Suicide is currently the third leading cause of death for adolescents ages 15-24. While much attention has been given to this topic, no research has examined what specific information is being taught to pre-service school counselors. The purpose of this descriptive study was to evaluate the pre-service suicide prevention training in CACREP accredited school counseling programs. Fifteen areas of suicide prevention were assessed. The participants were 89 CACREP accredited programs.

The instrument utilized was entitled Suicide Prevention Survey, and included fifteen areas of suicide prevention that could be included in program curriculum. The results were analyzed using frequencies and measures of central tendency.

Respondents to the survey indicated that no CACREP programs offer a required course in suicide prevention. However, the issues of suicide were reported as being addressed in 39 different required and elective courses. Four percent (n=9) of the programs reported covering all fifteen categories included in the survey. One program reported coverage in area of suicide was non-existent.

Implications for CACREP accredited programs as well as recommendations for future research is given.
A Formative Evaluation of Pre-Service Suicide Prevention Training in CACREP Accredited School Counseling Programs

By
Terrie J. House

A DISSERTATION

submitted to

Oregon State University

in partial fulfillment of
the requirement for the
degree of

Doctor of Philosophy

Presented April 30, 2003
Commencement June 2003

APPROVED:

Redacted for Privacy

Major Professor, representing Counseling

Redacted for Privacy

Dean of the School of Education

Redacted for Privacy

Dean of the Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader on request.

Redacted for Privacy

Terrie J. House, Author
ACKNOWLEDGEMENTS

I wish to thank and acknowledge my doctoral committee for their expertise, and support throughout my program: Dale-Elizabeth Pehrsson, Michael Ingram, Gene Eakin, and Cass Dykeman.

I would like to acknowledge Dr. Fred Bradley and my doctoral cohort for their continued supported during my experience as a doctoral student.

I would also like to acknowledge in loving memory my grandparents William House, Eunice House, and Roselyn Clarke.

Finally, I would like to acknowledge my parents for helping with the mailing of my surveys and for their undying love and belief in me.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHAPTER 1: INTRODUCTION</strong></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Rational</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Research Questions</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Glossary of Terms</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td><strong>CHAPTER 2: LITERATURE REVIEW</strong></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Overview of Suicide in the United States</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Rate</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Ethnic and Gender Differences</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Regional Differences in Suicide Rates</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Psychosocial Factors</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Prevention Strategies</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Adolescent Suicide in the United States</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Rate</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Contributing Factors</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>School Counseling</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>History</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Professional Organization Standards</td>
<td></td>
<td>33</td>
</tr>
<tr>
<td>Ethical and Legal Issues</td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>Adolescent Suicide Prevention in the United States</td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Introduction</td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Myths</td>
<td></td>
<td>37</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Knowledge of Contributing Factors to Suicidal Behavior</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Intervention</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Postvention</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>School Districts Suicide Prevention Policies</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Educating Students and School Staff</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Educating Parents</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>CACREP Standards</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Role of CACREP in School Counseling Training</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>CACREP School Counseling Standards</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Chapter 3: METHODOLOGY</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Measures</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Demographics</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Procedures</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Data Analysis</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 4: RESULTS</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Respondents Demographics</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Courses in Suicide Prevention</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Specific Information Covered in Suicide Prevention</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>Program and Student Demographics</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 5: DISCUSSION</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Discussion of Results</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Data Analysis</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Coursework</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>Specific Information Covered in Suicide Prevention</td>
<td>77</td>
<td></td>
</tr>
</tbody>
</table>
## TABLE OF CONTENTS (Continued)

- Limitation of Study .............................................. 83
- Sample .................................................................... 83
- Instrument .......................................................... 84

### Implications for CACREP School Counseling Programs
- Pre-Service Suicide Training .................................. 85
- Primary Prevention ............................................. 92

### Implications for Future Research ......................... 93

### Conclusion ....................................................... 94

### REFERENCES .................................................. 95

### APPENDICES ................................................... 106
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: U.S. Suicide Rates by Age, Gender and Racial Group..................</td>
<td>10</td>
</tr>
<tr>
<td>2: Characteristics of the 89 CACREP Respondents........................</td>
<td>66</td>
</tr>
<tr>
<td>3: Summary of Courses Offered.............................................</td>
<td>67</td>
</tr>
<tr>
<td>4: Responses to Survey Question 2........................................</td>
<td>70</td>
</tr>
</tbody>
</table>
## LIST OF APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Instrument</td>
<td>106</td>
</tr>
<tr>
<td>B: First Appeal Letter</td>
<td>108</td>
</tr>
<tr>
<td>C: Postcard</td>
<td>109</td>
</tr>
<tr>
<td>D: Second Appeal Letter</td>
<td>110</td>
</tr>
<tr>
<td>E: Third Appeal Letter</td>
<td>111</td>
</tr>
<tr>
<td>F: CACREP Standards</td>
<td>112</td>
</tr>
</tbody>
</table>
DEDICATION

This dissertation and completion of my doctoral degree would not have been possible without the commitment, continuous support, encouragement and love of my family. This work is dedicated with love to my parents George and Marlene House.
CHAPTER 1: INTRODUCTION

The prevalence of adolescent suicide in society has called researchers, educators, the medical community, policy makers, and counseling professionals to examine and research primary prevention approaches. The need for improvements in the training of school counselors to better deal with the issue of adolescent suicide is evident in the fact that the problem of suicide continues to increase. Primary suicide prevention information and school counseling programs that are nationally accredited have been identified as important factors in the masters level training of school counselors. The issue of addressing suicide is stipulated in the code of standards of the Council for the Accreditation of Counseling and Related Educational Programs (CACREP).

Rationale

Adolescent suicide has reached epidemic portions in the United States and around the world (WHO, 2000). This is evident in the national headlines. Further, there is an increase in research and prevention programs aimed at decreasing this phenomenon. According to Allberg & Chu (1990), “no matter how often the topic is reported or discussed, it always arouses dismay, disbelief, and confusion, because it defies comprehension why some adolescents choose to end their lives” (p.343).

As a group, adolescents in the United States are very aware of the issue of adolescent suicide. An adolescent may not have been exposed directly to a
completed suicide or know of a suicidal friend or family member but they are bombarded with the tragic issue through radio, newspaper, television and music (Capuzzi, 1988).

Suicide is generally described as the intentional taking of one's own life. Adolescence appears to be a time period like no other in the human life span where suicide attempts are at their highest (C.A. King, 1997). For the adolescents who commit suicide, the act usually represents a solution to a problem or life circumstance that the individual fears will only become worse (Alvarez, 1970). Believing that their suffering will continue or intensify, suicidal adolescents can envision no option other than death. As expressed by a prominent suicidologist, the common stimulus to suicide is intolerable psychological pain. Suicide represents an escape or release from that pain (Shneidman, 1986).

School counselors are often the people who other school personnel turn to when facing the issue of a suicidal adolescent (King, 2000). It is often the school counselors' responsibility to train and help others face mental health concerns of students (King, 2000). This dissertation examines school counselors' training at nationally accredited institutions to ascertain how masters level programs are preparing beginning counselors to deal with the issue of primary suicide prevention.

The area of school counseling has come a long way since its beginnings in the early twentieth century. The father of guidance, Frank Parsons, was a pioneer in his time recognizing the need for students to receive guidance in schools in the area of vocational counseling. According to Parsons (1909) the training of
counselors was paramount. He stated, "the present staff of workers is wholly inadequate to the need of this city (Boston) alone, and the widespread practical interest in the new institution justifies the belief that the movement will soon become a national one" (p.93).

Currently, counseling in schools does not just include career or vocational counseling, but academic and personal counseling, as well (ASCA, 2002). The profession now has many organizations, one of them being the American School Counseling Association (ASCA). Currently, according to ACSA, their membership is around 13,000 professionals worldwide.

ACSA has adopted a specific position on what is expected of the professional school counselor and students-at-risk (Adopted 1989-90; revised 1993, 1999). According to ASCA, "the school counselor provides proactive leadership in the area of prevention and consults in identifying "at-risk" students. The goal is to identify and intervene before the students move through a continuum of self-destructive behavior"(¶ 2).

Many states are adopting comprehensive school counseling programs. One of the principles of a comprehensive school counseling program is that it is for all students. A comprehensive program is organized, has a planned curriculum, is sequential, and is integrated into the total educational process. The program involves all school staff, helps students learn more effectively and efficiently, and includes counselors who provide specialized counseling services and interventions (Comprehensive School Counseling Programs, ¶ 1). The goal of these programs is to include all students at all development levels, and these programs are proactive
and preventative (King, 2000). The primary goal of many programs is to promote and enhance students' learning through three broad and interrelated areas of student development. The three areas include academic, personal/social, and career development.

Higher education also recognized the need for standards for school counseling graduate students. The Council for the Accreditation of Counseling and Related Educational Programs (CACREP) was created in 1981 to establish a set of standards by which graduate programs could be evaluated and improved.

According to Capuzzi, (2002), “generally, prevention, crisis management, and postvention activities should not be attempted by anyone who has not completed a 2-year CACREP accredited or CACREP equivalent graduate program” (p.44).

**Research Questions**

This study examines the following research questions:

Research Question 1:

In what course is suicide prevention covered in CACREP accredited school counseling programs?

Research Question 2:

What specific content is covered in the area of suicide prevention?

Research Question 3:

If a CACREP program does not currently offer a class in suicide prevention, what are the main reasons it does not?
Glossary of Terms

ASCA

American School Counseling Association, the professional association for school counselors.

At-Risk

Students who may exhibit signs of suicidal behavior.

CACREP

Council for the Accreditation of Counseling and Related Educational Programs, counselor education accrediting body.

Counselor Training Programs

The school counselor program or institution from which school counselors received their degree.

Gender

The division of adolescents into male and female categories.

Intervention

A specific and deliberate act to protect a student from committing suicide.

Postvention

The response a school takes after an actual suicide by a student.

Primary Prevention

“Programs that target groups of currently unaffected people for purposes of helping them to continue functioning in healthy ways, free from disturbance” (Conyne, 1987 p.6).
Psychology Autopsy Method

Inquiries about suicide victims after their death that look at their medical and psychological histories. This process can include interviewing family members and friends.

Secondary Prevention

“Early detection and treatment of people with problems or disorders” (Conyne, 1987, p.6).

Suicidal Ideation

A thought about suicide, which may or may not mean an individual actually wishes to take his or her own life.

Tertiary Prevention

“Tertiary prevention refers to the rehabilitation of seriously disturbed individuals” (Coyne, 1987, p.6), but in some literature also referred to as postvention which is a school’s response after a suicide has taken place by a student (King, 2001).

WHO

World Health Organization, United Nations organization responsible for monitoring global health and overpopulation, and provides valuable global statistics.
CHAPTER 2: LITERATURE REVIEW

Introduction

This review examines the literature on (a) suicide in the United States, (b) adolescent suicide in the United States, (c) the history of primary prevention and the role of school counselors in primary suicide prevention, (d) the history of CACREP and its role in school counselors training and (e) CACREP school counseling standards as they relate to primary suicide prevention. These areas provide the background and rationale for the examination of current CACREP programs and their training of primary suicide prevention to masters' level students.

Overview of Suicide in the United States

Suicide in the United States has been a growing epidemic for the past thirty years (Capuzzi, 2000; King, 2000; Ritter, 1990; Bette & Walker 1986). The enormous increase in the rate of suicide has caused many professionals to recognize the need for additional training in the area of primary suicide prevention. The investigation of adolescent suicide will be reported in a national perspective with a current review of national rates, ethnic/gender differences, psychological and psychosocial factors, and preventive strategies.

Rate

According to Clark, 1992, 2.9 percent of the adult population attempts suicide; the suicide rate in the general population over a lifetime of 70 years is
approximately one percent. In 2001, the United States Surgeon Dr. General David Satcher unveiled a national strategy to prevent suicide. He stated, "suicide has stolen lives and contributed to the disability and suffering of hundreds of thousands of Americans each year. There are few who will escape being touched by the tragedy of suicide in their lifetime" (p.1). The National Institute of Mental Health in 1999 reported that suicide was the eleventh leading cause of death in the United States accounting for 1.3 percent of all deaths. The three leading causes of death included diseases of the heart, cancer, and stroke (NIMH, 1999).

The World Health Report, 2001 states, "suicide is the result of an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome." This organization is in agreement with the Surgeon General and sees suicide as a major public health problem worldwide.

**Ethnic and Gender Differences**

The National Center for Health Statistics (NCHS) reported in 1999 that males are four times more likely to die from suicide than are females. However, females are more likely to attempt suicide than are males. In 1999, white males accounted for 72 percent of all suicides (NCHS).

In general, individuals who attempt suicide differ from those who complete suicide. Suicide attempters are likely to be female and generally attempt suicide by taking an overdose of medication. Suicide completers, by contrast, are more often male and tend to use more lethal means (Sorenson, 1991). Approximately 40 percent of individuals who commit suicide have made previous suicide attempts.
Together, white males and white females accounted for over 90 percent of all suicides (NCHS, NIMH, 1999). However, during the period from 1979-1992, suicide rates for Native Americans (a category that includes American Indians and Alaska Natives) were about 1.5 times the national rates. There were a disproportionate number of suicides among young male Native Americans during this period, as males 15-24 accounted for 64 percent of all suicides by Native Americans. Among the highest rates (when categorized by gender and race) are suicide deaths for white men over 85, who had a rate of 59/100,000 (NCHS, 1994).

Westefeld, J.S., Range, L.M., Rogers, J.R., Maples, M.R., Bromley, J.L., Alcorn, J. (2000) reported that Hispanic Americans have lower suicide rates than non-Hispanics. Asian Americans rate of suicide is lower than European Americans; however, the risk factors for Asian Americans increase with age (Westefeld et al., 2000).

The following chart depicts the differences in age, gender and Caucasian vs. African American ethnic groups. African American females have the lowest rate of suicide compared with other ethnic groups (Westefeld, et al., 2000).
Regional Differences in Suicide Rates

Suicide has been examined by region by the National Center for Health Statistics. In 1994, it was reported that rates were consistently higher in the Western United States. The specific reasons for these regional variations are unknown but may reflect regional differences in certain demographic variables. For example, suicide rates have been higher for males, for the elderly, and for certain racial/ethnic groups (e.g., non-Hispanic whites and American Indians/Alaskan Natives) (NCHS, 1994). Suicide rates are generally higher than the national average in the western states and lower in the eastern and mid-western states (MMWR, 1997).

The method by which someone uses to commit suicide was also examined by region. When suicide rates in each region were stratified by method, rates were
highest in the West for all methods except firearms. Firearms were the leading method in all regions, accounting for 69.8 percent of all suicides in the South, 58.3 percent in the West, 57.8 percent in the Midwest, and 44.9 percent in the Northeast (MMWR, 1997). Suicide by firearms was the most common method for both men and women, accounting for 57 percent of all suicides.

Psychosocial Factors

There is very little agreement in the literature about which suicidal factor contributes most to suicidal behavior. The U.S. Public Health Service (1999) has outlined several factors that increase suicide risk. They include (a) experiencing a significant personal loss, such that one feels unbearable psychological pain, (b) abusing drugs or alcohol, (c) having a family history of suicide or violence, (d) having a personal history of suicidal behavior, (e) having a mental illness (especially depression, schizophrenia, or panic disorder), (f) chronic physical pain, illness or disability, (g) feeling isolated, and (h) having access to a lethal weapon (gun, car, drugs, etc.).

Brody, 1999, examined the link between depression and suicide, and found that in writings as early as the 17th century, depression had been connected with melancholy and suicide. In 1621, Richard Burton wrote about the phenomenon in his book, Anatomy of Melancholy. He believed that melancholy was both a medical and psychological problem. Burton writes, "It is the result of melancholy that desires self-destruction: In other diseases there is some hope likely, but these
unhappy men are born to misery, past all hope of recovery, invariably sick, the longer they live the worse they are, and death alone must ease them” (p.172).

Another significant predictor of suicide is a feeling of hopelessness or helplessness, a principal symptom of depression. Hopelessness is the common factor that links depression and suicide in the general population. In fact, hopelessness is a better predictor of completed suicide than depression alone (Breitbart, 1993).

Depression, including major depression and depressive symptoms, is a critical risk factor for completed suicides, especially in older adults (Conwell & Brent 1995). A report by the Surgeon General estimates, “major depressive disorders account for about 20 to 35 percent of all deaths by suicide” (p.244). Many psychological autopsy studies have been completed looking at major depression in suicide. These studies find that the 20 to 35 percent rates of depression as a contributing cause of suicide to be conservative and that a rate of 30 to 40 percent is more accurate (Foster, T., Gillespie, K., McClelland, R., & Patterson, C. (1999); Henriksson et al., 1993; Brent et al., 1999). The aforementioned references included both secondary and primary depression as well as individuals who were comorbid with other disorders.

In a variety of studies, suicide estimates are higher for mood disorders than for depression alone (MHO, 2002). Mood disorders include Major Depressive Disorder, Bipolar I & II, Dysthymia and Adjustment Disorder. The numbers range from 36 percent to 70 percent depending on the study. The variability is attributed
to unreliable methods of diagnosis and differing interpretations of what is meant by the term Mood Disorders (MHO, 2002).

Thoughts about suicide, referred to as "suicidal ideation," are an important risk factor for suicide. However, many individuals experience suicidal ideation but never commit or attempt suicide (Wetzler, S., Asnis, G.M., Bernstein H.R., Virtue, C., Zimmermann, J., & Rathus, J.H., 1996).

Adults that have experienced depression in adolescence increase their risk for poor social adjustment in their adult lives (Goodyear, 1993). According to Goodyear (1993), adults with a history of depression in adolescence have "high rates of marital discord, poor work records and frequent episodes of psychological difficulties" (p.52).

Stressful life events have been a contributing factor in the high suicide rate in the United States. Brent, D.A., Perper, J.A., Mortiz, G., Baugher, M., Roth, C., Balach, L. & Schweers, J. (1993) established that, "life stressors, particularly loss, (i.e. death or disruption of a relationship), were associated with suicidal behavior" (p. 1). According to Lipschitz (1995) suicide is more frequent in people who are single, childless, separated, divorced, or widowed. These classifications are explained by either the loss of a relationship or lack of a family unit.

Cohesion, where family members have warm affective ties, characterizes a healthy functioning family environment. A negative family environment is described as very strict and controlled with resistance to change (Aydin, Betul, Oztutuncu, & Filiz, 2001). Family members who feel unsupported have been found to "experience more depression and work related stress" (p.1).
In a large study done by the National Institute for Mental Health (1999), adults who drank alcohol and suffered from depression reported an increase in suicidal ideation. In another survey, persons who reported that they had made a suicide attempt during their lifetime were more likely to have had a depressive disorder, and many also had an alcohol and/or substance abuse disorder (NIMH, 1999). In a study of all non-traffic injury deaths associated with alcohol intoxication, over 20 percent were due to suicide (NIMH, 1999).

The National Center for Health Statistics reports that nearly three of every five suicides in 1999 (57%) were committed with a firearm. Using a firearm was the most common method for both men and women. Brent & Perper (1991), state, “the rate of firearms suicide has been reported to be directly proportional to the domestic production, sales, and per-capita ownership of firearms” (p.2989). It is their recommendation that all firearms be removed from a home with a family member that is at-risk for suicide.

Prevention Strategies

On February 8, 2000 the Surgeon General, Dr. David Satcher, of the United States spoke before the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, and Education. He outlined a national strategy to aid in the international efforts to prevent suicide. He stated that in 1996, “the World Health Organization, recognizing that mental illness, including suicide, ranks second in the burden of disease in established market economies, urged member nations to address suicide” (¶ 6). WHO currently has
established its own suicide prevention task force, looking at the issue from an international perspective.

The Surgeon General explained that now there is an understanding that, “many suicides and intentional, self-inflicted injuries are indeed preventable” (6). The national strategy to address the issue of suicide is called A-I-M, which stands for Awareness, Intervention, and Methodology. He further explains what A-I-M means, stating,

"Awareness" signifies our commitment to broaden the public's awareness of suicide and its risk factors.
"Intervention" means we will enhance services and programs, both population-based and clinical care to reduce suicide.
And "Methodology" compels us to advance the science of suicide prevention (7).

The Center for Disease Control (CDC), is another important government agency that has been studying and examining ways to improve suicide prevention efforts. The CDC has worked closely with states, communities, universities, and partners in the private sector and others, to contribute to the understanding of suicide prevention. For example, CDC is supporting the development of a suicide-prevention research center that will describe the magnitude of suicidal behavior, promote research, and identify prevention activities (Satcher, 2000).

According to the Surgeon General (2000), the Centers for Mental Health Services and Substance Abuse Treatment, “is providing grants to schools and community organizations that have provided a plan to build consensus around and pilot an evidence-based program to promote healthy development and prevention of youth violence, including suicide” (13).
Adolescent Suicide in the United States

Rate

According to King, K. (2000), the rate of suicide for adolescents has increased more than 300 percent from 2.7 per 100,000 in 1950 to 11.1 per 100,000 in 1990. Annatto (1996) reported the increase as high as 400 percent, bringing the problem to a new level of intensity and recognition. According to the National Mental Health Association (2002), 5,000 young people ages 15-24 kill themselves each year. “Every day, 14 young people complete suicide. This means every 100 minutes a teen dies by suicide” (NMHA, 2002). The suicide rate for this age group has nearly tripled since 1960 making it the third leading cause of death in adolescents and the second leading cause of death among college age youth” (King, 2000; NMHA, 2002). Martin and Dixon, 1986 believe that the suicide rate of adolescents could be higher than researchers report. They state, “these statistics probably underestimate the frequency of suicide because of misreporting of accidents and underreporting as the result of cultural taboos related to the act” (p.265).

Professionals that work with adolescents and their families have become increasingly concerned with the issue of suicide. Henry & Stephenson (1993), state the actual numbers of reported completed suicides may be higher than official reports, but due to the social stigma of suicide these deaths are reported as accidents.

A survey conducted in 1995 by the Center for Disease Control and Prevention (CDC) found that one out of ten college students had seriously
considered suicide during the year preceding the survey. A 1997 survey of high school students reported that one in five had seriously considered suicide, and that one in ten had actually attempted it (Jamison, 1999). Attempted suicide among the young has increased significantly; it's estimated that more than half of all attempted suicides are under thirty years of age (Curran, 1987). The actual numbers are almost certainly higher, for many suicides are recorded as accidents, especially when the victim is an adolescent (Curran, 1987).

It is also important to mention that suicide and suicidal ideation also exist in children ages five to fourteen. In the literature there is a continuing debate concerning child suicide. Many experts question whether children understand death or have the means to carry out a suicidal act (Matter & Matter, 1984). Yet a study by Turkington (1983) reported that “about 12,000 children aged 5 to 14 are admitted to psychiatric hospitals for suicidal behavior every year,” but “this number could represent less than 5 percent of children who actually try” (p.15) to commit suicide.

Younger children may use different methods with a lower rate of success than adolescents. This has been attributed to their difference in cognitive capabilities; however, “young children do plan, attempt, and successfully carry out suicide” (Matter & Matter, 1984 p. 260).

Contributing Factors to Suicidal Behavior

According to Bettes & Walter (1986), “there is no agreed upon “suicide risk profile” for adolescents and children” (p.592). Crespi (1990) echoes this
statement by recognizing that there is no single predictor of suicide. The Committee on Adolescence also explains, "no specific tests are capable of identifying suicidal persons" (p.871). Despite these facts, researchers have discovered many factors that contribute to suicidal behavior. These factors include: the influences of developmental state, depression, family, substance abuse, gender differences, behavioral changes, and access to firearms. All have all been identified as contributing factors of adolescent suicide (O’Roark, 1982; Matter & Matter, 1984; Capuzzi & Golden, 1988; Flanagan, 1985; Berman & Jobes, 1995; Allberg, & Chu, 1990; Committee on Adolescence, 2000).

**Developmental Influences.** Berman & Jobes (1995) define adolescence as, “a transitional developmental period between childhood and adulthood, initiated by puberty. The physiological changes attendant to pubescence are precursors to a host of psychosocial demands and personality changes common to the years bridging to maturity (p.43).” The researchers claim in order to have an epidemiologic understanding of suicidal behavior the definition of an adolescent has to be clear.

Adolescent suicide is often difficult to understand and explain. According to Allberg & Chu (1990) contributing factors to adolescent suicide include depression, interpersonal conflicts and isolation, family background, emotional disorders and egocentrism. The Committee on Adolescence (2000) adds to this list by including legal difficulties, school difficulties or failure, and physical ailments.

Adolescence is a time for searching for identity, and beginning to establish autonomy. It is often during this stage that adolescents encounter more
interpersonal conflict, either within their families or with friends (Allberg & Chu 1990). When conflict is experienced both within family and with friends an adolescent may feel isolated and unsupported. Allberg & Chu (1990) state, “An isolated adolescent, without support from family or friends, in a time of stress, is at high risk” (p.344).

Other studies have suggested that the loss of a meaningful relationship can be a precursor to suicide (Flanagan, 1985; O’Roark, 1982). Losses such as the death of a parent, divorce or the breakup of a meaningful love relationship can cause adolescents to look for a quick solution to their problems. This can be found in the increase of drug or alcohol use and suicide (O’Roark, 1982).

**Depression.** Depression has been found to play a significant role in adolescent suicide (O’Roark, 1982; Bettes & Walker, 1986; Martin & Dixon, 1986; Curran, 1987; Neiger & Hopkins, 1988; Bagley, 1992; Culp, Clyman & Culp, 1995; Wetzler et al., 1996; Lewinsohn, P.M., Rohde, P., & Seeley, J.R., 1993; C.A. King, 1997; Committee on Adolescence, 2000; Borowsky, Ireland, & Resnick, 2001). There is a need for school counselors, parents, and teachers to be able to identify depressive symptoms in adolescents to minimize the risk of more serious problems such as suicide (Culp, Clyman & Culp, 1995).

Allberg & Chu (1990) reported that some researchers claim that, “depression is the most common ingredient in most suicides” (p.344). In a study completed by Tishler, Mckenry, & Morgan (1981) it was revealed that in most adolescent suicide attempts the individual had clear signs of a depressive state.
Some of the symptoms reported were sleep disturbances, appetite changes, and inappropriate affect.

It has been suggested that most suicide risk is linked with psychopathology. From the 1920's the risk of adolescents suffering from major depressive disorder has significantly increased in both the earlier onset of the disorder and the duration in which it lasts (Berman & Jobes 1995). Bagley (1992) examined studies from the 1970's to early 1990's to ascertain the occurrence of depression, as defined by the DSM-III-R and other valid depression measures such as the Beck Depression Inventory, shows an increase in the rate of adolescent depression. This increased rate directly parallels the increase in suicidal behavior in adolescents. Depression is clearly one of the warning signs of potential adolescent suicide (Bagley, 1992).

The Committee on Adolescence (2000) recommended, “all adolescents with symptoms of depression should be asked about suicidal ideation, and an estimation of the degree of suicidal intent should be made” (p.872). Depression in the adolescent may present itself in a variety of psychosomatic symptoms or behavioral problems. Sometimes psychosomatic symptoms present in adolescents the same way they do in adults, but often there is additional symptomatology. Additional psychosomatic problems may include: chest pain, abdominal pain, headache, and lack of energy, weight loss and dizziness. Behavior problems, which may be masking the depression, may include: truancy, decreased academic performance, running away from home, defiance of authority, self-destructive
behavior, substance abuse, delinquency and sexually acting out (Committee on Adolescence, 2000).

**Family.** Researchers have recognized that family disorganization and dysfunctional family relations may increase the risk of suicide in adolescents (Matter & Matter, 1984; Capuzzi & Golden, 1988; Jilek-Aall, 1988; Neiger & Hopkins, 1988; Berman & Jobes 1995; C.A. King, 1997; Allberg & Chu; 1990; Borowshy, I.W., Ireland, M., & Resnick, M.D., 2001). Over the past several decades, American society has seen a decline in the traditional dominant culture nuclear family (Capuzzi & Golden, 1988). Berman & Jobes (1995) have reported, “there is now significant evidence that family factors are an important correlate of suicidal behavior among youth” (p.144). Some of the major contributing factors to this risk are, “separation from and/or rejection by parents, poor family communication and problem solving, and parental psychopathology” (p.144).

Allberg & Chu (1990) further describe additional factors of family dysfunction, including parental neglect, cruelty, abandonment, divorce, separation, and death of one or more parents.

In an examination of families of suicide attempts compared to non-attempters there was found to be a difference between them (Tishler, Mckenry & Morgan, 1981). The families of suicide attempters studied showed not only organizational differences, but also an impaired communication style that led to lack of productive communication, which includes frequent conflict, lack of
problem-solving ability and more negative comments (Tishler, Mckenry & Morgan, 1981).

Adolescents who are exposed to suicidal acts or gestures by family members are at greater risk for suicide (Henry & Stephenson, 1993). It has been suggested that adolescents may perceive suicide attempts by family members as an appropriate way to deal with life stressors (Hawton, 1986). Family attempts increases adolescent risk because they perceive suicide as a viable option.

Depression has been consistently reported to affect a greater number of women than men (McCann & Endler, 1990). Therefore, it is important to examine adolescents and children who grow up in a home with a mother who suffers from depression. McCann & Endler (1990) report depressed women find it, “difficult to be warm and consistent parents and that they are less positive in their assessments both of their mothering capabilities and of their enjoyment of being mothers” (p.188). The authors conclude that given this information there is a growing body of evidence to suggest that children growing up with depressed parents, “are at an increased risk for a variety of psychological and social difficulties” (p.188).

For adolescents, the family is a source of social support and an important resource for coping with stressful life events (Aydin, 2001). A sense of connectedness to extended family and parents is considered a significant protective factor against suicide for all youth (Borowsky, Ireland & Resnick, 2001).

Cultural / Ethnic & Gender Differences. Cultural and gender differences in suicide rates must be considered in examining adolescent suicide. According to the World
Health Organization (WHO) self-inflicted injuries including suicide accounted for about 814,000 deaths in 2000. According to WHO (2000), “the precise explanation for variations in suicide rates must always be considered in the local context” (Jilek-Aall, 1988).

Suicide is considered a world health problem, but not all countries are experiencing suicide as a national problem. Jilek-Aall (1988) explains the difference in suicide rates can be attributed to different cultural and religious belief systems. For example, in Norway, where suicide is rare, the population tends to be spread out among the country in small isolated pockets. Old customs and traditions are passed from generation to generation. Traditional Protestant ethics dominates the culture in regard to family and child rearing. Jilek-Aall (1988) reports the act of suicide is classified as “dishonorable homicide”, and is still considered, “a shameful, meaningless act and a sin against God. Suicide is therefore looked upon as an evil deed” (p.89).

This is in sharp contrast to the country of Japan were suicide is glorified and at times encouraged. Jilek-Aall (1988) points out that Japan, “can be used as an example to demonstrate that religious and cultural attitudes influence suicide behavior. Ritualized suicide is an approved way to achieve self-esteem and honor” (p. 92). Throughout history, Japan has had some of the highest suicide rates along with epidemic and mass suicides (Jilek-Aall, 1988).

Depending on the study, the gender and ethnic rates in suicide attempts and completions vary. In one study of suicide, one of the patterns that emerged is the gender gap in rates. Vannatta (1996) identifies males as four times more likely to
complete suicide than females. Langhinrichsen-Rohling, J., Lewinsohn, P., Rohde, P., Seeley, J., Monson, C. M., Meyer, K.A., & Langford, R. (1998) report that the suicide rate for males in 1992 was 21.9 per 100,000, compared to a female rate of 3.7 per 100,000. This was despite the fact that females are more likely to report suicide attempts. One explanation for the difference in gender rates has been the fact; “females have a greater tendency toward depressive and mood disorders during adolescence” (Culp Clyman & Culp, 1995 p.2). An alternative explanation is that cultural norms impact suicide behavior, reporting of suicide, and help seeking behavior (Westefeld et al., 2000). American men and women perceive suicide differently. A woman’s suicidal behavior may be looked at as a call for help, while similar behavior in men is seen as weak and inappropriate (Westefeld et al., 2000).

According to Canetto (1997), “Between 1970 and 1980, the suicide mortality rates for females ages 15-24 showed a slight increase, while the suicide mortality rates for males of the same age group increased by 50 percent” (p.341). Yet females are three times as likely to engage in nonfatal suicidal behavior (Canetto, 1997).

Kalafat (1990) reported that girls attempt suicide nine times more frequently than boys, but boys complete suicide about five times more often than girls. The difference in rates is explained by the fact that boys tend to use more lethal means, such as firearms, hanging, and automobile accidents, while females use less lethal methods; for example, sleeping pills and carbon monoxide/dioxide poisoning (Popenhagen & Qualley, 1998).
Current research studies have shown that completion rates among Caucasian adolescent males is higher than any other ethnic group (Canetto & Sakinofsky, 1998; Metha, Weber & Webb, 1998; Popenhagen & Qualley, 1998). One explanation that has been given for the lower rates in African-American and Hispanic American adolescents compared to their Caucasian counterparts, it is speculated that social stresses and discrimination that may be encountered has helped to create protective factors such as extended networks of family and social support (Capuzzi, 2002; Westefeld et al., 2000). African American and Hispanic American culture appears to provide some protective buffers against suicide as compared with the dominant culture (Westefeld et al, 2000). Capuzzi (2002) reports that given the overall trend of African-American lower rates of suicide, “during the period between 1980-2000, the suicide rates for African American adolescent males showed an increase of approximately 200 percent” (p.37).

The finding among Native American adolescents differs considerably depending on the nation. The Navajos have a rate that approximates the national average of 11 to 13 per 100,000 (Popenhagen & Qualley, 1998), while some Apache groups have been found to have rates as high as 43 per 100,000 (Capuzzi, 2002). The higher rates among Native Americans have been attributed to such factors as acculturation, alcoholism, substance abuse, unemployment, availability of firearms, and child abuse and neglect (Capuzzi, 2002; Westefeld et al, 2000).

Hispanic Americans have a lower rate of suicide than non-Hispanics, 9.2 per 100,000 compared to 19.2 per 100,000, (Westefeld et al., 2000). It has been suggested that culture may contribute to this lower rate in several ways. "First,
Hispanic Americans have well developed social networks that include family, extended family and friends. Second, typically Hispanic Americans have strong religious convictions where it is believed that suicide is not appropriate under any circumstance. Third, Hispanic Americans “have an emphasis in fatalismo, the belief that divine providence rather than person control regulates the world, so individuals must strive to accept life’s circumstances” (Westefeld et al., 2000, p.459).

Asian Americans also have a lower rate of suicide compared to the majority culture, but the risk for Asian Americans appears to increase with age. One cultural force that may impact suicide is the de-emphasis of the individual and a corresponding emphasis on the group and group interdependence and interconnectedness (Capuzzi, 2002; Westefeld et al., 2000). This perspective would make suicide a selfish act that harms the entire group and shames the family therefore suicide would appear to be less of an option for Asian Americans. When a suicide does occur it may be tied to acculturation stress (Westefeld et al.).

Another high-risk group that is mentioned throughout the literature is gay and lesbian adolescents (Gibson, 1989; Hershberger & D'Augelli, 1995). According to Gibson (1989), gay and lesbian adolescents are two to three times more likely to commit suicide than other adolescents, and 30 percent of all completed adolescent suicides are related to the issue of sexual identity.

Hershberger & D’Augelli (1995) reported that confusion over sexual identity was a risk factor for suicide. In their study, the single largest predictor of mental health was self-acceptance. A critical factor for adolescent mental health is
a general sense of personal worth, coupled with a positive view of their sexual orientation.

**Behavior changes.** Behavior changes have been identified as a risk factor for suicide during adolescence (Capuzzi & Golden, 1988; Popenhagen & Qualley, 1998; Peach & Reddick, 1991; King, 2000; Capuzzi, 2000). It is often these behavioral cues that alert others that something is wrong. Behavioral changes may include: changes in eating or sleeping, withdrawal from friends, family and regular activities, lack of concern about personal welfare, decline in school achievement, drug or alcohol use, radical change in personality, physical complaints, and attempts to put personal things in order (Peach & Reddick; Capuzzi, 2000).

It is also important to point out that people considering suicide often tell others through verbal cues (Capuzzi & Golden, 1988, King, 2001). These cues may be subtle or very obvious. Verbal cues that have been reported include the following: “I can’t go on”, “I’m going home”, “Life has no meaning”, “I am going to kill myself”, “I want to die”, “I don’t want to be a burden anymore”, “My family would be better off without me” (Capuzzi & Golden 1988; King 2000). King (1999) states that indirect cues can be found in the form of notes, drawings, journal writings, and poems as well as giving away possessions.

Martin & Dixon (1986) report that, “social isolation is the primary variable differentiating true suicide intent from a suicide gesture” (p.267). An increase in social isolation is experienced by an estimated 25 percent of all suicidal adolescents (Martin & Dixon, 1996). Therefore, isolation is a significant
contributor for youth who are at risk for killing themselves (Culp Clyman & Culp 1995). Suicide may be avoided when adolescents feel that they have someone to turn to for help (Martin & Dixon, 1996).

Past Attempts. Past attempts have been reported as one of the strongest risk factors for suicide completions in all age groups (Capuzzi & Golden, 1988; Lewinsohn et al., 1996; Borowsky et al., 2001). According to Borowsky et al. (2001), “the most important correlate for youth suicide is a previous attempt” (p.485). These researchers state, “injurious suicide attempts are over 100 times more frequent than completed suicides” (p.485). Lewinsohn et al. (1999) reports that approximately one third of suicide completers, and fifty percent of female completers have had at least one prior suicide attempt. With adolescents who have attempted suicide, 12 percent will try again and succeed within a two-year period (Capuzzi & Golden, 1988).

Access to Firearms. Berman & Jobes (1995) explain that one in four adolescents with a history of substance abuse or prior suicide attempts live with firearms in their homes. The access to firearms by adolescents has been one of the most cited findings related to the increase in completed suicides (Berman & Jobes, 1995).

Over the past several decades, there has been a shift in the methods used by individuals that commit suicide (Lipschitz, 1995). In the past, women were more likely to use less violent means such as overdosing or poisoning. In 1990, guns accounted for “65 percent of the male suicides and 53 percent of female suicides” (Lipschitz, 1995 p. 155). In 2000, firearms were the leading cause of death in 67%
of suicides committed by both men and women. Due to the lethal nature of firearms, 90 percent of suicide attempts were completed because there is little chance of rescue (The Committee on Adolescence 2000).

In 1999 there were almost exactly the same numbers of suicides by firearms (16,889) as homicides (16,599) (NIMH). Access to firearms by adolescents, regardless of how they are stored in the home, for example, in a locked cabinet or unloaded, increases the risk of an adolescent suicide completion. The Committee on Adolescence (2000) and Brent et al. (1991) recommend that all firearms be removed from the home where there is an individual at risk for suicide.

Drug & Alcohol Use. Alcohol abuse has emerged as a distinct contributing factor in adolescent suicide (Capuzzi & Golden, 1988; Jilek-Aall, 1988). According to the Committee on Adolescence (2000) 50 percent of all suicides were associated with alcohol use.

Adolescents under the influence of drugs and/or alcohol tend to react atypically to life stressors. The use of drugs or alcohol often helps adolescents to escape pain, or the substances are used as a replacement for elements that are missing in their lives (Herring, 1990). It is suggested by Neiger & Hopkins (1988) that adolescents under the influence of alcohol may act more impulsively. It is than assumed that a suicide attempt or completion under the influence is often an impulsive act. Impulsivity is a trait that suicidal adolescents have in common with substance abusers (Capuzzi & Golden, 1988).

In a study by Brent et al. (1993) it was reported that interpersonal loss and conflict were more common in substance-abusing suicide victims than non-
substance abusing victims. Substance abusing victims were also found to have more employment and legal problems (Brent et al., 1993).

Substance abuse that coexists with depression is a significant risk factor for adolescent suicide (Capuzzi & Golden, 1988; Berman & Jobes, 1995). It is unclear which comes first, the depression or the substance abuse, but studies have shown that depression is common among relatives of alcoholics (Capuzzi & Golden, 1988).

**School Counseling**

The role of the school counselor and expectations for the profession are fundamental to this study. The role of school counseling, including history, professional organization standards, and ethical and legal implications will be reviewed in this section.

**History**

The history of the guidance movement can be traced back to Frank Parsons, also known as the Father of Guidance. In 1908, he started the Boston Vocation Bureau where he served as director and a vocational counselor (Rosenthal, 1993). Parsons (1909) felt the need for vocational counseling was growing rapidly, and recognized that counselors need specific vocational counseling training in order to meet the needs of individuals in schools, colleges, universities, and business establishments. The purpose for establishing the Vocational Department of the Boston Young Men’s Christian Association was explained by Parsons, “to fit men for this new vocation, this pioneer school for the training of counselors has been established” (p.93).
In the 1920's the services model of school counseling began to take shape. It emphasized six major areas of service: (1) orientation, (2) assessment, (3) information, (4) counseling, (5) placement, and (6) follow-up. The shortcomings to the services model are they are better suited for secondary school and student outcomes are difficult to ascertain (Gysbers, 1990). The process model of school counseling also has it roots in the 1920's and focuses on counseling, consulting, and coordinating. The major limitation to this model is the same as that of the services model, that student's outcomes are not easily identified (Gysbers, 1990).

Gilbert Wrenn (1962) was also a pioneer in the school counseling movement and recognized it as an American phenomenon. He states, "no other country in the world devotes so much attention to the child as an individual and to assisting children in the decisions they must make as they grow up" (p.1). He also recognized the role of the school counselor was changing as society as a whole changed. Wrenn (1962) describes many dilemmas a school counselor faces. First, the counselor must be available to everyone in a school and not just to select groups. Second, the counselor needs to be cognizant of school structure and must be sensitive to the overall educational climate in order to best serve students.

Several studies of school counselor preparation programs were examined by Wrenn (1962). It was found that counselors needed additional competencies in the areas of knowledge of psychology and personality development, sources of difficulty and their remediation, skills in counseling, and knowledge of testing (Wrenn, 1962).
In looking at how school counselors are trained, it was Wrenn’s recommendation to graduate programs that they continue to provide and expand the areas of: knowledge and skills in understanding and dealing with individual behavior dynamics; the study of cultures including the community, nation and world; skills in working with parents, and school staff; knowledge of school purpose, organization, curriculum, and instructional procedures; as well as a minimal understanding of research procedures and cautions. It was also recommended to current school counselors in the field that they recognize the expanding cultural changes in the world and continue to grow both personally and professionally (Wrenn, 1962).

As the school counselor profession continued to grow and change, Norman Gysbers acknowledged, “guidance in the schools began as vocational guidance with an emphasis on occupational selection and placement but beginning in the 1960’s, but particularly in the 1970’s, the concept of guidance for development emerged” (p.2). The profession began to take a turn away from the traditional idea of specific programs and began to emphasize the position of the school counselor. Since the guidance programs were not defined or organized, school counselors roles began to take on many new tasks, such as clerical and administrative (Gysbers, 1990).

The comprehensive guidance program model began in the late 1960’s. The main purpose was to address the, “lack of appropriate organizational structure for guidance in America’s public schools” (p.1). In 1974 the first manual was created
on how to create an organizational structure for comprehensive guidance programs.

Gysbers (1990) explains,

The program definition includes the mission statement of the guidance program and its centrality within the school district's total education program. It delineates the competencies individuals will possess as a result of their involvement in the program, summarizes the components and identifies the program's clients (p.13)

The roles and responsibilities of the school counselor have changed over the past century. Today many school counselors are part of programs that help to define their positions.

Professional Organization Standards and Core School Counseling Roles

American School Counseling Association. The organization that is recognized specifically for school counselors is the American School Counseling Association (ASCA). ASCA was founded in 1952 and states the purpose of the organization is to, “support school counselor’s efforts to help students focus on academic, personal/social, and career development so they not only achieve success in school but are prepared to lead fulfilling lives as responsible members of society” (¶, 1).

ASCA has created its own national standards for school counseling programs in preparing school counselors. These standards were created to provide a model for consistent practice in educating school counselors across the country. The National Standards for School Counseling Programs focus on the development of students in three broad areas: academic development, career development and personal/social development.
In a study by Perusse, Goodnough & Noel (2001) they examined how many school counselor preparation programs were utilizing the ASCA national standards. It was found that ASCA national standards were not being used with any consistency. Many of the respondents reported that their programs were CACREP accredited and that CACREP has specific guidelines for the training of school counselors and therefore no other standards were needed (Perusse, Goodnough & Noel, 2001).

According to ASCA there are currently around 12,000 members of the organization in the United States and the school counselor to student ratio is 1 to 513 (ASCA, 2003). It is not stated in the literature exactly how many school counselors are employed in the U.S. that are not members of ASCA.

**Ethical and Legal Implications**

There are ethical and legal issues that school counselors should be aware of when dealing with suicidal students. Issues such as privacy, confidentiality, and privileged communication need to be clearly understood by school counselors.

Privacy is generally broader in nature, and is defined as, “Allowing individuals to limit access to information about themselves.” Confidentiality is often defined as “allowing individuals to control access to information they have shared” (Glosoff & Pate, 2002). According to Glosoff & Pate (2002), confidentiality is considered a “professional’s promise or contract to respect clients’ privacy by not disclosing anything revealed during counseling except under agreed upon
conditions” (p. 22). The conditions that constitute a breach of confidentiality for school counselors include:

- The client is a danger to self or others.
- Client or parent requests that information be related to a third party.
- Suspected child abuse or neglect (Glossoff & Pate, 2002).

Very few relationships with students are considered privileged. This is because parents of minor students, rather than the minor counselees, are considered to control the privilege (Glossoff & Pate, 2002). The ethical standards are clear about parents’ rights of privileged communication. The standards state, “The professional school counselor respects the inherent rights and responsibilities of parents for their children…” (ASCA, 1998, B.1.a.).

The statute is clear in giving privileged communication to the client, not the counselor. Glossoff & Pate (2002) state, “Currently there are only 16 states who grant statutory privilege directly to counselors who are certified or licensed by state boards of education to practicing school counselors.”

Breaching confidentiality when a student is suicidal is extremely important. King (2000) states that a school counselor when faced with a suicidal student needs to notify the student’s parents and the school principal. Ethically students need to be told up front when confidentiality will be breached.
Currently courts have been reluctant to hold educators liable for injuries related to violence or self-harm (Huey & Remley, 2000), but courts in the future will probably expect schools to have prevention programs in place (Capuzzi, 2002).

The Maryland Court of Appeals in 1992 ruled that, "school counselors have the legal duty to protect students if they foresee or should have foreseen that the student was potentially dangerous to himself or herself" (King, 2000).

Adolescent Suicide Prevention

Introduction

School counselors are often responsible for dealing with the mental health issues of students and helping other staff members effectively deal with student mental health concerns (King, 2000). Adolescent suicide is a continued concern for parents and school based professionals (Matter & Matter, 1984). This concern has become nationwide, as is evidenced by current legislation, and continued research by the CDC, SAMHSA, through its Centers for Mental Health Services and Substance Abuse Treatment, and the World Health Organization. In recent years there has been a significant growth in school-based suicide prevention programs.

Prevention efforts in schools can usually be divided into two distinct areas that are interrelated (Boylan, 2001). The first level is primary prevention, which generally includes all efforts made to work with students before problems occur (Miller & DePaul, 1996). The second area of suicide prevention, which can also be
called secondary prevention, involves the identification of individuals dealing with problems while the problems are still minor (Miller & DePaul, 1996).

Myths

The act of suicide is often misunderstood, and there are many myths surrounding the topic. In order to get a better understanding of the act of suicide, these myths need to be identified and factual information presented. Researchers have identified common suicide myths that permeate our culture (Capuzzi, 2002, Pare, 2000; King, 1999; Popenhagen & Qualley, 1998; Capuzzi & Golden, 1988; Martin & Dixon, 1986). One of the more popular myths is that suicide happens with no warning. This is false due to the fact that most people who commit suicide often give clues or warning signs of their intentions. The majority of people who attempt suicide say or do something to express their intention before they act (Pare 2000).

Capuzzi and Golden (1988) discuss a similar myth that adolescents who talk about suicide are not serious about doing it. They state that almost all adolescents give some type of verbal or behavior warning signs before committing the act of suicide. All suicidal talk should be taken seriously and, “never assume such threats are only for the purpose of attracting attention or manipulating others” (p.14). Curran (1987) echoes the prevalence of this myth by stating that there is an, “insinuation that threats of suicide represent attention seeking behavior, especially among the young” (p.134). The truth is that suicide attempts of adolescents are
often to “check out the level of caring and responsiveness that exists out there for them in the world” (Curran, 1987, p.134).

Another misconception is that talking about suicide increases the risk of a suicidal person committing the act. Research has shown that asking a person about suicidal ideation, or talking with them about suicide and discussing options can often be a deterrent (Popenhagen & Qualley, 1998). It is also a myth that all suicidal people really want to die. Some may want to die but for the majority the suicide act is a calling out for help. This is evidenced by suicide attempts that use less lethal methods; for example, only taking a small number of pills. Popenhagen & Qualley (1998) state, “some may actually design their suicide attempts in such a way to ensure that they are discovered before it is too late” (p.31).

It is often assumed that once a person is suicidal that they will always and forever be considered suicidal. The twenty-four to seventy-two hour periods around the crisis is the most dangerous (Capuzzi & Golden, 1988). Another related myth is that a person who attempts suicide is safe from any further attempts. According to Martin & Dixon (1986) four out of five people that attempt suicide have made previous attempts. This is explained by Capuzzi & Golden (1988) that adolescents that attempt suicide have created a plan, found the means, and actually followed through with their plan. After the first attempt, the suicidal adolescent realizes that a second or third attempt is possible, and with each attempt more lethal means are used (Capuzzi & Golden, 1988).

Contrary to popular belief, most suicidal behavior happens in the spring and not the dark months of winter. April has been recognized as the peak month
where suicide attempts are, “up 120 percent above the average for the rest of the
year” (Martin & Dixon, 1986 p. 265). Similarly, suicide has been associated with
darkness and it is assumed that most suicide attempts happen late at night. This is
also untrue; adolescents most frequently chose a time between, “3:00 p.m. and
6:00 p.m. when others are home and usually readily available for rescue” (Martin

It is believed that most people that commit suicide leave notes or letters for
family members or friends. Capuzzi & Golden (1988) claim that this myth is not
ture because most adolescents actually want help. Martin & Dixon (1986) state
that only about 15 percent of adolescents that commit suicide actually leave a note.

There is another belief that suicide is inherited and can pass from
generation to generation. According to the University of Oregon crisis center myth
information and King (1999), suicidal behavior may run in families, but there is no
proof that suicidal tendencies are transmitted genetically.

Knowledge of Contributing Factors of Suicidal Behavior

“The professional literature is consistent in stating that school counselors
play a vital role in the prevention of adolescent suicide” (King, 2000, p.6).
Counselors may also be the first professional in a school confronted with a suicidal
student (Peach & Reddick, 1991) Several studies have looked at the preparedness
of school counselors to deal with the issues of suicide (King & Smith, 2000; King,
King & Smith (2000) surveyed school counselors in Dallas, Texas after a suicide-training program. It was reported that the majority of the school counselors surveyed were knowledgeable about the risk factors for suicide, and about appropriate interventions and postvention steps to take when dealing with suicidal adolescence. The discrepancy in the study was between school counselors' knowledge of suicide risk and their ability to actually identify students at risk for suicide. In an early nationwide study by King (1999), 38 percent of high school counselors believed they could recognize a student at risk for suicide. One explanation for this low rate in identification ability is that school counselors, especially at the high school level, have very large caseloads and additional responsibilities leaving them little time for one on one interaction with students (King, 2000).

Project SOAR (Suicide, Options, Awareness, and Relief) was created as an intensive suicide prevention-training program for school counselors in Dallas, Texas. The researchers revealed that after training 74 percent of counselors felt knowledgeable about the district's policy and procedures on suicide and 76 percent felt knowledgeable about how to refer suicidal students to a community health professional. Over half the counselors also reported knowing how to offer a no-suicide contract or understanding crisis theory and how it relates to crisis intervention. These two factors are important because they are common tools used when counseling a suicidal student. One-third believed strongly that teachers and other school staff know the warning signs for adolescent suicide.
Most counselors in the study knew that being depressed, possessing low self-esteem, being in a recent relationship breakup, and coming from an abusive home were all risk factors for adolescent suicide (King & Smith, 2000). The majority also knew what to do when dealing with a suicidal student; for example, calling the student's parents, listening to the student, notifying the principal, and asking for assistance from appropriate community agencies.

King & Smith (2000) established that counselors who received SOAR training in the past three years were significantly more knowledgeable about suicide intervention steps than counselors who had not received the training in the past three years. It is recommended that training of school counselors working in the field receive periodic training aimed at building their knowledge in the area of suicide risk factors and prevention skills. The use of role-plays and mock scenarios give school counselors the opportunity to practice new skills they need to increase their knowledge and confidence when dealing with adolescent suicide (King & Smith, 2000).

Peach and Reddick (1991) state, "school is one of the most important places outside the home to most adolescents" (p.108). In their study of six southeastern states 63 percent of counselors reported that they were aware of certain warning signs and approximately 20 percent stated that there was a formal suicide prevention or intervention program in their schools.
Prevention.

The prevention movement started in the mental health field offering educational materials and programs to strengthen the healthy functioning of people (Coyne, 1980). The underlying theory behind the primary prevention movement is that traditional approaches of dealing with individuals one-on-one are not practical.

Therefore, for those who are concerned about stemming the tide of new problem cases, the traditional palliative approaches must be supplemented by other methods to seek to lower incidence; that is, they are offered to avert problem occurrence in the first place (Coyne, 1980 p.13).

In order to be proactive and address the issue of suicide, many schools, communities, organizations, and associations have developed primary prevention programs (Capuzzi & Golden, 1988). Suicide programs at the K-12 levels mostly focus on the area of suicide prevention, but also include intervention and postvention. King (2001) states, “prevention offers the most direct method for saving student lives from suicide and therefore should receive much attention” (p.133).

Currently 19 states have adopted legislation regarding youth suicide prevention and in four states, the laws specifically mandate a school curriculum (Metha A, Weber B, & Webb L.D., 1998). California is one state that has created laws to mandate the implementation of school-based suicide prevention programs (Metha et al., 1998).

According to Harbor Injury Prevention and Research Center (2000), the goals of school based suicide prevention programs are to: “increase awareness,
promote identification of students at high risk of suicide and suicide attempts, provide information to students, teachers and parents on the availability of mental health resources, and enhance the coping abilities of teenagers” (p.1). King, 2001, describes school suicide prevention as referring to, “all school programs and activities aimed at decreasing student suicide thoughts, attempts and completions” (p.133).

In these programs school personnel are specifically taught warning signs of suicidal students, referral sources and procedures, and school crisis policies (Berman & Jobes, 1995). Warning signs are classified into three categories, behavioral, verbal and stressful life events. Capuzzi (1988) and King (2001), both national experts on the subject of suicide, list the following warning signs that should be covered in most training programs.

Behavioral warning signs include: being depressed, change in appetite/weight, change in behavior, change in school performance, helplessness/hopelessness, loss of energy, loss of interest in once-pleasurable activities, giving away cherished possessions, morbid ideation, substance abuse, becoming withdrawn/isolated.

Verbal warning signs include quotes similar to: “I am going to kill myself”, “I want to die”, “I can’t stand living anymore”, “don’t worry about me”, “I won’t be around much longer”, “I don’t want to be a burden”, “my family would be better without me”, and “I’ve had enough”; “I am ending it all”.

Stressful life events can include: Changes in close relationships, history of attempted suicide, previous suicides in the family, ready accessibility to firearms, recent disappointments, and recent losses.

Referral sources and district policy and procedures are usually included in prevention programs. Due to the fact that each school district and community is unique, referral sources and school policies and procedures differ from district to district. Currently there is no uniform suicide prevention program taught across the country.

**Intervention**

King, (2001) defines intervention as, “appropriate steps school professionals should take when a student threatens or attempts suicide” (p.135). Intervention should focus on securing the surrounding area, keeping the student safe, and referring the student to an appropriate outside source.

There is relatively little research on specific suicide intervention protocol. Some articles have recommendations for dealing with a suicidal student, but there is no uniform method described. There has also been relatively little evaluation of school-based programs, which includes suicide or suicide attempts as outcome measures (Harbor Injury Prevention and Research Center, 2000).

The following are some recommended intervention procedures. One current intervention protocol recommended to school counselors includes: “ensure student safety; assess the student’s suicidal risk; determine the mental health services needed; ensure the student receives appropriate care; and debrief school staff” (King, 2001). Another approach offered by Peach & Reddick, (1991),
suggest, "reduce the anxiety level of the individual. This may be accomplished by suggesting alternatives, trying to create hope, establishing channels of communication, and involving other appropriate professionals" (p.109).

Capuzzi & Golden (1988), recommend regardless of the specific intervention strategy used the following guideline should always be followed: be calm, reassuring and supportive; encourage self-disclosure; be non-judgmental; provide acknowledgement and normalize the reality of suicide as a choice, but encourage exploration of other alternatives to problem solving; acknowledge the adolescent's internal pain; and begin problem solving unless the adolescent is in a crisis situation.

One specific method of intervention is the S.L.A.P. scale. This scale is utilized to assess specificity, lethality, availability, and proximity (Sommers-Flanagan, 1997). In a condensed version the S.L.A.P method basically consists of the following:

The S.L.A.P. Scale

Development of a plan of suicide is a major indicator of the seriousness of suicidal ideas. A well-developed plan can be measured by the following factors, referred to as the S.L.A.P. Scale. This is not a foolproof method of assessing risk, but it can be a helpful tool for individuals faced with having to gather information from a potentially suicidal person. This kind of information is very valuable to a school counselor or other school staff.

S= How Specific are the Details of the Plan?

- The greater the specificity, the higher the risk.
Adolescents may, however, be impulsive and act without a plan.

L = How Lethal is the Intended Method?

- The more lethal, the higher the risk.
- How reversible are the means?
- How intent is the adolescent on dying?
- Adolescents who have difficulty with the concept of the finality of death may use a more lethal means than those with a higher level of understanding.

A = What is Availability of the Proposed Method?

- The more available the means, the higher the risk.

P = What is the Proximity to Helping Resources?

- The greater the distance from rescue, the higher the risk.
- Proximity is measured in physical, geographical, and emotional terms.

There is no current information available concerning evaluations of the effectiveness of the above-mentioned methods. Like many methods being used in school districts all over the country there is relatively little evaluation of intervention effectiveness (Metha et al., 1998). Currently there is no information provided in the professional literature on how school counselors are trained in their graduate programs on how to use these intervention strategies.
Postvention

Postvention is defined as how a school district reacts after a suicide has taken place (King, 2000). In a study by King, (2000) the overall findings showed the majority of the school counselors surveyed were knowledgeable about appropriate postvention steps to take once a suicide had occurred.

King (2000) suggests that in training school counselors the following should be taught as appropriate postvention methods: “Having counselors available to help other students in need; offering student support groups, forming a crisis intervention plan, allowing students to miss school in order to attend the funeral, and having the school behave in a quiet, conservative manner” (p.301).

The results of this study found only one demographic variable to be significant as it relates to school counselors’ knowledge of postvention issues. This variable was the number of years as a high school counselor. The participants on average had 11 years experience as high school counselors. The study does not discuss the issue of training, or how the counselors acquired their knowledge.

School Suicide Prevention Policies

Schools are viewed by many as a primary location to implement various suicide prevention programs that include activities to educate, identify, and intervene with potential at-risk adolescents (Malley & Kush, 1994). “Schools and school officials offer an enormous amount of consistent, direct contact time with large populations of adolescents. Because schools are found in almost every
community, they are seen as potentially strategic and possibly effective suicide prevention resources” (p.130).

For school-based programs to be effective they must be comprehensive and systematic (Malley & Kush, 1994; Gysbers, 1990; Capuzzi & Golden, 1988). Comprehensive and systematic school based suicide prevention and intervention programs deal with prevention before any suicidal behavior takes place, intervention skills during a suicidal crisis, and postvention following a completed suicide (Malley & Kush, 1994). Comprehensive and systematic programs also seek to be ongoing, intact, and an updated part of a school’s student services (Capuzzi & Golden, 1988).

In a study completed by Malley & Kush (1994) it was found that about half of the schools surveyed employed the necessary components to ensure their program was both comprehensive and systematic. Forty-seven percent of counselors reported that they had received faculty training in detection of suicide warning signs, and thirty-five percent had a written protocol that describes specific criteria for counselors to assess lethality of potential at-risk students.

Many school districts have a written protocol for dealing with students that show signs of suicidal behavior (Watkins, 2002). These protocols are usually taught in an in-service format. According to Miller & DuPaul (1996) one study found, “one 2-hour session presentation to educators resulted in significant increases in both knowledge of suicide warning signs and community resources” (p.225).
A discrepancy found in the literature was the fact that many schools have developed and adopted various prevention programs, but the detailed content and effectiveness of these programs are seldom reported in professional journals (Malley & Kush, 1994). Currently there are few resources available on the, “many already developed comprehensive and systematic school-based adolescent suicide prevention and intervention programs in the United States” (p.130).

Educating Students and School Staff

Often suicidal adolescents turn to their peers or close friends in a time of crisis (Popenhagen & Qualley, 1998; Coggan, C., Patterson, P., & Fill, J., 1997; Nelson, 1988). Participants of a study by Coggan et al. (1997) stated that if students were going to tell anyone they were suicidal, it would be their closest friend. “Friends were chosen as confidants over the choices of parents, other adults, teachers, school counselors, school nurses, and clergy” (Nelson, 1988, p.254) It is important for parents, teachers, school staff, and students to be able to recognize suicidal warning signs, eliminate the myths, and utilize prevention methods (Popenhagen & Qualley, 1998, Nelson, 1988). Students should be trained in the detection of suicidal behavior and how/where to get help (Popenhagen & Qualley, 1998).

There are currently two curriculum approaches to suicide prevention. The first approach emphasizes a positive school climate and includes instruction to all students in the areas such as problem solving and life affirmation, and the second
more popular approach involves direct classroom instruction about suicide (Miller & DePaul, 1996).

Educating students about suicide using a classroom curriculum approach has been found to be beneficial (Kalafat, 1990). These curriculum based programs should include the following information: (1) increasing awareness among students of adolescent suicide, (2) training students to recognize possible contributing factors to suicidal behaviors in adolescents, and (3) providing students with available school-based and community resources they can use for further assistance (Miller & DePaul, 1996).

Several researchers have criticized the classroom curricular approach because it often downplays the fact that most adolescents that commit suicide have at least one psychological disorder. It has even been suggested that by destigmatizing suicidal behavior, curricular programs are normalizing the very behavior they wish to prevent (Miller & DePaul, 1996). Other criticisms include the fact that curriculum based programs can be unsettling for students at greatest risk for suicidal behavior and that they lack efficiency as well as effectiveness (Miller & DePaul, 1996).

According to Garland & Zigler (1993) all school staff should receive in-service training regarding the warning signs of suicide, school and community resources that are available, and the school district’s protocol for students suspected of possible suicidal behavior. Often, it is teachers and other staff members that may learn of a suicidal adolescent before it is brought to the attention of the school counselor. Capuzzi (2002) reiterates the above statement by
saying, “it is imperative that all school staff be educated about both adolescent suicide and building and district policies and protocols for prevention, crisis management, and postvention” (p.40).

Educating Parents

The main reason for the education of parents in suicide prevention is that, according to Nelson (1988), nine out of ten suicide attempts take place at home. “Parents of students in a school in which a suicide prevention program is to be initiated should be involved in the school’s efforts to educate, identify, and assist young people” (Capuzzi, 2002, p. 40). In order to educate parents about suicide risk factors, evening or late afternoon parent education classes can be offered. This way, parents have the same information as school staff about the topic of adolescent suicide (Capuzzi, 2002).

CACREP Accreditation

Introduction

The American Counseling Association (ACA) created the Council for Accreditation of Counseling and Related Educational Programs (CACREP) in 1981. One of the missions for this accreditation was to provide national based standards, which promote quality education for the training of graduate level counselors.
CACREP Role in School Counselors Training

The CACREP standards (2001) for the training of school counselors consist of, "a structured sequence of curricular and clinical experiences" (p.1) that extend beyond the common core curriculum and skills. The additional curricular experiences are divided into four distinct categories: Foundations of School Counseling, Contextual Dimensions of School Counseling, Knowledge and Skills Requirements for School Counselors, and Clinical Instruction. For example, Foundations of School Counseling (CACREP) required that all students in the program demonstrate knowledge and skills that consist of the following:

1. History, philosophy, and trends in school counseling;
2. Role and function of the school counselor in conjunction with the roles of other professional and support personnel in the school;
3. Knowledge of the school setting and curriculum;
4. Legal and ethical issues relevant to school counseling (ACA and ASCA code of ethics);
5. The role of demographic, sociocultural, and lifestyle diversity in the student population;
6. Knowledge and understanding of community, environmental, and institutional opportunities, as well as barriers to student success (p.29)

The Contextual Dimensions provide educational experiences that "provide an understanding of how to coordinate counseling program components as they relate to the total community (p.30)." The standards break down the Knowledge
and Skill Requirement into three subsections: Program Development, Implementation and Evaluation, Counseling and Guidance, and Consultation. These three areas require the study of school based information, evaluation of comprehensive developmental school counseling programs, identifying students' academic, career and personal/social competencies, peer facilitation programs, individual and group counseling, developmental approaches to assist students with issues that may affect functioning, methods of consulting with parents, teachers and other school personnel, and strategies for working with parents, teachers and the community.

Under the section entitled Clinical Instruction it is the responsibility of the training program to provide school counselor trainees an experience that is supervised by a certified school counselor in a school setting. See Appendix F for CACREP standards for school counseling programs.

Researchers have examined the identity, role and responsibilities of school counselors, but little attention has been given to the specific skills and knowledge necessary for the actual practice of school counseling (Holcomb, Bryan & Rahill, 2002). In a study conducted to examine the importance of the CACREP School counseling standards, participants were asked what components made up the standards. They reported there are four factors that may comprise the standards. They include: program development, implementation, and evaluation; counseling and guidance knowledge and skills; contextual dimensions; and knowledge and skills for specialized assistance. Participants rated program development lower than the other factors.
The implication for counselor education suggests that school counselor preparation should be based on the setting in which the counselor will work. Also, additional exploration of knowledge and skill domains necessary for effective school counseling practice are needed. The researchers suggest one area of continued research should be designed to determine if the CACREP standards actually improve the quality of services rendered to students (Holcomb-McCoy, C., Bryan, J., & Rahill, S., 2002).

CACREP School Counseling Standards

Suicide Prevention. Holcomb-McCoy (1998) looked at school counselor preparation. As of March 1993, only 74 out of the 343 institutions offering a degree in school counseling were CACREP accredited. Today that number has risen to 139 institutions with accreditation. The conclusion of the above-mentioned study was that school counselors across the country in rural, urban and suburban settings are not receiving consistent training.

Even though CACREP standards were not in place in 1972, Schnacks'e study on counselor training informs the literature concerning this issue. Schnacke, (1972) completed a study designed to explore counselors' knowledge and training. The counselors were asked if they had ever participated in formal class work seminars, workshops, etc. in suicidology. Ninety-two percent responded no. The eight percent that said yes stated their course work, etc. was moderate to extensive. The participants were also asked what percentage of time was spent on adolescent suicide during their counselor-training program. Over half (52%) responded they
had received no training. The participants were also asked about how much required reading in adolescent suicide was part of their counselor education program. Eighty-one percent responded that no reading was required.

In reviewing the literature, it appears there are two places school counselors receive suicide prevention training: in counseling programs at the university level and during school district in-services (Capuzzi, 2002; CACREP Standards, 2001; Miller & DuPaul, 1996; Capuzzi & Golden, 1988; Schnacke, 1972). There may be additional training opportunities; for example, at conferences and workshops, but this was not addressed in the literature.

Westefeld et al. (2000), recommends that training in suicidology begin early in a student’s academic career, and should continue through their internships and other field placements. It is also recommended that training include coursework on death and suicide, as well as workshops, group discussions, and training exercises. Laux (2002) explains “Counselor trainees benefit from training using a standardized operating protocol to which they can refer when working with suicidal clients” (p.381).

In a study completed by the National Alliance for the Mentally Ill (NAMI, 2002) the authors agreed that it is, “imperative that school counselors attend workshops, classes and training sessions that stress knowledge and the acquisition of clinical skills pertinent to at-risk student” (¶ 5).

According to the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards for school counselors under section two, Counseling and Guidance, item D, it is stated that counselors need to be
prepared to deal with, "issues that may effect the development and functioning of students (e.g., abuse, violence, eating disorders, attention deficit hyperactivity disorder, childhood depression and suicide)."

The literature reviewed did not address how CACREP institutions meet these requirements. Again, no specific protocol was found for the teaching of suicide primary prevention to prospective school counselors at the university level.

CHAPTER 3: METHODOLOGY

This chapter will outline the methods that will be used in this study. The specific items that will be addressed include participants, measures, demographics, procedures, and data analysis.

Participants

The participants for this study consist of 139 CACREP school counseling programs. This was an inclusive and exhaustive list of all school counseling programs accredited by The Council for Accreditation of Counseling and Related Education Programs (CACREP). The programs were chosen using the Joseph Hollis's book Counselor Preparation: Programs, Faculty and Trends 1999-2001. The CACREP programs were then crosschecked with a directory of accredited programs provided by The Council for Accreditation of Counseling and Related Educational Programs.
Measures

The instrument used in this study was a two-page questionnaire entitled “Suicide Prevention Survey.” It was designed by the author to obtain descriptive information about each CACREP accredited program.

The questionnaire contained one section (see Appendix A for the questionnaire). The survey first asks participants to choose whether their school uses a semester or quarter system. The first question addressed suicide prevention and where the content was covered in the program. The second question addressed what specific content was covered in the area of suicide prevention. The third question addressed whether suicide prevention was covered in the content, and if it was not, what were the reasons. At the end of the instrument, six demographic questions were asked.

Face and content validity were established by distributing the instrument to eight current professors from CACREP institutions. Their recommendations were incorporated into the instrument. There was consistency of administration and scoring of the survey due to the fact that only one person administered and scored the each response.

Demographics: Demographic information was asked on page two of the survey. Participants were asked to state the following: (a) their gender, (b) race/ethnic group, (c) current position held at their institution, (d) number of master level graduate students currently enrolled in their program, (e) estimated
number of school counseling students usually accepted into their program each year, and (f) estimated number of students in each race/ethnic group.

Procedures

**Mailing:** The Total Design Method by Dillman (2000) was used in the mailing of the surveys. All mailings were initiated from Corvallis, Oregon.

Beginning on February 10, 2003, each CACREP program was mailed a signed cover letter, which described the purpose of the study and, in accordance with the Institutional Review Board, ensured confidentiality. The letter explained that participation was voluntary and by returning the survey informed consent was given (see Appendix B). The mailing also included: a survey and a self-addressed stamped envelope.

Exactly one week after the first mailing of the survey, on February 17, 2003, a follow-up postcard was sent to all programs of the first mailing. The intention in sending the postcard is to thank those that had already sent it back, and to remind those that had not to please send it back as soon as possible (see Appendix C).

A second follow-up letter (see Appendix D), survey and self addressed stamped envelope was sent to non-respondents exactly three weeks after the original mailing on February 10, 2003. The third and final follow-up letter (see Appendix E) along with a survey and self addressed stamped envelope was sent on March 10, 2003 exactly four weeks after the original mailing.
Coding: Each of the research variables will be coded and entered into an SPSS database (Noursis, 2000). The following were the codes adopted:

School system

Description. School system will be determined by respondents’ choice between semester system and quarter system:

Coding. School system will be coded for data analysis in the following manner:

<table>
<thead>
<tr>
<th>1: Semester system</th>
<th>2: Quarter system</th>
</tr>
</thead>
</table>

Question 1

Description. In what course suicide prevention is covered is determined by the respondents’ choices between three categories.

Coding.

<table>
<thead>
<tr>
<th>1: Required class - yes</th>
<th>2: Required class - no</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Module in required course - yes</td>
<td>2: Module in required course - no</td>
</tr>
<tr>
<td>1: Module in elective course - yes</td>
<td>2: Module in elective course - no</td>
</tr>
</tbody>
</table>

Question 2

Description. What specific content is covered in the area of suicide prevention is ascertained by respondents’ choices.
**Coding.**

<table>
<thead>
<tr>
<th>1: Behavior risk factors – yes</th>
<th>2: Behavior risk factors – no</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Verbal risk factors – yes</td>
<td>2: Verbal risk factors – no</td>
</tr>
<tr>
<td>1: Situational risk factors – yes</td>
<td>2: Situational risk factors – no</td>
</tr>
<tr>
<td>1: General risk factors – yes</td>
<td>2: General risk factors – no</td>
</tr>
<tr>
<td>1: Gender differences – yes</td>
<td>2: Gender differences – no</td>
</tr>
<tr>
<td>1: Cultural differences – yes</td>
<td>2: Cultural differences – no</td>
</tr>
<tr>
<td>1: Gay and lesbian issues – yes</td>
<td>2: Gay and lesbian issues – no</td>
</tr>
<tr>
<td>1: In school peer training – yes</td>
<td>2: In school peer training – no</td>
</tr>
<tr>
<td>1: Assessing suicidality – yes</td>
<td>2: Assessing suicidality – no</td>
</tr>
<tr>
<td>1: Specific interventions – yes</td>
<td>2: Specific interventions – no</td>
</tr>
<tr>
<td>1: Postvention – yes</td>
<td>2: Postvention – no</td>
</tr>
<tr>
<td>1: School based prevention programs – yes</td>
<td>2: School based prevention programs – no</td>
</tr>
<tr>
<td>1: Psycho-education for students and parents – yes</td>
<td>2: Psycho-education for students and parents - no</td>
</tr>
<tr>
<td>1: Referral sources – yes</td>
<td>2: Referral sources – no</td>
</tr>
</tbody>
</table>

**Question 3**

**Description.** Respondents select reasons their programs do not cover suicide prevention.
Coding.

| 1: No room in the curriculum to add more credits – yes | 2: No room in the curriculum to add more credits – no |
| 1: Covered in other courses – yes | 2: Covered in other courses – no |
| 1: Lack of financial and staff resources – yes | 2: Lack of financial and staff resources – no |
| 1: Too specialized – yes | 2: Too specialized – no |
| 1: Not relevant – yes | 2: Not relevant – no |

Demographic information coding

Gender

Description. Gender will be determined by respondents’ choice between male and female categories on the survey.

Coding

| 1: Male | 2: Female |

Racial/Ethnicity Status

Description. Respondents’ self report of the following category choices will determine racial/ethnicity status.
### Coding

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>White/Caucasian</td>
</tr>
<tr>
<td>2</td>
<td>Black/African-American</td>
</tr>
<tr>
<td>3</td>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>4</td>
<td>Asian/ Pacific Islander</td>
</tr>
<tr>
<td>5</td>
<td>American Indian</td>
</tr>
<tr>
<td>6</td>
<td>Bi or Multiracial</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Description.** Respondents’ will report their current employment status by the following categories.

### Coding

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Full professor</td>
</tr>
<tr>
<td>2</td>
<td>Associate professor</td>
</tr>
<tr>
<td>3</td>
<td>Assistant professor</td>
</tr>
<tr>
<td>4</td>
<td>Adjunct professor</td>
</tr>
<tr>
<td>5</td>
<td>Instructor</td>
</tr>
</tbody>
</table>

**Description.** The number of masters level graduate students with an emphasis in school counseling currently enrolled in the respondents’ program will be reported numerically.

### Coding

Whole numbers.
Description. The estimated number of students usually accepted into each respondent's school counseling program each year will be reported numerically.

Coding.
Whole numbers.

Description. Each respondent using the following categories will estimate percentages of racial/ethnicity status of their current student population.

<table>
<thead>
<tr>
<th>Coding</th>
<th>Racial/Ethnicity Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>White/Caucasian</td>
</tr>
<tr>
<td>2</td>
<td>Black/African-American</td>
</tr>
<tr>
<td>3</td>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>4</td>
<td>Asian/Pacific Islander</td>
</tr>
<tr>
<td>5</td>
<td>American Indian</td>
</tr>
<tr>
<td>6</td>
<td>Bi or Multiracial</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
</tr>
</tbody>
</table>

Data Analysis

Descriptive statistics are utilized to describe the basic features of the data in this study. They provide simple summaries about the sample and the measures. Descriptive Statistics are used to present quantitative descriptions in a manageable form.

For each question, frequencies, and measures of central tendency, including mean and standard deviation, will be computed. The SPSS computer program will be utilized in the data analysis.
Question 1: The name of each course will be reported in three clusters depending on whether the course was required, a module in a required course, or an elective module in a course. The number of credits for each course will be reported numerically corresponding with the specific course.

Question 2: There are three opportunities for additional information reporting in the second survey question. They include specific intervention techniques, referral sources, and "other". Written information will be reported verbatim in a summary of question two.

Question 3: This question offers an opportunity to report additional information under "other". Written information will be reported verbatim in a summary of question three.

Missing Data: According to the SPSS 11.5 Manual (2002), missing values defines specified data values as user missing. Data values specified as user missing are flagged for special treatment and are excluded from most calculations. You can enter up to three discrete (individual) missing values, a range of missing values, or a range plus one discrete value. All missing data for all questions where the respondent refused to answer, or the question was not relevant, was coded as 999.

Human Subject Approval

The Oregon State University Institutional Review Board approved this research study on February 7, 2003.
CHAPTER 4: RESULTS

The primary purpose of this dissertation was to gather information concerning pre-service suicide prevention training in CACREP accredited school counseling programs. Thus questionnaires were sent to all CACREP accredited programs in the United States. A total of 139 questionnaires were mailed, adhering to the Dillman Total Design Method (2000).

A total of 89 CACREP programs responded to receiving the questionnaire, resulting in a response rate of 64 percent. All questionnaires were determined to be usable.

Respondents Demographics

The majority of respondents reported the semester school system \((n=80, 89.9\%)\) as being the system used at their schools (Table 2). The greater part of the respondents responding to the questionnaires was females (54%). The majority of respondents were full professors at the CACREP programs surveyed (53.4%). The highest percentage of respondents (88.6%) reported being EuroAmerican. The remainder of the respondents reported their race/ethnicity as follows: African-American (4.5%), Latino (1.1%), Asian/Pacific Islander (2.3%), Native American as (2.3%) and Multiracial (1.1%).
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School System</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semester</td>
<td>80</td>
<td>89.9</td>
</tr>
<tr>
<td>Quarter</td>
<td>9</td>
<td>10.1</td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>47</td>
<td>54</td>
</tr>
<tr>
<td>Male</td>
<td>40</td>
<td>46</td>
</tr>
<tr>
<td><strong>Race/Ethnic Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EuroAmerican</td>
<td>78</td>
<td>88.6</td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Latino</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Current University Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Professor</td>
<td>47</td>
<td>53.4</td>
</tr>
<tr>
<td>Associate Professor</td>
<td>25</td>
<td>28.4</td>
</tr>
<tr>
<td>Assistant Professor</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Adjunct Professor</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Instructor</td>
<td>1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Courses in Suicide Prevention

Courses offered in suicide prevention were based on responses to survey question one. All respondents to the survey (n=89) indicated that their program did not offer a required course in suicide prevention (100%). Eighty-eight percent (n=79) of the respondents indicated that their program offered a module in a
required course that specifically focused on some aspect of suicide prevention.

Twenty two percent (n=20) indicated that their program offered an elective course with a module including suicide prevention. One program (n=1) offered an entire elective course in suicide prevention. This course is entitled “Preventing Adolescent Suicide”. The respondents who offered a module in a required course indicated that they offered training in suicide prevention, primarily by addressing the topic in a variety of courses. There was great variability in the training provided in a format other than a required or elective course in suicide prevention. Respondents cited 38 classes that dealt with the topic of suicide prevention in some manner. The 38 courses described each deal with a specific topic, for example crisis intervention, introduction to school counseling, and ethics. It is unclear how the issue of suicide prevention is dealt with in each of these courses. Course credits also varied from one to twelve per term hours. A summary of the required classes that contain a module in suicide prevention and elective courses also including a suicide prevention module is presented in Table 3.

<table>
<thead>
<tr>
<th>Course</th>
<th>Semester Credits converted into quarter hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required courses</strong></td>
<td></td>
</tr>
<tr>
<td>No suicide prevention course offered</td>
<td>0</td>
</tr>
<tr>
<td><strong>Modules in Required Courses</strong></td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>4.5-6</td>
</tr>
<tr>
<td>Intervention Treatment Planning and Evaluation</td>
<td>4.5</td>
</tr>
<tr>
<td>Micro skills in Counseling</td>
<td>4.5</td>
</tr>
<tr>
<td>Course</td>
<td>Semester credits converted into quarter hours</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Pre-Practicum</td>
<td>4.5</td>
</tr>
<tr>
<td>Practicum</td>
<td>4.5 - 9</td>
</tr>
<tr>
<td>Introduction to School Counseling</td>
<td>4.5 - 6</td>
</tr>
<tr>
<td>Introduction to Community Counseling</td>
<td>4.5 - 6</td>
</tr>
<tr>
<td>Internship</td>
<td>4.5 - 12</td>
</tr>
<tr>
<td>Ethics</td>
<td>3 - 9</td>
</tr>
<tr>
<td>Legal and Ethical Issues</td>
<td>4.5</td>
</tr>
<tr>
<td>Organization and Administration of School Counseling</td>
<td>4.5</td>
</tr>
<tr>
<td>Intervention/Prevention School Counseling</td>
<td>3 - 4.5</td>
</tr>
<tr>
<td>Theory</td>
<td>4.5</td>
</tr>
<tr>
<td>Sociocultural Counseling</td>
<td>3</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td>3</td>
</tr>
<tr>
<td>Counseling Skills</td>
<td>4.5</td>
</tr>
<tr>
<td>Fundamentals of Counseling</td>
<td>4.5</td>
</tr>
<tr>
<td>School Counseling Program delivery and evaluation</td>
<td>6</td>
</tr>
<tr>
<td>Counseling Children &amp; Adolescents</td>
<td>4.5 - 6</td>
</tr>
<tr>
<td>Assessment in Counseling</td>
<td>4.5</td>
</tr>
<tr>
<td>Diagnosis and Treatment Planning</td>
<td>4.5</td>
</tr>
<tr>
<td>Pupil Personal Service Concepts &amp; Organization</td>
<td>6</td>
</tr>
<tr>
<td>Human Growth and Development</td>
<td>4.5</td>
</tr>
<tr>
<td>Trauma Counseling</td>
<td>4.5</td>
</tr>
</tbody>
</table>
### TABLE 3 (Cont.)

**Summary of Courses Offered**

<table>
<thead>
<tr>
<th>Course</th>
<th>Semester credits converted into quarter hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing Adolescent Suicide</td>
<td>3</td>
</tr>
<tr>
<td>Professional Orientation</td>
<td>4.5</td>
</tr>
<tr>
<td>Youth at-risk</td>
<td>4.5</td>
</tr>
<tr>
<td>Group Processes</td>
<td>4.5</td>
</tr>
<tr>
<td>DSM</td>
<td>4.5</td>
</tr>
<tr>
<td>Mental Health in the Schools</td>
<td>4.5</td>
</tr>
<tr>
<td>Professional Seminar II</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Modules in Elective Courses</strong></td>
<td></td>
</tr>
<tr>
<td>Workshop</td>
<td>4.5</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>1-6</td>
</tr>
<tr>
<td>Grief Counseling</td>
<td>4.5</td>
</tr>
<tr>
<td>Trauma Theory and Crisis Intervention Models</td>
<td>4.5</td>
</tr>
<tr>
<td>Advanced Counseling Techniques</td>
<td>4.5</td>
</tr>
<tr>
<td>Rehabilitation Counseling</td>
<td>4.5</td>
</tr>
<tr>
<td>Advanced Assessment</td>
<td>4.5</td>
</tr>
</tbody>
</table>

**Elective Course**

| Preventing Adolescent Suicide               | 3                                              |

---

**Specific Information Covered in Suicide Prevention**

In the second set of questions respondents were asked what specific information is covered in the area of suicide prevention in their programs. They were given fifteen choices. One choice included “other” to facilitate inclusion of additional information. Four percent of the programs reported teaching all fifteen
items on the survey. One respondent stated that their program provided no suicide training.

Each choice was calculated based on responses to survey questions 2 (Table 4).

**TABLE 4**

**Responses to Survey Question 2**

<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Risk Factors</td>
<td>86</td>
<td>96.6</td>
</tr>
<tr>
<td>Verbal Risk Factors</td>
<td>85</td>
<td>95.5</td>
</tr>
<tr>
<td>Situational Risk Factors</td>
<td>82</td>
<td>92.1</td>
</tr>
<tr>
<td>General Risk Factors</td>
<td>83</td>
<td>93.3</td>
</tr>
<tr>
<td>Gender Differences</td>
<td>67</td>
<td>75.3</td>
</tr>
<tr>
<td>Cultural Differences in suicide behavior</td>
<td>62</td>
<td>69.7</td>
</tr>
<tr>
<td>Gay and Lesbian Issues in suicide</td>
<td>59</td>
<td>66.3</td>
</tr>
<tr>
<td>In School Peer Training</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>Assessing Suicidality</td>
<td>83</td>
<td>93.3</td>
</tr>
<tr>
<td>Specific Intervention Techniques</td>
<td>55</td>
<td>61.8</td>
</tr>
<tr>
<td>Postvention</td>
<td>39</td>
<td>43.8</td>
</tr>
<tr>
<td>School Bases Prevention Programs</td>
<td>52</td>
<td>58.4</td>
</tr>
<tr>
<td>Psycho-education for students and parents</td>
<td>40</td>
<td>44.9</td>
</tr>
<tr>
<td>Referral Sources</td>
<td>52</td>
<td>58.4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>5.6</td>
</tr>
</tbody>
</table>
The findings reported in the category of “other” were many. Respondents reported they included issues such as breaking confidentiality to acquire services, presentations by suicide prevention groups, age differences in suicidal behavior, gifted students at risk for suicide, developing school and district interventions programs and teams.

Respondents also had the opportunity to write in specific referral sources covered in their classes. These included: crisis hotlines, local school district resource packets, hospitals and agencies, community resources, and web sites related to suicide.

In response to the question, “If your program does not currently offer a class in suicide prevention, what are the main reasons it does not?” The reason offered by 50.6 percent (n=45) of those who responded was that the topic was covered in other courses. Other reasons cited included (n=44, 49%) there not being enough room in the curriculum to add any more classes or credits. Other reasons offered were that the topic of suicide prevention is too specialized (n=16, 18%). Further, the lack of financial and staff resources (n=5, 5.9%) was an impediment to the course offering. Other reasons cited for not offering a class in suicide prevention included, “not sufficient for 3 credit course” and “infused into other coursework.”

Program and Student Demographics

Program demographic information was ascertained by three inquires. These related to current enrollment, projected enrollment and ethnicity data. The number of master students currently enrolled in CACREP school counseling programs was
reported as percentages ($M=55.58$, $SD=46.1$). The estimated number of students usually accepted into each program on a yearly basis was reported as ($M=23.37$, $SD=16.97$).

The respondents reported student demographic information in percentages. The majority stated that EuroAmericans represented the majority of students ($M=83.29$, $SD=17.66$) followed by African American ($M=8.11$, $SD=12.5$), Latino ($M=4.01$, $SD=7.52$), Asian/Pacific Islander ($M=1.97$, $SD=4.68$), Native American ($M=1.01$, $SD=2.53$), Multiracial ($M=.98$, $SD=2.37$), and other ($M=.60$, $SD=2.41$).

Summary

This chapter presented the results of this study. The results of the descriptive statistics indicated that none of the CACREP programs surveyed offered a required course in suicide prevention, however eighty-eight percent did offer a module in a required course that addressed suicide issues.

CHAPTER 5: DISCUSSION

Adolescents are increasingly subjected to the pressures of a perplexing and complicated society. The ways in which adolescents attempt to deal with their environment and themselves are subjects of extreme importance to school counselors and concomitantly to the counselor educator (Schnacke, 1972).

Unfortunately, one manner in which some children and adolescents may choose to deal with their stressful personal environment is suicide. Among adolescents between the ages of 15 to 24, suicide ranks nationally as the third

Researchers agree that many adolescent suicides are never reported as such, due to the cultural taboos related to the act or the absence of specific corroborative evidence to indicate a verdict of suicide (Martin & Dixon, 1986). Henry & Stephenson (1993), state the actual numbers of reported completed suicides may be higher than official reports, but due to the social stigma of suicide, these deaths are often reported as accidents. The Committee of Adolescence (2000) also reports that actual suicide rates may be much higher than reported, because some deaths are reported as "accidental".

Another aspect of adolescent suicide that must be considered is the number of attempted but unsuccessful suicides. Currently, according to the National Institute of Mental Health (1999), there is no annual national data on attempted suicides. However, reliable scientific research has found that there are an estimated 8-25 attempted suicides to one completion; the ratio is higher in women and youth. The strongest risk factors for attempted suicide in youth are depression, alcohol or other drug use disorder, and aggressive or disruptive behaviors (NIMH, 1999).

A thorough review of the academic literature on counselor education programs reveals little academic preparation in the area of adolescent suicide prevention included in the training programs. As a direct result of the unavailability of information about training and the absence of formal training in
suicidology, it can be posited that pre-service school counselors are not being trained to possess adequate knowledge or skills. Therefore, they may not be adequately prepared to effectively deal with suicidal students.

The purpose of this study was to determine what specific information is provided in the area of suicide prevention to pre-service school counselors at CACREP accredited school counseling programs.

A total of 139 questionnaires were mailed to all CACREP accredited school counseling programs. The Dillman Total Design Method system (2000) was utilized for this study. A total of 89 respondents responded to the questionnaire, resulting in a response rate of 64 percent. All questionnaires were included in this study. This may be an indicator that the survey utilized was straightforward and understandable. Further, the survey was concise and succinct and therefore, facilitated rapid completion and quick return.

The specific information school counselors are receiving in the area of suicide prevention was assessed in the second question. The question detailed a checklist of fifteen items. The items included: behavioral risk factors, verbal risk factors, situational risk factors, general risk factors, gender differences in suicide attempts, cultural differences in suicide attempts, gay and lesbian issues in suicide attempts, in-school peer group training in suicide issues, assessing suicidality, specific intervention techniques, postvention, school-based prevention programs, psycho-education for school students, and parents, referral sources, and other. The suicide issues covered were calculated based on the responses to survey question two.
This chapter provides a discussion of the results of this study. Limitations of the study will follow the discussion. Finally, implications for CACREP school counseling programs and future research will be addressed.

**Discussion of Results**

The respondents that participated in the study indicated that not one of the CACREP school counseling programs offers a required course in suicide prevention. However, the issues of suicide were reported as being addressed in 39 different required and elective courses. Four percent \((n=9)\) of the programs reported covering all fifteen categories included in the survey. One program reported coverage in the area of suicide was non-existent.

**Data Analysis**

Descriptive statistics are used to simply describe what is happening with the data in this study. Inferential statistics are used to make inferences from data to more general conditions. The purpose of this study was to look at the pre-service suicide prevention activity in CACREP accredited school counseling programs. Therefore descriptive statistics were the appropriate measure (Gall, Gall & Borg 1999).

All responses were coded and entered into SPSS 11.0. The statistical program computed frequency counts for all questions. In addition, the statistical program for all appropriate items also computed measures of central tendency.
Coursework

The survey results indicate that the CACREP school counseling programs incorporate suicide prevention and other suicide issues in modules in required and elective courses dispersed throughout their curricula. In the majority of programs the issue of suicide was presented in only one module in one required class in the curriculum. This is not consistent with the recommendations of Westefeld et al. (2000) who determined that training in suicidology begins early in a student’s academic career and should continue through their internships and other field placements. It is also recommended that counselor training includes course work on death and suicide, as well as workshops, group discussions, and training exercises. Westefeld et al. (2000), suggests that training in suicide assessment, intervention and postvention should be an essential component of all counselor-training programs.

It is not known how much time is spent on the issues of suicide in modules in required or elective counseling classes. Some influencing factors may include individual teaching style, knowledge of suicide content, importance placed on teaching suicide information, and instructor skills in the area of suicide prevention. The data analysis revealed, for practical purposes, an inconsistent and incomplete approach of academic training in suicide prevention to school counseling graduate students.
Specific Information Covered in Suicide Prevention

The results indicate that the majority of programs address the issues of behavioral risk factors (96.6%), verbal risk factors (95.5%), situational risk factors (92.1%) general risk factors for suicide (93.3%) and assessing suicidality (93.3%). The percentage numbers can be deceiving, due to the fact that it is not known how much time or to what extent these issues are covered in each program.

Evans (2000) explains that school counselors are not expected to diagnose mental health disorders, but awareness of depression and suicide warning signs can help to identify students in need of referral for such services. One of the more popular suicide myths is that suicide happens with no warning. This is a misconception, since a good number of people who commit suicide often give behavioral or verbal warning signs of their intentions. The majority of people who attempt suicide indicate their intention verbally or behaviorally before they act (Pare 2000).

Warning signs are classified into three categories: behavioral, verbal, and stressful life events. Capuzzi (1988) and King (2001), both national experts on the subject of suicide, summarize the suicidal warning signs that should be covered in all school counselor education and training programs.

Behavioral warning signs include: being depressed, change in appetite/weight, change in behavior, change in school performance, helplessness/hopelessness, loss of energy, loss of interest in once-pleasurable activities, giving away cherished possessions, morbid ideation, substance abuse, and becoming withdrawn and isolated.
Verbal warning signs include quotes similar to: “I am going to kill myself,” “I want to die,” “I can’t stand living anymore,” “Don’t worry about me,” “I won’t be around much longer,” “I don’t want to be a burden,” “My family would be better off without me,” “I’ve had enough,” and “I am ending it all.”

Stressful life events can include: Changes in close relationships, history of attempted suicide, previous suicides in the family, ready accessibility to firearms, recent disappointments, and recent losses.

Assessing for suicide is an activity that every working school counselor will be faced with at one time or another. It is essential that all counseling professionals be informed of and trained in basic suicide assessment procedures (Sommers-Flanagan, 1997).

Sommers-Flanagan (1997) suggests that a general checklist of suicide assessment procedures should include (1) assess risk factors, (2) ask about suicidal thoughts, (3) assess suicide plans, (4) assess student or client intent or goals associated with suicidal behaviors, (5) obtain psychiatric or collegial consultation, and (6) determine appropriate action and degree of intervention. Accurate assessment is an important component of determining the appropriate steps to take with a young suicidal student.

Gender and cultural differences exist when it come to suicide and suicidal behavior. There is great variation in gender and cultural differences in suicide attempts and completions. This information is vital for all school counselors working in a pluralistic society. Of the respondents to the survey, 75 percent covered gender differences within their program curriculum. Currently, the
reported gender ratio for completed suicides in 1999 by the NIMH was 6:1 (males: females). Kalafat, (1990) reported that girls attempt suicide nine times more frequently than boys, but boys complete suicide about five times more often than girls. The difference in rates is explained by the fact that boys tend to use more lethal means, such as firearms, hanging, and automobile accidents, while females use less lethal methods; for example, sleeping pills and carbon monoxide/dioxide poisoning (Popenhagen & Qualley, 1998).

Sixty-nine percent covered cultural differences in suicide behavior. Issues of cultural diversity and ethnicity in the area of suicide behavior are an essential component for school counselors' training.

Historically, African-Americans have had much lower rates of suicides compared to EuroAmericans. However, beginning in the 1980s, the rates for African-American male youth began to rise at a much faster rate than their white counterparts. It has been suggested that some African-American male youth may engage in “victim-precipitated homicide”. This includes intentionally getting in the line of fire of either law enforcement or gang activity. This idea emerges as an important research question in the literature. One can construe that these deaths are not typically ruled as suicides (NIMH, 2000).

Sixty-six percent of respondents addressed gay and lesbian issues in suicide attempts. According to Gibson (1989), gay and lesbian adolescents are two to three times more likely to commit suicide than other adolescents, and 30 percent of all completed adolescent suicides are related to the issue of sexual identity.
Therefore, it is incumbent upon school counselors to be educated in the area of sexual identity matters and gay identity development (Capuzzi, 2002).

Little over one-third, or thirty-six percent, of the respondents indicated that In-School Peer Training was addressed within the curriculum of their programs. The literature is clear that adolescents would go to a close friend before anyone else. It is essential that students are educated about warning signs and where to go to get help. Participants of a study by Coggan et al. (1997) stated that if they were going to tell anyone they were suicidal, it would be their closest friend. As Nelson states, “Friends were chosen as confidants over the choices of parents, other adults, teachers, school counselors, school nurses, and clergy” (Nelson, 1988, p.254).

Peers are in the direct line of fire. It is essential that school counselors be prepared to train peers to recognize the warning signs for suicide. There is a deficiency in the training of school counselors in the area of in-school peer training. Therefore, attention to this issue and inclusion in the school-counseling curriculum is strongly suggested.

Specific intervention techniques were addressed by only 61 percent of the respondents. This statistic is surprising, given the current attention given to suicide and the rate at which suicide occurs. According to Culp (1988), “Lack of specific training in assessing the seriousness of suicidal signs and intent appears to be a major factor in the problem of suicide prevention” (p.19). Only four respondents wrote in specific techniques taught in their programs. Included was the S.L.A.P method, which assesses specificity, lethality, availability, and proximity (Sommers-Flanagan, 1997). Another method was contracting, or “no suicide”
agreements. A third method was the SADPERSONS approach which assesses: Sex, Age, Depression, Previous attempts, Ethanol abuse, Rational thought loss, Social support lacks, Organized plan, No spouse, and Sickness (Sommers-Flanagan, 1997). Cognitive behavioral approaches were mentioned, as were teaching students about decompression and self-soothing.

King, (2001) defines intervention as, “appropriate steps school professionals should take when a student threatens or attempts suicide” (p.135). Intervention should focus on securing the surrounding area, keeping the student safe, and referring the student to an appropriate outside source.

Postvention was addressed by 43 percent of those returning the survey. The school counselor is often the first person both students and school personnel turn to after a suicide takes place. In a study done by King (2000) it appears that school counselors receive this training on the job and not in their master’s level programs.

More than half (58%) of the respondents reported teaching school-based prevention programs to pre-service school counselors. Prevention is defined as community activities where everyone in a community or school receives the same training concerning an issue that may affect the entire population (Conyne, 1987). Suicide is a preventable event. Therefore, it is imperative that school counselors become skilled during their graduate programs to be leaders in the area of suicide prevention. Only a little over half of the CACREP respondents reported teaching school-based prevention programs to their students. This might indicate that some graduating school counselors may not be prepared to lead efforts of prevention throughout a school community.
Due to the preventable nature of suicide, educating school-age students and their parents is an important activity. The main reason for the education of parents in suicide prevention is that, according to Nelson (1988), nine out of ten suicide attempts take place at home. “Parents of students in a school in which a suicide prevention program is to be initiated should be involved in the school’s efforts to educate, identify, and assist young people” (Capuzzi, 2002, p. 40).

Forty-four percent of the CACREP programs reported teaching psycho-educational material to their graduate students. This may point in the direction that many school counseling graduate students are not prepared to teach students and parents concerning vital information about suicide prevention.

Knowing how and where to refer suicidal students is an important task for school counselors. Fifty-eight percent of programs responding to the survey said that they address referring as part of their suicide module. Without proper referral information, a suicidal student will not receive the care needed. The literature is clear that a prior attempt is a good indicator that without proper care, the student is at higher risk to attempt suicide again. Past attempts have been reported as one of the strongest risk factors for suicide completions in all age groups (Capuzzi & Golden, 1988; Lewinsohn et al., 1996; Borowsky et al., 2001). According to Borowsky et al. (2001), “the most important correlate for youth suicide is a previous attempt” (p.485). With more attempts the method usually becomes more lethal, and therefore could become a completed suicide.
Limitations of the Study

Sample

The results of this study must be interpreted cautiously because of several limitations. These include the following: (1) the surveys were mailed to the CACREP designated individual provided by the CACREP directory. The presumption was that this individual would be aware of the suicide prevention activities and demographics of the program, (2) only one individual completed the survey in each CACREP program, therefore it can not be ascertained that the finding accurately reflect the total suicide training activities of all staff members, (3) the one person that completed the survey may not have accurate information on whether, for example, other faculty or staff were including suicide prevention modules in their courses, (4) some bias might be introduced into the study due to the fact that the majority of the respondents were EuroAmerican females who had attained full professorships. It is uncertain how respondents from other ethnicity might view and respond to the area of suicide prevention.

The response rate for this survey was 64 percent. According to Rubin & Babbie (2001) a response rate of 60 percent is generally considered a good response rate and provides for less of a chance of significant response bias. A limitation is that all CACREP accredited programs are not represented. The results are biased in favor of programs with persons who are willing (a) to take the time to respond to a survey on this topic and (b) to reveal their strengths and weaknesses in suicide prevention training.
In a through search of the literature, databases, professional organizations, and professionals in the field, a survey that examined school counselor’s training in suicide prevention could not be located. Due to this fact the author designed the instrument. Therefore there could be bias in the survey due to wording of questions or confusion about specific questions.

In an attempt to limit bias, face and content validity were established by distributing the instrument to eight current professors from CACREP institutions. Their recommendations were incorporated into the instrument.

Some respondents were confused about how to report demographic information. They wrote next to the “student demographic information in the survey” that they were not sure if they should report in percentages or whole numbers. Using the word percentage would have helped to clarify this issue.

One important element of suicide prevention is debunking the myths that are prevalent in American culture. This area was not included in the survey therefore it cannot be ascertained whether or not this issue is taught in the respondents programs.
Implications for CACREP School Counseling Programs

According to Capuzzi, (2002), "generally, prevention, crisis management, and postvention activities should not be attempted by anyone who has not completed a 2-year CACREP accredited or CACREP equivalent graduate program" (p.44). Given the results of the study, I believe there has been an assumption made by Capuzzi (2002) that school counselors are actually being trained to complete the above-listed activities. Yet, the information received from the survey conflicts with this assumption.

Pre-service Suicide Training

The survey results present a generally mixed picture of the state of suicide prevention training in CACREP accredited school counseling programs. Only four percent of the programs addressed all of the fifteen areas assessed in the survey on suicide prevention. One respondent reported that suicide prevention training was non-existent in their program.

Although most CACREP school counseling programs addressed suicide in some way, graduate school counseling programs must be responsive to the changing mental health needs of students. Therefore, counselor education programs must work to enhance in a proactive manner to improve and update training to meet the ever-changing needs of school-age students.

CACREP programs not providing proper training in the area of suicide prevention may inadvertently create ethical dilemmas. Graduates being asked to function in a professional manner in the area of suicide prevention without

...
appropriate training would be practicing outside their boundaries of competence. This would violate both the American School Counseling Association and the American Counseling Association code of ethics.

One way for counselor education programs to respond to the issue of suicide prevention is to make it a priority in the training of school counselors. This would involve making a commitment to design curriculum that incorporates suicide training throughout a graduate student’s academic career. As suggested by Kitzrow (2002), “programs might be designed to incorporate the training into their strategic plan in order to strengthen and formalize the commitment of counselor education to provide the training” (p.113).

The issue of suicide is present in the CACREP standards, but I found that at least one of the respondents to the survey did not know it was a CACREP standard. It would be helpful if CACREP would assume an advocacy role and add additional specifications to the standards regarding specific information that must be taught in the area of suicide prevention. The following are suggested components that CACREP programs might include in the preparation of school counselors in the area of suicide prevention:

**Pre-Service Suicide Prevention Training for School Counselors**

**Myths.** One of the most important elements in the training of school counselors is to dispel the myths surrounding suicide. Martin & Dixon, 1986; Capuzzi & Golden, 1988; K. King, 1999; and Pare, 2000, outline 21 common myths relating to adolescent suicide. They include the following:

1. A person who attempts suicide and fails is safe from future attempts.
2. Most suicides happen during the winter months and in the dark.

3. Suicide occurs mostly late at night.

4. Adolescents that complete suicide leave notes.

5. Those adolescents who talk about suicide are not seriously considering it.

6. Suicide happens without warning.

7. Once an adolescent is suicidal, that person must always and forever be considered suicidal.

8. Never use the word "suicide" when talking to adolescents because it may "put ideas in their heads." Educating adolescents about suicide leads to increased suicide attempts, since it provides them with ideas about and methods for killing themselves.

9. People with strong religious beliefs will not attempt suicide.

10. Adolescent suicide is a decreasing problem.

11. Adolescent homicide is more common than adolescent suicide.

12. Most adolescents who attempt suicide fully intend to die.

13. Adolescents cannot relate to a person who has experienced suicidal thoughts.

14. No difference exists between male and female adolescents regarding suicidal behavior.

15. Because female adolescents complete suicide at a lower rate than male adolescents, their attempts should not be taken too seriously.

16. The most common method for adolescent suicide completion involves drug overdose.

17. All adolescents who engage in suicidal behavior are mentally ill.
18. If adolescents want to commit suicide, there is nothing anyone can do to prevent its occurrence.

19. Suicidal behavior is inherited.

20. Adolescent suicide occurs only among the poor.

21. Only a counselor or a mental health professional can help a suicidal adolescent.

   In order for school counselors to be effective with suicidal adolescents they must be armed with accurate information. Discussing the myths and their implications provides school counselors with an understanding of the problem and its prevalence in our society.

   **Interventions and assessment.** One of the most important skills a school counselor can possess is the ability to intervene with a suicidal student. In assessing the risk of suicide, several principles need to be considered (Culp, 1988):

1. The first need is to determine whether or not the student will admit to being suicidal or at risk for suicide. At this point, it is important to ask the question, “Have you been thinking of harming yourself”. A major warning sign for suicide is a threat or other statement indicating a desire to die.

2. The next step is to determine if a suicide plan exists. When exploring and evaluating a student’s suicidal plan, the following four areas should be assessed (Sommers-Flanagan, 2003): (a) specificity of the plan; (b) lethality of the method; (c) availability of the proposed method; and (d) proximity of social or helping resources. It is appropriate at this point to ask the student if they have access to firearms or drugs and alcohol.
3. Assess the student for previous suicide attempts. A history of previous attempts puts a student at higher risk. The probability of success increases with each attempt.

4. It is important to assess whether the student will be willing to use outside resources. Do they have people nearby that care about them? The greater the distance from those who could rescue the student in crisis, the greater the degree of risk.

5. Assess for depression. This can be done by the use of a depression assessment, or by asking about specific depressive symptoms. If appropriate, the student should be referred to an outside resource for assessment of possible mental disorders.

Other areas to address include: affects and behaviors, family background, precipitating events, and concept of death (Davis, 1988).

In order for school counselors to complete a thorough assessment that is up to professional standards, according to Sommers-Flanagan (2003), the following need to be included in any suicide assessment:

1. The limits of confidentiality and informed consent were discussed with the students (Remley & Herlihy, 2001).

2. A thorough suicide assessment was conducted, including: risk factor assessment, and suicide assessment instruments or questionnaires utilized, assessment of suicidal thoughts, plans, client self-control, and suicidal intent completed.
3. Relevant historical information from the student regarding suicidal behavior (e.g. suicidal behaviors by family members, previous attempts, lethality of previous attempts) was obtained.

4. Previous treatment records were requested and obtained if appropriate.

5. Consultation with one or more licensed mental health professionals was sought.

6. An appropriate no-suicide contract was established.

7. The student was provided with information regarding emergency and crisis resources.

8. In cases of high suicide risk, appropriate and relevant authority figures (administration) and family members were contacted.

An adequate suicide assessment will help the school counselor to determine if the adolescent needs hospitalization or outpatient treatment. It is recommended that school counselors routinely consult with other mental health professionals regarding assessment and management of suicidal adolescents.

It appears from the survey data that the only way suicide information is being provided to pre-service school counselors is in modules in required or elective courses. Therefore, courses should be structured and time allotted for the inclusion of specific material on suicide prevention.

In studies by Boylan (2001) & King (2000), it was found that school counselors knew the warning signs of suicide, but were not confident about their ability to recognize a student at-risk for suicide. Training and support to improve counselor self-efficacy in this area is essential. Bandura (1997) reports that people
differ in the areas in which they cultivate their self-efficacy, and in the levels in which they are developed. Counselor educators need to be aware of graduate students' developmental level and support them as they learn new skills related to working with students at risk for suicide.

This would indicate that graduate students need not only didactic training, but specific clinical training as well. Students need not only sound theoretical knowledge, but also clinical skills to provide effective counseling services for suicidal students. The theoretical knowledge base should include: warning signs, risk factors, gender and cultural differences, in-school peer training, assessing suicidality, specific intervention techniques and protocol, postvention, psycho-education for students, school personnel, and parents, referral sources, and myths.

Clearly, the pre-service school counselor needs to be exposed to the difficult facts regarding adolescent suicide. This would include statistical and demographic data, with the etiologies and dynamics of adolescent suicide. The facts and figures can be incorporated into existing course content.

More importantly, however, are the opportunities for students to experience at the practical level the suicidal adolescent. This can be accomplished by the use of audiovisual materials, or through vicarious experiences. Both experiences can assist the pre-practicum student in learning appropriate suicide intervention skills.

Counseling practica students should be encouraged to seek out experiences in crisis centers or other facilities where they can observe others working with suicidal students or clients. Further, practica students and practica supervisors
should seek out both real-life and simulated experiences, which provide the student with a sound background in the area of suicide (Culp, 1988).

A good theoretical base is essential for school counselors to understand the issue of suicide, but it is equally, if not more important, for students to receive training and supervision in clinical skills from experienced faculty who have training in the area of suicidology.

Primary Prevention. Berman & Jobes (1995) describe primary suicide prevention as efforts to educate and train groups of individuals who are potential gatekeepers about the signs and hazards of lethal methods of suicide. The concern is to reach groups of people before they have developed any appreciable signs of psychological disturbance (Coyne, 1987).

In studies completed by K. King, (2001); and Capuzzi & Golden, (1988), the following recommendations were made for establishing 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 school counselors 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 students in crisis to the school counselor. (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. Having an appropriate primary prevention plan helps school personnel effectively deal with the issue of suicide, and creates a protocol for dealing with a suicidal student. According to Miller & DuPaul (1996) one study found, “one 2-hour session presentation to educators resulted in significant increases in both knowledge of suicide warning signs and community resources” (p.225).

**Implications for Future Research**

Although this survey has provided informative data on the status of suicide prevention in CACREP accredited programs, additional research is needed to more fully ascertain the state of suicide prevention training.

This study focused on suicide prevention training. Additional studies could examine the amount of time that is spent on suicide training in CACREP programs. It would also be helpful to ascertain whether CACREP accreditation affects whether or not a program includes suicide prevention in the program curriculum. An examination of non-CACREP accredited school counseling programs would give a more global view of all suicide training activities provided to school counselors.

Another important factor to examine would include exactly where and when in graduate programs the issue of suicide prevention is being presented. This information would help counselor educators decide when to offer training to pre-service school counselors.

Additional studies could focus on describing course syllabi and content, as well as faculty experiences and knowledge with the issue of suicide.
Conclusion

Training in the area of suicide prevention is no longer a choice. For counselor educators, the training of students in suicide prevention is a matter of meeting the appropriate educational standard of care. Students graduating from CACREP programs need to be prepared to meet the standard of care in treating adolescents at risk for suicide. Suicide is preventable. Therefore, there is nothing as disturbing as the self-inflicted death of an adolescent that could have been prevented. Yet, over 3,900 adolescents in the United States choose to end their life each year.

School counselors have an ethical, legal and moral obligation to the students they counsel. Further, school counselor educators have an ethical, legal and moral obligation to the students they teach and train. It is the responsibility of CACREP school counseling programs, and their faculty, to adequately prepare graduate students for the real-life situations they will face while working in schools (CACREP standard IV, C, 2,d). In the United States, suicide claims the life of an adolescent every 100 minutes. This means everyday, 14 young people complete suicide (NMHA, 2002).

Fortunately, adolescent suicide is preventable. School counselors armed with the appropriate skills and knowledge can mean the difference between life and death for a suicidal student. It is time for counselor educators to explore the necessary means to help stop this useless loss of life.
References


Glosoff, H.L., & Pate, R.H., Jr. (2002). Privacy and confidentiality in school


Appendix A
Suicide Prevention Survey

Directions: Please check or fill in all of the following that apply to your program. Your responses will be kept strictly confidential. Thank you in advance for your support and time.

Seminar system ______ Quarter System______

Question #1: Your program covers suicide prevention by the following means:
Check all that apply--

☐ Required Course in Suicide Prevention [Name of course__________________________] [Number of credits______]

☐ Module in Required Course [Name of Course__________________________] [Number of credits______]

☐ Module in Elective Course [Name of course__________________________] [Number of credits______]

Question #2: What specific information is covered in the area of suicide prevention?

☐ Behavioral Risk Factors (i.e. previous suicide attempts)

☐ Verbal Risk Factors (i.e. “I want to die”)

☐ Situational Risk Factors (i.e. loss of a loved one)

☐ General Risk Factors (i.e. being depressed)

☐ Gender differences in suicide attempts

☐ Cultural differences in suicide attempts

☐ Gay and lesbian issues in suicide attempts

☐ In school peer group training in suicide issues

☐ Assessing suicidality

☐ Specific intervention techniques____________________________________________________

☐ Postvention

☐ School based prevention programs

☐ Psycho-education for school students and parents (i.e. impact of families and friends)

☐ Referral Sources__________________________________________________________

☐ Other__________________________________________________________

Question #3: If your program does not currently offer a class in suicide prevention, what are the main reasons it does not?

☐ No room in the curriculum to add more credits

☐ Covered in other courses

☐ Lack of financial and staff resources

☐ Too specialized

☐ Not relevant
Question #4: Does CACREP accreditation affect whether suicide prevention is included in your programs curriculum?

☐ Yes
☐ No

Please turn over and fill out the demographic information!!

DEMOGRAPHIC INFORMATION

1. Your gender: _____ male _____ female

2. Your Race/Ethnic Group:
   _____ White / Caucasian / EuroAmerican
   _____ Black / African American
   _____ Hispanic / Latino
   _____ Asian/Pacific Islander
   _____ American Indian/Alaska Native / Native American
   _____ Bi or Multiracial
   _____ Other

3. Current position at your college or university:
   _____ Full Professor
   _____ Associate Professor
   _____ Assistant Professor
   _____ Adjunct Professor
   _____ Instructor
   _____ Other ________________________________

4. Number of masters level graduate students with an emphasis in School Counseling currently enrolled? ______

5. Estimated number of students usually accepted into your School Counseling program each year? ______

6. Estimated student demographic information
   _____ White / Caucasian / EuroAmerican
   _____ Black / African American
   _____ Hispanic / Latino
   _____ Asian/Pacific Islander
   _____ American Indian/Alaska Native / Native American
   _____ Bi or Multiracial
   _____ Other

Thank You Very Much!!
Appendix B
February 03, 2003

Dear CACREP Professor,

Suicide in the United States has been a growing epidemic for the past thirty years. According to the recent 2002 National Mental Health Association statistics, 5,000 young people ages 15-24 kill themselves each year. This makes suicide the third leading cause of death for the above-mentioned age group.

I am currently a doctoral candidate researching the training of school counselors in the area suicide prevention. My interest in pursuing this research is a result of my experience working with school counselor’s dealing with suicidal students at their work sites. I have seen first hand the various ramifications of suicide on youth, families and the community.

The results of this descriptive study are intended to be used to ascertain in what classes suicide prevention is taught, what information school counseling students are taught in this area, and if CACREP accreditation makes a differences in including suicide prevention in program curriculum. The results will be used as part of my dissertation.

I need your help. You are one of the CACREP institutions that provide graduate training of school counselors who is being asked to participate in this research. Your participation will provide unique and invaluable insight into the training of school counselors in the area of suicide prevention. In order that the results will truly represent the training of school counselors in CACREP programs, it is very important that each questionnaire be completed and returned.

You may be assured of compete confidentiality to the extent the law provides. The questionnaire envelope has an identification number for mailing purposes only. This is so I may check your institution off of the mailing list once 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 more than happy to answer any questions you might have. Please feel free to e-mail me at houset@onid.orst.edu or Dr. Pehrsson at dale.pehrsson@orst.edu. The phone number you may contact me is (541)-754-6392. If you have questions about your rights as a research subject, you may contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator at (541) 737-3437 or by e-mail at IRB@oregonstate.edu.

Thank you very much for your assistance and time.
Sincerely,

Terrie J. House
Appendix C

Postcard

February 17, 2003

Last week a questionnaire seeking your insights on CACREP School Counselors training on suicide prevention was mailed to you. You were selected as a CACREP program, all of who are being asked for their input. Your participation in this study is strictly voluntary.

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 CACREP accredited school counseling programs it is extremely important that yours also be included in the study if the results are to accurately represent CACREP programs.

If, by some chance, you did not receive the questionnaire, or if it has been misplaced, please email me at houset@onid.orst.edu. Another one will be placed in the mail today.

Sincerely,

Terrie J. House
Ph.D. Candidate
Appendix D

Second Appeal Letter

February 24, 2003

Dear NAME,

About three weeks ago I wrote to you seeking information on the training of school counselors in suicide prevention in CACREP accredited programs. As of today I have not received your completed questionnaire. Your participation in this study is voluntary.

I have undertaken this study because of the importance of the issue of school counselor training in the area of suicide prevention and recognizing the unique and important role you play in addressing this phenomenon.

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 all the CACREP programs, of which you are a member. In order for the results of this study to be truly representative of the CACREP School counseling programs, it is essential that each member return their questionnaire.

In the event that your questionnaire has been misplaced, a replacement is enclosed. I would be more than happy to answer any questions you might have. Please feel free to e-mail me at houset@onid.orst.edu.

Your cooperation is greatly appreciated.

Cordially,

Terrie J. House
Appendix E

Third Appeal Letter

March 10, 2003

Dear Name,

I am writing to you about my study of school counselors training in suicide prevention. I have not received your completed questionnaire. Your participation in this study is voluntary.

The large number of questionnaires returned is very encouraging. But, whether I will be able to describe accurately how CACREP programs train their school counselor in the area of suicide prevention depends on you and the others who have not yet responded.

This is the first study of CACREP programs and their training of school counselors in the area of suicide prevention. Therefore, the results are of particular importance to you, and your program. The usefulness of my results depends on how accurately I am able to describe your program.

It is for these reasons that I am sending this questionnaire to you again, in case my other correspondence did not reach you. 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 would like. 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 beginning of fall.

Your contribution to the success of this study will be greatly appreciated. I would be more than happy to answer any questions you might have. Please feel free to e-mail me at houset@onid.orst.edu.

Most Sincerely,

Terrie J. House
Appendix F

CACREP Standards

1. PROFESSIONAL IDENTITY - studies that provide an understanding of all of the following aspects of professional functioning:
   a. history and philosophy of the counseling profession, including significant factors and events;
   b. professional roles, functions, and relationships with other human service providers;
   c. technological competence and computer literacy;
   d. professional organizations, primarily ACA, its divisions, branches, and affiliates, including membership benefits, activities, services to members, and current emphases;
   e. professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues;
   f. public and private policy processes, including the role of the professional counselor in advocating on behalf of the profession;
   g. advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients; and
   h. ethical standards of ACA and related entities, and applications of ethical and legal considerations in professional counseling.

2. SOCIAL AND CULTURAL DIVERSITY - studies that provide an understanding of the cultural context of relationships, issues and trends in a multicultural and diverse society related to such factors as culture, ethnicity, nationality, age, gender, sexual orientation, mental and physical characteristics, education, family values, religious and spiritual values, socioeconomic status and unique characteristics of individuals, couples, families, ethnic groups, and communities including all of the following:
   a. multicultural and pluralistic trends, including characteristics and concerns between and within diverse groups nationally and internationally;
   b. attitudes, beliefs, understandings, and acculturative experiences, including specific experiential learning activities;
   c. individual, couple, family, group, and community strategies for working with diverse populations and ethnic groups;
   d. counselors' roles in social justice, advocacy and conflict resolution, cultural self-awareness, the nature of biases, prejudices, processes of intentional and unintentional oppression and discrimination, and other culturally supported behaviors that are detrimental to the growth of the human spirit, mind, or body;
   e. theories of multicultural counseling, theories of identity development, and multicultural competencies; and
   f. ethical and legal considerations.
3. **HUMAN GROWTH AND DEVELOPMENT** - studies that provide an understanding of the nature and needs of individuals at all developmental levels, including all of the following:

a. theories of individual and family development and transitions across the life-span;

b. theories of learning and personality development;

c. human behavior including an understanding of developmental crises, disability, exceptional behavior, addictive behavior, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior;

d. strategies for facilitating optimum development over the life-span; and

e. ethical and legal considerations.

4. **CAREER DEVELOPMENT** - studies that provide an understanding of career development and related life factors, including all of the following:

a. career development theories and decision-making models;

b. career, a vocational, educational, occupational and labor market information resources, visual and print media, computer-based career information systems, and other electronic career information systems;

c. career development program planning, organization, implementation, administration, and evaluation;

d. interrelationships among and between work, family, and other life roles and factors including the role of diversity and gender in career development;

e. career and educational planning, placement, follow-up, and evaluation;

f. assessment instruments and techniques that are relevant to career planning and decision making;

g. technology-based career development applications and strategies, including computer-assisted career guidance and information systems and appropriate worldwide web sites;

h. career counseling processes, techniques, and resources, including those applicable to specific populations; and

i. ethical and legal considerations.

5. **HELPING RELATIONSHIPS** - studies that provide an understanding of counseling and consultation processes, including all of the following:

a. counselor and consultant characteristics and behaviors that influence helping processes including age, gender, and ethnic differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills;

b. an understanding of essential interviewing and counseling skills so that the student is able to develop a therapeutic relationship, establish appropriate counseling goals, design intervention strategies, evaluate client outcome, and successfully terminate the counselor-client relationship. Studies will also facilitate student self-awareness so that the counselor-client relationship is therapeutic and the counselor maintains appropriate professional boundaries;

c. counseling theories that provide the student with a consistent model(s) to conceptualize client presentation and select appropriate counseling interventions. Student experiences should include an examination of the historical development
of counseling theories, an exploration of affective, behavioral, and cognitive theories, and an opportunity to apply the theoretical material to case studies. Students will also be exposed to models of counseling that are consistent with current professional research and practice in the field so that they can begin to develop a personal model of counseling;
d. a systems perspective that provides an understanding of family and other systems theories and major models of family and related interventions. Students will be exposed to a rationale for selecting family and other systems theories as appropriate modalities for family assessment and counseling;
e. a general framework for understanding and practicing consultation. Student experiences should include an examination of the historical development of consultation, an exploration of the stages of consultation and the major models of consultation, and an opportunity to apply the theoretical material to case presentations. Students will begin to develop a personal model of consultation;
f. integration of technological strategies and applications within counseling and consultation processes; and
g. ethical and legal considerations.

6. GROUP WORK - studies that provide both theoretical and experiential understandings of group purpose, development, dynamics, counseling theories, group counseling methods and skills, and other group approaches, including all of the following:
a. principles of group dynamics, including group process components, developmental stage theories, group members' roles and behaviors, and therapeutic factors of group work;
b. group leadership styles and approaches, including characteristics of various types of group leaders and leadership styles;
c. theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature;
d. group counseling methods, including group counselor orientations and behaviors, appropriate selection criteria and methods, and methods of evaluation of effectiveness;
e. approaches used for other types of group work, including task groups, psycho-educational groups, and therapy groups;
f. professional preparation standards for group leaders; and
g. ethical and legal considerations.

7. ASSESSMENT - studies that provide an understanding of individual and group approaches to assessment and evaluation, including all of the following:
a. historical perspectives concerning the nature and meaning of assessment;
b. basic concepts of standardized and non-standardized testing and other assessment techniques including norm-referenced and criterion-referenced assessment, environmental assessment, performance assessment, individual and group test and inventory methods, behavioral observations, and computer-managed and computer-assisted methods;
c. statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations;
d. reliability (i.e., theory of measurement error, models of reliability, and the use of reliability information);
e. validity (i.e., evidence of validity, types of validity, and the relationship between reliability and validity);
f. age, gender, sexual orientation, ethnicity, language, disability, culture, spirituality, and other factors related to the assessment and evaluation of individuals, groups, and specific populations;
g. strategies for selecting, administering, and interpreting assessment and evaluation instruments and techniques in counseling;
h. an understanding of general principles and methods of case conceptualization, assessment, and/or diagnoses of mental and emotional status; and
i. ethical and legal considerations.

8. RESEARCH AND PROGRAM EVALUATION - studies that provide an understanding of research methods, statistical analysis, needs assessment, and program evaluation, including all of the following:
a. the importance of research and opportunities and difficulties in conducting research in the counseling profession,
b. research methods such as qualitative, quantitative, single-case designs, action research, and outcome-based research;
c. use of technology and statistical methods in conducting research and program evaluation, assuming basic computer literacy;
d. principles, models, and applications of needs assessment, program evaluation, and use of findings to effect program modifications;
e. use of research to improve counseling effectiveness; and
f. ethical and legal considerations.

Section III

CLINICAL INSTRUCTION
Clinical instruction includes supervised practica and internships that have been completed within a student’s program of study. Practicum and internship requirements are considered to be the most critical experience elements in the program. All faculty, including clinical instruction faculty and supervisors, are clearly committed to preparing professional counselors and promoting the development of the student’s professional counselor identity.

A. Each regular or adjunct program faculty member who provides individual or group practicum and/or internship supervision must have
1. a doctoral degree and/or appropriate clinical preparation, preferably from an accredited counselor education program;
2. relevant professional experience and demonstrated competence in counseling; and
3. relevant training and supervision experience.
B. Students serving as individual or group practicum supervisors must
1. have completed counseling practicum and internship experience equivalent to those within an entry-level program;
2. have completed or are receiving preparation in counseling supervision; and
3. be supervised by program faculty, with a faculty/student ratio that does not exceed 1:5.

C. A site supervisor must have
1. a minimum of a master's degree in counseling or a related profession with equivalent qualifications, including appropriate certifications and/or licenses;
2. a minimum of two (2) years of pertinent professional experience in the program area in which the student is completing clinical instruction; and
3. knowledge of the program's expectations, requirements, and evaluation procedures for students.

D. A clinical instruction environment, on- or off-campus, is conducive to modeling, demonstration, and training and is available and used by the program. Administrative control of the clinical instruction environment ensures adequate and appropriate access by the faculty and students. The clinical instruction environment includes all of the following:
1. settings for individual counseling with assured privacy and sufficient space for appropriate equipment (for example, TV monitoring and taping);
2. settings for small-group work with assured privacy and sufficient space for appropriate equipment;
3. necessary and appropriate technologies that assist learning, such as audio, video, and telecommunications equipment;
4. settings with observational and/or other interactive supervision capabilities; and
5. procedures that ensure that the client's confidentiality and legal rights are protected.

E. Technical assistance for the use and maintenance of audio and videotape and computer equipment is available as well as other forms of communication technology.

F. Orientation, assistance, consultation, and professional development opportunities are provided by counseling program faculty to site supervisors.

G. Students must complete supervised practicum experiences that total a minimum of 100 clock hours. The practicum provides for the development of counseling skills under supervision. The student's practicum includes all of the following:
1. 40 hours of direct service with clients, including experience in individual counseling and group work;
2. weekly interaction with an average of one (1) hour per week of individual and/or triadic supervision which occurs regularly over a minimum of one academic term by a program faculty member or a supervisor working under the supervision of a program faculty member;
3. an average of one and one half (1 1/2) hours per week of group supervision that
is provided on a regular schedule over the course of the student’s practicum by a
program faculty member or a supervisor under the supervision of a program
faculty member; and
4. evaluation of the student’s performance throughout the practicum including a
formal evaluation after the student completes the practicum.

H. The program requires students to complete a supervised internship of 600 clock
hours that is begun after successful completion of the student’s practicum (as
defined in Standard III.G). The internship provides an opportunity for the student
to perform, under supervision, a variety of counseling activities that a professional
counselor is expected to perform. The student’s internship includes all of the
following:
1. 240 hours of direct service with clients appropriate to the program of study;
2. weekly interaction with an average of one (1) hour per week of individual and/or
triadic supervision, throughout the internship, (usually performed by the on-site
supervisor);
3. an average of one and one half (1 1/2) hours per week of group supervision
provided on a regular schedule throughout the internship, usually performed by a
program faculty member;
4. the opportunity for the student to become familiar with a variety of professional
activities in addition to direct service (e.g., record keeping, supervision,
information and referral, in-service and staff meetings);
5. the opportunity for the student to develop program-appropriate audio and/or
videotapes of the student’s interactions with clients for use in supervision;
6. the opportunity for the student to gain supervised experience in the use of a
variety of professional resources such as assessment instruments, technologies,
print and non-print media, professional literature, and research; and
7. a formal evaluation of the student’s performance during the internship by a
program faculty member in consultation with the site supervisor.

I. The practicum and internship experiences are tutorial forms of instruction;
therefore, when the individual supervision is provided by program faculty, the
ratio of 5 students to 1 faculty member is considered equivalent to the teaching of
one (1) three-semester hour course. Such a ratio is considered maximum per
course.

J. Group supervision for practicum and internship should not exceed 10 students.

K. Clinical experiences (practicum and internship) should provide opportunities
for students to counsel clients who represent the ethnic and demographic diversity
of their community.

L. Students formally evaluate their supervisors and learning experience at the end
of their practicum and internship experiences.
M. Programs require students to be covered by professional liability insurance while enrolled or participating in practicum, internship, or other field experiences.

Section IV

C. KNOWLEDGE AND SKILL REQUIREMENTS FOR SCHOOL COUNSELORS

1. Program Development, Implementation, and Evaluation

a. use, management, analysis, and presentation of data from school-based information (e.g., standardized testing, grades, enrollment, attendance, retention, placement), surveys, interviews, focus groups, and needs assessments to improve student outcomes;
b. design, implementation, monitoring, and evaluation of comprehensive developmental school counseling programs (e.g., the ASCA National Standards for School Counseling Programs) including an awareness of various systems that affect students, school, and home;
c. implementation and evaluation of specific strategies that meet program goals and objectives;
d. identification of student academic, career, and personal/social competencies and the implementation of processes and activities to assist students in achieving these competencies;
e. preparation of an action plan and school counseling calendar that reflect appropriate time commitments and priorities in a comprehensive developmental school counseling program;
f. strategies for seeking and securing alternative funding for program expansion; and
g. use of technology in the design, implementation, monitoring and evaluation of a comprehensive school counseling program.

2. Counseling and Guidance

a. individual and small-group counseling approaches that promote school success, through academic, career, and personal/social development for all;
b. individual, group, and classroom guidance approaches systematically designed to assist all students with academic, career and personal/social development;
c. approaches to peer facilitation, including peer helper, peer tutor, and peer mediation programs;
d. issues that may affect the development and functioning of students (e.g., abuse, violence, eating disorders, attention deficit hyperactivity disorder, childhood depression and suicide);
e. developmental approaches to assist all students and parents at points of educational transition (e.g., home to elementary school, elementary to middle to high school, high school to postsecondary education and career options);
f. constructive partnerships with parents, guardians, families, and communities in order to promote each student's academic, career, and personal/social success;
g. systems theories and relationships among and between community systems, family systems, and school systems, and how they interact to influence the students and affect each system; and
h. approaches to recognizing and assisting children and adolescents who may use alcohol or other drugs or who may reside in a home where substance abuse occurs.

3. Consultation
   a. strategies to promote, develop, and enhance effective teamwork within the school and larger community;
   b. theories, models, and processes of consultation and change with teachers, administrators, other school personnel, parents, community groups, agencies, and students as appropriate;
   c. strategies and methods of working with parents, guardians, families, and communities to empower them to act on behalf of their children; and
   d. knowledge and skills in conducting programs that are designed to enhance students’ academic, social, emotional, career, and other developmental needs.

D. CLINICAL INSTRUCTION

For the School Counseling Program, the 600 clock hour internship (Standard III.H) occurs in a school counseling setting, under the supervision of a site supervisor as defined by Section III, Standard C.1-2. The requirement includes a minimum of 240 direct service clock hours.
The program must clearly define and measure the outcomes expected of interns, using appropriate professional resources that address Standards A, B, and C (School Counseling Programs).