AN ABSTRACT OF THE DISSERTATION OF

Mary Boylan for the degree of Doctor of Philosophy in Counseling presented on August 8, 2001. Title: The Self-Efficacy of Irish Guidance Counsellors for Identifying and Assessing Students At Risk for Suicide.

Abstract approved: Signature redacted for privacy.

Cass Dykeman

Suicide is the primary cause of death of adolescents in Ireland. While much attention has been given this phenomenon, no research has specifically examined the role of guidance counsellors in secondary schools in Ireland in addressing this phenomenon. The purpose of this research was to examine the self-efficacy of guidance counsellors in Ireland for identifying and assessing students at risk for suicide, including four hypothesized predictors for such self-efficacy. These predictors were gender, institution of training, membership of the Irish Institute of Guidance and Counselling, and exposure to a suicidal student. The participants were 405 members of the Irish Institute of Guidance Counselling, a professional organization whose membership was inclusive of all guidance counsellors in secondary schools in Ireland.

The instrument utilized was entitled Adolescent Suicide, and included fourteen questions measuring the three components of self-efficacy (i.e., efficacy expectations, outcome expectations and outcome values). The results were analyzed using measures of central tendency and logistic regression. Analyses using measures of central tendency indicated that Irish guidance counsellors as a whole had high global self-efficacy when it comes to intervening with suicide. Logistic regression analyses

supported two of the four hypothesized predictors. In terms of the gender predictor variable, males were almost three times more likely than females to have high suicide intervention self-efficacy. In terms of the exposure to suicidal ideation variable, Irish guidance counsellors who were exposed to suicide in their work were more than three times more likely to have high suicide intervention self-efficacy than those guidance counsellors who had no such exposure.

While the global suicide intervention self-efficacy score was high for the majority of Irish guidance counsellors, individual item level analyses of the Adolescent Suicide instrument revealed areas of low suicide intervention self-efficacy in the efficacy expectation and outcome expectation components. In particular, Irish guidance counsellors questioned their ability to recognize a student at risk for suicide.

The limitations of the present study were presented. Also, the research and professional practice implications of the findings of this study were discussed.

The Self-Efficacy of Irish Guidance Counsellors for Identifying and Assessing Students At Risk for Suicide.

By
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DEDICATION

This accomplishment would never have been possible without the constant and unwavering support, encouragement, understanding and love of my family. Thus I dedicate this work to my family in Ireland and America, especially my parents Anne and John Boylan, and my uncle Monsignor John Twomey.

The Self-Efficacy of Irish Guidance Counsellors for Identifying and Assessing Students At Risk for Suicide

CHAPTER 1: INTRODUCTION

Throughout history, adults have incessantly puzzled over the phenomenon of youth suicide. Suicide by its very nature poses an infinite number of questions, and often if not always, results in a search for meaning and understanding. C. A. King (1997) proposes there is a generally accepted social consensus that suicidal behaviors among adolescents are tragic. Youth suicides appear tragic and particularly meaningless given the multiple futures open to their victims, making any comprehension even more difficult to ascertain. Also, such suicides resonate more loudly within a community because youth suicide is perhaps the strongest repudiation of any society or culture.

C. A. King (1997) stated that there was no other time in the human life span that the prevalence of suicide attempts was as high as during adolescence. In Europe, many continental and national health organizations are currently reporting an alarming rise in adolescent suicide rates. These same organizations are reporting that this rise is outstripping the existing mental health professionals' ability to address youth suicide. The Republic of Ireland is one of the 23 European countries that have experienced an increase in suicide rates. In this country, the only mental health professional that all teenage youth have access to is the school guidance counsellor. Thus, I will examine

Irish guidance counsellors' perceived ability to intervene with the major mental health and social problem of adolescent suicide.

The last census of guidance counsellors was conducted in 1993, and revealed there were 565 guidance counsellors employed in secondary schools in Ireland (Ryan, 1993). These counsellors were secondary school teachers who chose to continue their education to obtain guidance counsellor diploma. The guidance counsellor curriculum is one year of full time study in length. Enrollment in this curriculum or course requires that the guidance counsellors take a sabbatical for a year from their school and upon completion usually return to that same school. Irish guidance counsellors have three primary areas of responsibility as outlined in their professional handbook. These areas are personal counselling, career counselling and educational counselling. The fact that the secondary school educational system is an exam based one sets an informal priority ranking of these three areas. The highest priority goes to educational counselling with students in the grades where high stakes national exams occur (i.e. 10^{th} and 12^{th} grades). The second priority goes to career counselling. Again, these services are not systematically provided to all students but rather are offered only upon student request. The lowest priority goes to personal counselling. Like career counselling services, personal counselling is provided only upon request. This informal positioning of personal counselling occurs despite the fact that personal counselling can aid in abating adolescent suicide and dispelling the myths that surround adolescent suicide.

There are many myths that persist about adolescent suicide. Some of these myths are (a) most suicides occur without warning signs, (b) adolescents who talk about suicide do not attempt it, and (c) educating teens about suicide leads to increased suicide attempts (K. King, 1999). To prevent youth suicide K. King recommended that

> ...school professionals must possess accurate information. Remaining aware of and refuting the myths of adolescent suicide will assist in this process. All school staff must feel they have a responsibility to play in preventing suicide for an effective and comprehensive suicide prevention program to take effect. (p. 5)

If school personnel have a responsibility to address youth suicide, and guidance counsellors are the only trained mental health professional in Irish schools, then the leadership role for youth suicide prevention and intervention falls to these professionals. Are Irish guidance counsellors ready for this leadership?

Irish guidance counsellors can only assume a leadership role in preventing youth suicide if they believe they possess the skills to impact this particular problem. The belief in their skills refers to the self-efficacy beliefs of the guidance counsellors. Why is this self-efficacy belief important? Sutton and Fall (1995) summed up the importance of self- efficacy by stating that this construct "has the potential of becoming a powerful construct in helping school counselors to understand their influence over people and systems, and more important, to understand themselves" (p. 335).

Statement of Purpose

The purpose of this dissertation was to examine the self-efficacy of Irish school guidance counsellors, in identifying and assessing students at risk for suicide. The first step in achieving this purpose was to conduct a thorough review of the literature. This review provided the necessary background and focus for this dissertation. The second step was to study the youth suicide intervention/prevention self-efficacy of Irish guidance counsellors.

Research Questions

Research Question 1:

What is the level of self-efficacy of Irish guidance counsellors for identifying and assessing students at risk for suicide?

Research Question 2:

What relationship do the following variables have on the guidance counsellors' self-efficacy?

a. Gender

b. Professional experience

c. Ideation exposure

d. Training background

Statement of Research Hypotheses

The following five null hypotheses were made with respect to this study:

(1) The majority (51%) of guidance counsellors in Ireland have high self-efficacy for suicide intervention.

(2) Gender does not predict the suicide intervention self-efficacy of Irish guidance counsellors.

(3) Professional experience does not predict the suicide intervention self-efficacy of Irish guidance counsellors.

(4) Training background does not predict the suicide intervention self-efficacy of Irish guidance counsellors.

(5) Suicidal ideation exposure does not predict the suicide intervention self-efficacy of Irish guidance counsellors.

Glossary of Terms

Self-efficacy

The term "self-efficacy refers to beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments" (Bandura, 1997, p. 3).

Gender

The division of counsellors into male or female categories.

Chartered

Refers to a counsellor who has had membership in the Institute of Guidance Counsellors for more than four years and is currently working as a guidance counsellor.

Qualified

Refers to a counsellor who has had membership in the Institute of Guidance for less than four years and may or may not be working full-time as a guidance counsellor.

Course

The term used in Ireland to refer to a university diploma program.

Training background

The educational program or institution from which the counsellor received their diploma in counselling.

Suicidal ideation exposure

The experience of working with a suicidal adolescent.

Secondary school

The equivalent to high school in the United States of America and encompasses grades 7-12.

Department of Education

The government department in charge of the educational system in Ireland.

Para-suicide

This refers to "any act deliberately undertaken by a patient which mimics the act of suicide, but does not result in death" (Kelleher, 1996, p. 53).

CHAPTER 2: LITERATURE REVIEW

This literature review examines the literature on (a) suicide in Ireland, (b) adolescent suicide in Ireland, (c) the history and role of guidance counsellors in Ireland, (d) adolescent suicide in America and (e) the theory of self-efficacy and its applications. These areas provide the background and focus for the examination of the self-efficacy of Irish guidance counsellors and their ability to identify and assess students at risk for suicide.

Overview of Suicide in Ireland

Suicide in Ireland is a phenomenon that transcends all ages. The examination of adolescent suicide in Ireland will be placed in a national context with a review of national rates, gender differences, psychosocial factors and preventative strategies in the Republic of Ireland.

Rate

The actual rate of suicide in any given population is difficult to ascertain. First, it depends on the definition used by researchers and health officials. Second, many times people try to conceal the real cause of death from such researchers and officials. Third, there are legal implications that stem from a ruling of suicide (Aware, 1998). In Ireland, the difficulty of compiling suicide data is compounded because of the process

that must be undertaken to determine if a death is ruled a suicide. There must be a coroner's report and a confidential police report. However under the present legislation there is debate about whether the coroner is even permitted to return a verdict of suicide. The process is further complicated in that the special form filled out by police is only completed 95% of the time (Connolly, Cullen, Walsh, McGauran, & Phelan, 1999). Another author, F. Hogan (1999) suggested:

> It is generally accepted that figures for suicides in Ireland may have been under-represented historically. Some of the increase in the currently reported rate of suicide may be, in part, due to the decriminalization of suicide in the Criminal Law Suicide Act 1993, and to the rapid changes in religious influence in Ireland. (p. 24)

The decriminalization of suicide and changes in religious influence are just two of numerous speculations underlying this complex phenomenon.

While debate about the accuracy of the statistics will continue, there is agreement that there has been a substantial increase in the reported rate of suicide in Ireland. In 1945 there were 71-recorded suicides. By 1997 there were 443 (Aware, 1998). The year 1998 saw a 15% increase in suicide from 1997 with 504 deaths recorded as a result of suicide. Since 1995 there have been 5000 reported attempted suicides, which translated into twelve attempts for every suicide (Timmins, 1999). Accompanying the documented increase in reported suicide rates is the acceptance of a conjoint study by the Central Statistics Office and the Southern Health Board, which suggested "that the official suicide rate may be under-reporting the true suicide rate by some 15% to 20%," (Kelleher, 1996, p.16).

Gender Differences

The rise in reported suicide rates in Ireland, first identified in 1987, has been confirmed by many studies (Kelleher, Heeley, & Corcoran, 1997). Kelleher (1997) proposed that the female rate of suicide was generally only a third of the male rate, a phenomenon that was typical throughout the Western world. Kelleher et al. (1997) stated, "the average national suicide rate for males over the years 1976 to 1994 is almost three times that of the females (12.9 and 4.5 per 100,000 for males and females respectively)"(p. 262). However, the ratio for the age group of 15-24 year olds may have been higher. Kelleher (1998a) documented the ratio for the age group of 15-24 year olds, for the years 1988-1992, was 7.1: 1. This represented the highest ratio for all countries that returned statistics to the World Health Organization (WHO).

While the majority of researchers agreed that Irish males, especially those aged between 15-24 were more at risk for suicide than Irish females, there appeared to be disagreement about how much more at risk males were than females. Birchard (1998) stated that recent "reports by WHO and in several journals have shown that young Irish men are seven times more likely to kill themselves than women-the highest ratio in the world " (p. 1452). Yet, according to the National Suicide Research Foundation males were five times more likely than females to commit suicide (Timmons, 1999). Aware (1998) suggested in Ireland the low rate of reported suicide "in those under 24 years changed in the early 1980s with a gradual increase in the suicide rate in young men, culminating in a four-fold increase in the rate in this age group between 1990-1996 " (p. 6).

There was not complete agreement in the professional literature about a disparity between the number of males and females who attempt suicide. One policy paper, written by the organization Barnardos, suggested that women were more likely to (a) attempt to kill themselves, and (b) engage in parasuicidal behavior (Barnardos, 1999). Another author supported this view when he suggested that while "there are now as many men as women attempting suicide in Ireland, men are also choosing more violent ways of killing themselves, and are therefore succeeding" (F. Hogan, 1999, p. 24). Regardless of the discrepancy regarding male and female suicide it is now believed based on reported deaths that suicide is the leading cause of death in young people in Ireland. Suicide has exceeded accidents and cancer, and the figures are still considered to be underreported (Aware, 1998).

One author looked at perceived gender role differences as a way to examine the gap between male and female suicide rates. Birthistle (1999) suggested that rigid gender role stereotypes and beliefs in Irish society might have had an impact on suicide rates among males. He stated that "due to male gender role pressure to be self-reliant, assertive, and emotionally inexpressive, men's options to cope with problems may be considerably reduced, and this may lead to hopelessness and increased suicidal ideation" (p. 4). The results of this study suggested that males who increased their restrictive emotionality might have experienced an increase in feelings of hopelessness, fear, and anxiety. Birthistle said "unexpressed emotions, fear and anger, can be internalized, causing chronic depression, self-hate and serious health problems and may possibly be resolved through suicide"(p. 5). This concept was supported by another researcher (F. Hogan, 1999), who discussed socially constructed gender

differences as a key reason for the dramatic differences highlighted between men and women suicides. Men were not supposed to be vulnerable, at least in appearance. This worldview may have led to the belief that men felt they could not avail themselves of the different types of therapy and supports available. Thus, men contained their emotions and hid their vulnerabilities, and did not seek help for their problems.

Psychosocial Factors

The literature tended to be less divergent on factors that contributed to an Irish citizen choosing to attempt or complete the act of suicide. The Report of the National Task Force on Suicide (1998), presented that suicide risk was greater where there was (a) recent loss/break up of a close relationship, (b) unhappy change in health/circumstances, (c) chronic physical illness, (d) use or dependency on alcohol or drugs, (e) history of suicide in family, (f) history of suicidal behavior, and (g) depression.

One survey of Irish people's attitude towards depression and those suffering from depression found that 60% of people did not consider depression a form of mental illness (McKeon & Carrick, 1991). Another finding of this study indicated that Irish people did not perceive depressed individuals in a negative way. However, in actuality behavior indicated otherwise. A follow up study found that only 25% of people living in rural areas, and 15% of people living in urban areas would consider a consult with a doctor for depression. Not only was there a reluctance of sufferers to consult with a doctor, but also there was a widespread ignorance about depression and

its effects on people suffering from depression and their families (McKeon, Gavigan, & Carrick, 1996). Thus, most people suffering from depression in Ireland continue untreated.

Aware (1998) also posited that suicide might also result from a domino effect of three components: depression and related disorders, traumatic losses in life, and depressing effects of alcohol/drug use and abuse. Malone (1999) suggested the "increase of Irish suicide rates, particularly amongst younger males may in part be explained by the rise in youth alcohol consumption in Ireland and its suggested toxic effects on sensitive brain neurotransmitter pathways, which protect against suicidal impacts in the context of depressive feelings and dysphoria" (p.121).

There were alternative explanations of suicide offered in these articles. Aware (1998) suggested that 90% of people who commit suicide had a diagnosable psychiatric disorder. Others agreed. Malone (1999) emphasized that there may be factors within the individual especially of a biological nature that predisposed them to suicidal acts during times of stress.

Prevention Strategies

The suggested solutions for addressing suicide in Ireland most often targeted schools and school aged youth. Thus, the reviewed literature often proposed recommendations for the educational system in Ireland. The publication Counselling the Adolescent in a Changing Ireland: National Survey of Second Level Schools in Ireland (1993) was an example of this literature. According to this report, there were

383 students in Irish secondary schools identified with suicidal tendencies in 1992. Schools in which students were enrolled represented 48% of all secondary schools in the country. A further 189 students were identified as participating in self-inflicted violence. These students were enrolled in 17% of all secondary schools in Ireland. Though these schools had guidance counsellors "the more serious problems such as suicidal tendencies, self-inflicted violence, emotional withdrawal and depression get passed on to professional counsellors" (Ryan, 1993, p. 40). However, this referral activity was problematic. Ryan reported many complaints from guidance counsellors about inadequate mental health back-up services for schools. Counsellors reported that referring to outside professional agencies seemed futile as these services had long waiting lists and could not respond immediately (Ryan).

Seven years later it would appear that the inadequate mental health situation has not improved. For instance, a survey by the Association of Secondary Teachers in Ireland, found that 13% of secondary schools had reported a suicide. Many teachers said there was a need for guidelines on how to respond to the death of students through suicide or other traumatic events (Walshe, 1998, p. 13).

The influential publication Suicide in Ireland: A Global Perspective and a National Strategy (1998) called for schools to adopt preventative strategies in dealing with the issue of youth suicide. Educational programs in the schools were considered essential to address the alienation of young people and the addressing of youth suicide. This report considered that the most efficient way to address youth suicide prevention in the long term was through the educational system and the media (Aware, 1998).

The Barnardos organization, which works to improve the general welfare of children and families in disadvantaged areas in Ireland, acknowledged that youth suicide was a growing reality and a reality that was difficult for society to acknowledge. It recommended a range of counselling and support services for young people and their parents. It questioned the counselling and psychological services available in schools, which, even if they existed, were understaffed. It was clear, from their report, that schools in Ireland needed guidance on how to bridge to suicide prevention services in the community (Barnardos, 1999).

The rationale for the majority of preventative strategies focusing on the Irish educational system and youth may be because adolescents have the highest rate of suicide in Ireland. Therefore an examination of adolescent suicide in Ireland is warranted.

Adolescent Suicide in Ireland

Rate

Kelleher (1997) predicted that it was likely that in the future, suicide would become the leading cause of death among young Irish males, surpassing the current leading cause of road traffic accident deaths. Kelleher emphasized that the rise of suicide rates among young Irish males was part of an international trend. By 2001, suicide has become the most common cause of death among 15-24 year olds in Ireland (D. Hogan, 2001).

The suicide rates for adolescents in Ireland are still relatively low as reflected in Table 1. The rates are low when compared to the rates in America and Australia. Leane and Shute (1998) stated Australia had "the highest rate of adolescent suicide in the world, with 16.4 per 100,000, for those ranging in age from 15-25" (p. 165). K. King (2000) reported that the rate for adolescent suicide in America had increased more than 300% from 2.7 per 100,000 in 1950 to 11.1 per 100,000 in 1990. The rate of adolescent suicide in Ireland is less than 1 per 1,000. However, the total population of Ireland is approximately 3,500,000, and in the last eight years 733 adolescents died as a result of suicide. The number of families, friends and peers affected by these acts was conservatively estimated as five thousand by Kelleher (1997). The number of adolescents committing suicide has steadily risen each year, with the exception of 1999, culminating in suicide being the most recorded reason for the death of an adolescent (D. Hogan, 2001).

Table 1

Suicide Rates for Adolescents in Ireland 1992-1999

Year	Number of suicides for 15 - 24 yrs old	Total population of 15-24 yrs old	Estimated true rate for 15-24 yrs old	Nationwide total of suicides
1992	74	610,100	88	363
1993	54	615,900	64	327
1994	82	621,100	98	395
1995	87	625,600	104	404
1996	96	632,900	115	409
1997	104	642,500	124	444
1998	138	652,600	165	504
1999	98	657,900	107	439
Total	733		865	3285

Impact

Suicide as a form of death is still a comparatively rare occurrence as only a little more than 1% of deaths in Ireland are due to suicide (Kelleher, 1997). Amongst the young however " the proportion of deaths due to suicide appears larger because today death is very rare in this age group (Kelleher, Heeley, & McAuliffe, 1998, p. 27). Kelleher states that every day at least one person ends their life in the Republic of Ireland. If such a person has on average six relatives, then every day six people are affected by the act of a suicide. Para-suicide is approximately 20 to 25 times more common than suicide, which means each day 25 people make a suicidal attempt and these attempts impact 150 additional people. In summary, almost 2500 Irish people are affected by the act of a completion of suicide each year. In addition over 60,000 Irish people are directly impacted by the social and psychological impact of acts of attempted suicide.

Contributing Factors

There are many factors that can contribute to an adolescent contemplating, attempting, or completing suicide. The influences of developmental state, religious beliefs, family, gender differences, alcohol use, changes in education, and social services, on adolescent suicide in Ireland are discussed in this section.

Developmental state. Kelleher (1996) proposed that two factors might have contributed to the situation of increasing suicide rates in Ireland. The first of these

related to the individual and was likely to be shared with young people worldwide, the period of adolescence. If adolescence was "construed as the period between puberty and one's first job, then the length of adolescence has greatly increased throughout the twentieth century" (Kelleher, 1996, p.21). The period of adolescence was traditionally seen as a time of stress when adolescents worried that their intentions, motives, behavior and personality were being examined by the people around them (Kelleher et al., 1998). Suicide appeared to be a viable solution for adolescents to cope with stressful situations (O' Sullivan & Fitzgerald, 1998).

Religious beliefs. Kelleher (1996) proposed that the second contributing factor related to changes in Irish social and cultural life. Ireland is by its constitution a Catholic country with 94% of the population Roman Catholic (Kelleher, 1998a). However, Ireland has witnessed changes in religious practice, worship and beliefs. Kelleher (1998a) stated religious and doctrinal belief had waned "for example, in such concepts as hell, infallibility of the Pope and the Bible as the word of God" (p. 196).

Recent work has shown that religious denomination, even if one was not practicing does influence suicide rates. If Catholicism had some protective quality against suicide then Ireland should have a low rate of suicide by comparison with Britain. In the past this has been accurate. However "the grip of the Catholic Church on the minds of the people has weakened over the past two or three decades" (Kelleher, 1996, p. 24). Kelleher also purported that the general outlook on life in Ireland has changed from the religious to the secular, and must have affected how Irish

people responded to stress. As religion lost its hold its capacity to allow sublimation of troubles and disappointments diminished (Kelleher).

Family. The last two decades have witnessed significant changes in family life in Ireland. The traditional nuclear family gave way to different family configurations. Kelleher (1998a) argued these changes in family structure might provide one reason for higher rates of male suicides. Divorce was only legalized in Ireland in 1996, however prior to the introduction of divorce the number of legal separations had been increasing over the years. The usual occurrence in a separation was for the father to leave the family home, "therefore male role-models for adolescents may be perceived in a less permanent and more negative way today than they were twenty years ago" (Kelleher, 1998a, p. 197).

Gender differences. As noted earlier, the most striking rise in Irish suicide rates has been among young males. The disparate patterns of suicide among young Irish males and females raised important and complex questions. They suggested "that whatever stresses our young people encounter, boys are more vulnerable than girls" (Kelleher, 1996, p. 19) The author noted that this followed a worldwide trend that men were more predisposed to suicide than women.

The socialization of boys and girls in Ireland provided some insight as to why boys were more likely to commit suicide. Kelleher (1996) proposed that it was likely that girls had traditionally received a broader emotional education than boys. Boys might have been taught to define themselves by what they did, versus girls who were

taught to define themselves by who they were. Any expression of emotion may have been seen as more acceptable in girls than boys. Girls were typically more in touch with and better able to discuss their feelings than boys.

The commonly used expression "Boys don't cry" may be a dangerous one. "It is important to be in touch with one's own feelings; to be able to express them to oneself as well as to others, and to recognize that seeking help is not a sign of permanent weakness" (Kelleher, 1996, p. 41). If boys viewed expressing feelings as a sign of weakness they might have been less likely to admit feelings of despair, depression, hopelessness, etc. to themselves or others, and thus not seek help from others. Kelleher (1997) reported that in a psychological autopsy carried out by the National Suicide Research Foundation only one in five young men who committed suicide were known to have been in contact with a health service in the year before they died. Kelleher (1998b) stated when women died by suicide it was usually after they had sought help and this "greater tendency to seek help may be one of the most important explanations for the lower rate of female suicide" (p.107).

Drug and alcohol use. The use of drugs and alcohol may also contribute to adolescent suicide. Kelleher (1996) found a high correlation between youth suicide rates and drug convictions. He continued to iterate that one may not be causatively related to the other, but there were two ways they could be connected. Firstly, some suicide victims may have abused drugs. Secondly, the increase in street drugs usage in Ireland might reflect " a malaise within our society, one expression of which is an increase in deliberately self-inflicted deaths" (p. 42).

The relationship between alcohol and suicide was very complex. There were psychological explanations for the effect of alcohol on an individual. Alcohol reduced impulse control and affected serotonin metabolism. Low levels of brain serotonin have been shown to be associated with aggression, either directed towards oneself or others (Kelleher, 1996).

Changes in education. Kelleher (1998b) discussed the Irish educational system and how it had changed dramatically in the last thirty years. In 1971, only 28% of 15-24 year olds were still in school. By 1991 this percentage had risen to 46%. The gender ratio had also changed. University places (third-level places) were filled 62% of the time by males in the academic year 1975/76. This ratio fell steadily. The 1995/1996 school year was the first year in Irish history, where the majority of third-level students were female. Access to third level education was dependent on the number of points achieved in the state Leaving Certificate examination. The entry points/requirements for courses had increased each year, making competition for places very intense. Kelleher (1996) proposed that males might have experienced a more stressful time achieving educational success. Because female students did better overall in the Leaving Certificate, many high prestige subjects/courses now had more female students than males. This may have put added pressure on the male students.

Economics. A further stress on adolescence may be the possibility of unemployment (Kelleher, 1996). The job market in Ireland is continually changing. Nowadays, few jobs last longer than five years. "The threat of unemployment and the

fear of job curtailment is at least as harmful, psychologically, as actually being unemployed" (p.44). Kelleher also suggested that there appeared to be an association between the young male suicide rates and the overall unemployment rate.

Social services. Kelleher et al. (1997) examined suicide rates and services in the different areas in the Republic of Ireland. The counties with the highest suicide rates in this study were predominantly rural, and those with the lowest rates were predominantly urban. The authors articulated the difficulties in delivering services in rural areas with low population densities. These rural areas were often far from specialized centers of care. There may have been considerable problems of transportation, including financial and professional time costs. Vulnerable individuals in country areas may have found it more expensive and more difficult to make use of available resources (Kelleher et al.). This may be considered one explanation for the discrepancy in suicide rates in urban and rural areas.

Kelleher (1998b) proposed that young people lacked awareness of relevant services. A survey of 93 third-level students indicated that less than 50% knew of where they could go in times of distress. The service that most students were aware of was a telephone crisis hotline called The Samaritans. None of the students mentioned a medical doctor or local medical service. Kelleher concluded it appeared "that professional health services might need to put more emphasis on encouraging and facilitating help-seeking behaviors in this age group" (p. 107).

Guidance Counsellors in Ireland

The role and history of guidance counsellors in Ireland is fundamental to this study. The history of the profession and the core role areas as outlined by the professional organization, the Institute of Guidance Counsellors in Ireland will be reviewed.

History

The emergence of counselling as a distinct profession in Ireland began in the 1960s (O' Leary, 1990). Counselling in Ireland began in a unique setting where the Irish person had the expectation that their extended family (e.g., grandparents, uncles, aunts, nieces and nephews) could be relied on in times of crisis (O' Leary). Thus, the original emphasis in Irish counselling was on family relationships and informality (O' Leary).

Guidance counsellor preparation began in 1960, with the establishment of a Guidance and Counselling Unit by the University College Dublin (Chamberlain & Delaney, 1977). University College Dublin in 1967 established a 1-year full-time course in guidance and counselling which resulted in a postgraduate diploma in guidance and counselling (O' Leary, 1990). In 1968 the Department of Education established two-week guidance courses "for teachers who on completion of these courses would assume responsibility for guidance in their respective schools" (Chamberlain & Delaney, 1977, p. 50).

An Advisory Committee on Pupil Guidance was formed and assessed "the ambiguity surrounding the status of guidance in schools" (Chamberlain & Delaney, 1977, p. 50). The committee "felt that the form taken by school guidance in Ireland should meet the distinctive educational and cultural needs of Irish society" (p. 51). One of the recommendations of this committee was the phasing out of the short-term courses in guidance in 1971. Another recommendation was the release of teachers in schools where the number of students exceeded 250, to attend a full-time course in guidance and counselling.

The Department of Education (referred henceforth as "Department") encouraged schools to introduce a guidance service by introducing incentives described in this paragraph. The Department placed the position of a guidance counsellor outside the quota of teachers allotted to a school. The Department also agreed to provide subsidies for the purchasing of guidance material by the school. The Department paid for the salaries and fees of teachers who were attending guidance courses. This financial incentive however was eliminated in September of 1975 due to an economic recession in Ireland. The Department also insisted on some mandatory requirements including: (a) the guidance counsellor spent no less than three hours teaching in a classroom and (b) at least twelve hours per week was spent doing guidance work (Chamberlain & Delaney, 1977).

By 1979 Ireland had four hundred guidance counsellors in secondary schools (O' Leary, 1990). The ratio of students to guidance counsellor was 250 to 1 and guidance counsellors were overworked (O' Leary). Economic problems in the early 1980s resulted in the ratio rising to 500 students to 1 guidance counsellor. There are

currently approximately 600 guidance counsellors working in secondary schools in Ireland.

Organization of the Profession

The Institute of Guidance Counsellors is the professional organization for guidance counsellors in Ireland. The Role Document promulgated by the Institute of Guidance Counsellors, 1995, defines the scope of practices for guidance counsellors. All citations in the Role section are direct references from the Role Document. This document "seeks to reflect 'best practice' for the unique Irish guidance and counselling service for all who seek to avail of it" (p. 1). The primary purpose of the document "is to provide useful guidelines to assist guidance counsellors in planning and fulfilling their role and function in the context of the school ethos, culture and environment in which they work" (p. 1). The document is not prescriptive but rather a guide and is written with the view of the recommended ratio being 1 guidance counsellor per 250 students.

Role Document

The Role Document outlines the core areas of responsibilities of Irish guidance counsellors. This section will describe these areas as proposed by this document.

Core areas. The guidance counsellor has three core areas of responsibility, which are (a) personal counselling, (b) educational counselling and (c) career

counselling. Personal counselling includes individual counselling, group counselling, and supervised peer counselling. The Role Document states:

> Counselling is an essential and integral part of the school's educational provision. Counselling facilitates the individual students/clients in a holistic way to realistically appraise their abilities, interests, and aptitudes in order to make appropriate life choices and achieve personal happiness and fulfillment in society. (p. 10)

Furthermore, it is important to note that counselling only takes place when an individual requests it, and is willing to participate in the process. Thus, there are no provisions within Irish school guidance for a systematic and developed guidance program that by design reaches all students.

Core area: Personal counselling. As noted above personal counselling is delivered in three formats. The Role Document defines individual counselling as an "interaction process which facilitates meaningful understanding of the self and environment and/or clarification of goals and values for future behavior"(p. 10). Group counselling encapsulates all types of counselling including two or more people. There are many potential formats for group counselling however, the role document only mentions the following process, "the idea with most of them is that members listen to, support and challenge each of the members, who thus learn to be assertive and to experience how other people see them" (p. 10). Peer counselling is defined as "a variety of interpersonal helping behaviors assumed by non-professionals (i.e. students/clients etc.) who undertake a helping role with others (i.e. guidance counsellor)" (p. 10). If the student's problem is one that the guidance counsellor feels

their expertise is inadequate to deal with the problem effectively "then the guidance counsellor will refer the student to a more specialized service where such is available, and will monitor progress of such a referral" (p. 10).

Core area: Educational counselling. The second core area of responsibility for a guidance counsellor is educational guidance. This area is described as being developmental in nature and begins with the student's entry to the secondary school. It includes "assistance in the areas of subject choice, study skills and examination techniques, learning–related problems, opting for non-traditional areas of study" (p. 11). Educational guidance can also assist parents in helping their children to make academic choices. Thus, educational guidance incorporates the following sub-areas: psychometric testing, study skills and examination techniques, counselling for learning-related problems, teacher consultations, motivation, course selection and program selection.

Core area: Career counselling. The third core area of responsibility for a guidance counsellor is career guidance. Career guidance is a process that begins when the student enters secondary school and continues until the student leaves the school. Career guidance "has vocational, educational, social and personal dimensions which cannot be isolated in practice" (p. 12). The following are the components of the career guidance process: career information management, pathways to vocational education, pathways to higher and technical education, decision-making skills, planning skills,

unemployment coping skills, job search skills, interviews, work experience, aptitude, intelligence, interest testing, and employment opportunities awareness.

Role with developmental programmes. The guidance counsellor also has a role to play in developmental programmes and work preparation programmes. The guidance counsellor has "particular skills in group developmental work focusing on life skills such as: decision-making skills, conflict- resolving skills, relationship and communication skills, time-management skills etc." (p. 13). These developmental programmes include: life skills education, health promotion, pastoral care, social and personal development, work based experiences, and career planning.

Developmental programmes also include the guidance counsellor's role in test administration and interpretation. Guidance counsellors are "trained administrators and interpreters of psychological and other standardized educational tests" (p. 14). Thus, the guidance counsellor is responsible for the "maintenance of professional standards in the administration, interpretation and dissemination of tests and the results" (p. 14).

The gathering of information, and its organization and dissemination is also a role of the guidance counsellor. The main function is to provide the most information possible "on the widest range of options open to students/clients and on any other matters which can help students/clients to cope better with their concerns (e.g. legal rights, trade unions, helping agencies, health related matters, study skills etc.)" (p. 15). Information management involves the following areas: class/group work, information technology/computer access, research, managing the guidance library, exhibitions,

parent meetings, college open days, work place visits, and visiting speakers. Information management also involves consultation with parents and staff.

Administration of guidance and counselling services. The final role of guidance counsellor is in the administration of the guidance and counselling services. Part of the guidance counsellor's "time each week will be spent in clerical, secretarial, and administrative duties" (p. 16). These duties encompass the following tasks: development programme planning, programme negotiation and time-tabling, report writing, evaluation of the service in conjunction with the school plan, correspondence, phone calls, filing and office organization, and information collation.

Research on the Role of Guidance Counsellors

This section will review the research conducted on the role of guidance counsellors in Ireland in the 1980s. The reason why no research was conducted in the 1990s may stem from the fact that there were no major educational reforms regarding guidance counsellors conducted in the 1990s in the Irish educational system.

O' Brien, Tuite, McDonagh and Deffely (1982) examined the role of guidance counsellors from the perceptions of teachers and counsellors. The authors stated, "there were not too many areas of difference in the perception of the role of counsellor as seen by themselves and by classroom teachers" (O' Brien et al., p. 35). There was a significant difference in perceptions when it involved the counsellor's activities that may have infringed upon the teacher's activities in their classroom. These counsellor

activities included withdrawing a student from a class or using class time to administer a test (O' Brien et al.).

Another difference in perceptions that the authors, O' Brien et al. (1982) articulated was in the area related to the support classroom teachers received from the counsellors. The differences in teachers' expectations of support occurred in areas such as disciplinary matters, providing access to students' test scores, student rules, and the coordination of pre-employment services. However, in their conclusion the authors stated that from their comments it was obvious that teachers appreciated both the role and the function of the guidance counsellor.

O'Leary and Adams (1986) examined the classroom responsibilities of a guidance counsellor. The findings of their survey of 265 guidance counsellors suggested that the circumstances regarding the number of hours spent teaching subject classes each week was contrary to the wishes of guidance counsellors. The authors stated that guidance counsellors found their teaching loads excessive and requested they be reduced. The maximum amount of time spent on subject teaching according to the results of the study was between 0 and 5.5 hours per week. O' Leary and McCay-Morrissey (1987) corroborated this finding and stated that 42% of guidance counsellors believed the ideal amount of time spent on subject teaching was 3 hours. Another finding of O' Leary and McCay-Morrissey also proposed that effective communication was essential between guidance counsellors and school administrators in order to remedy the disparity in the number of hours counsellors were expected to be teachers in the classroom. O'Leary and Adams proposed that guidance counsellors

were succumbing to pressure exerted by school authorities when they really wished to be more involved in the school's guidance counseling service.

O' Leary and McCay-Morrissey (1987) examined the time spent by guidance counsellors on various duties. One finding indicated that guidance counsellors spent two-thirds of their time on guidance and counselling activities and the remaining one-third on non-guidance and counselling activities. This one-third seemed to be a considerable percentage of guidance counsellors' time spent on non-guidance and counselling activities, especially as the guidance counsellors asserted they needed more time for their guidance and counselling activities. This finding raised the question of whether this time allotment was a matter of choice or a decision by the school administrators.

O' Leary and McCay-Morrissey (1987) had another interesting finding on how guidance counsellors spent their time. They reported that only 2.5% of counsellor time was spent engaging in parent contact. The authors questioned this given the influential role of parents in their adolescent's life and believed guidance counsellors needed to pay more attention to getting parents involved in the guidance and counselling process.

O' Leary and McCay-Morrissey (1987) had one final finding which suggested that guidance counsellors spent between five and seven more hours per week doing school-based activities than is the normal practice. This suggested that the allotted time for guidance and counselling activities was insufficient for the guidance counsellor to meet all the demands of their job. The authors proposed that since guidance counsellors spent one-third of their recorded time on non-guidance

counselling activities a solution was needed. The proposed solution encouraged guidance counsellors to restrict themselves to guidance and counselling activities only. This suggested action would involve the negotiation of the role guidance counsellors with school administrators.

Do the findings from the role research literature of the 1980s still hold today? In the absence of any empirical refuting or the implementing of major educational reforms in the intervening years, it is posited that the findings of these studies still hold.

Adolescent Suicide Prevention in Ireland

Introduction

Counsellors are on the front line for identification and prevention of adolescent suicide (Stefanowski-Harding, 1990). Thus effective combating of adolescent suicide falls primarily to the counsellor in a school. In Ireland it is the guidance counsellor who assumes this role as part of their responsibilities as outlined in the Role Document (Institute of Guidance Counsellors, 1995). Given this defined role responsibility, an examination of the literature that describes the necessary components for counsellors in schools to be successful at identifying and assessing students at risk for suicide is necessary.

Suicide prevention in schools can be separated into two distinct yet related levels. The first level is primary prevention, which generally refers to efforts made to

intervene with individuals before any problems occur (Miller & DuPaul, 1996). The second level is secondary prevention involving the identification of problems in individuals while they are still minor problems (Miller & DuPaul).

Knowledge of Contributing Factors to Suicidal Behavior

The effectiveness of primary or secondary suicide prevention depends on the counsellor's knowledge of the contributing factors or antecedents of suicidal behavior (Bolger, Downey, Walker & Steininger, 1989; Perrone, 1987; Crespi, 1990). Popenhagen and Qualley (1998) propose that success of any prevention effort hinges upon the counsellor's familiarity with the contributing factors of suicidal behavior. These contributing factors are often the first signal that the adolescent needs help from a professional. Thus, the guidance counsellors in Ireland need to be knowledgeable of the aforementioned myths and contributing factors to suicidal behaviors. Similar to many counsellors in schools they may be the first professional confronted with the symptoms or threats of suicide (Peach & Riddick, 1991; Stefanowski-Harding, 1990).

Interviewing an Adolescent At-Risk for Suicide

It would be erroneous however to "assume that the more factual information one has about suicide the better that person is to respond to suicidal people" (Inman, Bascue, Kahn, & Shaw, 1984, p. 183). Success depends on a combination of knowledge and specific interviewing techniques (Inman et al). Counsellors must

possess knowledge of the types of questions that can elicit information on suicidal tendencies (Crespi, 1990).

Martin and Dixon (1986) outline key aspects of the interview between a counsellor and an adolescent considered at risk for suicidal behavior. The success of the interview depends on an initial establishment of a relationship with the adolescent. Success is important, as the primary objective is to keep the adolescent alive and safe. The counsellor should offer support, hope and help while "simultaneously assuming the role of authority and exemplifying an air of confident professionalism" (p. 268).

The beginning stages of the interview should include the obtaining of general demographic information such as names and telephone numbers of significant family members or friends (Martin & Dixon, 1986; Crespi, 1990). The student's individual characteristics and an appraisal of any stressors or problems should be conducted (Crespi, 1990). The contributing factors to suicidal behaviors can provide an outline for this procedure (Crespi, 1990). The counsellor evaluates the level of stress within the student and may use a supplementary scale to gather information, to supplement the findings of the interview (Martin & Dixon).

If the student presents with a suicidal plan the counsellor should investigate three elements of the plan. The first is the specificity of the plan's details. The second is the lethality of the proposed method in the plan. The third is the availability of means open to the student to follow through with the plan. These three elements will provide the counsellor with the information necessary to decide on the appropriate actions to take. The counsellor should conclude the interview by obtaining the student's signature on a contract to live (Martin & Dixon, 1986).

School Suicide Prevention Policy

Coy (1995) recommends that schools should have a written suicide prevention policy. This policy should be presented to and reviewed with all staff members at the beginning of each school year (Coy; Popenhagen & Qualley, 1998). The policy should include: (a) an overview of the scope and severity of adolescent suicide, (b) how to recognize a student at-risk, (c) the contributing factors associated with suicidal behavior and (d) how to approach a potentially suicidal adolescent (Coy). This would be one of the consultations with administrators and staff that guidance counsellors in schools in Ireland are responsible for conducting (Institute of Guidance Counsellors, 1995). Schools that have a written policy on suicide are considerably more comprehensive and systematic in their approach to the prevention of adolescent suicide (Malley, Kush, & Bogo, 1994).

Education of Students

Guidance counsellors in Ireland are responsible for educational counselling (Institute of Guidance Counsellors, 1995). The education of adolescents about suicide prevention is imperative (Wodarski & Harris, 1987). This education is imperative as "most suicidal adolescents first go to their peers for help, rather than go to trained professionals or teachers" (Popenhagen & Qualley, 1998, p. 33). Friends and students must be educated in how to handle a crisis properly (Popenhagen & Qualley). However, the success of the education of adolescents on suicide prevention depends on the comfort level of the presenter in discussing the dynamics of suicide (Wodarski

& Harris, 1987). Thus, guidance counsellors must be comfortable with the material to facilitate discussion and respond to questions.

Classroom sessions on suicide are very beneficial to prevention (Kalafat, 1990). The basis of the sessions should include: (a) increasing awareness among students of adolescent suicide, (b) training students to recognize possible contributing factors to suicidal behaviors in adolescents, and (c) providing students with available school-based and community resources they can turn to for assistance (Miller & DuPaul, 1996). The most receptive time for these classroom presentations is early adolescence, years twelve to thirteen (Wodarski & Harris, 1987).

Popenhagen and Qualley (1998) discuss an interesting teachable moment counsellors could use during classroom sessions. The counsellor presents a fictitious person's life events on a timeline beginning at birth, and continuing to death by old age. The counsellor then remembers that the fictitious person committed suicide during their adolescent years. The class is then invited to discuss their reactions to the suicide. Thus, students receive a simulated effect of suicide without a real person dying.

Education of Parents

The education of parents should accompany the education of staff and students (Coy, 1995; Malley et al., 1994; Perrone, 1987). The primary reason for this education is the fact that most adolescent suicides occur at home (Malley et al.). Communication from school to parent decreases as a student progresses through school. By high

school there is minimal communication from school to parent. Home to school and school to home communication needs to be increased to assist in the success of the prevention of adolescent suicide (Perrone, 1987).

American Literature on Adolescent Suicide

The importance of cultural differences in examining adolescent suicide must be seriously considered. Adolescent suicide is not solely an Irish concern but rather a phenomenon that transcends all cultures. The World Health Organization ranks suicide as the second leading cause of death worldwide, with 800,000 cases per year (Parker, 1998). However, not every nation has experienced a rise in youth suicide rates (Lester, 1998). The fluctuations in rates in different countries could be explained by individual religious and cultural beliefs (Jilek-Aall, 1988). Suicide in Norway is very rare where "self-destructive behavior is abhorred and viewed as cowardly and senseless" (Jilek-Aall, p. 98). In sharp contrast to this Norwegian view, Japanese culture has a tendency to "glorify suicide as the ultimate expression of self-control and courage and it offers several patterns for ritualized suicide" (Jilek-Aall, p. 98). Japan has one of the highest suicide rates and epidemic and mass suicides are common occurrences (Jilek-Aall).

However, there are common myths about suicide that transcend cultural differences. This section will begin by first addressing those myths. The second part will review the literature on contributing factors to suicidal behavior in American adolescents.

Myths

There are many myths that persist about the phenomena of adolescent suicide. The most prevalent myth is that adolescents who talk about suicide are not serious about it (Capuzzi & Golden, 1988; Curran, 1987; K. King, 1999; Martin & Dixon, 1986; Neiger & Hopkins, 1988). This belief that those who threaten suicide are less likely to do it "is supported by the insinuation that threats of suicide represent attention seeking behavior, especially among the young" (Curran, 1987, p. 134). In reality suicide attempts are often carried out by adolescents to "check out the level of caring and responsiveness that exists out there for them in the world" (Curran, p.134).

Contrary to popular belief suicide does not happen without any warning. Most suicidal adolescents give numerous hints or clues prior to their actions (Capuzzi & Golden, 1988; K. King, 1999). A related myth is that one should never use the word "suicide" when talking to an adolescent as it may "put ideas in their head" (Capuzzi & Golden; K. King). K. King supports the education of teenagers about suicide, as it does not lead to increased suicide attempts. In actuality the use of the word suicide can assist the adolescent in verbalizing their feelings and it also demonstrates to them that the person they are talking to is not afraid to approach the subject of suicide (Capuzzi & Golden).

Many people erroneously presume that once adolescents are suicidal they must always and forever be considered suicidal. Suicidal ideation usually lasts for a limited period of time. The twenty-four to seventy-two hour periods around the peak of the crisis is the most dangerous (Capuzzi & Golden, 1988). However, there is a related

myth that must be considered. It is not true that when adolescents attempt suicide and survive they will not make an additional attempt. In actuality each following suicide attempt will be more lethal in nature (Capuzzi & Golden). Statistically "four out of five people who kill themselves have made previous attempts, 12% of those who attempt suicide will do so again and succeed within 2 years" (Martin & Dixon, 1986, p. 265).

Many people believe that the majority of people, adults or adolescents, leave a suicidal note or letter. This is not true. Only a small percentage of people do actually leave a note. The percentage of adolescents who commit suicide and leave notes is only 15% (Martin & Dixon, 1986).

Most adolescent suicides contrary to popular belief do not occur late at night, but rather in the mid to late morning or afternoon. This may be because someone is most likely to be around and discover the adolescent (Capuzzi & Golden, 1988; Martin & Dixon, 1996). Martin and Dixon state that suicide in most prevalent in the spring, with April being the peak month, 120% above the average for the remainder of the year. This fact dispels the idea that the majority of people commit suicide during the dark and dreary winter months. Christmas is also a period of high rates because of the "emphasized dichotomy between the depressed person's low alienated feelings and the high feelings generally associated with the so-called "happy season"" (Martin & Dixon, 1986, p. 265).

Contributing Factors to Suicidal Behavior in American Adolescents

Factors found to contribute to suicidal behavior in American adolescents are similar to those found among Irish adolescents. Those factors are depression, family dynamics, use of alcohol and gender issues. Research in America also discusses changes in behavior, past attempts and access to firearms as contributing factors to adolescent suicidal behavior.

Suicidal risk or behaviors in adolescents is somewhat subjective and "varies according to operational definitions and conceptualizations" (Ritter, 1990, p. 83). Thus, there is a lack of consensus on the definitions of suicidal ideation, suicidal attempts and suicide completions (C.A. King, 1997). Lewinsohn, Rohde and Seeley (1996) propose very broad definitions when they state suicidal behaviors fall on a continuum ranging from ideation to attempts to completions. "Suicidal ideations can be defined as thoughts or wishes to be dead or to kill oneself; suicide attempts are defined as self-inflicted behaviors intended to result in death; and suicide completions are self-inflicted deaths" (Lewinsohn et al., p. 26). These broad definitions encompass all aspects of suicidal behaviors, which forms the basis for this section discussing the contributing factors to suicidal behaviors in adolescents.

Curran (1987) outlines four very general antecedents of adolescent suicidal behavior. First, the adolescent experiences a history of problems from their childhood to the beginning of adolescence. Second, the problems of the adolescent escalate for a period of time following the beginning of adolescence. The problems tend to be greater than those normally associated with the turbulent period of adolescence. Third,

the adolescent consistently fails to cope with old problems and increasing new problems. This failure leads to social isolation from social relationships. Finally, there is a chain reaction termination of any remaining important social relationships immediately prior to a suicide attempt.

There is no absolute profile of an adolescent contemplating suicide, contrary to what Wetzler et al. (1996) state that, "adolescent suicide attempters are clearly differentiated from non-suicidal adolescents" (p. 37). It is estimated that as many as 10%-15% of adolescent youth experience meaningful suicidal thoughts within a one week to one month period of time (C.A. King, 1997). The same percentage of adolescents do not attempt or complete suicide. Thus there are multiple contributing factors to be considered when examining suicidal behavior in adolescents.

Depression. Depression is a major contributing factor to suicidal behavior in adolescents (Bettes & Walker, 1986; Martin & Dixon, 1986; Curran, 1987; Neiger & Hopkins, 1988; Culp, Clyman, & Culp, 1995; Wetzler et al., 1996; Lewinsohn et al., 1996; C.A. King, 1997; Committee on Adolescence, 2000; Borowsky, Ireland, & Resnick, 2001). Approximately 50% of all adolescents experience depressed mood (Neiger & Hopkins; Culp et al.). For some adolescents these feelings are temporary and in part are a response to developmental changes occurring during the adolescent period (Culp et al.). This relatively high prevalence of depression among adolescents "clearly contributes to the frequency of suicidal behaviors in this age group" (C.A. King, 1997, p. 73).

Depression is strongly associated with suicidal ideation, but ideation can occur without depression (Lewinsohn et al., 1996). Suicide attempts are also associated with depression (Borowsky et al., 2001). However, many children especially males may not demonstrate the signs of depression (Bettes & Walker, 1986).

The Committee on Adolescence (2000) recommended that all adolescents demonstrating signs of depression should be asked about suicidal ideation, and an assessment of suicidal intent should be made. Depression may manifest itself in psychosomatic symptoms or in behavioral problems. Psychosomatic symptoms include: abdominal pain, chest pain, headaches, lethargy, weight loss and/or dizziness. Behavioral problems masked by depression include: truancy, deterioration in academic performance, running away from home, defiance of authorities, self-destructive behavior, vandalism, alcohol or other drug abuse, sexual acting out and /or delinquency (Committee on Adolescence).

The severity and duration of depression is noteworthy (Curran, 1987). The severity and duration may indicate the presence of a depressive disorder. Adolescents with a depressive disorder are particularly at risk for suicidal behavior. In fact, among adolescents with depressive disorders, one study found that, "85% experienced significant suicidal ideation and 32% attempted suicide by the time of their late teens" (C.A. King, 1997, p. 73).

Family. Family dynamics may increase the risk of suicidal behaviors in adolescents (Molin, 1986; Smith & Crawford, 1986; Jilek-Aall, 1988; Neiger & Hopkins, 1988; Bolger et al, 1989; Beutrais, Joyce, & Mulder, 1997; C.A. King, 1997;

Bell & Clark, 1998; Garber, Little, Hilsman, & Weaver, 1998; Sandin, Chorot, Santed, Valiente, & Joiner, 1998; Borowsky et al., 2001). Sandin et al. state, "family problems appear to be most prominent reported precipitants of suicide attempts" (p. 418). This is not surprising "given that family influences are usually long-standing and cumulative, affecting values, levels of resilience, coping styles and interaction patterns" (C.A. King, p. 76).

Some commonly found family dynamics that contribute to suicidal behaviors in adolescents are: instability, a negative view of family, negative relationships, parental conflicts or marital discord, parents perceived as unhappy or arguing individuals, family violence, loss of a parent, and a history of disturbance in the family during childhood (C.A. King, 1997; Smith & Crawford, 1986; Neiger & Hopkins, 1988; Molin, 1986; Jilek-Aall, 1988; Beutrais et al., 1997). Thus, parent and family connectedness is a protective factor for adolescents at risk (Borowsky et al., 2001). In fact suicide victims are significantly more likely to come from a non-intact family (Bell & Clark, 1998).

An adolescent who is exposed to suicidal threats or behaviors in family members is at risk for emulating the same behaviors (Bolger et al., 1989). Many teenagers who commit suicide have a close relative who has attempted or committed suicide (Bell & Clark, 1998). This risk may stem from the adolescent's perception that death is a viable escape from pain. It also provides a tangible way of rejoining a loved one who has died (Bolger et al.).

Maternal depression is also associated with both family disruption and adolescent suicidality (Garber et al., 1998; Bell & Clark, 1998). Maternal depression

can lend itself to a poor family environment, and less frequent and satisfying communication between parent and adolescent (Garber et al.; Bell & Clark).

Alcohol. Alcohol use is associated with 50% of adolescent suicides (Bell & Clark, 1998). Neiger and Hopkins (1988) hypothesized that this phenomenon amongst adolescents is correlated to the fact that adolescents under the influence of alcohol are more apt to act on impulse, and attempted or completed suicide is often an impulsive act.

Alcohol abuse is a primary risk factor for suicidal behavior (C.A. King, 1997; Jilek-Aall, 1988). More than 50% of completed adolescent suicides occur in adolescents with histories of significant alcohol use problems (C.A. King). When violent crimes, reckless driving and accidents occurring under the influence of alcohol are included the figures for suicidal behaviors amongst adolescents rises sharply (Jilek-Aall).

Gender. In all age groups, females are more likely to attempt suicide and males are more likely to complete suicide (Bolger et al., 1989). In America, six times more adolescent males ages 15-19 years commit suicide, than adolescent females (Committee on Adolescence, 2000). However, females attempt suicide more (Neiger & Hopkins, 1988). Two to three times as many girls as boys report they have made at least one suicide attempt (C.A. King, 1997).

Gender differences in suicidal behaviors appear to be genuine (Culp et al., 1995). One explanation for the higher completed suicide rates among males is their

use of more violent methods than females, for example using a firearm (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999). Approximately 90% of suicide acts using a firearm are fatal as there is little chance of rescue (Committee on Adolescence, 2000). A second explanation is that females tend to be more vocal about their suicidal thoughts and tend to make more frequent self-harming attempts than males (Ritter, 1990). Thus, females exhibiting suicidal behaviors may be more easily identifiable than males.

Behavioral changes. There are some changes in the behaviors of adolescents that may be precursors to suicidal behaviors (Curran, 1987; Capuzzi & Golden, 1988; Martin & Dixon, 1986; Culp et al., 1995; Davis, 1988). These behaviors may be evident in the school environment. They include: declining grades, difficulties in concentrating, changes in mood, changes in interests or hobbies, reckless behaviors, giving away prized possessions, termination of a key romantic relationship, changes in eating or sleeping habits and running away (Curran; Capuzzi & Golden; Davis).

Verbal cues are also very important as people who are thinking about suicide often tell others (Capuzzi & Golden, 1988; Davis, 1988). These cues may be direct or indirect. Some verbal cues include the following: "I can't go on", "I wish I were dead", "There is only one way out", "You will be sorry you did that", and "I am not the person I used to be" (Capuzzi & Golden). Davis says an indirect cue may be in the form of a joke, or through references in school writing or creative assignments.

Adolescents contemplating suicide may move towards social isolation before the attempt (Davis, 1988). In fact according to Martin and Dixon (1986) "25% of suicidal adolescents experience an increase of social isolation before their suicide attempts. Social isolation is the primary variable differentiating true suicide from a suicide gesture" (p. 267). Thus, isolation is a significant contributing factor for many adolescents at risk for killing themselves (Culp et al., 1995).

Past attempts. A past history of suicide attempts is the strongest risk factor for future suicide attempts or completions in all age groups (Lewinsohn et al., 1996; Borowsky et al., 2001; Neiger & Hopkins, 1988; Brent et al., 1999). Approximately one third of suicide completers, and fifty percent of female completers have made at least one previous attempt (Lewinsohn et al.). According to Borowsky et al., the most important correlate for adolescent suicide is a previous attempt as "injurious suicide attempts by adolescents are over 100 times more frequent than completed suicides" (p. 485).

Firearms. The most common method for committing suicide is firearms (McKeown et al., 1998). Firearms are used in more than 67% of suicides, and are the leading cause of death for both males and females who commit suicide (Committee on Adolescence, 2000). The phenomena of using firearms to commit suicide has risen drastically since 1970 when only 25% of suicides were as a result of using a firearm (Berman & Jobes, 1995). As previously stated the use of a firearm is also the method that is most fatal as there is little chance of rescue (Committee on Adolescence). There

is also a strong correlation between substance abuse and suicide victims who use firearms (Bell & Clark, 1998). Thus, adolescents who do not have access to guns in the home are less likely to attempt suicide (Borowsky et al., 2001). According to Bell and Clark (1998) the presence of a firearm in the home "whether locked up or not, whether loaded or not, is associated with a higher risk for adolescent suicide even after controlling for most psychiatric variables" (p. 365).

Self-Efficacy

General Theory

Few theories have exerted more influence on research and practice in counselling than the theory of self-efficacy (Larson & Daniels, 1998). Self-efficacy is an essential component of social cognitive theory. Bandura (1986) proposed the following synopsis of the social cognitive perspective:

> In the social cognitive view people are neither driven by inner forces nor automatically shaped and controlled by external stimuli. Rather, human functioning is explained in terms of a model of triadic reciprocality in which behavior, cognitive and other personal factors and environmental events all operate as interacting determinants of each other. (p. 18)

Social cognitive theory encompasses numerous factors that act as regulators and motivators of an individual's cognitive, social, and behavioral functions. These factors operate through forethought, future thought, predictive knowledge (i.e.,

the ability to predict the outcome of actions), goals, and internal standards (Bandura, 1997).

Bandura (1997) explained the role of self-efficacy within social cognitive theory by saying:

> Perceived self-efficacy occupies a pivotal role in social cognitive theory because it acts upon the other classes of determinants. By influencing the choice of activities and the motivational level, beliefs of perceived efficacy can make an important contribution to the acquisition of knowledge structures on which skills are founded. An assured sense of efficacy supports the type of efficient analytic thinking needed to ferret out predictive knowledge from causally ambiguous environments in which many factors combine to produce effects. Beliefs of perceived efficacy also regulate motivation by shaping aspirations and the outcomes expected for one's efforts. (p. 35)

The theory of self-efficacy emerged originally as a theory of behavioral change. One of Bandura's earliest articles on self-efficacy examined the use of self-efficacy in bringing about behavioral changes in severe phobics (Bandura, 1977). Efficacy expectations are instrumental in bringing about changes in behavior. Bandura defines an efficacy expectation as the "conviction that one can successfully execute the behavior required to produce the outcomes" (p. 193). The four sources of efficacy expectations are: performance accomplishments (later termed enactive mastery), vicarious experience, verbal persuasion and emotional arousal (later referred to as physiological and affective states) (Bandura, 1977, 1997). Thus, self-efficacy is influenced by successful past experiences, positive and credible role models and feedback, and emotional

and physical states. Furthermore, efficacy expectations can differ in magnitude or strength.

Bandura (1997) held that the influences of self-efficacy beliefs can be far-reaching and diverse in nature. He stated:

> People's beliefs in their efficacy have diverse affects. Such beliefs influence the courses of action people choose to pursue, how much effort they put forth in given endeavors, how long they will persevere in the face of obstacles and failures, their resilience to adversity, whether their thought patterns are self-hindering or self-aiding, how much stress and depression they experience in coping with taxing environmental demands, and the level of accomplishments they realize. (p. 3)

In other words Bandura holds that self-efficacy is the ground upon which all behavior change occurs.

The theory was tested in an experiment conducted "wherein severe phobics received treatments designed to create differential levels of efficacy expectations, and then the relationship between self-efficacy and behavioral change was analyzed" (Bandura, 1977, p. 205). Results showed that the greater the increase in self-efficacy the greater the changes in behavior. The focus of the study was not solely on behavioral change. "The theoretical framework presented in the present article is generalizable beyond the psychotherapy domain to other psychological phenomena involving behavioral choices and regulation of effort in activities that can have adverse effects" (Bandura, 1977, p. 204).

Components of Self-Efficacy

There are three essential components of self-efficacy. These components are efficacy expectations, outcome expectations, and outcome values. Efficacy expectations center around the beliefs of an individual, that one can successfully perform a behavior to bring about a desired outcome. The higher the efficacy expectations the more likely it is that the individual will sustain effort through adversity, to obtain the outcome. Thus, in activities "where outcomes are highly contingent on quality of performance, the types of outcomes people anticipate depend largely on how well they believe they will be able to perform in given situations" (Bandura, 1997, p. 23). Outcome values refer to the significance given to an outcome by the individual. The greater the significance, the higher the value the individual places on the task (Bandura, 1997). Thus, people are most likely to engage in and sustain effort in tasks/actions that have a high outcome value, a high outcome expectancy, and involve a high self-efficacy (Bandura, 1977, 1982, 1986, 1997).

Differences in Self-Efficacy

According to Bandura (1997), people differ in the areas in which they cultivate their self-efficacy and in the levels to which they are developed. This difference amongst individuals depends on natural ability, socio-cultural expectations, and circumstances that can be positive or negative. Also, self-efficacy varies across domains of functioning. These beliefs are not just

concerned with exercising control but also include self-regulation of thought processes, motivation, and affective and physiological states (Bandura, 1997).

Skills across all domains must be integrated, organized and effectively utilized in courses of action under differing circumstances. Self-efficacy is determined by the number of skills one possesses and what one believes one can achieve with the skills one has, across numerous circumstances. People with similar skills do not always have similar performances. According to Bandura (1997):

> Efficacy beliefs affect thought processes, the level and persistency of motivation, and affective states, all of which are important contributors to the types of performances that are realized. People who doubt their capabilities in particular domains of activity shy away from difficult tasks in these domains. (p. 39)

Thus, belief can determine a person's successful or unsuccessful performance, despite skill level.

Impact of Self-Efficacy on Performance

Efficacy beliefs can be influenced in three primary ways that can in turn have an effect on performance. First, the level of the task can range from simple to difficult. Thus, providing a variety of challenges that can impact performance. Second, the generality of tasks can impact performance. If skills being asked for are similar to those the individual already possesses, then the individual can generalize his/her efficacy beliefs. Third, the strength of efficacy beliefs can be

influential on performance. An individual with a strong belief will persevere in a difficult task longer, despite obstacles. The higher the self-efficacy, the greater the perseverance, the more likely the activity will be performed successfully (Bandura, 1997).

Thus, self-efficacy affects many aspects of the life of an individual. The level of perceived self-efficacy will (a) determine the decisions or courses of action a person will undertake, (b) how long they will continue the undertaking, (c) how much effort they will expend and for how long in the face of obstacles, and (d) how much their thought patterns and emotions will be influenced (Bandura, 1982). The extensive and pervasive nature of self-efficacy lends itself to wide application in various human behaviors.

Applications of Self-Efficacy

The theory of self-efficacy has been successfully applied to numerous and diverse fields of study. Bandura, in his book Self-Efficacy: The Exercise of Control (1997) applied his theory to depression, phobias, political arenas, organizational structures, coaches and athletes, teachers and students. Other people adapted the theory to conduct studies in the areas such as career choice (Betz & Hackett, 1981) and addictions (DiClemente, 1986). The following section reviews the application of self-efficacy to counselling, school counsellors and suicide prevention.

Counselling

Larson and Daniels (1998) demonstrated the suitability of utilizing the construct of self-efficacy in counselling. These two researchers provided an integrative review of the counselling self-efficacy literature conducted from 1983 to 1998. The review included 32 studies, two-thirds of which had been conducted since 1990. The studies examined the following aspects of counselling: counsellor characteristics, personal agency, counselling performance, the supervisional counselling/work environment, significant predictors of counsellor self-efficacy, and counsellor anxiety. Larson and Daniels espoused counsellor self-efficacy beliefs were "the primary causal determinants of effective counseling action" (p. 180). Thus, positive self-efficacy beliefs were more likely to result in positive counselling outcomes.

Counselling trainees. Ridgway and Sharpley (1990) examined the self-efficacy of counsellor trainees regarding success at learning the basic counselling skills. The authors stated that self-efficacy was one of the variables that could predict counselling effectiveness for a group of counselling trainees.

Larson et al (1999) examined the differential effect on counselling self-efficacy of two common training techniques, namely videotapes of counselling sessions and role- plays with mock clients. These two techniques had been used for many years in training novice counsellors. This study indicated "that trainees' perceptions of their counseling performance success may alter dramatically the potency of role-plays as a means to increase counseling self-efficacy" (p. 239).

Trainees who believed they had not performed well with a mock client experienced a lowering of their counselling self-efficacy. Trainees, who believed they have performed well, experienced an increase in their counselling self-efficacy.

Modeled videotaped counselling sessions seemed to "provide novice trainees a uniformly beneficial intervention with minimal deleterious effect" (Larson et al., 1999, p. 239). Videotapes might be considered a safer though less influential intervention for novice trainees, early on in their skill acquisition. Modeling was also an effective intervention early on in skill acquisition and may increase the chance of the role play being successful by gradually increasing trainees' counselling self-efficacy, thereby increasing the chance that role-plays would be successful (Larson et al.) All of these interventions were specifically derived from Bandura's (1997) theory of self-efficacy.

Friedlander, Keller, Peca-Baker, and Olk (1986) examined the affect of role conflict in a supervision session. Results indicated that role conflict produced few negative effects on trainees' self-evaluations, affect, or behavior. The authors stated that individual differences amongst counselling trainees in performance and anxiety, and between anxiety and counsellor self-efficacy were "important predictors of trainees' counseling-related behaviors" (p. 76). Thus, trainee performance was related to the strength of the trainees' self-efficacy expectations.

Sipps, Sugden, and Faiver (1988) examined the relationship between graduate training and counsellor trainees' self-efficacy when using basic counselling skills. There was a significant relationship between graduate school level of students and efficacy expectations. This finding implied that efficacy expectations increased with experiences of success, a finding supported Bandura's theory. The students' level of

efficacy expectations far surpassed their expressed levels of outcome expectations. Thus, counselling trainees appeared "to possess greater confidence in their ability to make a response of a particular type to a client that they do in their ability to bring about a counselor-intended change in the client" (p.400).

School Counsellors and Suicide Prevention and Intervention

Researchers used the concept of self-efficacy to examine counsellors' performances in their different tasks. One area of research was the ability of school counsellors to deal with the problem of adolescent suicide. King, Price, Telljohann and Wahl (1999) studied a group of American school counsellors and their confidence for recognizing students at risk for suicide. The authors stated counsellors needed to feel confident in their abilities to identify and work with students at risk for suicide. King et al. felt that such confidence was important because when it was lacking counsellors would be less likely to intervene effectively. Outcomes of this study revealed that while most counsellors believed it was their job to identify students at risk for suicide, and that if they did it would reduce the chances of a student committing suicide, only 38% believed they could recognize a student at risk.

King et al. (1999) noted that given their findings serious questions existed regarding the effectiveness of school based suicide prevention and intervention programs. The authors claimed that the confidence of counsellors in recognizing students at risk needed to be raised in order for counsellors to be more effective. Thus,

the confidence of counsellors needed to be high in order for them to successfully fulfill their roles in schools.

The findings of King et al. (1999) were that 74% of counsellors said they believed they could effectively offer support to a student at risk for suicide. Furthermore, 66% said that their schools had a crisis intervention team to handle suicide attempts. It appeared that a key component missing was the ability to identify students at risk for suicide.

K. King (2000) extended the aforementioned study in an attempt to ascertain if high school counsellors knew the risk factors for preventing adolescent suicide. This knowledge base was considered an important aspect of school counsellors' self-efficacy. Part of a person's self-efficacy came from their knowledge and skill base. In fact according to Bandura (1997) self-development of personal self-efficacy required "mastery of knowledge and skills attainable only through long hours of arduous work" (p. 16).

The overall findings showed that the majority of school counsellors were "knowledgeable about the risk factors of adolescent suicide and about the appropriate intervention and postvention steps schools should take regarding suicidal students" (K. King, 2000, p. 258). The author suggested that a deeper analysis of the findings might have revealed that despite being familiar with the risk factors for suicide high school counsellors lacked the ability to apply this knowledge to determine whether a student has any of the risk factors. Thus, they may have the knowledge but have not mastered the skills to conduct an interview with a suicidal adolescent.

School counsellors in Dallas, Texas received suicide prevention training through Project SOAR (Suicide, Options, Awareness and Relief). King and Smith (2000) found that 56% of school counsellors from Dallas believed they could recognize a potentially suicidal student. This finding was significantly higher than the 38% of counsellors in the previous study of King et al. (1999). King and Smith held that this difference indicated that effectiveness of the SOAR program was its ability "in increasing counselors' efficacy expectations to identify students at risk for suicide. Such skill-building attention may be an important factor in increasing counselor confidence" (King & Smith, 2000, p. 403). Thus, the program provided counsellors with the pertinent knowledge of adolescent suicide and risk factors.

Mikinski (1993) had findings similar to those of King et al (1999). Mikinski examined what factors affected the ability of school counsellors to intervene effectively with suicidal adolescents. The factor most related to ability of school counsellors to intervene was counsellor self-efficacy in suicide prevention (Mikinski). A questionnaire was sent to 1101 Kansas school counsellors. The questionnaire was composed of six efficacy questions, two instruments measuring suicide intervention response, and a measure of verbal interview responses. A measure of suicide knowledge was also administered.

The major findings of Mikinski's (1993) study suggested that training was significantly related to counsellor efficacy in suicide intervention. This finding supported the basic premise of self-efficacy that people were "more likely to complete a specific task if they are self-efficacious or confident in their ability to complete a task" (Mikinski, 1993, p. 159).

Mikinski (1993) examined differences in responding patterns of male and female school counsellors. The male respondents tended to be more confident that school counsellors could identify suicidal behaviors and could intervene with a suicidal person. Counsellors who had received special trainings in youth suicide were more confident in a school counsellor's ability to identify warning signs and subsequently intervene. The author suggested that the trainings might have had components of the theory of self-efficacy (i.e. modeling, role plays and vicarious experience). These components were particularly applicable to prevention trainings as students could be provided with opportunities to view modeling, participate in role-plays and have vicarious experiences (Romano, 1996).

An interesting finding was that counsellors with the least years of experience were more confident in their own ability and the ability of their fellow counsellors to identify suicidal warning signs. Mikinski (1993) posited this might be because they had less time in the field to encounter a suicidal student and also because they may be more likely to have had received training most recently in their counsellor education program.

Pitcock (1987) corroborated the findings of King et al. (1999) and Mikinski (1993) with similar findings from regular education counsellors, vocational education counsellors, and special education counsellors. All three groups of counsellors demonstrated weaknesses in their ability to identify suicidal behavior in adolescents. The specific weaknesses occurred in the areas of family and emotional indicators of suicidal behaviors.

Counsellors articulated many reasons that prevented them from effectively meeting the needs of students. Some of these reasons were (a) high student to counsellor ratios, (b) increasing numbers of crisis cases, (c) inadequate trainings, and (d) school structure (Gora, Sawatsky & Hague, 1992; K. King, 2000). High school teachers echoed some of the same concerns (King, Price, Telljohann, & Wahl, 2000).

The climate of a school was found to be a contributing factor to counsellor self-efficacy. Sutton and Fall (1995) stated that the higher the grade level the higher the counsellor's self-efficacy. The strongest predictor of efficacy and outcome expectations was support of colleagues. This correlated with Bandura's findings on collective efficacy. This finding contributed to the explanation of why the higher the grade-level the higher the self-efficacy. Elementary school teachers and counsellors tended to be in more self-contained situations than their colleagues at the high school level. Administrative support for the counsellor and the counselling program was also influential on efficacy and outcome expectations, which corresponded to Bandura's proposition that administrators needed to be educational leaders, and the quality of leadership affected the work environment for teachers and counsellors (Bandura, 1997).

Thus, self-efficacy has been successfully applied as a measure of counsellor behaviors. It has been used to measure the ability of American school counsellors to address adolescent suicide. In this study it will be applied to examine the self-efficacy of Irish guidance counsellors in identifying and assessing adolescents at risk for suicide.

CHAPTER 3: METHODOLOGY

Participants

The participants for this study were 795 members of the Institute of Guidance Counsellors in Ireland, as outlined in a membership roster for the year 2000-2001. This membership was inclusive of all guidance counsellors in Ireland and thus was an exhaustive list. It should be noted that the total membership of the Institute was 935. However, the following members were excluded from the study: 117 student members, 7 retired members, 13 affiliate members, and 3 members living outside of Ireland. The 795 members surveyed were qualified or chartered members of the institute. A chartered member had membership for more than four years and was working as a guidance counsellor. A qualified member had membership for less than four years and may not have been working as a guidance counsellor.

Measures

The instrument used in this study was a four-page questionnaire entitled Adolescent Suicide. It was designed and used by King, Price, Telljohann and Wahl (1999) to examine the self-efficacy of school counsellors in America for recognizing students at risk for suicide. The development of the instrument was based on Bandura's (1977) self-efficacy model.

The questionnaire contained three sections (see Appendix A for the questionnaire). The first section asked questions determining the role of the guidance

counsellor in identifying students at risk for suicide, and the experience of the guidance counsellor in dealing with this phenomenon. The second section asked participants to rate their beliefs in their abilities and choices in dealing with adolescent students at risk for suicide. These items were those based on Bandura's (1977) components of self-efficacy (i.e., efficacy expectations, outcome expectations, and outcome values). The third section asked questions on risk factors for adolescent suicide attempts, appropriate school responses, and sources of information on youth suicide. At the end of the instrument five demographic questions were asked.

One change had to be made to the items of the instrument to make it applicable in the Irish context. "School counsellor" is not a term used in Ireland, so the words "guidance counsellor" were substituted into the questions, incorporating Irish spelling for the word "counsellor".

Experience with Suicidal Ideation

The participants were asked on page 1, item 6 of the questionnaire if a student had ever expressed suicidal thoughts to them. Their answer was either yes or no. This item was to measure the exposure the counsellors had to students expressing suicidal ideation.

Self-Efficacy

The three components of self-efficacy were included in the instrument. Efficacy expectations were measured by 6 items, these items were 8A through 8F.

Outcome expectations were measured by 6 items; these items were 8G through 8L. Outcome values were measured by 2 items; these items were 8M through 8N. Each item was measured on seven point Likert-scale, ranging from 1 strongly disagree to 7 strongly agree. Participants were asked to circle the number that best represented their response to the item.

Face and content validity were established by distributing the instrument to six national experts on adolescent suicide and three national experts on self-efficacy evaluated the instrument, and their recommendations were incorporated into the instrument (King et al., 1999). Construct validity was established "by using principal axis factoring with subsequent varimax rotation" (p. 459). Stability reliability was established by "distributing the survey on 2 separate occasions (1 week apart) to a convenience sample of 10 school counsellors" (p. 459). Using a Pearson's r correlation coefficient King et al. found suitable stability reliability (i.e., .71 for efficacy expectations, .63 for outcome expectations, and .67 for outcome values).

Demographics

Demographic information was requested on page four of the instrument. Participants were asked to report the following: (a) their gender, (b) the institution of graduation, and (c) the type of membership they held in the Institute of Guidance Counselling.

Procedure

Mailing

The contents of the mailings and the mailing procedures followed the Total Design Method proposed by Dillman (1978). All mailings were initiated from within Ireland to ensure adherence to the Dillman system, which would have been difficult to adhere to with mailings from the United States.

Beginning on April 20, 2001, each guidance counsellor was mailed a signed cover letter, which described the purpose of the study and emphasized that confidentiality was ensured. The mailing also included: a questionnaire and a self-addressed stamped envelope (see Appendix B).

Exactly one week after the initial mailing, on April 27, a follow-up postcard was sent to all recipients of the first mailing. This follow up thanked those who had already returned their questionnaire and served as a reminder to those who had not (See Appendix C).

A second follow-up was sent to non-respondents exactly three weeks after the original mailing on May 11, 2001. This included the same contents as the original mailing but the cover letter was slightly different (See Appendix D). The third and final follow up occurred on June 8, exactly seven weeks after the original mailing, with a different cover letter (See Appendix E).

Coding

Each of the predictor variables were coded and entered into an SPSS database (Norusis, 2000). The variables were coded as dummy variables allowing for the utilization of logistic regression in the analysis of the variables. The following were the codes adopted:

0: Low efficacy scores (14- 56)	1: High efficacy scores (57-98)
0: Female	1: Male
0: Qualified	1: Chartered
0: No exposure to suicidal ideation	1: Exposure to suicidal ideation

The coding of the training institutions involved creating four dummy variables, as there were more than two possible institutions. The following matrix outlines the coding of these dummy variables.

	D1	D2	D3	D4
University College Cork	1	0	0	0
University College Maynooth	0	1	0	0
Institute outside of Ireland	0	0	1	0
Other Irish Institute	0	0	0	1
University College Dublin	0	0	0	0

Missing information due to a lack of response was originally coded as 9 for each of the variables.

Scoring

The self-efficacy scores were calculated according to the guidelines outlined by Bandura (1997). He suggested that any efficacy strength scores should be summed and divided by the total number of items in the instrument, which indicates the strength of perceived efficacy for what is being measured. Thus, a measure of efficacy level can be "extracted by selecting a cutoff value below which people would judge themselves incapable of executing the activities in question" (Bandura, 1997, p. 44). The selection of a cut-off value resulted in dichotomization of the scores into either a low score category or a high score category.

The dichotomization of the scores followed the procedures articulated by King et al. (1999). The overall potential range of scores was 14-98. This was computed based on the fact that there were 14 items and each used a 7-point Likert scale (14 x 7 = 98). Since one was the lowest score available on the scale for each item, 14 became the lowest possible score that a guidance counsellor could receive. Thus, scores could have ranged from 14-98. To dichotomize the scores or cut the scores in half (one category for a low score, and one category a high score), the lowest score of 14 was added to the highest possible score of 98, and then divided by two, which results in a cut-off value of 56. Therefore a score below 56 indicated low self-efficacy, and a score 56 or above indicated high self-efficacy.

Statement of Null Hypotheses

The following five null hypotheses were made with respect to this study:

(1) The majority (51%) of guidance counsellors in Ireland have high self-efficacy for suicide intervention.

(2) Gender does not predict the suicide intervention self-efficacy of Irish guidance counsellors.

(3) Professional experience does not predict the suicide intervention self-efficacy of Irish guidance counsellors.

(4) Training background does not predict the suicide intervention self-efficacy of Irish guidance counsellors.

(5) Suicidal ideation exposure does not predict the suicide intervention self-efficacy of Irish guidance counsellors.

Data Analysis

Hypothesis 1

The dichotomous nature of the self-efficacy variable allowed the utilization of logistic regression to determine the self-efficacy of the respondents for identifying and assessing students at risk for suicide. Measures of central tendency, specifically mean and standard deviation were also computed. The computer program SPSS was utilized.

Hypotheses 2-5

The dichotomous nature of the criterion/dependent variable self-efficacy meant that logistic regression was employed to determine the validity of the predictor variables operationalized in hypotheses 2-5. Logistic regression coefficients were used to estimate odd ratios for each of the predictor variables: (a) gender, (b) professional experience, (c) ideation exposure and (d) training background.

The assumptions of logistic regression as outlined by (Wright, 1995) were met. The criterion variable was dichotomous. The outcomes were statistically independent, i.e. a single case was represented in the data set only once. All predictors were relevant, meeting the specificity assumption. The categories of the predictor variables were mutually exclusive and collectively exhaustive. A large sample with a minimum of 50 cases was employed.

The interpretation of the logistic regression coefficients was based on the concept of odds and odds ratios. Self-efficacy scores were the dependent/criterion variable, and each of the predictor variables were entered into SPSS, which was utilized to compute the independent effect of each predictor variable on the odds ratio.

Missing Data

Data missing from items A-N was handled by utilizing the expectation–maximization (EM) procedure in SPSS (Norusis, 2000). Expectation-maximization "is the recommended approach for dealing with most data problems. It has the advantages of the SPSS implementation of the regression approach, plus it uses additional

information through the iteration process" (Acock, 1997, p. 94). EM uses an expectation-maximization algorithm to estimate the means, the covariances and Pearson correlations of quantitative variables. It is an iteration process, with two stages for each iteration. The SPSS Program has a default of 25 iterations. The E stage computes expected values on the observed data and estimates of the parameters. The M stage calculates maximum likelihood estimates of the parameters based on the values computed in the E stage.

CHAPTER 4: RESULTS

The primary purpose of this dissertation was to examine the self-efficacy of Irish guidance counsellors to identify and assess students at risk for suicide. Thus questionnaires were sent to the members of the Institute of Guidance Counsellors in Ireland. A total of 795 questionnaires were mailed, adhering to the Dillman Total Design Method (1978).

A total of 495 members of the Institute of Guidance Counsellors in Ireland responded to receiving the questionnaire, resulting in a response rate of 62%. Of the 495 questionnaires returned 90 were determined to be unusable. Seventy respondents indicated that they were unable to complete the questionnaire, as they were no longer working as guidance counsellors in secondary schools in Ireland. Twenty additional questionnaires were eliminated from the final data analysis due to incomplete data. Thus, a total of 405 Irish guidance counsellors were included for the final data analysis.

The majority of guidance counsellors responding to the questionnaires were female (64%). The majority of respondents were chartered members of the Institute of Guidance Counsellors in Ireland (65%), meaning they had a minimum of four years experience working as a guidance counsellor in a secondary school in Ireland. The highest percentage of respondents (46%) reported receiving their Diploma in Guidance and Counselling from University College Dublin. A total of 279 (69%) respondents reported they had been exposed to a suicidal student at some point in their career (Table 2).

Table 2

Characteristics of the 405 Guidance Counsellors in Ireland

Characteristics:	n	(%)
Sex:		
Female	261	64.4
Male	144	35.6
Membership:		
Qualified	137	33.8
Chartered	265	65.4
Institution of Training:		
Cork	94	23.2
Dublin	186	45.9
Maynooth	32	7.9
Other Irish Institution	45	11.1
Educated outside of Ireland	14	3.5
No diploma in guidance counselling	34	8.4
Exposure to a suicidal student		
Exposure	279	68.9
No exposure	126	31.1

Efficacy Scores

Efficacy scores were calculated based on responses to survey questions 8A-8N. Efficacy scores had a potential range of 14-98. To dichotomize the scores or cut the scores in half (one category for a low score, and one category a high score), the lowest potential score of 14 was added to the highest possible score of 98, and the result was divided by two, which yielded a cut-off value of 56. Therefore, a score below 56 indicated a respondent with low self-efficacy and a score of 57 or above indicated a respondent with high self-efficacy.

Measures of central tendency were utilized to compute the efficacy scores. The sum of each respondent's answers to 8A-8N was calculated and the respondent was assigned to the low self-efficacy group (coded 0), or the high self-efficacy group (coded 1). The vast majority of Irish guidance counsellors had high self-efficacy scores (81.2%). The mean self-efficacy score with standard deviation in parentheses was 68.49 (13.63).

The mean respondent's scores on items 8A-8N were above the mean possible on a Likert- scale, i.e. 4, except for responses to item 8A (Table 3). All standard deviations were between 1 and 2. Item 8A asked respondents about their ability to recognize a student at risk for suicide. The remainder of the items asked respondents questions about intervention techniques or outcomes with a suicidal student.

Table 3

Responses to Items 8A-8N

Item	Mean Response	Standard Deviation
8A	3.89	1.48
8B	4.89	1.69
8C	4.64	1.56
8D	5.07	1.83
8E	4.79	1.58
8F	5.24	1.74
8G	4.78	1.65
8H	4.43	1.66
8I	4.59	1.53
8J	4.07	1.62
8K	5.45	1.24
8L	4.99	1.29
8M	5.99	1.52
8N	5.68	1.46

Logistic Regression Analysis

A logistic regression analysis was conducted to determine the various odds of four predictor variables (gender, membership, institute of training, and exposure to a suicidal student) on the self-efficacy scores of Irish guidance counsellors. Self-efficacy scores were dichotomized into low scores (coded 0) and high scores (coded 1) and utilized as the dependent variable in the regression analysis.

The proposed logistic regression model was statistically significant, i.e., it fit the data better than the null model, which was a straight line ($\chi^2 = 34.693$, $p < .001$). A summary of the variables in the logistic regression equation is presented in Table 4.

Table 4

Variables in the Logistic Regression Equation

Variables	B	S.E.	Wald.	Sig.	Exp (B)
Gender	1.052	.316	11.096	.001	2.862
Membership	.224	.291	.594	.441	1.251
Exposure	1.229	.275	20.050	.000	3.419
D1 (Cork = 1)	.446	.355	1.585	.208	1.563
D2 (Maynooth = 1)	.788	.604	1.703	.192	2.199
D3 (Educ outside Ire = 1)	.127	.708	.032	.858	1.135
D4 (Other Irish Instit = 1)	-.445	.402	1.224	.269	.641
Constant	.084	.336	.063	.802	1.088

Results from Table 4 demonstrated that holding the other variables constant, the gender of an Irish guidance counsellor was a significant predictor of their self-efficacy score ($\chi^2_{wald} = 11.096$, $p = .001$). The exponentiated regression coefficient b^e

($e^{1.052} = 2.862$) demonstrated that both male and female guidance counsellors had high self-efficacy scores, but male Irish guidance counsellors were 2.9 times more likely to have higher self-efficacy scores than female Irish guidance counsellors. The mean scores for males and females with standard deviations in parentheses were 71.05 (12.10) and 67.08 (14.24) respectively.

Holding the other variables constant, the type of membership held by a guidance counsellor in the Irish Institute of Guidance and Counselling was not a significant predictor of their self-efficacy score ($\chi^2_{\underline{wald}} = .594$, $\underline{p} = .441$). The mean scores for qualified and chartered members with standard deviations in parentheses were 67.07 (13.01) and 69.15 (13.96) respectively.

Maintaining the other variables constant the exposure of an Irish guidance counsellor to a suicidal student was a significant predictor of their self-efficacy score ($\chi^2_{\underline{wald}} = 20.050$, $\underline{p} = .000$). The exponentiated regression coefficient b^e ($e^{1.229} = 3.419$) demonstrated that though counsellors with or without exposure to a suicidal student had high self-efficacy scores, the Irish guidance counsellors who had been exposed to a suicidal student were 3.4 times more likely to have higher self-efficacy scores than guidance counsellors who had not been exposed to a suicidal student. The mean score for guidance counsellors who had been exposed to a suicidal student with standard deviations in parentheses was 70.81 (12.41) and for those that had not been exposed it was 63.35 (14.82), both scores indicating respondents with high self-efficacy scores.

Holding the other variables constant the institution from which the guidance counsellor received their Higher Diploma in Guidance and Counselling was not a significant predictor of their self-efficacy score ($\chi^2_{\underline{wald}} = 1.585$, $\underline{p} = .208$; $\chi^2_{\underline{wald}} =$

1.703, p = .192; χ^2_{wald} = .032, p = .858 and χ^2_{wald} = 1.224, p = .269). The mean scores of guidance counsellors from the different institutions with standard deviations in parentheses were (a) University College Cork, 69.40 (12.94), (b) University College Dublin 67.94 (14.26), (c) University College Maynooth 68.69 (11.57), (d) educated outside of Ireland 68.71 (12.99) and (e) other Irish institute 67.74 (14.91).

Item Level Analyses

In the study of American school counsellors' suicide intervention self-efficacy, King et al. (1999) employed item level analyses in order to gain a more detailed understanding of this professional self-efficacy. For each of the fourteen items, King et al. calculated the percentage of participants that circled "1" or "2" on the item's 1-7 Likert scale. King et al. described these participants as being in "Strong Disagreement" with the self-efficacy statement made in the item. Participants that circled "6" or "7" on the item's 1-7 Likert scale, were described by King et al. as being in "Strong Agreement" with the self-efficacy statement made in the item. The following item level analyses utilize the King et al. approach detailed above. As such, comparisons between the American school counsellors in the King et al. study and the Irish guidance counsellors in the present study can be made.

Item 8A

Approximately 12% of Irish guidance counsellors strongly agreed that they could recognize a student at risk for suicide and 21% strongly disagreed with the

statement. In contrast 38% of American school counsellors strongly agreed with this pursuit, and 5% strongly disagreed with the item.

Item 8B

Less than half of Irish guidance counsellors (43%) and American school counsellors (44%), strongly agreed with the statement that they could talk to a teacher or fellow counsellor to ascertain if a student was at risk for suicide. More Irish guidance counsellors (11%) strongly disagreed with the statement than American school counsellors (2%).

Item 8C

Approximately 35% of Irish guidance counsellors strongly agreed that they could talk to a parent to determine if a student was at risk for suicide, while 47% of American school counsellors agreed. Approximately 11% of Irish guidance counsellors strongly disagreed with the statement in comparison to only 3% of American school counsellors.

Item 8D

While 50% of Irish guidance counsellors strongly agreed that they could ask a student if he/she was suicidal, the majority of American school counsellors (79%)

displayed similar agreement. More Irish guidance counsellors (13%) strongly disagreed with the statement in comparison to American school counsellors (4%).

Item 8E

Approximately one third of Irish guidance counsellors (37%) strongly agreed that they could effectively offer support to a student at risk for suicide, versus the majority of American school counsellors (74%) with similar agreement. While 11% of Irish guidance counsellors strongly disagreed with the statement only 1% of American school counsellors strongly disagreed with the statement

Item 8F

Approximately half of Irish guidance counsellors (55%) strongly agreed that they could refer a student to a fellow counsellor in comparison to the majority of American school counsellors (85%) who strongly agreed that they could refer a student to a fellow counsellor. While 10% of Irish guidance counsellors strongly disagreed with this statement, only 1% of American school counsellors strongly disagreed.

Item 8G

One-third of Irish guidance counsellors (35%) strongly agreed that if they recognized a student at-risk for suicide it would reduce the chances that a student

would commit suicide, in contrast to two-thirds of American school counsellors (65%) who had similar agreement. The percentage of Irish guidance counsellors (11%) and American school counsellors (8%) who strongly disagreed with this statement was similar.

Item 8H

One third (30%) of Irish guidance counsellors strongly agreed that talking with teachers and counsellors would reduce the chance of a student committing suicide while one half of American school counsellors (51%) had similar agreement. Approximately 15% of Irish guidance counsellors strongly disagreed with the statement and only 9% of American school counsellors.

Item 8I

Fewer Irish guidance counsellors (30%) strongly agreed that talking to parents would reduce the chance of a student committing suicide than American school counsellors (47%). One in ten Irish guidance counsellors (10%) strongly disagreed with the statement and 6% of American school counsellors.

Item 8J

Only one-fifth of Irish guidance counsellors (18%) strongly agreed that if they asked a student at risk if they were suicidal it would reduce the chance of them

committing suicide, in contrast to one third of American school counsellors (37%). More than twice the number of Irish guidance counsellors (20%) strongly disagreed with the statement in comparison to American school counsellors (8%).

Item 8K

The majority of Irish guidance counsellors (55%) and American school counsellors (64%) strongly agreed that if they effectively offered support to a student at risk for suicide it would reduce the chance that the student would commit suicide. Only 3% of both Irish guidance counsellors and American school counsellors strongly disagreed with the statement.

Item 8L

Approximately 36% of Irish guidance counsellors and 59% of American school counsellors strongly agreed that if they referred a student at risk for suicide to a school/guidance counsellor it would reduce the chance of the student committing suicide. More than twice the number of Irish guidance counsellors (7%) disagreed with the statement in comparison to American school counsellors (3%).

Item 8M

The majority of both Irish guidance counsellors (75%) and American school counsellors (82%) strongly agreed that one of the most important things they could do

was to prevent a suicidal student from committing suicide. Only 5% of Irish guidance counsellors and 4% of American school counsellors strongly disagreed with this statement.

Item 8N

Fewer Irish guidance counsellors (62%) than American school counsellors (79%) strongly agreed that one of the most important things a school system could do was to establish a program to help recognize and treat suicidal students. Slightly more Irish guidance counsellors (5%) than American school counsellors (1%) strongly disagreed with this view of a school system.

Summary

This chapter presented the results of this study. The results of descriptive statistics indicated that the majority of Irish guidance counsellors (81%) had high global self-efficacy scores for identifying and assessing students at risk for suicide.

A logistic regression analysis was conducted to determine the various odds of four predictor variables (gender, membership, institute of training, and exposure to a suicidal student) on the global self-efficacy scores of Irish guidance counsellors. A summary table of the variables in the logistic regression equation was presented. Two predictor variables, gender and exposure to a suicidal student, were found to be statistically significant. Male guidance counsellors were 2.9 times more likely to have higher self-efficacy scores than female Irish guidance counsellors. Guidance

counsellors who had been exposed to a suicidal student were 3.4 times more likely to have a higher self-efficacy score than guidance counsellors who had not had experience with a suicidal student. Two predictor variables, membership of the Irish Institute of Guidance and Counselling, and institution of training were not statistically significant.

A comparison of global self-efficacy scores of Irish guidance counsellors and American school counsellors found that American school counsellors had a higher overall mean score for efficacy (73.2), than Irish guidance counsellors (68.49). In addition to global suicide intervention self-efficacy score computation, item level analyses were conducted. These analyses revealed that the majority of Irish guidance counsellors did not strongly agree with the statements measuring their self-efficacy in relation to the specific suicide intervention behaviors examined in items 8A-8L.

CHAPTER 5: DISCUSSION

Suicide is the primary cause of death for adolescents in Ireland (D. Hogan, 2001). Thus, the purpose of this study was to determine the suicide intervention self-efficacy of Irish guidance counsellors in secondary schools, the only mental health professional that all Irish youth can access.

A total of 795 questionnaires were mailed to members of the Irish Institute of Guidance and Counselling, the professional organization for Irish guidance counsellors. The Dillman Total Design Method system (1978) was utilized for the study. A total of 495 counsellors responded to the questionnaire, resulting in a response rate of 62%. However, 90 questionnaires were eliminated from the data analysis, as 70 respondents indicated they were no longer working in a secondary school with adolescents, and twenty additional questionnaires provided incomplete data. Thus, 405 questionnaires were included for the final data analysis.

The self-efficacy of guidance counsellors in the area of suicide prevention was assessed through a fourteen-item instrument called "Adolescent Suicide". Responses to the items were on a seven-point Likert-scale. The self-efficacy scores were calculated based on the responses to survey questions 8A-8N using measures of central tendency and descriptive statistics, mean and standard deviation. Total efficacy scores were dichotomized with a score below 56 indicating a respondent with low self-efficacy, and a score of 57 or above indicating high self-efficacy. Item analysis was conducted to determine the specific areas of adolescent suicide identification and assessment that guidance counsellors exhibited the highest efficacy. The majority of

Irish guidance counsellors (81%) had high self-efficacy scores for identifying and assessing students at risk for suicide.

The guidance counsellor respondents also answered four additional questions addressing, membership of the Irish Institute of Guidance and Counselling, gender, the institution of training, and exposure to a suicidal student. The responses to these four questions were analyzed using a logistic regression model to determine if they had an effect on the efficacy scores. Gender and exposure to a suicidal student were found to be statistically significant predictors of self-efficacy, while institution of training and membership of the Irish Institute of Guidance and Counselling were not found to be statistically significant predictors of self-efficacy.

This chapter provides a discussion of the results of this study. Limitations of the study will follow this discussion. Finally, implications for practitioners and future research will be addressed.

Discussion of Results

Self-Efficacy

The null hypotheses stating that the majority of guidance counsellors in Ireland have high self-efficacy for suicide intervention was unable to be rejected. The results indicated that 81% of Irish guidance counsellors had high self-efficacy. The mean overall self-efficacy score was 68.5, which was more than twelve points higher than the cutoff value of 57 indicating high self-efficacy. While the vast majority of guidance counsellors had high self-efficacy, these results were based on a global self-

efficacy score and can be misleading. An item-analysis of the instrument provided a keener picture of the areas that the guidance counsellors felt most efficacious and least efficacious. The item-analysis involved looking at the percentage of guidance counsellors who strongly agreed or strongly disagreed with the statements of the questionnaire.

The data would suggest that the ability of Irish guidance counsellors to identify a student at risk for suicide is limited. Approximately only one in ten guidance counsellors strongly agreed with item 8A of the instrument that examined their confidence in identifying a student at risk for suicide. One in five guidance counsellors strongly disagreed with this item. Thus, Irish guidance counsellors may not have sufficient knowledge of the warning signs for a student at risk for suicide. Irish guidance counsellors may also not have sufficient opportunities for interacting with students to be able to identify those at risk for suicide. The Role Document, which defines the scope of practice for guidance counsellors in Ireland, stated that guidance counsellors meet regularly with students in exam years but with other students only when they self-refer, or are referred by a teacher.

Suicide prevention is dependent on the ability to recognize students at risk for suicide. Once a student at risk is identified an intervention can be attempted. Approximately four out of ten guidance counsellors (38%) strongly believed that if they recognized a student a risk for suicide it would reduce the chance of a student committing suicide. Thus, guidance counsellors may not feel confident in their ability to prevent a student from committing suicide.

A correlated finding was that a high percentage (50%) of guidance counsellors felt efficacious in asking a student if they were suicidal. Only one in ten guidance counsellors disagreed with this item. Thus as indicated by the previously mentioned finding, fewer guidance counsellors (38%) feel efficacious about identifying students at risk for suicide, but if a student is referred to them they feel more confident in their ability to talk with the student and it would reduce the chance of a student committing suicide.

Irish guidance counsellors felt more efficacious in the area of assessing students at risk for suicide, than in the area of identifying students at risk for suicide. Almost half (43%) of the guidance counsellors felt they could consult with teachers to determine if a student was at risk for suicide. Consultation with teachers is an important key to suicide prevention. Students typically spend more time in the classroom than doing other activities in school, thus making teachers key collaborators in determining students at risk for suicide (K. King, 2001). In contrast only one in three counsellors felt they could consult with a parent of a suicidal student. Parents should be viewed as a valuable resource in combating suicide as they can provide much valuable insight into the lives of their children (Malley et al., 1994). As previously mentioned the limited contact between parents and guidance counsellors was reported by O' Leary and McCay-Morrissey (1987).

The area of reducing the risk of a student committing suicide was not an area of high efficacy for the majority of guidance counsellors. Less than one in five counsellors (18%) believed that if they asked a student if they were suicidal it would reduce the risk of the student committing suicide. A similar number of counsellors

(20%) disagreed with this statement. This finding may be related to one of the prevalent myths of suicide proposed by K. King (1999) that to talk about suicide with a student increases the likelihood that the student will commit suicide.

The vast majority of guidance counsellors (75%) believed that one of the most important things they could ever accomplish, as a guidance counsellor was to prevent a suicidal student from committing suicide. Similarly, the vast majority of guidance counsellors (62%) believed that one of the most important things a school could do was to establish a program for recognizing and treating suicidal students. This outcome is not surprising, as it would be expected that guidance counsellors recognized the important role they and their school can play in adolescent suicide prevention.

Comparing the Self-Efficacy of Irish Guidance Counsellors to American School Counsellors. The percentage of American school counsellors strongly agreeing with the items of the instrument was consistently higher than Irish guidance counsellors, as presented in Chapter 4. Similarly the percentage of American school counsellors strongly disagreeing with the items of the instrument was consistently lower than Irish guidance counsellors.

The percentages for American school counsellors and Irish guidance counsellors were most similar in their beliefs that one of the most important roles they or their school could fulfill was in preventing adolescent suicide. Areas that provided the most striking differences were: (a) asking students if they were suicidal, (b) effectively offering support to a student at risk for suicide, (c) recognition of a student

at risk will reduce the chances of a student committing suicide, and (d) referring a student to a counsellor will reduce the risk of a student committing suicide.

More American school counsellors (38%) strongly agreed in their ability to identify a student at risk for suicide, in comparison to Irish guidance counsellors (12%). While 21% of Irish guidance counsellors disagreed with this statement only 5% of American school counsellors did. It is worth noting however, that the majority of American counsellors like Irish guidance counsellors did not indicate they were confident in their ability to recognize students at risk for suicide. This occurrence raises the question of how effective suicide prevention is in the schools on both sides of the Atlantic Ocean.

Significant Predictor Variables

Gender. The null hypothesis that gender does not predict the suicide intervention self-efficacy of Irish guidance counsellors was rejected. Gender was found to be a statistically significant predictor of self-efficacy. Though both genders had high self-efficacy scores male guidance counsellors were found to be almost three times more likely than female guidance counsellors to have higher self-efficacy scores. Two possible explanations for this occurrence are offered.

The first explanation may be social desirability bias on the part of male respondents. Social desirability bias is "the tendency of people to say or do things that will make them or their reference group look good" (Rubin & Babbie, 2001, p. 178).

Thus, male respondents may have inflated their responses to create a more positive view for their profession.

The second explanation for differences in gender and self-efficacy comes from the literature examining careers and self-efficacy beliefs (Betz & Hackett, 1981; Clement, 1987; Wheeler, 1983; Hackett & Betz, 1981; Jome & Tokar, 1998; Lent & Hackett, 1987). While this body of career literature has concentrated on differences between men and women in traditional and non-traditional occupations, the literature has provided some insights into differences in men and women's perceived self-efficacy.

Clement (1987) stated that traditionally researchers have accepted male behaviors as the norm and measured women's behaviors against these male behaviors. Thus, psychological sex differences have been misconstrued as evidence of inadequacy amongst females. Clement also proposed that sex differences in self-efficacy were interpreted as women erroneously constructing their abilities and men accurately constructing their self-appraisal. This author postulated that an alternative interpretation of the sex difference in evaluating self-efficacy could stem from women having "a realistic awareness of their limitations, whereas men tend to overestimate their capabilities and have inaccurate self-perceptions" (Clement, 1987, p. 263).

Lent and Hackett (1987) stated that self-efficacy might develop differently in women and men "due to differential gender-role socialization and resultant differential access to the four sources of efficacy information". Betz and Hackett (1981) agreed with Lent and Hackett when they proposed that women and girls "are either not

encouraged or are actively discouraged from engaging in a variety of activities that serve to increase and strengthen expectations of personal efficacy" (p. 400).

Bandura (1997) postulated that differences in sex-role socialization begin in childhood. Differential patterns of appraising self-efficacy "have their origins in parents' gender-linked beliefs about their children's capabilities" (p. 430). Parents often judge school to be more difficult for daughters than sons though in actuality they do not differ in academic achievement. An example of this erroneous parental judgment can be demonstrated using mathematics. Girls are often perceived to be less talented in mathematics than boys, despite equivalent grades in mathematics.

Bandura (1997) continued to propose that the gender bias in socialization operates in classrooms as well as in the home, through the peer system and through cultural modeling of gender role stereotypes. Teachers often convey, in subtle ways, that they expect less of girls than boys. Gender stereotyping of occupations and intellectual capabilities is conveyed in peer systems. Television, children's stories, books and other forms of media provide a more widespread cultural modeling of gender-role stereotypes. Thus, Bandura concluded that women's beliefs "about their capabilities and their career aspirations are shaped by the family, the educational system, the mass media, and the culture at large" (p. 430).

Kelleher (1996) proposed that the socialization of boys and girls in Ireland is different. Boys may be taught to define themselves by what they do, versus girls who may be taught to define themselves by who they are. Birthistle (1999) suggested that Irish society might have rigid gender role stereotypes and beliefs. F. Hogan (1999) discussed socially constructed gender differences amongst males and females in

Ireland. Thus differences in socialization may provide an explanation into why male guidance counsellors in Ireland are almost three times more likely to have a higher self-efficacy score, than female guidance counsellors, for identifying and assessing students at risk for suicide.

Exposure to a suicidal student. The null hypothesis stating suicidal ideation exposure does not predict the suicide intervention professional self-efficacy of Irish guidance counsellors was rejected. Exposure to a suicidal student was found to be a statistically significant predictor of self-efficacy. Guidance counsellors who had been exposed to a suicidal student were more than three times more likely to have a higher self-efficacy score than those guidance counsellors who had not been exposed to a suicidal student.

The statistically significant relationship between exposure to a suicidal student and higher self-efficacy scores is a direct result of what Bandura (1997) termed enactive mastery. Enactive mastery occurs when an individual learns from the direct experience at dealing with a particular situation, problem or task. Bandura's premise is that "enactive mastery experiences are the most influential source of efficacy information because they produce the most authentic evidence of whether one can muster whatever it takes to succeed" (p. 80). The successful completion of a task or problem builds the self-efficacy beliefs of an individual.

Learning from the outcomes of one's actions is termed response outcomes (Bandura, 1997). Response outcomes serve two primary functions (Bandura, 1997). The first function of a response outcome is that it imparts information on how a person

must behave to achieve a given purpose. An individual examining the outcome of their performance can arrive at conceptions of what resulted in a successful endeavor and determine the rules of behavior that contributed to the outcome (Bandura).

The second function of a response outcome is that it serves as a motivator and incentive for future actions. According to Bandura (1997) people "mobilize and sustain their efforts to secure outcomes which they value highly" (p. 106). The vast majority of Irish guidance counsellors (75%) believed that the outcome of preventing an adolescent from committing suicide was very important.

Encountering a suicidal student can be stressful and difficult for the guidance counsellor. Bandura (1997) indicated that difficulties and set backs in dealing with a suicidal student will serve to bolster an individual's self-efficacy and serves as a teacher that success usually requires a sustained effort. After individuals become convinced that they have what it takes to succeed they will persevere in situations of adversity and quickly rebound from any setbacks (Bandura). Thus, the vast majority of guidance counsellors in Ireland (69%) have had exposure to a suicidal student at some stage in their career, which is why it would help to explain the high overall self-efficacy scores. Ultimately, according to Bandura (1986) enactive experience is "a ubiquitous tutor, however toilsome and costly the lessons learned from experience might be at times" (p. 106).

Non-Significant Predictor Variables

Institution of training. The null hypothesis that training background does not predict the suicide intervention professional self-efficacy of Irish guidance counsellors was unable to be rejected. This result may indicate that Irish institutions have a uniformity of suicide prevention training. The results may also indicate a lack of training in suicide prevention. It is difficult to ascertain the significance of the training variable since Irish institutions have no published guidance counsellor training standards or syllabi.

The primary goals of any training typically revolve around the participants acquiring knowledge and skills pertinent to their professional responsibilities. The premise of perceived self-efficacy is based not on the number of skills one possesses but rather what one believes one can do with what they possess under different circumstances (Bandura, 1997). In fact there is a considerable difference between possessing skills and being able to integrate them into appropriate courses of action (Bandura). Hence, people with similar skills, or the same individual under various circumstances may perform poorly, adequately or extraordinarily (Bandura, 1986).

Bandura (1986) also illustrated how knowledge and skills are necessary but on their own insufficient for a successful performance at a task, by using a ski analogy. A person learning to ski given a complete lecture on how to ski, a set of decision rules, and launched from the top of a mountain will most likely end up in an orthopedic ward or intensive care in a hospital. Knowledge must be transformed into skilled action and

self-efficacy beliefs through self-referent thought mediates the transformation of knowledge into action (Bandura, 1986).

Thus, the training of Irish guidance counsellors may provide them with knowledge and skills. However, their perceived self-efficacy for suicide intervention is determined by individual guidance counsellor's judgment of their own capabilities in organizing and executing the appropriate courses of action to prevent a student from committing suicide. Thus, the guidance counsellor's self-efficacy is not dependent on the skills and knowledge they possess after their training but rather on their individual judgments of what they can do with whatever skills they actually do possess.

Membership of the Institute of Guidance and Counselling. The null hypothesis that professional experience does not predict the suicide intervention professional self-efficacy of Irish guidance counsellors was unable to be rejected. Throughout a career as a guidance counsellor one may and hopefully does acquire more knowledge and skill in their related field. However, for reasons stated previously unless the professional experience includes an enactive mastery experience, years of experience as a guidance counsellor will not result in a higher sense of self-efficacy for identifying and assessing students at risk for suicide.

Limitations of Study

Sample

The response rate for this study was 62%. A response rate of 60% is generally considered a good response rate and provides for less of a chance of significant response bias (Rubin & Babbie, 2001). However, this questionnaire was not completed by approximately one-third of the population of guidance counsellors in Ireland. Thus, the survey results represent the perspective of the majority of Irish guidance counsellors but not the whole population.

Instrument

Two items of the instrument caused some confusion for respondents. These items were 8F and 8L, which asked participants about their beliefs in their ability to refer a student to a guidance counsellor. Some respondents wrote next to the item that they were the guidance counsellors. Placing the word "another" before guidance counsellors may have assisted in dissipating this confusion.

Data Analysis

The dichotomization of self-efficacy scores into two categories, 56 or below indicating low self-efficacy, and 57 or above indicating high self-efficacy was limiting. Having just two categories of self-efficacy resulted in a loss of the variance

of responses to items. The item-analysis conducted attempted to address this limitation.

Implications for Practitioners

The majority of Irish guidance counsellors believed that one of the most important things they could ever do was to prevent a student from committing suicide. However, only one in ten counsellors reflected confidence in their abilities to identify a student at-risk for suicide. Approximately only four out of ten guidance counsellors (38%) strongly believed that if they recognized a student a risk for suicide it would reduce the chance of a student committing suicide. The areas of identification and prevention of adolescents at risk for suicide can be addressed in the preparatory courses or pre-service of guidance counsellors have to undertake in order to receive their qualification of a Higher Diploma in Guidance and Counselling, or in in-service trainings. The theory of self-efficacy can be applied to the training of guidance counsellors for identifying and intervening with an adolescent reporting suicidal ideation. The following is a proposal of components of a preparatory curriculum or workshop to address the area of suicide prevention, and in the process raise the efficacy of the individual Irish guidance counsellors in this endeavor.

Suicide Training for Irish Guidance Counsellors

Myths. First, guidance counsellors need to be aware of the prevailing myths surrounding adolescent suicide. K. King (1999) documented fifteen prevalent myths concerning adolescent suicide. These were as follows:

1. Adolescent suicide is a decreasing problem.
2. Adolescent homicide is more common than adolescent suicide.
3. Most adolescent suicides occur unexpectedly and without warning signs.
4. Adolescents who talk about suicide do not attempt or commit suicide.
5. Most adolescents who attempt suicide fully intend to die.
6. Educating teens about suicide leads to increased suicide attempts, since it provides them with ideas and methods about killing themselves.
7. Adolescents cannot relate to a person who has experienced suicidal thoughts.
8. No difference exists between male and female adolescents regarding suicidal behavior.
9. Because female adolescents complete suicide at a lower rate than male adolescents, their attempts should not be taken too seriously.
10. The most common method for adolescent suicide completion involves drug overdose.
11. All adolescents who engage in suicidal behavior are mentally ill.
12. If adolescents want to commit suicide, there is nothing anyone can do to prevent its occurrence.
13. Suicidal behavior is inherited.

14. Adolescent suicide occurs only among poor adolescents.
15. Only a counsellor or a mental health professional can help a suicidal adolescent.

A discussion revolving around these myths and their ramifications will provide the guidance counsellors with a good overview and understanding of the problem of adolescent suicide. It will also provide them with valuable information for when they encounter a client exhibiting suicidal ideation.

Interventions and assessment. The primary interventions with adolescents displaying suicidal ideation usually involve some type of assessment. Assessment/ intervention usually occurs in three phases, depending on the adolescent. Davis (1988) referred to them as (a) looking for suicidal indicators, (b) a suicide evaluation and (c) post-evaluation options. The actions or interventions of the guidance counsellor will be determined by what phase they assume the adolescent to be in.

While this primary intervention is not directly influenced by Bandura's model of self-efficacy, aspects of his model are relevant. The success of the following interventions will be dependent on the guidance counsellor's beliefs in their self-efficacy for dealing with the situation, specifically efficacy expectations, outcome expectations and outcome values. The guidance counsellor may also have to utilize verbal persuasion in the interaction with the adolescent, and do an assessment of their physiological and affective state.

The guidance counsellor must first assess the client for suicidal indicators. Davis (1988) indicated that there are five general warning signs: (a) a suicide threat or

other statement indicating a desire or intent to die, (b) a previous suicide attempt, (c) mental depression, (d) marked changes in behaviors and/or personality, and (e) making final arrangements.

The guidance counsellor must then conduct a suicide evaluation. Davis (1988) said that the following nine areas need to be addressed so that decisions regarding the adolescent can be made:

1. Suicidal potential
2. Suicidal plan
3. Past suicide attempts
4. Affects and behaviors
5. Family background
6. Precipitating events
7. Response from the support network
8. Concept of death
9. Ego functioning

Finally the guidance counsellor must assess post-evaluation options. Davis (1988) proposed the two primary questions that need to be answered by the suicide evaluation are: "(a) In your professional opinion, is the child or adolescent at risk for attempting suicide? and (b) What interventions are necessary given the answer to the first question?" (p. 197). The answers to these two questions will determine if the adolescent needs hospitalization or outpatient treatment.

Another common intervention with a student displaying suicidal ideation may require the guidance counsellor to use Bandura's technique of verbal persuasion. This

is the persuading of the student to agree to a suicide contract. This contract ensures the student will follow certain protocols if their feelings of suicidal ideation persist and the guidance counsellor is/ is not accessible. Research supports that the use of suicidal contracts is an effective intervention with suicidal students.

Use of the components of self-efficacy. Once the threat of suicide has been assessed and addressed there are some interventions a guidance counsellor can use with a suicidal adolescent that flow directly from Bandura's model of self-efficacy. Bandura (1982) proposed that thinking can be altered through "informative corrective experiences" (p. 515). Mastery experiences help to instill strong self-beliefs of coping efficacy. Thus, suicidal students should be assigned performance assignments of enjoyable activities. Bandura (1997) stated the purpose of these graded behavior assignments are "to disconfirm misbeliefs and provide mastery experiences that affirm personal capabilities and help to restore positive self-evaluations" (p. 344). The mastery experiences must be chosen carefully, as they need to be attainable so the adolescent develops a stronger sense of efficacy.

A guidance counsellor can also utilize Bandura's idea of vicarious experience, as an intervention. This can be achieved through the use of role-plays with the student. The role-play should be directly related to the difficulties being experienced by the student. This technique may provide the adolescent with new insights into their situation. The guidance counsellor can also model appropriate/alternative coping skills/behaviors. The guidance counsellor must be very careful not to discount the

student's story, or rush in with what they perceive to be the omniscient solutions to the student's problems.

Bandura (1997) also discussed the use of social persuasion. This technique can also be used as an intervention with adolescents at risk for suicide. The role of the guidance counsellor is to persuade the individuals to believe in themselves, thus ideally this will lead to them to exert more effort and increase their chances of success. Bandura did issue this caution, "effective social persuaders do more to strengthen self-efficacy; they try to arrange things for others in ways that bring success and avoid placing them prematurely in situations where they are likely to fail" (p. 5). Thus, social persuasion should be used in conjunction with enactive mastery experiences. The enactive mastery experiences must be individualized, and directly determined by the student's past successful experiences and positive self-beliefs.

Bandura (1987) proposed the "inability to influence events and social conditions that significantly affect one's life can give rise to feelings of futility and despondency as well as anxiety" (p. 140). Self-efficacy theory distinguishes between two sources of futility. The first is when a person gives up trying because he/she doubts they can do what is required. The second is when a person may believe he/she has the capabilities, but they give up trying because they expect " their efforts to produce no results due to unresponsiveness, negative bias, or punitiveness of the environment" (p. 140). Any remedy for these sources of futility must involve an examination of efficacy beliefs and outcome beliefs. This point is very important to consider when doing any intervention with an adolescent displaying suicidal ideation.

The adolescent must believe in their ability to successfully participate in the intervention and believe in the outcome of any intervention, if it is to be successful.

These interventions should provide the focus and curriculum content of the training of guidance counsellors to intervene with an adolescent experiencing suicidal ideation. The goal of any training, using the theory of self-efficacy, is to have the participants achieve a strong sense of self-efficacy in their abilities to carry out a particular behavior/action. In this case it will be to increase the self-efficacy beliefs of guidance counsellors to be able to successfully intervene, with an adolescent exhibiting suicidal ideation.

Outcome expectations. The outcome expectations of the guidance counsellors must be addressed. They must be convinced that using the aforementioned interventions will lead to the desired outcome. Thus, a discussion of the interventions and their potential uses should occur at the beginning of the training. This should also be accompanied by a goal-setting discussion. Curtis (2000) stated goal setting "can be an effective way to help beginning counsellors focus on important developmental issues" (p. 194). Setting goals will diffuse any confusion about the outcome expectancies of the training. There are other advantages to using goal setting, as Curtis said:

> Using goal-setting strategies with beginning counsellors is an effective way to direct their attention, mobilize their effort, enhance their persistence, and develop new learning strategies. Helping beginning level counsellors understand their orientation toward goal setting can help them set more realistic goals; this process helps to reduce their anxiety by having them balance self-improvement goals with client outcome goals. (p. 205)

These conditions are conducive to creating an environment where self-efficacy beliefs can be developed.

Efficacy expectations. Self-efficacy beliefs are influenced by efficacy expectations. Efficacy expectations are based on four sources of information/experiences. In the order of descending impact on personal efficacy these are: enactive mastery, vicarious experience, verbal persuasion, and physiological and affective states (Bandura, 1997). The training of guidance counsellors should provide opportunities for the participants to experience each of these sources of information, and thus increase their sense of efficacy.

Bandura (1997) proposed that enactive mastery experiences are the most influential source of efficacy information "because they provide the most authentic evidence of whether one can muster whatever it takes to succeed" (p. 80). Successful experiences will increase one's efficacy beliefs, while failures will undermine them. However, in the process of training guidance counsellors will not be afforded the opportunity for enactive mastery experiences with adolescents exhibiting suicidal ideation. These experiences will be gained when they are working independently as guidance counsellors in their secondary schools.

Vicarious experience and modeling. The remainder of the training of guidance counsellors on how to intervene with an adolescent student who reports suicide ideation should focus on providing the guidance counsellors with vicarious

experiences of using the aforementioned interventions. The focus on vicarious experiences is because Bandura (1997) stated that it is a much more influential source of information, than verbal persuasion and physiological and affective states. The results from vicarious experiences tend to be lasting, while the results from the latter two appear to be more temporary and unstable. Vicarious experiences will be influenced by and supplemented with the use of verbal persuasion, and the drawing of attention to physiological and affective states.

The premise of a vicarious experience is that "seeing or visualizing other similar people perform successfully can raise self-percepts of efficacy in observers that they too possess the capabilities to master comparable activities" (Bandura, 1986, p. 399). The primary technique used in vicarious experiences is modeling. The beginning of the training should involve guidance counsellors viewing videotapes of successful models intervening with students at risk for suicide. This technique is based on Bandura's (1986) premise that perceived self-efficacy can be readily changed by "relevant modeling influences when people have had little prior experience on which to base evaluations of their personal competence. Lacking direct knowledge of their own capabilities they rely more heavily on modeled indicators" (p. 400). A discussion of what was observed should follow. Particular attention should be paid to the skills utilized by the model, and the choice of and implementation of the intervention.

The second set of videotapes observed by the guidance counsellor should include peers intervening with a student. These peers will receive specific instructions and scripts that will outline the intervention, and the techniques and strategies used in the implementation of the intervention. The use of peers is based on Bandura's (1997)

belief which stated that modeling exerts its effects on efficacy beliefs "through social comparative inference, the attainments of others who are similar to one self are judged to be diagnostic of one's own capabilities" (p. 86). Seeing people similar to one self perform successfully typically raises efficacy beliefs in observers. Individuals persuade themselves that if others can do it, they can do it. Peers provide the greatest similarity for an individual, and therefore the more persuasive the models' successes are.

The guidance counsellor should then receive the opportunity to self-model. The process of self-modeling occurs when "people observe their own successful attainments achieved under specially arranged conditions that bring out their best" (Bandura, 1997, p. 87). The optimal self-modeling is achieved by "structuring performance tasks in ways that ensure progressive mastery or by arranging conditions that bring out the best of one's capabilities" (Bandura, 1997, 94). The guidance counsellors should receive coaching and prompting, before and during the videotaping of the intervention. The tape is directly diagnostic of what they are capable of doing, thus increasing their self-efficacy. The success is viewed as authentic rather than partially contrived. The benefits of seeing oneself perform successfully can, according to Bandura (1997), "enhance proficiency in at least two ways: It provides clear information on how best to perform skills, and it strengthens belief's in one's capability" (p. 94).

The final set of modeling performances should involve videotapes of models experiencing difficulties and models that comment on the process and strategies as they are implementing the intervention. The use of models experiencing difficulties

has two benefits according to Bandura (1997). Firstly, "models who express confidence in the face of difficulties instill a higher sense of efficacy and perseverance in others than do models who begin to doubt themselves as they encounter problems" (p. 88). Secondly, seeing a skilled person fail by using deficient strategies can increase the perceived efficacy of observers who believe they have more suitable strategies at hand.

Having models verbalize their thought processes and strategies aloud as they engage in problem-solving activities provides the observers with a clear view and understanding of the process they are observing. Modeling influences that convey effective processes and strategies can boost the self-efficacy of the observer. Bandura (1987) continued by saying, "even the self-assured will raise their perceived self-efficacy if models teach them better ways of doing it" (p. 400). The guidance counsellors can adapt the thought processes and strategies in their own inventions if necessary, or if they are perceived as being more desirable/successful.

The use of so many modeled examples may be questioned. However, this training is based on the theory of self-efficacy attributed to Bandura (1997), who proposed the use of many modeled examples. The use of numerous modeled examples demonstrates how the interventions can be widely applied and adjusted to fit changing circumstances or students.

The use of role-plays should be introduced in the training of guidance counsellors after they have been exposed to all forms of modeling. This seems supported by the findings of Larson et al. (1999) that "modeling may increase the chance of the role play being successful by gradually increasing trainees' counseling

self-efficacy, thereby increasing the chance that role plays will be successful" (p. 241). The role-plays will encompass the different interventions, strategies and techniques the guidance counsellors have observed and discussed.

The success of the observational learning and the assessment of the guidance counsellors will be governed by the four sub-processes governing observational learning outlined by Bandura (1997). These four processes are categorized as: (a) attentional processes, (b) retention processes, (c) production processes, and (d) motivational processes.

Bandura (1997) stated attentional processes "determine what is selectively observed in the profusion of modeling influences and what information is extracted from ongoing modeled events" (p. 89). Some of the influential factors influencing this process are cognitive skills, preconceptions and value preferences. Thus, guidance counsellors will be allowed to discuss what they are observing and how it would relate to their experience as a guidance counsellor. The pre-conceived notions of the guidance counsellors about suicide and a person at risk for suicide should also be explored.

The second sub-function governing observational learning relates to cognitive representational processes. Specifically, " retention involves an active process of transforming and restructuring information about events for memory representation in the forms of rules and conceptions (Bandura, 1997, p. 90). Guidance counsellors should be asked and encouraged to recall the protocols of the interventions they have observed on an ongoing basis, and discussions of the protocols should be conducted.

According to Bandura (1997), the process of retention is also aided by "symbolic transformations of modeled information into memory codes and by cognitive rehearsal of the coded information" (p. 90). Guidance counsellors should have the opportunity to study the information they are receiving, and practicing the interventions without any assistance. The guidance counsellors should be encouraged to use their recalling of events as a process for reconstruction, rather than simply retrieving the modeled experiences they observed. Thus, this opportunity will attempt to ensure that the guidance counsellors comprehend the underlying principles and guidelines for the interventions, but also "enable the observers to create new variants of actions that fit the structure, but go beyond what was seen or heard" (Bandura, 1997, p. 90).

Bandura (1997) stated the third sub-function of modeling occurs when conceptions are translated into appropriate courses of action. This involves the comparing of the actions of the guidance counsellors in implementing the interventions, against the conceptual models they observed. The behaviors of the guidance counsellors can then be modified on the basis of this comparative information. The more extensive the sub-skills that the guidance counsellors possess the easier it will be for them to integrate them based on the modeled interventions. This may mean a review of skills, extra practicing of skills, or further modeling until the requisite skills are attained and demonstrated.

The fourth sub-function of modeling involves motivational processes. A distinction is drawn between acquisition and performance because people do not perform everything they learn. "Performance of observationally learned behavior is

influenced by three major incentive motivators: direct, vicarious, and self-produced" (Bandura, 1997, p. 90). The concept of outcome values becomes important at this stage of the training. The guidance counsellors will be more likely to exhibit modeled behavior if it results in a valued outcome. People are also motivated by the successes of others who are similar to them. The guidance counsellor's personal standards will also provide a source of motivation. Thus, the activities the guidance counsellors participate in should lead them to experience an increased sense of satisfaction and self-worth.

Verbal persuasion. Verbal/social persuasion serves as a further means of strengthening people's beliefs that they have the capabilities to achieve what they need to achieve. This technique is central to any training or learning experience based on the theory of self-efficacy. Bandura (1997) says, "people who are persuaded verbally that they possess the capabilities to master given tasks are likely to mobilize greater effort and sustain it than if they harbor self-doubts and dwell on personal deficiencies when difficulties arise" (p. 101).

The use of verbal persuasion is contingent on two important factors. Firstly, the person using verbal persuasion must be honest and realistic, for it to be effective. Secondly, the person using verbal persuasion must be perceived as credible and knowledgeable by the recipient. If both of these conditions exist then it will lead people to try harder to develop the requisite skills. Therefore, these conditions will have to be established in the training of guidance counsellors.

The framing of performance feedback for the guidance counsellors should be based on the guidelines of Bandura (1997) for the use of verbal persuasion. "The way in which persuasory influences and performances feedback are framed or structured can affect the appraisal of personal efficacy" (p. 102). Ability feedback will be given to the guidance counsellors at the early stages of their skill development. No reference to effort will be made as "telling people they have ability and that they gained it by hard work produces a lower sense of efficacy than does telling them that their progress shows they have ability without reference to the effort they had to exert" (p. 102).

Feedback will be given in terms of gains, and this will promote the development of the guidance counsellor's self-efficacy. Thus, it is an individual process and each guidance counsellor will receive feedback privately and constructively. These conditions are essential as the gains for each guidance counsellor may be quite different. Bandura (1997) proposed a positive focus for the process of feedback, as "feedback framed as gains is likely to support self-efficacy development, whereas informative feedback that is objectively equivalent but framed in term of shortfalls is apt to diminish a sense of personal efficacy by highlighting one's deficiencies" (p. 103).

Social comparison among individuals is a common occurrence. Individuals often rate their own performance in reference to the performance of a peer. People often benefit from seeing comparable peers succeed. It may provide the individual with the initial belief that they too, can accomplish the task. However, Bandura (1997) encouraged people "to measure their successes in terms of self-improvement rather than, in terms of triumph over others" (p. 106).

Physiological and affective states. The final component of any training should be the addressing of the impact of physiological and affective states. Bandura (1997) said, "the fourth way of altering efficacy beliefs is to enhance physical status, reduce stress levels, and negative emotional proclivities and correct misinterpretations of bodily states" (p. 106). This is an important component of training as the situation of intervening with an adolescent displaying suicidal ideation is a situation that is fraught with emotions and stressors. Guidance counsellors must be made aware of how stress and moods affect performance. Especially as "in guiding their capabilities, people rely partly on somatic information conveyed by physiological and emotional states" (p. 106).

The affects of stress on performance should be discussed with the guidance counsellors. Especially as "stress reactions to inefficacious control generate further stress through anticipatory self arousal" (Bandura, 1997, p. 106). By conjuring up and concentrating on negative thoughts about ineptitude and stress reactions a person can elevate their levels of distress. Too much stress/ arousal and too little stress/arousal can have a negative impact on self-efficacy. Guidance counsellors should be encouraged to monitor and gain self-knowledge about their ability to deal with stressful situations.

Situational or environmental factors can also exert a strong influence on how people will react. Guidance counsellors should be encouraged to pay attention to what is happening around them and how they are interpreting it.

Bandura (1997) stated, " moods provide an additional source of affective information for judging personal efficacy because they often accompany changes in

quality of functioning" (p. 111). Mood states can bias attention and affect how events are interpreted. Guidance counsellors should be encouraged to monitor and pay attention to their own mood states, and things/events that affect them.

The guidance counsellors' acquisition of self-knowledge regarding reactions to stress, environmental or situational factors and mood states will be especially important when they encounter a suicidal adolescent. It will be a stressful situation, involving an individual experiencing difficulty in dealing with their environment or situation, stress levels or changes in mood states.

The interventions and training of guidance counsellors on how to identify and intervene with an adolescent who reports suicidal ideation, outlined here, are based on the theory of self-efficacy of Bandura, and specifically focused on the raising of the efficacy beliefs of Irish guidance counsellors The training is based on the premise of Bandura (1997), who stated:

> Efficacy beliefs are best instilled by presenting the pursuit as relying on acquirable skills, raising performer's beliefs in their abilities to acquire the skills, modeling the requisite skills, structuring activities in masterable steps that ensure a high level of initial success, and providing explicit feedback of continued progress. (p. 105)

Each of these components received attention in the recommended components of a training.

Primary Prevention

Irish guidance counsellors as outlined in the Role Document (1995) are responsible for the gathering of information, and its organizing and dissemination. Thus, the guidance counsellor in a secondary school acts as a consultant to teachers, staff, students and parents. Thus, the gathering, organizing and disseminating of information related to adolescent suicide is as a function of the Irish guidance counsellor. As such, guidance counsellors play a pivotal role in the primary prevention of adolescent suicide. To fulfill this role guidance counsellor must have received training, similar to the training previously outlined, to be efficacious in imparting knowledge to others involved in the school community, (i.e., teachers, staff, students, and parents).

Primary suicide prevention encapsulates efforts to educate and train groups of individuals who are potential gatekeepers about the signs and hazards of lethal methods of suicide (Berman & Jobes, 1995). K. King (2001) outlined the following steps to establish primary prevention in schools: (1) Schools need to develop a school policy concerning student suicide, including procedures to be followed to identify, assess and intervene with a suicidal student. (2) School professionals need to be provided with education about suicide warning signs and risk factors. (3) Collaboration between teachers, staff and guidance counsellors must be encouraged. (4) Suicide prevention education should be included in the teaching curriculum. (5) A peer assistance program should be established, and students educated about warning signs and how to refer troubled peers to the guidance counsellor. (6) Implementing

activities aimed at increasing school connectedness. (7) Supportive school-family, and school-community partnerships need to be established. (8) The establishment of a school crisis team. Implementation of these steps will raise the effectiveness of schools and school personnel for addressing adolescent suicide.

McArt and Shulman (1999) proposed two further aspects of primary suicide prevention. A partnership between the local hotlines, crisis services, and health provider should be established. Second, a website should be designed to inform individuals about services and resources.

Little research has been conducted on the effectiveness of primary prevention education on teachers and school personnel. However, one study conducted by Kirchner, Yoder, Kramer, Lindsey, and Thrush (2000) found that participants gained awareness from a workshop about the biological and psychosocial foundations of depression and suicidality, and how to get the appropriate assistance for adolescents suffering from depression. A follow-up conducted nine months later found that the increased awareness was maintained in the participants perceived ability to identify and respond to a depressed or suicidal adolescent.

Irish guidance counsellors in this study did not exhibit high self-efficacy for consulting with teachers, parents and students in determining if a student was a risk for suicide. Educating parents, teachers, and students about suicide warning signs and risk factors may result in a more collaborative approach to suicide prevention in secondary schools in Ireland. In turn, such collaboration could raise the efficacy beliefs of all involved parties.

Implications for Future Research

The results of this study revealed areas that need to be addressed in future research. First, the ability of guidance counsellors to recognize students at risk for suicide could be reevaluated after the guidance counsellors have undergone specialized training to determine their increased awareness of the indicators of suicidal behavior. Research implementing pre-testing and post-testing would provide insight into the effectiveness of any suicide training.

Second, research needs to explore the relationship between training, efficacy and performance relationships. The premise of self-efficacy lends itself to training modules. An examination of which training components lend themselves to promoting efficacy could be conducted. The training based on Bandura's theory of self-efficacy, outlined in this study could be delivered to guidance counsellors, and a reexamining of their self-efficacy could be conducted to determine the effectiveness of the training.

Third, this study focused on the ability of guidance counsellors to identify and assesses students at risk for suicide. The study could be expanded to include other groups of school personnel, specifically teachers and administrators. The instrument used in this study could be utilized in such an endeavor with minor changes in vocabulary to match the new participants, e.g. substituting the words "teacher" or "administrator" for "guidance counsellor".

Fourth, collaboration between guidance counsellors, teachers, parents and students is essential for preventing adolescent suicide. Best practices of such collaboration should be investigated and implemented.

Finally, research investigating gender differences in traditional and non-traditional career options has been conducted. However, no research has been conducted on gender differences amongst professionals in the same career. Research specifically directed at gender differences in the self-efficacy of men and women in the same careers may reveal valuable information.

Conclusion

Suicide has been a fact of life for societies for the last two millennia (Shneidman, 2001). Over time we have gained much knowledge and numerous tools to assist us in the prevention of suicide, yet according to the World Health Organization approximately 800,000 suicides occur worldwide per annum (Parker, 1998). Societies much ensure they are doing everything possible to protect their most valuable resource, their young people. Schools are microcosms of societies where suicide prevention can be most effective given the fact that adolescents spend the majority of their day in school. Thus, school personnel must possess the requisite knowledge, skills, and beliefs in their ability to address the preventable phenomenon of adolescent suicide.

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APPENDICES

APPENDIX A

Instrument

ADOLESCENT SUICIDE

Directions: Please answer each of the following questions. Your responses will be kept **strictly confidential**. Please check appropriate answer. Thank you in advance for your support and time.

1. Do you believe it is the role of the guidance counsellor to identify students at risk for suicide?
   _____ yes _____ no _____ not sure

2. Does you school have a crisis intervention team to handle suicide attempts?
   _____ yes _____ no _____ not sure

3. Does your school include teaching about suicide prevention in its curriculum?
   _____ yes _____ no _____not sure

   If yes, how many hours in the curriculum deal with suicide prevention?
   _____

4. Has your school offered an in-service program, to guidance counsellors, teachers and staff on adolescent suicide in the past 5 years?
   _____ yes _____no _____not sure

5. Has a student(s) from your secondary school ever attempted suicide since you have worked there?
   _____ yes _____no _____not sure

   A. If yes, how many students have attempted suicide? _____
   B. If yes, how many students have completed suicide? _____

6. Has a student ever expressed suicidal thoughts to you?
   _____ yes _____no

   If yes, how many students have expressed suicidal thoughts to you in the past five years? _____

7. What would you do if a student told you that he/she felt suicidal, had a specific suicidal plan, **and** had lethal means to carry out that plan (e.g., knife, pills, handgun)?

Please check all that apply.

___Attempt to take the lethal means away by force
___Ask the student why he/she feels suicidal
___Have other students help you talk to a student
___Promise to not tell the student's parent(s)
___Remain with the student until they are in the custody of a legal guardian
____Contact the principal
____Contact the police
____Contact the parent(s)
____Listen to the student
____Other(Please specify)
_____

8. **Please rate your level of agreement with the following statements: (Please circle the response that best represents your opinion).**

A) I believe I can recognize a student at risk of attempting suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

B) I believe I can talk with teachers and staff at my school to help determine whether or not a student is at risk of attempting suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

C) I believe I can talk with the parent(s) of a student to help determine whether or not the student is at risk of attempting suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

D) I believe I can ask a student at risk of attempting suicide if he/she is suicidal.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

E) I believe I can effectively offer support to a student at risk for attempting suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

F) I believe I can refer a student at risk of attempting suicide to a guidance counsellor.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

G) I believe if I recognize a student at risk of attempting suicide it will reduce the chance that the student will commit suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

H) I believe if I talk with fellow teachers and counsellors at my school to help determine whether or not a student is at risk of attempting suicide it will reduce the chance that the student will commit suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

I) I believe if I talk with the parent(s) of a student to help determine whether or not the student is at risk of attempting suicide it will reduce the chance that the student will commit suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

J) I believe if I ask a student at risk of attempting suicide if he/she is suicidal it will reduce the chance that the student will commit suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

K) I believe if I effectively offer support to a student at risk of attempting suicide it can reduce the chance that the student will commit suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

L) I believe if I refer a student at risk of attempting suicide to a guidance counsellor it will reduce the chance that the student will commit suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

M) I believe as a guidance counsellor, one of the most important things I could ever do is to prevent a suicidal student from committing suicide.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

N) I believe one of the most important things a school system could ever do is to establish a program to help recognize and find treatment for suicidal students.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

9.Which of the following are risk factors for adolescent suicide attempts? Please check all that apply.

___Being depressed
___Having a previous suicide attempt
___Having a recent relationship breakup
___Having a tattoo
___Being male
___Having a low self-esteem
___Being homosexual
___Coming from an abusive home
___Being financially disadvantaged
___Being withdrawn/isolated
___Being involved in drug use
___Having easy access to a handgun
___Being an only child
___Being obese
___Having low grades
___Entering puberty at a late age

10. Which of the following do you feel would be an appropriate school response if a student committed suicide?
Please check all that apply.

___Planting a tree in honor of the student
___Holding a memorial for the student
___Forming a crisis intervention plan
___Having counsellors available to help other students in need
___Having the school behave in a quiet, conservative manner
___Offering student support groups
___Closing school for a day
___Providing teachers with the facts of the situation
___Allowing students to miss school in order to attend the funeral
___Other (pleasespecify)_____

11. Where have you received most of your information on youth suicide?
Please check all that apply.

___I have never received any formal information on youth suicide
___College classes
___On the job training
___Textbooks
___Professional workshops/conferences
___Mass media (Television, newspapers, magazines)
___Professional journals
___Other (please specify)_____

DEMOGRAPHIC INFORMATION

1. Your sex: ____male ____female

2. Name of the university that you received your Higher Diploma in Guidance Counselling: _____

3. Membership of the Institute of Guidance Counselling:
Qualified_____ Chartered_____
Number of years as a guidance counsellor: ____years

4. Your education level: (Please check your qualifications)
____Bachelors degree
____Masters degree
____Doctoral degree
____Higher Diploma in Education
____Higher Diploma in Guidance and Counselling
____Other (please specify)_____

5. Number of students enrolled in your school _____

6. Number of guidance counsellors employed in your school_____

9. In what type of area is your secondary school located:
____City ____ Town ____Rural Community

Thank You Very Much!!

APPENDIX B

First Appeal Letter

April 20th, 2001

Dear NAME,
Adolescent suicide has become a major area of concern in Ireland as during the last ten years it has reached epidemic proportions. *The Irish Times* on January 20, 2001 reported that suicide is now the most common cause of death among 15 to 24 year olds. I am currently a doctoral student researching the role of guidance counsellors in identifying and assessing students at-risk for suicide in Irish schools. My interest in pursuing this research stems from the fact that I am an Irish citizen who graduated from University College Cork with a B.A. and H.D.E. My interest is also as a result of my work experience and having seen the various ramifications of suicide on youth, families and the community. I really need your help. You are one of all of the members of the Irish Institute of Guidance Counsellors who is being asked to participate in this research. Your participation will provide unique and invaluable insights into the experience of guidance counsellors and adolescent suicide. In order that the results will truly represent the thinking of all guidance counsellors in Ireland, it is very important that each questionnaire be completed and returned.

You may be assured of complete confidentiality. The questionnaire envelope has an identification number for mailing purposes only. This is so that I may check your name off of the mailing list when your questionnaire is returned. Your name will never be placed on the questionnaire. Your participation in this study is voluntary, and the return of the questionnaire indicates your informed consent.

You may receive a summary of the results by writing "copy of results requested" on the back of the return envelope, and printing your name and address below it. Please do not put this information on the questionnaire itself.

I would be most happy to answer any questions you might have. Please feel free to write or e-mail me at the address maryboylan@yahoo.com. The phone number for my contact in Ireland is 021-4292164.
Thank you very much for your assistance and time.

Sincerely,

Mary Boylan

APPENDIX C

Postcard

April 27th, 2001

Last week a questionnaire seeking your insights on the role of guidance counsellors and adolescent suicide was mailed to you. You were selected as a member of the Institute of Guidance Counsellors, all of who are being asked for their input.

If you have already completed and returned it to me please accept my sincere thanks. If not, please do so today. Because it has been sent to all guidance counsellors it is extremely important that yours also be included in the study if the results are to accurately represent the members of the Institute of Guidance Counsellors.

If by some chance you did not receive the questionnaire, or it got misplaced, please call 021-4292164, and another one will be placed in the mail to you today.

Sincerely,

Mary Boylan

APPENDIX D

Second Appeal Letter

May 11th, 2001

Dear NAME,

About three weeks ago I wrote to you seeking your opinion on the role of guidance counsellors and adolescent suicide. As of today I have not received you completed questionnaire.

I have undertaken this study because of the importance of the issue of adolescent suicide and recognizing the unique and important role you play in addressing this phenomena.

I am writing to you again because of the significance each questionnaire has to the usefulness of this study. I am seeking an accurate portrayal of the members of the Institute of Guidance Counsellors, of which you are a member. In order for the results of this study to be truly representative of the opinions of the members of the institute, it is essential that each member return their questionnaire.

In the event that your questionnaire has been misplaced, a replacement is enclosed.

Your cooperation is greatly appreciated.

Cordially,

Mary Boylan

APPENDIX E

Third Appeal Letter

June 8th, 2001

Dear NAME,

I am writing to you about my study of the role of guidance counsellors and adolescent suicide. I have not received your completed questionnaire.

The large number of questionnaires returned is very encouraging. But, whether I will be able to describe accurately how the members of the Institute of Guidance Counsellors view their role in dealing with adolescent suicide depends on you and the others who have not yet responded. This is because my past experiences suggest that those of you who have not yet responded may hold different opinions from those that have.

This is the first national study of your organization, and adolescent suicide. Therefore, the results are of particular importance to you, and your organization. The usefulness of my results depends on how accurately I am able to describe your views of your role and adolescent suicide.

It is for these reasons that I am sending this questionnaire to you again, in case that my other correspondence did not reach you. May I urge you to complete and return it as quickly as possible.

I will be happy to send a copy of the results if you want one. Simply put your name, address, and "copy of results requested" on the back of the return envelope. I expect to have them ready to send by the end of the year.

Your contribution to the success of this study will be greatly appreciated.

Most Sincerely,

Mary Boylan