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Counselor Perception of Effective Components of Suicide Prevention Programs in Four-Year Colleges and Universities

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Counselor Perception of Effective Components of Suicide Prevention Programs in Four-Year Colleges and Universities

By

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A Dissertation submitted to the Education Faculty of Lindenwood University

in partial fulfillment of the requirements for the

degree of

Doctor of Education

School of Education

DECLARATION OF ORIGINALITY

I do hereby declare and attest to the fact that this is an original study based solely upon my own scholarly work at Lindenwood University and that I have not submitted it for any other college or university course or degree here or elsewhere.

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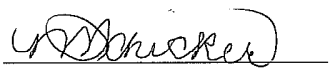
Signature:  Date: 5/16/11

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The School of Education has approved this dissertation as partial fulfillment of the requirements for the degree of Doctor of Education at Lindenwood University.

Dr. Graham Weir – Dissertation Chair — Date: 5/6/11

Dr. Marsha Andreoff – Committee Member — Date: 5-6-2011

Dr. Owen van den Berg – Committee Member — Date: 5/6/11

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Abstract

More than 34,000 Americans take their lives each year. Twelve percent of those suicides are in the 15-24-year-old age group. Although, overall for this age group, suicide is the number three cause of death, across college campuses it is quickly becoming the second leading cause, with accidents being number one. There are multiple contributing factors for suicide and suicidal ideation among the college population and many campuses have suicide prevention information; however, fewer have actual suicide prevention programs in place.

Several areas that contribute to suicide risk for college-aged students were reviewed including: (a) depression, suicidal history, and hopelessness; (b) alcohol and drug abuse; (c) relationships; (d) sexual identity issues; (e) academic concerns and pressures; (f) social media and the Internet.

This study is a combination of multiple methods of qualitative analysis, case study, and autoethnography. The purpose was to investigate what counselors on college campuses thought were effective components of their suicide prevention programs. The research was conducted using a seven item online survey comprised of both questions and statements. An invitation was sent to 150 counselors across the U.S. Each of the survey recipients was randomly chosen from a comprehensive list of colleges and universities. Follow-up items, from which conclusions were drawn about what components aided in the success of the college suicide prevention programs, were sent to all of the colleges that had previously been invited to participate in the survey. After receiving all of the responses, conclusions were drawn about what components aided in the success of the program. One hundred and fifty survey invitations were sent and of

those 74 college counselors initially responded. Item one, an elimination statement, brought the number of participating colleges to 64. Each of the 64 college counselors participated in the entire survey.

Ninety percent of college counselors claimed that their suicide prevention program was effective. Fourteen counselors responded to a follow-up item regarding how counselors know that their program is effective. There was no consistent method of measurement, and few colleges could demonstrate a clear method of data collection or parameters to show successful outcomes.

Table of Contents

List of Tables

List of Figures

The suffering of the suicidal is private and inexpressible, leaving family members, and friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description. *Kay Redfield Jamison, 2001*

Chapter One - Introduction

Suicide has a profound and lasting impact that continues for generations (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). "Suicide knows no political or ideological boundaries. It affects people and families in all walks of life, without regard to color or creed" (Suicide Prevention Action Network USA, 2011, para. 1). The overwhelming uncertainty about why a suicide occurred, leaves friends and family with ongoing internal dialogues about the reason suicide was chosen and about what, if anything, could have been done to prevent it (Levine, 2008). Those who are left behind not only have the uncertainty and grief to work through, but also may have hurt, anger, guilt, and remorse. These feelings, along with the frequent isolation brought about by the stigma of suicide, make the reality of the manner of death even more unbearable.

Suicide affects all age groups. Over 34,000 people end their lives by suicide in the U. S. every year (American Foundation for Suicide Prevention [AFSP], 2009). There are an estimated 500,000 nonfatal suicide attempts annually in the United States, which account for about 324,000 emergency room visits and 90,000 hospitalizations (Martin, Ghahramanlou-Holloway, Lou, & Tucciarone, 2009). Many of these attempts are by college-aged students; in fact, suicide is the third leading reported cause of death in young adults ages 15-24 (AFSP, 2009). Suicides by age group are depicted in Figure 1.

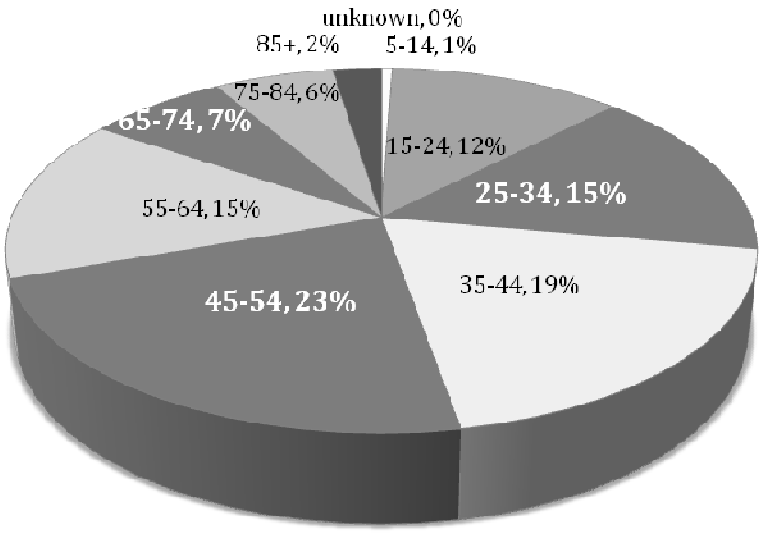

Figure 1. Adapted from the AFSP (2007) this chart represents the percentage of suicides by age group in the U. S.

In the United States, 25% of young people aged 18-24 are college students (Barrios, Everett, Simon, & Bener, 2000), and the concern for college administration, college counselors, and parents is that suicide has become the second leading cause of death in that age group on American college campuses, with only automobile accidents causing more fatalities (Haas et al., 2008).

According to the Centers for Disease Control (2009) the United States final data for 2007 demonstrated that suicide ranks 11th in causes of death for all populations, with heart disease and cancer accounting for nearly half of all deaths nationally. Suicide accounts for 1.4% of all U.S. deaths. However, for the 15-24 year old age group, suicide ranks third, and in the U.S. college population, suicide is second in causes of death (Suicide.org, 2010) behind accidents, accounting for over 13% of college deaths. Of those college students who die by suicide, 75-80% are male (AFSP, 2009).

The largest increases in suicides have occurred among the 10-14 year old age group, which has doubled over the past 20 years, and the African-American male population aged 15-19 years old, which has also doubled in the 16-year period between 1980 and 1996. Table 1 illustrates reported causes of death for the overall U.S. population, while Table 2 illustrates, in contrast, the causes of all deaths in the 15-24-year-old age group.

Table 1

U. S. Causes of Death All Age Groups – 2007

Cause	Percent of all Deaths
Heart Disease	25.4
Malignant Neoplasms	23.2
Cerebrovascular Disease	5.6
Chronic Lower Respiratory Diseases	5.3
Accidents	5.1
Diabetes Mellitus	3.1
Alzheimer's Disease	2.9
Influenza and Pneumonia	2.2
Nephritis, Nephrotic Syndrome and Nephrosis	1.9
Septicemia	1.4
Suicide	1.4
Liver Disease	1.2
Essential Hypertension	1.0
Parkinson's Disease	0.8
Assault	0.8
All Other Causes	18.6

Note. Adapted from the Centers for Disease Control (CDC) National Vital Statistics Report dated December 9, 2010.

Table 2

U. S. Cause of Death Ages 15-24 - 2007

Cause	Percent of all Deaths
Motor Vehicle Accidents	46.0
Homicide	15.0
Suicide	13.0
Malignant Neoplasms	5.0
Heart Disease	3.0
Congenital Illnesses	1.5
All Other Causes	16.5

Note. Adapted from the CDC National Vital Statistics Report, dated December 9, 2010, which shows the most current cause-of-death data for young adults' ages 15 to 24. Of note is that opposed to the general population, suicide is the third leading cause of death in this age group (Minino, Xu, & Kochanek, 2010).

The data might, however, be affected by the way classifications are listed. For instance, often suicides are classified as accidents and because the percentages are based on reported data, there is no indication about what percentage of accidents were, in fact, suicides of some kind, possibly alcohol or drug related, or if it was an intentional "accident" such as steering a car into a hazardous situation. Homicides may involve a suicidal person taking another life and then putting him or herself in a situation where he or she will likely be killed. A common phrase related to this is *suicide by cop*, those situations where someone wields a firearm, sometimes unloaded, knowing that if they do not release it, they will be shot (Suicide.org, 2010).

According to Stolinsky (2000), suicides may be underreported (as accidents, most

commonly) to spare the family additional grief by classifying the death as *accidental*. Although these numbers reflect what is reported, they do not necessarily reflect what is reality. Despite the fact that suicide accounts for 13% or over 4,500 reported deaths annually of 15-24 year olds in the United States, there are still those who believe that occurrences are infrequent and therefore of little concern. Students who attempt or complete suicide during vacations and holiday breaks are not included in college suicide data either (Department Of The Public Advocate, 2009).

Some college administrators believe suicide is a problem that may eventually overtake alcohol and drug abuse as the number-one risk on college campuses (Lake, 2002). Because of this, many colleges are reevaluating campus suicide prevention programs and determining how they can better identify and serve students at risk. As a previous attempt is a risk factor for suicide completion (National Institute of Mental Health, 2009), it makes sense that if attempts were prevented, completion would be reduced. This makes the need for early intervention and treatment programs of utmost importance.

The primary cause of college student suicide is thought to be untreated depression brought about by the college transition, which can cause confusion, anxiety, feelings of inadequacy and stress (Suicide.org, 2010). In fact, it is estimated that 90% of college students who die by suicide experience some level of depression (AFSP, 2010). Students may recognize that they are depressed, but may not seek help. According to Suicide.org (2010), a not-for-profit suicide resource website, only 6% of students with depression actually seek help despite the fact that they recognize that they are depressed.

Statement of the Problem

While most four-year college counseling programs attempt to address depression and suicidal behavior at the time a student seeks assistance, not all counseling programs include prevention strategies or structured programs specifically designed to identify at-risk students who might not otherwise seek assistance. Counselors who do work with programs aimed specifically at suicide prevention are, therefore, potentially a valuable resource for evaluating which components of such programs might be most effective. It is important for colleges to implement suicide prevention programs that include training for educators, counselors and students, as well as processes for evaluating students (The Jed Foundation, 2010).

In a survey performed by Furr, Westefeld, McConnell, and Jenkins (2001), college students were polled regarding whether they had experienced defined symptoms of depression (as outlined in the *Definitions* section of this chapter). The results showed that 81% of these students stated that they had experienced symptoms indicative of depression caused by grades, relationship issues, loneliness, and financial problems, and 32% of those who had experienced depression had seriously considered suicide as an option. These stressors, which are a normal part of the college experience, may, when combined with other life pressures such as grades, finances, and/or relationships, lead to anxiety and depression.

For some students, the symptoms become unbearable and the stress and depression may lead to suicidal ideation, and ultimately suicide. It is beneficial for colleges to have programs in place that attempt to identify and assist these at-risk students. In order to address the issue of suicide, prevention could be made a priority in

college counseling programs. Well-planned prevention programs could protect the student and the college. These programs could include components such as identification, early intervention, and an emergency response plan as well as education and prevention tactics for suicidal gestures, recommendations for treatment, on-campus counseling, and a plan for follow-up (The Jed Foundation, 2010). Identifying the components of existing programs that are considered to be the most effective is one way to build new and improved programs.

In some cases, however, prevention and intervention appear to not be priorities. Some college administrators might be more concerned with protecting other students and limiting school liability, often deeming it appropriate to discharge students at risk from the school as soon as they are identified (Pavela, 2006). In fact, in two well-known cases, Schieszler versus Ferrum College and Shin versus MIT, the colleges were found negligent in the student deaths because they knew of the students' depression (Capriccioso, 2006). In a 2005 study, researchers held that 24% out of 1,865 participating students had contemplated suicide (Westefeld et al., 2006).

College student suicide "is an issue of critical importance, and though steps have been taken to address this issue, much more needs to be done." (Westefled et al. 2006, p. 932). Because lawsuits are becoming more frequent, colleges should be cognizant of the way students are approached (Higher Education Center, 2010), making sure that interventions are happening in accordance with the program, or in the best interest of the student. Most administrators do, however, understand the importance of identification and appropriate intervention that may help to protect the at-risk student using a best practice intervention method depending on the student's need.

There is also risk to the college, so this might help to protect their own interest as well. Currently, the United States Department of Education (2010) holds that before colleges involuntarily remove a student, administration would be well advised to offer proof that nothing further can be done to keep the student at the school (Department of The Public Advocate, 2009). Regarding liability, Pavela (2006) believed the approach that is most appropriate to the threat of suicide is to look closely at the conduct of the student and address specific behaviors, evaluate the legitimacy of the threat, and implement the campus' written process for threats of violence.

It should be noted that often the suicide prevention program documentation is found in the *Threats of Violence* section of the school policies and procedures. Generally, Pavela (2006) recommended that after appropriate interventions have been attempted, the college administrators and counselors evaluate whether a student should be allowed to proceed with his or her education. Caution has to be exercised to apply the criteria for involuntary dismissal equitably (Pavela, 2006).

An effective prevention program can serve the dual role of maximizing opportunities to prevent college suicides and minimizing school liability by identifying and referring at-risk students who might otherwise go unnoticed by peers, instructors and/or staff members, or simply be labeled as troublemakers. Another issue is that media attention is growing and can be sensational (Stack, 2003). In response to a recent rash of on-campus suicides, the news media have begun to pay even greater attention to the issue (Laster, 2010).

In early 2010, there were multiple *copycat* suicides when six Cornell students died by suicide by jumping from bridges and a gorge edge (Beautrais, Gould, & Caine,

2010). Additionally, stories of suicides and attempts secondary to bullying, particularly at colleges and in the military, are appearing in the media with increasing frequency as this dissertation is being written.

Purpose of the Study

The purpose of this study was to identify the components of current suicide prevention programs that are perceived by college counselors as most promising for identification of, and follow-through for, students deemed to be at-risk. In this study, suicide prevention program components found in the literature were compared to what college counselors from a number of U.S. colleges believe are the most effective components of their school's suicide prevention program. Perhaps these results will promote more meaningful dialogue and encourage college-counseling centers to consider incorporating into their suicide prevention programs the components deemed by other college counselors to be the most effective. Additionally, the study is intended to bring attention to the issue of young adult suicide, whether in college, in the community, or in the military.

Importance of the Study

With suicide as the second leading cause of death on college campuses, the need to understand what colleges are doing to prevent suicide by taking a look at the current practice is imperative. The effectiveness of suicide prevention programs, including an identification, intervention, prevention, and postvention process is largely unanalyzed. Understanding which components of current programs college counselors believe are best suited to identify students at risk could serve as a resource to assist colleges in designing or tailoring effective programs. A benefit of this study might be that administrators of

colleges along with college counselors could begin to have richer discussions regarding identification, intervention, and prevention of suicide.

Definition of Terms

Common terms in literature about suicide do not necessarily have shared meanings. The list below should assist the reader in understanding the use of particular terms found in this study.

Best Practice. This is the term that defines the use of the most current, globally accepted, methodology for any given activity (Zemelman, Daniels, & Hyde, 2005) based on guidelines that are developed as a result of research, evidence and experience (Sartorius, 2007).

College/College Students. For the purpose of this dissertation, the word *college* connotes both colleges and universities when used in a general sense; only specific universities or colleges are identified with differentiating monikers. The term *college student* traditionally refers to a college student aged 18-23 (Crede & Kuncel, 2010).

Depression. Depression is also referred to as a *major depressive disorder*. This diagnosis is only made when a patient has at least five of the following symptoms: (a) depressed or unhappy mood, (b) loss of interest, (c) unintentional weight loss or weight gain or a change in usual appetite, (d) insomnia or prolonged (or frequent) sleeping referred to as *hypersomnia*, (e) agitation or slowness in movement, (f) fatigue, (g) excessive guilt or feelings of worthlessness, (h) inability to focus, and (i) suicidal ideation (American Psychiatric Association, 2000).

Environmental factors. This refers to all external influences in one's life. For the purpose of this study, the term will generally refer to physical location, such as home,

community, gathering places and school, and to familial relationships (Bridge, Goldstein & Brent, 2006).

Intervention. Intervention refers to the action taken to assist students experiencing suicidal ideation. Interventions may take the form of individual counseling, group counseling, or outreach programs (Smith et al., 2007) and may be individual or universal, spanning an entire targeted population. Interventions for individuals are often clinical, such as hospitalization or individual counseling, whereas universal interventions include mass email messages or other general distribution of information (Burns & Patton, 2000).

Method. This is the means by which a student chooses to attempt or complete suicide. The most common methods of suicide are hanging, firearm, poisoning, drowning and jumping, although this is certainly not a definitive list (Bridge et al., 2006). Methods of suicide by gender are depicted in Figure 2.

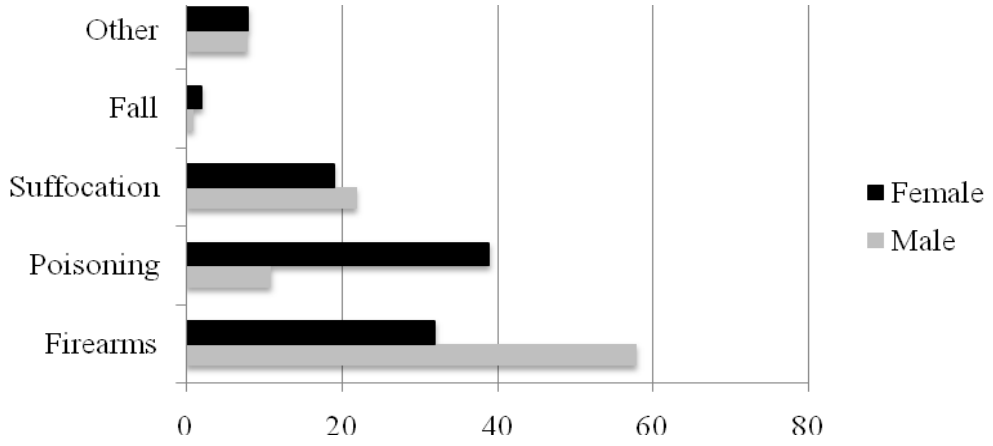

Figure 2. Methods of Suicide by Gender. Adapted from the CDC National Suicide Statistics for 2002-2006 illustrates Suicide method by gender across all age groups (Centers For Disease Control, 2009).

Method choice generally is determined by what is *acceptable* in a given culture as well as what is available when the choice is made to end one's life (Ajdacic-Gross et al., 2008).

Plan. A plan is a suicide strategy that includes such variables as date, method, time, correspondence, and other circumstances. Having a plan is an indication of high risk for suicide (Salvatore, 2009).

Prevention Programs. Prevention programs are psycho-educational in nature, often with a therapeutic component, and are designed to influence students and increase knowledge regarding their perceptions of suicide (Protzky & Van Heering, 2006). Prevention programs are generally designed to reduce overall suicide risk (Bridge et al., 2006). Individual intervention, both educational and therapeutic, is typically conceptualized and designed as a one-on-one counseling process.

Postvention. There are three pillars of Suicidology: (a) prevention; (b) intervention; and (c) postvention, which is the act of taking care of the bereaved, also known as *suicide survivors* (Linn-Gust, 2010).

Stigma. Stigma is a term used to indicate that there is disgrace or dishonor associated with a suicide or suicidal behavior. It affects both the attempter/completer and the family. Because suicide is different from other deaths, the bereaved suffer from being socially stigmatized. This often makes the grieving process difficult for family and others close to the student who took his or her life. Often this becomes a great source of stress and can interfere with the normal grieving process (Cvinar, 2005).

Suicide/Suicide Attempt, Suicide Threat, and Suicidal Ideation. Suicide is a self-inflicted injury that results in death, and is sometimes also referred to as *completed suicide*. An attempt is a self-inflicted injury that may result in temporary or permanent

injury, but not resulting in death. Many times, a student can have a plan and the means to act out the plan, but does not truly intend to complete the suicide. Suicidal ideation refers to persistent thoughts of death using a self-inflicted method. Often people who suffer from depression experience suicidal ideation, or thoughts of suicide, which may be secondary to a psychological disorder. In fact, approximately 90% of people who complete suicide have previously displayed some behavior that has resulted in a psychological diagnosis (Goldsmith et al., 2002).

Social Networking. The phenomenon of social networking has grown in the past five years to an industry utilized by hundreds of millions worldwide. Those who use social networking create a profile and build their own networks of friends, family, and sometimes strangers.

> The growth in the popularity of these sites has generated concerns among some parents, school officials, and government leaders about the potential risks posed to young people when personal information is made available in such a public setting. 55% of online teens have created a personal profile online, and 55% have used social networking sites like MySpace or Facebook. (Lenhart & Madden, 2000-2008, para. 1)

Suicidology. According to Suicidology.org (2010), Suicidology is "the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services" (FAQ section, question 1).

Survivor of Suicide is anyone affected by the loss from a suicide. The term generally applies to first-degree relatives (i.e. parents, siblings, children), but can be

extended to all those who are closest to the person who died. Being a survivor of suicide can result in what can be more complicated grief due to the uniqueness of the cause of death as well as the stigma attached to the act of suicide (American Foundation for Suicide Prevention, 2009).

Limitations

Because not all colleges have specific suicide prevention programs in place, this study is limited to seeking responses from counselors at colleges that claim to have such programs. Any counselor responding negatively to the initial survey item related to whether such a program existed at their college was included in the response total, but was considered not to have information to contribute to the rest of the survey. Statistically, among college students who take their own lives, the male-to-female ratio of completion is disproportionate at 3:1 (Haas et al., 2008), with the majority of those being Caucasian and Native American males (Department of the Public Advocate, 2009). However, attempts are significantly greater in females (Centers for Disease Control, 2010).

Another statistical limitation is discrepancies in suicide rates among college-aged students due to the inability of any organization to produce fully accurate data. In addition to the data-gathering inconsistencies mentioned earlier, suicides are often reported as actions, such as a fall or accidental overdose of medications (Berman, Jobes, & Silverman, 2007). Further, there are perhaps as many individual reasons why college students choose suicide, as there are suicides, although several overarching themes are discussed in much of the literature reviewed. Some of the more common themes are represented in this chapter: (a) depression, suicidal history, and hopelessness; (b) alcohol

and drug abuse; (c) relationships; (d) sexual identity issues; (e) academic concerns and pressures; and (f) social media and the Internet. This should not, however, be seen as a definitive list.

A final limitation is that there really is not a way to effectively measure the efficacy of a suicide prevention program. Because there is not a template that all colleges use, the measurement system at each college varies according to the program they have in place. This leaves colleges with no benchmark data, so colleges have to make assumptions about whether or not their data is indicative of any level of effectiveness. Also, for some colleges, a suicide program might be new, while at others the program has been in existence for a while and is imbedded in the culture. The maturity of the program could have a significant impact on the effectiveness of a suicide prevention program.

Assumptions

The reviewed literature and survey results provide a strong indication that programs of varying intensity are present in most colleges and that many colleges are striving to improve their programs for better identification and prevention of college-student suicide. Therefore, there is an assumption in this study that most colleges have some form of a counseling program in place that may or may not include a specific suicide prevention program designed for early intervention.

Summary

On every college campus there are students at risk for suicide. Suicidal behavior by young adults is rapidly becoming an epidemic (Brown, 2001). College counseling programs should be one line of defense against what has become the third-leading cause of death in the 17-24 year old age group in the U. S. The National Strategy for Suicide

Prevention, developed by the United States Office of the Surgeon General, is a "comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life course," and was developed in response to the 34,000 lives lost to suicide annually in the United States (Brown, 2001, p. 2). With responsible reporting, hopefully there will be an increase in public awareness, which will help motivate college administrators to make prevention programs a top priority. Media attention could also have a positive or negative effect on the incidence and perception of suicides (Stack, 2003). There is hope that, instead of sensationalism, media will give attention to suicide prevention and that this will inspire more research and action. Changing the emphasis to finding ways to prevent suicide, and determining what is working and what is not working, would be encouraging steps forward. To date there are few studies, and therefore little evidence, with which to critique the current programs that are in place (Burns & Patton, 2000).

Chapter Two

Review of Literature

Overview

In this chapter suicides are discussed under several categories. It should be noted that suicide (and suicidal ideation) is a unique and complex phenomena that cannot always be easily compartmentalized. Most often, when students die by suicide they take the answers about why they chose to die by suicide with them. That being said, most suicides, whether attempted or completed, when the reason is known, are related to or attributable to one of the following broad categories:

1) Depression, suicidal history and hopelessness
2) Alcohol and drug abuse
3) Relationships
4) Sexual identity issues
5) Academic concerns and pressures

Additionally, the ready availability of electronic media and the emerging issues associated with it may be contributing to the likelihood of depression and suicidal ideation (Goldston, 2000). This information inspired investigation into the final topic of:

6) Social media and the Internet

Depression, Suicidal History, and Hopelessness

Students are at a more significant risk for suicide, according to Goldston (2000), when they experience any of the following: suicidal ideation, past attempts, depression, drug/alcohol use, or hopelessness, particularly if any of these are serious enough to warrant professional assistance (Goldston, 2000). Studies show that a psychological

diagnosis is present in 90% of students who are suicidal (Engin, Gurkan, Dulgerler, & Arabaci, 2009).

Approximately 10% of all students surveyed in one study (11% of females and 8% of males) reveal that in a one-year period, they had nine episodes of being "so depressed it was difficult to function" (Garlow et al., 2008, p. 486). In fact, one study showed that students with *intermediate and high* levels of depression had an 11% to 17% chance of attempting suicide (Engin et al., 2009).

In a study conducted for the American Foundation for Suicide Prevention, Garlow et al. (2008) found significant correlations between psychological disorders and suicide. There were positive correlations between suicide and such symptoms as feeling out of control, anxiety and irritability, and feelings of desperation and rage as well as depression. Data from a Garlow et al. (2008) study found that, using a sample of Emory University students (as represented in Figure 3), the more severe the depression, the more frequently suicidal ideation occurred.

A commonality among suicidal students with depression is the concern that he or she is becoming a burden to his or her family and friends (Joiner, 2005). This can lead to despair and increase the possibility that a student will attempt suicide (Borowsky, Ireland, & Resnick, 2001). Garlow et al. (2008) also held that the most significant indicator of suicide completion was whether there had been a previous attempt. In their journal article, they also stated that "A past suicide attempt or deliberate self-harm is associated with more prominent current symptoms of depression" (p. 486). With the hindsight of a previous attempt, suicide may feel like a more reasonable solution (Joiner, 2005).

In his book, Joiner (2005) stated that suicide attempts are most commonly related

to psychological issues and substance abuse, but may be linked as well to a whole host of other symptoms and history, involving both individual issues and family issues. According to the Suicide Prevention Resource Center (2004), a study of 36 counseling centers at colleges showed a statistical increase in the incidences of student psychological problems. The study showed that suicidal ideation tripled, depression doubled, and anxiety and alcohol/drug abuse showed a significant increase over the 10-year period studied. The study also showed that in that same 10-year period the number of cases of students who were victims of violence had increased four-fold. Additionally, there were increased issues with dysfunctional families and more diagnosis of bipolar disorder (Suicide Prevention Resource Center [SPRC], 2004). In one study, a student stated,

> I think about suicide when I've gone down a long dead end street and am depressed, because of unhappiness, dissatisfaction with where I am living, failure in my classes, loneliness, shyness, serious illness in my family, death or economic reasons. (Engin et al., 2009, p. 346)

Garlow et al. (2008) demonstrated the correlation between the severity of students' depression and the percent of students, at each level of depression that had suicidal ideation. As depression became more severe, the instances of suicidal ideation became more frequent. Even though suicides might be reduced if students are appropriately treated, there is a decided lack of students seeking treatment. In fact, in one study, 84% of students who had suicidal ideation and 85% of students who fell into the *moderately* to *severely* depressed categories failed to seek any treatment (Garlow et al., 2008). The correlation between severity of depression and suicide risk is illustrated in Figure 3.

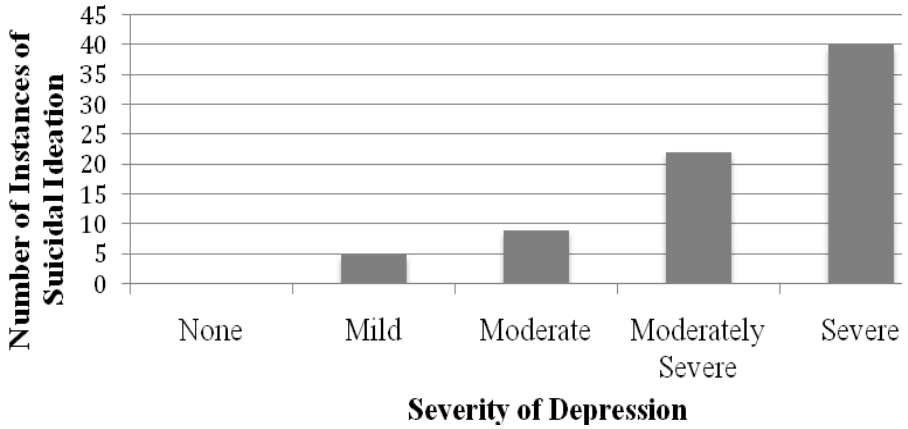

Figure 3. Correlation between severity of depression and suicidal ideation adapted from *Depression, desperation, and suicidal ideation in college students: Results from the American Foundation for Suicide Prevention College Screening Project at Emory University,* by Garlow et al. (2008).

The most significant factor for suicidal behavior is hopelessness (Beck, Brown, Berchick, Stewart, & Steer, 1990). Joiner (2005) found that there was supporting data to indicate that hopelessness was a predictor of suicide. In a 1990 study of nearly 2,000 psychiatric outpatients, using the Beck Depression Inventory (BDI) and the Beck Hopelessness Scale (BHS) – both developed by Dr. Aaron T. Beck – it was found that there was a significant link between hopelessness and suicide. In fact, during this study, 17 of those being studied completed suicide, and 16 of those 17 had a very high score on the hopelessness scale (Beck et al., 1990), which is significant because Beck then concluded that people who have scores ranging high on the hopelessness scale were up to 11 times more at risk to complete suicide than those with lower scores (Joiner, 2005).

In conclusion, depression and suicide are clearly factors in suicide risk for college

students, supported by multiple studies and convincing data. Studies have demonstrated that there is a direct correlation between the symptoms of depression and hopelessness and suicide. Of great concern is the fact that the number of college students with psychological issues is steadily increasing (SPRC, 2004).

Alcohol and Drug Abuse

When college students are changing environments from one where there is often parental supervision to one where there is virtually no supervision, it is tempting for them to begin to experiment, particularly when drugs and alcohol may be more available to them (Ross, 2004). With an estimated 80% of college students consuming alcohol (Lamis, Ellis, Chumney, & Dula, 2009), an increase from the estimated 38% of students consuming alcohol in high school (Morbidity and Mortality Weekly Report, 2010), excessive alcohol and drug use have been behaviors of concern on college campuses for many years.

Because illegal substance consumption in college is often excessive, the National Survey on Drug Use and Health (2006) indicated that it has become a significant concern with the knowledge that there was a definite "link between substance abuse and suicidal risk". In a 1994 study of more than 17, 500 students, nearly half admitted to having had an episode of binge drinking, and one-fifth of students admitted to binge drinking on a regular basis (Wechsler, Davenport, Dowdall, Moeykens, & Castillo, 1994). According to Wheeler (2010), this data has remained steady over time. Ross (2004) held that it is important to remember that risk for suicide is greatly increased when a student has both substance abuse issues and depression. Interestingly, one study showed that students who consumed large amounts of alcohol had fewer moral objections to suicide (Lamis et al.,

2009), which increased risk for those students.

A survey represented in Figure 4, adapted from a 2005 college student survey by the National Survey on Drug Use and Health (2006), a branch of the U.S. Department of Health and Human Services, demonstrated the use of alcohol among college-aged students between the ages of 18 and 22. The results of the study showed that "Young adults aged 18 to 22 enrolled full time in college, were more likely than peers not enrolled full time (i.e., part-time college students and persons not currently enrolled in college) to use alcohol" (para. 1). The study specifically asked about whether the students surveyed consumed some alcohol, binge drank, or drank heavily over any one-month period (National Survey on Drug Use and Health, 2006). Figure 4 illustrates the use of alcohol over 12 months.

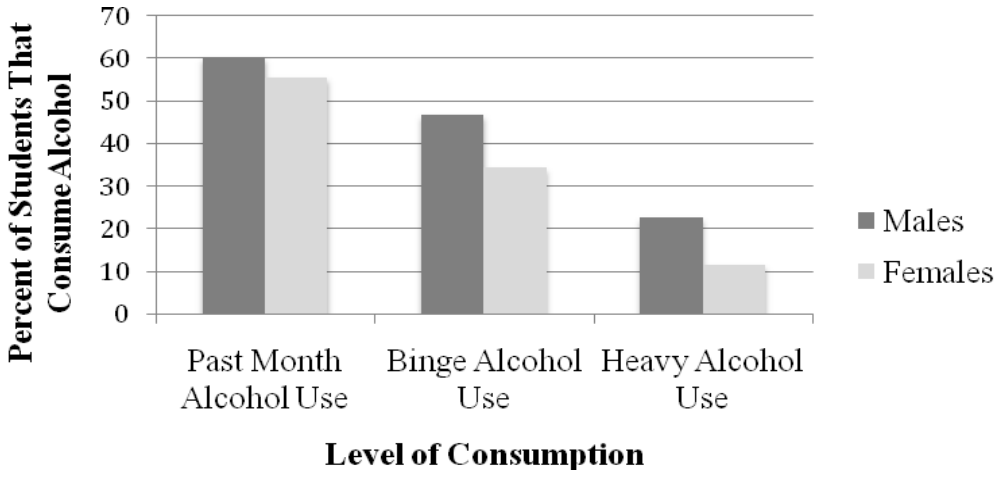

Figure 4. Alcohol Use by College Students ages 18-22. College student alcohol consumption data adapted from the National Survey on Drug Use and Health (2006), a branch of the U.S. Department of Health and Human Services represents alcohol use over a one-month period by students in the 18-22-year-old age groups.

Ross (2004) found that substance abuse was reported as a factor in both college

student depression and suicidal ideation. Substance abuse can cause intense depression and it has been suggested that it can put students at 10 times the risk for suicide than the non-substance abuse population (U.S. Department Of Health And Human Services, 2009). Alcohol mimics and enhances depression, because it is a depressogen, which, with repeated use "produces both the subjective feelings of depression and the neurovegetative signs such as sleep and appetite disturbance, cognitive impairment, and decreased energy characteristic of the depressed syndrome" (Deykin, Levy, & Wells, 1987, p. 178).

In short, alcohol consumption on college campuses is a significant problem. Although historically there has been drinking on campuses seen by some as a *rite of passage*, it is now known that it is likely contributing to student suicidal risk (National Survey on Drug Use and Health, 2006). Alcohol, when consumed, is a depressogen, which is linked to depression, and depression is significant because it increases suicidal risk (Ross, 2004).

Relationships

There are many stressors that might affect the college student including interpersonal conflicts with siblings and peers, and particularly conflicts with parents (Hampel & Petermann, 2005). These stressors can sometimes lead to psychological symptoms, and if stressors begin to compound due to the increasing demands of life, students might become very depressed, and increasing depression is linked to suicidal ideation (Hampel & Petermann, 2005). Family problems were identified in many studies as the key reason for suicidal ideation because the student relies on the family for social support and when this is not present, it may cause an increase in depression (Engin et al.,

2009). College students often depend on the support of friends and family for feelings of self-worth and a feeling of belonging (Engin et al., 2009) even as they are trying to break those ties to live more independently (Westefeld et al., 2006). So, during college years, students begin to separate themselves from family and make new connections (Westefeld et al., 2006). That does not imply that students do not still need the support of family. These confused needs can become a double-edged sword in that normal development causes distancing from family, but family can also provide much needed assistance with decision-making, judgment, intellectual development, and motivation (Westefeld et al., 2006).

Despite many students feeling that they do not need family, distancing may cause students to become angry, anxious, and to feel hopeless (Engin et al., 2009). Having strong connectedness to family and friends may prevent depression and suicidal behavior (Westefeld et al., 2006). Conversely, when there is difficulty with family relationships, and these feelings persist, the student may have suicidal ideation or behavior, and, in fact, multiple studies point to family struggles as the most significant reason for suicidal behavior in the college age group (Engin et al., 2009).

Romantic relationships pose another set of dynamics that can be significant for depression and suicidal ideation. Combined with the stressful change brought about by college life, a breakup, and particularly a romantic rejection, can exacerbate depression (Tolpin, Cohen, Gunthert, & Ferrehi, 2006). Females are at a higher risk because studies have indicated that women have higher scores for breakup distress, particularly if the breakup is sudden (Field, Diego, Pelaez, Deeds, & Delgado, 2009). Having a relationship may generally give students a feeling of support and belonging which decreases the

isolation sometimes felt by them and may decrease depressive symptoms (Cramer, 2004). Students reported feelings of betrayal, loss of self-esteem, as well as increased depression and anxiety, following a breakup of a significant relationship (Field et al., 2009). The intrusive thoughts, obsessing, and anxiety could be similar to symptoms of drug withdrawal (Field et al., 2009). Furthermore, the end of a relationship often involves the loss of a confidant (Tolpin et al., 2006) and the loss of emotional intimacy (Cramer, 2004).

Often, as Baker and Stith (2008) have noted, the difficulty in a relationship has to do with abuse. There are some estimates that claim potentially one in three college couples will have violence in the relationship perpetrated by one or the other partner (Baker & Stith, 2008). There is often abuse in a relationship when the abusing partner has witnessed abuse in his or her own family, or was the victim of abuse himself or herself (Gutierrez, Thakkar, & Kuczen, 2000) and may be linked to suicidal behavior, especially for women who were abused in childhood or as an adult (Stephenson, Pena-Shaff, & Quirk, 2006). Despite the fact that it is more likely women who consider suicide when abused, there is also evidence that males who had been abused may have suicidal ideation although it is not well documented because males are more reluctant to report abuse and often simply call it *being in a fight* (Stephenson et al., 2006). Suicidal behavior could become more prominent when the abuse is more severe, particularly when the abuse is sexual in nature (Gutierrez et al., 2000). However, regardless of the circumstances, there remains an association between any type of aggression imposed on a student and suicidal ideation (Stephenson et al., 2006).

To summarize, relationships are one of the many stressors that students must deal with. Occasionally, issues with relationships can result in serious psychological symptoms, which may increase potential for depression, hopelessness, and suicide (Hampel & Petermann, 2005). Abusive relationships are associated with an increased likelihood of suicidal ideation (Stephenson, et al., 2006).

Sexual Identity Issues

Despite being considered, in many other ways, a progressive society, in the United States today there is still a pervasive homophobic culture (Lund, 2002) that makes it difficult for lesbian, gay, and bisexual (LGB) students to feel like accepted members of society (Ridner, Frost, & Lajoie, 2006). In fact,

> Aversion to homosexuals for many in the American society comes close to a true phobia, as a persistent and irrational fear. National surveys investigating attitudes toward homosexual relations between adults reported a majority of those responding believed that such relations were wrong. Taken to an extreme, homophobia and antigay discrimination result in the verbal and physical abuse of gays. (Lance, 2008, p. 789)

Students may be homophobic for a variety of reasons: (a) fear of something they do not understand, (b) religious belief, (c) lack of social contact with LGB persons socially or, (d) any combination of any of these (Chonody, Rutledge, & Siebert, 2009). College-aged students who are LGB are far more likely to have depression and suicidal ideation than their heterosexual peers (Russell & Joyner, 2001). In fact, LGB students could be up to three times more likely to have suicidal thoughts than their heterosexual classmates (SPRC, 2008) and two times more likely to make a suicide attempt (Russell &

Joyner, 2001). It should be noted however, that there is no evidence that there are more completed suicides within the LGB group (Berman et al., 2007). What is known is that there are significantly higher levels of alcohol use in students who have same-sex partners and a larger number of suicide attempts (Russell & Joyner, 2001). One survey revealed that, when asked about the past 12-month period, 35.3% of participating LGB students reported at least one suicide attempt (SPRC, 2004).

Part of the issue for many students is that college is seen as an opportunity to come to terms with their identity. Students at this point are often feeling that they do not understand who they are in multiple realms, including sexually (World Health Organization, 2001), so this is likely a time for students to begin to explore their sexual orientation. However, it is difficult because as LGB sexuality emerges, depending on whether there is a culture of acceptance of LGB students, there might not be anyone to serve as a role model to openly help them through their uncertainty, which can cause feelings of isolation (Garcia, Adams, Friedman, & East, 2002).

Those students who are LGB, and particularly if they are male students, often feel rejected by the mainstream, isolated and unaccepted by family, and particularly by parents (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999). An added dimension is that LGB students are less likely than heterosexual students to complete their undergraduate degree because of real or perceived lack of support related to their sexuality (Van Puymbroeck, 2001).

Males who have a same-sex attraction are more likely to become suicidal than females who have a same-sex attraction (Borowsky, Ireland, & Resnick, 2001). This is likely due to the stigma associated with being a gay male in a world where gay men are

ostracized (Lund, 2002). Additionally, Goodenow, Szalacha, and Westheimer (2008) found that LGB students faced higher incidences of violence and victimization than their heterosexual peers. The Equality NC Project, a North Carolina democracy project which encourages collaboration between organizations, issued a statement that essentially said that hate crimes had risen 61% since 1992 (Lance, 2008) with much of this aggression aimed at the gay population. When the feelings of isolation and loneliness are paired with a lack of support and protection such as parental connectedness, students' emotional well-being may be compromised, so that ultimately they might become depressed and suicidal (Borowsky et al., 2001).

In summary, the college years are often a time when LGB students may be coming to terms with their sexuality. Being LGB may lead to vulnerability and isolation (Garcia et al., 2002). LGB students, particularly males, may feel rejected by the mainstream, which contributes to their isolation (Garofalo et al., 1999). Violence and victimization are also significant suicide risk factors for the college-aged LGB population (Borowsky et al., 2001).

Academic Concerns/Pressures

There is a significant relationship between depression and academic performance expectations, according to Engin et al. (2009). In fact, in one study 45% of respondents indicated that many issues stemmed from academic concerns including concern over grades, which might impact parental relationships and finances (Williams, Galanter, Dermatis, & Schwartz, 2008). One-half of students reported having problems in college, particularly in the first year, which might be due to difficulty with adjusting to a new environment (Williams et al., 2008). Having poor scholastic performance is linked to

suicidal thoughts and tendencies, possibly due to loss of self-esteem and self-respect (Engin et al., 2009). College is commonly thought to provide the opportunity for a positive life change, however, it can be extremely stressful when students realize the way expectations change from their high school experience, including difficult assignments, deadlines, and more demanding writing assignments can all be major academic stressors (Deroma, Leach, & Leverett, 2009).

A student's perception of what a parent expects, and trying to reach or exceed those perceived expectations, might increase the student's anxiety and depression (Agliata & Renk, 2009). This desire for perfection could also lead to acts of misconduct including plagiarism (Bennet, 2005), which could result in increasing concern over not meeting parental expectations for their academic achievement (Agliata & Renk, 2009) or anxiety about being found out (Bennet, 2005). If the student feels a constant need to be perfect and fails, he or she could become depressed and stressed. They could worry about bad grades and the fact that their imperfections may be apparent to others (Landphair, 2007). Changing from high school, where students might know everyone, to a college where most people are strangers, can also cause isolation and subsequent depression (Enochs & Roland, 2006). This is a time when self-esteem and confidence become even more important for program effectiveness. Enochs and Roland (2006) stated that students need an environment of socialization and acceptance.

Overall, academic pressure is a stressor that can lead to depression and anxiety. Fear of disappointing parents and the desire for perfection can lead to misconduct, which can lead to suicidal thoughts and/or actions. The most common time for this to occur is in the first year of college (Williams et al., 2008).

Social Media and the Internet

The number of hours that the Internet is used worldwide by all age groups grew 117% from 2004 to 2009 (Davis, 2009). Although Internet use is commonplace, and necessary for today's college student, one study showed that of 277 undergraduate students, 8.1% showed signs of problematic use of the Internet. Each of the 8.1% identified experiencing at least one of a list of 13 symptoms including extreme moodiness, relationship issues, and being increasingly withdrawn. If the student experienced a combination of four or more of the 13 symptoms (Shaw & Black, 2008) they were considered to be extremely addicted to the Internet.

Much of the use of the Internet in college is related to participation in surfing the Internet and social networking such as Facebook, Twitter, and MySpace, which occurs generally for four reasons: socializing, entertainment, self-status seeking, and information (Park, Kee, & Valenzuela, 2009). In the Journal of Mental Health, Bell (2007) stated,

> The Internet is typically discussed as if it were a set of activities when it is actually a medium upon which various activities can occur. It is, therefore, neither 'good' nor 'bad' for mental health, although specific activities may have an influence. (p. 445)

Addiction to the Internet was identified as long ago as the mid-1990s (Young, 1996) and with the addition of social media such as Facebook, it is a growing issue today (Nauert, 2010). In fact, in 1996 a name was given to this addiction, Internet Addiction Disorder or IAD, which could well be included in the next version of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) (Davis, 2009). Those who are lonely and isolated may use the Internet for entertainment, sexual gratification,

and socialization (Bell, 2007). Eventually, they may begin to phase out family and friends in favor of the Internet (Bell, 2007). This isolation can lead to loneliness, tension, and depression (Meerkerk, Van Den Eijnden, Vermulst & Garretsen, 2009). Ultimately, distress may occur because the student might neglect other aspects of his or her life in order to be online, and this behavior progresses to a full-blown addiction (Hall & Parsons, 2001).

According to researchers at the University of Maryland, students with an addiction to the Internet had withdrawal symptoms similar to those produced by addictive drugs (Kandell, 2010). When away from the Internet for prolonged periods of time, college students reported similar symptoms to drug and alcohol addiction, including anxiety and jitters (Nauert, 2010). In one study using Korean students, Kim et al. (2006) measured suicidal ideation of varying levels over time via a *Diagnostic Interview Schedule* – a survey that addressed levels of time spent, symptoms and feelings specifically regarding depression and suicidal ideation when using, and away from, the computer.

This study examined the relationship between depression with suicidal ideation and Internet addiction in Korean adolescents. In this study, 1,573 students completed the Diagnostic Interview Schedule. The results showed that 1.6% of the students surveyed said they were addicted to the Internet and 38% claimed they were possible addicts. There was no variation relative to gender. Students who were classified as highly dependent on the Internet were shown to have increased suicidal ideation.

The major concern is that students may become too dependent on the instant information and feedback that they receive from the Internet (Nauert, 2010) instead of

seeking other sources for information and socialization. Some students revealed that, as they were previously lonely, the Internet was a source of comfort. They felt safer than making public connections, and had more of a sense of confidentiality using instant messaging and texting (Lester, 2008-2009).

Conversely, the Internet can also be a source of great pain. Possibly because it is such a new phenomenon that it has not garnered the attention needed so there are few studies to review, cyberbullying seems to be on the increase in the college population (Daniloff, 2009). This relatively new phenomenon involves "an individual or a group willfully using information and communication involving electronic technologies to facilitate deliberate and repeated harassment or threat to another individual or group by sending or posting cruel text and/or graphics using technological means" (Dilmac, 2009, p. 1308).

Although most people would assume that cyberbullying occurs mostly in middle school and high school, it is expanding to college and beyond. Perhaps emboldened by anonymity, bullying has more recently migrated to college campuses (Valentino-Devries, 2010) and appears to be more prevalent in the female population than the male population; in fact, 61% of females in one study reported that they had been victims of cyberbullying at least one time, as opposed to 39% of males who reported being bullied on the Internet (Mesch, 2009). In general, according to Laster (2010), females had a greater tendency toward psychological bullying, including cyberbullying, while males tended to be more physically aggressive with their bullying, using hitting and kicking as their ammunition. However, cyberbullying seems to be gaining a male base perhaps

because of the anonymity or because it doesn't require a test of physical strength (Laster, 2010).

There has been recent media attention given to the topic of cyberbullying. Several cases of college cyberbullying have been reported in the news, including the case of Tyler Clementi, who "drove to the George Washington Bridge and jumped into the Hudson River" (Trenlowski, 2010, p. 56). This suicide occurred three days after his roommate at Rutgers had used a webcam to distribute images of Clementi having an intimate encounter with another man (Trenlowski, 2010). This act may have been related to the issues of homophobia discussed earlier in this chapter.

This recent exposure may help to shine some light on cyberbullying because as Daniloff (2009) states in Boston University's school paper, "Grown victims are embarrassed to come forward" (para. 8). However, despite this reluctance, one website administrator of the website *Working to Halt Online Abuse* (WHOA) stated that in 2007 (the most current report) "the site documented 249 cases of online harassment reported, with white females between the ages of 18 and 30 making up more than 60% of the victims" (Daniloff, 2009, para. 8).

As stated earlier, college does not exempt students from bullying; in fact, there is one particularly interesting study out of Turkey that discussed the more significant differences between traditional bullying and cyberbullying (Dilmac, 2009). The explanation that most applied to college-aged students is that, generally, other students know who the bully is in elementary and secondary school (although cyberbullying is increasingly becoming an issue even for the young), whereas bullies online (the most likely scenario in college) are largely anonymous unless they choose to make themselves

known. This cover of anonymity can make the bullying more painful to the receiver because it could be anyone doing the bullying and not just the known school bully (Dilmac, 2009).

Because there is little censorship or control over Internet content, anything can be written or found (Bell, 2007) without the author having to take time to think about the ramifications. This includes bullying, social networking, or searching for advice on how to do most anything. Often this is also directed at the most vulnerable, so that a student can easily find advice on how to die by suicide (Alao, Soderberg, Pohl, & Abosed, 2006). In fact, there are over 100,000 web sites that deal specifically with methods of suicide (Alao et al., 2006), making it easy for students to find information that will assist them in choosing a method to complete a suicide.

Social media connectedness has a strong influence on most college-aged students (Whitworth, 2008) and often contains information to facilitate, rather than prevent, suicide (Lester, 2008-2009). On one of these pro-suicide websites that promotes suicide (Lester, 2008-2009), a group of Internet "onlookers" encouraged a 23-year-old to keep taking pills with messages such as "eat more!" until he died from an overdose (Joiner, 2005). This behavior is due, at least in part, to what is known as the "extreme communities" (Bell, 2007, p. 445), online groups that actually provide advice on bulimia and anorexia (Bell, 2007) and advice on how to take, rather than save a life (Lester, 2008-2009). Whether a student's suicidal ideation begins with the Internet, or is facilitated by the Internet, what is known is that excessive Internet use can lead to depression, and depression is common to most of those who attempt or complete suicide (Goldston, 2000).

In conclusion, with so many social media sites available, combined with the infinite amount of information available on the Internet, students increasingly rely on computers for relationships, information and guidance. Studies show that prolonged Internet usage can cause or worsen a student's depression and as a result increase their potential for suicidal ideation (Goldston, 2000). Additionally, cyberbullying has increased possibly because bullies can remain essentially anonymous (Dilmac, 2009).

Evidence-based Practice in Current Literature

According to Ross (2004), it is important for college counselors to understand that studies show that 45% of college students who seek counseling state that they have thought about suicide. Westfeld et al. (2006) stated that in order to assess the suicide risk of students, there should be an assessment early in the college experience, such as student orientation, where students are asked questions about any history of abuse, substance use, hopelessness and depression, or mood problems. Additionally, per Gutierrez et al., (2000), assessment could be done at regular intervals during the school year. With the results of such assessments, an individualized plan could be developed when a student at risk is identified (Baker & Stith, 2008). Miller, Eckert, & Mazza (2009) believed that for a program to have a chance to be effective, it should have multiple components, and be evaluated on a regular basis using current literature regarding best practice.

The SPRC (2004) suggested that college suicide prevention program developers could include not only a good screening tool, but also could include a coordinated approach. This approach could include utilization of programs for prevention and intervention that include: (a) education, (b) immediate management of risk, (c) programs for managing psychological issues, (d) a referral program for long term counseling and

care, (e) restriction of items that can be used as implements of suicide (including weapons, drugs and alcohol), (f) wellness programs with ongoing evaluation of risk, and (g) promotion of these programs and services. Westefeld et al. (2006) stated that one college's website has a mandatory screening tool and students must comply with completing the screening or be subject to discipline up to, and including, withdrawal from the program. Withdrawal of the student could potentially have the benefit of protecting the student and the college, if the student provides honest information, and the college appropriately acts on the information provided.

Colleges are beginning to build programs that have very specific strategies for depression screening and suicide prevention (Haas et al., 2008). Because there are various factors leading to depression and suicide, one study suggested that schools put very specific programs in place to attempt to meet individual needs, such as anger management. About half of students who utilize services admitted that intervention was helpful to them by getting them involved in care, which is potentially the first step in effective control of suicide (Westefeld et al., 2006).

According to Lamis et al. (2009), interventions are essential if suicidal behavior is to be prevented. The focus, according to Brown (2001), is best placed on identification of students at risk and working at finding interventions that work. Most colleges have mental health programs (Kraft, 2009), but these programs need to be more effective and more specific. A start toward this, for many colleges, may be to have students complete an assessment at the onset of the college academic year and design programs and plans around the responses (Westefeld et al., 2006).

In a journal article, Ridner et al. (2006) suggested that students should complete

psychological evaluations when they enter college, and the evaluations should be repeated on a periodic basis. These evaluations could include screenings for battery, aggressive relationships, sexual abuse or assault, or increased alcohol or drug use (Ridner et al., 2006). In a journal article, Muehlenkamp, Gray, and Brown (2009) noted that often the college campus is where first-time psychological interventions might occur. Despite the fact that most colleges have programs, many students believe that colleges could do more by improving existing programs for suicide prevention (Westefeld et al., 2006) because depression and suicidal feelings are treatable when the behavior is observed and the student accepts treatment, or when those feelings are self-reported by the student (American Academy of Child and Adolescent Psychiatry, 2009).

The SPRC (2004) suggested that students should know how to self-report psychological conditions and be made more aware of how to access counseling. Whereas in the past, according to The Jed Foundation (2010), counseling centers were solely responsible for identification and intervention, some suicide prevention programs now involve the faculty and students (The Jed Foundation, 2010).

Individuals in the college community can be trained, or at least sensitized to identify and intervene by referring at-risk students to professionals. This is known as the gatekeeper approach, and might be more effective in identifying students appropriate for referral to the counseling center (Brown, Wyman, Brinales, & Gibbons, 2007). Many schools already train the resident advisors (RA) and resident directors (RD) to identify risk factors, and tactics for intervention. As stated by Haas et al. (2008), a helpful approach could be to teach the gatekeeper some basic methods for communication. For instance, for students who are potentially at risk but often considered not to be in

immediate danger, making contact could be as easy as sending a postcard or an email (Haas et al., 2008). The Jed Foundation (2010) suggested that the emphasis should be on campus-wide programs that operate under a public health model (Miller et al., 2009). The public health model has five essential steps:

> (a) Clearly define the problem by collecting data and other information. (b) Identify risk and protective factors. Risk factors are associated with (or lead to) suicides and suicide attempts. Protective factors reduce the likelihood of suicide. (c) Develop and test interventions. Most interventions seek to reduce risk factors and/or enhance protective factors. Such preventive measures should be scientifically tested to determine if they actually work before being disseminated and implemented. (d) Implement interventions. (e) Evaluate effectiveness. Suicide prevention programs should always be evaluated to verify that they are working and to understand how to make them more effective in the particular situation in which they are being used. (SPRC, 2009, Suicide Prevention Basics section, para. 2)

An effective program would likely include student and faculty education, according to the Suicide Prevention Resource Center (2009). Westefeld, Maples, Buford, and Taylor (2001) suggested that there has to be a culture change within the college to promote an environment where faculty and students communicate on a more personal level so that faculty is more comfortable engaging in conversations that contain open dialogue about depression and suicide. This also might mean that the institution provides opportunities for conversations with students about suicide, education regarding how to make *no suicide contracts*, and learning how to have important and sometimes difficult discussions (Westefeld et al., 2006, p. 941). Another behavior is that of violent student

behavior, which, if left unaddressed may lead to self-harm and puts the student's future relationships at greater risk for violence (Baker & Stith, 2008). Violence often continues on to more permanent relationships unless the cycle can be broken (Baker & Stith, 2008).

Campaigns to promote prevention programs including support for students who do not fit the traditional college student profile, (gay, lesbian, bisexual, and transgender students, specifically) could be implemented, according to the Suicide Prevention Resource Center (2009). Also, instead of stigmatizing suicide as only a violent behavior, and housing their suicide prevention program within their campus violence policies, make the prevention program more prevalent because it is interesting to note that the violence is not perpetrated by people who have mental disorders, and in the absence of substance abuse present no more risk than any one else in the general population Williams et al. (2008) suggested that colleges have to be more innovative not only by making counseling available, but also by offering more services to students such as relaxation and group sessions. Nearly one-third of students questioned felt that such options were attractive.

In summary, suicide prevention programs vary across college campuses and opinions about what should be included in programs vary as well. Many organizations are developing, or have developed programs currently being used by some universities. Most desirable are programs that support students and do not add to the stigma.

Web-based Intervention Programs

Where Internet and social networking are concerned, there is a positive side. There are Internet programs that are designed to teach students about identification and prevention of suicide (Seabury, 2005). One web-based intervention program showed that

students were three times more likely to seek counseling after using a web program to engage in initial dialogue regarding their depression (Haas et al., 2008). In fact, when surveyed, 64% of a study sample of 200 students indicated that students would rather use the Internet for support partially because it is always readily available (Feigelman, Gorman, Beal, & Jordan, 2008). Today's student is far more comfortable with the Internet than previous generations, and might find the option of online screening more desirable and might also be more inclined to participate with screenings knowing that the screenings can be done on the Internet and a counselor can respond and assess the information received (Lester, 2008-2009).

One of the web-based efforts in place today includes an online screening program in which students are able to self-identify, and counselors can follow the students' symptoms and progress with the initial evaluation as well as with ongoing treatment (Haas et al., 2008). Research shows that students feel freer to talk to other students, so teaching students to respond appropriately to issues that come up in their meetings, and teaching students to recognize when immediate care is needed, will make these communications more effective. Education of student responders is essential (Thompson & Mazer, 2009).

The Internet is being used, in some cases very successfully, for counseling and identification of students at risk for suicide (Lester, 2008-2009). Because of students' comfort with the Internet, some programs are proving to be successful in the identification of these at-risk students (Haas et al., 2008). Those students who participated in online screening were three times more likely to enter into treatment, and continue treatment (Haas et al., 2008). Internet-based programs for students at risk are

growing in popularity (Lester, 2008-2009) and may be an option, but will require more development and clinical trials (Bell, 2007). There are, however, some programs that have been studied that claim to be effective, according to Seabury (2005). Students might be more responsive because the Internet is more convenient and private (Haas et al., 2008). One particular advantage is that having familiarity with social networking makes students less fearful of self-disclosing and communicating with online individuals or groups (Bell, 2007).

It is not uncommon for colleges to dismiss students from college if they are suicidal (Capriccioso, 2006). For some colleges the rationale is threefold: it (a) limits liability to the college (Pavela, 2006), (b) limits concerns of the suicidal student's potential violence toward others (Department of the Public Advocate, 2009), and (c) relieves the school of the responsibility for counseling those students (Pavela, 2006). Pavela (2006) also contends that colleges have to measure the appropriateness of their action against their need to self-preserve, along with their implied intent to protect the faculty and students from potentially troublesome behavior.

Efforts toward developing instruments to identify students at risk have yielded varying results; however, there has not been as much attention to evaluation of the efficacy of what is already available (Goldston, 2000). One study, as reported in the World Health Organization Bulletin (2001), indicated that when there is focus on those who attempt suicide, there could be a significant reduction in completion (Fleischmann et al., 2008). Additionally, the development of programs that acquaint students (particularly new students) with faculty, other students, and activities might help students adjust better to college life, and limit isolation. These activities, when held outside of the classroom,

might encourage socialization among students and again potentially lessen the opportunity for isolation (Enochs & Roland, 2006). The Suicide Prevention Resource Center (2009) and The Jed Foundation (2006) each recommends a comprehensive suicide prevention program that involves multi-faceted education for students and faculty/staff, evaluation and treatment with referral to a mental health professional, and, if necessary, follow-up.

Examples of Current Practice

There are several organizations that have programs written to assist in student education regarding suicide prevention. The Trevor Project (2010) was started following the 1981 release of a story about a 13-year-old who took his life after developing a crush on a boy. This website and the associated programs continue to be very active with educational programs. The description of The Trevor Project can be found in their mission statement:

> The Trevor Project is determined to end suicide among LGBTQ (lesbian, gay, bisexual, transgender and questioning) youth by providing life-saving and life-affirming resources including our nationwide, 24/7 crisis intervention lifeline, digital community and advocacy/educational programs that create a safe, supportive and positive environment for everyone. (The Trevor Project, 2010)

The Jed Foundation, named for the founders' son Jed, identified a need for resources to help "colleges, students and parents recognize and address the signs of emotional distress and suicide" (The Jed Foundation, 2010, History section, para. 2). In 2006, The Jed Foundation held a roundtable of college administrators, counselors, attorneys, and mental health professionals to determine participant perception of the best

approach to a comprehensive suicide prevention program. The result was the *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student* (The Jed Foundation, 2006), a guide to assist colleges in developing a safety protocol. Additionally, the document assists the college in building emergency contact lists and developing a *leave of absence and re-entry policy* instead of altogether removing students from school. The Jed Foundation's suicide prevention program recommendations for optimum student safety are based on three phases: prevention, intervention, and postvention, which are dependent on each other if there is to be a fully comprehensive program as illustrated in Figure 5.

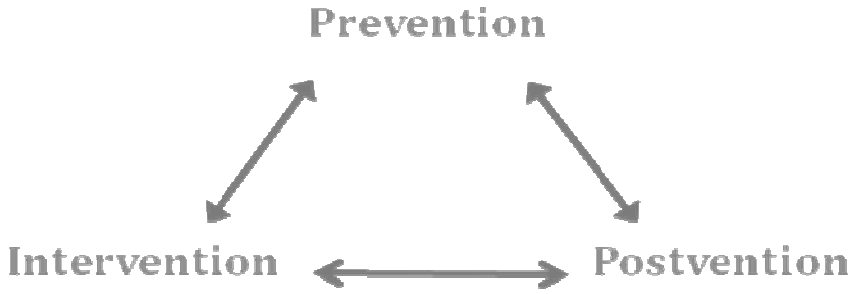

Figure 5. Elements of an Effective Suicide Prevention Program adapted from The Jed Foundation Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student (2006). This diagram demonstrates the program's three pillars: prevention, intervention, and postvention, and how they are interdependent in a comprehensive program.

Regarding Figure 5, suicide *prevention* might include student and faculty education, restriction of weapons on campus, having campus-wide programs to raise awareness; *intervention* might include crisis management programs, counseling, or

personal contact by the resident advisors and/or resident directors; and, *postvention* might include bereavement groups, providing grief resources, or holding campus meetings to address suicides. These three processes do not necessarily occur in any particular sequence, for instance The Jed Foundation (2006) document gives the example of holding a bereavement group where someone manifests suicidal thoughts and moves from postvention to prevention.

Most of the colleges responding to the survey for this study had programs in place, but not all were as comprehensive as The Jed Foundation Framework. Several programs that I reviewed were located via an Internet search using *college suicide prevention programs* in the search engine. Overall, the programs that were found on each website were of very similar content. The colleges were: University of Illinois at Urbana-Champaign, University of Florida, The Ohio State University, Connecticut College, and University of Michigan. These colleges had varying methodologies for approaching the issue of students at risk. For instance, the University of Illinois at Urbana-Champaign had a program that entailed student education, staff training, and mandatory assessment for students who are identified as being at-risk (University of Illinois at Urbana-Champaign, 2010).

The program section entitled *Mandated Assessment Following Suicide Threats and Attempts* states:

> In the event that the University is presented with a credible report that a student has threatened or attempted suicide, engaged in efforts to prepare to commit suicide or expressed a preoccupation with suicide, that student will be required to attend four sessions of professional assessment. (Suicide policy section, para. 1).

If a student fails to comply, that student is subject to disciplinary action up to and including suspension or withdrawal (University of Illinois at Urbana-Champaign, 2010).

Another example of a suicide prevention program is the *University of Florida Faculty and Staff 911 Guide for helping students in distress* (University of Florida, 2010). The University of Florida program is primarily directed at university employees and educates the staff regarding signs, symptoms, and action to be taken when a student is deemed at risk. It contains a logarithmic methodology for evaluation of students and each of the choices terminates in a contact number or action. Although there are sections for evaluation, assessment, education, and notifications, the program primarily focuses on crisis management (University of Florida, 2010).

The Ohio State University (2010) Campus Suicide Prevention Program is a comprehensive program that involves students and college staff and has many components including a resource network for staff and students; crisis management; policy development; outreach; data evaluation; training programs for students, faculty and staff; program development to reduce the stigma of psychological services; and assessment of outcomes. Each of The Ohio State University's program components are represented in the survey for this study.

Connecticut College has a program that encompasses many of the components suggested by The Jed Foundation and the Suicide Prevention Resource Center, including student and staff education, treatment, evaluation, and referral. Connecticut College also has a policy similar to the University of Illinois program which is entitled *Mandatory Medical Leave* (Connecticut College, 2010), which entails a mandatory leave of absence for any student deemed a risk to himself or herself, or a risk to others. The college can

then require that a professional evaluate the student before he or she is allowed to return to school (Connecticut College, 2010).

The University of Michigan has a comprehensive program that includes sections for assessment and treatment, parent education, student and faculty education, and additionally discusses topics such as depression and attention deficit disorder. Of course, in order for the program to be effective, each of these groups has to access the college website and search for the information.

Over 200 college campuses engage in a program called *Active Minds*. This program involves encouraging students to talk openly about psychological issues, and stresses communication and help-seeking behaviors (Active Minds, 2010). This program attempts to promote student involvement and education (Substance Abuse and Mental Health Services Administration, 2009).

Suicide and the Military Related to the 18-24 year old Age Group

Suicide has become a significant issue in the military, which for the purposes of this paper are all active military personnel, both stateside and deployed, among the 18-24-year-old age group. Fifty percent of those who are part of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are in the 17-26 year old age group (Martin et al., 2009). In an already stressful environment, suicide is now the second leading cause of death in the military after accidents. Because, as discussed earlier, firearms are the most common means of suicide for men in this age group (National Center For Health Statistics, 2010), it makes sense that the majority of those who die by suicide in the military are male since 86% of the military is comprised of men (United States Census Bureau, 2010). Therefore, since men primarily use firearms for suicide as

illustrated in Figure 2, it also makes sense that this is the primary method of suicide in the military since there is ready access to firearms (Martin et al., 2009). The military is making attempts to understand the reasons for these deaths in order to decrease the number of suicides, but to date the efforts have been poorly coordinated and the suicide rate continues to rise (Fox, 2010).

It has been made even more difficult to address suicide in the military due to some political resistance. For instance, The Huffington Post ran an article citing the fact that the U.S. Senate failed to put through legislation for military suicide prevention that was included in the National Defense Authorization Act for 2011. The section on prevention programs for reservists was removed from the legislation at the behest of Senator John McCain (R-Ariz) (Terkel, 2010). In an environment where suicide is often seen as a cowardly act, the military is a hotbed of men and women who are fearful that if they seek assistance they will be seen as weak (Martin et al., 2009).

As stated by Fox (2010), some college counseling professionals have realized that the way to combat suicide is to have solid, well-coordinated suicide prevention programs. These should include a program to identify students at-risk if there is a possibility of truly having an impact on the college suicide rate. As evidenced by rising rates of suicide and increased media attention, the military and colleges are now faced with similar issues. Programs, however, might be even more difficult for the military because historically soldiers have a fear and general mistrust of the system and pervasive doubt that treatment will help them (Fox, 2010). The general death rate, which includes suicide, has grown significantly since 2000 as illustrated in Figure 6.

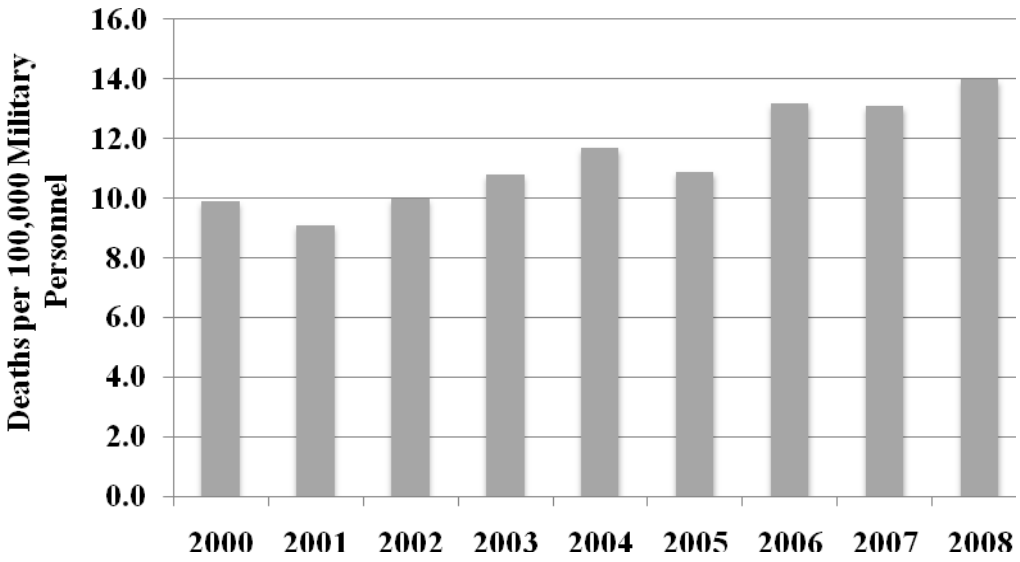

Figure 6. Deaths per 100,000 Military Personnel adapted from the United States Census Bureau U.S. Active Duty Military Deaths by Manner of Death, 2010. Statistical Abstract demonstrates the number of suicides per 100,000 military personnel. The total number of suicides was over 250 in 2008.

Summary

Students often feel overwhelmed with life. When they are at the point where they feel there is little hope and they have little control, there is an increase in the risk for suicide (Westefeld et al., 2006). Although it should be noted that coping poorly with stress is not necessarily an indicator of suicidal behavior, many students do not tolerate stress well (Engin et al., 2009). Seeking counseling might feel like a dilemma for students who believe that their only choices are to ask for assistance and risk being removed from school, or not seeking assistance at all (Capriccioso, 2006). Students might have concerns that parents will find out about their psychological state because The Family Educational Rights and Privacy Act (FERPA) allows for notification of parents (Seabury, 2006) when "the information is necessary to protect the health or safety

of the student or other individuals" (United States Department of Education, 2010, section §99.36).

There is a struggle for colleges to avoid liability and still act in the best interest of students according to Dyer (2007), who added that the college has to walk the fine line of what they know, and then what to do with the knowledge. If they know of suicide attempts, suicidal ideation and/or suicidal behavior and do not act, they may well be held responsible for the death in the media or in a court of law if a student completes suicide (Dyer, 2007).

Very little research is available for colleges, however, regarding what components of existing programs work and do not work to prevent suicides and identify students at risk. This study was designed to make a contribution towards evaluating program efficiency in order to assist in improvement of existing programs and provision of information for building new programs.

This chapter provided a discussion of the literature regarding the issue of college student suicide. The literature included causes, evidence-based practice, and comparisons to the issue of suicide in the military. How colleges address these issues varies, some using best practice, and some using programs developed by the counselors at the college based on college experience. This study attempts to determine which components of college suicide prevention programs are considered the most effective. The following chapter outlines how this study was conducted including methodology, survey contents and rationale.

Chapter Three

Research Methodology and Rationale

The purpose of this study was to determine college counselors' perceptions of the effectiveness of the components of suicide prevention programs. There are multiple approaches that a researcher can use to understand the subject being studied. Because the opinions of college counselors lend insight into what sense they are making of what they are currently experiencing, a college counselor opinion survey was used to determine the overarching research question: *What are deemed to be the most effective components of suicide prevention programs in colleges?* One purpose of the study was to assist colleges in determining the components that should be included in or potentially excluded from existing college programs in order to make suicide prevention, identification, and student-at-risk interventions more effective. During the course of my research I did not find other studies on counselor perception of effective components of suicide prevention programs.

Framework

Counselors are on the frontline every day working with and observing students who need assistance, while searching for ways to prevent student self-harm. Frequently counselors must balance whether to notify parents or to take other action. Francis (2003) noted that the families frequently ask why they did not know that their student was at risk or why the school did not prevent the suicide from happening. Further, Francis (2003) further stated that this can cause a troublesome dilemma for counselors who every day have to balance the need to protect a student's privacy with the need to protect the

student's safety.

The assumption for the purposes of this research was that college counselors are able to evaluate what is effective and ineffective in each college's suicide prevention program since they assist in the program development, and are generally responsible for updates and evaluations. Additionally, there is an understanding that it is difficult to determine what works and what does not work since those who complete suicide take much of that information with them, and many students who have suicidal ideation might be reluctant to reveal their thoughts or ideas about what might help, or what is not helpful to him or her for fear of being found out.

Prior to the conception of this study, and relevant to my personal loss, I had already conducted some independent research into suicide prevention programs. This research included speaking with some college counselors. Because of this personal experience and gathering of information, I formed opinions that created an inherent bias. When the determination was made to survey a cross-section of United States colleges, there was more likelihood that I could draw general conclusions and therefore avoid what might be regional variations or personal bias. The questions and/or statements were designed to demonstrate which components of suicide prevention programs were considered to be the most effective by the professionals charged with implementing and utilizing these programs on college campuses.

The survey (see Appendix A) was developed because I intended to find out how we can better protect older adolescents and young adults from the growing phenomenon of suicide. Originally it was my intention to work with survivors, generally first degree relatives or those very close to the deceased, in an informal group setting to discuss

journal writing and reflection and discuss what we may have missed with our own children. I wanted to know if there were signs, issues, words that stood out during each of our child's last days that might be helpful information for college counselors. I had to take a more conservative approach rather than study what was in my initial proposal (to work with families who have survived a suicide of a 15-24 year old) due to the Institutional Review Board rejection of my first several proposals.

The next best option seemed to be to survey the counselors who work with students every day and ask them what they perceived to work in their setting. My hope was that they would look at the program that they currently have in place, and draw conclusions about which components they thought were effective and which they did not think were particularly effective and make adjustments where necessary.

Methodologies

This study is a combination of multiple methods of qualitative analysis. There are elements of case study via survey questions and statements (about what is being done, and what is working or not working), as well as elements of ethnography secondary to my personal experience interspersed with the information gleaned from experts.

The qualitative data analysis (QDA) process was used for this research. This process suggests that the researcher is in a continuous process of thinking, noticing, and collecting (Seidel, 1998). This is a progressive process where, as one thinks about the information being gleaned, new ideas are emerging for new collections of information, and as the information is being collected, new aspects are noticed which may again lead to either further collection or thought or noticing. The dynamic pattern seems almost elegant in its simplicity with a pattern that perfectly fits the type of information being

collected. The data is coded to "facilitate discovery and further investigation of the data" (Seidel, 1998). The QDA process is depicted in Figure 7.

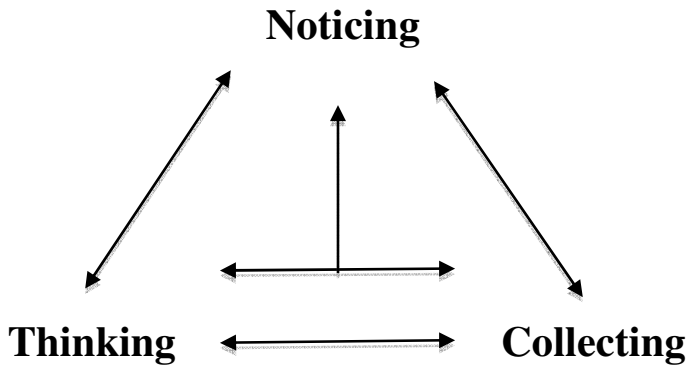

Figure 7. The QDA (qualitative data analysis) process adapted from Seidel, J. V. (1998).

All of the data from 64 responses to the initial survey as well as responses to the follow-up items were placed into categories, evaluated, and frequently reevaluated in the context of each of the other responses. This process of reexamining the information is the step that Seidel (1998) refers to as *thinking about things*. As a result of this reexamination, further information was requested from the colleges. Personal notes were maintained throughout the process to document results, personal reactions, biases, preconceptions, and comments by those surveyed.

Procedure

Since there seem to be regional variations in the data regarding suicide, it ultimately became apparent to me that there might be richer information by going out of the immediate St. Louis area for gathering survey responses. However, in discussions with my dissertation committee members, the initial decision was to stay within a particular region and if other studies existed, compare the regional results to determine

potential regional differences. Two issues emerged with regard to this plan: (a) the initial parameter was the St Louis area and surrounding counties, which would have offered little room for regional variations and, (b) response was very poor. Fifty surveys were sent to 50 college counseling departments of all types without consideration to program length, or educational programs available. No surveys were returned after an initial waiting period of 10 days. At 14 days, a new parameter was drawn to include a 200-mile radius and 100 additional surveys were sent to 100 different college counseling departments, which yielded two responses after another 14-day waiting period.

At that time, the decision was made to randomly select 150 four-year colleges and email survey invitations (see Appendix B) to the directors of the college-counseling program at each. The 150 colleges and universities were chosen from the United States Department of Education listing of the 2,476 four-year institutions in the United States both public and private. The colleges and universities were numbered. The list of numbers was placed in an Internet randomizer, which selected 150 numbers. The college names that correlated to the numbers were then contacted for email addresses for the counseling departments, if the email addresses were not listed. The survey was made available online by invitation with a direct Uniform Resource Locator (URL) to the college counseling director. The invitation and link were submitted to the colleges by email via an online survey software company. The survey company then electronically collected the information and the researcher was able to access the responses via a unique login and password. The college counseling director or designee completed the survey with the promise of anonymity. Therefore, the researcher was unaware which college's responses were being used, and there was no tracking of respondents.

Included in the email language was a commitment to send a copy of the results to participants who made a request via email. This would not break the confidentiality, as there was no way to determine which response was associated with any particular requestor. Participants were informed that they would receive these results upon request following completion and submission of this research, whether they chose to participate in completion of the survey or not. Within 24 hours of mailing the invitation and survey link, 30 responses had been received and 41 emails came back as undeliverable.

Participants

The invitations were sent to the directors of college counseling departments. Their names were obtained from each college web site and confirmed by phone call, although not all of the colleges had someone available at the time of the call to confirm the names. Seventy-four participant responses were received, with 10 eliminated with the first item regarding whether there was a suicide prevention program in place. Because 10 of the college counselors responded that they did not have a suicide prevention program in place, these 10 were automatically eliminated leaving 64 college counselors who completed the survey in its entirety.

Instrument

A seven-item survey was developed and sent to prospective participants as detailed earlier in this chapter. The survey items were developed after reviewing multiple suicide prevention programs from multiple colleges. The survey contained components of various plans including activities, education, and general actions. The dissertation committee reviewed and approved the survey, and a copy was sent with the IRB proposal prior to distribution to colleges.

Survey Items.

The survey is composed of seven questions or statements (items) in various forms, including "yes" and "no" items, measurement items similar to a Likert scale, and a final ranking item.

Item one. *We have a suicide prevention/student at risk program in place*. The first item served as an elimination tool. This study required that a college had a program in place in order to complete the survey. If the counselor responded to item one in the negative, he or she was thanked for his or her time and was not asked to respond to further items. If the counselor responded in the affirmative, he or she was automatically forwarded to items two through seven.

Item two. *How long has the program been in place?* Item two asked how long the college had had a program in place. There were several choices ranging from one year or less to five years or greater. This item lent perspective to how mature each program was, and additionally would indicate whether or not an update to the program would possibly have taken place since in many institutions, policies, procedures, and programs are reviewed on an annual basis.

Item three. *If 3 years or greater, how often are the programs reviewed or updated?* Because information changes often in the wake of an increased number of research organizations, availability or more literature, and increased media attention, best practice may change frequently as well. The third item inquired how frequently the program was reviewed and updated. This item was significant to understand how many programs were kept current.

Item four. *Using the following scale rate the effectiveness of the educational components of your program.* Rating scale four required very specific ratings related to what kinds of educational opportunities were employed to support the program, including (a) in-service at faculty orientation; (b) handout to faculty that lists specific warning signs; (c) email to faculty that lists specific warning signs; (d) training for resident advisors and resident directors regarding warning signs; (e) informational posters in housing, student union, newsletters, etc., with warning signs; (f) information on the student website with warning signs; or (g) other, with a blank for free text in order to describe the other components. Educational components are the initial phase of any program and likely to be ongoing.

Item five. *Using the same scale please rate the following activities related to your program.* Each of the activities was derived from literature and conversations with college counselors about what they provided. The education rating choices were as follows: not at all effective, minimally effective, occasionally effective, effective, very effective, or not applicable (N/A). Their choices were as follows: a) encouraging counselors to seek out students who are potentially at risk; b) encouraging educators to seek out students who were potentially at risk; c) encouraging students to seek out students who were potentially at risk; d) promoting education regarding identification of at risk behaviors and how to respond; and e) promoting education for staff/faculty regarding the identification of at risk behaviors and how to respond. The activities are different from the education because they are less formal and are meant to be just informational. This generally includes posters, signs, emails, text messages, and individual interventions by non-professional staff and students.

Item six. *I believe we have been successful in identifying students at risk.* In item six, I asked for a "yes" or "no" to this statement. This item was designed to ascertain to what extent the counselors believed they had an effective program. The responses received from this item led me to request further information regarding how they measured effectiveness in order to determine what was meant by *success*. I was curious to know if the definition held by the counselors was different from what the literature suggests and/or my idea of what would be a determinant of success. The results of this item can be found in the appendix and are discussed later in this chapter.

Item seven. *Rank the following components of your program*. Finally, the participants were asked to rank each of the suicide prevention components that they used from the most effective to the least effective. The components were as follows (a) initial education program for educators; (b) initial education program for students; (c) ongoing education for students; (d) ongoing communication to students; (e) ongoing support and education for educators; (f) evaluation of students identified and/or seeking assistance; (g) referral system (referrals to groups, outside counseling or hospitalization); (h) individual counseling program for follow up on identified students; and (i) other (which I requested that they list). These components were formal ongoing components that are hallmarks of a prevention program as outlined in much of the literature.

Follow-up items. *1) Please tell me how you measure the success of your suicide prevention program. 2) I expected that most schools would respond that they placed the most importance on student education programs for suicide prevention because so much literature supports this component, but this was not the case; in fact, student education*

ranked third and seventh in importance. Why do you think the other components are more, or equally, important?

As I read through the responses, I was very curious about the fact that so many counselors thought that their program was successful in the prevention of suicide. I wondered how they knew that the program was successful and secondly, I wondered why so little emphasis was placed on educating students. Therefore, I chose to send two follow-up items (see Appendix C) to the entire list for the most current survey. I could not narrow the follow-up to only those who had responded to the survey due to anonymity.

Fourteen responses to these follow-up items were received (see Appendix D) and the results are included in Chapter 4. Because the follow up items were in the form of open-ended statements, the participants had plenty of space in which to answer. The responses were requested to be in narrative form.

Data Collection

Of the 150 surveys sent, 41 were returned undeliverable. This left 109 surveys sent of which 74 responses were received. The numeric goal for survey responses was 50 college counselor respondents and this was exceeded by 24 survey responses. This gave a return rate of 68% (74), which exceeded the desired rate of a 30% (50) return. Sixty-four responded yes to item number one; this item was an elimination item that asked if the college had a suicide prevention program in place. The 10 negative responses caused those college counselors to be eliminated from continuation of the survey.

In the email notification requesting participation in the survey, I informed the potential participants that they could receive results of the survey by emailing a request to

me at any time whether they chose to participate or not. I received emails from 12 participants requesting to have results sent to them. Six of those 12 also requested a dialogue about their individual college's suicide prevention program once my research was completed. Each of the 12 college counselors who contacted me via email expressed interest in improving the programs that they already had in place.

Data Analysis

Coding was used for all results, including data, responses, comments, and information from literature via a simple list method maintained on a spreadsheet. Then each component was divided into categories and sub-categories. For instance, each of the responses to the survey was placed in columns according to item, and then sub-categorized into number and type of components used in each program, and finally, broken down further under categories of combinations of responses. Each of the totals for each of the components was also placed in columns.

The responses were reviewed for patterns and further items. Formal analysis was not completed until near the end of the study. A quasi-statistical approach was used to analyze the numeric data, while content analysis was used for all other data gathered. Charts and graphs were used to represent the numbers of responses and the sums of the responses to each item.

Authenticity, Reliability, and Integrity of the Study

Authenticity of the survey recipients was established during the initial emailing process by contacting the colleges to confirm email addresses for the counseling departments. Although many were returned undeliverable, it should be noted that many college operators had information that they stated they "assumed" was current, or if

transferred to the counseling department, there might only have been a generic voice mail. Voice mails were left with the remaining counseling departments requesting confirmation of the name of the person to whom a survey could be sent. Those calls were not returned. The returned emails validated that the information had come from the college server. Detailed notes were kept regarding responses both to the survey and follow-up items throughout the research process. Additionally, I did not reveal the personal significance of this study to the respondents.

Limitations and Assumptions

The first and most significant of these limitations is that I did not have the opportunity to interact personally with those who responded to the survey. The ability to have a dialogue about the survey might have gleaned more information and clarified some of the responses. However, it should be noted that I was able to obtain some additional information from counselors who chose to return responses to follow up items, or share insights with me in the form of emails.

Another limitation that has to be considered is personal bias of the counselors as well as individual agendas. Armed with the knowledge that the results of this study would be available to the counselors who requested it, this survey may have served to satisfy the counselors' own agendas and biases. This appears more possible in light of the inconsistency with responses. I would expect that if the responses were all coming from the counselors' general beliefs about the program, the responses would have been more consistent from section to section. Even though items four, five, and six are subtly different representing education, activity, and major component categories, I would think

there would be a consistent flow, that if something stood out in item four or item five, it would have been reflected in the more specific responses in item seven.

A final limitation is that there does not seem to be a consistent way of determining that a program is preventing suicide. Presumably, if a program does not work there are suicides. But in suicide prevention programs, prevention is not necessarily the only measure of effectiveness of the program. For example, one year there might be one suicide on campus, but no other documented attempts or completions; then the following year there might be no suicides on campus, but, six students identified as severely depressed, and when they arrive home over the summer they each attempt or complete suicide.

On paper it would appear that the first example is the ineffective program because there was an on-campus suicide and the second example would be considered the better outcome; this is because the college measures only on-campus activity. There are many other considerations that would reflect a program that works, such as students seeking out counseling, a decrease in the number of attempts, reduction in the number and severity of identified depressed students, decrease in alcohol and substance abuse, and improvement in the quality of relationships, to name a few. The wide range of potential program effectiveness benchmarks and no sound measurement methodology, was limiting.

Summary

This study was conducted using a survey methodology with a significant return rate of 68%. As responses were returned, the information was placed into a coding spreadsheet, and significant patterns began to emerge which could assist in demonstrating whether there is consistency in programs, and what components college counselors deem

most useful. Data analysis was ongoing as the information was received from the respondents. As the analysis was in progress, patterns began to emerge. Those patterns were noted on the coding spreadsheet. Each of the items, as well as each of the components of the items was summarized, and corresponding charts and graphs were developed. The results are discussed in the following chapter.

Chapter Four

Results

This was a qualitative study, evaluating college counselors' responses to a survey regarding college suicide prevention programs. In addition, some counselors responded to follow-up items requesting the rationale for the responses they had provided on the initial survey. Each of the items will be discussed individually in this chapter, followed by an overall impression of the results.

Survey Responses

The survey was comprised of seven statements or questions. Some items had more than one choice, and several asked for a ranking. One hundred and fifty surveys were sent via email and of those, 41 were returned undeliverable. Of the remaining 109, 74 responses from college counselors were received. Of these 74, 10 were eliminated in response to the first item as to whether there was a program in place. If the respondent answered in the negative, he or she was thanked for his or her time and was not invited to proceed with the survey. The remaining 64 respondents completed the survey fully. The survey addressed various components of suicide prevention programs such as educational offerings and activities.

Each of the items received a response from the 64 respondents. The responses to items four, five, and six on the survey prompted further items, which are also outlined and discussed in this chapter. After the first 45 responses had been received, it became clear to me that the responses were not as I had expected, therefore I took the opportunity to ask two follow-up items of the 64 respondents, which were answered by 14 recipients.

At the end of the survey, the final item required a ranking of what the literature supports as essential components of a suicide prevention program.

Item one result. *We have a suicide prevention/student at risk program in place.* Regarding the first item, 10 recipients responded that they did not have a formal suicide prevention program in place; the other 64 recipients responded that there was a program in place at their college. The results are illustrated in Figure 8.

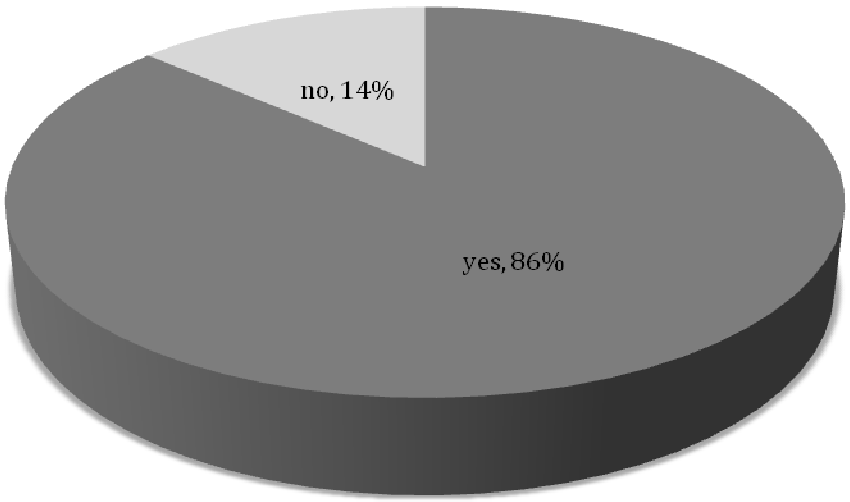

Figure 8. Item one results. Of a total of 74 surveys returned, 10 did not have a suicide prevention program in place. The 64 colleges that had programs proceeded with the remainder of the survey items.

Item one served as an elimination item. If there was no program in place, the respondent was thanked for his or her time and taken to an exit screen. The remaining respondents were taken to item two and beyond.

Item two results. *How long has the program been in place?* The results of item two showed that the majority of the 64 programs in the survey (51% / 33) were fairly

new, having only been in existence for three to five years. Twenty programs or 32% had only been in existence for one to two years and 17% or 11 had been in place five years or more. If the participant's program had been in place less than three years, he or she was not required to respond to the next item in the survey. Twenty programs were disqualified from this item by indicating that their program was only in existence one to two years. This means 20 of the colleges had just put programs in place in the previous three years, despite the fact that there has been a startling increase in student suicidal behaviors over the past 20 years. It should be noted that considering the fact that college suicide has been a growing issue over the last 20 years, surprisingly many in this sample had programs less than five years old as illustrated in Figure 9.

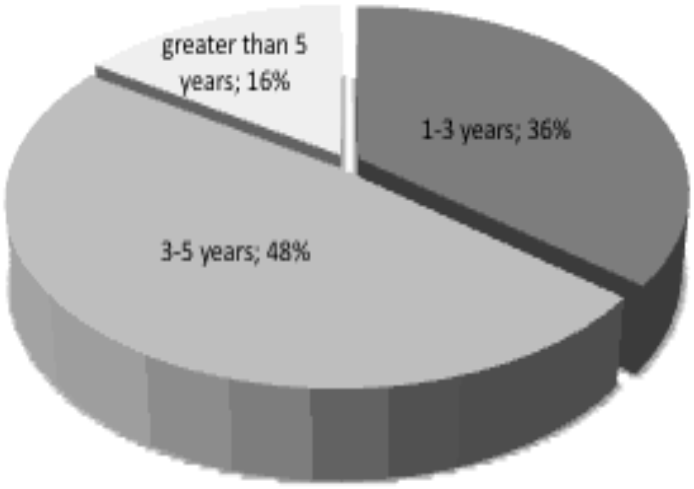

Figure 9. The number of years participating colleges have had a suicide prevention program.

Item three results. *If your program has existed more than 3 years, how often is the program reviewed or updated?* Because there were 20 colleges that had programs

less than three years old, only 44 counselors responded to this item. Table 3 illustrates that 25 of the 44 respondents to this item indicated that they review their suicide prevention program annually, 14 reviewed every two to three years, four reviewed every four years, and one has not reviewed their program. The advantage to frequent reviews is the ability to stay current with new information and best practices.

Table 3

Frequency of Review of Suicide Prevention Plans

Frequency of Review/Update	Percent Rank/Number
Every year	57% (25)
Every 2-3 years	32% (14)
Every 4 years	9% (4)
Program has existed at least 5 years and has not been reviewed/updated	1% (1)

Note. Item three results reveal that 25 of the 44 colleges responding to this item reviewed their suicide prevention program annually, while14 reviewed the program every two to three years, four programs were reviewed every four years, and one program had been in existence for at least five years but had not been reviewed or updated.

Item four results. *Using the following scale rate the effectiveness of the educational components of your program.* Different from activities, education is more directed and specific, and aimed at a target audience, as opposed to activities, which are more generalized. So for rating scale four, I wanted to know what kind of suicide prevention education was occurring at colleges. Table 3 indicates that 61 colleges trained

the resident advisors and resident directors regarding warning signs, 54 colleges used inservice time at faculty orientation, handouts to faculty, and placement of information on the student website as part of the education provided. Forty-eight colleges emailed warning signs to faculty and 41 sent informational packets.

Table 4

Education Used in Suicide Prevention Programs

Education	% and Number of Colleges Using This Component	
	%	Number
Training RA and RD regarding warning signs	95%	61
Inservice at faculty orientation	85%	54
Handout to faculty that lists specific warning signs	85%	54
Information on the student website with warning signs	85%	54
Emailing to faculty that lists specific warning signs	75%	48
Informational posters in housing, student union, newsletters, etc.	64%	41

Note. Item four results indicate how many of the respondents use the activities listed. Most significant is that most of the 64 colleges use Resident Advisor and Resident Director training, and focus less on education of faculty using online media or placement of information in frequented student areas.

Item five results. *Using the same scale please rate the following activities related to your program.* An activity is something that requires action. The activities in item four are common in the literature and used in many of the programs of the colleges represented in the survey. Forty-four of the responding counselors acknowledged that

they communicated a list of warning signs (i.e. withdrawal, aggression, increase in alcohol or illegal substance use, etc.) to faculty via email, and 95%, or 61 of the 64 colleges, said they trained the resident advisors and resident directors regarding suicide prevention. Forty-one counseling departments placed informational posters in strategic places around the campus. All 64 counselors responded to each aspect of this survey item.

Many activities take place on college campuses related to suicide prevention. Some of the activities that were discussed in literature and were currently being used on some college campuses were represented in item five. Because the literature suggests that student education is imperative, I assumed that all college programs would have a student education component. As a result, I expected that most schools would respond that they placed the most importance on student education programs for suicide prevention because so much literature supports this component, but this was not the case; in fact, the two components that included student education regarding signs of suicide risk ranked third and seventh in importance. When asked why they thought the other components were more, or equally important, the responses varied from, “It may be hard to get into the classroom to train students” or, “Easier to get in to faculty meetings and faculty orientations” to, “Worried about students affect and maturity to tolerate concerns surrounding suicide”. There was one activity, “encouraging counselors to seek out students who are potentially at risk” that two counselors deemed as “not at all effective”. Twenty-six counselors thought that “promoting the education of students regarding identification of at-risk behaviors and how to respond” was the “most effective” activity.

The largest area of agreement was that "educating staff/faculty regarding the identification of at-risk behaviors and how to respond" was an "effective" activity, although this appears to be in stark contrast to the responses to item seven which indicated that staff/faculty activities was not as important as counselor activities. Twenty-five of the counselors attached a high score to encouraging students to seek counseling, once again supporting the notion that counselors believed that activities performed by or through counseling were more effective overall. The results for item five are illustrated in Table 5 on the following page.

Table 5

Perception of Effectiveness of Activities Related to the Suicide Prevention Program

Activity	Not at all Effective % (Number)	Minimally Effective % (Number)	Occasionally Effective % (Number)	Effective % (Number)	Very Effective % (Number)	N/A % (Number)
Encouraging counselors to seek out students who are potentially at risk	3.1% (2)	7.8% (5)	20.3% (13)	43.8% (28)	15.6% (10)	9.4% (6)
Encouraging educators to seek out students who are potentially at risk	0.0% (0)	10.9% (7)	23.4% (15)	53.1% (34)	12.5% (8)	0.0% (0)
Encouraging students to seek out students who are potentially at risk	0.0% (0)	4.7% (3)	20.3% (13)	42.2% (27)	31.3% (20)	2.0% (1)
Promotion of education of students regarding identification of at-risk behaviors and how to respond	0.0% (0)	0.0% (0)	4.7% (3)	53.1% (34)	40.6% (26)	2.0% (1)
Promotion of education of staff/faculty regarding the identification of at-risk behaviors and how to respond	0.0% (0)	3.1% (2)	12.5% (8)	54.7% (35)	29.7% (19)	0.0% (0)
Encouraging students to seek our assistance	0.0% (0)	0.0% (0)	18.8% (12)	42.2% (27)	39.0% (25)	0.0% (0)

Note. Item five results indicate how the respondents ranked the effectiveness of each of the activities that supported the components. N/A indicates that this activity was not part of a college's suicide prevention program.

Item six results. *I believe we have been successful in identifying students at-risk.* As illustrated in Figure 9, item six asked counselors to state whether or not they thought that their suicide prevention program was being successful in identifying students at risk. Sixty-one, or 95% of school counselors stated "yes" that they did think that their program was being effective in that regard. The results of this item were the impetus for asking a follow-up item regarding how effectiveness of the suicide prevention program was measured. Those responses are outlined later in this chapter. The results from item six are illustrated in Figure 10.

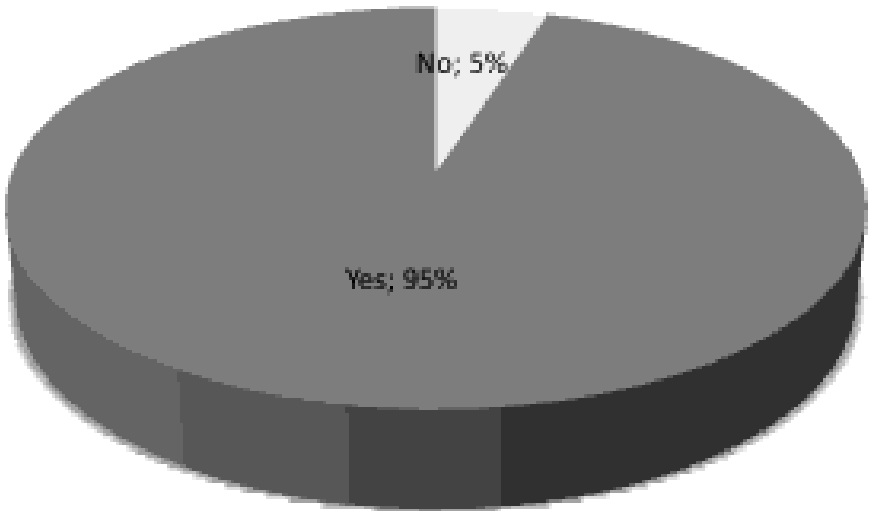

Figure 10. Illustrates the results for question 6 which states I believe we have been successful in identifying student at risk.

Item seven results. *Rank the following components of your program.* The results of item seven indicated that individual counseling was considered the most important component of the list of eight suggested components, while the second highest rated was evaluation of students who sought counseling, both of which were activities

performed by the counseling department. This is also supported in item five where 25 counselors deemed students being encouraged to seek out counseling as an effective component.

Counselors rated program components much lower when they were related to a student or faculty activity. Individual counseling was rated the highest, although research indicates that getting students to counseling was an issue. If the counseling department is unsuccessful in creating an atmosphere in which students feel comfortable attending counseling, then counseling effectiveness is a moot point. It can only be effective if students attend.

Table 6

Importance of Program Components of the Suicide Prevention Programs

	Components	% Ranking	(#)
1)	Individual counseling program for follow up on identified students	26%	(17)
2)	Evaluation of students identified and/or seeking assistance	20%	(13)
3)	Initial education program for students	14%	(9)
4)	Initial education program for educators	11%	(7)
5)	Referral system	9 %	(6)
6)	Ongoing communication to students	8%	(5)
7)	Ongoing education for students	7%	(4)
8)	Ongoing support and education for educators	5%	(3)

Note. Item seven results, which are the ranking, by considered importance, of the components of a suicide prevention program. Seventeen counselors, or 26%, thought that individual counseling programs for follow-up of students identified to be at risk was most important.

Results of follow-up items. Regarding item six, which was a statement regarding whether counselors thought their program was effective, 90% of responding counselors responded in the affirmative. As a result, I felt that a follow-up item was probably necessary since I had found in the literature no discernable way to measure effectiveness of a program. The follow-up items were (a) *Please tell me how you measure the success of your suicide prevention program, and, (b) I expected that most schools would respond that they placed the most importance on student education programs for suicide prevention because so much literature supports this component, but this was not the case; in fact, student education ranked third and seventh in importance. Why do you think the other components are more, or equally, important?* I expected that the results of this survey would indicate that counselors thought that they had a superior program, largely because as the *keepers* of the program, there would be bias. Regarding item six, which was a statement regarding whether counselors thought their program was effective, 90% of responding counselors responded in the affirmative. As a result, I felt that a follow-up item was probably necessary since I had found in the literature no discernable way to measure effectiveness of a program.

After receiving those results, follow-up items were sent to the same 64 counselors regarding how effectiveness was measured, to which 14 responses (see Appendix D) were received. The responses ranged from, "I feel it was successful" to the following:

> We (the college) use the following: Certain questions on the National College Health Assessment (NCHA-II), certain questions on the Missouri College Health Behavior Survey (administered by Missouri Partners in Prevention), intake items at the Counseling Center (e.g. what brought you to counseling), tracking analytic

> data on website (traffic, items downloaded, etc.), behavioral Intervention Team data (number of students through BIT processes for suicidal ideation, etc.), and focus groups. (Appendix D)

From the varied 14 responses, the respondents showed that there was no one clear way to measure the effectiveness of a suicide prevention program. It would be very difficult to determine what worked and did not work since there was no real measurable information available, and the information that would potentially be most helpful often died with the student, or because students who had been prevented from attempting suicide were often reluctant to answer questions. In fact, many programs had little measure for their effectiveness even in narrative form as typified in this response, "Number of participants in programs and increase in campus wide resources" and a very simple "I feel it is successful". Others attempted to have more significant measures such as, "Number of participants who attend programs, change in the number of inquiries received about suicide, change in the number of messages reporting concern about a student". Several determined effectiveness in terms of training such as in this response:

> (It is) difficult to measure outcome because often times the verification is through personal narratives and given our campus size, 28K students, it is hard to quantify the personal narratives. Mostly, just track the number of gatekeeper trainings and how many people are trained. As of today's date over 5,000 students, faculty, and staff on our campus have been trained as QPR Suicide Prevention gatekeepers.
>
> It appeared that there was not a consistent way to measure program effectiveness, and that colleges use whatever indicators of effectiveness they had available to measure the success of their programs. (Appendix D)

Summary

This study used a survey to find out what components of suicide prevention programs that college counselors felt were most effective in identifying students at risk. Sixty-four of the 74 respondents indicated that their college did have a program in place. Those 64 voluntarily responded to a seven-part survey. The results were not consistent and lent little initial insight into what works and what does not work, nor did they show consistent patterns with which components were being used. This corroborates what I was seeing as the results were coming in, that we simply do not know what constitutes an effective program. Overall, the survey left more questions than provided answers, which gives a better sense of what is happening in higher learning institutions related to suicide prevention. In Chapter 5, I discuss my own experience, the inconsistencies in the responses from the 74 colleges across the country and what the responses mean in the context of the literature.

Chapter Five

Reflections

Inspiration for This Research

This study held a significant personal interest for me. Three years ago, at the time of writing, I lost a 19-year-old child to suicide. The road that ultimately led to his death was a jagged, sometimes beautiful, and occasionally horrific path. Daniel dealt with many demons during his 19 years on earth; at an early age he was deserted by his biological mother, bounced between homes, and never quite secure in any of his relationships. He fought depression and anger control issues that would frequently get the best of him. He was too involved, too soon, in a romantic relationship that ended before he was ready or willing to let go. This was the final blow to his already fragile psyche and would take us through seven months of dizzying ups and downs, threats, and an attempt to take his life, until he ultimately ended his life on October 6, 2007. Daniel was not yet in college, was in the process of enrolling, but was at the age of the group in which I chose to focus this research. I realized after he was gone that there were signs that I missed, things said and left unsaid, questions unanswered, and behaviors observed and unaddressed.

It was during this reflection that I received some very good advice about the direction for my dissertation, and it seemed right to me that, because this degree was in education, the focus should be on college students who suffer the same angst that Daniel had and are at an age where they are coming to terms with their adulthood, while leaving the things of childhood behind; an age where they are not quite ready for the

responsibilities of being a grownup, but they are no longer children. This is the plight of the average 17-24 year old college student, and the ability to cope with the stressors of being this age, along with the additional responsibility of being a college student, warranted a good look at what colleges are doing to identify those students who are most at risk, and further, what the institutions are doing right, what is or is not going well, and to answer the question of whether anything worthwhile is being done at all. I learned through the pain that confronting the behaviors and seeking advice about how to deal with Daniel would ultimately have been less difficult and painful than dealing with the aftermath, the blinding pain of emptiness and second-guessing, and the searing need for a second chance. This work in many ways is my second chance.

Examination of Results

When I began to conduct this study I expected to find that most programs were similar. It was surprising to find out how different most programs were when compared to one another. By the time I got deep enough into the literature, I realized that there was not a widely used template for colleges to follow, although some organizations such as The Jed Foundation, which has a college suicide prevention program, and the American Foundation for Suicide Prevention, which has multiple tools for college students, are both readily available, well researched, and based on best practice. Most of the colleges reviewed have only some of the components including the education and activities mentioned in the survey, but not all. None of the respondents had all of the elements.

Item one. *We have a suicide prevention/student at risk program in place.* With media attention and so much information available to colleges, I was very surprised to find that 10 colleges, or 14% of the colleges, surveyed did not have a suicide prevention

program in place. This does not necessarily mean that they do not have any psychological services and I did not ask for clarification, but the fact that there was not a program specific to suicide was not what I expected to see.

Item two. *How long has the program been in place?* Only 17% of programs have been in existence five years or longer. About one-third of the programs have been in existence for one to two years. It should be noted that considering the fact that college suicide has been a growing issue over the last 20 years, it was surprising that so many in this sample had programs less than five years old since literature indicates that suicide in colleges has been on the rise over a 20-year period. It would be interesting to find out what, if anything, the colleges were doing prior to these formal programs. It would also be interesting to know what motivated each of the colleges to put a program in place, such as a specific event or events, publications, professional organizations, seminars, etc. If motivated by a specific suicide or threat of suicide event, there is a lesson to be learned about being proactive rather than reactive in changing lives, which also is apropos to the next item.

Item three. *If three years or greater, how often is the program reviewed or updated?* I expected that all programs would have an annual review because there has been so much media attention given to college suicide recently, and therapies, treatments and educational approaches change constantly. Of the 64 programs in the survey, 51% or 33 were fairly new, having only been in existence for three to five years. Twenty programs or 32% had only been in existence for one to two years, and 17% or 11 programs had been in place five years or greater. With college suicide rates on the rise over the past 20 years and available resources, like the Jed Foundation, CHADS

Coalition, and the American Foundation for Suicide Prevention, there is good reason to perform annual reviews. Frequent reviews would allow colleges to adapt their program to new information and best practices. Like the previous item, it would be interesting to know if the reviews that did take place were scheduled reviews or if reviews occurred secondary to specific events. If review and/or change in the program occurred secondary to an event, once again, the college is likely to require a change in their practice from being reactive to being proactive. By reviewing current best practice, reviewing the literature, and attending educational offerings by suicide prevention organizations, particularly those organizations specifically designed for college-aged students such at The Jed Foundation, CHADS Coalition, or The Trevor Project, colleges will be in a position to alter their programs to reflect necessary changes. In order to be optimally effective, programs have to remain up to date and reflect current best practice.

Item four. *Using the following scale, rate the effectiveness of the educational components of your program*. Most of the colleges responding to the survey used the educational components on this list. Item four demonstrates that 61 colleges train the resident advisors and resident directors regarding warning signs, 54 colleges used inservice time at faculty orientation, handouts to faculty and placement of information on the student website as part of the education provided. Forty-eight colleges email the list of warning signs to faculty and only 41 utilize a multi-medium educational approach directed at students.

The fact that literature supports student education as an effective strategy should be the impetus for colleges to put something in place that is shown to be effective. I was quite surprised, since the whole idea of a suicide prevention program is to reach students,

that the student body was not the primary target for education, and in fact the counselors themselves were the primary focus. Counselors say that the most effective component is one-on-one counseling. The problem is that most students are unlikely to seek out counseling without an adequate outreach program. If the students are educated and encouraged in a non-threatening way to seek assistance, I believe the chances are far better that there would be an increase in students seeking the assistance of the counseling department.

Item five. *Using the same scale please rate the following activities related to your program*. Few counselors thought that these components were not at all effective or minimally effective, and although they did not all agree on what was effective, the fact is that, for the most part, all of these activities were deemed by many of the counselors as effective to some degree. In stark contrast to their responses to item four, almost half of the responding counselors indicated that teaching students to identify other students was the most effective activity. So while counselors believed that their counseling activities were most important, they also recognized that student education must be central to the suicide prevention process. In other words, counselors cannot counsel students if students do not know the warning signs and how to access help from the counseling department. The responses would indicate that there is not a consistent focus across the colleges for the suicide prevention programs.

It appears to me that the best option is to design a focused, forward-facing program that is aimed at engaging students in the program processes. Some of the colleges might have such a program in place; it would be difficult to know from the answers provided in the survey.

Optimally, students should receive education in identification and crisis intervention, and should be given the latitude to intervene and make decisions about whether to report issues to the counseling department without fear of retribution or concern that they are *causing* a difficult situation for friends and classmates. The counseling department can achieve this by being a body of inquiry and education and not being purely reactive. This can be a fine line that the counseling department might struggle with but it can be navigated by keeping current with literature, attending further educational offerings by specialized college suicide prevention organizations, and by communication with other institutions of higher learning via their professional organizations.

Item six. *I believe we have been successful in identifying students at risk.* In item six, I asked for a *yes* or *no* to this statement in order to ascertain to what extent the counselors believed they have a successful program. No suggestions or choices were given. Since 90% of counselors indicated that their program was effective, this item needed to be followed-up. Having full confidence in the effectiveness of the suicide prevention program's success would beg the question "How could your college prove that a program to prevent suicide is or is not effective?" I would have been interested in whether the measured results that were given to college administrations are an accurate portrayal of what the counselors were actually seeing, or if these measures were simply a way to satisfy the university administration's requirement to report results.

Item seven. *Rank the following components of your program.* Understanding that when items are being ranked, something must be first and something must be last, I was still surprised that there was not a more even distribution. The last two components,

which are supported in the literature, are used by only 5-7% of the colleges compared to the first two components, which were used by about one-fourth of the colleges. This item shows that 46% of the counselors thought that activities that they perform such as evaluation and counseling, were the most important components. In some ways counselors justify their position by claiming that activities such as individual counseling and identification are the most important.

If I could rewrite this survey, I would have phrased this item differently. I would have asked counselors to reflect on the responses to items four and five before responding to item seven. I believe that if they had responded to the item in context I could have had a much clearer picture of what they really believed was working. There is a possibility that counselors responded in the way they felt obligated to respond as counselors. By choosing the other options as most significant, they possibly felt that they were devaluing their own job.

Follow-up item one. *Please tell me how you measure the success of your suicide prevention program.* This particular item yielded a wide variety of responses from 14 college counselors. This item was developed in response to item six, which asked if the counselors considered their program successful. When I noticed that the responses were overwhelmingly affirmative, I wondered how the counselors felt they knew that the program was effective. I provided a free text response box. The most comprehensive response of the 14 received was also the most telling:

> Success is a variety of things in this work, and it depends on the objective. The ultimate objective for us is to create momentum for change in attitudes of the total community of (our college) positively toward mental health, and along the way to

> increase ease and knowledge in communicating about issues related to suicide. So we measure success by numbers of participants, evaluations of activities, knowledge change six months after training activities, anecdotes of behavior change or stories about special contacts, as well as positive relationships and behavior change among students who have been actively suicidal and receiving treatment from our mental health counselors.

While it was apparent from the responses that most of the college counselors responding to the survey had some type of metrics, several of the counselors surveyed equated clinic visits with effectiveness and without criteria or some other sort of measurement such as pre and post testing and/or assessments.

Follow-up item two. *I expected that most schools would respond that they placed the most importance on student education programs for suicide prevention because so much literature supports this component, but this was not the case; in fact, student education ranked third and seventh in importance. Why do you think the other components are more, or equally, important?* Overall the responses to the initial survey were so varied that it was impossible to glean much usable information; therefore I again requested follow-up comments.

I anticipated that a theme would emerge that would show gaps. This would have presented an opportunity to further research components that could fill in those gaps. However, what I saw was inconsistency. My concern is that programs were in place simply for the sake of having programs on record rather than having meaningful strategies that are actually used and best address the needs of students at risk. More focus on those things that studies indicate are likely to work, like student-focused education and

activities, surprisingly are not the things seen by counselors as significant. For the most part, there is no clear connection between the literature and the practice.

Implications of the Findings

The fact that overall there were few areas where there was consensus about what works and what does not work is an indication that there are imponderables that should be addressed. Since it is virtually impossible to measure effectiveness with any degree of accuracy, it will be difficult to determine what the ideal program will look like. Although several components are similar, and similarly rated, there was not a high enough rating of any of the components to indicate that any particular element consistently seems to work. Although there is no definitive measurement, it makes sense that the counselors at least have the appropriate knowledge and experience to have a *feel* for what is working.

The survey results could be used to assemble a list of the highest rated components that in combination could be a model for development of a program that is consistent across higher learning institutions. If the most highly rated components were used as additions to a general mental health approach, and presented in a *user-friendly* environment, this would possibly produce a program that works. Such a non-threatening and less complex model could potentially yield much better results because using this approach might mainstream the process and make it seem less intimidating to students. With regular program reviews, the program design could be altered as results become available.

If I were to conduct the same study (study of the components) again, I believe that it would be more effective to conduct face-to-face interviews with college counselors and with students to ascertain their impression of not only what works in their estimation, but

also why they believe it works. It would be interesting to know if there were other components that counselors are using besides what was listed in the survey and if those contributed to the perceived effectiveness of their programs. Interviews would also allow further inquiry and discussion for clarification of responses. Additionally, I would spend more time on the subsections of the causes of suicide and how each of those causes (discussed below in Discussion and Recommendations by Cause) is addressed in the individual programs, or in other college counseling programs and not attached to the suicide prevention program.

Discussion and Recommendations by Cause

In Chapter 2, major causes for college student suicide were introduced and discussed by category. For each cause presented, there were multiple suggestions presented in the research. From that research and the suggestions it yielded, I was able to make some recommendations that may help to combat college student suicide.

Depression, suicidal history, and hopelessness. It would be very helpful when developing a program to know how many students come to college with depressive symptoms as opposed to how many develop symptoms once they are in college. This information could be helpful so that the focus of identification and prevention could be placed more on identifying students on admission and not just through the school year. For instance, if it could be shown that more students begin college with a significant history of depression, programs might contain more emphasis on discussion during first year orientation activities regarding support groups and counseling, or even sending information with acceptance letters each session. Conversely, if students more often develop symptoms of depression after they begin their college experience, the emphasis

would be placed on education and intervention activities throughout the school year, with particular emphasis on the periods just prior to high stress times (i.e. mid term and final exams).

Alcohol and substance abuse. Alcohol and substance abuse is an issue that I had not anticipated would be so severe on college campuses. Like most people, I was aware of "frat parties" and underage alcohol use, but until I began this research it was not clear that this is an issue of epidemic proportions. This problem is more than just finding students having the occasional weekend "kegger", but extends to issues of regular and addictive consumption of alcohol and drugs. It has become a rite of passage for college students to drink excessively and it is commonplace to use drugs. With drug and alcohol abuse so closely linked to depression and suicidal behavior, colleges have to take a stand regarding this and dedicate the resources necessary to address the underage use, and the general overuse of alcohol. Regular monitoring of fraternities, sororities, dormitories, and common student campus hangouts as well as engaging local law enforcement in monitoring local establishments is essential. Providing frequent and dramatic education regarding the danger of abuse is necessary. Presentations from organizations such as Mothers against Drunk Driving (MADD), the American Foundation for Suicide Prevention, CHADS Coalition or other local college counseling organizations, local treatment facilities and law enforcement could be scheduled on a regular basis, or made mandatory as an online or in class educational opportunity. Making Alcoholics Anonymous, Alateen, and Al-Anon meetings available to students both on-campus and off campus, having on-campus support groups, making agreements with local treatment centers for outpatient treatment, developing *check in* programs at the counseling center

are all viable options for colleges. Some employ these methods; others provide only one or two options, and some leave it solely to students to seek treatment if they feel it is necessary.

Relationships. Relationships are difficult under the best of circumstances, and more so when there are pressures and changes going on in the students' life. Addressing relationships by presenting education, advertising the availability of individual, and couples counseling availability and keeping information regarding domestic abuse identification and counseling in front of students is essential. Education for suicide prevention should include recognition of signs of domestic abuse. Resident advisors and resident directors in particular should be trained to recognize the danger signs of abusive relationships.

Sexual identity issues. In some ways we, as a society, are becoming more enlightened. Some states are legalizing same-sex marriage; some have allowed domestic partners to be insured under their partner's policy. In many ways, however, society as a whole has not advanced. Lifestyles different from the majority are more accepted in general but continue in many ways to be stigmatized, potentially resulting in bullying due to fear, religious belief, or ignorance. Lesbian, gay and bisexual students might be subject to ridicule, isolation, and physical abuse if there is a culture of intolerance. Creating an atmosphere of tolerance, discouraging, and if necessary punishing students for aggressive or otherwise inappropriate behavior toward LGB students is not only the enlightened thing to do, but critical for saving lives. There are stories throughout the media on a regular basis of students being harmed, or harming themselves due to intolerance. All suicide prevention programs should have a tolerance component.

Academic concerns and pressures. When grades become an issue for students, they often do not know where to turn, and when coupled with concerns that parents will be upset, that their financing may be reduced or discontinued, or that they may have to repeat classes, students can develop immense anxiety and depression. Communication and the offer of assistance, rather than taking a punitive approach, can diminish some of the anxiety. Information regarding how to deal with financial issues and grade issues can be placed on the parent web page. Making tutoring and counseling available and training faculty to offer these options would potentially ease some of the burden of concern for students who are performing poorly.

The implications of cheating have to be strongly reinforced at the beginning of each course, and a reminder given with written assignments and tests. Repetition will reinforce the importance of avoiding plagiarism and other forms of cheating, and may make students more cognizant of the fact that there are serious consequences to their actions. The implications of cheating such as grade sanctions or expulsion, can be devastating and can set up a scenario where students can become depressed enough to consider suicide. The more the college can prevent this from happening—with the realization that in some cases it will still happen—the better chance there is that students at risk will get the message that serious offenses have serious consequences, so at the very least students will not be surprised if they are caught cheating.

Social media and the Internet. It is not possible to monitor Internet use or content without violating the student's privacy. But there are some activities that can be attempted. Schools can offer socialization opportunities for students based around interests that may not necessarily be mainstreamed. Students who isolate themselves and

have little or no interest in college happenings might respond to activities that are designed to include the interests of all groups. Then students may be drawn out of their rooms and onto the locations of the various gatherings. Asking the resident advisors and resident directors to gently push students who isolate themselves and do not socialize well may help with getting the student to attend. Thinking outside the box and offering activities such as game nights, video or computer game competitions, movie nights, volunteer projects, study groups, and other non-threatening activities that play to the student's need to not feel forced into communication, may help to avoid internet addiction and the isolation that comes with it. Training resident advisors and resident directors to watch for isolation behavior and to recommend activities to these students, or even to host those activities can be the first steps.

There are many positive uses for the Internet, so it should certainly not be construed that use of the Internet is a negative activity. In fact, one positive use for the Internet would be as a screening tool for health issues, including mental health, and could include a mandatory suicidal risk screening using a standardized screening tool. An example of a screening tool can be found in the appendices of this document (see Appendix E). Education in the form of interactive *games* or challenges could be developed for students so that screening and education are not viewed as tedious.

Further Discussion

While it is believable, as the surveys indicated, that counseling is the most effective aspect of a college suicide prevention program; literature suggests that getting students to attend counseling is a challenge. Until students feel safer disclosing their history, or self reporting depression, suicidal history, suicidal ideation, hopelessness,

substance abuse, or any other risk factors, emphasis has to be placed on a program that delivers the message about getting help. The program should be delivered during all phases of the college experience.

Generally, there is concern that depression begins after the student begins college, negating the belief that students who have depression arrived with depression. Categorizing when and where the student's depression began is futile, although some attorneys see this as a point of liability. Instead of being concerned with the *chicken or egg* argument, the college should be concerned with getting the appropriate treatment to students instead of spending too much time trying to ascertain whether the student was having symptoms before he or she arrived at the college. In the scheme of things it really does not matter because the goal is to aid the student and prevent a devastating outcome. The suicide prevention program emphasis should be placed on identification of students at risk throughout the academic year, with particular emphasis on support during those common stressful events such as exams and grades. Colleges might consider investing in prescreening products that students can complete at the start of each academic session. Some colleges have made this mandatory, and although I do not necessarily agree with "forcing" students to reveal their history, it would certainly give focus to the prevention and identification efforts if there were a mental health history obtained on each student. Perhaps the logical thing to do would be to give incentives to students for compliance with completing the evaluation. The incentive program could be accomplished by giving meal vouchers, or bookstore gift cards (or some other enticement that the majority of students might find valuable enough to induce compliance) in exchange for their completed assessment.

Unless students feel completely safe in revealing their mental health history to the college, it is unlikely that obtaining accurate information regarding their mental health history will occur for the majority of students. Additionally, students have to be in an environment of acceptance and encouragement so that they feel non-threatened if they choose to come forward to ask for help. Students are likely only to believe they are safe to report if the college develops a history, and hence, a reputation for being helpful and not punitive. Obviously, if students think that they are going to be sent home, or parents are going to be notified, they are less likely to believe that the college is acting in their best interest.

When I was researching four-year college programs via an Internet search, I began to wonder what community colleges do in regard to suicide prevention. I assumed that because they were only two-year colleges, there would not be comprehensive suicide prevention programs in place. However, I discovered that many community colleges, including the local community college in my area, St Louis Community College (SLCC) have programs. SLCC has a program for suicide prevention education on their main website found under *student resources* and then *counseling*. The impressive thing about this is that it appears to be as well done as any of the four-year college programs that I investigated. There is not only good general information with resources, but also crisis intervention information. This comprehensive program could serve as a model for other colleges.

Other Countries

In countries other than the U.S., suicide is also being studied, with some very interesting results. One fascinating study from Europe looked at *social capital* and

suicide. The findings reflected that connectedness and trusting social relationships resulted in people being less likely to attempt suicide. But perhaps most interesting is the notion that if one has *social trust* in their country, there is an inverse relationship to suicide (Kelly, Davoren, Ni'Mhaola'in, Breen & Casey, 2008). This does seem to support the fact that relationships and feeling secure in their environment might be a factor for students here in the U.S., but this would have to be studied further. The social capital study also indicated that trust in government is essential. This means that people believe that the government is working for the people and not "out to get them". Feeling secure in the government that oversees the homeland allows people to go about their business without feeling overwhelmed with paranoia about the government. How to achieve this goal has been a mystery to politicians for years.

There are several Asian studies related to Internet usage and suicide, one of which was discussed earlier in Chapter 2 of this dissertation. There is also a study from Vietnam that reminds the readers that a significant suicide prevention tool is teaching students how to deal with life stressors (Huong, Guo-xin, Tuong, Duc Pham, Hans & Wasserman, 2005). A study from India explored the cross-cultural differences in feelings of hopelessness related to gender roles. The countries studied were India and the U.S., and significant differences were found (Upmayu, Upmanyu, & Lester, 2000). Studies such as these can lead to further exploration about why differences exist in the statistics, prevention programs, suicide methods, and kinds of stressors related to college students, which may lead to new ways to prevent suicide. There are studies from most major countries available and should be used to evaluate suicide prevention programs here in the United States.

Politics on the Campus and the Military

Like the 1960s, politics and students are mixing and clashing. Student activism is on the rise on what were fairly docile campuses in the 1980s and 1990s. Whether a person agrees with the political viewpoint being touted by the students, it is difficult to dispute the fact that there is power in their numbers and their passion. I would like to see colleges capitalize on this passion and ask them to use their momentum to help prevent bullying, abuse, substance abuse, etc. Of course, then there is the issue of the other politics; the politics of campus administrators who would prefer to see students not using their power and passion. Similar to any other business, there are politics of rank, struggles for departments to get what they perceive is needed to do a more effective job. In a private conversation with a college counselor, she divulged to me that they are not always given the resources required to do as effective job as she believes the counseling center could do to address depression and substance abuse in particular. These struggles can also work in favor of the counseling department as one of the counselors who responded to the survey stated "There are also political and funding benefits to talking directly to faculty (e.g. they often had a loud voice to the president) and keeping counseling issues in the foreground just makes sense."

While the military has taken historical steps to prevent suicide as it continues to rise to historical proportions, there was a task force last year, dispatched by Congress to evaluate the current program. "The report, sent to Defense Secretary Robert M. Gates, makes 76 specific recommendations" to improve the program, according to the Associated Press (The Washington Post, 2010). It appears that the government, after long ignoring the issue, is taking it much more seriously which may be the result of the

over 1,100 deaths in the four-year period between 2005 and 2009. The new military model, still in progress, might offer components that can be used for college campus programs.

Measurement

What is considered effective may vary. The real measure of success is no suicides, and some day that may be a reality. Until that time, however, a general system of measurement may be helpful, particularly if an institution uses the same measures consistently so that they can compare their results month-to-month and/or year-to-year. Some of the measures that could be used include any combination of the following:

1. Percent of students who attend educational offerings
2. Percent of staff/faculty educated annually
3. Number of educational opportunities
4. Program review completed annually (including review of literature and current practice information from prevention organizations)
5. Number of students who attempt
6. Disposition of those who attempt:
    a. Treatment Center
    b. Home
    c. Hospitalized and returned to school
    d. Hospitalized and returned home
    e. Private practice practitioner
7. Subsequent attempts and disposition
8. Number of completed suicides

9. Percent of students who complete the annual assessment

If all colleges used the same measurements, benchmarks could be established so that programs would be compared using data as the determinant of effectiveness. Colleges could adjust their programs according to results and best practice information based on statistical findings.

Summary

There were no definitive answers found in the survey, which may be a hint about what needs to be done. Perhaps colleges should take stock of their programs and determine, based on some solid data, what is working and what is not. Those components that are in place and are known by counselors to be ineffective should be stopped and replaced with components that have shown even mild promise. As effective evaluation programs are put into place with solid data, components can be shifted, eliminated, and replaced.

Perhaps the ideal situation would be the standardization of a single program, which is based in research, utilizing best practice, and capable of being used across all campuses with variations for regional or college-specific contexts in addition to, not in place of, the standard components. The common component data could be warehoused and benchmarked. Annually, a panel of experts could evaluate the data and change the program based on what is showing as effective in the data. This takes the guesswork out of establishing a plan. Because even though several organizations have plans in place, the plans are not exactly the same, which indicates that we have many different ways to construct programs. Ultimately, we may find that multiple programs with various components could be effective in suicide prevention, but must have a starting point for

measurement. If overseen by experts, a program that works could be developed over time. While I do not believe that college student suicide can be completely eradicated, I do think that standardized programs could significantly reduce the incidences of suicide across U.S. college campuses. But, there is much more work to be done. In the next chapter, I will discuss some ideas that could be further explored, as well as some personal reflections regarding this study.

Chapter Six

Going Beyond the Study

As I began writing the fifth and presumably final chapter of this dissertation it became apparent that I was not finished. There is still a great deal to be said about the phenomenon of suicide and what could be done about it on college campuses across the United States. There is a plethora of writings, groups and blogs related to the impact of suicide, but not enough of it is used to glean information that could be helpful to combat suicide and assist those who are at risk and those left behind.

There are several organizations devoted to research and education, most notably the American Foundation for Suicide Prevention (ASFP), the International Association for Suicide Prevention (IASP), Suicidology.org, The Jed Foundation, The Trevor Project, and CHADS Coalition (see Appendix F). Several have programs, or aspects of programs, aimed at college student suicide. Some have study information and discuss best practice in addition to an abundance of resources and educational opportunities. It is from this information that I wish to draw some conclusions about the current state of suicide prevention, discuss what works in the real world regarding coping with suicidal behavior and the aftermath of a suicide, and compare programs that seem to have promise and why. From all this, posit some ideas about how other kinds of programs could be built.

General Comments Regarding Suicide

Suicide goes by many names, some inappropriate, showing a lack of insight into the desperation that someone must feel when it seems that leaving this life is the only option. Suicide is sometimes called “the coward’s way out” and “a selfish act”, both of which are untrue. When you are placed in the wake of a suicide, these terms are painful

and inappropriate. It is more likely that those who end their own lives feel desperation, utter loneliness, and profound sadness.

Those who have lived through a suicide attempt, and the many letters from those who did not, indicate that people who die by suicide are often not only trying to escape their pain and hopelessness, but are performing what they believe is a noble act brought about by a need to stop being a burden to those whom they love. Instead of labeling suicide as anything, students should be educated that it is an often an impulsive, desperate and heartbreaking act.

It is difficult to put pressure on colleges to work harder on their suicide prevention plan if there is not buy-in from those who should be trained, and if there is such a stigma of selfishness attached to suicide people will be less invested. Education must include stories about loss, and preferably by someone who has experienced a loss to suicide. There are support groups and organizations in every major city, and having a speaker who knows the pain of suicide could make a huge difference in how the education is received.

Adding to the stigma of suicide is that it is often categorized as *violence*. Official reference to it is generally housed with the violence policy at colleges, and is considered a violent act. While it is technically violence against oneself, there may not be a better way to generally categorize it. There are extremely violent methods, firearms, homicide followed by suicide, hanging, but there are also less violent or non-violent methods such as poisoning with chemicals, medications, etc. So while this categorizing of the term *suicide* might increase the stigmatization of suicide, it also is a necessary placement in policies and procedures for college in order to protect the others on campus. Having a

better understanding of suicide and suicide prevention will make the categorization less significant to those who currently do not understand.

Survivors

The term *suicide survivor* would seem to indicate that a person had attempted to take his or her own life and lived. However, it refers to those who are left behind in the wake of a suicide; these are the *survivors*. This moniker is appropriate because many go through the harrowing episodes of depression, hopelessness, previous attempts, isolation and sadness of their loved one, only to see it end with the loved one taking his or her own life. Survivors will tell you that they "belong to a club that no one wants to join" and that they are living a *new normal*. One of the members of a bereavement group refers to being a survivor as being on a roller coaster with "Sybil at the switch". Unlike the so-called *natural death* of a loved one, suicide brings with it so much guilt, second-guessing, overwhelming pain, and grief because the death cannot be blamed on a disease, a bad driving decision, or other ways that one dies *naturally*, and can only be blamed on the loved one's own hand. We survivors suddenly see ourselves as somehow culpable for the death. Although rationally we can see that the decision belonged to the deceased, it is, we feel, somehow irrevocably connected to some shortcoming that we most certainly have. The days, then months and years in the wake of the suicide remind us that time does not heal all wounds. It does not heal our hearts, and it does not lessen the pain. We just learn to live with it and that is our *new normal*. Those of us left behind are most definitely *survivors*.

Being in this unique club, survivors often make their way to groups of other survivors who meet to give mutual support, share their experiences, and reveal their

feelings of powerlessness over what happened. These members are rich with knowledge, and often state that they thought of things since the death that they realize pointed to the fact that the suicide was going to happen, but at the time they were not able to see. The wealth of information available at these meetings could fuel researchers and community workers and inspire activists to continue the struggle to combat suicide for years to come. Varying stories and varying circumstances with the same outcome represent opportunities that should be rigorously explored.

Anthropology, Ethnography, and Autoethnography

I initially wanted to perform a study based on journaling of survivors, where survivors journal daily then meet every month to conduct a roundtable discussion of their writings with the specific goal of analyzing the information that their journals revealed, and their responses to that information. I would have encouraged those who were journaling to use a *stream of consciousness* approach to writing, because it is often in our deepest, unfiltered thoughts that the pearls of wisdom are found.

The ultimate goal was to use the ideas found in those writings to deliver education in the form of performed *stories*, using composites of the writings. Even though the University's Institutional Review Board did not approve my initial proposal, I still believe it would be an immensely worthwhile and meaningful study that might well save more lives and bring understanding and comfort to others. There is so much to be gleaned from those who know the horror of suicide first hand that this should not continue to be such an untapped resource.

This is not to say that there is not a plethora of resources available. Most communities have small groups such as *Survivors of Suicide* and hospital or counseling

center based survivor groups. In addition there is a multitude of books and articles available. I have included a list of books with a brief explanation (see Appendix G). Many of these books are research-based, and some are personal stories. There are even books that contain both story and research in order to show the connection between real life and research and are a readable blend of science and humanity. Additionally, there are over 100 references at the end of this dissertation that can serve as suggested readings for anyone interested in the phenomenon of suicide.

Perhaps colleges could take a better look at their campus risk ethnographically. Studying, or having a study done about life on the campus, could reveal much about the culture, attitudes, and cohesiveness of the students and faculty. Each campus has its own personality; each has a unique culture of unwritten rules and beliefs. Some have a culture of tolerance and acceptance; some are less tolerant and accepting; and still others may have a culture of fear and silence. Often students do not know the unwritten *codes*, or the informal expectations for behavior and attitudes, before entering a college, and the stressfulness of being in an environment that is so contrary to their beliefs or behaviors brings additional pressure that could lead to self-destructive behavior.

By the same token, if an ethnographic study is performed on the campus, it might be revealed that students overall feel that what other students do is none of their business, or perhaps overall students feel that certain lifestyles are wrong. If this is the case, then the college can work to teach tolerance, or teach students to get involved and report issues, to watch out for their fellow student's well being. But until the culture of the school is more fully understood by administrators and counselors, and helping students to

cope with it is seen as part of their task, it would be difficult to understand what type of suicide prevention program would best work.

Ethnography is a method of looking at people's behavior in the context of their culture. In order to perform an ethnographic study, a researcher would work with people in their natural environment, being in their world for a given amount of time. The difference between ethnography and other kinds of studies is that ethnography is far more personal. It is finding what is significant and meaningful in a person's life and what drives them to behave in certain ways. The intimacy of the study lends itself to seeing those subjects being studied in a much more extensive way.

Ethnography is not just looking at behaviors, norms, actions, relationships and activities; it is also focused on emotions, feelings, and psychosocial behaviors in the context of life experiences. Recording people in their natural environment using writing, film, or audio and exploring the world in which they exist, gives a more intimate look at what their life is about and helps to explain behaviors and feelings. One of the most important challenges to the ethnographer is laying bare his or her own cultural encapsulations, so that his or her preconceived ideas are not able to distort the investigation unduly. In short, that he or she did not reflect upon in terms of personal bias.

Autoethnography is essentially when the researcher is studying or attempting to explain what he or she is doing in response to certain types of emotional stimulus. For instance, part of what I have done in this dissertation is autoethnographic. Much of what I have written autoethnographically is in the context of my struggle with my son Daniel's

death and recognizing how my own feelings and biases are affected by, and embedded in, this research. Often autoethnography is used to understand painful experiences.

As stated, my initial plan for my dissertation was to work with other parents and siblings who were survivors of suicide and who were already participants in grief support groups. The idea was to ask them to make regular entries into their journals about their experience with suicide and where they are in their grief journey. From these writings, I would construct an ethnography of the journey that would, theoretically, assist in the development of suicide prevention programs and also, in the process, create an autoethnography regarding the process and my reactions, feelings rooted in the research activity. I made the assumption that what would be entrenched in their writings would be those things that could be looked at more closely as educational elements.

Within the *if only* world in which we survivors exist, there lies an abundance of information that could be very useful. The *what ifs* of the past might be what saves a life in the future. I continue to believe that this would be a worthwhile study from both a therapeutic and a suicide prevention point of view.

Another way this process could apply is by gathering small groups of college students who could either discuss their experiences with suicide or suicidal ideation, depression and hopelessness, or could journal as a group, then hold a discussion after journaling. The meeting experience could be a discussion of feelings that they themselves have had, or experiences they had had with others who had been depressed, hopeless, or suicidal. Learning what college students respond to, and how they think about suicide in the context of the college culture could lend additional insight to how suicide prevention programs should be structured.

One of the college counselors who responded to the survey indicated that the college uses a *no cancel* policy for classes if the faculty member cannot be there. Instead, someone from the counseling department uses that day to go to that faculty member's classes and deliver suicide prevention education. One school gives information when students meet with faculty advisors, uses health or psychological services, and has information on the college website that is readily available. This is a significant point. As I was searching college programs, there were many websites that were very difficult to negotiate. It often took me up to 15 minutes to locate exactly what I was looking for – information about suicide prevention.

For some colleges, suicide prevention information is buried deep in the website and not apparent. There are some websites where the suicide prevention information amounts to little more than the emergency phone number located with the phone number for counselors with no information related to suicide prevention or identification. Other colleges have full pages with signs and symptoms, prevention techniques and resources, but again, some of these pages are very difficult to locate on the website. Accessibility is key if the program is to be used by students. The more accessible suicide prevention information is on the website or on the campus, the less likelihood there will be a stigma attached to its use. If information is hidden from students, they will get the message that this is not an open topic.

Colleges could host open group sessions where those who have been exposed to suicides around them, including a loved one, can go and speak to others with similar experiences. I had a student at a local college approach me during the course of a fundraiser and tell me the story of a student in the dorm who hung himself. She told me

that all of his friends and family were offered counseling, but was wondering where she could go to talk to someone because of her own history of depression and her past history suicidal ideation. She did not know the young man well, and the most they saw each other was when they had a class together. She would see him coming and going from the building where they each had a dorm room one floor from one another. Yet, she was tremendously influenced by his death. She asked if she could attend a group counseling session that she had heard was scheduled that week to discuss the suicide and she was told that the sessions were *private*, but that she could set up an appointment for counseling with the next available appointment, which was several days away. She then felt embarrassed for asking and opted not to speak with anyone until she asked me. She agreed to meet with someone from the resource list that I gave her, and contact me if she could not find the assistance she needed. She was not, by her own admission, suicidal at the time. It was clear, however, by the relief she verbalized, that she was grateful for the information. In short, a comprehensive college program should include outreach to all students including programs that address on-campus losses in order to prevent missed opportunities.

A Last Word about Measurement

Perhaps measurement is not the only way to demonstrate that a program is effective. The important thing seems to be whether the counseling departments are preventing suicide that would indicate they are getting to the students who most need their attention. The one issue that is the most bothersome remains the issue of indices of effectiveness. Just because college counselors believe their programs are successful does not make it so.

Since no one can give a clear way to measure success, this is an indication that there is still work to be done related to defining success. Literature indicates that research for preventing suicide is still being developed, but development of new processes without knowing what works and does not work could be futile. Finding solid methods not only for prevention, but also for discerning and evaluating the usefulness of those methods should be the focus.

Logic tells me that there must be a concrete, number-driven methodology for measuring effectiveness, but perhaps there is no such methodology. If there is no number-driven criterion, some type of scoring system could possibly be developed in order to determine program effectiveness. Saying something works just is not enough. The absence of on-campus suicides does not necessarily indicate that a program is effective as this may merely be coincidence. But the need to concretely measure effectiveness does not negate other types of measures. I believe that understanding and optimally using the suicide prevention program, having true compassion for students, decreasing the anxiety related to seeking assistance, and creating a culture of acceptance and assistance is the true measure of an effective suicide prevention program.

Campus Involvement

There are more innovative ways that instruction can be brought to students and faculty than just dry *standing-at-the-podium* delivery. Standard issue posters and handouts that are bright and colorful or have attention grabbing words are not likely to be as effective as an ethnographic/autoethnographic reading, a one-act play, or a talk given by a formerly suicidal student or a survivor of suicide.

Although, overall, grief is felt most by those closest to the death, the undeniable fact is that a death by suicide can have a far-reaching effect on a college campus. This is one of the reasons that the press has an established code of ethics in place. News of a suicide can affect many who are not directly related and they might be closely watching the way it is handled by school officials.

Conclusion

Overall, campuses must focus on trying to do what is right to save their students from suicidal behavior. One way this can be accomplished is to seek out new ways of delivering the message about suicide. Although it is essential to have a suicide prevention program in place, education does not have to be confined to an Internet search of the college website and some posters around campus. There are creative ways to get the word out. A solid suicide prevention program, innovative educational design, and open dialogue about this previously taboo subject will save lives. We owe it to those who, every day, choose to take their lives, and to those who survive them.

"Every day I remember. But sometimes for a split second I don't. For just that brief moment in time I think it isn't true, that any moment I will hear your laughter coming from another room, but then … I remember. And my heart breaks all over again. What I wouldn't give for just one more chance." From the journal of Melanie Schicker

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Appendix A: Survey Items

1) We have a suicide prevention/student at risk program in place.

Yes No

2) How long has the program been in place?

1-2 years 3-5 years Greater than 6 years

3) If 3 years or greater, how often is the programs reviewed or updated?

Every year Every 2-3 years 4 years or greater has not yet been updated

4) Using the following scale rate the effectiveness of the educational components of your program: 1=Not at all effective 2=minimally effective 3=occasionally effective 4= effective 5=very effective or N/A

_____In-service during faculty orientation at the beginning of each year.

_____Handout or brochure that lists behavioral changes in students that faculty may need to be aware of in order to identify a possible student who needs help.

_____ Emailing faculty information of specific warning signs of a student who may be in trouble.

_____ Other education of faculty and staff (please specify).

_____ Training RAs and RDs for warning signs of students in trouble and who to when there is a concern.

_____ Informational posters on bulletin boards in the dorms, student union, etc

_____ Information on the university's student website that lists warning signs of problems, reputable websites where students can get more information and how to contact the counseling center.

_____ Other means of educating students (Please specify).

5) Using the same scale please rate the following activities related to your program:

1=Not at all effective 2=minimally effective 3=occasionally effective

4= effective 5=very effective or N/A

_____ Encouraging counselors to seek out students who are potentially at risk.

_____ Encouraging educators to seek out students who are potentially at risk.

_____Encouraging students to seek out students who are potentially at risk.

_____Promoting education regarding identification of at risk behaviors and how respond.

_____Promoting staff/faculty education regarding the identification of at risk behaviors and how to respond.

_____ Encouraging students to seek our assistance.

6) I believe we have been successful in identifying students at risk. Yes No

7) Rank the following components of your program from:

most effective (1) to least effective (9)

_____Initial education program for educators

_____Initial education program for students

_____Ongoing education for students

_____Ongoing communication to students

_____Ongoing support and education for educators

_____Evaluation of students identified and/or seeking assistance

_____Referral system (referrals to groups, outside counseling or hospitalization)

_____Individual counseling program for follow up on identified students.

_____Other (please list here):

Appendix B: Survey Letter to College Counselors

Date

Dear College Counselor:

I am a doctoral student at Lindenwood University in St Charles, Missouri researching effective components of adolescent suicide prevention programs in colleges and universities asking for your assistance by completing the attached survey. Participation is optional and confidential. When you complete the survey, it will be returned to me without identifying information, hence, when I view your results, I will not know your name or the institution for which you work.

If you do not have a specific “suicide prevention” or an “identification of students-at-risk” program, please disregard this message.

Please click the following link to complete the survey:

Whether you choose to participate or not, and would like a copy of the results of the survey, you may email me at mschicker@lindenwood.edu with your name and email address and I will send a summary to you once the results are compiled. Please complete the survey by August 31, 2010.

To opt out of this email and receive no further emails, please click this link:

Sincerely,

Melanie A Schicker, RN, MHSA

Appendix C: Survey Follow-up Items

1. Please tell me how you measure the success of your suicide prevention program.

2. And Finally: I expected that most schools would respond that they placed the most importance on student education programs for suicide prevention because so much literature supports this component, but this was not the case; in fact, student education ranked third and seventh in importance. Why do you think the other components are more, or equally, important?

Appendix D: Responses to Follow-up Items

Item One:

1. We currently look at the number associate with our outreach (how many people attended) and then survey them about the quality of the program (e.g. what they learned)
2. I feel it was successful.
3. With outcomes from programs - short term and 1 year follow up
4. NCHA data, Counseling Center intakes, focus groups and pre post surveys
5. We use the following: Certain questions on the National College Health Assessment (NCHA-II), Certain questions on the Missouri College Health Behavior Survey (administered by Missouri Partners in Prevention), Intake items at Counseling Center (e.g. what brought you to counseling?), Tracking analytic data on website (traffic, items downloaded, etc.), Behavioral Intervention Team data (number students through

BIT processes for suicidal ideation, etc.), Focus Groups

6. Number of participants who attend programs, change in the number of inquiries received about suicide, change in the number of messages reporting concern about a student

7. Number of participants in programs and increase in campus wide resources

8. We used pre and posttests for all Campus Connect Gatekeeper trainings. We then have the data ran and look for ways to improve our efforts. This is the main area of evaluation at this time. We have also complied with all Garrett Lee Smith evaluation requirements.

9. Difficult to measure outcome because often times the verification is through personal narratives and given our campus size 28K students it is hard to quantify the personal narratives. Mostly, just track the number of gatekeeper trainings and how many people are trained. As of today's date over 5000 students, faculty, and staff on our campus have been trained as QPR Suicide Prevention gatekeepers.

10. We measure success through the number of individual contacts (i.e. attendance) at our screening and information sessions.

11. Student training feedback

12. Trainee crisis responding skills (SIRI 2), # of consults with counseling about "at risk" students, # of referrals to counseling from trained community member, # of students seen in counseling as a result of community referral

13. Local surveys that are pre test post test measures of knowledge and skills, qualitative surveys of experience, MIS data that examines service utilization

14. This is pretty tricky. Success is a variety of things in this work, and it depends on

the objective. The ultimate objective for us is to create momentum for change in attitudes of the total community of (*deleted for anonymity*) positively toward mental health, and along the way to increase ease and knowledge in communicating about issues related to suicide. So we measure success by numbers of participants, evaluations of activities, knowledge change six months after training activities, anecdotes of behavior change or stories about special contacts, as well as positive relationships and behavior change among students who have been actively suicidal and receiving treatment from our mental health counselors.

Item Two:

1) I think both are helpful---like anything, you can't just focus on one piece of the puzzle. There are also political and funding benefits to talking directly to faculty (e.g. they often had a loud voice to the president and keeping counseling issues in the foreground just makes sense)

2) Worried about student's affect and maturity to tolerate concerns surrounding suicide.

3) I am unsure - we use students

4) We used to assume that faculty would notice and intervene. Students respond more to their peers so we switched our focus to peer education.

5) We use licensed counselors and faculty who work on campus because (1) they have expert knowledge on the topic, (2) it introduces students to this resource, thereby

making it more likely that a student may seek out counseling services for problems (in many students often stay after presentations to talk about counseling and inquire about setting up appointments), and (3) should a student have an adverse reaction as the result of a presentation (tried suicide, had friend/family who died by suicide, etc.), the counselor can make sure the student is appropriately cared for

6) Perhaps it comes from a belief that there are behaviors that are "markers" for suicide risk and that educating people in the students' environment might increase the chance that those behaviors would be recognized and reported.

7) We had more staff and it was voluntary Faculty could have been required

8) I think a lot of schools feel faculty see the students almost daily, and will recognize the signs. They also might feel faculty is easier to reach since they are co-workers. That is the only reasons I can think of.

9) It is not our philosophy, and we focus our primary efforts on peer-to-peer gatekeepers and reaching out to the students.

10) It may be hard to get into the classroom to train students. Easier to get in to faculty meetings and faculty orientations. I personally have created an excellent way to get into the classroom to train students by creating a "Don't Cancel Class" program with faculty. For example, instead of cancelling class faculty contact me and I go in the class and give a QPR Suicide Prevention gatekeeper training. The faculty have bought into this concept and many of them pre-schedule in advance for me to come in to the classroom.

11) Liability.

12) Good question...we developed our own student education program because there weren't enough good models out there.

13) We use student education but we have experienced that the University BELIEVES that it is impossible to get students to commit to education on this topic. We went forth in the face of this perception and found that it was not true.... students are eager and hungry. So we are focusing on the students.

14) Can only speak for us. We have 373 full-time faculty/650 adjuncts, and 18,000 students per semester; 35,000 per year, with four Counselors and one grant coordinator. Every student connects with faculty, so by building infrastructure with faculty, we can increase contact with students strategically. We do both. But even when we ask faculty to allow us into their classes to connect with students, we are hoping to connect with the faculty member, and indirectly to all of their students, not just a single class of 30. Also, faculty provides continuity. They will be here 5-7-10 years from now (mostly) but not the students. They change continually. To change the culture of communication about mental health we have to change the way the faculty and staff think about it, talk about it, and respond to challenges. Same is true for students, but we have briefer access to them. Lots more I could say, but this is the brief story.

Appendix E: Example of a Depression Screening Test

Scale: A. Never B. Rarely C. Sometimes D. Very Often E. Most of the time

FOR MORE THAN TWO WEEKS:

1. Do you feel sad, blue, unhappy or "down in the dumps"?
2. Do you feel tired, having little energy, unable to concentrate?
3. Do you feel uneasy, restless or irritable?
4. Do you have trouble sleeping or eating (too little or too much)?
5. Do you feel that you are not enjoying the activities that you used to?
6. Do you feel that you lost interest in sex or experiencing sexual difficulties?
7. Do you feel that it takes you longer than before to make decisions or unable to concentrate?
8. Do you feel inadequate, like a failure or that nobody likes you anymore?
9. Do you feel guilty without a rational reason, or put yourself down?
10. Do you feel that things always go or will go wrong no matter how hard you try?

Adapted from NYU School of Medicine, 2001

Appendix F: Internet Resources

Website	Organization
www.suicidology.org	American Association of Suicidology
www.afsp.org/	American Foundation for Suicide Prevention
www.befrienders.org	Befrienders Worldwide (now maintained by Samaritans)
www.mentalhealth.org/suicideprevention	Substance Abuse and Mental Health Services Administration
www.bhrstl.org/	Behavioral Health Response
www.suicideinfo.ca/	Center for Suicide Prevention
www.psycom.net/depression.central.html	Dr Ivan's Depression Central
www.suicideprevention.org	A Grassroots.org Project for Suicide Prevention
www.hopeline.com	Brooks Hope Center
www.lifeline.web.za	Lifeline International
www.psycom.net/depression.central.suicide.html	National Suicide Prevention Hotline
www.nopcas.com	National Organization for People of Color Against Suicide
www.save.org	Suicide Awareness Voices of Education
www.spanusa.org	Suicide Prevention Action Network, USA
www.sprc.org	Suicide Prevention Resource Center (a.k.a. www.suicide.org
www.ulifeline.org	ULifeline
www.youthsuicide.ca/youth/youth.htm	Youth Suicide Prevention

Appendix G: Suggested Reading List

Night Falls: Understanding Suicide
By: Kay Redfield Jamison
Discusses suicide in people under 30 from an author who was, herself, an attempter

Time to Say Goodbye: Surviving the Suicide
By: Carla Fine
Husband of 21 years completed suicide; research based, discusses stigma, support and guilt/anger.

Silent Grief: Living in the Wake of Suicide
By: Christopher Lukas & Henry M Seiden
One author is a suicide survivor and writer and one is a clinical psychologist; research based study of prevention and postvention related to adolescent suicide.

Myths About Suicide
By: Thomas Joiner
Researcher, sociologist discusses groundless beliefs about suicide.

How I Stayed Alive When My Brain Was Trying to Kill Me: One Person's Guide to Suicide Prevention
By: Susan Rose Blauner
Practical advice for those contemplating suicide based on 12-step model

My Son … My Son … - A Guide to Healing
By: Iris Bolton & Curtis Mitchell
Dealing with grief after the loss of her son

Why Suicide? Questions and Answers About Suicide

By: Eric Marcus

Interviews with people who have dealt with suicide of someone close

Surviving Suicide: Help to Heal Your Heart – Life Stories from Those Left Behind

By: Heather Hayes

Stories of survivors

Why People Die by Suicide

By: Thomas Joiner

Research based, but very readable; give guidance to those who are left behind

Half in Love: Surviving The Legacy of Suicide

By: Linda Gray Sexton

Uses her own personal experience to discuss healing

Vitae

Professional Experience

11/2009 to Present Centene Corporation St Louis, MO
Director, Medical Management Operations
Responsible for overall direction of medical management for a national corporation
Development of departmental strategic goals, department budget, staffing models

12/2008-present SSM Healthcare St Louis, MO
Regulatory Coordinator
Regulatory oversight of all hospital departments at two major medical centers
Coordination of all regulatory activity including Joint Commission, State, CMS

2/2007 to 11/2009 Andrea Frazier and Associates St Louis, MO
Sr. Lead Consultant
Performance of all professional consultant activities and training/development
Designs, conducts and abstracts managed care and regulatory audits

2000-2007 Select Specialty Hospital-St Louis St Louis, MO
Director of Quality Management
Management of compliance issues and interpretation of all regulatory requirements
Management of all Quality Assurance programs and processes

Adjunct Professor

Lindenwood University - 2007-Present
Webster University –2010-Present
Washington University –2007
University of Phoenix Online – 2005-2007

Education

Lindenwood University, St Charles, MO, EdD, 2011
University of St Francis Joliet, IL BS Health Arts 2000
MHSA 2004
Missouri Baptist Hospital School of Nursing St Louis, MO Nursing 1983

Organizations

Current President of the Board of Directors – American Foundation for Suicide Prevention-St Louis (AFSP)
Current Board President – Case Management Society of America – St Louis (CMSS)

Certifications/Licensure

RN licensure1984-present
Certified Case Manager (CCM) 2009-Present