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Therapeutic intervention with suicidal adolescents: A problem-solving approach

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THERAPEUTIC INTERVENTION WITH SUICIDAL ADOLESCENTS: A PROBLEM-SOLVING APPROACH

A Dissertation Presented to

The Faculty of The School of Education

The College of William and Mary

In Partial Fulfillment

of the Requirements for the Degree of

Doctor of Education

By

William Worth Bradley

July 1986

APPROVAL SHEET

We the undersigned do certify that we have read this dissertation and that in our individual opinions it is acceptable in both scope and quality as a dissertation for the degree of Doctor of Education.

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DEDICATION

To my wife, Joy, for fifteen years of understanding and support as well as much time spent reading and rereading. And for the encouragement she provided.

ACKNOWLEDGMENTS

The author is indebted to many individuals who played key roles in this study. Ruth K. Mulliken, Ph.D., Committee Chairperson, who always taught me more than psychology, provided advice and constant encouragement. She was always available when a need for consultation arose. I extend my gratitude and appreciation to Dr. Mulliken and to the other committee members, Myron W. Seeman, Ph.D., who never stopped believing in me or my study and Roger R. Reis, Ph.D., whose advice and editorial guidance was most appreciated. In addition, I would like to acknowledge Michael Politano, Ph.D., who provided assistance with my research design.

Special acknowledgment must go to the students involved and their families. Without their interest and willingness to participate, this study would not have been possible.

I am very grateful to Marion Brown, M.S.W., Joanna Newman,Ph.D., and Electra Taylor, M.S.W., who unselfishly gave time and expertise in working with these students.

Particular appreciation goes to Pat Graham who spent many hours reading and typing this manuscript. Without her efforts and assistance, this project could not have been accomplished.

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CHAPTER I

INTRODUCTION

Statement of the Problem

The purpose of this study was to investigate the effectiveness of a problem-solving intervention strategy as applied to mildly suicidal adolescents.

Need for the Study

The death of a young person is a tragic and disturbing occurrence which leads to feelings of grief, anger, confusion and guilt for those friends and family members left behind. The feeling that we have failed a young person who takes his life is common.

Statistics indicate that in the United States alone roughly 6,000 adolescents per year take their life. It is further estimated that half a million attempts are made by our youth every year (Peck, Farberow, and Litman, 1985).

While the wealth of information relating to suicide is enormous, the phenomenon of adolescent suicide has only recently received extensive attention. The rate of teenage suicide increased by 66% during the 1970's and by an alarming 300% since 1950. At present, it ranks as the second or third leading cause of death among those aged 15-24 (Davis, 1985).

According to a recent article by Davis (1985), it is predicted that, given a high school population of 2,000 students, "a school psychologist could expect suicidal ideation in perhaps as high as

25-30% of the student body and attempts by as many as 50 students each year" (p.314-315). This statistic alone dictates the need for knowledge and understanding of adolescent suicide by school psychologists.

Peck, Farberow, and Litman (1985) define schools as "agencies where the behavior and feelings of the majority of children first come to the close attention of professionally trained adults outside the nuclear family, more even than come to the attention of pediatricians or family practitioners" (p. 120). The authors continue by identifying and defining needed services within the schools.

Most research relating to suicide of the young has been restricted to the identification and discussion of characteristics of the adolescent's environment, family, or personality. There has been very little systematic research that has addressed the efficacy of actual therapeutic intervention strategies with such a population. The purpose of this study is to examine specifically the effect of a problem-solving intervention strategy with mildly suicidal adolescents.

Theoretical Rationale

Toolan (1978) states that suicide among adolescents has shown the greatest increase of any age group. This comment is supported by such authors as Petzel and Riddle (1981), Miller (1981), Joffe and Offord (1983), and Peck, Farberow, and Litman (1985). Toolan further indicates that suicide ranks as the fourth leading cause of death among the 15 to 19 year old age group. Other more recent researchers (Petzel and Riddle, 1981); Peck, Farberow, and Litman, 1985; Davis, 1985) rank suicide as high as the second or third leading

cause of death among adolescents. Most researchers and treatment specialists agree, however, that the actual death rate by suicide among the young could very likely be even higher if better statistics and reporting procedures were available.

Why adolescents kill themselves remains specifically unclear. Reasons vary from case to case. It is known, however, that certain characteristics frequently associated with suicidal young people include disturbed interpersonal relationships (Malmquist, 1978; Swensen, 1973), hopelessness and depression (Toolan, 1978; Miller, 1978; Lee, 1978), substance abuse (Peck, 1968), and social isolation (Peck, 1968). Another group of youngsters which is described by Shaffer (1973) as angry, impulsive, and sensitive to and resentful of criticism also need to be considered at high risk for self-destructive actions.

Other writers have attempted to link self-destructive behavior to a diminished problem-solving capacity (Shneidman, 1957; Neuringer, 1964). It is generally felt that the suicidal individual finds it difficult to generate new or alternative solutions to debilitating emotional problems. Such constricted problem-solving ability could very well be lethal in that the person may feel that there is no way out of a painful situation except by death.

D'Zurilla and Goldfried (1971) point out: "Much of what we view clinically as abnormal behavior or emotional disturbance may be viewed as ineffective behavior and its consequences, in which

the individual is unable to resolve certain situational problems in his life, and his inadequate attempts to do so, are have undesirable effects such as anxiety, depression, and the creation of additional problems" (p. 107).

D'Zurilla and Goldfried (1971) go on to argue that "our daily lives are replete with situational problems which we must solve in order to maintain as adequate level of effective functioning" (p. 197). The inability to resolve such conflicts leads to immediate upset and negative consequences which will create future problems.

Further support for the problem-solving hypothesis is offered by Caplan (1964) who states that life crises are characterized by a breakdown of previously adequate problem-solving or coping abilities.

Meichenbaum (1977) reports on the application of creative problem-solving and self-instructional training procedures as applied to traditional academic concerns and clinical problems. His research indicates that "psychotherapy clients may benefit from self-instructional creativity or problem-solving regime. Instead of the clinician's dealing with the details of the client's maladaptive behaviors, he could provide the client with training for solving personal problems" (p. 65).

According to Meichenbaum (1977), the problem-solving treatment is designed to "have the client learn how to identify problems, generate alternative solutions, tentatively select a solution and then test and verify the efficacy of that solution" (p. 194).

D'Zurilla and Goldfried (1971) view problem-solving as "a behavioral process whether overt or cognitive in nature which makes available a variety of potentially effective response alternatives for dealing with problematic situations and which increase the probability of selecting the most effective response for the various alternatives" (p. 108).

The general goal of problem-solving is not to offer specific solutions to specific situations but to provide general coping skills so that the individual is better able to deal more effectively with a variety of problems (Goldfried, 1979). This goal is further emphasized by research in the area of problem-solving which supports the theory that maladjustment is characterized by deficiencies in response alternatives (Spivack and Shure, 1974). Investigations with disturbed children, psychiatric patients and delinquents have revealed that these people frequently possess inadequate skills for effective problem-solving.

Problem-solving intervention has been identified as useful in varied situations. D'Zurilla and Goldfried (1969) report problem-solving training as helpful to students who experienced difficulty adjusting to college life. Copemann (1973) used problem-solving techniques as part of a behaviorally-oriented treatment program for heroin addicts. The problem-solving was particularly beneficial in helping these individuals cope without reverting to drug use when they returned to their original environments.

Chancy, O'Leary and Marlatt (1978) used problem-solving strategies effectively in avoiding relapses in alcoholics. Problem-solving training has also been successful in improving the interpersonal functioning of children (Spivak and Shure, 1974; Spivak, Platt, and Shure, 1976).

Problem-solving techniques have also been reputed as useful in crisis situations. In crises, the benefit is not necessarily training, but it is helping the individual think through more intelligently and effectively what may otherwise be an overwhelming situation (McGuire and Sifneos, 1970). The authors also argue that such a systematic approach can help sort out and resolve serious crises such as suicide.

More recently, Slaikeu (1984) has successfully used a problem-solving structure in his "psychological first aid" treatment approach to crises, including suicide. Treatment of the suicidal situation has been effective with his intervention strategy.

Rabkin (in Husain and Vandiver, 1984, p. 91) quotes Diane Syer, Director of the Crisis Intervention Unit at Toronto East General Hospital, as saying that the "typical suicidal patient is a person with a series of problems, strained emotional resources, and with coping abilities becoming more and more difficult. Thus, suicide is seen as the only way out."

Until 1971, the hypothesis that adolescent suicide was related to poor or inadequate problem-solving abilities had not been

adequately tested. Levinson and Neuringer (1971) attempted to evaluate the assumption that suicidal behavior in adolescents was linked to diminished problem-solving capacity. They compared problem-solving skills for thirteen suicidal, thirteen psychiatric but non-suicidal, and thirteen normal adolescents. The authors found that the suicidal group demonstrated significantly lower performance and failure with problem-solving than did the psychiatric and normal subjects. Levinson and Neuringer indicate that problem-solving incapacity is of dangerous consequence and suggest that those individuals working with potentially suicidal adolescents focus on having these young people learn problem-solving skills.

Meichenbaum (1977) reports extensively on the application of creative problem-solving and self-instructional training procedures as applied to traditional academic concerns and clinical problems. Self-instructional training, he reports, creates a more generalized stance to view ones' life in a more creative manner. Subjects reported applying creativity training to their own personal or academic problems which, according to Meichenbaum (1977), suggests that "psychotherapy clients may benefit from self-instructional creativity or problem-solving regimens. Instead of the clinician's dealing with the details of the client's maladaptive behaviors, he could provide the client with self-instructional creativity training for solving problems" (p. 65).

Both D'Zurilla and Goldfried (1971) and Goldfried and Goldfried (1975) suggest that a client's cognitions are evidence of a deficit in systematic, problem-solving skills. The counselor with a problem-solving orientation attempts to identify the lack of specific, adaptive cognitive skills and responses.

Sample and Data Gathering Procedures

The population for this study consisted of male and female adolescents aged 14 to 19 who were referred because of suicidal behavior. The subjects are public high school students from separate high schools in Henrico County, Virginia. These students were self-referred or referred by teachers, counselors, or parents. Subjects for this study were considered to be mildly suicidal. Serious or critical cases were referred immediately to local mental health or psychiatric agencies. Four to six case studies were projected.

An interview was conducted with each subject for the purpose of collecting data relating to family factors, social/environmental factors, interpersonal factors, academic performance/ability, depression, feelings of hopelessness, presenting problem(s), and assessment of suicide potentiality.

In addition to the interview, each subject was given the Checklist for Solving Problems in Real Life, The IPAT Depression Inventory, and the Suicide Potentiality Scale. A behavior rating scale was completed by each of the student's teachers at the time of referral. Subjective teacher observations were also reviewed.

Within 48 hours of the referral, a parent conference was held at which time an interview and social history was completed. The presenting problems and intervention strategy were discussed with the parents during this meeting and permission for intervention was obtained.

All objective measurements, except for the teacher checklists, were completed by the school psychologist. The school psychologist met with the family. Individual students were seen by the school psychologist weekly and more often if necessary. At the end of six sessions, these instruments were administered again. The family was also contacted again at the time of post-testing.

Definition of Terms

Adolescent: A student between the ages of 14 and 19 (for purpose of the present study).

Intentional Suicide: An act or pattern of self-destructive behavior of high lethality, deliberately planned by the subject.

Subintentional Suicide: An act or pattern of self-destructive behavior of low or uncertain lethality, not clearly perceived by the subject as likely to result in his death.

Suicide Attempters: Persons who at any time have made an intentional or subintentional suicide attempt.

Suicide Contemplators: Those persons who manifest suicide ideation.

Suicide Ideation: Thoughts, contemplations, reveries, fantasies and obsessions in which a person invents themes and stories with his suicidal death as an essential element.

Suicidal Thinking: A person is considered to be suicidal if he thinks about killing himself.

Suicidal Threats: A person is said to be suicidal if he threatens to kill himself.

Therapeutic Intervention: Strategy or strategies implemented by a counselor so as to assist clients in resolving personal problems.

Unintentional Suicide: An act or pattern of self-destructive behavior of variable levels of lethality, not consciously expected by the subject to result in his death.

Limitations

This study analyzed only the efficacy of one intervention strategy, problem-solving training, with mildly suicidal adolescents.

This study included only six adolescents aged 16 to 19 who were identified as potentially suicidal.

This study did not control for previous therapeutic interventions relating to an individual's emotional or behavioral difficulties, and did not control for the effect of the experimenter's personality on the subjects.

This study also did not control for the effect that age, sex, race, socioeconomic class, religion or number of years experiencing difficulties may have had on subjects.

This study was a case study qualitative approach rather than a strictly experimental investigation. It was completed without control groups, with a small n, and without formal statistical analysis.

While suicide research is plagued with methodological problems, it is critical to get as much information about suicide as possible. Case studies are found throughout the literature on suicidal behavior and serve as an acceptable method, along with other descriptive and qualitative measures such as surveys and questionnaires, of collecting data about the characteristics and personalities of those young people who attempt and complete suicide.

Methodological problems begin with the definition of suicide itself (Neuringer, 1974) and extend to such aspects as adequate control populations and validity of predictions.

Adequate control groups in suicidal research should be as nonsuicidal as possible, however, every control group is very likely to have people with "normal" death wishes and fantasies. An even bigger problem may be that despite careful screening of potential control subjects some may not admit a history of suicidal activities and, therefore, be used as actual members of control groups (Neuringer, 1974, p. 13).

Another factor affecting the meaningful use of controls in a study similar to the present one is the ethical and legal impossibility of withholding intervention from any individual referred for suicidal behavior. Providing treatment for one set of individuals while withholding it from another group, for the sake of experimental control, is unacceptable.

Comparisons between two different treatment approaches such as group vs. individual is beyond the scope of the present study, but such comparisons would be possible, however. For instance, a

problem-solving strategy with groups of suicidal adolescents could be the focus of a different study with results being compared with the present case study data.

Almost all authors identify the need for ongoing research with suicidal adolescents. Davis (1985), in particular, cites the need for a greater volume of research data involving suicide in school psychology journals. He states that "while parametric studies would be difficult, case studies or nonparametric studies may be a valuable addition to the literature and may enable one to set realistic and manageable goals" (p. 322).

This study, because of the previously mentioned limitations, requires scrutiny regarding generalization of these results to similar populations.

CHAPTER II

Review of Related Research

Historically, suicide is not a new phenomenon. Emile Durkeim published his book Suicide in 1897, and Sigmund Freud discussed suicide in his psychoanalytic literature. Freud discussed suicide in relation to anger toward a love object which was turned back on one's self.

Until the early 1900's, suicide was not identified as a behavior that could or should be treated or prevented. Early physicians refused to treat suicidal individuals, describing them as insane or doomed by heredity. Suicide was viewed as both a crime and a sin and was refused acknowledgment by the medical profession. Today, however, all medical professions believe suicide to be a major problem requiring attention.

Psychologists Edwin Shneidman and Normal Farberow were the first professionals to propose and develop a well-defined preventive approach to suicide. Shneidman's major preventive focus was educational in nature, believing that increasing public knowledge and awareness would aid in attacking the problem. Other professionals expressed concern, however, that large scale advertising might possibly make matters worse.

Treatment procedures over the past 10 to 15 years have been numerous and varied. Despite these efforts the suicide rate, particularly among adolescents, has increased dramatically.

According to Ray and Johnson (1983), this alarming increase has sparked extensive research efforts into the problems of adolescence in order to discover the causes, symptoms, treatment and prevention of adolescent suicide.

Hollinger (1978), in his study of self-destructiveness among the young, supports both Toolan and Miller when he reports that "while accident rates are the largest component of the youthful violent death rate, followed by homicide and suicide rates, respectively, the recent increase in the violent death among the young has been due to the doubling of the homicide rates over the past fifteen years, and the tripling of suicide rates over the past twenty years" (p. 277).

Hendin (1975) describes the rising death rate among the young as "a diminished involvement in life, an attempt to find in numbness and limited controlled experience, some escape from the anger and turmoil without and within" (p. 322).

Characteristics

Despite extensive and continuous research into suicide of the young, no exact profile can yet be identified. It is still not possible to predict with certainty who will and will not kill themselves. No suicidal "type" of individual has been specifically identified (Ray and Johnson, 1983). What we have learned, however, is that there are certain characteristics or problem areas which are indicative of those adolescents who attempt suicide.

In 1969, Joseph Sabbath discussed the fact that child/parent problems are often an indicator of possible suicide. He suggested that

as conflicts increase, frustration and anger grow until the parent sees the adolescent as a threat to family or enjoyment, and the teenager begins to view the parent as persecutor. The situation may escalate until parent and child drift dangerously apart, and a serious suicidal attempt occurs.

Home or family problems are found consistently throughout the literature as common features in the history of adolescent suicide. Toolan (1978), in his analysis of 102 young people admitted to Bellevue Hospital in New York City for suicide attempts and threats, found that many came from troubled homes. Less than one-third resided with both parents, and fathers were frequently absent from the homes. Toolan further reported that these young people were generally immature and impulsive and reacted excessively to stresses that were often minor in nature. His patients were divided into five categories in terms of dynamics:

1. Anger at another which is internalized in the form of guilt and depression. Usually the parents or parent substitutes were the original objects.
2. Attempts to manipulate another, to gain love and affection or to punish another.
3. A signal of distress. The youngster often felt impelled to make a dramatic gesture to call the parents' attention to his problems, which the parents often overlooked or ignored.
4. Reaction to feelings of inner disintegration, for example, in response to hallucinatory commands.

5. A desire to join a dead relative (Toolan, 1978, p. 340).

It was Toolan's opinion and that of Carlson (1981) that the majority of youngsters who threaten or attempt suicide are significantly depressed. Depression manifests itself differently depending upon the developmental stage of the youngster. Early adolescents' depression is often masked by acting out behavior, while older youngsters will turn to drugs or alcohol to avoid facing their painful feelings. Many adolescents exhibit excessive boredom and restlessness. Complaints of feeling isolated, empty and alienated are frequent (Miller, 1981). Other symptoms include fatigue, insomnia, truancy and a decline in academic achievement. Many admit to having numerous acquaintances among peers, but very few or no close friends.

Peck (1981) supports the concept of high risk, isolated, alienated adolescents by defining the loner as one subtype of suicidal youngster. This adolescent frequently is male and has a long history of spending time alone. Poor interpersonal relationships with peers and adults are common, as are feelings of isolation, loneliness and lack of someone in whom to confide. Friendships, when made, are superficial. Contrary to other youngsters, the loner usually comes from an intact family with relatively normal parents. Peck continues by pointing out that these parents exhibit some difficulty with self-image and lack confidence as parents. The loner generally grows to feel inadequate, overwhelmed and hopeless.

Loss, loneliness and hopelessness are factors of suicidal psychology also presented by Tobachnick (1981). He reports that most people in suicidal states are concerned with the loss of something very important to them. While this infers something external, what Tobachnick refers to is that "within the individual, something crucial is felt to be gone. The object may be human, relative or friend, or nonhuman, for example, health, fortune or status" (p. 401). As with other authors, Tobachnick describes a feeling of loneliness or a sense of being alienated from the whole world as a feature of suicide.

Episodes of hopelessness are frequently associated with suicidal states. Such periods are times when the individual attaches no special meaning to his life. Feelings of uncertainty are evident in personal relationships and values. Feelings of emptiness become pervasive.

Particularly in adolescence, Tobachnick reports loneliness and alienation as related to the realization that supportive childhood contacts with adults lessen and that life must be faced alone. In struggling with his identity development, the adolescent may experience feelings of hopelessness relating to expectations and actual accomplishments.

Because the previously supportive parental figures are no longer available and because the adolescent has tremendous inexperience in living, there is a feeling of helplessness in attempting to deal with life's problems.

The depressed suicidal patient, according to Kiev (1975), is overwhelmed by feelings of despair, fear and uncertainty. Methods of coping have failed, and judgement and reality testing are inadequate. In such instances suicide is a way to end suffering rather than the result of a clear decision to die.

Martin and Dixon (1983) report that suicidal teenagers are generally described as depressed, ambivalent, socially isolated and experiencing stress. Depression is indicated as a major factor of adolescent suicidal profiles (Carlson, 1981; Martin and Dixon, 1983; and Litman and Wold, 1974).

Depression alone, however, should not be used as the only predictor. Many adolescents experience depression, but it becomes a more significant factor when coupled with the deterioration of relationships with peers and family (Hersh, 1975).

Identifying depression in adolescents is felt to be more difficult then with adults because of the natural mood swings experienced by many teenagers. There are, however, significant signs to consider which may be indicators of depression, such as truancy, disobedience, substance abuse, antisocial behavior, confusion, social withdrawal and isolation (Litman and Wold, 1974).

Some suicidal adolescents are often angry, ambivalent and feeling stress that is perceived as unresolvable (Grollman, 1971). This stress and lack of resolution can often lead to insomnia, lack of appetite, fatigue and decreased concentration. In school, dropping

grades and decreasing social activity may be clues to potential problems.

Social isolation may be the key factor in differentiating suicide intent from suicide gesture (Arieti and Benporady, 1978). They report that the greatest danger of suicide occurs with social isolation. If suicidal individuals have someone to turn to, suicide may be avoided. The isolation may not actually be physical but may be a perceived alienation from friends, family, or peers.

Helping the adolescent avoid a suicide attempt and possibly even death is, of course, the major thrust of any intervention. McBrien (1983) believes "the goal is to intervene before students reach the stage in their crisis or depression that initiates an overt cry for help" (p. 76).

Martin and Dixon (1983) stress the importance of establishing a relationship with the adolescent and offering support, hope and help. Proper assessment is critical and should at least include the following areas: age and sex, suicide plan, and level of stress being experienced.

Determining the prediction of suicide is obviously a major objective, but also a major problem. The ability to be precise about suicide risk would be ideal, however, this is an area full of conflict and disagreement among experts on how to identify such individuals. Hatton, Corrie and Valente (1984) do identify four major necessary components of the assessment process in recognizing potential

attempts. Their components are : demographic data; high risk factors, such as alcohol abuse, isolation, withdrawal, disoriented, disorganized behavior and multiple high lethality suicide attempts; risk rating categories such as low, moderate, high and emergency and long term. The final component of clinical characteristics include such variables as previous attempts, previous psychological history, social and personal resources, coping strategies, and significant others.

The authors strongly emphasize trust and rapport as critical factors. Techniques will only be effective as initial rapport. They recommend a focus on immediate problems with the goal of making sure the individual clearly understands the crisis. Beyond this, they suggest helping the person to mobilize internal and external resources, organize priorities and take advantage of those coping devices still intact. Use of assigned structured tasks, continuance of routine activities, exploration of alternative solutions and instruction in problem-solving skills are also recommended.

Lewis (1979) argues that "the therapist involved in suicidology cannot rely solely on his classical knowledge and expertise in psychopathology and psychotherapy. One can neither retain professional isolation nor maintain a stereotyped, structured professional posture. The therapist must be alert and ready to amplify and modify techniques to fully utilize necessary life saving measures" (p. 7).

Due to the potential lethal urgency of a suicide crisis, assessment techniques may not always be in accordance with standard protocol, i.e. the traditional one hour may become two or three hours in such a situation.

Qualitative assessment is still required, and data from rating scales or tests help despite questionable reliability and validity (Lewis, 1979).

Karl Slaikeu in Crisis Intervention: A Handbook for Practice and Research (1984) views suicide as one of the most severe crisis a practitioner may face. He defines crisis as a : "Temporary state of upset and disorganization characterized by an individual's inability to cope with a particular situation using his customary methods of problem-solving" (p. 13).

This stance is supported by earlier authors such as Caplan (1964) who viewed emotional upset and disequilibrium as a breakdown in problem-solving skills or coping abilities.

In 1971, Thomas D'Zurilla and Marvin Goldfried provided an extensive study of problem-solving. They stated that man, because of a complex and constantly changing society, finds himself continuously faced with problems, either trivial or crucial, with which he must cope.

Although these authors did not address suicide exclusively, they did feel that ineffective problem-solving with minor difficulties could escalate to more serious circumstances of which suicide is certainly a possibility.

Liberman and Eckman (1981), in their study of behavior therapy vs. insight-oriented therapy, report that a majority of their subjects were found to be significantly lacking in social and emotional coping skills, therefore, "using suicidal threats and gestures as one of many maladaptive behaviors in a long-standing manipulative life style" (p. 1129).

Assessment

Proper assessment of suicidal intent is imperative. Emile Durkeim approached his assessment from a sociological perspective, while Freud used such techniques as interview, dream analysis and free association.

Miller (1981) feels the initial interview with adolescents is more helpful in determining thoughts of self-destruction. One of the most crucial elements to be determined during this initial stage is the individual's treatability which is assessed primarily by the adolescent's ability to relate to the therapist in a positive way so that the problem behavior can be contained, the cause(s) can be understood and the severity of the situation can be determined.

During the interview history taking is important, since many young people who are vulnerable to suicide have a long history of social and psychological problems. Proper assessment demands knowledge of the adolescent's ability to develop and maintain interpersonal relationships, as well as the presence of feelings such as emptiness, depression, alienation, low self-esteem and helplessness.

Another clue to potential suicide is a history of repeated attempts, previous treatment and parental suicide. Those individuals who attempt suicide are identified as being different from those who commit suicide. Weiss (1957) states that "successful and unsuccessful suicides are two different kinds of acts performed by different people in different ways" (p. 18). It is further accepted that the classification of attempts, or the difference in attempters and committers, is based on the degree of suicidal intent (Weiss, 1957; Rubenstein, Moses, and Lidz, 1958; Dorpat and Boswell, 1963; Dorpat and Ripley, 1967). These authors, as well as Resnik and Hawthorne, (1974), Politano (1976, 1986), and Slaikeu (1984), agree that lethality of intent must be thoroughly evaluated as the first step in the assessment of suicidal risk.

Many researchers and practitioners continue to use lethality indices for the purpose of assessing the degree of risk for a suicide attempt. Weiss (1957) developed an index which graphically describes the lethal probability of an individual's behavior as it ranges from minimum to maximum intent. Two distinct, but overlapping, populations were identified. The middle group appeared to be those individuals who attempted suicide but died by accident rather than intent.

Rubenstein, Moses, and Lidz (1958) conducted an extensive study of suicide vs. attempted suicide. They presented six major areas to be addressed when evaluating suicide attempts. One of these

areas, severity of attempt, was evaluated by a lethality scale ranging from 0 (less serious) to 5 (very serious). The severity was determined by assessing one's method, seriousness of hurt, how the person was discovered, and the behavior and comments of both patient and others in the emergency room. The authors communicated that a continuum of severity (intent) evolves based on motivation, psychopathology, and seriousness of attempt. The study stressed that the evaluation and treatment of a suicide attempt requires an assessment of intent.

Resnik and Hawthorne (1974) support Rubenstein by stressing the assessment of lethality, motivation, and method of the suicide attempt. In addition, they presented the need to determine the availability of rescue as an important factor to be considered.

Dorpat and Boswell (1967) conducted an evaluation of suicidal intent in attempted suicides and presented a classification of attempts based on degree of suicidal intent. In their study, the degree of intent was assessed by the use of a five point scale where a one represented suicidal gesture; a three indicated ambivalence; and a five revealed serious suicidal intent. The authors reported that the difference between attempters and committers was due to the difference in suicidal intent. The difference between groups (gesture, ambivalent, serious) was also reported to be distinguishable by differences in the degree of intent. Several indices can be found and have been used consistently and successfully in determining the risk of suicide. The scale developed and used by the Los Angeles Suicide

Prevention Center, in particular, has been widely accepted and used in a variety of settings with good results.

Other researchers, including Litman and Farberow (1965), Victoroff (1983), Neuringer (1974) and Politano (1967, 1986), strongly support the assessment of lethality and provide indexes for such use.

Litman (in Neuringer, 1974) supports the use of rating scales for determining lethality and suicide potentiality. He reports that "a successful assessment model of suicidal behavior will assign a suicide probability to individuals and to groups according to well-defined traits, characteristics, and behaviors."

Assessment scales, such as the one by Litman and Farberow, (in Shneidman and Farberow, The Cry for Help, 1965) and that used by the Los Angeles Suicide Prevention Center printed in Brief Counseling with Suicidal Persons, (1983) by Getz, Allen, Myers, and Lindner, have been used successfully to predict high risk suicidal individuals.

Bellack and Small (1979) consider that assessment or diagnostic procedures follow those generally utilized in brief therapy. They describe the approach as direct and active with inquiry when necessary. If suicide is not mentioned by the individual, and selfdestructive tendencies are suspected, then the topic should be raised by the therapist. Open and specific questioning is recommended with regard to intent, manner or plan of suicide and accessibility of lethal means.

They suggest an alertness to all communications from the subject: open or disguised, verbal or non-verbal, and those made in person or through another. Repeat references to suicide should also be acknowledged and considered as an indicator of ongoing trouble, if not of impending suicide itself.

Further attention to such factors as previous suicidal attempts, a family history of suicide, the death of one or both parents and feelings of depression, alienation, hopelessness, intense anxiety with fears of loss of control, impulsivity, and a lack of involvement with people and activities (Mintz, 1971; Bellack and Small, 1979) is a must.

Danto (1971) comments on the "assessment of the suicidal person in the telephone interview" and discusses the shortcomings of telephone interviews as a means of assessing the dangerousness of suicidal intents. He provides as evidence a situation which occurred at the Suicide Prevention Center in Detroit, Michigan, where a lack of appropriate information led to the failure of detection of a person in a suicidal crisis.

In an attempt to offer suggestions for the improvement of interviews in crisis situations, Danto presented a short schedule for the assessment of self-destructive potentiality as offered in Shneidman's book, The Cry for Help (1965):

1. Case History: Factual

   A. Age and sex

B. Onset of self-destructive behavior; chronic, repetitive pattern, or recent behavior change? Any prior suicide attempts or threats?

C. Method of possible self-injury: availability, lethality?

D. Recent loss of loved person: death, separation, divorce?

E. Medical symptoms: history of recent illness or surgery?

F. Resource: available relatives or friends, financial status?

II. Judgemental: Evaluative

A. Status of communication with patient

B. Kinds of feelings expressed

C. Reactions of referring person

D. Personality status and diagnostic impressions.

E. Reaction of interviewer (Danto's addition, p. 49).

Numerous researchers such as Petzel and Riddle (1981), Ray and Johnson (1983) and Lee (1978) reinforce the assessment of such variables as depression, loss of a loved one, feelings of isolation, low self-esteem, hopelessness, and school performance as essential. This data is most often collected by interview and history taking with the adolescent and family.

McIntire and Angle (1980) in Husain and Vandiver (1984) used the following information to help determine suicide potentiality:

1. Circumstantial lethality - the probability of rescue.
2. Prior self-destructive behavior.
3. Depression or negative self-concept.

4. Hostility

5. Stress

6. Reaction of parent or parent surrogate

7. Lack of supportive resources.

8. Loss of communication.

9. Extremes of parental expectations and control (p. 125).

Suicide attempts may be classified as intentioned, subintentioned and unintentioned. High and low lethality may be determined on that basis according to McIntire, et.al. (1977). The more serious the suicide intent, the more dangerous the means that will be employed.

Miller (1981) supports this when he emphasizes the critical issue of initial assessment is determining the need of the patient for life protection. This assessment is made by review of the social, psychological and biological factors affecting the adolescent and by the strength of the relationship which develops between the adolescent client and interviewer. Other factors critical in this assessment are continuity of service provided by the counselor and the availability of support from other people in the adolescent's environment.

Karl Slaikeu (1984) discusses in detail the importance of thorough assessment when confronted with a crisis, particularly suicide. He makes a special point of assessing the strengths of an individual as well as the weaknesses. Slaikeu indicates that the

prediction of whether an individual will kill himself has been studied extensively with inconclusive results. He does, however, present a consensus of guidelines for assessment. In addition, a list of factors associated with suicidal risk is presented.

Slaikeu states that an assessment of lethality involves first listening for clues to physical danger. Such clues may be verbal, nonverbal or initiated by another person. Next, a structured inquiry is necessary to gather information required before implementing an action plan.

Slaikeu strongly emphasizes that the assessment of dangerousness must include three key variables: plan, history of previous attempts, and willingness to use outside resources.

1. Plan: How far has the individual progressed in thinking about committing suicide? If an adolescent has developed a plan of death, then he is at much greater risk for suicide than one who has no plan. Furthermore, if this person has the means available to carry out his plan, the risk becomes still greater.
2. Previous Attempts: An individual who has never attempted to commit suicide is at lower risk than one who has, because the probability of success increases with each attempt.
3. Willingness to Use Outside Resources: Individuals who are physically or emotionally alone or isolated are at greater risk than those who have someone to whom they may turn. He stresses the importance of differentiating between the

availability of others and the individual's willingness to reach out.

In summary, Slaikeu states that lethality is low if responses to plan, previous attempts and isolation are negative. According to Slaikeu's psychological first aid model, if the lethality is assessed to be low, then the helper takes a facilitative stance, while if the potentiality for suicide is high, the helper then takes a directive approach.

The outcome of adequate assessment then is a determination of whether the adolescent is of mild, moderate or severe suicide potential. This determination seems best made after a thorough review of all available social, psychological and medical data along with an extensive and, if necessary, probing interview focusing on such factors as presented by Petzel and Riddle (1981), Miller and Lee (1978), and Slaikeu (1984). Other information which relates to interpersonal relationships, school performance, and coping skills is also important. Objective as well as subjective measures may be useful in this search. Without proper assessment, appropriate treatment is impossible.

Treatment

Depending upon whether the risk for suicide is high or low, various treatment procedures have been used. For individuals in severe crisis and with a high risk of self-destructive behavior, direct emergency measures such as hospitalization, and/or drug therapy must be considered. Referral to such treatment specialists or facilities is urgent; however, the intervention required to facilitate

such a referral is extremely important and requires as much involvement and technique as does crisis intervention counseling itself. For those who are considered to be mildly or moderately suicidal, less drastic action is needed. However, intervention must begin immediately with an intensive focus on crisis (problem) resolution.

Ray and Johnson (1983) separated treatment procedures into three perspectives: biophysical, psychological, and sociological. The biological and biochemical facets of treatment are the responsibility of the medical profession, which frequently uses a combination of hospitalization and chemotherapy, often the supplemental psychotherapy.

The psychological treatment perspective depends on the therapist or counselor helping the adolescent face presenting problems. This procedure is effective only after a sense of trust and rapport is developed between the adolescent and the counselor. Individual and/or group sessions may be utilized depending on the problem and personality of the youngster.

Treatment from a social perspective views the environment as the main contributor of suicide. Family interactions are felt to be directly involved in the adolescent's problems, therefore, making family intervention as part of the treatment process a must.

Many authors (Petzel and Riddle, 1981; Kelv, 1975; and Hendin, 1975) stress the importance of assessment and intervention involving all three aspects: biological, psychological and social.

Toolan (1978) stresses that intervention with depressed and/or suicidal youngsters must be individualized and tailored to each one's specific needs and problems. The student/counselor relationship is stressed as a significant and critical factor for productive treatment. Complete trust is a must for the youngster and may take time to develop due to adolescent's feelings of inadequacy and fear of another troubled relationship. Therefore, establishing a meaningful psychological contact with the adolescent is a top priority.

A face-to-face setting is recommended by Lesse (1983) for all counseling during the initial treatment stages, with the therapist assuming an active, supportive role. He, too, stresses the importance of optional rapport which he calls "positive transference relationship" but states that in order to avoid dependency this support should be gradually withdrawn as the person improves.

Other authors, while agreeing on characteristics of depressed suicidal patients and basic therapeutic requirements, seem to approach actual intervention from more of a problem-solving attitude by focusing on present, day-to-day, here and now issues, at least initially, rather than deep seated, underlying dynamics.

Kovacs, Beck, and Weissman (1975) state: "Some patients essentially report that their goal was to give up and escape from life and to seek surcease;" life is "simply too much" or "not worth living." Their mental or emotional "distress is intolerable;" they see "no way out" of their problematic situations and are "tired of fighting" (p. 363).

In their study, Kovacs, Beck, and Weissman surveyed 200 patients (aged 17 - 62) hospitalized for suicide attempts to assess whether levels of hopelessness and depression are informative clinical predictors and to discuss their usefulness in the treatment of a suicidal individual. The reason for suicide attempts was obtained from interview data within 48 hours of the patient's admission. Other data was obtained from various quantitative measures.

Results indicate that the majority (56%) of the patients felt that life held nothing desirable, wanted to part from it and viewed suicide as the preferred "solution" to their problems.

These authors report that "the majority of our patients tried to kill themselves because of a conviction that their problems were insoluble or because they wished to escape from a life which they viewed as impossible or not worth living" (p. 366).

Kovacs, Beck and Weissman go on to state that "regardless of therapeutic strategy, eliciting the reason for a suicide attempt provides a practical starting point. The cognitive-behavioral techniques hold a special promise in the psychotherapy of those individuals who seek suicide as the means of escape from life or as the final solution to the problems of living" (p. 367).

One form of treatment which is now widely accepted with adolescent suicide attempters is crisis intervention or brief, short-term intervention. Sifneos (in Bellack and Small, 1979) defines brief intervention as encouraging the patient "to examine the areas of

emotional difficulty which he tends to avoid in order to help him become aware of his feelings, experience the conflicts and learn new ways of solving this problem." Along these same lines, Burdon (in Bellack and Small, 1979) views brief psychotherapy as a push toward further problem-solving.

Brief psychotherapy as discussed by Bellack and Small, 1978 and Davanloo, 1978 received increased interest and study during the late 1970's and early 1980's. Reduced mental health funding has been partly responsible for this new examination of short-term intervention, as well as a renewed appreciation by mental health workers for the therapeutic success which could be accomplished in six to eight sessions instead of the earlier interventions of months or even years.

Crisis counseling or brief psychotherapy has a relatively short history, but it is important that those in school psychology, school social work, and school counseling learn more about the ideas and techniques of short-term intervention.

Caplan (1964) views an emotional crisis as "a psychological disequilibrium in a person who confronts a hazardous circumstance that for him constitutes an important problem, which he can, for the time being, neither escape nor solve with his customary problem-solving resources" (p. 53). For Caplan, a crisis is a period when the individual is temporarily out of balance.

Emotional hazards or crisis faced by school children are many, ranging from losses of significant relationships related to death,

divorce, etc. to more expected maturational or developmental challenges. Most children manage these situations without ill effect. Others, however, will come to the attention of school psychologists, who must be prepared to help.

Long-term intervention by school psychologists, social workers, and counselors is not possible or even appropriate; however, brief, short-term intervention is. Very often crisis counseling is necessary in order to "move" a student and family to referral sources which can provide the necessary long-term support.

Sandoval (1985) discusses the varied principles of crisis counseling of which school personnel should be knowledgeable. Through such intervention youngsters may regain balance, not lose time from learning due to emotional disorganization, and possibly develop successful new problem-solving strategies as a result of successfully resolving a crisis situation. Such resolutions hopefully will lead to greater confidence and success in future difficulties.

Additional support of brief problem-solving intervention are the comments of Bellack and Small (1979) who describe brief intervention or therapy as being useful only to the extent that a central problem can be selected for solution. French (1964) adds to this by defining the task of therapy as "emotional re-education" or the focusing upon the resolution and correction of here-and-now problems. Bellack and Small suggest a "Therapy Contract" which establishes an agreement

between therapist and patient identifying the problem to be addressed, responsibilities of each participant, and time available before reassessment. They stress the selection of a real-life goal (problem) to be addressed. Interventions of this nature should emphasize learning techniques so that the client will acquire skills in problem solution applicable to other situations he may face (Bellack and Small, 1979). "Possessing an approach to problem-solving, a method of organizing solution-seeking steps, structures what otherwise might become a chaotic rout" (Bellack and Small, 1979).

Klev (1975) bases the development of his crisis intervention therapy on the premise that the depressed suicidal patient is overwhelmed by feelings of despair and is faced with the failure of his usual methods of coping. Suicide is viewed as a way out or as an end to the pain rather than as a clear desire to die.

The first phase of Klev's therapy is the identification of symptoms and reinforcement of self-interest. His second phase is devoted to improving the individual's confidence and strengthening his ability to cope by aiding in the development of alternative methods of functioning. The major emphasis here is one of re-education, that is helping the client learn new ways to solve problems. This approach requires that the therapist act as a "guide" in solving problems.

Slaikeu, in his 1984 book Crisis Intervention, adopted the problem-solving approach as the intervention of choice for crises, including suicide. He defines a crisis as a "temporary state of upset and disorganization characterized by the individual's inability to cope with a particular situation using customary methods of problemsolving" (p. 13). This definition is supported by Caplan (1964) who views a crisis as a breakdown in problem-solving or coping.

Slaikeu suggests using his approach for what he calls First-Order Intervention: Psychological First Aid, and Second-Order Intervention: Crisis Therapy. Psychological First Aid is what one uses when faced with a crisis in helping an individual to restore immediate equilibrium or coping. The five components of psychological first aid are:

1. Make psychological contact
2. Explore dimensions of problem
3. Examine possible solutions
4. Assist in taking concrete action
5. Follow up (p. 87-88)

Slaikeu presents his "Psychological First Aid" as something that takes place as a first step in crisis resolution. His five steps are presented as a guide to intervention which do not have to be followed step by step in the order presented. This immediate intervention,

according to Slaikeu, may take minutes to hours, with the result of problem resolution being an agreement on the part of the client to begin short-term counseling.

Follow up crisis counseling or Second-Order intervention, according to Slaikeu, picks up where psychological first aid leaves off in helping the individual work through the crisis event. Crisis therapy is felt to be most effective when it coincides with the period of disorganization or disequilibrium which is described as roughly six weeks.

In crisis therapy, Slaikeu borrows from Lazarus's model of multimodel perspective of crisis therapy, and his second order intervention, which, incorporating different techniques and procedures, continues to follow the same general problem-solving outline of his "psychological first aid".

Lewis Wolberg in his book Handbook of Short-Term Psychotherapy discusses the feasibility and therapeutic importance of short-term or crisis intervention procedures. Some key concepts of short-term intervention as described by Wolberg were a focus on problem-solving, attention to immediate life conflicts, and the diverting of an individual's energy toward new attempts to solve problems as opposed to regressive interviews.

Sifneos also supports the problem-solving process, as indicated by several points of his intervention outline, such as a prioritized

listing of problems to be resolved, a focus which helps the person learn new modes of solving difficulties and a goal of helping the individual to be better able to use his new or modified skills, acquired in treatment, to better deal with other problems occurring in the future. D'Zurilla and Goldfried (1971) in discussing the clinical application of problem-solving state that "whenever the individual's difficulties are resulting from the ineffectiveness with which he handles a broad range of problematic situations, we would suggest that problem-solving training might be useful" (p. 120).

They state also that problem-solving might be helpful in difficult situations where neither client nor therapist has a clear understanding of the appropriate course of action. The authors regard problem-solving as a very beneficial technique for crisis intervention with regard to the resolution of the presenting problem and preparation for future crises.

While most of these techniques or intervention strategies are not presented in regard to intervention with suicidal adolescents, they are discussed as useful and suggested means of coping with individual's who are suicidal. Neither have these techniques been presented as restricted to only adult populations.

There is, however, some research which presents a problem-solving approach as beneficial to the suicidal adolescent. Petzel and Riddle (1981) in their extensive study of suicidal adolescents say that having the adolescent develop or learn problem-solving skills might also be important.

Until 1971, the hypothesis that adolescent suicide was related to poor or inadequate problem-solving abilities had not been empirically tested. Levinson and Neuringer (1971) attempted to evaluate the assumption that suicidal behavior in adolescents was linked to a diminished problem-solving capacity. They compared problem-solving skills for 13 suicidal, 13 psychiatric, but non-suicidal, and 13 normal adolescents. The authors found that the suicidal group demonstrated significantly lower performance and failure in problem-solving than did the psychiatric and normal groups.

Levinson and Neuringer state that problem-solving incapacity is of lethal consequence and suggest that those individuals working with potentially suicidal adolescents focus on having the client learn problem-solving skills.

Numerous other authors have presented adolescent suicide attempts as resulting from long-standing unresolved problems, failure of adaptive coping or problem-solving skills, and young people reaching a point at which they feel overwhelmed by their problems and unable to change their circumstances.

According to McGuire and Sifneos (1970), an "increasing amount of clinical evidence suggests that patients must learn problem-solving techniques if they are to effectively utilize short-term psychotherapy. Most patients need to learn that behavior and/or symptoms are actually problems that need to be solved" (p. 667). Individuals must learn to identify intrapsychic conflicts and the way

to approach changing circumstances in order to resolve those conflicts.

Skills training of varying kinds is argued by Getz, Allen, Myers, and Lindner (1983) as "applicable to short-term counseling which will facilitate the acquisition of skills that help one in dealing more effectively with events that precipitate suicidal crises" (p. 47). They advocate educating the client so as to improve coping and problemsolving skills which strengthens psychological resources and reduces anxiety.

Getz, et.al. (1983) continues by stating that it may be "useful to understand adolescent suicide attempts as problem-solving attempts." For these reasons, a problem-solving approach should be used primarily in crisis counseling with insight oriented techniques as secondary approaches. Such an approach, according to the authors, is helpful in reaching the immediate goal of reducing regression in the person and restoring him quickly to a more functional level.

The amount of literature relating to adolescent suicide is considerable. Most of it is descriptive in nature and has consistently defined the relationship between characteristics, assessment and suicidal adolescents. The breakdown of coping strategies and problem-solving skills has also been well reported in the literature as a contributing factor to emotional distress and suicidal behavior, however, research relating to adolescent suicide and inadequate problem-solving is less available. The present study will attempt to

contribute to the literature by further investigation of the relationship between problem-solving skills and suicidal behavior in adolescents. In addition, this project is designed to evaluate the efficacy of actual intervention strategy with suicidal youngsters which will provide new data in the field.

CHAPTER III

Methodology

Population and Selection of Sample

The population for this study consisted of adolescents aged 14-19 who were referred because of suicidal concerns. Subjects were male and female students of two Henrico County high schools. These students were either self-referred or referred by teachers, counselors or parents.

Of those adolescents referred because of suicidal behavior, only those considered to be of mildly suicidal status were included in the present study. Those with serious suicidal behavior were not included in the present study. Students who presented in a critical or emergency state were referred immediately to appropriate agencies.

The present project was a clinical case study approach consisting of six subjects. While this is a limited number, a larger group would create a situation which would be unmanageable considering the nature of this project. Intervention with suicidal adolescents requires careful, intensive work with adequate time for proper assessment. Flexibility, availability and accessibility are critical factors when intervening with potentially suicidal young people. Therefore, it is felt that greater numbers of subjects would jeopardize service. In addition, there is no way to assure the referral of a large number of students at any one time.

Permission for participation in this study was obtained from both students and parents.

Data Gathering

At the time of referral, the IPAT Depression Scale, The Suicide Probability Scale, and The Checklist for Solving Problems in Real Life were administered. Completion of The Classroom Performance Profile was also requested of the teachers. These assessment procedures could be easily be incorporated into the initial interview and provided preliminary information regarding appropriateness of referral of the student for this study. Scoring was done by the school psychologist.

Assessment instruments were administered by the psychologist or social worker with all information considered confidential. All information was kept in a confidential file in the psychologist's office, not in the school or in any existing student folder.

After receiving a referral, the psychologist or social worker conducted a clinical interview for the purpose of gathering social/background data and clinical information. This interaction served as the first step in the intervention process as defined by Slaikeu (1984) "making psychological contact."

In this study, the school psychologist or school social worker conducted the primary clinical interview and subsequent interv. ıtion strategy. This eliminated the uncomfortableness of others created by requiring them to intervene therapeutically with potentially suicidal adolescents. This created, however, the potential for experimenter bias, but could not be helped in order to minimize the predispositions

of others involved. The fact remains that many individuals in public schools are very uncomfortable when dealing with adolescents in suicidal trouble.

An interview guide was developed and used which identified areas needing thorough assessment and data collection, however, it did not provide specific questions to be asked. All individuals involved were experienced in interviewing adolescents. Each had their own style of building rapport; and, therefore, could obtain the necessary data with an outline only. While this diminished some control, everyone approached the situation in their own style, it was felt necessary in order to reduce tension by having interviewers adjust to a new procedure. The nature of this study required thorough and sensitive data collection; changing a person's style or even structuring it too much might have hampered rapport or interaction.

Within 48 hours of the initial referral, the psychologist contacted the student's family to obtain social data including a report of the student's adaptive behavior. During this conference referral concerns were discussed with the student's parents. The proposed intervention strategy was presented and discussed with the parents. The family was also advised of the present study. Permission was obtained for intervention and inclusion in the research.

Treatment

Each subject received the same intervention strategy. A problem-solving approach was initiated with each student focusing on his own personal problems as identified through interview (self-report) or by other assessment. The issue or issues which led him to the point of considering suicide was targeted for change.

The intervention strategy is based on the problem-solving approach presented by D'Zurilla and Goldfried (1971) and more recently by Slaikeu (1984) who applied the problem-solving framework to crisis intervention and short-term crisis therapy. His approach is structured as:

a. psychological contact
b. general orientation
c. problem definition and formulation
d. generation of alternatives
e. exploration of possible consequences (positive and negative)
f. goal setting and action
g. follow up

This outline was followed for the intervention with each student and his (or her) specific problem(s). Comprehensive case notes were kept for all sessions. These notes recorded the movement through the above stages detailing each specific area. All qualitative data was recorded and discussed. This data came from the various interviews, individual session notes and observations.

Each student was seen at least once a week for six weeks. Students were seen more often, if during the first interview, it was

felt to be necessary. Sessions focused on the identification and resolution of problems via the problem-solving framework presented above. For some students, the entire six sessions had to be devoted to the discussion and resolution of one problem, while for others, several problems were addressed during the same time period.

Each session was approximately one hour in length with some flexibility, allowing for more time if necessary. No session exceeded ninety minutes, however.

At the end of six sessions, the student was assessed again using the IPAT Depression Scale, Suicide Probability Scale, Problem Checklist, Student Classroom Performance Profile, and interviewed. Parents also were recontacted at the end of six weeks.

Ethical Considerations

Due to the nature of this study, established procedures for protecting the rights of human subjects were followed. A "Proposal for Research with Human Subjects" was submitted to the following committees for approval: (1) The College of William and Mary Human Subjects Research Committee; and (2) Henrico County's Research Committee.

In addition, this study was supervised by Dr. Ruth Mulliken, Licensed Child/Clinical Psychologist, and Dr. Myron Seeman, Licensed School Psychologist. Each provided regular contact and supervision.

Participation in this study did not exclude emergency referral for subjects if the need arose. If during the course of this project a

student became more suicidal and reached a critical status. Immediate referral for emergency services was made. One student was referred for more intensive and comprehensive services and, therefore, was dropped from the study.

All discussions, interviews, and written results of this study were treated in a confidential manner in order to protect the student's anonymity. Students were advised that they could terminate treatment at any time and seek assistance elsewhere.

Instrumentation

Lethality Index

The index developed by Politano (personal communication, 1986) was used in the present study as a means to determine the degree of lethality for each student referred. Those students identified as high risk individuals were not included in the present study. Instead, parents were contacted and referrals to other agencies were made. Numerous authors (Weiss, 1957; Rubenstein, Moses, Lidz, 1958; Dorpat and Boswell, 1963; Dorpat and Ripley, 1967) stress the importance of thoroughly assessing lethality of intent as the first step in dealing with suicidal individuals. More recent authors (Resnik and Hawthorne, 1974; Politano, 1976, 1986 and Slaikeu, 1984) support these findings and, in addition, stress the need to assess the availability of rescue as an important factor in determining intent.

The index developed by Politano can easily be completed as part of an initial interview. In addition to identifying data such as age, sex, marital status and race which are important factors (Davis,

1983) other critical factors such as, suicide plan, suicide method and availability of method are assessed. Each of these three factors is weighed on a scale ranging from no (0 points) to vague (1 point) to yes (2 points). Different methods of suicide are listed also with varying degrees of lethality rated differently. For example, a method which includes a firearm is rated much higher than a method which includes nonprescription drugs. Politano's index also includes number of previous attempts, previous attempts requiring hospitalization, time lapsed since last attempt and likelihood of rescue.

Reliability and validity data are difficult to obtain for lethality indexes, however, most authors who use them report positive and meaningful results. Victoroff (1983) admits that his scale may err on the side of false positives, which should not create a burden for doctor or patient, but he states that his "purpose is not to collect numbers but save lives" (p. 63). His scale has been used successfully to aid in this task.

Dorpat and Boswell (1963) report good reliability for their scale because of the high correlations among trained, independent judges using the intent scale. When using the five (5) point ordinal scale of suicidal intent, a group of judges made judgements of 121 attempted suicides with a high degree of agreement.

The index developed by Politano (1976, 1986) has been modified further to include such critical items (Resnik and Hawthorne, 1974) as time since last attempt and likelihood of rescue. This particular

index has been used with marked success in identifying high risk individuals.

Suicide Probability Scale

The Suicide Probability Scale (SPS) is a self-report instrument consisting of 36 descriptive statements designed to aid in the assessment of suicide risk in adolescents and adults. Individuals are asked to rate the frequency of their subjective experiences and past behaviors using a 4-point Likert scale ranging from "None or little of the time" to "Most or all of the time." An overall assessment of suicide risk is reflected in three summary scores: a total weighed score, a normalized T-score, and a suicide probability score. The SPS also provides four clinical subscales: Hopelessness, Suicide Ideation, Negative Self-Evaluation, and Hostility.

The SPS has use as a routine screening instrument in conjunction with other methods (e.g. clinical interviews, additional testing) and can also be used to monitor changes in suicide potential over time. Another function of the SPS is to provide hypotheses for areas of clinical investigation. The authors suggest attention to patterns of individual responses, which may provide information about coping and defense mechanisms. Finally, the SPS is indicated as useful as a research instrument to evaluate intervention strategies or monitor changes in suicide ideation in individuals over times of stress (Cull and Gill, 1982).

The SPS was standardized on a sample of 562 individuals (220 males and 342 females). Despite the limitations of over-representing

single college students in early twenties, under-representing males and persons with a high school education or less and a restricted geographic region, the authors feel that the size and diverse nature of the sample do indicate the ability to generalize from the test results and make valid assessments of suicide risk.

The SPS has a total scale internal consistency of alpha = .93. Alpha coefficients (Cranbach, 1951) were computed on the sample of 579 even numbered cases and replicated on the sample of 579 oddnumbered cases. With norm alphas of .80 and .78 for the two independent samples.

Split-half estimates were computed by dividing each subscale and the total test into approximately equal halves and the correlating scores on each half for the total sample of 1,158 cases (562 normals, 260 psychiatric inpatients, and 336 suicide attempters). The Spearman-Brown computational formula was used. Corrected correlation coefficients ranged from .58 for negative self-evaluation to .88 for suicide ideation, with a correlation of .93 for the total test.

Test - retest reliability was determined in two different studies with two separate samples. The correlations from the first study was .92 while the second study yielded a .94 correlation. The authors report that the SPS is not subject to situational variability which they feel allows for more confidence when interpreting across repeated administrations.

Item-subscale and item-total correlations for each of the 36 items was computed. For the four subscales, average item-subscale

correlations ranged from .51 for negative self-evaluation to .75 for suicide ideation. Most items are also reported to correlate significantly with other subscales.

Intercorrelations between the four subscales and between subscales and total SPS scores were also computed. The lowest correlation was reported between negative self-evaluation and hostility (r = .42) while the highest was between suicide ideation and hopelessness (r = .75). Subscale to total correlations ranged from .67 for negative self-evaluation to .92 for hopelessness. The authors report that the subscales are interrelated, but yet distinct enough to provide helpful clinical information.

Correlation between the SPS total scores and the suicide threat scale, developed for the MMPI by Farberow and Devries (1967) was .70.

Some limitations, according to Buros (1985) must be noted. The internal consistency of the total scale (.93) and the hopelessness subscales for hostility (.78) and negative self-evaluation (.58) are significantly lower.

While test-retest reliability is reported for the total score, it is not for individual subscales or clinical subpopulations. Also, data are not reported on the sensitivity of the SPS to suicidal crises.

Buros also reports concern about the discriminate validity of the SPS and states that further proof of its usefulness is necessary.

Golding (in Buros, 1985) points out in his review of the SPS that misclassification is high for both low and high risk groups.

In general, Golding does not feel that the SPS has yet been proven useful against a clinical interview for predictive purposes. The authors Cull and Gill do feel, however, that the scale can at the least provide beneficial clinical data.

The Checklist for Solving Problems in Real Life

The Checklist for Solving Problems in Real Life is composed of twelve statements which describe personal problem-solving behaviors. This checklist was designed to assess an individual's needs and desires for training in effective problem-solving behaviors. Statements 1 -10 are designed to reflect whether or not the person typically displays behavior in each of the six skill areas of problem-solving when attempting to solve their own personal problems.

Statements 11 and 12 give each individual an opportunity to express a desire to train in effective problem-solving. In #11, individual's can request training in improving general problem-solving skills while #12 addresses the desire to focus on specific behaviors identified in statements 1 - 10.

The Checklist for Solving Problems in Real Life was used by Brian Jones (in Krumboltz and Thorenson, 1976) in assessing problem-solving competence as it related to problem-solving strategies.

Responses before and after exposure to training experiences are studied for changes in an individual's self reports of personal

problem-solving behaviors and changes in requests for assistance. This instrument was used in the present study as an interview supplement. It was used in discussion with the students, as with other interview data, to identify problem areas for attention.

Student Classroom Performance Profile

The Student Classroom Performance Profile (SCPP) developed by Joseph M. Mayfield, Ph.D., (1983) is a 31 item behavioral description of a student's classroom performance as perceived and rated by his teacher. The instrument is useful in grades 3 - 12 and requires about ten minutes for a teacher to complete. The procedure is sensitive to differences in academic/social functioning among talented and gifted, normal and handicapped populations. It is an internally reliable instrument with a split-half reliability of .96.

The SCPP is not just a measure of pathology. It provides a description of a student's general school functioning. Each of the descriptors is arranged on a 5-point Likert scale, ranging from severe behavioral dysfunction to integrated adjustment and leadership. Descriptions relate to observable behavioral trends, not specific incidents.

The SCPP is reported to have two major uses: clinical/applied and psychometric. From the clinical/applied standpoint, the scale can be immediately used for obtaining objective teacher observations about a student's performance. The format allows for narrative descriptions from teachers as well as forced choice responses in

behavioral areas. Scoring and summary divides the 31 items into four factors: classroom skills, self-concept/self-control, social skills and creativity. The scale may also identify student strengths and provide useful information for the initiation of counseling.

As indicated by Miller (1981), Petzel and Riddle (1981) and Lee (1983), school performance is an area of importance in identifying and assessing potentially suicidal adolescents. The Student Classroom Performance Profile provided objective data from teachers about the student's behavior before and after intervention.

IPAT Depression Scale

The IPAT Depression Scale consists of forty statements relating to how people feel or think. The authors goal was to develop a psychometrically sound instrument which could be easily used in practice to produce a reliable and valid estimate of depression level.

The construction of this scale is the result of a blend of factor analysis and empirical keying. The authors feel that the test represents a good understanding of depression as a factorially distinct trait and demonstrates practical validity as well.

The standardization sample consisted of individual records from the Clinical Analysis Questionnaire for 1,915 normal and clinically diagnosed adults. These individuals had been evaluated at more than 60 locations across the United States and Canada. The 950 clinical subjects (598 males, 352 females) were all hospitalized or receiving outpatient therapy. The normal sample consisted of 488 males and 477 females.

Item selection criteria were required which would yield an item having its highest correlation with the depression factor rather than any other factor, that the item significantly differentiate normals from depressives and depressives from other types of clinical disorders. The 36 items which comprise the final scale are not untested items but ones which have survived previous item analyses used in the construction of scales for primary depression and clinical factors.

Test-retest reliability coefficient is .93 in a sample of normal adults. Being a new test, ongoing studies are being conducted to determine more precise data about test stability.

A correlation of .88 between the 36-item scale and the pure depression factor is a sample of 1904 normals and clinical cases was reported in response to the question of how well the test differentiates normals from diagnosed depressives. Predictive potential, therefore, is reported as satisfactory.

The Clinical Interview

Since the beginning of the efforts to prevent, treat, or identify suicidal individuals, the interview has been a consistently used clinical tool. It has been used by psychiatrists, psychologists, social workers, nurses and other professionals.

Hadley (1960) writes extensively about the interview as a clinical tool. He described the interview as a must to be compared

with projective data. Hadley believes that the interviewer should create a warm, positive atmosphere which will in turn facilitate rapport. He further states that the interviewer should be cheerful, optimistic and friendly but impersonal and neutral. The interviewer should project an image of self-assurance, confidence, and professionalism.

Hadley believes that the diagnostic personal interview can be used with all clients including children, regardless of age. He describes the interview as particularly valuable because it allows the clinician or counselor to obtain information directly from the client . It makes it possible to gain the client's own point of view.

Hadley emphasizes a number of principles which he feels are critical to good interviewing. They are:

1. The interviewer needs to set a good tone with an attitude of sincerity and understanding.
2. A good start is important. This is the time to discuss interview purpose and possible direction.
3. Notes should be taken during the interview (with permission) and immediately afterwards.
4. Questions should be presented in a clear, natural and straightforward way.
5. Get beneath superficial answers without a pushy antagonistic tone.
6. Note and check discrepancies.

7. Encourage free expression but control behavior.

In addition, Hadley presents numerous content areas which he feels should be covered in the interview setting. Having the client describe his own problem as he sees it is essential. It is felt that doing this helps to build rapport and ease anxiety. The client's own communication also allows the counselor an opportunity to recognize defensive mechanisms and self perceptions. Other content areas which Hadley presents as important are the client's motivation, mood, anxieties, worries, fears, depressing experiences, ambitions, sources of conflict and anger, guilt feelings, sleeping and eating habits and religious beliefs.

Hadley also suggests that immediately following the interview the counselor write his reaction to it including clinical impressions and observations. Behavioral observations should also be recorded.

Cormier and Cormier (1979) regard the interview as one of many ways to help. They describe the goal of the interview as developing hypotheses about factors influencing a client's problems and possible strategies for change.

The Cormiers describe three distinct advantages of the interview as compared to other ways of helping. First, the interview situation allows the client to become more involved in the process and may even reinforce the subject to change. Secondly, the interview provides important and useful data for both client and counselor. Thirdly, the interview can help the individual learn about the counselor and his approach.

In their text, Cormier and Cormier discuss categories for defining problems.

1. Determining the purpose of the interview.
2. Identify problem concerns - set priorities.
3. Identify present problem behaviors.
4. Identify antecedent contributing conditions.
5. Identify consequent contributing conditions.
6. Identify client's coping skills.
7. Identify problem intensity.

The Cormiers describe the interview as one of the easiest and most convenient helping strategies because of its minimal cost and the requirement for little extra time. They do discuss limitations of the interview, however, indicating that the interview is the least systematic and standardized intervention.

Miller (1981) used clinical interviews to determine information and factors relating to the incidence of an actual act of suicide among adolescents. Interviews were used further to identify different types of suicidal behavior.

Miller uses the initial interview with an adolescent to help determine the likelihood of self-destructive behavior. During the interview careful study of potential social, sociological, and psychological determinants of suicidal behavior is necessary. Miller states that during the interview, the client's treatability is assessed on the basis of the adolescent's ability to relate to a therapist, the

type of frustration that caused the behavior and the severity of the problem.

Litman and Farberow in A Cry for Help (1961) used the clinical interview to assess self-destructive potentiality during an emergency situation. They developed a short interview schedule for intervention consisting of a series of factual questions followed by a set of questions nonjudgemental and evaluative in nature.

The first set of questions are primarily historical in nature and relate to such issues as age and sex, onset of self-destructive behavior, methods of possible self injury, recent loss of a loved one, medical background and available resources.

The second schedule of questions is more evaluative in nature and encompasses such issues as the status of communication with the client, kinds of feelings expressed, reactions of the referring person and finally the personality status and diagnostic impression of the counselor/therapist about the client.

Litman and Farberow consider these data categories critical in the assessment of self-destructive potentiality prior to making recommendations for appropriate follow up action.

For Sabbath, the interview was successful in eliciting critically useful data about patient's background, including parents, problems, and suicidal thoughts.

Other authors have also used the interview as the primary tool in their assessment and intervention with suicidal adolescents (Petzel

and Riddle, 1981; Toolan, 1978; Ray and Johnson, 1983; Tobachnick, 1981).

Wolberg (1980), Ornum and Mordock (1984), Husain and Vandiver (1984) and Slaikeu (1984) have all written books relating to counseling, crisis intervention, short-term therapy and suicide with the young. Each author uses the clinical interview as a major tool for assessment and follow up. Even if other quantitative measures are used, they are done so as supplements to the interview.

Borg (1984) cautions, however, that although the interview can provide valuable data, it must be remembered that it is a highly subjective technique. He suggests the development of an interview guide and subsequent pilot study. An interview guide was used in this study and adapted by combining the input of various authors in the field of adolescent suicide.

Borg goes on to point out that the interview, while advantageous in its face-to-face data collection, is also at a disadvantage because of this same direct interaction. The interview is adaptable in that it allows the interviewer to follow leads from the client, thus obtaining more data and greater clarity. The adaptability and direct interaction between helper and the suicidal adolescent is also viewed by many authors in the field of adolescent suicide as not just advantageous, but necessary.

Another advantage presented by Borg is that an interview, performed by a skilled interviewer, is more likely to obtain sensitive

information from a client than is a questionnaire. Jackson and Rothney (in Borg, 1984) indicate that "the interview is likely to produce more complete information when open-ended questions pertaining to negative aspects of the self need to be asked" (p. 437).

However, despite some advantages the interview does have definite limitations. One is that the interview is often misused by collecting quantitative data that could be measured more accurately by other means.

According to Borg, the flexibility, adaptability and person-to-person format can also be limiting in that these may lead to biases and subjectivity in the research. Eagerness of the respondent to please the interviewer, vague antagonism between interviewer and respondent or the tendency for the interviewer to seek out answers that support his research may contribute to biasing.

While it is impossible to control for all response effect in this study, an attempt to minimize it was made by: (1) providing inservice training for the counselors involved concerning (a) details of the study itself, (b) assessment procedures they used (c) the referral process to the psychologist for further assessment and intervention. The counselors involved in this study are all professionals with state certification and years of experience working with adolescents. Each has had experience intervening with potentially suicidal youngsters and their families referring cases to the school psychologist and discussing such referrals with students.

It is felt that any predisposition of the student was not a major problem since his participation was not solicited per/se. In fact, just the opposite was done - we responded to students's requests, in most cases. It has been our experience that, for the most part, adolescents are anxious for help once they reach the point of contemplating suicide. If a student was resistant to help, he was not included in the study but was assisted as is any other student in our school system . No student was unattended!

The instruments used in this study were chosen not only because they provided the information desired, but also because they could be easily integrated into the basic interview process. Adolescents frequently are resistant to testing, therefore, instruments which could be completed relatively easily and quickly were felt to be necessary in order to maintain the subjects' interest and validity of responding. Also, lengthy or involved written assessment with potentially suicidal adolescents was not felt to be appropriate. One of the goals of this study was to intervene with the subjects in an attempt to help them resolve their problems, therefore, instruments which would enhance this process were necessary.

Research Design

This research was conducted by using a clinical case study approach as defined by Borg (1984). The actual design is as follows:

O_1 X O_2

Specific Hypothesis:

$H0_1$: There will be no difference between pre and post results on the Suicide Potentiality Scale.

$H0_2$: There will be no difference between pre and post results on the IPAT Depression Scale.

$H0_3$: There will be no difference between pre and post results on the Student Classroom Performance Profile.

$H0_4$: There will be no difference between pre and post responses to the Checklist for Solving Problems in Real Life.

No formal statistical analysis was performed although comparisons between pre and post measures for each subject were made. Results are presented and discussed on an individual basis as well as among subjects. Other areas of discussion related to family factors, school factors, social factors and academic factors. Other areas of focus were:

1. Do suicidal adolescents demonstrate deficient problem-solving abilities:

2. Do students become more confident in resolving their problems:

3. Do suicidal adolescents demonstrate a knowledge of inadequate problem-solving and a desire to improve weak areas?

CHAPTER IV

RESULTS

Because of the nature of this project, a case study approach was selected by the investigator. In question, was the efficacy of an intervention strategy based on a problem-solving model. To investigate whether there were differences between subject's responses to pre and post assessment, four null hypotheses were constructed. Each case will be presented separately including pre and post test results and discussion of the four null hypotheses.

Key to Instrument Interpretation

Suicide Probability Scale

Total Weighted Score: refers to the individual's cumulative score for the entire SPS profile. Used to obtain T-scores and Probability scores.

T-score: is interpreted in terms of standard deviation units. Suicide risk increases with the elevation of the score above the mean of 50T. Absolute cutoff points are arbitrary; however, a score of 60T or above indicates the need for careful evaluation of suicide risk. Scores of two or more standard deviations above the mean (70T or greater) are considered highly significant. Negative deviations (40T or lower) may indicate the possibility that the person has consciously or unconsciously sought to minimize actual suicide potential.

Probability Score: This score does not refer to the probability that a particular will make a lethal suicide attempt. Instead, it refers to

the statistical likelihood that an individual belongs in the population of lethal suicide attempters as evidenced by SPS responses. For example, a probability score of 72 does not mean that the individual has a 72% chance of killing himself but that there is a 72% chance that the individual belongs in the population of lethal attempters.

Clinical Subscales: These were designed to help distinguish, in addition to a global dimension of suicide risk, a more precise pattern of factors expressed in a particular individual. They may be used to identify areas of strength and vulnerability in individual clients. These scales were normalized (+ = 50, SD = 10) and interpretable in terms of standard deviations. Scores above 70T are considered to be significantly different from the normative sample.

Definition of Subscales

Suicide Ideation - reflects the extent to which an individual reports thoughts or behaviors associated with suicide.

Hopelessness - this scale assesses an individual's overall dissatisfaction with life and negative expectations about the future.

Negative Self-Evaluation - reflects an individual's subjective appraisal that things are not going well, that others are distant and uncaring, and that it is difficult to do anything worthwhile.

Hostility - reflects a tendency to break or throw things when upset or angry and includes a cluster of items reflecting hostility, isolation and impulsivity.

Classification of risk reported in the SPS results was determined by using the intermediate-risk category. This category is

to be sued with general outpatient clinic populations who have been referred for general symptoms but show no clinical signs of suicidal ideation or major depression.

This category was chosen instead of the high-risk group, which is used to classify individuals in settings such as suicide prevention centers, crisis clinics, and psychiatric inpatient facilities, and the low-risk category is provided for routine screening procedures applied to a general population (e.g., in selecting personnel for highly stressful positions). Since all subjects used in the present study were referred because of concerns about the possibility of suicidal behaviors, it was felt that the intermediate-risk category was most appropriate.

IPAT Depression Scale (Personal Assessment Inventory)

Results are determined by converting raw scores to STEN scores or standard scores and then plotting them as a continuum ranging from 1 to 10. Standard scores of 5 and 6 are considered the mean and contain between 40 to 60 percent of the population. The further standard scores move away from the mean in a lower direction (SS of 4,3,2,1) the less depression is indicated. Conversely the further standard scores move away from the mean in a higher direction (SS of 7,8,9,10) the more depression is indicated.

The norms used for obtaining standard scores and percentiles on the IPAT Depression Scale were those developed for college students. These norms also included men and women together. Adolescent

norms were not available. College norms were chosen because it was felt that they more closely approximated the individuals in the present study in age and occupation, that is, college students are also involved in academic endeavors.

Interpretation of the Classroom Performance Profile

Results are based on the compilation of data from three different groups. Group 1 were regular education students referred by teachers who described them as making adequate but not remarkable progress. Group 2 were middle and high school Talented and Gifted students. Group 3 were handicapped students (Learning disabled and Emotionally Disturbed) from middle and high schools.

Classroom Skills		Self-Control/Self-Concept	
Group 1	21.10	Group 1	21.33
Group 2	27.49	Group 2	25.82
Group 3	12.79	Group 3	13.89
Social Skills		Total Score	
Group 1	22.50	Group 1	63.89
Group 2	24.12	Group 2	77.03
Group 3	14.79	Group 3	41.47

No special formula is used to determine factor scores. Teacher responses on each of the factors is summed and reported as the individual's score for that particular subscale. Each factor score and total test score can then be compared to the standardized samples for

determination as to whether an individual is performing more like the normal group, TAG group, or handicapped group. Post testing can be used to discuss movement on a student's part toward or away from certain groups.

For some of the students in the present study, more than one teacher completed the checklists. In such cases, scores were rank ordered with the median score being chosen to represent performance in the different descriptive areas.

Checklist for Solving Problems in Real Life

Interpretation of this instrument is purely subjective in terms of differences between pre and post results. Each item can be compared with itself for pre and post assessment in order to identify changes but no mathematical or statistical scoring is available.

CASE I

D, a sixteen year old female.

D was referred by school personnel because of concerns about her angry, defiant attitude and lack of classroom success and achievement. D was described as argumentative, oppositional and easily frustrated. Her counselor indicated that D was very "street wise" and demonstrated feelings of anger and hostility. In addition to these concerns, personnel were worried about periods of depression and possible suicidal tendencies. Her aunt and legal guardian, with whom D lives, was also concerned about D's mood swings and aggressive outbursts.

Prior to coming to the Richmond area, D lived in North Carolina with her mother. Apparently D was sent to live with her aunt because her mother did not want her. D, of course, has been upset and angry about this rejection and never seems to have quite resolved the issue. D's father has not been in the picture for some time. She has not seen or heard from him for years. Also living in the present home is D's grandmother.

D reportedly has had similar behavioral and social problems for some time. She has historically been described as angry, moody, and emotionally labile. Concern was expressed this year by her school counselor that D may have an eating disorder such as Anorexia or Bulimia. D reports having previously attempted suicide.

The school child-study team had referred D and her aunt to a local agency for follow up; however, they were placed on a waiting list. Since the family did not have enough money to pursue private treatment, participation in this study was offered as an interim service despite the fact that D was more seriously involved than the other students in the study. (According to the Lethality Index, D was a moderate risk student.)

D was being worked with by the school social worker who had met with her briefly. In those sessions, D was described as open, cooperative and responsive to intervention. D was talkative, spontaneous and interested in seriously working toward resolving some of her problems. D had identified specific problem areas to be addressed in three different categories: behavior, attitude, and weight. Some of the more specific behaviors D identified were: "learning to keep my mouth shut, don't talk smart to anyone, stop getting bad grades, stop putting myself down, try to overcome my hate feelings, eat healthy foods, work on my behavior, and keep up my personal hygiene." Teachers reported that D's behavior and school performance had improved noticeably with the initiation of intervention.

Although D had made some good first steps in a positive direction, she was not at a point where she was ready to cope with all circumstances. After a confrontation at home with her grandmother, D took an overdose of her grandmother's heart medicine and had to

be taken to MCV Hospital. D had gotten angry with her grandmother and wanted to get back at her. If D had been able to stop and think before acting, she may have been able to respond with a different, less lethal alternative.

The key, of course, is stopping and thinking before acting. Although D had to be dropped from the study, her situation does provide some useful information. As Shaffer (1973) indicates, it is not always the quiet, depressed adolescent who attempts suicide. Those young people who must contain feelings of anger and impulsivity may be potentially more dangerous. Their "I'll get even with you" attitude can obviously be lethal, even if their desire is to get even instead of dying. Suicides can occur by accident.

D's situation also reinforces the necessity of assessing why previous attempts may have occurred, e.g., did the individual truly want to die or did they primarily want to get even. The results may not matter, but the reason may lead to different intervention.

When confronted with a problem, D's way of coping or resolving the issue was to get even. Simply intervening to reduce the anger or intense feelings at crisis, while necessary and valid, may not necessarily help prepare the individual for the next time. Hopefully not, but such intervention may tend to reinforce the feeling that someone will intervene and rescue, thus keeping the focus and burden of responsibility on others. If D could learn to better control her impulses and if she could develop new and potentially less dangerous

solutions to problems, she may not reach the point of attempting suicide again.

D was at MCV for a short while but returned to school to complete the year. She is being followed on an outpatient basis.

Suicide Probability Scale

Total Weighted Score	106	
T-Score	77	
Probability Score	90	
Subscale scores:	Raw Score	T-Score
Hopelessness	28	69
Suicide Ideation	30	76
Negative Self-Evaluation	13	54
Hostility	25	79

Classification of risk - Severe

No post scores were obtained because D was dropped from this study after she was hospitalized.

T-scores for both the total scale and clinical subscales were above the mean and indicative of serious suicidal tendencies. The only score not elevated was on the Negative Self-Evaluation subscale which indicates that D felt that things in general were going pretty well and felt a sense of closeness with others. Other subscale results revealed feelings of dissatisfaction, impulsivity and fairly frequent thoughts about suicide.

IPAT Depression Scale

(Personal Assessment Inventory)

Pre:	Total Raw Score	41
	Standard Score	9

The standard score of 9 places D about 1 3/4 standard deviations above the mean and at the 94th percentile which is indicative of significant depressive tendencies.

No post testing completed.

Checklist for Solving Problems in Real Life

D indicates that when confronted with a problem, she usually does not consider different possible solutions to solving it. She does not know how to tell if new information will be helpful and has difficulty actually defining a problem appropriately.

Other responses indicate that D usually has a method to look for possible solutions, and usually considers the possible results, good and bad, of each solution. She reportedly knows a good solution from a bad one, chooses a second solution in case her first one doesn't work and knows how to figure out what needs to be done to carry out the necessary plan for problem resolution.

D also indicated that she wanted to learn how to solve her problems better.

CASE II

W, sixteen year old male.

W is a high school freshman who was referred by both parents and teachers. At school he was described as inattentive, disruptive and disobedient. Despite being in a special education program, W was failing almost all classes primarily because of his lack of interest and productivity. He reportedly attempted very little work and frequently refused to turn in those assignments which he did complete. His teachers expressed concern that W had few friends and seemed to be interpersonally and socially isolated. They went on to describe him as "immature" and "unable to cope" with a regular school day. W was reportedly moody and labile in behavior, ranging from quiet, withdrawn periods to open aggression and defiance. He was further described as frequently depressed and unhappy as evidenced by crying and tantrums. W was viewed as more of a victim of his environment than one who maintained any control over it.

W's teachers were additionally concerned about him committing suicide. His lack of coping skills and extreme vulnerability to stress universally concerned teachers. Confrontation with peers or other environmental stressors leads to quick deterioration in W. He is very easily frustrated and defensive. What coping skills he has break down quickly resulting in impulsive and infantile responses.

During a conference, W's parents expressed strong concern about the lack of his social, emotional and academic progress. They

described him as extremely difficult to discipline due to his impulsive, oppositional and argumentative manner. Problems of impulsivity and quick emotional deterioration also occur at home. Parents view him as easily frustrated and immature. He does not get along well with siblings and when confronted will display tantrum behavior. His parents are concerned about W's social contacts because they feel he spends too much time with older individuals and the "wrong crowd." He has very few friends with relationships in general described as superficial. The fact that W craves attention, they feel, makes him even more vulnerable "on the street."

Mother and father are very concerned about the possibility of W attempting suicide. Although there have been no such attempts, W has threatened suicide several times in the past. His parents indicate that those threats occur when W is feeling overwhelmed and trapped.

During the interview, W presented as a very young, almost childlike adolescent. He smiled easily but frequently inappropriately. W was responsive and spontaneous, however, his comments were frequently off the topic requiring redirection. W says he has only one friend, an older man (young adult) who is now in jail. He reports no friends his own age at school or home. W stays to himself at home but does enjoy going out and around the neighborhood. W admits to feeling lonely, sad, depressed and angry. He admits to having considered suicide numerous times and doesn't

know why he didn't try it. He just recently contemplated suicide again (within the last week). This time he planned to go to the railroad track near his home and sit in front of a train. He thinks of this when things don't go right at home or school and feels he has no other way out.

The following is a brief outline of six sessions with W which is designed to demonstrate the structure used each conference. For the other students, a general summary is presented instead.

Session I

Problem:

"The teacher. He makes me feel embarrassed and makes me cry. He makes me angry and I want to quit." W was pushed for more specifics or a better definition of exactly why the teacher had to confront him so often. Specific issues related to lack of completed class work, lack of attention in class, and behavior outbursts.

Possible Solutions:

1. Behave myself, don't talk out.
2. Do the work.
3. Stay out of trouble.

Consequences:

Positive -

1. Teacher won't yell at me.
2. I won't be embarrassed and cry.
3. I won't fail.

4. I won't get disciplined.

Negative -

1. Teacher will yell at me.

2. I'll be embarrassed and cry.

3. I'll fail.

4. Get in trouble.

Action Planned:

Try to behave and do my work.

Follow up:

Review next week.

Session 2

Problem:

Assigned to In School Suspension Program for not doing work and receiving too many Alternative Placement for Attitude Developments. Does not like In School Suspension Program because it is boring and embarrassing.

Possible Solutions:

1. Do required work.

2. Keep up with class notebook.

3. Do class work.

Consequences:

Positive -

1. Won't fail.

2. Less embarrassing.

3. Won't get ISSP or grounded at home.

4. Teacher will leave me alone.

Negative -

1. More ISSP, grounded at home.

2. Fail the class.

3. Get sent to principal.

Action Planned:

Improve work production by doing required assignments.

Follow Up:

Review status next week.

Session 3

Problem:

Another boy with his girlfriend and W was being threatened by the boy. W was depressed, upset and mad.

Possible Solutions:

1. Nothing - let him have her.

2. Find a new girl - "There's more than one fish in the sea."

3. Fight.

Consequences:

Positive -

1. Fighting - beat him up.

2. Nothing - not have to talk about it.

3. New one - be happier.

Negative -

1. Fighting - get beat up.

2. Nothing - lose her.

3. New one - haven't found one yet.

Action Planned:

Leave her alone - fine a new one.

Follow up:

Review status next week.

Session 4

Problem:

Girls - "They don't stay with me because they think I'm dumb and retarded.

Possible Solutions:

1. Forget them.

2. Keep trying.

3. Learn how to talk to them better.

Consequences:

Positive -

1. Forget - not have to worry about it, less anxiety.

2. Keep trying - find another one who likes me.

3. Talk to them better - they will know me better, they won't leave.

Negative -

1. Forget - lonely.

2. Keep trying - more failures, disappointments.

3. Talk to them better - can't do it.

Action Planned:

Keep trying with them.

Follow Up:

Review next week.

Session 5

Problem:

Stopped by the police for riding a stolen bike. W was upset and angry because he had borrowed the bike to ride, not taken it, but nobody believed him. His parents were angry and he was being punished again.

Possible Solutions:

1. Be home on time.

2. Not always believe other people.

3. Tell the truth more so people will believe me.

Consequences:

Positive -

1. On time

   a. will be off the streets at night.

   b. will behave when my parents want me to.

c. stay out of trouble with my parents.

2. Not always believe others

a. won't be lied to.

b. stay out of trouble.

c. won't get hurt.

3. Tell the truth more

a. parents will believe me.

b. not get caught in a lie.

Negative -

1. On time

a. miss the fun.

b. bored at home.

2. Not always believe others

a. lose friends

3. Tell the truth more

a. nothing

Action Planned:

W decided he would try and tell the truth more and buy a watch so he could get home on time.

Session 6

Problem:

W was accused of being in the woods with an older male adult who was suspected of being homosexual.

Possible Solutions:

1. Don't go there (woods).

2. Say no.

3. Don't be with the older guys.

4. Go to school.

Consequences:

Positive -

A way to stay out of trouble and not be with a bad crowd.

Negative -

Lose friends.

Problem 2:

W has been called names (gay) by other students which hurts him and makes him angry.

Possible Solutions:

1. Ignore it.

2. Fight.

Consequences:

Positive -

Ignoring the name calling would avoid a fight but fighting would be getting even.

Action Planned:

W plans to stay away from the older individuals and stay out of the woods. He also decided to try and ignore remarks by others.

Suicide Probability Scale

Pre:	Total Weighted Score	115	
	T-Score	85	
	Probability Score	97	
Subscale Scores		Raw Score	T-Score
	Hopelessness	35	75
	Suicide Ideation	35	80
	Negative Self-Evaluation	24	76
	Hostility	21	75

Classification of risk - Severe

Post:	Total Weighted Score	86	
	T-Score	73	
	Probability Score	56	
Subscale Scores		Raw Score	T-Score
	Hopelessness	26	68
	Suicide Ideation	18	68
	Negative Self-Evaluation	22	73
	Hostility	20	73

Classification of risk - Moderate

The first null hypothesis was:

There will be no difference between pre and post results on the Suicide Probability Scale. Obtained results do reveal differences between measures, therefore, this hypothesis can be rejected.

Both pre and post T-scores (85, 73) for the overall scale fall three and two standard deviations above the mean respectively, and are considered to be significant with respect to suicidal tendencies. T-scores for the clinical subscales are also significantly high and at two standard deviations above the mean deviate significantly from the normative sample.

The difference between pre and post results indicates a drop of one standard deviation for the overall scale T-score. While post test results indicate continued significance with respect to suicidal tendencies, W has begun to move in the direction of less suicidal probability. According to the Probability score, W has dropped from a classification of Severe to Moderate Risk.

Analysis of clinical subscales also reveal differences. While Negative Self-Evaluation and Hostility scale results remain virtually the same, scores on the scales relating to Hopelessness and Suicide ideation have been reduced by roughly one standard deviation. This translates to the possibility that W's feeling less dissatisfied with life overall, more hopeful about the future, and less likely to report thoughts or behaviors associated with suicide.

IPAT Depression Scale

(Personal Assessment Inventory)

Pre:	Total Raw Score	47
	Standard Score	9
Post:	Total Raw Score	25
	Standard Score	7

A Standard Score of 9 places W at 1 3/4 standard deviations above the mean and at the 98th percentile which is indicative of significant feelings of depression. The post test Standard Score of 7 corresponds to 3/4 standard deviation above the mean and the 71st percentile. This is a difference between pre and post results which can be interpreted to mean that W has become less depressed. It is a move in W in the direction of the mean and a less depressed condition. Caution must be exercised for, even though W does demonstrate possibly fewer feelings of depression, a Standard Score of 7 remains above the mean and indicative of depressive tendencies.

The second null hypothesis was:

There will be no difference between pre and post results on the IPAT Depression Scale. Due to the difference discussed above, the null can be rejected.

Comparison of pre and post results on the SPS and Depression Scale, indicate substantial changes in a positive direction for W. However, extreme caution must be exercised in stating that W is markedly less suicidal or depressed despite the SPS reclassification

of risk. W is a young man who desperately wants the attention of those around him, particularly adults. Results may reflect the fact that W has received significant adult attention recently and, therefore, does feel better. Whether he is actually less suicidal or depressed than previously is supported slightly by the changes seen in post testing, however, withdrawal of attention at this point could possibly result in W returning to a more serious level of risk. Continued follow up is required.

W is the only student in the study who had to have the questionnaires read to him. He is the only special education student in the group and has the lowest reading level. Other students required and received help with some words or items, but for the most part, they were able to answer the questions on their own. W did not receive any coaching on test items, but the extra attention may have influenced his responses and, therefore, the results.

Student Classroom Performance Profile

Pre:	Classroom Skills	5
	Self-Concept/Self-Control	4
	Social Skills	5
	Factor Four	1
	TOTAL	15
Post:	Classroom Skills	8
	Self-Concept/Self-Control	7
	Social Skills	10
	Factor Four	2
	TOTAL	27

The third hypothesis was:

There will be no difference between pre and post results on the Student Classroom Performance Profile.

Despite differences between pre and post results, this null cannot be rejected. Results indicate the assessment of two different teachers at two different times. For SCPP to have meaning, scores from the same teacher should be used for comparison. The differences in the areas reported before may be due strictly to different raters and not intervention. It is unlikely that two teachers would describe a student in exactly the same way, although W's teachers did verbally agree about his difficulties.

Checklist for Solving Problems in Real Life

W's responses on the pre test reveal overall inadequate problem-solving skills but a desire to improve. W indicates that he does not have a good method for finding solutions, does not learn from experience, does not figure out what needs to be done to carry out a plan and does not know how to use new found information to his advantage. He does not consider possible consequences of his solutions and reports not knowing how to tell a good solution from a bad one. W also reports trouble in defining what the problem actually is.

Post testing reveals improvement in the areas of problem definition, recognition of good and bad solutions, and consideration of the consequences of those possible solutions. He reports that he feels he does have a method for finding problem solutions and feels he will learn from his experiences.

The fourth null hypothesis was:

There will be no difference between pre and post results on the Checklist for Solving Problems in Real Life. In W's case, there was reported differences, therefore, the null can be rejected. The same caution must apply as with the Suicide Probability Scale and IPAT Depression Inventory. Results may reflect the adult attention involved and the possibility that W's responses reflect a deliberate attempt to please the examiner.

CASE III

B, sixteen year old female.

B lives at home with her mother and an older and younger sister. Her parents have been divorced for years and her father now lives out of state. There is no regular contact between her father and the family. B reports that he periodically will call her late at night after he has been drinking. The divorce not only meant a fracture of the family but also resulted in a drop in socioeconomic level for B, her mother, and sisters.

B, a high school sophomore, was initially referred because of poor school attendance and failing grades despite adequate skills. Attempts by teachers and school counselors to improve B's performance had been unsuccessful. Major concern was also expressed about the possibility of serious depression, particularly due to the recent family history. In the spring of 1985, B's brother was killed in an automobile accident. Although he was not living with the family at the time, his unexpected death was very painful.

In September, 1985, B's older sister was killed in an automobile accident following an argument between her and B, in which B said to her "I wish you were dead." The last time B ever saw her sister alive was when they were arguing. This sister also seemed to have been given much of a father role in the family so it was almost as if B had lost a father once again. Impressions from the parent conference indicates that the family has not yet completed a grieving process and may actually even be denying some feelings of grief.

B and her mother were first seen at a disciplinary hearing with the school principal. This meeting was scheduled in order to discuss B's present academic status and plans for the remainder of the year. It was determined that B could only pass two subjects for sure and possibly a third, so her schedule was reduced to only three periods. During the conference, B was quiet and subdued. She cried softly when her mother talked about family problems and the recent deaths of her children. It was evident that both mother and B still have many unresolved issues to cope with.

B is a polite and cooperative adolescent who fairly openly discusses her problems and feelings. She admits to periods of depression and as having considered suicide at times as an option. She does not consider herself suicidal, however, and according to the Lethality Index, B is a mild risk. B did feel that she needed help with problems and feelings and easily agreed to participate in the study.

Throughout the early sessions, B talked about her brother and sister who had died. Her feelings about these incidents certainly created a painful problem for her which she did not always choose to address. She did come to feel that talking about what had happened might be a better solution than ignoring or denying how she felt. While openly talking about what had happened was painful, it was perhaps of less negative consequence than keeping everything inside.

With respect to school, B faced the problem of studying when she didn't want to and having to attend a class (English) which she did

not like and which she could not pass. Her solutions included not attending which meant certain failure for the year or "toughing" out the year in order to complete the two subjects she could and, therefore, gain two more credits toward graduation. She chose to continue in the two classes she could pass since the consequences of passing these two was less painful than failing which would have meant summer school at the least which was not only unpleasant but expensive.

In regard to English, B's solution was to not continue going to class. For her, staying away from English and repeating it in summer school was the solution with least negative consequences. Continuing to sit in a class she could not pass with a teacher she did not like led to consequences such as boredom and anger that B chose not to want to cope with.

In regard to the problem of her father calling, B generated several options to cope with the difficulty these calls created. She decided she could refuse to talk with him, continue as she has or let him know how she feels about his calls and how they make her feel. B would like to share her feelings with him, but was unsure how to do so. While some brief role playing allowed for practice, B is leaning more toward maintaining her present method of coping.

Suicide Probability Scale

Pre:	Total Weighted Score	67	
	T-Score	66	
	Probability Score	27	
Subscale Scores		Raw Score	T-Score
	Hopelessness	24	67
	Suicide Ideation	13	62
	Negative Self-Evaluation	17	63
	Hostility	13	63

Classification of risk - Mild

Post:	Total Weighted Score	56	
	T-Score	62	
	Probability Score	19	
Subscale Scores		Raw Score	T-Score
	Hopelessness	22	65
	Suicide Ideation	9	53
	Negative Self-Evaluation	14	57
	Hostility	11	58

Classification of risk - Subclinical

The first null hypothesis was:

There will be no difference between pre and post test results on the Suicide Probability Scale. Data presented does indicate a difference in pre and post measures, therefore, this null hypothesis can be rejected.

Initial assessment results in a mild classification for suicidal risk. T-scores for the overall scale and individual clinical subscales are all above 60 and represent the need for careful clinical evaluation and follow up.

While the authors consider a T-score of 70 or above on the clinical subscales a significant elevation (x = 50T), they caution that cutoff points are arbitrary and that T-scores approaching 70T must be closely considered. B's initial assessment revealed a subscale score in the 60's which represents tendencies toward hopelessness, suicidal thoughts and behaviors, angry, impulsive feelings and beliefs that people are distant and uncaring.

Post testing reveals a similar T-score to pre results, however, enough of a difference for the Classification of Risk to drop from the Mild to Subclinical level.

Investigation of clinical subscales reveals virtually no change on the Hopelessness scale but a definite movement on the Suicide Ideation, Negative Self-Evaluation and Hostility subscales toward the mean and opposite from the trend indicated on initial testing. This is interpreted as the possibility that B is experiencing fewer suicidal thoughts, less anger, and a greater sense of concern from others.

IPAT Depression Scale

(Personal Assessment Inventory)

Pre:	Total Raw Score	36
	Standard Score	8
Post:	Total Raw Score	20
	Standard Score	6

A standard score of 8 places B 1 1/4 standard deviations above the mean. This score corresponds to the 90th percentile which is indicative of significant depressive tendencies. Post results reveal a Standard Score of 6 which is 1/4 standard deviation above the mean but within the upper limits of the average range, and corresponds to the 60th percentile. While depressive tendencies are still indicated, a move away from the more serious results of the initial testing is indicated. B has definitely moved more toward the average range. The second null hypothesis was:

There will be no difference between pre and post results on the IPAT Depression Scale. Due to the differences discussed above, the null can be rejected.

Student Classroom Performance Profile

Pre:	Classroom Skills	16
	Self-Control/Self-Concept	10
	Social Skills	12
	Factor Four	6
	TOTAL	44
Post:	Classroom Skills	12
	Self-Control/Self-Concept	9
	Social Skills	10
	Factor Four	4
	TOTAL	35

The third null hypothesis was:

There will be no difference between pre and post results on the Student Classroom Performance Profile.

Results indicate no difference between the initial screening and follow up testing, therefore, this null hypothesis cannot be rejected.

B's schedule had been reduced to just three periods a day, two she could still pass for the year and one that staying in would "help her" when she repeats it in summer school. Although emotionally B seemed happier as the weeks passed, she became less interested in some school work, particularly the class she could not pass.

B's scores for the first three factors are similar to the handicapped sample in each instance which means that teachers describe her behavior as much problematic as average. Few , if any strengths were described. Total scores for both pre and post results are similar to that of the handicapped population.

Checklist for Solving Problems in Real Life

B's responses on this checklist indicate that she would like to learn how to solve personal problems better. Pre testing reveals that B does not consider different possible solutions to problems, does not have a good method for determining possible solutions, does not learn from her experiences and does not know how to use new information in problem-solving. B also reports that she usually does not know how to define problems or consider the consequence, good or bad, of the possible solutions. On the positive side, B reports that she does figure out how to carry out her plans once she decides what to do, does know how to find helpful problem-solving information and usually chooses a second way to solve a problem in case her first solution does not work.

Follow up testing indicates several changes. B now considers different possible solutions to problems, feels she has a strategy to solve difficulties, and is more likely to learn from experiences. She also indicates that new information is more useful in problem-solving and that problem definition is improved. Improving problem-solving skills is still something B wants to continue to work on.

The fourth null hypothesis was:

There will be no difference between pre and post results on the Checklist for Solving Problems in Real Life. This null hypothesis can be rejected based on the differences discussed above.

CASE IV

J, sixteen year old female.

J was referred by school counselor and teachers because she was failing all academic subjects and seemed depressed and withdrawn. J would not complete assignments and frequently did not turn in those tasks which she had done. J was described by her teachers as quiet and reserved to the extreme. She reportedly will not volunteer in class or even answer direct questions. J does not talk about herself and her family (something most adolescents do) and when she does speak, it is so quiet that it is almost impossible to hear her. Others describe her as extremely shy and very careful not to do anything which may draw attention to herself.

According to the social worker who worked with J in this study, J is also extremely quiet at home. Both of her parents are concerned about her because she refuses to share her feelings with anyone and will withdraw from conversation. Parents are worried because they don't know what J is thinking and are afraid that she may attempt suicide as one of her neighbors had done earlier.

J's overall lack of energy and lack of personal investment in anything peer appropriate has her parents worried about the existence of serious depression. Her failure to respond to incentives, punishment or other parental interventions also gives reason for concern.

J is very dependent upon her mother and interacts very little with her father. He tends to criticize, causing J to withdraw and

retreat to her room, and her radio. J will not rebel or stand up to her father in any way. Her preferred stance is compliance to his criticism and authority. She would rather defer to him than assert herself which is not typical of youngsters her age.

In a one-to-one session, J remains quiet and subdued. She will respond to direct questions but offers very little spontaneously. Her voice is frequently so soft that one cannot hear her. She will repeat answers when asked but is only slightly more assertive. Eye contact is basically good although her affect is generally flat. Rapport is possible with J and once established she is willing to share some concerns and feelings.

J identified her major problems as: not knowing how to interact with peers, low self-concept, poor body image, sexual issues, and interacting with parents. Possible solutions ranged from seeking regular counseling at a community agency to making attempts to participate more actively with peers, ie. social settings like skating, sports activities and parties to using third parties, such as a counselor, to interact with parents.

Negative consequences related to new risk taking behaviors, J opening herself up to possible rejection from peers and the possibility of increased tension in the family due to openly confronting issues which require resolution.

Positive consequences reflected the possibilities of improved feelings of self-worth, better communication with parents and peers, and the likelihood to more positive social experiences.

The sessions focused on the problems mentioned above with improvement seen in J allowing the social worker to help her to negotiate more time (fewer restrictions) with her boyfriend. They dated more, thus allowing for increased social interaction, increased communication between the two as opposed to J's previous style of repression and withdrawal.

Suicide Probability Scale

Pre:	Total Weighted Score	59
	T-Score	63
	Probability Score	21

Subscale Scores	Raw Score	T-Score
Hopelessness	20	63
Suicide Ideation	10	56
Negative Self-Evaluation	17	63
Hostility	12	61

Classification of risk - Subclinical

Post:	Total Weighted Score	57
	T-Score	63
	Probability Score	19

Subscale Scores	Raw Score	T-Score
Hopelessness	20	63
Suicide Ideation	10	56
Negative Self-Evaluation	17	63
Hostility	10	55

Classification of risk - Subclinical

The first null hypothesis was:

There will be no difference between pre and post results on the Suicide Probability Scale. Data represents no difference between measures, therefore, this hypothesis cannot be rejected.

The classification of risk factor yields a subclinical level on both pre and post testing, however, T-scores in the 60's demand attention. Subscale scores are not considered significantly elevated according to the authors and show no difference between pre and post assessment except for the Hostility scale which shows only a slight movement in a more positive direction.

IPAT Depression Scale

(Personal Assessment Inventory)

Pre:	Total Raw Score	28
	Standard Score	7
Post:	Total Raw Score	23
	Standard Score	6

The pre test Standard Score of 7 places J 3/4 standard deviation above the mean at the 77th percentile. Post results reveal a Standard Score of 6 which is 1/4 standard deviation above the mean and at the 67th percentile. Neither score is highly representative of depression and no noticeable difference between the two is felt to exist.

The second null hypothesis was:

There will be no difference between pre and post results on the IPAT Depression Scale. Data reveals no difference, therefore, this null cannot be rejected.

Student Classroom Performance Profile

Pre:	Classroom Skills	17
	Self-Control/Self-Concept	20
	Social Skills	17
	Factor Four	6
	TOTAL	60
Post:	Classroom Skills	15
	Self-Control/Self-Concept	20
	Social Skills	18
	Factor Four	4
	TOTAL	57

The third null hypothesis was:

There will be no difference between pre and post results on the Student Classroom Performance Profile. No differences are indicated, therefore, this null cannot be rejected.

Total scores for both the pre and post testing approximate the control group in each instance. J's pre and post performance in Classroom skills and Social skills fall between the means for handicapped and control group samples; however, Self-Control/Self-Concept scores are similar to the control group for that factor.

Checklist for Solving Problems in Real Life

Initial assessment indicates that J usually considers many different possible solutions, usually has a method to look for possible solutions, considers the consequences of possible solutions, good and bad, and knows how to tell a good solution from a bad one. J reports that she knows how to define a problem and usually picks out a second way to solve a problem in case her first solution doesn't work. She apparently knows how to find information helpful in solving problems but does not always know how to use this information in a meaningful way. Based on this information, J's problem-solving skills seem basically intact, however, her behavior does not reflect this. J does indicate that once she has decided on a plan for solving a problem, she does not figure out what needs to be done to carry out that plan.

At post testing, only two items changed in a positive direction. J, at second assessment, reports that she does now figure out what needs to be done to carry out plans she makes, and knows how to use the new information she has found to resolve her problems.

J indicated at both pre and post examinations that she wants to learn how to solve her personal problems better.

The fourth null hypothesis was:

There will be no difference between pre and post testing on the Checklist for Solving Problems in Real Life. Based on test results, this null cannot be rejected.

J presents a worse clinical picture than might be expected according to her performance on some of the quantitative measures. J's style is to deny and internalize which may make her reluctant to risk herself when responding to questionnaires. Because of her defensive style, J may have made an attempt to present herself as more healthy than she is or "faking good."

CASE V

M, seventeen year old male.

M was referred by a private counselor who was to undergo surgery and be out of her office for four to six weeks. Referral concerns related to depression and possible suicidal tendencies. The author met with the counselor and M for introductions and then with M only once. The counselor did not have surgery and so returned to her case load. A second meeting was held with the counselor to discuss the study and strategy which she felt would work well with M. She agreed to use the study's approach with M and collect pre and post data. Weekly meetings with the counselor were held.

School personnel were very concerned about M because of the drastic changes in his mood, social functioning and academic performance over the last year. During the 85-86 year, M's interest, motivation, productivity, and overall school performance declined markedly. Last year M had good grades, many friends, and participated in extracurricular activities. This year his grades have been predominately F's with class attendance and academic performance described as poor. M has become increasingly withdrawn and is identified as interacting very little with friends. Teachers have become concerned but disappointed in M because of his decline in responsible, dependable behavior.

M has reportedly dropped out of all extracurricular clubs in addition to leaving his job. He is seen as moody and distant with

increasingly more withdrawn behavior. He apparently denies problems and declines to discuss personal concerns.

M's parents have been divorced since he was young. His mother has always felt M was mature, dependable and responsible, however, this year M has demonstrated a decline in these behaviors. She has noticed an almost total reversal in M's behavior resulting in a loss of trust on her part. M's mother is very concerned, particularly about the depression and possible self-harm.

In the initial interview, M was very pleasant and polite but quiet and generally subdued. Affect was relatively flat with a basically depressed mood. Language and social skills were good, however as was eye contact and responsiveness to questions. In conversation, M admitted he had had a bad year and said that he did feel sad and depressed. He was experiencing considerable problems with interpersonal relationships, particularly with his girlfriend. He felt that he had disappointed many people which only added to his feelings of unhappiness and guilt. Because of M's inability to resolve some of his personal issues, he found himself confronted with even more negative situations to cope with. M wanted help and was receptive to intervention.

Suicide Probability Scale

Pre:	Total Weighted Score	41
	T-Score	49
	Probability Score	11

Subscale Scores	Raw Score	T-Score
Hopelessness	16	57
Suicide Ideation	11	58
Negative Self-Evaluation	7	36
Hostility	7	40

Classification of Risk - Subclinical

Post:	Total Weighted Score	56
	T-Score	62
	Probability Score	19

Subscale Scores	Raw Score	T-Score
Hopelessness	13	52
Suicide Ideation	8	44
Negative Self-Evaluation	10	44
Hostility	7	40

Classification of Risk - Subclinical

The first null hypothesis was:

There will be no difference between pre and post results on the Suicide Probability Scale. Results presented reveal no positive

difference between measures, therefore, this hypothesis cannot be rejected.

Overall scores on the SPS do not differ considerably when incorporating the standard deviation of 10. In fact, the post measure of potentiality actually increases when considering the T-score. However, the Probability Score changes very little and the Classification of Risk remains at a Subclinical level. The pre T-score of 49 falls just about at the mean while the post T-score of 62 becomes more significant and indicates a need for closer evaluation of suicidal risk.

One explanation of this difference is that M has moved to a more suicidal posture despite intervention; however, his self reported comments, teacher comments, and subscale analysis do not support this possibility.

A second explanation is that the pre testing is the result of M's attempt at "faking good," ie. his attempt to disguise or deny suicidal tendencies. When one considers the comments from others indicating his style of denying problems and internalizing feelings, this possibility becomes even more likely. Thus, the higher T-score on post testing actually indicates a move on M's part to be more open and honest.

Clinical subscale analysis indicates a reduction in the Suicide Ideation T-score of one standard deviation. This represents a considerable change and the hypothesis that M is experiencing fewer

suicidal thoughts. The Hopelessness scale also shows a move in a positive direction which indicates less negative feelings about his environment in general. Despite these positive trends, M's T-score on the Negative Self-Evaluation subscale reveals a slight rise indicating a tendency to feel less worthwhile.

IPAT Depression Scale

(Personal Assessment Inventory)

Pre:	Total Raw Score	17
	Standard Score	5
Post:	Total Raw Score	11
	Standard Score	4

A Standard Score of 5 places M only 1/4 standard deviation below the mean and at the 51st percentile, which is within the average range for the standardized sample. Post results reveal a Standard Score of 4 which is 3/4 standard deviation below the mean and at the 31st percentile. Neither pre nor post testing is indicative of depression beyond what would be expected in the population used for developing this instrument, however, results do indicate only the slightest move on M's part toward lesser feelings of depression.

The second null hypothesis was:

There will be no difference between pre and post results on the IPAT Depression Scale. The difference discussed above between pre and post results is minimal, therefore, the null cannot be rejected. While results are not strong enough to reject the null, M has at least begun to move in a healthier direction.

Student Classroom Performance Profile

Pre:	Classroom Skills	18
	Self-Control/Self-Concept	21
	Social Skills	26
	Factor Four	10
	TOTAL	75
Post:	Classroom Skills	19
	Self-Control/Self-Concept	22
	Social Skills	28
	Factor Four	9
	TOTAL	78

The third null hypothesis was:

There will be no difference between pre and post results on the Student Classroom Performance Profile. Results do not indicate a difference in test results, therefore, the null hypothesis cannot be rejected.

Results show only the beginning of a very slight improvement in several areas, however, this is much too small to address or proclaim as positive movement.

As indicated, these scores were obtained by rank ordering teacher responses on pre testing, finding the median score and then using that teacher's responses for pre and post comparisons.

When all teachers who responded were included in pre and post assessment and then using median score, results are quite different.

In this way, the null would be rejected with positive movement away from the handicapped group toward the normal sample indicated. In addition, a strong move toward the normative group is seen, particularly with respect to Self-Control/Self-Concept and Social skills. The total test score also indicates more of a trend away from the handicapped sample toward the normal population.

Along this same vein, unstructured teacher comments on pre test items describe M as a bright young man who tends to dwell on personal problems and lacks assertiveness. Class attendance is reported as erratic resulting in lowered grades. He likes socializing with peers who do above average work and seems popular with peers. Some teachers view M as entirely different this year in that he has lost confidence, has become more moody and impresses as sad, depressed and suicidal. His energy level vacillates between being active and productive to lethargic; he is either "up" or "very down."

Comments on post measure are mixed. Some teachers view M as much the same as before (moody, disinterested), however, others describe M as more "normal," less moody, happier and more secure.

Complete positive change was not expected with such short intervention, however, movement in a more healthy direction is apparently taking place. Such small improvements are felt necessary before any significant differences are to be realized on larger measures such as suicide potentiality or depression.

Checklist for Solving Problems in Real Life

Pre results indicate the M wants to learn how to solve his personal problems better. He indicates that he usually considers different solutions to a problem, has a strategy for identifying possible solutions, but does not learn from experience. He says he does not know how to find or use new information or define a problem appropriately. M says he considers consequences of possible solutions and can tell good solutions from bad ones. Once he has a solution in mind, M will act, almost impulsively, without considering a second option if the first one fails.

Post results remained basically the same except that M indicates a lack of an appropriate method to look for solutions, and a tendency to not consider positive or negative results of his solutions. He changes from saying he knows how to define a problem (pre) to stating that he actually does not define problems well.

These differences are in the opposite direction one would expect, however, they may support the previously mentioned contention that M has moved to a more honest position. He may, at post testing, be ready for more meaningful intervention.
However, the fourth null hypothesis was:

There will be no difference between pre and post results on the Checklist for Solving Problems in Real Life. This hypothesis could not be rejected.

CASE VI

E, sixteen year old male.

E was referred by the school because of concerns about his lack of interaction with others and his generally angry, tense affect. He was viewed as a "time bomb" waiting to explode. E had displayed aggressive tendencies on occasion but without any serious incident. He was described as the type of student that was "unreachable," ie. unable to talk with, establish rapport with, or confront about even small, day-by-day issues. E was reported to be a hard worker but basically a loner who had little to say to anyone. The administration was concerned that E would "explode," hurting himself or others.

An interview with his mother revealed similar concerns. She too saw E as an angry adolescent who keeps his feelings to himself. He's quiet and stays to himself at home but does occasionally show periods of intense anger. E's mother was in favor of the referral because she was concerned that he may attempt to harm himself. She related a recurring dream in which she calls the school to talk with E. When E cannot be located in class, subsequent searching finds him in the nearby woods where he has hung himself. E's mother expressed serious concern about her son and hopes that he can be helped before her dream comes true.

E lives with his mother and father. Family conflict is frequent and sometimes serious. Father, while a hard worker, drinks heavily and is both verbally and physically abusive. E works with his father

after school, but it is a situation of serious tension and constant possibilities for conflict. E's mother works two jobs. She would like to move to a place of her own but cannot finalize such a decision. She feels she is too often in a position of referee. Counseling and protective service options have been offered this family.

In the initial interview, E did present himself as an angry, sullen young man. He entered the room with a frown, demonstrating poor eye contact and little spontaneity. He seemed quite distant, giving the impression that he did not want to be there. E was responsive to questions, however, and surprisingly accepted the author's reason for wanting to talk with him.

With little encouragement, E began talking about his feelings and problems. He spoke openly about his strong negative feelings towards his father and how he felt mistreated by him. E is allowed little free time because he is expected to work daily with his father. He feels unappreciated and unfairly treated. His father is easily angered, thus, becoming verbally threatening and abusive. E claims he does not fear physical abuse but does feel trapped and unable to enjoy many privileges his peers do.

E admitted to frequent periods of depression and even more frequent periods of anger and hostility. His anger seems almost constant with periodic intensification. His problems have led E to consider such solutions as moving out, running away, and suicide. He had attempted none of these at this point in time.

Our first session lasted easily an hour, which was totally unexpected when E first came in the room. After hearing the explanation and the details of the study, E agreed to participate. According to the Lethality Index, E was categorized as a low risk and, therefore, considered for the present study.

Pre intervention data was obtained at the beginning of our next session.

E's major problem related to the relationship between him and his father. E would become extremely angry and resentful but internalize these feelings because he had no other way of coping with them beyond acting out in some way.

One of the first problems E had to address was how to handle his feelings. His options basically included sharing his feelings with others or continuing to internalize them. When considering the consequences of each, E felt that sharing, while perhaps helping to reduce some tension and generate other possible solutions, would mean having to trust someone else. Allowing someone that close was another difficulty E had to overcome. He realized, however, that not trusting or not sharing his feelings would add to continued feelings of anger and resentment which would make his life unpleasant. E also said that another negative consequence to continuing his present methods of coping was the possibility of him hurting himself or others. He chose to pursue the counseling route.

Another problem E identified as needing consideration was what to do when directly confronted with his angry, abusive father. Negative solutions he generated were physically fighting, leaving home, suicide or destruction of property. The only positive consequence he could identify in regard to these possible solutions was that he would feel better and not have to listen to his father anymore if he left home or killed himself. Negative consequences ranged from not wanting to hurt his father to not really wanting to die to feeling guilty about what he had done. E seemed to reach an understanding that most of his negative solutions would only lead to further problems for either himself or others.

Positive solutions to the problem of having to face his father ranged from ignoring him to telling him how he didn't like his behavior to walking away, thus, refusing to help his father with his work. (E is an excellent worker and is valuable to his father's business). Negative consequences to these solutions included: things won't change and I may not feel better. Defined positive consequences included: things might improve, my father will know how I feel and realize how much I help.

E chose leaving home. He moved in with his girlfriend for several weeks but this did not prove to be a good arrangement. It upset his mother, made it difficult for E to get back and forth to school and strained their relationship. E then had the additional problem of how to return home. Two solutions seemed possible;

moving somewhere else or returning home. Not returning only meant further problems while returning would indicate that he had failed and had to accept whatever his parents "dished out." I pointed out to him that his leaving in the first place may have caused his father to think about the situation and that going home may not be as difficult or embarrassing as he thought. E returned home and chose the previous solution of staying away from the work until his father calmed.

Another problem which E had to confront was the break up of him and his girlfriend because of another boy. Not only was he angry, he wanted to get even and get the presents back which he had given to her. He had asked for them back but she would not let him come to the house and had not mailed them. His first solution was to go to her house and get them by force or gun point if necessary. The other solution was to wait for her to mail them. The negative consequences of force fortunately did not appeal to E so he decided to wait for the mail.

Suicide Probability Scale

Pre:	Total Weighted Score	94	
	T-Score	74	
	Probability Score	73	
Subscale Scores		Raw Score	T-Score
	Hopelessness	29	70
	Suicide Ideation	25	71
	Negative Self-Evaluation	22	73
	Hostility	18	71

Classification of Risk - Moderate

Post:	Total Weighted Score	98	
	T-Score	75	
	Probability Score	80	
Subscale Scores		Raw Score	T-Score
	Hopelessness	32	72
	Suicide Ideation	24	71
	Negative Self-Evaluation	17	63
	Hostility	25	79

Classification of Risk - Severe

The first null hypothesis was:

There will be no difference between pre and post results on the Suicide Probability Scale. Results presented reveal no difference between measures, therefore, this hypothesis cannot be rejected.

Both pre and post T-scores (74, 75 respectively) for the overall scale, fell 2 standard deviations above the mean and are considered to be significant with respect to suicidal tendencies. T-scores of subscale scores are also significantly high although analysis of pre and post subscale profiles do reveal some differences.

E's T-score on the Negative Self-Evaluation subscale dropped 1 standard deviation (73 to 63) between pre and post testing. This change would indicate that E may feel greater self-worth, more positive about things in general and that others do care and are not quite so distant. This measured change may reflect E's feelings about having someone to talk with about his problems, concerns, etc. He seemed to look forward to the meetings and, over time, became more relaxed and more open as evidenced by frequent smiles, laughter and the emergence of a sense of humor.

The T-score on the Hostility subscale, however, increased almost 1 standard deviation (71 to 79). This change is difficult to explain. One would hypothesize that if an individual becomes less negative about himself that he would also be likely to be less hostile. However, more positive feelings about oneself may possibly allow one to feel more confident and more secure in expressing his feelings whether they be positive or negative.

Also of concern is the change in Classification of Risk category from Moderate to Severe. This may be a reflection of the increased hostility level, however, other data such as observations and

comments from school personnel do not support the increase in risk. What it does mean is that intervention cannot be terminated. Further assessment and follow up is necessary.

In E's case, environmental issues may have accounted for the increase on the Hostility subscale. Only a few days prior to the post exam, E was suspended from school for fighting. Although he did not initiate the fight, it did mean he would not return for the remainder of the year (about four days). He was allowed to return to take his exams. The school administrator indicated that E handled himself well during the discipline process, accepting his suspension appropriately. E was, however, still angry with the other student.

E will return to school this summer and work for the staff there. This is at their request.

IPAT Depression Scale

(Personal Assessment Inventory)

Pre:	Total Raw Score	47
	Standard Score	9
Post:	Total Raw Score	31
	Standard Score	7

A Standard Score of 9 places E 1 3/4 standard deviations above the mean and at about the 94th percentile, which is indicative of significant depressive tendencies. Post results reveal a Standard Score of 7 which is 3/4 standard deviation above the mean and at about the 89th percentile. While a Standard Score of 7 continues to be indicative of depressive tendencies, it does represent a drop in the amount of depression present at pre testing. This difference between pre and post results can be interpreted as a move on E's part away from serious depression toward a less depressive condition and the mean.

The second null hypothesis was:

There will be no difference between pre and post results on the IPAT Depression Scale. Because of the difference discussed above, the null can be rejected.

Student Classroom Performance Profile

Pre:	Classroom Skills	10
	Self-Control/Self-Concept	11
	Social Skills	8
	Factor Four	0
	TOTAL	29
Post:	Classroom Skills	14
	Self-Control/Self-Concept	21
	Social Skills	19
	Factor Four	0
	TOTAL	54

The third null hypothesis was:

There will be no difference between pre and post results on the Student Classroom Performance Profile.

Results do reveal noticeable differences between pre and post assessment, therefore, this null hypothesis can be rejected.

Analysis of pre and post data indicates a general trend away from the handicapped sample in favor of the more normal group. The difference with respect to Classroom skills is minimal, however, the margin of change for Self-Control/Self-Concept and Social skills is much greater. These changes are supported by teacher comments which also describe E as less tense, less angry and generally more friendly and relaxed.

Checklist for Solving Problems in Real Life

E's responses indicate overall inadequate problem-solving behaviors. Despite being able to identify or define a problem, E indicates that he does not consider different solutions and lacks a good method or strategy for which to consider possible solutions to problems. E reports that he does not usually know what needs to be done to carry out a plan and usually fails to learn from his experiences. E does not know how to find information which may be helpful in solving a problem; does not consider consequences, good and bad, of each possible solution; and is not able to tell a good solution from a bad one. He does indicate, however, that he usually picks a second way to solve a problem in case something goes wrong with his first solution.

E indicates that he wants to learn how to solve personal problems better and would like to learn how to use the problem-solving behavior identified on the checklist.

Post testing on this instrument reveals no change except for the item which indicates that E does now consider what needs to be done in order to carry out a plan for problem solution. Due to this lack of difference between pre and post measures, the fourth null hypothesis which states there will be no difference between pre and post responses on the Checklist for Solving Problems in Real Life cannot be rejected.

Although not reflected on the Checklist, E verbally indicated that he felt more comfortable and confident when confronted with problems. He also reports feeling better about himself and less likely to become upset with his father.

CHAPTER V

Summary

The purpose of this study was to investigate the efficacy of a problem-solving intervention strategy with adolescents referred because of concern about suicidal behavior. A case study design was used for this research project with six adolescents who were all determined to be of mild suicidal risk. Each student received pre and post assessment with the Suicide Probability Scale, IPAT Depression Scale, Student Classroom Performance Profile, and the Checklist for Solving Problems in Real Life. Pre and post results were discussed qualitatively for each individual subject in regard to four null hypotheses.

The null hypotheses were:

HO_1: There will be no difference between pre and post results on the Suicide Probability Scale.

HO_2: There will be no difference between pre and post results on the IPAT Depression Scale.

HO_3: There will be no difference between pre and post results on the Student Classroom Performance Profile.

HO_4: There will be no difference between pre and post results on the Checklist for Solving Problems in Real Life.

Discussion

Overall results of this study must be considered inconclusive. There is no overwhelming or statistically significant proof that the problem-solving approach is successful with mildly suicidal adolescents. A major limitation of this study is the small number of subjects and the lack of formal statistical analysis which would define more accurately what differences, if any, were actually statistically significant. Additional data using this intervention approach is necessary in order to address this issue.

Conclusions with respect to the specific hypotheses was determined in a subjective manner based on differences of actual calculated scores or change of subject response patterns between pre and post assessment. In those few instances where the null hypothesis was rejected, it was done so on the basis of change which this examiner determined to be noticeable enough to comment on, e.g., as in the case of E where post testing on the Depression Scale revealed a drop of two standard scores. Such decisions are certainly open to experimenter bias, however, another consulting psychologist also agreed that these changes represented a move in a positive direction. It does mean that others should consider this information carefully and determine for themselves whether the differences were enough to reject any hypotheses. It is also important for caution to be exercised in the generalization of these results to other similar adolescents.

It is felt that results do indicate that adolescents referred for depression and suicidal concerns also experience weak problem-solving skills. Each subject indicated that they wanted help in learning how to solve their personal problems better. This is supported, not just by their responses to the Checklist for Solving Problems in Real Life, but by subjects' verbal comments and self reports about why they reach points of contemplating suicide. It is not uncommon to hear "I didn't know how else to solve my problems" and "everything I tried didn't work."

Of the five students who participated in post testing, each indicated that they felt more confident in confronting future problems, however, analysis of the combined results on the problem-solving instrument do not represent noticeable growth in this area. This may be due in part to the instrument itself. While it focuses on appropriate items of the problem-solving process, it is constructed in a manner which was confusing to the students and may have led to faulty responses (marking true where false was meant or vice versa). In addition, six sessions may not be enough time for an individual to learn new problem-solving skills or even structure for using the process in the future, particularly when primary energy is being focused on resolving immediately painful or troublesome issues. Subjects were able to utilize the problem-solving method in actual problem resolutions with guidance from the counselor.

More than six session is very probably necessary for an individual to actually learn new problem-solving skills. Training programs such as the ones proposed by Spivack and Shune (1974) are likely to be better suited for actually teaching problem-solving to young people, although its success with adolescents has not been determined. It must be noted, however, that even though the present study cannot verify the problem-solving intervention as effective in teaching new skills, the method does have merit in terms of providing structure for the intervention process. When confronted with potentially suicidal adolescents, it is extremely important for the counselor to be able to intervene in a calm, supportive and goal directed manner. Using the problem-solving format as a guide for intervention creates such a structured, yet flexible approach which helps both the student and therapist to focus on specific issues. The social workers and counselor who participated in this study felt that the problem-solving approach was both appropriate to use with referring concerns and easy to learn.

Expanding the present study to resemble more of a well structured teaching process like the one described by Weissberg, Gestu, Liebenstein, Doherty, Schmidt and Hutton (in Weissberg and Gustu, 1982) might possibly provide an instructional tool to be used for middle and/or high school curriculums. Its preventive approach to reducing suicidal problems would certainly be helpful in reducing some of the reactive measures needed when students become more serious suicidal risks.

To expect scores on different instruments to change dramatically after such short-term intervention may well be unrealistic. On the Suicide Probability Scale for example, one might notice changes or the beginnings of change on the different subscales before any difference in the total score takes place. If an individual has reached the point of considering suicide because of feelings of hopelessness or depression, then that person may have to feel less hopeless or less depressed before feeling less suicidal.

However, the difficult challenge of the issue is that a person may well show a decline in suicide risk or potentiality due to intervention without actually resolving some of the underlying problems. To terminate intervention at this point would be obviously premature and may create a situation where future suicide attempts are likely.

This serves to reinforce the need for thorough assessment, not just initially, but throughout the intervention process. It also demonstrates the potential usefulness of more objective measures (checklists, questionnaires) as supplemental to interview data. It also demonstrates the importance of specific problem definition which not only aids in resolving the immediate crisis but helps structure follow up services.

Differences among subjects may also be related to readiness for change. While all students were interested in receiving help, they were at different places in terms of their capacity for and willingness to deal with certain issues.

Although short-term intervention utilizing the problem-solving format may not teach new problem-solving behaviors in comparison to some of the more in-depth structured training programs, it is extremely useful in terms of structuring the counselors approach and time with an individual. This can be particularly beneficial in a crisis situation where chaos can be dominant.

It is also a strategy which can be easily taught to others who may come into contact with troubled adolescents such as teachers or parents. By having a format to follow when confronted with a young person and their problems, more specific and useful decisions may be possible. Even if the goal is referral to another person, this method allows for a systematic approach to considering possible solutions and consequences.

Having a structured approach to problem resolution or crisis intervention could also increase the confidence of some who become anxious or feel unsure when confronted with troubled youth. This problem-solving strategy could, in effect, serve as a "map" to help them through the confusion that frequently accompanies our students and their problems.

Conclusions

The following conclusions were drawn from this study:

1. All adolescents surveyed indicate that they would like to have help solving their personal problems. All report that they want to learn more about the procedures necessary to do so.
2. Based on obtained data, the efficacy of a problem-solving intervention strategy utilizing only six sessions with mildly suicidal adolescents is inconclusive.
3. Brief intervention did appear to have a positive effect on most of the students used in this study. Even though no differences were noted between testing for some students, movement toward acceptable position was seen on some instruments.
4. The Suicide Probability Scale, IPAT Depression Scale, and Checklist for Solving Problems in Real Life may need further refinement in order to detect more subtle changes in suicide probability, depression and problem-solving skills.
5. Data obtained supports the literature in regard to the characteristics of adolescents which may be considered as suicidal risks.
6. The Checklist for Solving Problems in Real Life is worded in such a way that it is confusing to the examinee. Some of the individual items need to be rewritten in order to make them easier to understand, therefore, reducing the possibility of misinterpretation and faulty responding.

7. The results of this study must be very closely scrutinized in regards to generalizability to similar populations.

8. No proper assessment of suicide is complete without thorough clinical assessment. While questionnaires and attitude checklist can provide useful diagnostic information, such instruments are not felt to be sensitive enough to accurately predict degree of risk.

9. An assessment of lethality must be a part of any initial assessment of suicidal behavior.

Recommendations

The following recommendations are made based on the findings of this research:

1. It is recommended that this approach be further studied to aid in the investigation of the efficacy of a short-term problem-solving intervention strategy with mildly suicidal adolescents. Further data is required to permit proper statistical analysis of research results.
2. It is recommended that instruments more suitable for adolescents be used in future studies.
3. It is recommended that video taping, tape recording, or co-therapy (observation) be used in future research in order to better validate intervention techniques.
4. It is recommended that students receive instruction in decision making, problem-solving and general coping techniques as part of their school curriculum.
5. It is recommended that school teachers and counselors receive in-service information concerning the recognition of and intervention with depressed and potentially suicidal adolescents.
6. It is recommended that parents be included in the treatment process with depressed and suicidal adolescents.

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APPENDICES

APPENDIX A

THERAPEUTIC INTERVENTION WITH SUICIDAL ADOLESCENTS: A PROBLEM-SOLVING APPROACH

Letter of Explanation

Dear Parent,

Each year we receive referrals for students who are reportedly feeling depressed and possibly suicidal. In addition to performing poorly academically, many of these young people find themselves in difficulty because of weaknesses in their ability to cope with or solve their problems.

In an attempt to help some of these students, I am conducting a research study with adolescents referred for feelings of depression and suicide. The purpose of this study is to work with these students on an individual basis to help them improve their problem-solving ability.

Each student will be seen for six sessions and (before and after the counseling begins) will receive screening tests which will assess the student's feelings of depression, suicide and ability to solve problems. All results will be kept confidential. No records will be kept at the school and no information will be included in the student's school folders.

Attached is a permission form where you may give or refuse consent for your child to participate in this study. If you have any questions, please call me at 644-1202.

Sincerely,

APPENDIX B

PERMISSION FORM

Please sign in the appropriate place.

I do grant permission for my son/daughter, _____,
to participate in the study of problem-solving skill instruction conducted
by Worth Bradley, School Psychologist.

_____ _____
Parent Signature Date

I do not grant permission for my son/daughter, _____,
to participate in the study of problem-solving skill instruction conducted
by Worth Bradley, School Psychologist.

_____ _____
Parent Signature Date

APPENDIX C

Screening procedures used:

Lethality Index

Suicide Probability Scale

IPAT Depression Inventory

Checklist for Solving Problems in Real Life

Classroom Performance Profile

VITA

William Worth Bradley

Birthdate: November 26, 1948

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Education:

1979-1986 The College of William and Mary in Virginia
Williamsburg, Virginia
Doctor of Education in School
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1970-1972 Radford College
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ABSTRACT

THERAPEUTIC INTERVENTION WITH SUICIDAL ADOLESCENTS: A PROBLEM-SOLVING APPROACH

William Worth Bradley

The College of William and Mary in Virginia

Chairman: Dr. Ruth K. Mulliken

The purpose of this study was to investigate the effectiveness of a problem-solving intervention strategy as applied to mildly suicidal adolescents. The population for this study consisted of male and female adolescents aged 14 to 19 who were referred by teachers, counselors, parents or self because of concerns about suicidal behavior. This project was a case study approach focusing on six mildly suicidal adolescents who volunteered from a pool of referrals received during the 1985-1986 school year. Prior to beginning intervention, each student's lethality was assessed by using the Lethality Index which allowed for the identification of those adolescents who were more seriously suicidal. These students were referred to appropriate agencies.

Pre and post assessment which included interview, the IPAT Depression Inventory, the Suicide Probability Scale, the Checklist for Solving Problems in Real Life and the Classroom Performance Profile was conducted by the school psychologist or social worker involved. Each subject received the same intervention strategy which was a problem-solving approach initiated with each student focusing on his/her own personal problems. Each subject was seen at least once a week for six weeks, however, some students were seen more frequently if necessary.

Overall results of this study were considered inconclusive, as there was no overwhelming or statistically significant proof that a problem-solving intervention approach is successful with mildly suicidal adolescents. It was felt, however, that results did indicate that adolescents referred for depression and suicidal concerns also experience weak problem-solving skills. Each subject indicated that they wanted help in learning how to solve their personal problems better.

Subjective reports from post intervention interviews revealed that students felt more confident in confronting future problems, however, results on the problem-solving inventory did not demonstrate growth in this area.

Generalization of results must be made with caution as there were several major limitations to this study. The problem-solving framework, however, does appear to have merit as a structured format for counselors to use when working with suicidal students and their problems.