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SUICIDE PREVENTION WORKSHOP FOR PARENTS OF STUDENTS WITH AUTISM

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling,
School Counseling

By

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Dedication

I would like to dedicate this thesis project first and foremost to my beautiful children Bryana and Nathan. I especially want to dedicate this project to my daughter for always supporting me in my educational journey. I began this journey for her because I wanted to show her that anything in life is possible when you set your mind to it. It has been a long journey and I appreciate her patience and encouragement all these years, especially for taking the role of mom and helping me raise her younger brother. Without the support of my children, cousin, and friends I would have not been able to complete this chapter of my life. My hard work, dedication, and sacrifice have been to make my children proud and I hope I have successfully completed that mission. This project is for you guys!
ABSTRACT

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By

Araceli Mejia

Master of Science in Counseling, School Counseling

Middle school is a time of change both physically and mentally for all adolescents. During this time adolescents seek to belong in society. Unfortunately, many adolescents with autism spectrum disorder find themselves isolated from their peers or withdrawing from interacting with others because of their disability. Loneliness and sometimes depression can lead to suicidal ideation in these students. Parents can be a protective factor in the lives of their adolescents by providing them guidance and support when these adolescents are faced with challenges. For this graduate project, a suicide prevention workshop has been created for parents of students with autism in order for parents to better help their children make meaningful relationships with their peers. The workshop is designed for school counselors to discuss with parents common behaviors found in students with autism and provide parents/guardians important statistics, facts, and strategies to help their child build positive social skills, connectedness within the family dynamic, and find ways to help them interact with their peers in a developmentally appropriate way.
Chapter 1

Introduction

As noted by Maples et al. (2005), “Youth who are at risk of suicide differ dramatically from those of adult suicide. Adolescence is the most volatile period of transition in the human growth cycle. It is often an unstable and challenging time between childhood and adulthood” (p.399). This critical developmental period in a child’s life puts him or her at a higher risk for suicidal ideation. According to the Centers for Disease Control and Prevention [CDC](2015), suicide today is the third leading cause of death among adolescents between the ages of 10 to 14. Suicide unfortunately continues to remain a prevalent issue in the United States and affects many adolescents and families each year. The CDC (2015), reported 41,149 suicides in 2013 in the United States. With approximately 4,600 lives lost each year, youth suicide in the United States continues to remain a significant problem among adolescents. A nationwide survey of adolescents in public and private schools in the United States found that 16% of students reported seriously considering suicide, 13% reported creating a plan, and 8% reported trying to take their own life 12 months preceding the survey (CDC, 2015).

The CDC (2015), indicates that each year the deaths of innocent young people between the ages of 10 and 24 are taken by suicide, and students with physical, emotional and cognitive disabilities are at high risk for depression and suicide. The number of young teens dying each year by suicide remains a significant problem among adolescents in the United States and it is important to consider a student’s environment and protective factors (i.e. family, friends, community, and culture), which may influence whether a student engages in suicidal thoughts or behaviors (2015).
Students with autism often find themselves isolated from their peers and lack the ability to engage in meaningful relationships due to their lack of social skills and find it difficult to make sense of the world around them (Hebron & Humphrey, 2014). These students continuously have to deal with many stressors such as bullying, body image and the media, depression, and mental health and behavioral problems. Although all students could potentially consider suicide, Wachter and Bouck (2008) indicate that students with disabilities like autism and other mental health related disabilities have higher rates of suicide ideation and suicide attempts than their general education peers and may be at increased risk. Stressors like these place a significant stress on growing adolescents especially on middle school students with autism and many parents, teachers, and friends overlook their cry for help (2008).

**Statement of Need**

According to Wachter and Bouck (2008), students with autism have unique experiences in school that differ from those of their peers. The researchers found that students with high incidence (mental illness and behavior disorders) disabilities have higher rates of suicide ideation and suicide attempts than those of the general education peers. One prevalent risk factor for students with disabilities is the lack of school social supports and they face social isolation. In addition, these researchers suggest that students with disabilities might be more prone to depression, another risk factor for suicide. Their research, in part, validates that students with disabilities are more susceptible to suicidal thoughts and behaviors. A relationship seems to exist among emotional and/or behavioral disorders, suicidal ideation and suicide attempts (2008). Since the number of suicide attempts among adolescents continues to rise each year in the United States, it is
imperative that effective measures be taken at the middle school level to help parents of students with disabilities like autism find ways of helping their children cope with their emotional and social struggles.

**Purpose of Graduate Project**

The purpose of this project is to develop a suicide prevention workshop to be facilitated by a professional school counselor that will raise the awareness of parents and provide them with tools to recognize suicidal behaviors in adolescents with autism. The suicide prevention workshop would consist of a Power Point slide and brochure that would give parents knowledge of what type of behaviors to look for in potentially suicidal students as well as provide parents resources to use in order to better help them and their children. This project is designed to allow parents to better understand the social impact a disability like autism has on a student and ways in which they can help the adolescent understand and cope with their disability. In addition, this project is designed to help parents become aware of the signs of struggling students who may seem unmotivated when in reality they are struggling emotionally. Finally, this prevention workshop could be used by all middle school counselors to promote awareness to all parents of students with disabilities. Many people believe that talking about suicide can cause students to act on it, but the reality is that not talking about suicide is causing students to feel like the only option they have is suicide. This suicide prevention workshop graduate project is designed to educate and provide parents/guardians with information and strategies to help their child with autism succeed and find a sense of connectedness to school and home. By using a Power Point presentation, parents will be given examples of real life situations of the challenges that students with autism face on a
daily basis and ways they can minimize this sense of isolation at home. It can also help alleviate the sense of loneliness in students with autism and find ways to help them feel connected to their peers, school, and family members. By implementing this workshop, school counselors will work collaboratively with the families of students with autism to help them find resources within their community as well as provide them strategies to engage in meaningful activities with their children. It is hoped that parents/guardians will learn more about their role in the social development of their child, and the ways in which the family can help facilitate a child’s sense of belonging and connectedness.

**Terminology**

*Autism:* a mental condition, present from early childhood, characterized by difficulty in communication and forming relationships with other people and in using language and abstract concepts (CDC, 2015). For the purpose of this project, these terms will be used interchangeable.

*Autism Spectrum Disorder (ASD):* a developmental disability that is caused by differences in how the brain functions (CDC, 2015). For the purpose of this project, these terms will be used interchangeable.

*Special Education:* a form of learning provided to students with exceptional needs, such as students with learning disabilities or mental challenges (CDC, 2015).

*Developmentally Appropriate Practice [DAP]:* DAP is an approach to early childhood education that means teachers meet individual children where they are and help them reach challenging but achievable goals that will support their development and learning (Kostelnik, Soderman, and Whiren, 2011).
Student Victimization: experience of being the target of physical, social, emotional, or psychological harm (Roekel, Scholte, and Didden, 2010).

Bullying: being exposed, repeatedly and over time, to negative actions on the part of one or more other persons (Roekel, Scholte, and Didden, 2010).

In order to better understand this issue, it is necessary to review previous studies and research regarding middle school students and social development, middle school students with autism and risk factors for suicide, parents of students with autism, previous suicide prevention programs, the role of the school counselor in middle school, and benefits of intervention programs at the middle school level, which will be covered in the following chapter.
Chapter 2

Review of Literature

This chapter will begin with a description of middle school students and social development, including middle school students with autism and risk factors for suicide. There will then be a review of previous suicide prevention programs and the impact on parents and schools, as well as the role of the school counselor in middle school and the benefits of intervention programs.

Middle School Students

Adolescence is the period roughly between twelve to eighteen years of age. According to Erikson’s (1993), stages of psychosocial development, this particular stage is called the Identity vs. Role Confusion, in which the goal of the adolescent should be to achieve a sense of self-identity. This is the period in which adolescents ‘try on’ different roles, and try to discover their strengths and weaknesses. This may include experimenting with non-risky or risky behaviors such as sex, drugs, friends, and physical appearance. Adolescents typically become less dependent on adults and become more dependent on peer groups. Peer groups are important during the adolescent years. According to Erickson, “during this period, adolescents increasingly rely on their friends and peers as sources of information… this increasing dependence on the peer group enables adolescents to forge close relationships. Comparing themselves to others helps them clarify their own identities” (1993, p.149). Adolescents also face changes in their development in their brains and bodies. This is a rapid period of growth and change for many adolescents (1993).
According to the American Psychological Association (2002), adolescent development begins with the physical attributes, such as boys developing a deeper voice and broadening shoulders. Girls, on the other hand, develop breasts and begin their menstrual period. Adolescent development includes physical, puberty, brain, and socio-emotional development. Although it seems that an adolescent’s body changes overnight, puberty actually occurs over a period of several years. Secondary sex traits are physical characteristics that are visible that result from hormone production, but not related to reproduction. This includes hair growth underneath the arms and pubic area in males and females. Male secondary sex traits also consist of the voice deepening, hair growth all over the body, and broader shoulders. Female secondary sex characteristics are breast development and widening of the hips (2002).

The American Psychological Association (2002), reports that the adolescent years are a period of rapid growth and that an adolescents developing brains are able to obtain higher thinking cognitive skills, which enhances their reasoning and ability to think abstractly. This developmental period is critical to their development and higher-level thinking skills, which allow them to think about the future and set personal goals. Although few cognitive differences have been identified between boys and girls, it appears that boys and girls differ in their confidence with certain cognitive skills and abilities. Adolescent boys tend to be more confident in their math and athletic skills, and adolescent girls tend to feel more comfortable with social and reading skills (2002).

Erickson’s theory emphasizes the importance of achieving self-identity during adolescence. Adolescents begin to develop their identities by spending more time with
their peers because the peer group provides them with the opportunities to experiment with roles relating to authority, their sexuality, and responsibilities (Erickson, 1993).

**Middle School Students and Peer Acceptance**

In adolescence, peer relationships become more important as their need to belong within a social group increases (Masten, Eisenberger, Pfeifer, Colich, & Dapretto, 2013). This is a time of change and discovery for an adolescent and according to Sigelman and Rider (2012), during this period of growth, there is a rapid increase in cognitive, biological, social and emotional changes. According to Oberle, Schonert-Reich, and Thomson (2010), feelings of relating and belonging to peers are thought to be significant in early adolescents’ adjustment to school, for their self-esteem, and their feelings of self-worth. Peers are remarkably important to adolescent’s academic, social, psychological development and well-being. Peer acceptance (the degree to which an individual is liked or disliked by his or hers peers) is particularly of importance and correlated to an adolescents’ well-being. During the adolescent years, peer acceptance plays in an important role in the life of adolescents because it provides an important context for gaining and learning interpersonal skills which are necessary for relationships (2010).

Oberle et al. (2010), conducted research and found that adolescents who are anxious perceive themselves as being isolated and rejected by their peers and report having fewer friends than their non-anxious peers. Oberle et al. (2010), also investigated the relationship of self-reported empathy, optimism, positive affect and peer acceptance in early adolescence; one of the few studies conducted to investigate peer acceptance as opposed to peer rejection. Participants were early adolescents who were part of a bigger
study examining the effects of a school-based social and emotional competence promotion program. Participants included 56 boys and 43 girls in 4th and 5th grade classrooms attending public elementary in middle class neighborhoods. Student’s ages ranged from 9-to- 11 years old. Regarding students’ family composition, 84% reported living in two parent home (including both biological and step-parent families), 9% reported living with mother only, and the remainder reported living in dual custody arrangements (i.e., ½ time mother, ½ time father). In regards to language, 66% reported English being their native language, 27% East of Asian origin (Korean, Mandarin, Cantonese), and 10% indicated a range of other languages (e.g., Spanish, Russian, Polish). The language background of each participant is reflective of the cultural and ethnic diversity of the Canadian city the research took place in. Students’ teachers reported that all participants were competent in English to participate and complete the study measures. Students were administered a questionnaire in their during a 45-min class period in the spring of the school year. Each item was read out loud by a trained research assistant while students completed the measures (2010).

Oberle et al. (2010), measured general personality characteristics of children using The Seattle Personality Questionnaire for Children (SPQC). The SPQC is composed of four subscales: Conduct Problems, Depressive Symptoms, Anxiety, and Somatization. In this research, only one of the subscales, Anxiety, was used by the researchers in the analyses. The researchers provided students a roster with all participating classmates’ with which they “would like to be in school activities,” in order to assess students’ level of peer acceptance. Oberle et al. (2010), analyzed a score for peer acceptance of boys and girls separately. This gender specific analysis was used in
order to analyze the girls’ vs. boys’ acceptance of peers. Peer nominations were also used to assess early adolescents’ pro-social behaviors and characteristics, and anti-social behaviors. The nomination questions included questions like: “shares and cooperates,” “helps other kids when they have a problem,” “who can you trust,” “who understands others’ points of view,” “start fights,” “break the rules and do things they are not suppose to do.” These behaviors/characteristics correspond to positive and negative interactional qualities that correlate to peer liking and disliking among young adolescents (Oberle et al., 2010).

Oberle et al. (2010), described their research results, stating that they found that peer acceptance by girls was positively and significantly related to pro-social behaviors, pro-social characteristics, empathy, optimism, and negatively related to anti-social behaviors. Peer acceptance by boys was positively and significantly related to positive affect, and negative related to anxiety and empathy. There were positive and significant correlations between pro-social behaviors and empathy and pro-social behaviors and optimism, and negative and significant correlations between antisocial behaviors and pro-social behaviors and between antisocial behaviors and optimism. Next, they examined whether gender played a key role in the nominations of boys to boys, girls to girls, boys to girls, or girls to boys on the peer acceptance item. Researchers found no significant difference was found between the peer acceptance scores girls received by same-gender classmates versus cross gender classmates. This was also true for the boys in that there were no significant differences between levels of acceptance from girls versus boys. These researchers also found that these finding were in agreement with other research that found 90% of early adolescence having cross-gender friends. They then proceeded to
investigate what predicts being accepted by girls, and what predicts being accepted by boys. They concluded that positive predictors of peer acceptance were determined by pro-social behaviors and characteristics. Peer-rated anti-social behaviors did not predict peer acceptance significantly. Unlike the girls, the boys’ acceptance of peers was not statistically significant explaining only 1.2% of the variance in peer acceptance. None of the three predictors were found to be significant. Optimism, gender, and peer-rated antisocial and pro-social behaviors and characteristics were not significant predictors in the model. The study showed that girls’ and boys’ peer acceptance were gender specific. Boys had higher levels of peer acceptance significantly predicted by lower empathy and lower anxiety scores. Boys during adolescence begin to exert gender-roles in their socialization and being emotionally expressive can be considered “uncool.” Surprisingly, positive affect negatively predicted peer acceptance by girls (2010). This result challenges previous research that has revealed that being happy is associated with greater peer acceptance and relationships.

In another study by Bowker, Thomas, Spencer, and Park (2012), these researchers examined peer acceptance by measuring rejection sensitivity (anxiously expect, readily perceive, and intensely respond to rejection), by measuring appearance-based rejections, and by measuring psychological maladjustment during early adolescence. Participants were 150 seventh-grade students from one public school in Western New York. All seventh grade students were recruited for participation, and 76% participated with parent consent. The sample was racially and ethnically diverse with 58% Caucasian, 20% African-American, 3.6% Hispanic/Latino, 1.4% as North-East Asian, 0.7% as Native American, and biracial/other. The students were asked to complete a questionnaire
during spring semester in their classrooms for approximately one hour. The questionnaire consisted of 15 hypothetical scenarios that were modified to be age-appropriate. For example, “You are at a school dance and all your friends have been asked to dance except you;” “You are trying on clothes at the mall and notice that you are a few heavier than last week;” “Your new boyfriend or girlfriend thought you a new gym membership for your birthday;” “Your boyfriend or girlfriend of 3 mons is considering breaking up with you.” “Following the scenarios, participants specified how anxious they would feel and how likely they felt they would be rejected based on their physical appearance on a 6-point Likert scale, ranging from 1 (not nervous) to 6 (very, very nervous) for anxiety items, and 1 (very unlikely) to 6 (very likely) for the expectation of rejection items” (Bowker et al., 2012, p. 378).

For this research, personal-rejection sensitivity was the shortened version of the Children’s Rejection sensitivity Questionnaire, which was used to assess Personal-RS. Participants were provided with 6 hypothetical scenarios that involved the possibility of rejection (e.g., “Imagine that a famous person is coming to visit your school. Your teacher is going to pick five kids to meet this person. You wonder if she will choose you.”) Each scenario was followed by questions assessing anxious feelings (e.g., “How nervous would you feel, right then, about whether or not the teacher will choose you?”) and expectations of rejections (e.g., “Do you think the teacher will choose you?”). Participants reported on a 6-point Likert scale, ranging from 1 (not nervous) to 6 (very, very nervous) for the anxiety items, and 1 (very unlikely) to 6 (very likely) for the expectations of rejection items. The Personal-RS scores were calculated by multiplying the expected likelihood of rejection by the degree of anxiety reported for each situation.
and dividing by the total number of situations (Bowker et al., 2012, p.379).

Researchers found that the correlations revealed a pattern, which was consistent with previous research and provided validity for Appearance-RS measure in adolescents. Appearance-RS and Personal-RS were also moderately correlated. Appearance-RS was associated with self-esteem and the two social anxiety subscales. Appearance-RS and social avoidance is consistent with previous research showing that high Appearance-RS individuals often cope with appearance rejection using avoidant behaviors. “Early adolescence is the developmental period during which boys and girls are most sensitive to general rejection by peers and when the onset of puberty and the emergence of other-gender peer relationships tend to heighten concerns about physical appearance” (Bowker et al., 2102, p.383). In summary, these researchers describe adolescence as a time of discovery and self-awareness in which an adolescent relies highly on peer approval and the connections and relationships made with their peers and found that peer rejection in middle school may be detrimental to the self-esteem of some students (2012).

**Middle School Students with Autism**

Autism Spectrum Disorder (ASD) is described as a neurodevelopmental disorder that hinders a person’s socialization, communication, and is characterized by individuals who display a pattern of repetitive behaviors and interests (Baghdadli et al., 2012). Autism is a disorder that is apparent in most children at an early age. Ozonoff, Heung, Byrd, Hansen, and Hertz-Picciotto (2010), examined the onset of autism and found that Autism occurs in one of two patterns. “In one onset, children show abnormalities in social and communication development in approximately the first year of life” (Ozonoff
et al., 2010, p.320). “In the second pattern of onset, regressive autism, the child seems to be developing typically for the first year or two and in the second year, they lose skills that they had previously acquired” (Ozonoff et al., 2010, p.320). These researchers found that most children show signs of autism over the first year and a half of life. These researchers attest that, “although these two patterns can be seen in most children with autism, these two patterns do not account for all the ways that autism can emerge. “Some children demonstrate a developmental plateau marked by failure to progress, while other children display mixed features, with both early delays and later losses evident” (Ozonoff et al., 2010, p. 320).

In contrast, adaptive behaviors are age-appropriate behaviors used daily to function independently, safely, and appropriately in daily life routines. Baghdadlin et al. (2012), attest that individuals with ASD have shown to have lower intellectual adaptive behavior levels at an early age, but these skills improve over time in most ASD individuals along with their everyday functional communication skills. Baghdadli et al. (2012), attest that although improvements in adaptive behaviors do occur from childhood to adolescence and adulthood, social interaction impairments among individuals with ASD remains consistent through adulthood even within high functioning ASD individuals.

In a study by Baghdadli et al. (2012), the researchers examined change in clinical and environmental variables at two points in time separated by 3 years, in a cohort of young ASD children. The researchers collected data for an extended time (10 years) using group-based trajectory analysis to investigate the three dimensions of adaptive behaviors (communication, socialization, and daily living skills). The purpose if this
research was to describe the trajectories of adaptive skills in individuals with ASD and their risk factors (2012, p.1315). The cohort consisted of 152 children with ASD. They entered the cohort with a median age of 5 and were again assessed at age 8 and 15. Participants were picked from the following criteria: are under 7 years of age; have written parental consent after being clearly informed; have a diagnosis of childhood ASD or atypical autism. Between 1997 and 1999, 280 children with ASD (82% male), aged between 3 and 7 years were clinically assessed. They were recruited among 362 eligible children of whom 66 were dropped from the study because they did not meet research criteria and 16 had moved away. Three years later, 219 of the original group were reassessed. Finally, the remaining 152 children were assessed between 2007 and 2009.

The researchers found that deficits in adaptive abilities in ASD children remained over time, but some changes were seen in this domain. Consistent with other studies, these researchers found that for children with ASD socialization and communication skills remained a concern (2012).

Cridland, Jones, Caputi, Magee (2014), investigated the experience of girls with ASD in adolescence. Cridland et al. (2014), postulate that since the ratio of males to females with ASD is 4:1, one reason for this may be that it is more difficult to detect girls with ASD because some girls with ASD have a lower IQ range, which can result in being diagnosed with a Learning Disorder. Another factor contributing to difficulty with diagnosing girls with ASD is their relatively strong social skills. In addition, girls with ASD have fewer behavioral problems in comparison to boys, which may hinder the diagnosis for ASD. Consequently, girls with ASD are usually diagnosed with ASD in their adolescent years and it is at this time that the disparity of their social impairment is
seen in comparison to their peers. In addition, adolescent relationships are based on reciprocal sharing, emotional support, and social problem-solving. These essential skills that ASD girls lack impede their ability to make meaningful relationships with other girls. In contrast, adolescent boys’ relationships are typically based on ‘doing’ rather than ‘talking’.

Cridland et al. (2014), focused on girl adolescents with ASD between the ages of 12-17 years who had a formal diagnosis of ASD based on the Diagnostic and Statistical Manual of Mental Disorders. Three mother dyads and two additional mothers were included in the interviews. A face-to-face interview was conducted with each girl who had parental consent. The interview with the mothers and adolescent ASD participants began with an open-ended question (‘What have been your experiences of being an adolescent girl with ASD/having an adolescent daughter with ASD?’). The interviewers encouraged participants to speak freely and willingly and at length about their own personal experiences. This method is consistent with Interpretative Phenomenological Analysis (IPA) because it allows the researcher to enter the social and psychological world of the participant. The findings of this research by Cridland et al. (2014), were that the mothers of children with ASD described the process of obtaining an ASD diagnosis as challenging. Some reasons the mothers cited included pre-sensation of symptoms, imitation of social behavior, higher incidence of ASD in boys, misdiagnosis, and reluctance from health professionals (e.g., pediatrics, psychologists, psychiatrists, etc.) to provide a formal diagnosis. Diagnosis for girls was considered to be more difficult according to four of the five mothers when compared to the experiences of those of friends who have boys who have ASD. Another aspect of being ASD as an adolescent
girl was the inappropriate placement within a school setting. Some ASD girls report that they felt negative towards their high school experience, which included finding the classwork difficult and/or uninteresting, challenges making friends, and managing the larger school environment. One participant described her negative experiences of trying to form friendships with neuro-typically developing teen (NTD) peers, “Because I have a disability, they ignore me or pick on me and bully me just because of that. It’s hard, especially with like the really popular girls, they won’t even listen to me- as soon as they hear that I have a disability they just won’t even listen to me and what I have to say” (2014, p.1266). Some of these challenges girls with ASD report may be similar to those experienced by boys with ASD. Cridland et al. (2014), attest that some of the girls’ experiences may be comparable to those experienced by adolescent boys with ASD, for example challenges in transitioning to and coping with high school, negative impact of late diagnosis, ‘hand-on’ role of parents into adolescence, difficulties dealing with puberty on-set and the increased hygiene routine demands, and the value in learning personal boundaries when interacting with others. The most prevalent aspect of ASD, according to Cridland et al. (2014), is the lack of socialization skills, which is a critical component when engaging in meaningful relationships. All participants with ASD reported a difficult time developing and maintaining friendships with NTD adolescent peers due to the length of time needed to process information when having conversations and a difficult time fitting in with their NTD peers. This research by Cridland et al. (2014) gives an insight to the experiences of adolescent ASD students and the implications of having a disorder like ASD (2014).
Bullying is another factor that has been associated with students who have autism. Schroeder, Cappadocia, Bebko, Pepler and Weiss (2014), indicate that bullying is common among children. However, children with ASD are more often ostracized by their peers, placing them at higher risk for being bullied. Wang, Iannotti, Luk, and Nansel (2010) examined the prevalence of specific forms of bullying among American students in grades 6-10 in a nationally representative sample of over 7,000. Researchers found that approximately 54% of students reported that they had experienced verbal forms of victimization, 51% reported social forms, 21% reported physical forms, and 13% reported cyber forms.

In a comparative study by Wainscot, Naylor, Sutcliffe, Tantam and Williams (2008), a study of 30 students with Asperger syndrome or high-functioning autism in mainstream schools were compared to typically developing students as far as reports of bullying. The authors found that students with ASD were four times more likely to report bullying than their peers. The individuals with ASD also experienced victimization more often than the typically developing students (40% to 15%). Bullying is a persistent issue among children and adolescents, and is associated with many negative implications such as negative academic, social, psychological outcomes. Students with ASD face a more challenging adolescence due to their social, communication, and behavioral difficulties. These students are placed at a higher risk of being victimized when compared to their peers (2008). Communication and social deficits also increase the risk of victimization for students with ASD because assertiveness and effective communication skills represent a protective factor when being bullied (2008). ASD students also demonstrate a lack of interests and stereotyped behaviors, which may be perceived by peers as being
different, this resulting in an increased risk of peers marginalizing and targeting individuals with ASD (Wainscot et al, 2008).

**Risk Factors for Suicide Among Students with autism**

Student victimization is the experience of being the target of physical, social, emotional, or psychological harm. Bullying, being exposed, repeatedly and over time, to negative actions on the part of one or more other persons, is a prevalent topic among school faculty. Blake, Lund, Zhou, K wok, and Benz (2012), found that students with disabilities are often targeted more often than their non-disabled peers. These researchers examined the prevalence rate of bully victimization and risk for recurring victimization among students with disabilities using the Special Education Elementary Longitudinal (LEAs) and special education schools. The second stage included selecting a representative sample of students with disabilities based on rosters provided by LEAs and special education schools. Using these two databases, 11,512 students with disabilities were initially recruited to participate, ages 6-12, who were enrolled in elementary and middle school. The Special Education Elementary Longitudinal Study (STEELS) was carried out over a 6-year period, beginning in 2000 and ending in 2006. The NLTS2 sample included 11,272 youth whose ages ranged from 13-16 years old in 2000. The NLTS2 was carried out over 10 years and encompassed five waves of data collection beginning the 2000-2001 academic year and ended 2008-2009 academic year. Students’ disability was established at the time of sampling based on students’ primary disability reported by student’s school. Respondents were asked several questions and were asked to indicate (yes or no) whether they had been a victim of bullying or had been picked on by other student during or after school (2012).
Blake et al. (2012), found that the overall rate of bullying for students with disabilities was 24.5% in elementary school to 34.1% in middle school and 26.6% in high school. Middles school students were more likely to be victims of bullying than elementary or high school students. This is one to one and a half times the average for students without disabilities, state the authors. They also found that elementary students who were bullied in Wave 1 of the study were over seven times more likely to be victimized again in Wave 2 than elementary students who were not bullied in Wave 1. Also, middle school students and high school students who were bullied in Wave 1 were five times more likely to be bullied again in Wave 2 than their peers with disabilities who were not bullied in Wave 1. Unfortunately, the risk of repeated victimization for students with Autism was significantly greater both at the elementary (13.8) and middle school (16.0) level (2012).

The risk and rates of bullying victimization in schools are not equal across student groups. The research found that students with disabilities are at greater risk of being bullied. Girls with special education services are 3.9 times more likely to be a victims and 4.8 times more likely to be bully victims than their peers without disabilities. Boys with disabilities were also 2.4 to 3.2 times more likely to be bully victims than their peers without disabilities (2012). Therefore, it is not surprising that students with disabilities who are often victims of bullying have a higher rate of depression and attempted suicide.

Given that students with Autism Spectrum Disorder (ASD) have a deficit in their social skills, many times these individuals are viewed as lacking the desire and skills to make meaningful relationships with others (Locke, Ishijima, Kasari, and London, 2010). Individuals with ASD are not always successful in engaging or seeking out meaningful
social interactions. This can make them an easy target for ridicule and can lead to deeper feelings of loneliness (2010). Locke et al. (2010), states that children with ASD seem aware of their social situations and desire personal connections and engagement with others, but may lack the skills and opportunity to do so. Locke et al. (2010), attest that that children with ASD seldom engage with others and are poorly accepted by their peers. These researchers examined the feelings of loneliness, friendship quality and social networks of adolescents with ASD who attended a ‘regular high school.’ Participants in the study were recruited from a high school with an autism spectrum program in the Los Angeles area. Eligibility for the ASD program was based on having previous clinical diagnosis of ASD, conversational speech and minimal behavior problems. All participants were enrolled in a regular education drama class at their high school. A total of seven adolescents with ASD [(4 male and 3 female)] mean age= 14.71 years and 13 typically developing (TD) students [mean age= 14.20 years)] participated in the study. The adolescents with autism were predominantly Caucasian (72% Caucasian, 14% African American and 14% Latino). Three questionnaires were given to the students to access loneliness, friendship quality and social network status. The outcome of the study revealed that adolescents with ASD (37.71) experienced significantly more loneliness that their TD peers (26.25). The researchers found that friendship quality among adolescents with ASD had significantly poorer friendship quality in companionship and helpfulness as compared with their TD classmates. The measure of adolescent’s social networks and connections of adolescents with ASD in an inclusive setting in comparison with their TD peers indicated that 92.4% of the TD adolescents felt connected and recognized by their peers in the social setting of their classroom. On the other hand,
adolescents with ASD felt either isolated or peripheral 71.4% of the time in this particular classroom and demonstrated a significantly lower social network rating in comparison to their TD peers (ASD 1.14 to TD 2.23). This study indicated a significant difference in feeling of loneliness between ASD and TD adolescence. Although adolescents with ASD desire social connectedness with their peers, many experience a lack of connection to what they want and what they are manifesting within their social networks and friendships. Therefore, it is not astonishing that adolescents with ASD tend to socialize and make friends with other students who are also on the autism spectrum. This research provides a glimpse of the social outcasting that many adolescents with autism experience and the feelings of loneliness associated with this disability (2010). The implication of a disorder like ASD can be long lasting. Many of these children face daily challenges that can be seen throughout most of their life. Adolescents who are outcasted within their peer groups face more challenges throughout their life and may have difficulty maintaining long lasting relationships.

**Suicide Prevention Programs**

Hooven (2013), points out that families and friends play a significant role in youth suicide prevention programs as a source of protection. Family relationships have proven to be the most consistent protective factor against adolescent suicide even when compared to other relationships outside the home. Since the family plays a protective role in the lives of adolescents, suicide prevention programs should include the family in order to help reduce the risk of adolescent suicidology (2013).
Hooven, Walsh, Pike and Herting (2012), state that engaging families in intervention programs is beneficial for all students, but unfortunately in most cases it is the family that places the child at risk through family stress or adversity, and is difficult for families to engage in intervention programs. The positive impact that families can make in the lives of their children is immense, but many programs such as CARE, Attachment Based Family Therapy, or Multi-Systematic Family Therapy (MST) that involve families, face a challenge in enrolling and retaining the family. The challenge is finding ways of helping parents become knowledgeable about the signs of distress in children and giving them the proper resources to help them (2012).

According to Hooven, Herting and Snedker (2010), CARE Suicide Prevention Program is a program geared towards helping adolescents who are in emotional crisis. This program provides students and parents with resources to get immediate help. Hooven et al. (2010), states that Promoting CARE is one of few the systemically evaluated comprehensive suicide prevention program delivered to youth who were assessed to be at risk of suicide. The CARE program integrates principles of behavior change maintenance particularly to improve skills acquisition, social support and motivation, and self-efficacy. In the longitudinal study by Hooven, et al. (2010), researchers examined this comprehensive program that was presented to 615 high school youth and their parents. The researchers looked at the long-term effects of this program rather than the short changes. The program was successfully given to six hundred at risk suicide high school youth and their families in the Pacific Northwest. The program addressed youth suicide risk by improving youth skills in managing emotion and coping with stress, as well as increase support-seeking skills. Of the 615 participants, 155 were
assigned to a brief parent intervention called (Parents CARE, P-CARE); 153 to a brief youth intervention called (Counselors CARE, C-CARE); 164, to a combination of both youth and parent (P&C-CARE); and 143, to a minimal-intervention comparison group (MI). Participants were in grades 9-12 and over 2000 adolescents were screened and 615 youth were identified at risk for suicide. All participants completed a comprehensive survey and a High School Questionnaire (HSQ). The HSQ tapped into suicidal risks and behaviors. The participants at risk were assigned to either participate in the CARE program or MI (minimal intervention) protocols. Teens who participated in the CARE program were assigned to complete a 1.5 to 2 hour assessment interview followed by a brief counseling protocol and the assistance of social connections with parents and school personnel. Teens who participated in MI participated in a brief 15 to 30 minute assessment interview using the 22-item Screen for Youth Suicide Risk (SYSR). Parents who were assigned to the P-CARE intervention completed 2-hour home visits designed in engaging parents in a partnership to learn suicide prevention “first aid” and were given skills in supporting their teen. Of the 615 participants, 86% of youth were eligible to participate in the long-term follow-up study (2010).

Hooven et al.’s (2010), study focused on the short-term outcome of Promoting CARE as well as the long-term. The short-term outcomes showed that P-CARE was effective at decreasing risk and increasing protective factors for suicide. All study options showed an instant and substantial result in minimizing suicidal ideation and threats, depression, hopelessness, anxiety, and anger. An increase in protective factors of coping, self-efficacy, and family support was observed in all participants. In all cases, P-CARE administered alone showed no significant difference from the MI comparison. Overall, in
the short-term evaluation results, C-CARE combined with P-CARE parent intervention showed the greatest and most continuous effects across risk behaviors compared to the MI, from the intervention. The study also revealed that white adolescents were more likely to be in the lower class of anger and being in a dual-parent biological family also lowered the odds of being in higher categories of anger. Hard drugs other than alcohol or marijuana played a role in suicide behaviors, but not in depression or anger (2010).

Hooven et al. (2010), were able to closely examine the long and short-term effects of the suicide prevention program. The successful outcomes of this community-based suicide prevention program indicated a decrease in risk patterns in teens over the transition to adulthood. Participants who showed signs of suicide risk in adolescence and who received intervention, did not revert to suicide because they continued to decline in risk levels for suicide. The study also addressed help-seeking behaviors in intervention by discussing suicide risk in a direct and supportive way and by providing youth possible support personal at school and at home. In reviewing the results of this study, it seems that all adolescents were given in the program the tools and resources to know what to do when they are faced with challenging situations or in emotional turmoil. Knowing where and who to reach out to in a time of need can save the life of a hopeless teen. The aim of all suicide prevention programs should be to provide parents, educators, and peers the knowledge, support, and resources to help youth find a way to deal with life’s obstacles and stressors (2010).

Langhinrichsen-Rohling, Lamis, and McCullars (2011), reviewed existing interventions for at-risk suicidal adolescents. In their review of the programs, these researchers found that family focused suicide interventions for youth focused on the
dynamic of the household and targeted the families function as a way to reduce the risk of suicide to the adolescent. One of these interventions is the multi-systematic family therapy (MST). The MST intervention was designed to help out families who have a child with emotional or behavioral issues. The intervention assists parents with their parenting abilities while also enhancing the families dynamic and ability to communicate effectively with their challenging adolescent. MST encourages the adolescent to seek outside social activities such as joining a club at school or joining a sport in order to establish social connections. In reviewing the existing interventions for adolescents one thing seems to be considered, which is the ability to enhance the suicidal adolescent’s connectedness and sense of belonging to their environment by increasing their social skills and enhancing communication with their immediate family (2011). Katz et al. (2013), also attests that the goal of a suicide prevention program should be to reduce the prevalence of suicidal thoughts, attempts, and deaths among adolescents. Various programs like MST have been implemented throughout schools, health care systems, and communities in order to reduce the risk factors or to identify and provide treatment.

Signs of Suicide (SOS) is a universal program that focuses on educating, training, and screening adolescents with emotional and behavioral problems as a mean to SOS includes strategies like suicide awareness, education, and screening. This program uses videos to give students the tools and knowledge to recognize the signs of suicide in others and take them seriously by informing an adult. The screening component for this program uses the Brief Screen for Adolescent Depression (BSAD). Students who are identified as being at-risk are then encouraged to seek outside help. Although all suicide prevention programs aim to reduce the risk of suicide in students, only three were measured for their ability to
reduce suicidal behaviors: SOS, The Good Behavior Game (GBG), and CARE/CAST. According to Katz et al. (2013), SOS and GBG are two of the few suicide prevention programs that are evidence-based programs and have been shown to reduce suicidal attempts in students. However, SOS has not proven to reduce suicide ideation in students. This may be because suicide ideation is more common among students than suicide attempts. Additionally, suicide ideation may also take further intervention and may take longer to treat. These programs have been supported by research and have been proven to reduce suicide attempts in students (2013).

**The Role of the School Counselor in Middle School**

Professional school counselors guide and assist students with academic achievement, personal and social issues, as well as achieving their college and career goals. The wide range of responsibilities a professional school counselor performs on a daily basis may include scheduling, consulting with school staff regarding academic or personal/social issues that arise with students, and helping students through the challenging time of middle school as the students transition from childhood to adolescence (ASCA, 2010). In order for a school counselor to practice counseling, they are required to obtain a state credential or license to practice in that state as well as a Master’s degree in school counseling or related field. In addition to the master’s degree, fifteen states also require on the job training or internship hours. The hours required for credentialing vary from 100-700 hours depending on the state. Thirty-four states require professional school counselors to pass a state exam in order to assess each professional school counselor before exiting the school program (American School Counselor Association, 2010).
A student’s personal and social life may affect the students’ well-being and academic success. Scheel and Gonzalez (2007), examined 346 high school students for self-efficacy in academics, goals, and individual support through professional school counselors. The participants were asked to complete a questionnaire about their academic self-efficacy and their future goals. This survey was used to access student efficacy expectancy beliefs. Theses researchers found that students who sought out help in school achieved better academically and more often displayed high self-efficacy in relation to their academics. A student’s personal beliefs about their abilities and skills can either help or hinder their own academic abilities, their motivation to succeed, and engagement within a class (2007).

Barna and Brott (2011), explored 212 professional school counselors’ perceptions of personal/social development as a means to support student academic achievement. These researchers targeted a total of 212 elementary school counselors. The average number of years employed as a counselor was 10 years and most of the participants (79%) were employed at school with an average yearly progress (AYP). Participants were asked 26 items which included 14 questions based on Academic standards and 12 Personal/Social standards. Rating ranged from 0= not important to 3= critical. Following the rating of the 26 standards as to importance and implementations, an open-ended question asked participants to indicate by item which of the listed 26 standards was most important for supporting academic achievement (Barna & Brott, 2011). The researchers found that based on the participant ratings, the same seven items on the questionnaire received the highest rankings for both importance and implementation. The Personal/Social standard was selected overall by all school professionals as the most
crucial item to support student academic achievement. In order to address a student’s academic achievement, a school counselor must also address the student’s social/emotional well-being. All students have different coping skills and deal with life stressors in different ways and many students with autism may have a hard time obtaining these types of skills (2011).

Beale (2003), states that professional school counselors have the task of providing students with academic and socio-emotional counseling. Professional school counselors are asked to be advocates for students and to be agents of change in the school system to ensure the needs of all students. In fact, creating and implementing programs on campus to meet the individual needs of the students is a task performed by professional school counselors (Beale, 2003). Lee (2001), attest that successful school programs involve consultation with other school personnel before, during, and after implementation. Professional school counselors should consult with supportive personnel, teachers, and administrators to help the school be effective in meeting the needs of their student population. Even though professional school counselors are expected to advocate for the needs of all students, teachers, administrators, parents, and even community leaders can offer their unique skills and knowledge to aid in the development of programs to meet student needs (Lee, 2001). The American School Counselors Association (ASCA) has ethical and legal standards for all professional school counselors to follow. A few guidelines pertinent to this graduate project are listed below:

A.5.a. Make referrals when necessary or appropriate to outside resources for student and/or family support. Appropriate referrals may necessitate informing both parents/guardians and students of applicable resources and making proper
plans for transitions with minimal interruption of services. Students retain the right to discontinue the counseling relationship at any time (ASCA, 2010, p.2).

A.5.b. Help educate about and prevent personal and social concerns for all students within the school counselor’s scope of education and competence and make necessary referrals when the counseling needs are beyond the individual school counselor’s education and training (ASCA, 2010, p.2).

B.1.a. “Respect the rights and responsibilities of parents/guardians for their children and endeavor to establish, as appropriate, a collaborative relationship with parents/guardians to facilitate students’ maximum development” (ASCA, 2010, p.4).

B.2.b. “Recognize that working with minors in a school setting requires school counselors to collaborate with students’ parents/guardians to the extent possible” (ASCA, 2010, p.4).

E.2.f. Provide regular workshops and written/digital information to families to increase understanding, collaborative two-way communication and a welcoming school climate between families and the school to promote increased student achievement (ASCA, 2010, p.5).

These standards of ASCA relate to the professional school counselor aiding the families and students with ASD. A student’s emotional well-being translates into their academic and social success and by providing parents/guardians information and resources, the workshop will help aid in preventing suicidal behaviors in adolescents.
This project is designed to aid families of students with autism by providing them strategies and information regarding students with autism and how peer isolation affects their emotional well-being as well as academically, and what families can do to prevent their child from having suicidal thoughts.

Today’s professional school counselor executes many roles in the school environment, however the end goal is to help students succeed. In order for middle school professional school counselors to assist in the development of all students, collaboration with all stake-holders (teachers, administrators, parents, and community) is imperative (ASCA, 2010).

**School Counselors Presenting Workshops to Parents**

Professional school counselors have the responsibility to act as an advocate for the well-being of all students. A good way of involving parents in the lives of their children is by encouraging parents to attend educational workshops facilitated by the school counselor. Educational workshops for parents are used to inform and educate parents on issues that may be relevant to school or home life. School counselors can choose to present to small or large groups of parents. School counselors should facilitate educational workshops because it provides parents the ability to engage in meaningful learning experiences which benefit the child and parent (Ritchie and Partin, 1994).

Ritchie and Partin (1994), stated that parent education programs have the possibility of reducing parent-child problems, fostering acceptance of the counselor by parents, increasing parents’ self-confidence, increasing knowledge of students and their family, reducing student problems both in and out of school, and creating a stronger
home-school alliance. These researchers assessed the involvement of school counselors in parenting skills training and consultation. Questionnaires were mailed out to 100 elementary, 100 middle school, and 100 high school counselors who were randomly selected from a mailing list of all the school counselors in the state of Ohio. A total of 213 questionnaires were received. Of the 213, 57 (26.8%) were elementary, 81 (38%) were middle or junior high, and 71 (33.3%) were high school counselors; 5 counselors (1.9%) failed to indicate their position. Ritchie and Partin (1994), asked questions like “Who is conducting parenting programs,” “Is there a need for parenting skills training,” “What kind of parenting programs are being offered,” “What should be included in parenting programs?” The researchers found that all counselors at all levels recognize the need and importance of working together with parents for the benefit of the student and their family. Although 84% of the counselors recognize a need for parenting skills training, only half of them have offered any such training. School counselors should focus on working with parents for the benefit of the student. Counselors indicated each skill as important: self-concept enhancement, 89.5%; Helping children succeed in school, 85.2%; behavior management and discipline, 82.4%; decision making, 82.4%; substance abuse issues, 72.4%. School counselors have the skills and knowledge to reach out to parents through educational workshops to provide parents with extra support and guidance (1994). It is in the best interest of all students that parents become involved in the education, and well-being of their child. Parents look for guidance from school counselors and teachers to help guide them in the rearing of their child. School counselors could offer parents workshops at different times of the day and provide refreshments, handouts, feedback forms, and special needs accommodations to ensure the
involvement of working parents (1994).

Based on the reviewed suicide prevention programs, the suicide prevention workshop created for this grad project is based on a family inclusive model such as the Multi-System Family Therapy (MSFT). This workshop will focus on the family and improving family problem solving and building communication. The MSFT program was intended for parents of adolescents who exhibit behavioral and/or emotional problems. This suicide prevention program could be greatly beneficial to meet the needs of parents with middle school students with autism since they also face challenging behaviors. This workshop will focus on teaching parents the tools to recognize suicidal behaviors, warning signs, depression, resources, learning effective communication skills, and ways to counter suicide in order to prevent suicide behaviors in ASD adolescents.
Chapter 3: Project Audience and Implementation Factors

Development of Project

The workshop was created by following other suicide prevention models and by relying on the information and studies discussed in Chapter 2. While researching autism spectrum disorder, I found that it was imperative to incorporate slides with information about students with autism and how their disability hinders their social life as an adolescent. I also found it important to address the characteristics of an adolescent with autism. In addition, I felt that it was necessary to provide parents with engaging tools to help facilitate conversation with their child by role-playing with the other parents. Wang, Iannotti, Luk, and Nansel (2010), concluded in their study of 7,000 American 6-10th graders that approximately 54% of students reported that they had experienced verbal forms of victimization, 51% reported social forms, 21% reported physical forms, and 13% reported cyber forms. Comparatively, research reports rates of above 50% for victimization of students with ASD or special needs (2010). The rates of victimization of ASD adolescents is high in comparison to their peers. This information was also added onto the Power Point presentation in order to make parents aware of the implications of bullying and how it affects their adolescent (2010).

Literature on autism and suicide ideation indicate that ASD individuals tend to have suicidal thoughts mostly due to a lack of social support within the home as well as at school. Since ASD individuals have difficulty with non-verbal language, many adolescents have a hard time making and keeping meaningful relationships. Research by Locke et al. (2010), friendship quality among adolescents with ASD is significantly poorer in companionship and helpfulness as compared with their TD classmates.
Research of adolescent’s social networks and connections of adolescents with ASD in an inclusive setting in comparison with their TD peers indicated that 92.4% of the TD adolescents were connected and recognized by their peers in the social setting of their classroom. On the other hand, adolescents with ASD were either isolated or outlying 71.4% of the time in this particular classroom and demonstrated a significantly lower social network rating in comparison to their TD peers (2010).

Social negative implications of middle school student with ASD is what propelled me to create a Power Point slide that provides parents with the tools and resource to become a protective factor in the lives of their adolescent. This workshop will help parents understand how important it is to conscientiously make an effort on a daily basis to communicate and interact with their adolescent to help prevent suicidal thoughts or behaviors.

**Intended Audience**

The intended audience for this workshop is parents of middle school students with autism. The purpose of the presentation is to help make parents aware of risks of suicidology in students with autism and the ways in which parents can help alleviate the feeling of suicidology or loneliness in their children.

**Personal Qualifications**

The professional to present this workshop would ideally be a professional school counselor in conjunction with a suicide outside agency or school psychologist. Professional school counselors are required to have completed a Master’s in the field of school counseling or a related field.
Environment and Equipment

The workshop is designed to take place in the multi-purpose room within the middle school either during school hours and afterschool to ensure that all parents have an opportunity to attend. The room should be able to hold all parents who have a child in special education with ASD. The facilitator may wish to provide drinks and snacks to all parents before and after the workshop. The workshop is designed as is to be roughly 1-2 hours depending on parent involvement, additional questions, and comments. The workshop is designed to be interactive so that parents of students with autism can get a chance to meet each other and also serve as a support system within the school.

Project Outline

The presentation slides are included in the Appendix portion of this project. The presenter(s) should read the facilitator’s guide thoroughly before beginning and customize it for their particular school setting and school needs. On average, 5-6 minutes should be spent per slide. Equipment needed for this workshop is the projector or a smart board-projecting device, a white surface to project the presentation on, power outlets for the projector, handouts for parents, pens or pencils, and the actual presentation.
Chapter 4

Summary

In this graduate project, the idea was proposed of the need for professional school counselors to assist parents of middle school students with autism find ways to help their adolescent cope with the feelings of loneliness and risk of suicide by giving parents/guardians strategies to help build a strong family connection at home as well as build the child’s self-esteem and connections with their peers. This guided workshop is designed to help students with autism feel a sense of belonging with hopes of reducing suicide ideation among this group of students.

In Chapter 2, literature on middle school students, middle school students and peer acceptance, middle school students with autism, risk factors for suicide, suicide prevention programs, the role of the middle school counselor, and school counselor presenting workshops to parents were reviewed. In addition, chapter 2 expanded on the education, training, and ethical standards of the professional school counselor. The development of the workshop was discussed in chapter 3: The intended audience, how the program was developed, and the facilitator qualifications. The workshop is designed to be presented by a professional school counselor to the parents of middle school students with autism. The workshop is meant to assist the parents with tools to help their adolescent with autism form a sense of belonging at home to minimize the feelings of isolation that many students with autism encounter. It is also geared towards collaborating with parents in order to reduce suicidology in students with disabilities such as autism by helping parent learn about different strategies to prevent suicidal behaviors in their adolescent.
Evaluative Summary Results

After creating this suicide prevention workshop for students with autism, an evaluation of this project was created and provided to three professional school counselors in the field. One school counselor is employed in Ventura County and two school counselors are employed in the Los Angeles County, in the San Fernando Valley: two professional school counselors are employed at a middle school and two at a high school. All three professional school counselors have obtained a Masters in School Counseling and a Pupil Personal Services (PPS) credential in school counseling. All three counselors were given a survey regarding the effectiveness of the workshop. Based on a Likert scale of 1-5. The ratings were labeled as follows: (1) Strongly Disagree, (2) Somewhat Disagree, (3) Neutral, (4) Somewhat Agree, (5) Strongly Agree. In the survey, professional school counselors were to respond to the following: (1) This presentation provides parents useful information regarding autism and the risk factors for suicide. (2) This presentation provides parents useful tips and strategies to help them deal with a depressed or suicidal child. (3) The length and material of the presentation is feasible and relevant to the topic to present to parents of children with autism. (4) I would present this material to parents of children with autism at the middle school level. There was also a place were the counselors could provide feedback or comments regarding the project.

For question one all participants of the survey strongly agreed that the presentation provided useful information regarding autism and the risks factors for suicide. On question two, two participants strongly agreed that the presentation provides enough resource and information to become knowledgeable of the steps needed to take if this was to occur. The other participant somewhat agreed to this statement. On question
three, all three participants strongly agreed that the length and material of the presentation was feasible and relevant to the topic to present to parents of children with autism presentation. On question four, all participants strongly agreed this presentation would benefit parents of middle school students with autism. Question number five provided the counselors the opportunity to give feedback or suggestions. One professional school counselor suggested providing this information to all parents of children with Individualized Educational Plan (IEP) because many times these student’s are an easy target for bullying by the general education population. Another school counselor thought the information given was pertinent to many issues that students with autism encounter and believed it was an effective way to build relationships among parents with similar challenges. Lastly, one counselor suggested that a copy of the Power Point presentation be handed out to the parents at the end of the workshop so they could refer back to all the resources and information. Additionally, all three counselors stated that this was a relevant topic that needed to be discussed because of the continuous occurrences of bullying among students with disabilities like ASD.

Discussion

After discussing the suicide prevention workshop with professional school counselors and reading the research studies, I have become very interested in creating a similar presentation for all Spanish-speaking parents of children with autism. I feel this population would benefit greatly from this information and resources. In addition, I would also get speakers from the community to come speak about autism and the implications it has on young adolescents. In addition, this Power Point presentation could be presented to general education teachers to educate them about ASD and suicide
prevention among this group of students.

**Future Work/Research**

In the future, I would like to not only create a Spanish-speaking Power Point presentation, but I would also like to extend this type of information to all parents of students in middle school. I would also like to evaluate the effectiveness of this power point presentation throughout the child’s middle school years by providing this information to the parents as their child enters 6th grade. With the information given, students and parents would be able to better cope with school and home stressors.
References


Facilitator’s Guide for the parent workshop presentation

Dear Professional School Counselor,

Attached you will find a power point presentation for you to utilize on the topic of suicide prevention to be presented to parents of middle school students with autism. This presentation outlines common behaviors in autistic adolescents, what behaviors to look for in adolescents who may be at risk for suicide, and what strategies and resources parents can utilize to best serve their child who may be depressed or suicidal.

As the facilitator, you may wish to collaborate with your district school psychologist to add or remove any of the information suggested in this presentation in order to personalize the presentation to your school demographics. You will find the Power Point presentation outlined with behaviors an ASD student may display, what the behavior often looks like, and examples to utilize of strategies. On each page of the Power Point presentation you will find suggested Presenter’s Notes to aid you with discussion through the Power Point presentation. Feel free to print out the presentation as a handout for the parents to take home to refer back to all the information, strategies, and resources. This handout can be passed out before or at the end of the presentation.

This presentation should take on average 1-2 hours depending on time allotted for questions and comments. There is also a post survey provided here that you may distribute to gain a better understanding of whether parents felt that the information being presented was helpful. You may choose to utilize this with your audience/participants at the beginning of the presentation and at the end of the presentation to measure baseline
questions and comments. There is also a post survey provided here that you may
distribute to gain a better understanding of whether parents felt that the information being
presented was helpful. You may choose to utilize this with your audience/participants at
the beginning of the presentation and at the end of the presentation to measure baseline
and outcome knowledge of autism spectrum disorder, suicide behaviors, and suicide
prevention strategies.

There is a need for professional counselors to provide parents of students with
autism strategies and resources regarding suicide. Research indicates that, students with
autism have a difficult time making meaningful friendships due to their lack of social
skills and are constantly bullied and isolated from their peers. Each school is unique, so
please feel free to make any modification to tailor this presentation to the needs of your
school.
1. These are questions about how you might respond to a young person who may be at risk for suicide.

Please take a moment to imagine that you know a young person, 11-14 years old, who is showing signs of being suicidal. In order to know if this person might be in danger of attempting suicide, what 3 signs would you look for?

a. __________________________

b. __________________________

c. __________________________

2. In your opinion, is it appropriate for you to ask a person—who may be suicidal—the following question: “Are you thinking of harming yourself or attempting suicide?”

<table>
<thead>
<tr>
<th>Not at all appropriate</th>
<th>Neutral</th>
<th>Extremely appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How likely would you be to ask this person if they were thinking of harming themselves or attempting suicide?

<table>
<thead>
<tr>
<th>Not very likely</th>
<th>Neutral</th>
<th>Extremely likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Students with Autism or a disability are more likely to get bullied and have suicidal thoughts? **Check only one**

True __________

False __________

Not sure __________
4. Students with Autism or a disability are more likely to get bullied and have suicidal thoughts? **Check only one**

True ________________

False ________________

Not sure ________________

5. What are two strategies that parents can use in order to support their child with autism cope with school stress?

1. _______________________________________________________________

2. _______________________________________________________________

6. I feel confident that I could help my child cope with stress or suicidal thoughts? **Check one only**

Strongly Disagree ________________

Disagree ________________

Agree ________________

Somewhat agree ________________

Strongly Agree ________________

7. Comments, Questions, or Concerns:

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________
Slide 1: Welcome Parents and Introduce Topic

Presenters Notes:
Introduce your self and the presentations and welcome parents. Ask parents to save questions to the end of the presentation.
Presenters Notes:

1. Discuss the purpose of the workshop
2. Discuss Autism Spectrum Disorder and briefly ask parents to share their thoughts on ASD
3. Ask parents to briefly share their experience with having a child with ASD
Aims and Objectives

Participants will:

- Recognize bullying behaviors
- Recognize depression behaviors in their child
- Identify ways to help your child deal with stressful events
- Know ways to alleviate school stress at home
- Know resources in the community to help with a child who may be suicidal or depressed
- Leave with a greater understanding of ways to support children with autism in the context of bullying, depression, and suicide ideation

Presenters Notes:

1. Discuss the aims and objectives of the workshop and how it can benefit all students and families
Slide 4:

What is Autism or Autism Spectrum Disorder (ASD)?

- **Autism** is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them.
- Complex disorder in the brain development
- Characterized by difficulties in social interaction, verbal and non-verbal communication, and repetitive behaviors
- Can also be associated with intellectual disability, difficulties in motor coordination and attention and physical health issues such as sleep and gastrointestinal disturbances. Some persons with ASD excel in visual skills, music, math and art.
- ASD is a broad spectrum and characteristics vary from child to child. Some children exhibit more challenges than others.

**Presenters Notes:**

1. Discuss what is ASD and how it manifests differently in children
What is Asperger’s Syndrome?

- Asperger syndrome is a form of autism. People with Asperger syndrome are often of average or above average intelligence. People with Asperger syndrome have fewer problems with speech than people with autism, but may still have difficulties with understanding and processing language.

**Presenters Notes:**

1. Describe Asperger’s Syndrome
2. Describe the Spectrum of ASD
What do we know about bullying and autism?

A response from a survey by the National Autistic Society in 2013, one young person with Asperger’s said:

“Bullies can be made out of anyone. There is no prerequisite for a bully. If you hurt or offend someone with malicious intent, you are bullying”

**Presenters Notes:**

1. Ask parents what they know about bullying

2. Talk about the different ways ASD children are targeted by their peers
Play video

Presenters Notes:

https://www.youtube.com/watch?v=4CekVpgK3to

Afterwards, discuss video with parents.

1. What are their thoughts?
Presenters Notes:

1. Ask parents to describe the types of bullying their children have experienced and how have they handled the situation

2. How did their child handle the situation
Slide 9:

**Reasons why children with autism maybe bullied..**

- Increased gullibility
- Lack of social support and friendship
- Obvious lack of confidence presence an easy target
- The young person has less developed social and communication skills
- Motor difficulties/particular gait
- Less developed hand/eye co-ordination means not very good at sport/activities
- Demonstrations of anger or what might be considered ‘strange’ behaviours make people a target
- Meltdowns
- It is thought ‘fun’ to cause anger outbursts/meltdowns in these children

**Presenters Notes:**

1. Talk about why students with autism are bullied on campus
2. Ask parents to share ways in which they have helped their child not be bullied in school
3. Talk about protective factors in school and outside of school (teachers, friends, parents, family, clubs)
Presenters Notes:

1. Discuss why students with autism have a high risk of being suicidal compare to any other group? (loneliness, depressed, bullied, lack of connectedness at home and at school with peers).

2. Explain what Protective Factors are.
Presenters Notes:

1. Talk about the statistics of ASD

2. Suicide statistics

3. Ask parents if they were aware of these statistics and what they think
Presenters Notes:

1. Describe what it looks like for a child to be depressed and the characteristics of depression

2. Ask parents to think about some of these characteristics and if they have witnessed any of them in their child
Slide 13:

### Effects Of Teen Depression

- **Problems at school.** Depression can cause low energy and concentration difficulties. At school, this may lead to poor attendance, a drop in grades, or frustration with schoolwork in a formerly good student.
- **Running away.** Many depressed teens run away from home or talk about running away. Such attempts are usually a cry for help.
- **Drug and alcohol abuse.** Teens may use alcohol or drugs in an attempt to "self-medicate" their depression. Unfortunately, substance abuse only makes things worse.
- **Low self-esteem.** Depression can trigger and intensify feelings of ugliness, shame, failure, and unworthiness.
- **Internet addiction.** Teens may go online to escape their problems, but excessive computer use only increases their isolation, making them more depressed.
- **Reckless behavior.** Depressed teens may engage in dangerous or high-risk behaviors, such as reckless driving, out-of-control drinking, and unsafe sex.
- **Violence.** Some depressed teens—usually boys who are the victims of bullying—become violent. As in the case of the Columbine and Newtown school massacres, self-hatred and a wish to die can erupt into violence and homicidal rage.

**Presenters Notes:**

1. Discuss how depression is manifested in teenagers
Slide 14:

Ways to cope with a depressed teen:

- Be understanding: Your teen is suffering. So do your best to be understanding
- Encourage Physical Activity: Sports, outdoor activities, offer to take out with friends
- Stay Involved in treatment: Make sure teen is attending therapy and following all treatments

Presenters Notes:

1. Discuss ways to help children cope with depression
Presenters Notes:

1. Ask parents if they have used any of these strategies before.

2. If so, have these tips been helpful?

3. What other strategies do they use that work?
Presenters Notes:

1. How has having a child with ASD affected the family as a whole?

2. Ask parents to discuss ways in which they help other members in the family cope with family stress
Slide 17:

Learn F.A.C.T.S warning signs..

- **F**: Expressing hopelessness about the future
- **A**: Displaying severe/overwhelming pain or distress
- **C**: Showing worrisome behavioral cues or marked changes in behavior, including: withdrawal from friends or changes in social activities; anger or hostility; or changes in sleep
- **T**: Talking about, writing about, or making plans for suicide
- **S**: Experiencing stressful situations

Society for the Prevention of Teen Suicide (www.sptsusa.org)

**Presenters Notes:**

1. Teach parents the acronyms for F.A.C.T
2. Role play a situation where a child seems to be depressed and suicidal
3. Have parents partner up into pairs and role-play this situation.
4. Discuss feelings afterwards
8 CRITICAL MEASURES TO COUNTER SUICIDE

1. PAY ATTENTION Never minimize or trivialize words or actions indicating suicidal thoughts. Ignoring them won't make them go away. Additionally, monitor any changes in behavior, and be aware that such changes can follow head injuries including concussion. Be extra vigilant should your child receive a sports or other injury involving even a mild concussion.

2. TALK ABOUT IT Be open and frank with both your ASD and typical children when talking about suicidal thoughts and feelings of depression and anxiety. Don't be afraid to enlist help, from a healthcare professional, pastor, educator, therapist, etc.

3. PREVENT BULLYING Monitor your child's school or workplace and engage with teachers or employers to ensure any bullying is recognized and eliminated.

4. REDUCE SOCIAL ISOLATION Build social relationships, access community-based activities, and prioritize social skills and peer mentoring.

Presenters Notes:

1. Discuss the 8 critical measures to counter suicide

2. Talk about what parents can do to counter suicide in their child on a daily basis.

3. Discuss Protective Factors and how they can reduce suicidal thoughts
5 **PROMOTE HEALTHY LIFESTYLES** Good nutrition, daily exercise, regular sleep, and mindfulness practice go a long way in regulating mood and behaviors. Implement self-empowerment and self-awareness programs which enable your child to better handle life stressors. Meaningful, consistent work also acts as a buffer. Also, be alert for signs of alcohol and drug abuse and be prepared to seek professional assistance if needed.

6 **MONITOR MEDICATION SIDE EFFECTS** Some medications used for behavioral or mood problems can increase suicidal ideation. Maintain close dialogue with the prescribing physician if any worrisome symptoms appear.

7 **PLACE BARRIERS ON LETHAL MEANS** If you have concerns or are entering a crisis situation, keep firearms and sharp objects under lock and key. Be aware of any poisons—including medications—in your home that need to be secured. Lock upper story windows and engage child locks on car doors. Remove or prevent access to ropes and cords.

8 **ACT QUICKLY** If you recognize suicidal tendencies in an individual with or without an ASD diagnosis, reach out to a professional immediately. Monitor your child closely and constantly until he or she is seen by a professional.
Slide 20:

Resources:

- [www.helpguide.org](http://www.helpguide.org)
- [www.sptsusa.org/parents/](http://www.sptsusa.org/parents/)
- [http://www.dhcs.ca.gov/services/MH/Pages/SuicidePrevention.aspx](http://www.dhcs.ca.gov/services/MH/Pages/SuicidePrevention.aspx)
- [www.preventsuicide.lacoe.edu](http://www.preventsuicide.lacoe.edu)

Presenters Notes:

1. Discuss these websites and the how they benefit the child and family
Slide 21:

**Presenters Notes:**

Concluding the workshop:

Hand out the survey to assess outcome knowledge gained after the presentation. Collect after parents have filled out the survey.

- Thank parents for their time and participation in the workshop.
- Ask for any additional questions or comments