.

Chapter IV

Implications and Action Plan

In this chapter the implications of the research were discussed and an action plan was proposed. The action plan was used for inservice training of teachers concerned with the possibility of suicide among their students.

The increase in adolescent suicide needed to be addressed by educators. Educators spend the majority of the day with teenagers. This involvement provided an excellent opportunity for teachers to take on some of the responsibility to prevent adolescent suicide. From factors cited in chapters I and II an action plan was proposed which included:

1. A unified school program which addressed the issue of adolescent suicide.

2. An inservice training program for concerned teachers.

3. The use of consultants and referral agencies when the problem has become too serious for educators to handle effectively.

School involvement. Those teachers concerned about adolescent suicide have formed a school-wide network to reverse the increase in adolescent suicide. Students were made aware of the network and knew it was available when they needed someone to talk to who would not pass judgement, and who kept all matters discussed confidential unless otherwise instructed to by the teenager.

If the seriousness of the situation warranted, teachers would contact parents or other professionals. The teenager needed someone who was compassionate and empathetic and who treated the youth with respect (Konopka, 1983; Powers, 1979).

The network of teachers together with the health teacher(s) provided a unit on death and suicide. The realization that suicidal thoughts may have been shared by others was also a preventative device. There were many films and filmstrips available that discussed the topic of suicide, and proposed ways to cope with suicidal feelings. A sample of titles included:

1. Help Me! The Story of a Teenage Suicide. This film discussed a teenager who had committed suicide and how teachers, family, and friends recalled her acting "strange" before the death (S-L Film Productions, 1976).

2. Suicide: It Doesn't Have to Happen. This film depicted a high school teacher reflecting back to his youth when he thought about killing himself, and how he related to a student who had recently attempted suicide (BFA Educational Media, 1976).

3. Teenage Suicide. The film discussed adolescent suicide and myths surronding it (MTI Teleprograms, 1978).

Inservice training. Teachers who were interested in becoming part of a school-wide network of counselors for youths contemplating suicide were required to attend a full day inservice training program. Materials that were used and distributed to educators are provided in the appendices. The inservice training is outlined in a flow chart in Figure 1.

Figure 1

Stages in Development of In-service Training of Concerned Teachers

Related to Adolescent Suicide

Stage 1 - Overview of problem; Current statistics regarding adolescent suicide.

Stage 2 - Discuss causes of adolescent suicide: depression, family relations, social relations, and school failure.

Stage 3 - Present overt warning signs.

Stage 4 - Discuss suicidal lethality and present and discuss lethality assessment devices.

Stage 5 - View and discuss films: Help Me! The Story of a Teenage Suicide, Suicide: It Doesn't Have to Happen, and Teenage Suicide.

Stage 6 - "Brainstorm" counseling situations and techinques. Use no-suicide contracts.

Stage 7 - Role-play counseling situations. Introduce and use consultant list.

Stage 8 - Review causes, overt signs, lethality assessment devices, no-suicide contracts, and consultant list.

Stage 9 - Question and answer period.

Alternative interventions. If a suicidal youth posed too large
of a problem for a teacher, the teenager was referred to community
support networks (McNelly, Shafil, and Schwab, 1977). The educator
was made aware of the following:

1. Contacts and referral agencies in the social service agencies
of a community, which offered free or low-cost counseling.

2. Private counseling services if the teenager's family could
afford these services.

3. Contacts and referral personnel in community hospitals.

Summary Statement

The research cited in this paper indicated that adolescent suicide
is at a high level today. The number of actual completed suicides by
adolescents had been increasing each year (Emery, 1982; Hart, 1978;
Smith, E. J., 1981). Factors identified by reseachers that contributed to
adolescent suicide included: depression; family relations; social relations;
and school failure. Reseachers also identified overt behaviors which have
shown to be indicators of suicidal ideation in adolescents (McKenry, et al., 1980).

An action plan was proposed that could be implemented in schools to
reverse the increase in adolescent suicide. Along with the action plan,
recommendations were made for future research. These recommendations
included the effects of chemical abuse on adolescent suicide and research
to determine additional techniques to help educators cope with adolescent
suicide.

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Appendix A

Symptoms)

~~Overt Behaviors~~ Associated with Impending Suicide

1. A drastic change in the student's personal appearance, particularily from good to bad.

2. Somatic complaints - muscle aches and pains, stomachaches, backaches, headaches, diarrhea.

3. Inability to concentrate and problems in judgement and memory.

4. A dramatic shift in quality of school work.

5. Changes in daily behavior and living patterns, such as extreme fatigue, boredom, stammering and/or decreased appetite.

6. Statements such as, "I want to die".

7. Writing a will, or giving away prized possesions.

8. Behavioral disorders in class.

9. Falling asleep in class.

10. Emotional outbursts compounded with crying or laughter.

11. Inability to sit still.

12. Sudden bursts of energy followed by lethargy.

13. Excessive use of alcohol or drugs.

14. Open signs of mental illness, such as delusions and hallucinations.

15. A sense of overwhelming guilt and shame.

16. Loss of friends.

17. Running away from home.

18. Accident proness.

19. Impulsive acting out.

20. Temper tantrums.

21. Self-deprecation.

Appendix A continued

22. Serious conflict.

23. Loneliness.

24. Aggression, external and inhibited.

25. Excessive risk-taking.

Problems away from school that may be effecting the adolescent

26. The death of a family member, close friend or relative, or pet.

27. The divorce or separation of parents, siblings, or relatives.

28. Personal problems with the law or a family member who is having present difficulty with the law.

29. The marriage of a sibling or remarriage of a parent.

30. Change in residence.

31. The adolescent having trouble with a teacher or teachers or a parent having trouble with his/her own boss at work.

APPENDICES

Appendix A

Reasons for Living Inventory

Survival and Coping Beliefs

1. I care enough about myself to live.
2. I believe I can find other solutions to my problems.
3. I still have many things left to do.
4. I have hope that things will improve and the future will be happier.
5. I have the courage to face life.
6. I want to experience all that life has to offer and there are many experiences I haven't had yet which I want to have.
7. I believe everything has a way of working out for the best.
8. I believe I can find a purpose in life, a reason to live.
9. I have a love of life.
10. No matter how badly I feel, I know that it will not last.
11. Life is too beautiful and precious to end it.
12. I am happy and content with my life.
13. I am curious about what will happen in the future.
14. I see no reason to hurry death along.
15. I believe I can learn to adjust or cope with my problems.
16. I believe killing myself would not really accomplish or solve anything.
17. I have a desire to live.
18. I am too stable to kill myself.
19. I have future plans I am looking forward to carrying out.
20. I do not believe that things get miserable or hopeless enough that I would rather be dead.
21. I do not want to die.
22. Life is all we have and is better than nothing.
23. I believe I have control over my life and destiny.

Responsibility to Family

24. It would hurt my family too much and I would not want them to suffer.
25. I would not want my family to feel guilty afterwards.
26. I would not want my family to think I was selfish or a coward.
27. My family depends upon me and needs me.
28. I love and enjoy my family too much and could not leave them.
29. My family might believe I did not love them.
30. I have a responsibility and commitment to my family.

Child-Related Concerns

31. The effect on my children could be harmful.
32. It would not be fair to leave the children for others to take care of.

Appendix A continued

33. I want to watch my children as they grow.

Fear of Suicide

34. I am afraid of the actual "act" of killing myself (the pain, blood, violence).
35. I am a coward and do not have the guts to do it.
36. I am so inept that my method would not work.
37. I am afraid that my method of killing myself would fail.
38. I am afraid of the unknown.
39. I am afraid of death.
40. I could not decide where, when and how to do it.

Fear of Social Disapproval

41. Other people would think I am weak and selfish.
42. I would not want people to think I did not have control over my life.
43. I am concerned about what others would think of me.

Moral Objections.

44. My religious beliefs forbid it.
45. I believe only God has the right to end a life.
46. I consider it morally wrong.
47. I am afraid of going to hell.

Appendix C

Hopelessness Scale

<u>True</u>

2. I might as well give up because I can't make things better for myself.
4. I can't imagine what my life would be like in 10 years.
7. My future seems dark to me.
9. I just don't get the breaks, and there's no reason to believe I will in the future.
11. All I can see ahead of me is unpleasantness rather than pleasantness.
12. I don't expect to get what I really want.
14. Things just won't work out the way I want them to.
16. I never get what I want so it's foolish to want anything.
17. It is very unlikely that I will get any real satisfaction in the future.
18. The future seems vague and uncertain to me.
20. There's no use in really trying to get something I want because I probably won't get it.

<u>False</u>

1. I look forward to the future with hope and enthusiasm.
3. When things are going badly, I am helped by knowing they can't stay that way forever.
5. I have enough time to accomplish the things I most want to do.
6. In the future, I expect to succeed in what concerns me most.
8. I expect to get more of the good things in life than the average person.
10. My past experiences have prepared me well for my future.
13. When I look ahead to the future, I expect I will be happier than I am now.
15. I have great faith in the future.
19. I can look forward to more good times than bad times.

Appendix 𝓤

Appendix D

First Call for Help Assessment Scale

1. How specific are the ideas?
   0 - abstract and general thoughts - "I'm thinking about suicide". - but no specific events related to suicide as method, place of funeral.
   1 - has thought of some specific events or circumstances related to suicide.
   2 - has considered many specific acts or circumstances related to suicide.

2. Method
   0 - not thought about
   1 - possibilities have been considered, but no specific methods picked out
   2 - has been definitely chosen

3. The Availability of the Method
   0 - has not been purchased, e.g. pills not purchased, type of pill not decided, gun not bought
   1 - has been obtained, but not readily available
   2 - ready immediately, e.g. the gun is in the house

4. Stage of Plan
   0 - nothing ready
   1 - about to be put into effect
   2 - ready

5. Second Source - (a family member or close friend)
   0 - no chance of committing suicide
   1 - will try under certain conditions
   2 - definitely will try

6. Patient's Report of Intent to Commit Suicide
   0 - wants to live
   1 - isn't sure, waiting to see
   2 - wants to die

7. Patient's Attitude Toward Living
   0 - gives good reasons
   1 - says reasons for dying equal or outweigh reasons for living
   2 - sees no reasons for living

8. Patient's Feelings About His/Her Suicidal Thoughts
   0 - feels negative about them
   1 - is in acute distress or ambivalent about them
   2 - accepts them

Appendix 🅰 continued

9. Patient's Sense of Control Over His/Her Thoughts
   0 - keeps them under control
   1 - is afraid he/she will be driven to do something and wants someone to control him/her
   2 - no longer makes any attempt to keep suicidal thoughts under control

10. Frequency of Thoughts
    0 - isolated and fleeting
    1 - periods of persistent thoughts
    2 - constant and persistent thoughts

11. Patient's Perception of Sources of Help
    0 - has numerous and reliable sources of help
    1 - sources exist, but are few or unreliable
    2 - has nowhere to turn

12. Is the Person Seeking Help?
    0 - has not sought help because he/she hasn't felt a need for it
    1 - has sought or is seeking help
    2 - has not sought help because he/she doesn't want interference with any plans

13. Preparations for Death
    0 - none
    1 - has thought about them
    2 - planned out or written

14. Suicide Note
    0 - not thought about
    1 - considered but not planned out or written
    2 - planned out or written

15. Thoughts About the Future
    0 - definite plans
    1 - has mentioned vague plans
    2 - no plans at all

16. Alcohol and Any Other Drugs
    0 - not a drug taker
    1 - takes drugs socially
    2 - continually turning to drugs

17. Prior Attempt
    0 - none
    1 - any prior attempt
    There is no one in this category

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Appendix B continued

18. Causing Another's Death
    0 - don't believe
    1 - questioning
    2 - believe they had a hand in someone's death

19. Special Day
    0 - none at all approaching
    1 - one approaching
    2 - date imminent

Appendix D

McBrien's 10 Questions

1. How will you do it?

2. How much do you want to die?

3. How much do you want to live?

4. How often do you have these thoughts?

5. When you are thinking of suicide, how long do these thoughts stay with you?

6. Is there anyone or anything to stop you?

7. Have you ever attempted suicide?

8. Do you have a plan?

9. On a scale from 1 to 10, what is the probability that you will kill yourself?

10. What has happened that makes life not worth living?

These questions can be kept on index cards at the teacher's desk,

or memorized, and asked of the student when he/she comes in for counseling.

Fantasy Relaxation

Objective

To ease the individual into a more complex relaxation activity. This could be a bridge from progressive relaxation to guided imagery.

Preparation

Deep breathing exercise 1 or 2, Appendix C.

Procedure

When you are ready, visualize a small, imaginary opening at the very top of your head, about the size of a dime. Through this small opening are flowing rainbows of colors, pink, yellow, aquamarine, etc., flowing cloud-like as in puffs of smoke. Because they are soft and majestic they carry with them all the tension or tightness you have been experiencing. Let these puffs of soft cloudlike color flow in and around your head. Watch them circle effortlessly. As they move with the current of air, they vanish into the atmosphere.

Now once again imagine that the small opening at the top of your head is covered with bone, skin and hair.

Focus your attention on your breathing. Breathe slowly and deeply 6 times, in through your nose and out through your mouth.

Proceed to Reality Affirmation Exercise.

(adapted from Williams, unpublished paper)

APPENDIX E

GUIDED IMAGERY RELAXATION EXERCISES

GUIDED IMAGERY RELAXATION EXERCISES

Resentment Imagery

The resentment imagery process is not a way to avoid expressing true feelings by turning them into unnaturally positive images. Rather, it is a way to gain insight into one's old hurts to relieve the damaging side effects. This allows the client to deal with feelings effectively and, as a result, to experience less stress and tension. The energy tied up in resentment can then be redirected toward constructive decisions.

Procedure

Sit in a comfortable chair, feet flat on the floor, eyes closed.

If you feel tense or distracted, go through the progressive muscle relaxation technique.

Create a clear picture in your mind of the person toward whom you feel resentment. Picture good things happening to that person. Visualize that person receiving love, or attention, or money, whatever you believe that person would see as a good thing.

Be aware of your own reactions. If you have difficulty visualizing good things happening to that person, it is a natural reaction. It will become easier with practice.

Think about the role you may have played in the stressful scene, and how you might reinterpret the event and the other person's behavior. Imagine how the situaion might look from the other person's point of view.

Be aware of how much more relaxed, less resentful you feel. Tell yourself you will carry this new understanding with you.

You are now ready to open your eyes and resume your usual activities.

Proceed to Reality Affirmation Exercise.

(Simonton, Matthews-Simonton, and Creighton, 1981)

This exercise may be used whenever the client becomes aware of rerunning an unpleasant, painful, or angering episode from the past. It may be months before the client has to use it again, or there may be days when he or she uses it half a dozen times. The client may even wish to use this exercise during an unpleasant experience.

While releasing resentment frees the body from stress, the individual also gains a sense of accomplishment as the feelings surrounding old events begin to change, and the client recognizes a new sense of freedom and control as the client discovers he or she is no longer victimized by feelings.

Mental Imagery for Setting Goals

By asking the client to set goals, the therapist can help him or her conceptualize and focus on reasons for living, reestablishing the client's connection with life. It is a way for the client to focus on the things that he or she wants out of life to provide the impetus for the client to achieve these goals. The importance of this self-assertiveness stance is that it runs counter to the attitudes of hopelessness.

Procedure

Begin with the progressive muscle relaxation technique.

Select the goal on which you want to work. In your mind visualize the goal already met.

Experience the feelings you would have with your goal already met. What would people say to you? What would you be doing? What would you look like? Describe your surroundings. Add as many details as possible. See other people who are important to you responding to your achievement.

Look back over any steps it took to reach your goal. What was the first step? Decide to take some action on this first step. Feel a sense of accomplishment for achieving each step. Add details about the action steps and your feelings. Be happy and thankful for having reached your goal.

Gradually drift back to the present time.

Reality Affirmation Exercise.

Take action on that first step.

(Simonton, Matthews-Simonton, and Creighton, 1981)

The mental imagery process can help the client define a goal (or goals) more clearly. At times the mental imagery may reveal barriers to reaching the goal. When this happens,

encourage the client to openly discuss these barriers.

If the client has difficulty with creating a mental imagery and reaching the goal, it may well be that the client does not believe he or she is capable of meeting the goal. Encourage the client to continue practicing the mental imagery, at least the steps involved.

Each time the client discovers the goal imagery process interrupted by a negative belief, instruct him or her to stop and balance this with a positive belief. Then have the client return to the imagery and visualize reaching the goal.

Inner Guide Imagery

Clients are often more responsive to insights achieved in consultation with their Inner Guide than they are to the observations of others (the therapist). In this type of therapeutic exercise the client is taught to establish communication with the positive resources of the unconscious because it is believed that the messages from the unconscious, or self (Inner Guide), are always conducive to the person's welfare and good health.

Simonton and Matthews-Simonton have utilized this technique with cancer patients as a way of helping them to value self and take more responsibility with their own illness. Patients have reported receiving valuable information and guidance through getting in touch with their Inner Guides. Because the Inner Guide is an aspect of their own personality, relying on such a guide is a healthy step toward taking responsibility for their physical and psychological health.

Procedure

Breathing relaxation exercise.

Progressive muscle relaxation exercise.

Visualize a natural setting that gives a feeling of warmth, comfort, peace and serenity. Select a spot from memory or fantasies. Concentrate on the details of the scene. Try to experience it with all your senses, as if you were actually there.

Notice a path emerging near you which winds toward the horizon. Sense yourself walking along this path. It is pleasant and light.

Notice that in the distance there is a radiant blue-white glow which is moving slowly toward you. There is nothing threatening about the experience.

As the glow comes closer, you realize it is a living creature — an unknown person or a friendly animal.

As the person or creature comes closer, be aware of the details of its appearance. Is the creature masculine or feminine? See its shape and form as clearly as you can. If your guide is a person, notice details of face, hair, eyes, bone structure, build.

If this person or creature makes you feel warm, comfortable and safe, you know it is an Inner Guide. Engage the person or creature; get acquainted. Discuss your problems as you would with a very close friend.

Pay careful attention to any information you receive from your guide. It may come in the form of conversation or through symbolic gestures, such as the guide's pointing toward something or producing an object that represents its advice.

Establish an agreement with your guide about how to make contact for future discussions.

Then, when you are ready, let your consciousness come back slowly into the room where your are sitting or lying down.

Reality Affirmation Exercise.

(Simonton, Matthews-Simonton, and Creighton, 1981)

The client should not be discouraged if contact with the Inner Guide is not made at the first attempt. It is not unusual to take several attempts before reaching successful contact.

The Inner Guide is a part of self that often does not receive much attention. Getting in touch with the Inner Guide could help the client learn much about his or her feelings, motivations and behavior.

Mental Imagery for Managing Pain

Pain is caused by emotional stress as well as actual physical disease or dysfunction. In order to deal with pain, both aspects must be considered.

Pain is so often linked closely to tension and fear that many people are capable of feeling a decrease in pain after beginning to use relaxation mental imagery on a regular basis. The client will learn to visualize the body's healing capabilities and to communicate with the pain and picture it. This makes the body an active participant, pulling together its resources to deal with the abnormality.

Procedure

Prepare the client by doing the progressive muscle relaxation activity.

Focus on the pain. Describe its color, shape and size clearly. It may be a bright red ball or a clouded mass of gray or a white cube (whatever). It may be the size of a ping pong ball or grapefruit size.

Mentally place the ball or cloud out in space, possibly 10 feet away from the body. Make the ball (cloud, cube) bigger, about the size of a basketball. Then shrink it to the size of a pea. Now let it become whatever size it chooses to be. Usually it returns to the original size visualized.

Begin to change the object's color; make it yellow, then green. Now take the green object and put it back where it was originally seen. At this point, notice whether or not the pain has been reduced.

Reality Affirmation Exercise.

(Simonton, Matthews-Simonton, and Creighton, 1981)

MUSIC AS AN AID TO RELAXATION

Almost all people in any given society can relate to some type of music as a means of conveying feelings. Appropriate mood music may be used with any of the relaxation exercises to enhance the atmosphere of relaxation. Following is a list of music compiled by Williams (unpublished paper) that can be used for this purpose. The practitioner is encouraged to use any music he or she feels the client will respond to, but it is suggested that instrumental music is preferable, as vocal music can distract people as they focus on the words.

MUSIC SUGGESTIONS

Syntonic Research, Inc.

Wind in the Trees/Heartbeat
Wood-masted Sailboat/Country Stream
Thunderstorm/Gentle Rain in a Pine Forest
Pacific Ocean/Caribbean Lagoon

Complete Records

Paul Horn, Inside the Great Pyramid, Mushroom Records

Debussy, Afternoon of Faun/Daphnis and Chloe/Clouds, Feasts, Sirens, Columbia ML 5112

Pachelbel (side 1), Canon in D/Sinfonia in G/Sinfonia in A, RCA (Erato) F R L I - 5468

Appendix F

No Suicide Contracts

Verbal Contract: Have student repeat statement verbatim:

"I will not kill myself"

Do not accept qualifiable restrictions. If the student wants to
set a time limit, accept the date, but be sure to renew the contract
before it expires.

Written Contract: Have student sign contract and then make copies
for both the student and teacher:

I, _____, will not kill myself.

_____
Student

                                        _____
                                                date
_____
Teacher