MEASURING GATEKEEPERS' SUICIDE AWARENESS AND PERCEIVED SELF-EFFICACY REGARDING ADOLESCENT SUICIDE IN THE SAN MARCOS PUBLIC SCHOOL SYSTEM

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MEASURING GATEKEEPERS' SUICIDE AWARENESS AND PERCEIVED SELF-EFFICACY REGARDING ADOLESCENT SUICIDE IN THE SAN MARCOS PUBLIC SCHOOL SYSTEM

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Adolescent suicide is increasing at a significant rate. In fact, adolescent suicide is increasing at a greater rate than any other age group. This study addressed the problem of suicide in the San Marcos Public Schools (the location of the study) where two suicides were reported in the past year. While the researcher was working on this study, another student ended his life. In response to potential adolescent suicides, this study examined the extent to which counselors, coaches, nurses and diagnosticians in the San Marcos, Texas, Independent School System are prepared to recognize adolescents at risk for suicide. In addition, this study examined the school staff's perceived self-efficacy as it related to identifying students at risk for suicide. The present study made an effort to establish whether there is a need for suicide awareness education and training in the schools. The overwhelming majority of gatekeepers knew the appropriate risk factors for adolescent suicide; however, showed low levels of perceived self-efficacy in regards to adolescent suicide. This study recommends that education on adolescent suicide be implemented in the school systems examined.

CHAPTER I

REVIEW OF THE LITERATURE

Adolescent Suicide and its Direction

The rate of adolescent suicide is increasing at a greater rate than any other age group (Centers for Disease Control and Prevention/CDC 1998: 6). The rate of adolescent suicide has tripled from the 1950's, and today, suicide is the third leading cause of death for 10-24-year-olds in the United States (CDC 2001-2002:1-2). During 1970-1980, 49,496 of the nation's youth, 10-19 years of age, committed suicide (CDC 1987:87). Between 1980-1992, 67,369 of the nation's youth committed suicide (CDC 1995:289). Between 1980 and 1994 the suicide rate among youths 15-19 years old increased by 30.6% (from 8.5 to 11.1 per 100,000 persons), and among persons ages 10-14 years the rate increased by 120% (from .8 to 1.7 per 100,000 persons) according to data from the Centers for Disease Control (1995:289-290). The dramatic increase in the rate of suicide among youth aged 10-19 stresses the immediate need for increasing efforts to prevent suicide among persons in this age group.

In a recent study by the Youth Risk Behavior Surveillance System (CDC, 1998:11-12), of 16,262 high school students it was found that one in four had thought seriously about attempting suicide during the year before completing the survey. Of these students, 15.7 percent had gone as far as to make a suicide plan. According to this

study, 7.7 percent had made one or more actual suicide attempts during the previous year. Of these students, 2.6 percent had made a suicide attempt that resulted in an injury needing "serious medical attention" (CDC, 1998:11-12). For every completed suicide there are, on average, at least 100 suicide attempts (O'Carroll 1989:2).

In Texas (the location of the present study), the rate of adolescent suicide is 14.3 per 100,000 (1998 Texas Dept. of Health) individuals aged 5-24-years-old. From 1990-1997, Texas' rate for adolescent suicide was above or the same as the United States' overall rate of adolescent suicide (American Foundation for Suicide Prevention/AFSP 1999:1-2). From 1990-1998, 3,681 adolescents between the ages of 5-24 committed suicide (1998 Texas Dept. of Health). Currently, suicide is the second leading cause of death among youth 5 to 24 years of age in Texas (1998 Texas Dept. of Health). Researchers have recommended school staff be trained on recognizing adolescents at risk for suicide in an effort to reduce the rate of adolescent suicide.

School staff training needs regarding suicide and the pervasiveness of youth suicide have led to school gatekeeper training programs designed and implemented to help teachers and school staff identify students at risk for suicide (CDCa 1992:6). Research shows that suicide occurs much less often when schools make conscientious and deliberate efforts to prevent youth suicide, effectively intervene in potential suicide situations, and appropriately respond when a youth suicide has occurred. (Texas Education Agency, 1997:www.tea.state.tx.us). Efficiently recognizing risk factors for adolescents may help curb the mental health issue of adolescent suicide.

In a recently released call to action by the U.S. Surgeon General, Dr. David Satcher, suicide was identified as a serious public health problem (U.S. Public Health

Service, 1999). The Surgeon General's "Call To Action" introduces a blueprint for addressing suicide: awareness, intervention and methodology (AIM). According to Damon Thompson, the U.S. Surgeon General's spokesman, educating the public to recognize when someone seems at risk of suicide and how to get help is necessary. In this call to action Thompson said, "We want coaches, we want school teachers...we want people who interact with the community" to be able to recognize adolescents at risk for suicide (U.S. Public Health Service, 1999:11).

In addition, the Texas State Board of Education urges instruction on suicide prevention and intervention in teacher in-service and training preparation. The Texas State Board of Education submitted a report to the 71st Legislature revealing that only 20 of the 1,100 school districts in Texas had policies or procedures to address issues related to youth suicide (Texas Education Agency, 1997:http://www.tea.state.tx.us/).

Recognizing students at risk for suicide is important to our future. The educational system plays a vital role in children's everyday lives. One purpose of public schooling is to help children develop into productive, law-abiding adults with good mental health. One way to accomplish this goal is for school staff to be educated on youth risk behaviors, including risk factors for suicide attempts (CDC, 1998:2 http:/www.cdc.gov/), which in turn may lead to an increase in school staff efficacy levels in regards to adolescent suicide.

School Gatekeeper Training Programs

School gatekeeper training programs are "school-based programs designed to help school staff identify students at risk of suicide and to refer them for help (Centers for Disease Control 1992a:11). Any adult in the school (e.g., counselors, teachers, coaches,

administrators or cafeteria staff) that is in a position to observe and interact with students may be considered a gatekeeper.

According to the Centers for Disease Control (1992a:11), gatekeeper training usually consists of learning about warning signs of suicide, what referral sources exist and how to contact them, and what the school policy is for handling crisis situations. A school counselor's ability to identify at-risk behaviors in students is considered integral to an effective comprehensive school suicide prevention program (King et al 1999b:206).

The Centers for Disease Control has set the primary purpose of school gatekeeper training programs at educating staff on how to "identify students with emotional or other problems who may also be potentially suicidal (1992a:11)." These school based gatekeepers are not meant to replace professional mental health care or to empower school staff to act as counselors but is simply meant to enable staff to heed to the warnings of potentially suicidal students (CDC 1992a:11).

School gatekeeper training programs have been reported as effective, as can be seen by the New Jersey Adolescent Suicide Prevention Project. Three hundred seven educators took part in a suicide prevention project by completing questionnaires before and after a training program with results showing an increase in knowledge of adolescent suicide risk factors. Researchers evaluating the New Jersey Adolescent Suicide Prevention Project found that school personnel who participated in a 2-hour training program showed a heightened awareness of risk factors for suicide, understanding of approaches to treatment, and agreement to refer students to mental health professionals (Shaffer, et al. 1988: as presented in Centers for Disease Control 1992a:11).

On the other hand, in a review of adolescent suicide education programs, completed by Garland and Zigler (1993:176), the researchers failed to support the effectiveness of state mandated suicide prevention. They found that prevention knowledge about adolescent suicide could be used more effectively in suicide prevention programs for school personnel. Garland and Zigler argued "strongly against mandating suicide prevention curriculum, as they are now implemented." This finding does not negate efforts at suicide prevention, but "supports more efficient and effective strategies" (Garland and Zigler 1993:176) such as those which Silverman and Felner (1995:102) suggest in which more time, intensity and duration are involved.

Definition of Terms

Before the present study is detailed, a brief description of conceptual elements is discussed in the next section. Included are gatekeepers, risk factors, and self-efficacy. A clearer understanding of how this study defined these terms is appropriate in order to discuss the details of this study hereinafter.

Gatekeepers

The literature on gatekeepers is spread among a variety of disciplines, and for the most part, there is a lack of cohesion and precision with respect to how the term is used. Traditionally, gatekeepers were characterized as those who merely passed on or limited the access to a particular object or information. More recently, however, the literature reflects definitions of gatekeepers as persons who are capable of withholding information or blocking access to information.

The concept of the "*gatekeeper*" was initially identified in the social science literature by Kurt Lewin in the 1930's (Hargittai 2000:4). Lewin coined the term

"*gatekeeper*" to identify people or institutions that aid or prevent access to food (Lewin 1951:183). According to Lewin, gatekeepers are in a situation of power to decide between "in or out" (Lewin 1951: 186). Lewin's theory helps us to decipher more accurately "how certain 'objective' sociological problems of locomotion of goods and persons intersect with 'subjective' psychological and cultural problems (Lewin 1951:187). Gates can therefore be seen as "sociologically characterized places...where attitudes count most for certain social processes and where individual or group decisions have a particularly great social effect" (Lewin 1951:187).

As a student of Lewin, White (1950) performed research on why reporters as gatekeepers pick certain stories over others in the filtering process of journalism. He found, for example, that even though these reporters may not be consciously aware of it, as gatekeepers, their subjectivity causes them to only allow or censor information to the public when, as reporters, they believe that the information is true (White 1950:390).

Many disciplines continue to follow in Lewin's and White's paths and use gatekeeper as a term to refer to someone in a position to permit or prohibit passage of persons through a metaphorical gate. Included are gates having to do with journalism, criminal justice, medicine and suicidology. In short, the concept of gatekeeper may reflect a positive or negative connotation, depending upon the context in which it is used.

Extending the notion introduced earlier by White, Janowitz has characterized journalists as gatekeepers as to the extent that they "detect, emphasize and disseminate that which is important" (Janowitz 1975:618). Accordingly, he paints a picture of journalists functioning to filter public access to information (Janowitz 1975: 618 and

White 1950:383). The gatekeeper in this position controls the gate and designates the passage of information to the public through this gate.

In the criminal justice system, as well, police officers are frequently referred to as gatekeepers because of their strategic role throughout the criminal justice process. With these gatekeepers, the law attempts to control the referral process of youth and adults who have committed acts against the law (Kelling 1987: 215-216; Prenzler and Hayes 1998:21-22). As applied in this context, the term gatekeeper bears something of both a positive and negative connotation. The gatekeeper in this situation has charge of the gate and demands entrance into the gate of the criminal justice system while restricting exit until the appropriate time.

In the medical field, for example, primary care physicians are frequently referred to as gatekeepers because of their strategic role in the patient referral process. With these gatekeepers, managed care plans and insurance companies attempt to control expenditures for healthcare costs (Halm et al. 1997:1677). Halm, for example, characterizes primary care physicians as physicians whom "orchestrate and control the health care of its enrollees" (Halm 1997:1677). Absent an emergency, only the primary care physician can refer a patient to use a specialist or other expensive services (Halm, et al 1997:1678). As applied in this context, the term gatekeeper bears something of a derogatory connotation. These primary care physicians, or medical gatekeepers, as they are known, have come under attack in recent years by many involved in the medical field because the primary care physician is used as a method for control over patients (http://www.mentalhealth.org/suicideprevention/).

In a positive view, the field of suicidology uses the term gatekeeper as an individual who comes into close contact with children on a routine basis, so much so that they are in a position to provide valuable data to young adults (http://www.mentalhealth.org/suicideprevention/). These gatekeepers are seen as powerful and positive in terms of opening of the gate to resources if a child is in crisis (http://www.mentalhealth.org/suicideprevention/startegy.asp). The contemplation of suicide by a child is an illustrative case in point. In the present study, school counselors, coaches, nurses and diagnosticians in the San Marcos, Texas Public School System are considered "gatekeepers" and constitute the object of the study. These gatekeepers are in a strategic position to recognize a crisis and the warning signs that a student may be at risk for suicide.

In summary, the literature on gatekeepers runs through a variety of disciplines; however, there is a lack of cohesion and precision with respect to how the term is used. Gatekeepers have been characterized as those who merely passed on or limited the access to a particular object or information. Presently the literature focuses on gatekeepers as persons who are capable of withholding information or blocking access to information altogether. In light of this, the present study has used the term gatekeeper to mean an individual who comes into close contact with children on a routine basis, so much so that they are in a position to provide valuable data to young adults. This definition brings to light the importance of school staff who serves as gatekeepers for adolescents at risk for suicide.

Risk Factors

According to the Centers for Disease Control and Prevention (2001-2002:32), when risk factors exist they have an impact on the likelihood of an adolescent engaging in a particular behavior. The present study focuses on risk factors for adolescent suicide attempts.

In this regard, a risk factor can be defined as "a condition that, if present, increases the likelihood of a person developing an emotional or behavioral problem (Stevens and Griffin 2001: 32). Varieties of circumstances, including biological and physical characteristics of an individual and/or situations that youth experience are included in identifying risk factors.

Lists of warning signs or risk factors for suicide have been created in an effort to identify and increase the referral of persons at risk. Warning signs listed are not risk factors only for suicide. These risk factors may include common behaviors among distressed persons, behaviors that are not specific for suicide (Motto 1991:82). However, the literature emphasizes recognizing these risk factors in an attempt to reduce adolescent suicide.

According to the literature (Swedo et al, 1991: 620-621; Johnson 1999: 5-6), three categories of risk factors have been tested and continue to exist: biological, psychological, and environmental. In the current study, biological risk factors have been delineated as being depressed, having a previous suicide attempt and being involved in drug use. Psychological risk factors have been described as having low self-esteem and being withdrawn or isolated. The remaining risk factors used in the present study are

environmental risk factors including having a recent relationship breakup, having easy access to a handgun, and being homosexual.

Biological Risk Factors

Biological risk factors of suicide include psychiatric disorders that lead to an increase in the risk of suicide. Patients who are at risk for suicide due to major depressive disorders and substance abuse have a 20 times greater risk that they will commit suicide than the general public (Swedo et al. 1991: 620). Researchers have compared suicide ideation to depression and substance abuse and found a positive relationship between the variables (Horowitz et al 2001; Wright 1985; Gutierrez et al 2001; Kelly et al 2001; Dori and Overholser 1999). Mental and behavioral disorders and serious emotional disturbances in children and adolescents can lead to school failure, alcohol or illicit drug use, and/or suicide.

A recent study by Horowitz, et al. (2001) examined 155 children and adolescents who had come into the pediatric emergency department of a teaching hospital for psychiatric reasons. All answered 14 questions from the Risk of Suicide Questionnaire (RSQ) by a triage/admitting nurse. The patient also responded to a Suicide Ideation Questionnaire (which has previously demonstrated high reliability and validity) by a member of the psychology team who did not know the results of the patient's RSQ. This new rapid screening tool (RSQ) has proven to be positive in identifying patients at risk for suicide (Horowitz et al 2001: 1135-1137). This study compared suicidality to previous suicide attempt and alcohol and drug abuse and found significant predictors of risk for suicide.

Similarly, Wright (1985) studied 901 students enrolled in a freshman level college psychology course and 207 high school students. Each participant was given a survey that asked about risk behaviors, including drinking and drug abuse problems (Wright 1985:576). The participants were also asked whether they had considered a suicide attempt in the last six months (Wright 1985:576). This study of non-clinical respondents (respondents who have not been admitted to the hospital), found that both high school and college students were significantly more likely (three to six times) to think of themselves as having a drinking or drug abuse problem. Wright concluded that "while there appears to be a definite link between suicide and alcohol, the relationship is complicated (1985:580). Drinking or drug abuse problems may serve as an escape from the same problems that are related to suicide attempts. For others, it may be used as a distress signal. If the drugs and alcohol fail, then a serious consideration of suicide may be made. Still others may use alcohol and drugs as the "means to an end," or suicide (Wright 1985:580).

Along these same lines, a study by Gutierrez et al (2001) studied 34 patients admitted to the Adolescent Psychiatric Inpatient Program in a six-month period. Within 7 days of admission, patients were administered two measures of depression severity and two measures of suicidality, as related to attitudes toward death. First was the Reynolds Adolescent Depression Scale (RADS). Next was the Children's Depression Rating Scale. Third was the Suicide Ideation Questionnaire-Junior (SIQ-JR). Lastly, the Suicide Intents Scale (SIS) was used. Based on a diagnosis by clinical consensus using the DSM-II-R criteria, the overall prevalence of substance abuse and dependence disorder was 35% (Gutierrez et al 2001:12). In this sample 53% had a prior suicide attempt. Based on the

findings of this study, significantly stronger positive attitudes toward death were higher in patients who had a substance abuse and dependence disorder, a prior suicide attempt and were diagnosed with depression, which in turn influences risk of suicide behavior.

Moving on biological risk factors, Kelly et al (2001) studied 482 adolescents through the use of a daylong baseline assessment. These adolescents, who were diagnosed as having a mental disorder of either major depression, post traumatic stress disorder, attention deficit hyperactivity disorder or alcohol use disorder, were studied to determine predictors of suicide and attempts. Self-report questionnaires and direct interviews with the adolescents and at least one parent were conducted (Kelly et al 2001:183). Participants were asked if they had ever thought of killing themselves, if they had ever wished to die, if they had ever made a plan to kill themselves and if they had done any of these in the past six months. Adolescents who answered yes to the last two questions were considered having suicide ideations. Classification of a suicide attempter was defined as having ever made one or more suicide attempts (Kelly 2001:184). These participants where then given a modified version of the Substance Abuse Disorders section of the DSM-IV disorders interview to distinguish a presence of alcohol abuse disorder. In both males and females, depression was found to be positively correlated to suicide ideations and attempts. According to the results of this study, substance abuse was found to be a positive predictor of suicide ideation and attempt (Kelly et al 2001:187-189).

In regard to suicidality and depression, Dori and Overholser (1999:311) conducted a study of 90 adolescent psychiatric inpatients of a psychiatric hospital. The subjects all had a primary diagnosis of a depressive disorder. Interviews were conducted

and questionnaires were used to collect information on current suicide ideation, self-injurious behavior, and recent suicide attempts during the past month, and the lifetime number of previous attempts. Questionnaires consisted of The Children's Depression Rating Scale and The Children's Depression Inventory. Of the 90 patients, 34 patients were depressed but had never attempted suicide, whereas 56 patients had attempted suicide before. This study found that of the 56 patients who had attempted suicide, half had attempted once and the rest had multiple attempts ranging from 2 to 11 attempts in their lifetime. The findings of this study suggest that adolescents who had attempted suicide had significantly higher levels of depression than did the depressed adolescents who had never attempted suicide.

In short, known biological risk factors for adolescent suicide attempts include depression, previous suicide attempt and drug abuse problems or psychiatric disorders that lead to an increase in the risk of suicide. Patients who are at risk for suicide due to major depressive disorders and substance abuse have a greater chance of committing suicide than the rest of society (Swedo et al. 1991: 620). Researchers have compared suicide ideation to depression, previous suicide attempts and substance abuse and found positive relationships (Horowitz et al 2001; Wright 1985; Gutierrez et al 1996; Kelly et al 2001; Dori and Overholser 1999). Yet biology is just one of three groups of risk factors for adolescent suicide attempts. Psychological risk factors for suicide also exist.

Psychological Risk Factors

Psychological risk factors for suicide focus on how thoughts effect emotion and behaviors. Individuals view and interpret situations differently, affecting their emotions and feelings about the situation. Cognitive or psychological risk factors include low self-

esteem and being withdrawn or isolated (Kelly et al 2001; Dori and Overholser 1999; Jackson and Nuttall 2001).

Kelly et al (2001) compared self-esteem and suicide ideation and attempt. In this study, Kelly et al used the 12-item self-esteem sub scale of the Interpersonal Support Evaluation questionnaire to measure self-esteem. This study found that low self-esteem was a predictor of suicide ideation and attempt.

The study summarized in the biological section by Dori and Overholser (1999) compared low self-esteem to levels of suicidality. Depressed patients were grouped according to never having presented suicide attempts, attempting suicide once, or attempting suicide several times. Low self-esteem was found to be involved in all three groups studied. In this study, there was little difference in self-esteem between suicide attempters and non-attempters leaving the researchers to say that self esteem may be a predictor of depression only (Dori and Overholser 1999:313-314). However, depression, as seen in the studies presented, is a primary factor in suicide ideations and attempts.

In conclusion, psychological risk factors for suicide emphasize how thoughts effect emotion and behaviors. Emotions and feelings about a situation can create distinct views and interpretations about situations adolescents are involved in. As seen in the above studies, cognitive or psychological risk factors associated with adolescent suicide attempts include self-esteem and being withdrawn or isolated (Kelly et al 2001; Dori and Overholser 1999). In addition to biological and psychological risk factors for adolescent suicide, environmental risk factors have been found.

Environmental Risk Factors

Lastly, environmental risk factors deal with the stress of life events and the environment surrounding an individual. Common environmental examples that put adolescents at risk of suicide include a recent relationship up or fight with a loved one, same sex orientation and available lethal means (Russell and Joyner 2001; CDC 1997b; CDC 1997; Bower 1992).

The most common environmental risk factor that exists is access to firearms. According to the Centers for Disease Control, firearm-related deaths for adolescents are increasing. The United States surpasses any other country in number of firearm related suicides among youth (CDC 1997a:213; Bower 1992). The overall firearm-related death rate among US children less than 16-years-old was nearly 12 times that of the other 25 countries combined (CDC 1997b:102-103). According to CDC (1997)

In regard to environmental factors, Russell and Joyner (2001), in a review of data from the National Longitudinal Study of Adolescent Health, compared suicidality to sexuality. Of 458 high school students included in the data analysis, who had attempted suicide, same-sex orientation was a critical adolescent suicide risk factor (Russell and Joyner 2001:1277). Their findings suggest a strong link between adolescent sexuality and suicide attempts. These findings suggest that the strong effect of sexuality also may be related to biological risk factors, such as depression , hopelessness and alcohol abuse (1277-79). In conclusion, the stress of life, and the environment that surrounds an adolescent creates a fertile ground for risk factors for suicide. Adolescents face many challenges in their everyday life that may put them at risk for attempting suicide if such challenges are not dealt with properly (Russell and Joyner 2001; MMWR 1997; CDC 1997; Bower 1992).

The above risk factors provide support for a corresponding model of biological, psychological and environmental factors that lead to suicide attempts and risk of future suicides. Risk, by its very nature, is difficult to define. No one factor puts a student at risk of suicide, but suicidal attempts arise from an individual blend of factors. The above factors are those most prominent in prior cases of attempted or completed suicide. In spite of the complexity of deciphering suicide risk factors, knowing that such risks exist and being able to spot them are important to gatekeepers, who are often in the best position to help students become aware of and avoid these risks. Gatekeepers involved in recognizing adolescents at risk for suicide are faced with the question of whether their own actions affect outcomes, that in turn provokes a sense of efficacy.

Self Efficacy

Albert Bandura (1977:79) coined the term self-efficacy. Self-efficacy is defined by Bandura as "belief in one's capabilities to organize and execute the sources of action required to manage prospective situations" (Bandura 1997:3). Bandura distinguished between efficacy expectation, the belief in one's ability to successfully perform a given behavior necessary to reach an outcome and outcome expectancy, the belief that a certain behavior will lead to a particular outcome (Bandura 1997:19-24). Efficacy expectations and outcome expectations are differentiated because individuals can come to believe that a particular course of action will produce certain outcomes, but question whether they can perform those actions (Bandura 1977:79).

Efficacy expectation is "the conviction that one can successfully execute the behavior required to produce the outcomes" (Bandura 1977:79). Efficacy expectations determine how much effort people will expend and how long they will persist in the face

of obstacles and aversive experiences (Bandura 1977:80). Outcome expectations are "a person's estimate that a given behavior will lead to certain outcomes" (Bandura 1977:79).

Bandura later added the perceived value or importance of the behavior and its anticipated results to perceived self-efficacy, a concept that relates to interest in performing the behavior (Bandura 1997:22). This outcome value is described as the value an individual places on the action that is being performed.

According to Lenox and Subich (1994:303) interests lead to career-related actions and performance. Through the use of 180 participants at a midwestern university, a linear relationship was found to exist between self-efficacy and job outcome values or interest. A correlation was found between self-efficacy and interest, however only to a certain degree. In a study of 3,500 personnel at a university it has been shown that interest affects action and performances related to the activity (Harrison et al 1997:79), which in turn may affect perceived self-efficacy levels (Bandura 1997:22). The study by Harrison et al. (1997) did not test levels of interest, as Lenox and Subich did, finding a strong positive correlation of self-efficacy and interest.

According to Bandura (1986:390 and 1997:20) the belief in one's own actions as affecting outcomes provokes a sense of efficacy. Beliefs that outcomes are determined by one's own behavior can be either demoralizing or empowering, depending on whether or not one believes one can produce the required behavior. Individuals who consider outcomes personally determined, but who lack the skills required to complete this task, would likely experience low levels of efficacy (Bandura 1997:20).

According to Bandura (1997:36-37 and Bandura 1986:390) to get a task completed correctly does not include knowing what to do and wanting to do it. Neither is

efficacy an unchanging ability that one either possesses or does not. Efficacy is however, a culmination of certain behaviors, and thoughts. An individual may possess the necessary skills, yet, may lack the ability to execute them properly under difficult surroundings. People often fail to perform confidently even when they know exactly what to do and how to do it (Bandura 1986:433 and Bandura 1997:36-37). Skills that people already have, such as knowledge of risk factors, must be directed in new ways to meet varying situational demands (Bandura 1977:392).

As was found in King et al., study (1999b:209), the majority of high school health teachers believed it was their role to recognize students at risk for suicide, believed that if they did recognize students at risk for suicide it would reduce the chances that the student would commit suicide, and believed that one of the most important things they could ever do would be to prevent a suicidal student from committing suicide. Nevertheless, only 9% of these high school health teachers believed that they could recognize a student at risk for suicide. Thus, they had low efficacy expectations, high outcome expectations and high outcome values in regards to adolescent suicide.

The current study focuses on gatekeepers' perceived self-efficacy as it relates to knowledge of adolescent suicide. As stated earlier, the perceived value or importance of the behavior and its anticipated results relate to interest in performing the behavior (Bandura 1997:22). It is valuable to learn about self-efficacy of gatekeepers because their perceptions regarding their ability to perform an activity and the relevance of the activity may influence their interest in that activity. With this in mind, higher levels of self-efficacy may lead to an increase in productivity in regards to working with adolescents at risk for suicide.

Recognizing adolescents at risk for suicide may be a start at reducing adolescent suicide rates. A comprehensive review of the literature revealed only one study that looked at high school health teachers' knowledge of adolescent suicide (King et al 1999a) and perceived self-efficacy in identifying adolescents at risk for suicide (King et al 1999b).

According to this study the overwhelming majority (70%) believed it was their "role to identify students at risk for suicide" (King et al., 1999b:205). Just more than one-half (58%) responded that they worked in a school that had a crisis intervention team to handle suicide attempts, and two of three (65%) reported that their school included "teaching about suicide prevention in its curriculum." The number of hours in the curriculum dealing with suicide prevention was reported as 1 to 10 hours (M = 3.2, SD = 2.1) (King et al, 1999b:205). Just over half of the respondents (58%) indicated "their school had not offered an in-service program to teachers and staff on adolescent suicide in the past five years (King et al, 1999b:205)." Fifty-nine percent reported that a student from their high school had attempted suicide since they worked there. These respondents reported the number of student suicide attempts to be from 1 to 100 (M = 6.9, SD = 13.3) (King et al, 1999b:205). The number of student suicide completions since respondents worked at their present high school was from 0 to 25 (M = 1.2, SD = 2.7) (King et al, 1999b:205).

This study found that less than one-half (47%) of the high school health teachers reported that a student had expressed suicidal thoughts to them (King et al,1999b:205-206). The number of students who had expressed suicidal thoughts within the past five years to teachers was from 0 to 20 (M = 3.2, SD = 4.0) (King et al,1999b:206).

Professional journals (57%) and professional workshops/conferences (48%) were the most common "sources where respondents received information on youth suicide" (King et al,1999b:206).

This study also found most of high school health teachers accurately responded that "being depressed (99%), having a previous suicide attempt (95%), having low self-esteem (90%), being withdrawn/isolated (88%), being involved in drug use (83%), and having a recent relationship breakup (82%)" were risk factors for adolescent suicide attempts (King et al., 1999a:159-160). Similarly, most high school health teachers knew that "having a tattoo (94%), being an only child (86%), and being male (82%)" were not correct risk factors for adolescent suicide attempts (King et al, 1999a:159-160). Nevertheless, a large percentage believed that having easy access to a handgun (40%), being homosexual (32%), and coming from an abusive home (23%) were not risk factors, even though each is a risk factor (King et al, 1999a:159-160).

In addition, King's study showed approximately one in 10 (9%) high school health teachers "believed they could recognize a student at risk of attempting suicide" (King et al, 1999b:206). One-half (53%) "believed they could talk with teachers and counselors at their school", and one in six (18%) "believed they could talk with the parent(s) of a student to help determine whether or not the student is at risk of attempting suicide" (King et al, 1999b:206). Less than fifty percent believed they could ask students at risk of attempting suicide if they were suicidal or effectively offer support to a student at risk of attempting suicide (41% and 42%, each) (King et al, 1999b:206). The overwhelming majority (86%) believed they "could refer a student at risk to a school counselor" (King et al, 1999b:206).

Furthermore his study found one- half (53%) of high school health teachers believed that "if they recognized a student at risk or if they effectively offered support to a student at risk (53%), it would reduce the chances that the student would commit suicide"(King et al.,1999b:207-208). Over one-half believed that if they "talked with teachers and counselors to help determine if the student was at risk for suicide" (53%) or if they "referred a student at risk to a school counselor (53%) it would reduce the chances that the student would commit suicide" (1999b:208). One-quarter (27%) believed if they "talked with the parent(s) of students at risk" or if they "asked students at risk if they were suicidal, it would reduce the chance that the students would commit suicide" (1999b:208).

Likewise, King et al., found most respondents (72%) believed that, "as a health teacher, one of the most important actions they could ever take would be to prevent a suicidal student from committing suicide" (1999b:208). Similarly, the majority (71%) believed "that one of the most important things a school system could do would be to establish a program to help recognize and find treatment for suicidal students" (King et al.,1999b:208).

The Present Study

Because of the importance of having a staff with high levels of perceived self-efficacy in identifying adolescents at risk for suicide, and the lack of research into this subject matter, the present study attempted to apply the findings of King et al (1999a,b) to the San Marcos, Texas Public School System employees. More specifically, the following research questions were examined: 1) Do school counselors, coaches, nurses and diagnosticians in the San Marcos, Texas Public School System know the risk factors

for adolescent suicide attempts? 2) To what extent do school counselors, coaches, nurses and diagnosticians in the San Marcos area believe they can identify adolescents at risk for suicide? 3) To what extent do counselors, coaches, nurses and diagnosticians in the San Marcos area believe that by identifying adolescents at risk for suicide it will reduce adolescent suicide completions? 4) What overall value do counselors, coaches, nurses and diagnosticians in the San Marcos area place in reducing adolescent suicide completions?

CHAPTER II

METHODOLOGY

Participants

In his already cited study, King, et al. (1999a, b) examined high school health teacher's knowledge regarding adolescent suicide and determined their perceived self efficacy in identifying students at risk for suicide. This study used the same research approach as King et al (1999a:156-167 and 1999b:202-239). His original study included a random sample of high school health teachers from two health education membership lists including the American Association for Health Education and the American School Health Association. This study attempts to see whether King's findings are similar to those found in the San Marcos Independent School District.

King et al (1999 a, b) worked with a national sample of 357 high school health teachers. This study began with a convenience sample of 61 gatekeepers that included school counselors, coaches, nurses and diagnosticians in the San Marcos Public School System. This study examined an exhaustive list of gatekeepers employed at five schools ranging from fifth through twelfth grade. The sample included 16 school counselors, 38 coaches, 4 nurses and 3 diagnosticians. Five schools were identified and cross-referenced to ensure that a sampled gatekeeper was not employed at more than one school. These

five schools encompassed students age 10-19-years-old in the San Marcos Public School System. This procedure resulted in a total sample of 61 gatekeepers.

The San Marcos Public School System, including grades 5-12, was chosen by the researchers in an attempted to acquire a sample of respondents from a small area in hopes of acquiring further contacts for in-depth interviews. After this preliminary study, a comprehensive in-service program on suicide and a crisis intervention team to handle suicide threats and attempts was to be established. After reviewing the programs set up in this area, the results were to be used on a larger scale in the Texas area. While these ends did not follow from this research, it is important to know these original goals and intentions so as to understand the approach of this preliminary research.

Instrument

Through the use of a five-page questionnaire (appendix A), developed by King et al., (1999a,b) this study focused on gatekeepers' knowledge of risk factors for adolescent suicide attempts, gatekeepers' efficacy expectations, outcome expectations, and outcome values regarding adolescent suicide. The survey included a knowledge sub-scale that asked "Which of the following are risk factors for adolescent suicide attempts?" This sub-scale was in the "check all that apply" format and offered fifteen possible answers. Nine of these potential answers were obtained from the professional literature that listed them as risk factors for adolescent suicide attempts. While a comprehensive review of the literature showed additional risk factors for adolescent suicide, not all risk factors were included do to space limitations on the survey. Risk factors included "being depressed", "having a previous suicide attempt", "being involved in drug use", "having low self-esteem", "being withdrawn or isolated", "having low grades", "having a recent

relationship breakup", "having easy access to a handgun", and "being homosexual". The remaining six potential answers ("having a tattoo," "being financially disadvantaged," "being an only child," "being obese," "being male," and "entering puberty at as late age") were foils. Respondents received one point for each correct response (checked an appropriate risk factor or did not check an inappropriate risk factor or "foil") thus resulting in a knowledge score range for this item of 0-14. The higher the score was the more knowledgeable the gatekeeper was about risk factors for adolescent suicide.

The instrument also consisted of three perceived self-efficacy sub-scales: 1) efficacy expectations sub-scale 2) outcome expectations sub-scale and 3) outcome values sub-scale. The efficacy expectations sub-scale consisted of six items (for example, "I believe I can recognize a student at risk of attempting suicide") that required gatekeepers to respond using a seven-point Likert-type scale (e.g. 1=strongly disagree, 7=strongly agree). Similarly, the outcome expectations subscale consisted of six items (for example, "I believe if I recognize a student at risk of attempting suicide it will reduce the chance that the student will commit suicide") that required gatekeepers to respond using the same seven-point Likert –type scale. Finally, the outcome values sub-scale consisted of two items (for example, "I believe as a gatekeeper, one of the most important things I could ever do is to prevent a suicidal student from committing suicide") that required gatekeepers to respond using the same seven-point Likert –type scale.

Procedures

As a member of the American Foundation for Suicide Prevention, I requested information on the procedures in dealing with students with suicide ideations. The District Counseling Coordinator for the San Marcos, Consolidated Independent School

District was met with and agreed to speak with the researcher on procedures used when a staff member is met with adolescent suicide ideations. After meeting with the District Counseling Coordinator, in regards to adolescent suicide ideations, I then spoke with the Lead Counselor at the San Marcos High School where two students had committed suicide in the past year. From these informal meetings I found that counselors in the San Marcos area were at various levels of understanding suicide and depression, which greatly impacted the handling process of adolescents who present suicide ideations. It is common for these counselors to recommend that a student be sent home thereby treating suicide ideation as a discipline problem. In this regards, the current study looked at the levels of knowledge of risk factors for adolescent suicide and levels of self-efficacy in dealing with students who have indicated being in crisis or having suicidal thoughts. Because the sample size of counselors was low, coaches, nurses and diagnosticians in the San Marcos Public School System were also included in this study.

The researcher received permission by the Human Subjects Review Board at Southwest Texas State University to perform this study. Permission was then granted by the San Marcos Independent School District to continue. Each principal of the schools involved was contacted in order to receive permission to hand out surveys at their school. Initially a cover letter (appendix B) explaining the nature of the survey and a survey (appendix A) was sent to each respondent. After one month an e-mail (appendix C) was sent to each respondent again requesting their assistance in the study, including a link to the survey online. After another month a third letter (appendix D) was sent to each respondent requesting their assistance in this study. Surveys were then picked up (two

weeks later) at each participating school and the information gathered was used in the final data analysis.

CHAPTER III

FINDINGS

Response Rate

In the present study, of the sixty-one surveys sent out to gatekeepers, seven were undeliverable because the gatekeeper was no longer employed at the school. Twenty-seven gatekeepers responded, resulting in a 53% response rate from the 54 eligible gatekeepers. These 27 respondents were included in the final data analysis. Two responses were returned to the researcher by electronic mail, while five were returned by mail and the remaining twenty were picked up by the researcher from the participating schools.

Characteristics of the Sample

Of the twenty-seven respondents, the majority were female (59%), Caucasian (90%) coaches (56%). Less than half (41%) had bachelors' degrees. Ages ranged from 25-58, with the mean age of respondents being 41.33 years (SD=12.28).

Gatekeepers' Experience with Adolescent Suicide and Prevention

Of the gatekeepers who responded, the overwhelming majority (78%) believed it was their role to identify students at risk for suicide (Table 1). Over half (56%) reported that they were unsure whether their school had a crisis intervention team to handle suicide attempts. No one reported that his or her school included teaching about suicide prevention. The majority (56%) responded that they were unsure whether their school

had offered in-service training on adolescent suicide to teachers in the last 5 years, while slightly fewer (44%) responded that their school had not offered in-service training about adolescent suicide. All gatekeepers reported that a student had attempted suicide while they have worked there. These respondents reported the number of student suicide attempts to be from 0 to 5. The number of believed reported suicide completions since respondents worked at their present school ranged from 0 to 5.

The majority of gatekeepers (67%) had an experience with a student who expressed suicidal thoughts to them (Table 1). The number of students who had expressed or who were believed to have expressed suicidal thoughts to gatekeepers within the past five years ranged from1 to 100 (M=8.89, SD=20.12). Gatekeepers were asked to identify potential sources where they received most of their information on youth suicide. The most common sources were mass media (49%), on the job training (44%) and textbooks or in-service programs (44%).

Gatekeepers' Knowledge of Risk Factors for Adolescent Suicide

Of the gatekeepers who responded, all correctly reported that being depressed and being withdrawn or isolated were risk factors for adolescent suicide attempts (Table 2). The majority of gatekeepers correctly responded that having a previous suicide attempt (96%), having a recent relationship break up (93%), being involved in drug use (93%), having low self esteem (85%), being homosexual (59%) and having low grades (59%) were risk factors for adolescent suicide. Half of gatekeepers (51%) knew that having easy access to a handgun was a risk factor for adolescent suicide attempts. Likewise, gatekeepers knew that being financially disadvantaged (59%), being an only child (82%), and having a tattoo (85%) were not risk factors for adolescent suicide attempts.

However, the majority of gatekeepers believed that being obese (59%) and being male (59%) were risk factors for adolescent suicide attempts. The average risk factor score for these gatekeepers was 10.6 out of 14 and the range was 8-13.

Gatekeepers' Efficacy Expectations

The majority of gatekeepers (60%) believed that they could not recognize a student at risk of attempting suicide (Table 3). Almost half (41%) of gatekeepers believed that they could talk with teachers and counselors at their school to determine if a student is at risk for suicide. One in four gatekeepers (25%) believed that they could talk with parents of a student to help determine if a student is at risk for suicide. Less than one in three gatekeepers (30%) believed that they could ask a student at risk of attempting suicide if they are suicidal. Half of gatekeepers (51%) believed that they could effectively offer support to a student at risk of attempting suicide, as well as refer a student at risk of attempting suicide to a school counselor. The average efficacy expectation score was 31.3 out of 40 with a range of 19-40.

Gatekeepers' Outcome Expectations

One third (37%) of the gatekeepers believed that if they recognized a student at risk it would reduce the chance that a student would commit suicide (Table 4). Almost one-third (30%) of the gatekeepers believed that if they were to talk with school staff, it would reduce the chance the student would commit suicide. One in four gatekeepers (26%) believed that if they talked with parents, it would reduce the chance that the student would commit suicide. One in three gatekeepers (33%) believed if they asked a student if he or she were suicidal it would reduce the chance that they would commit

suicide. Nearly half (44%) believed if they effectively offered support to a student at risk, it would reduce the chance a student would commit suicide. One third (33%) of the gatekeepers believed that if they refer a student at risk to a counselor it will reduce the chance the student would commit suicide. The average outcome expectation score was 32 out of 42 with a range of 15 to 41.

Gatekeepers' Outcome Values

Just over half (56%) of gatekeepers who responded believed that one of the most important things they could do is prevent a suicidal student from attempting suicide (Table 5). Under half of gatekeepers (41%) believed one of the most important things a school could do is establish a program to help recognize students at risk for suicide. An outcome value score was computed resulting in a range of 8 to 14 (M=12.41, SD=1.76) of a possible range of 2-14. A self-efficacy score was computed from the efficacy expectation, outcome expectation and outcome value score that resulted in a range from 40 to 96 (M=74.52, SD=14.28) of a possible 14-98.

Limitations of the Present Study

The initial sample size resulted in only a 53% return rate. The present study was used to enhance our understanding of the level of suicide awareness by gatekeepers in San Marcos in order to analyze the need for further research for the state of Texas and its school systems.

Using a respondent code number assigned to each gatekeeper, this study attempted to generate a sample of gatekeepers in order to interview gatekeepers on an in-depth, qualitative level. However, the respondent number codes were not entered by the

respondents on their completed survey. In order to generate a sample to perform qualitative, in-depth interviews the researcher needed a number code entered by the respondent in order to contact them or would have to have been reached by phone or e-mail as requested in the cover letters presented with the surveys. The researcher in this study was unsuccessful in generating a list of further contacts due to an unwillingness by respondents to enter the designated number code when filling out the returned surveys or to have been contacted by any of the respondents.

Although this research was intended as a pilot study, a larger sample size would have been more effective in examining and generalizing the samples' knowledge of and perceived self-efficacy in regards to adolescent suicide. Also, due to a small sample size, a meaningful analyses based on demographic variables could not be done. Analysis of variance could not be performed on sub-scale items due to the homogeneity of demographic variables. Lastly, gatekeepers involved in this study were members of a limited area; therefore these results may not be generalized to the population as a whole.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

The overwhelming majority of gatekeepers believed it was their role to identify students at risk for suicide. However, the majority of those gatekeepers who responded were unsure if their school had a crisis intervention team to handle suicide attempts or if their school had offered an in-service to teachers in the last five years on adolescent suicide. This lack of knowledge about appropriate responses to suicide attempts and about approaches by the school district to deal with adolescent suicide may be seen by some as problematic since at least two students have completed suicide in recent years leaving room for many unsuccessful attempts going unnoticed. Even more problematic may be the low number of believed suicide attempts by gatekeepers. Even more problematic may be this number of believed suicide attempts since research suggests that, on average, there are 100 unsuccessful suicide attempts for every completed suicide (O'Carroll 1989:2). Furthermore, as cited earlier by the Youth Risk Behavior Surveillance System (CDC, 1997c), in a study of 16,262 high school students, one in four had thought seriously about attempting suicide during the previous year. While nearly one in four had gone as far as to make a suicide plan and one in ten had made one or more actual suicide attempts during the previous year. The above information suggests further

research into the number of attempted and completed suicide by students in the area, as well as the development of methods for better informing gatekeepers about adolescent suicide activity.

The findings of this study show discrepancies in respect to where gatekeepers received most of their information on adolescent suicide. Nearly half of the gatekeepers responded that they received most of their information on adolescent suicide from "on the job training" and "textbooks/in-service programs." This conflicts with the responses from the other gatekeepers who responded they were unsure if their school had a crisis intervention team to handle suicide attempts or if their school had offered an in-service to teachers in the last five years on adolescent suicide. Possibly, the subject matter may have resulted in gatekeepers responding with socially accepted responses. This suggests additional research about gatekeeper knowledge, perhaps using another data collection method.

The overwhelming majority of gatekeepers correctly responded that being depressed, being withdrawn/isolated, having a previous attempt, having a recent relationship breakup, being involved in drug use, having low self-esteem or grades, and being homosexual were risk factors. At the same time, the overwhelming majority believed that they could not recognize a student at risk of attempting suicide. In addition, the overwhelming majority believed that if they recognized a student at risk of attempting suicide it would reduce the chances that the student would commit suicide. From these findings it can be concluded that although the gatekeepers know the risk factors they may not know how to spot a student who has, for example, low self-esteem. Knowing the risk

factors and applying them to students are two separate actions. This suggests additional research into self-efficacy of gatekeepers.

As noted in the methods section, the researcher, as a member of AFSP, talked to the members of the counseling team. During these conversations, one person, when asked about suicide, responded that "some students want to kill themselves just because their boyfriend broke up with them, how silly." If this attitude is widespread, suicide intervention may not succeed. Could it be that gatekeepers have forgotten what it was like to be an adolescent and in turn disregard some of the most influential risk factors for adolescent suicide? Could the risk factors for adolescent suicide seem minor to gatekeepers involved with adolescents? Concern arose when the researcher spoke with another counselor. She responded to dealing with adolescent suicide this way: "I don't primarily do what I actually went to school for." Gatekeepers may not have time to develop relationships with students in order to identify those at risk for suicide.

Also, in speaking with some of the non-coaching gatekeepers concerns arose in regards to lack of time available to spend on students. One counselor said that "most of the time counselors are calling students at home when they are absent because of the fact that we lose money when a student is absent." Is the staff spending most of their time merely ensuring that students are present rather than dealing with the students who are present? Further research into the attention given to health topics discussed by gatekeepers at school is justified.

Based on the findings of this study the following recommendations are offered: 1) suicide awareness education and training should be implemented in the schools involved in the present study, specifically as it relates to recognizing adolescents at risk

for suicide; 2) included in this training should be education that deals with the stigma that surrounds suicide; 3) the schools involved in the present study should offer in-service programs on adolescent suicide; 4) the schools in the present study should safeguard that all staff are aware if the school includes a crisis intervention team; 5) education for school staff should be included that deals with attempted and completed suicide; 6) the media should pay particular attention to issues dealing with adolescent suicide and present these issues in a frank and open manner.

Table 1. Gatekeepers' Experience with Adolescent Suicide and Adolescent Suicide Prevention, Number (n) and Percentages (%).

Question	n=Yes (%)	n=No (%)	n=Not sure (%)	N=Total (%)
Do you believe it is the role of gatekeepers to identify students at risk for suicide?	21 (78%)	0 (0%)	6 (22%)	27 (100%)
Does your school have a crisis intervention team to handle suicide attempts?	5 (19%)	6 (22%)	16 (59%)	27 (100%)
Does your school include teaching about suicide prevention in its curriculum?	0 (0%)	15 (56%)	12 (44%)	27 (100%)
Has your school offered an in-service to teachers and staff on adolescent suicide in the past five years?	0 (0%)	12 (44%)	15 (56%)	27 (100%)
Has a student from your school ever attempted suicide since you have worked there?	27 (100%)	0 (0%)	0 (0%)	27 (100%)
Has a student ever expressed suicidal thoughts to you?	18 (67%)	3 (11%)	6 (22%)	27 (100%)

Table 2. Gatekeepers' Knowledge of Risk Factors for Adolescent Suicide Attempts, Number Correct (n), and Number Incorrect (n), and Percentages (%).

Statement	n=Number correct (%)	n=Number incorrect (%)	N=Total (%)
Being depressed	27 (100%)	0 (0%)	27 (100%)
Having a previous suicide attempt	26 (96%)	1 (4%)	27 (100%)
Having a tattoo	25 (93%)	2 (7%)	27 (100%)
Having low self-esteem	23 (85%)	4 (15%)	27 (100%)
Being withdrawn/isolated	27 (100%)	0 (0%)	27 (100%)
Being an only child	22 (81%)	5 (19%)	27 (100%)
Being involved in drug use	25 (93%)	2 (7%)	27 (100%)
Having a recent relationship break-up	25 (93%)	2 (7%)	27 (100%)
Being male	11 (41%)	16 (59%)	27 (100%)
Being financially disadvantaged	16 (59%)	11 (41%)	27 (100%)
Being homosexual	16 (59%)	11 (41%)	27 (100%)
Entering puberty at a late age	19 (70%)	8 (30%)	27 (100%)
Having easy access to a handgun	13 (48%)	14 (52%)	27 (100%)
Being obese	11 (41%)	16 (59%)	27 (100%)

Table 3a. Gatekeepers' Efficacy Expectations for Adolescent Suicide, Number and Percent

Statement: I believe I can recognize a student at risk of attempting suicide.	Number	Percent
Strongly Disagree		
Disagree	0	0
Disagree Somewhat	5	19
Neutral	8	30
Agree Somewhat	9	33
Agree	5	19
Strongly Agree	0	0
Total		101*

*Percentages do not add to one hundred due to rounding.

Table 3b. Gatekeepers' Efficacy Expectations for Adolescent Suicide, Number and Percent

Statement: I believe I can talk with teachers and counselors at my school to help determine whether or not a student is at risk of attempting suicide.	Number	Percent
Strongly Disagree		
Disagree	0	4
Disagree Somewhat	5	7
Neutral	8	15
Agree Somewhat	9	19
Agree	5	41
Strongly Agree	0	15
Total		101*

*Percentages do not add to one hundred due to rounding.

Table 3c. Gatekeepers' Efficacy Expectations for Adolescent Suicide, Number and Percent

Statement: I believe I can talk with the parents of a student to help determine whether the student is at risk of attempting suicide.	Number	Percent
Strongly Disagree		
Disagree	0	4
Disagree Somewhat	5	15
Neutral	8	15
Agree Somewhat	9	41
Agree	5	19
Strongly Agree	0	7
Total		101*

*Percentages do not add to one hundred due to rounding.

Table 3d. Gatekeepers' Efficacy Expectations for Adolescent Suicide, Number and Percent

Statement: I believe I can ask a student at risk of attempting suicide if he/she is suicidal.	Number	Percent
Strongly Disagree	0	0
Disagree	2	7
Disagree Somewhat	1	4
Neutral	5	19
Agree Somewhat	6	22
Agree	5	19
Strongly Agree	8	30
Total		101*

*Percentages do not add to one hundred due to rounding.

Table 3e. Gatekeepers' Efficacy Expectations for Adolescent Suicide, Number and Percent

Statement: I believe I can effectively offer support to a student at risk of attempting suicide.	Number	Percent
Strongly Disagree	0	0
Disagree	1	4
Disagree Somewhat	1	4
Neutral	3	11
Agree Somewhat	5	19
Agree	14	52
Strongly Agree	3	11
Total		101*

*Percentages do not add to one hundred due to rounding.

Table 3f. Gatekeepers' Efficacy Expectations for Adolescent Suicide, Number and Percent

Statement: I believe I can refer a student at risk of attempting suicide to a school counselor.	Number	Percent
Strongly Disagree	0	0
Disagree	1	4
Disagree Somewhat	0	0
Neutral	1	4
Agree Somewhat	6	22
Agree	5	19
Strongly Agree	14	52
Total		101*

*Percentages do not add to one hundred due to rounding.

Table 4a. Gatekeepers' Outcome Expectations for Adolescent Suicide, Number and Percent

Statement: I believe if I recognize a student at risk of attempting suicide it will reduce the chance that the student will commit suicide.	Number	Percent
Strongly Disagree	1	4
Disagree	0	0
Disagree Somewhat	1	4
Neutral	3	11
Agree Somewhat	7	26
Agree	5	19
Strongly Agree	10	37
Total		101*

*Percentages do not add to one hundred due to rounding.

Table 4b. Gatekeepers' Outcome Expectations for Adolescent Suicide, Number and Percent

Statement: I believe if I talk with staff at my school to help determine if a student at risk of attempting suicide it will reduce the chance the student will commit suicide.	Number	Percent
Strongly Disagree	2	7
Disagree	0	0
Disagree Somewhat	2	7
Neutral	3	11
Agree Somewhat	7	26
Agree	5	19
Strongly Agree	8	30
Total		100

Table 4c. Gatekeepers' Outcome Expectations for Adolescent Suicide, Number and Percent

Statement: I believe if I talk with the parents of a student to help determine if a student at risk of attempting suicide it will reduce the chance that the student will commit suicide.	Number	Percent
Strongly Disagree	1	4
Disagree	1	4
Disagree Somewhat	5	19
Neutral	3	11
Agree Somewhat	5	19
Agree	6	22
Strongly Agree	6	22
Total		100

Table 4d. Gatekeepers' Outcome Expectations for Adolescent Suicide, Number and Percent

Statement: I believe if I ask a student at risk of attempting suicide if they are suicidal it will reduce the chance that the student will commit suicide.	Number	Percent
Strongly Disagree	1	4
Disagree	3	11
Disagree Somewhat	4	15
Neutral	4	15
Agree Somewhat	9	33
Agree	4	15
Strongly Agree	2	7
Total		100

Table 4e. Gatekeepers' Outcome Expectations for Adolescent Suicide, Number and Percent

Statement: I believe if I effectively offer support to a student at risk of attempting suicide it will reduce the chance that the student will commit suicide.	Number	Percent
Strongly Disagree	0	0
Disagree	0	0
Disagree Somewhat	0	0
Neutral	3	11
Agree Somewhat	3	11
Agree	12	44
Strongly Agree	9	33
Total		99*

*Percentages do not add to one hundred due to rounding.

Table 4f. Gatekeepers' Outcome Expectations for Adolescent Suicide, Number and Percent

Statement: I believe if I refer a student at risk of attempting suicide to a school counselor it will reduce the chance that the student will commit suicide.	Number	Percent
Strongly Disagree	0	0
Disagree	0	0
Disagree Somewhat	0	0
Neutral	2	7
Agree Somewhat	9	33
Agree	9	33
Strongly Agree	7	26
Total		99*

*Percentages do not add to one hundred due to rounding.

Table 5a. Gatekeepers' Outcome Values for Adolescent Suicide, Number and Percent

Statement: I believe as a gatekeeper, one of the most important things I could ever do would be to prevent a suicidal student from committing suicide.	Number	Percent
Strongly Disagree		
Disagree	0	0
Disagree Somewhat	2	7
Neutral	2	7
Agree Somewhat	2	7
Agree	6	22
Strongly Agree	15	56
Total		99*

*Percentages do not add to one hundred due to rounding.

Table 5b. Gatekeepers' Outcome Values for Adolescent Suicide, Number and Percent

Statement: I believe one of the most important things a school system could ever do would be to establish a program to help recognize and find treatment for suicidal students.	Number	Percent
Strongly Disagree		
Disagree	0	0
Disagree Somewhat	0	0
Neutral	2	7
Agree Somewhat	5	19
Agree	9	33
Strongly Agree	11	41
Total		100

APPENDIX A

Adolescent Suicide Survey

Directions: Please answer each of the following questions. Your responses will be kept strictly confidential. Thank you!

Please enter your number code here _____

Do you believe it is the role of school gatekeepers* to identify students at risk for suicide?

_____Yes _____No _____Not Sure

Does your school have a crisis intervention team to handle suicide attempts?

_____Yes _____No _____Not Sure

Does your school include teaching about suicide prevention in its curriculum?

_____Yes _____No _____Not Sure

Has your school offered an in-service program to teachers and staff on adolescent suicide in the past 5 years?

_____Yes _____No _____Not Sure

* For purposes of this study, "gatekeeper" is defined as a professional in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. They are strategically positioned to recognize and refer someone at risk of suicide.

Has a student(s) from your school ever attempted suicide since you have worked there?

_____Yes _____No _____Not Sure

If yes, how many students have attempted suicide?

_____

If yes, how many students have completed suicide?

_____

Has a student ever expressed suicidal thoughts to you?

_____Yes _____No

If yes, how many students have expressed suicidal thoughts in the past 5 years?

_____

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

_____ Attempt to take the lethal means away by force
_____ Contact the principal
_____ Ask the student why he or she feels suicidal
_____ Contact the police
_____ Have other students help you talk to the student
_____ Contact the parent(s)
_____ Promise not to tell the student's parent(s)
_____ Listen to the student
_____ Contact the school counselor
_____ Remain with the student until they are in the custody of a legal guardian
_____ Other(pleasespecify)

_____

_____

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

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

F) I believe I can refer a student at risk of attempting suicide to a school counselor.

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

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

_____ Being depressed
_____ Being obese
_____ Being financially disadvantaged
_____ Being an only child
_____ Having a previous suicide attempt
_____ Being withdrawn or isolated
_____ Having low grades
_____ Having a recent relationship breakup
_____ Being involved in drug use
_____ Having a tattoo
_____ Having easy access to a handgun
_____ Being male
_____ Having low self-esteem
_____ Being homosexual
_____ Entering puberty at a late age

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

_____ Planting a tree in honor of the student
_____ Offering student support groups
_____ Holding a memorial for the student
_____ Closing the school for a day
_____ Forming a crisis intervention plan
_____ Providing teachers with the facts of the situation
_____ Having counselors available to help other students in need
_____ Allowing students to miss school to attend the funeral
_____ Having the school behave in a quiet, conservative matter
_____ Other (Please Specify)

_____

_____

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

_____ I have never received any formal information on youth suicide
_____ College classes
_____ Professional workshops
_____ On the job training
_____ Mass media (TV, newspapers, magazines)
_____ Textbooks
_____ In-service programs by the school district
_____ Professional journals
_____ Other (Please Specify)

Demographic Information

Your sex

_____ Male _____ Female

Your age

_____

What is your title?

_____

Number of years at your present school

_____

Ethnicity you most closely identify with

_____ African American
_____ Asian
_____ Hispanic
_____ White
_____ Other (Please Specify)_____

Your education level (Please select highest degree)

_____ Bachelor's Degree
_____ Education Specialist's Degree
_____ Master's Degree
_____ Doctoral Degree
_____ Other (Please Specify)_____

Please indicate the grade level you teach

_____

In what type of area is your school located?

_____ Urban _____ Suburban _____ Rural

We welcome any feedback. Please write any additional comments you may have in the area provided.

_____
_____
_____
_____
_____
_____
_____
_____

Thank You!!

APPENDIX B

Dear Mr./Mrs, **CODE:00000**

The most current statistics show that suicide took the lives of 30,627 Americans in 1998. Overall, suicide is the eighth leading cause of death for all Americans and the third leading cause of death among our youth. In Texas, alone, it is the second leading cause of death between the ages of 10-19. According to U.S. national data, about one million students between that age group attempt suicide each year.

Hi, my name is Marci E. Price. I am a Graduate Student in the Department of Sociology at Southwest Texas State University. I received a Bachelor of Science in Criminal Justice in 1999 from Southwest Texas State University. Dr. Donna Holland Barnes, a nationally recognized expert on suicide, and myself are currently conducting research on youth suicide, specifically in the area of prevention and intervention.

The suicide of a young person is a tragedy. Fortunately, schools can make a difference in reducing the number of students who commit suicide. School faculty work closely with the population that has the largest increase of suicide in the past 10 years.

Here is a URL (http://www.soci.swt.edu/afsp/suicidesurvey.htm) for the webpage which administers a survey designed specifically for faculty of San Marcos Consolidated Independent School District. Your participation is extremely important in this study. *Please* take a few minutes of your time to complete the application either online or use the form enclosed and mail back to me. If you need further information, please contact me at Marci@swt.edu or 512-245-2173. Please contact me if you would consent to an interview which would provide my research with in-depth information.

Thank you and have a nice day!

Sincerely,

Marci E. Price
Southwest Texas State University
Graduate Assistant

APPENDIX C

Dear Mr./Mrs, **CODE:00000**

The most current statistics show that suicide took the lives of 30,627 Americans in 1998. Overall, suicide is the eighth leading cause of death for all Americans and the third leading cause of death among our youth. In Texas, alone, it is the second leading cause of death between the ages of 10-19. According to U.S. national data, about one million students between that age group attempt suicide each year.

Hi, my name is Marci E. Price. I am a Graduate Student in the Department of Sociology at Southwest Texas State University. I received a Bachelor of Science in Criminal Justice in 1999 from Southwest Texas State University. Dr. Donna Holland Barnes, a nationally recognized expert on suicide, and myself are currently conducting research on youth suicide, specifically in the area of prevention and intervention.

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Thank you and have a nice day!

Sincerely,

Marci E. Price
Southwest Texas State University
Graduate Assistant

APPENDIX D

Dear Mr./Mrs,

Hi, my name is Marci Price. ***PLEASE*** **TAKE A FEW MINUTES OF YOUR TIME TO FILL OUT MY SURVEY ON SUICIDE AWARENESS.** I am a Graduate Student in the Department of Sociology at Southwest Texas State University. Dr. Donna Holland Barnes, a nationally recognized expert on suicide, and myself are currently conducting research on youth suicide, specifically in the area of prevention and intervention.

The most current statistics show that suicide took the lives of 31,000 Americans in 1998. Overall, suicide is the eighth leading cause of death for all Americans and the third leading cause of death among our youth. In Texas, alone, it is the second leading cause of death between the ages of 10-19. According to U.S. national data, about one million students between that age group attempt suicide each year.

The suicide of a young person is a tragedy. Fortunately, schools can make a difference in reducing the number of students who commit suicide. School faculty work closely with the population that has the largest increase of suicide in the past 10 years.

Here is a URL (http://www.soci.swt.edu/afsp/suicidesurvey.htm) for the webpage which administers a survey designed specifically for faculty of San Marcos Consolidated Independent School District. Your participation is extremely important in this study. ***PLEASE*** **TAKE A FEW MINUTES OF YOUR TIME TO FILL OUT THIS SURVEY** either online or on the survey provided. Completed surveys may be placed in the box labeled survey that has been left in the main office which will be picked up on 4/18/01.

Included you will find information on a ***FREE*** training session in Austin, TX that addresses suicide risk assessment and risk management. If you have any questions please feel free to contact me at work (512) 245-2113, online marci@swt.edu or at home (512) 353-3442.
Thank you and have a wonderful day!

Sincerely,

Marci E. Price
Southwest Texas State University
Graduate Assistant

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VITA

Marci Elizabeth Price was born in San Antonio, Texas, on May 8, 1976, the daughter of Evelyn Ceil Price and Thomas Edwin Price. She received a Bachelor of Science from Southwest Texas State University in August of 1999. At this same time she entered the Graduate Department of Sociology at Southwest Texas State University, San Marcos, Texas, where she was employed for two years as a Graduate Assistant.

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