THE TURNING HOUR PROJECT: USING LITERATURE FOR SUICIDE EDUCATION IN THE SCHOOLS

By

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To my husband, Jim,
with love and appreciation
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Adolescent suicide is a salient concern in the United States. It is the third leading cause of death for our young population (ages 15-24). There have been a number of strategies created to address this issue, a number of these strategies are directed towards our high school population. While the typical high school suicide prevention strategy includes a video or a lecture by a mental health professional followed by a brief classroom discussion, my research examines a newly developed strategy which combines the traditional suicide prevention information with literature. The Turning Hour Project uses a fictional peer and her decision-making processes as a foil to invite teen introspection and discussion about suicide and other real adolescent issues into the language arts curriculum.

My study compared the impact of this twelve-lesson, literature-based suicide education curriculum and a traditional suicide prevention presentation upon high school students’ knowledge about and attitudes towards suicide.

The sample consisted of 154 students from six high schools in Alachua County. A pretest-posttest, control group design was used. There were two treatment groups. Group one received a suicide prevention lecture from the local suicide prevention agency; Group two received the same lecture and the Turning Hour curriculum. The teachers who facilitated in this study
participated in a training session prior to teaching their students. Data collected included a demographic sheet and an instrument to assess the effects of the intervention: the Lifelines Questionnaire.

Results indicated a significant increase in a student’s willingness to seek help for a suicidal friend after participating in the Turning Hour Project. No significant improvement in student’s attitudes or knowledge about suicide was found.

Further studies should be conducted to more adequately determine the usefulness of this strategy by developing a qualitative study for this project where classroom interactions are accounted for in the results. Further research should focus on refining the psychometrics for this study.
CHAPTER 1
INTRODUCTION

“'Tis the good reader that makes the good book; a good head cannot read amiss: in every book he finds passages which seem confidences or asides hidden from all else and unmistakably meant for his ear."
--Ralph Waldo Emerson

Ralph Waldo Emerson describes the process readers can experience, immersed in a good book. Often our own experiences are echoed through the voice of a character in a well-written story. The Turning Hour Project uses literature for suicide education in the schools. Facilitators report the program inspired even otherwise quiet, reluctant teenagers to talk about real problems in their lives. This happened in ways they have not seen with traditional suicide prevention presentations. This suicide awareness program uses literature to reach adolescents and help them find their voices--to talk about taboo subjects that, when invisible, can devour the lives of young people.

A variety of school-based suicide prevention programs have been designed in the past decade. The typical program includes a video or a lecture by a mental health professional followed by a brief classroom discussion. The Turning Hour Project still incorporates this traditional school suicide prevention presentation, but it also offers quite a bit more. The Turning Hour Project offers connection among peers and with adults through literature. This school-based program uses a fictional suicidal peer and her decision-making process as a foil to invite teen introspection, in depth. The program weaves thought-provoking discussion about suicide and other real adolescent issues into the language arts curriculum. This vehicle seems to inspire more genuine, open engagement with the real struggles in the lives of these teens than a shorter and more didactic format. The purpose of my study was to determine the effectiveness of The Turning Hour Project, a high-school based suicide prevention program. This study compared the impact of this twelve-lesson, literature-based suicide education curriculum and a
traditional suicide prevention presentation on high school students’ knowledge, about and attitudes towards, suicide.

The Turning Hour, which is based on a true story, explores teen suicide. When the novel, by Shelley Fraser Mickle, commences, Bergin Talbot, a smart and popular high school senior, has attempted suicide and has been found by her eleven year-old step brother, Dylan. Bergin is hospitalized and then spends several months in inpatient treatment. Readers are privy to Bergin’s individual and family therapy sessions with the hospital psychiatrist. At the end of chapter one, Bergin asks herself, “How do I get back?” This question is descriptive of her struggle to discover how she will be able to get past her attempt to end her life and return to living a full life. Alternate chapters are narrated by Leslie, Bergin’s mother. Leslie, examines her own life looking for clues to explain Bergin’s suicide attempt. Leslie is filled with self-recrimination as she reveals details about her divorce from Bergin’s father and her experience with post-partum depression after Bergin’s birth. Divorce, relationships, sexual intimacy, peer rejection and depression are among the issues discussed in this book—issues which are the source of real crises which increase suicide danger among adolescents.

Students who participated in The Turning Hour Project read the book over a period of two to three weeks. Both in-class and homework reading were assigned. In each classroom, teachers worked with a school guidance counselor to guide the class through a 12-session program that combines language arts skills with communication skills. The program itself has been developed and is compiled in an “Educator’s Guide” for The Turning Hour, created by Mary Anne Wagner with other language arts and guidance specialists (Appendix E). The authors have described their purpose in the Educator’s Guide as follows:

The goal…is to provide assistance to teachers, guidance counselors, ministers and other helping professionals as they use The Turning Hour in classroom literary study or
counseling group bibliotherapy”…it should be a starting point to facilitate dialogue between adults and teens. The novel’s theme of resilience provides a positive approach to dealing with tough personal issues (Wagner, Mickle, Page, Myrick, Shaw, Berg, Lucas & Johnson, 2002).

Besides being a suicide education program, the Turning Hour Project is a genuine literature class. This may be one reason the program appears to be so valuable. The problems in a student’s life are viewed from a traditional mental health and mental illness lens, which may encourage adolescents to clam up, in order to appear normal. Literature presents the students with their own problems, viewed as part of the human condition. This project is consistent with their ongoing study of literature. It is also consistent with respected scholars and experts in suicide prevention, who view suicide as a multi-faceted human problem deserving multiple perspectives of response (Shneidman, 1985).

The Educators Guide includes comprehension and vocabulary checklists, a discussion guide, a character map and a journal. (Appendix E) The comprehension and vocabulary checklists provide questions which are to be answered in a short answer format by the students. These questions help teachers examine each student’s comprehension of the novel’s content and vocabulary. The discussion questions include; themes from *The Turning Hour*, (resilience, guilt, connection, loss), differences in relationships (Bergin’s relationship with her father versus her step-father), and sexual and cultural pressures.

Teachers use these questions to guide the students in a discussion on the novel itself and issues brought up in the novel. The character guide is used to discuss the individuals in the book and their relationship to Bergin. This guide is another checkpoint for teachers to insure that students are tracking the novel. It is also an opportunity for the class to discuss the characters in detail. Students contribute their opinions of each character and their choices, thoughts and behaviors.
While the everyday crises students face are reframed and dignified by literature, many safeguards are in place within The Turning Hour Project. Before beginning the program, all participating teachers and counselors completed their own training session—preparing them to spot suicide warning signs which may become visible through the classroom experience. While the problems adolescents face are normalized, the need for students to get appropriate adult help for any suicidal peer is clearly emphasized. Students may be more likely to involve adults in responding to their peers after completing The Turning Hour Project. They may also be more able to engage their peers appropriately and effectively because engagement is taught experientially throughout the project rather than only encouraged didactically in a brief lecture on the value of peer crisis intervention.

Each student was also provided with a journal in which to write their thoughts about the book and how it relates to their lives. They were given prompts to help guide their answers. The students were made aware that the journal is a private form of communication between themselves and the guidance counselor. This journal is believed to have its own intrinsic value, potentially helping students work through difficult issues and solidify new coping skills. The guidance counselor read each journal and returned it to the students with comments. If a student writes anything of concern in their journal that may require more action than a written comment, the guidance counselor can decide how to respond appropriately.

A traditional suicide prevention presentation was incorporated into the project. A suicide preventionist from the community attended one session with each group. This presentation on suicide included a profile of warning signs for adolescent suicide, an outline of what helps and what is not helpful in responding to a suicidal peer, and an introduction to local resources in the community (Appendix D). Students received brochures with information about the Alachua
County Crisis Center and a national suicide prevention hotline. For the purpose of research, this traditional suicide prevention presentation was identified as a second treatment within the experimental design to study its separate and interactive effects. The Turning Hour Project has always included this essential component.

**Adolescent Suicide**

On Tuesday, September 30th, 1997, Katja took an overdose of antidepressants. She died around 3:00am. She was 19 years old. On November 7th, 1999, Trevor hung himself from a steel beam in the basement. He was 15 years old. On June 20th 2005, Aaron shot himself in the mouth with his father’s gun. He was 13 years old. These and other similar tragedies are re-enacted every day, every hour across the United States of America (American Association of Suicidology, 2004). Adolescent suicide is a tragic problem for our society. In 2004, 4,316 young people (ages 15-24) decided that the only way to cope with the pain they were enduring was to end their life (American Association of Suicidology, 2007). This number is reflective of the maladaptive coping skills being learned by adolescents in the U.S. In a discussion on suicide and adolescents, Goldman and Beardslee (1999) point out that “suicide may be a way of attempting to regain control for someone who feels truly out of control and unable to handle the situation more reasonably and rationally” (p. 422). When an individual feels unsupported and disconnected from his family and peers, he becomes hopeless that his life will change for the better. At this point, suicide can become the only option that seems viable.

One of the greatest myths about suicide is that by talking about it, we will put the notion into a person’s head and increase the chances that they will kill themselves. This is like the argument against sex or drug education. Classroom lessons will not be the first exposure to kids on any of these topics. We only stand to lose an opportunity to make a difference by pretending the problem of suicide does not exist. The invalidity of this idea has been stated repeatedly in
the literature. Kalafat and Elias (1992) explain that talking about suicide will not plant the idea in the heads of adolescents, because they are aware of suicide from their experience with suicidal peers and the media (Kalafat & Elias, 1992). Clinicians in the crisis center movement state that the need to avoid planting the idea of suicide is a myth (e.g. A.C.C.C. Training Manual, 2004). The Center for Disease Control and Prevention has stated in regard to school-based suicide prevention and education programming, “there is no evidence of increased suicidal ideation or behavior among program participants” (Youth Suicide Prevention Guide, 1992). There is evidence that participants of school-based suicide prevention and education programs are more likely to intervene and tell an adult about a suicidal peer than those students who do not participate in these programs (Kalafat & Elias, 1994; Eggert, Thompson, Herting, & Nicholas, 1995; Kalafat & Gagliano, 1996).

Scope of the Problem

Suicide is the third leading cause of death among teenagers, ages 15-19 in the United States of America. The rate of suicide for children ages 10-14 increased 100% from 1984 to 1996. There is an average of 84 suicides daily in the United States. Twelve of these are aged 15-24 (McIntosh, 2000). Perhaps a more dramatic statistic is that “within every 2 hours and 15 minutes, a person under the age of 25 dies by suicide [and] for every completed suicide by youth, it is estimated that 100 to 200 attempts are made” (American Association of Suicidology, 2004). Sixty percent of American adolescents have reported some history of suicidal ideation. In a typical American high school classroom of 30, there will be one boy and two girls that will report having either thought seriously about or having actually attempted suicide in the last twelve months.

Reports show that females are three to four times more likely to attempt suicide, whereas, males are 4.8 times more likely to die by suicide. Males are more likely to use firearms than
females; research consistently shows that firearms are the most common suicidal method chosen by American adolescents to complete suicide, regardless of race or gender (American Association of Suicidology, 2004). In his research, King (1999) finds that, “girls are one and a half to two times more likely to report suicidal ideation than are adolescent boys” (p.63). He suggests that this may be due to differences in socialization and cultural expectations between young males and females.

Today’s society does not offer sufficient opportunities for teenagers in general to talk about their concerns, their pain or for them to truly connect with their peers and with the adults in their lives. Adolescent goals often center on obtaining high academic scores and having an acceptable social life. The pressures can often feel insurmountable. And most teens feel that there are not many, if any, safe places to talk about their fears. After all, that would not be “cool.”

In their chapter on adolescent suicide, Goldman and Beardslee (1999) explain that communication between adults and children is a protective factor against depression for adolescents. Having adults who help teens normalize their emotions and developmental processes is crucial to the prevention of suicidal behaviors (424). When individuals feel isolated, misunderstood and unloved they are experiencing a disconnection from their world. This disconnect limits the resources available to them in the moment when they need it most.

Although there continues to be an immense need for suicide education and intervention with adolescents, there is an unfortunate dearth of empirically-based programs in place. Students and school personnel are in a key position to prevent adolescent suicide and yet their knowledge and training in suicide related behavior continues to be inadequate (Mazza, 1997; Miller & Barber, 2002).
Pam Harrington lost her teenaged daughter to suicide in 1997. Since then she has become an activist in suicide prevention and awareness. She travels around the country talking to government leaders about suicide. Pam was preparing for a lobbying trip to Tallahassee, Florida when she impulsively packed one of her daughter’s beloved jigsaw puzzles. She was not sure what she would do with this box of puzzle pieces but had faith that her impulse would lead to something good. As she was finishing her talk with a diverse group of leaders, she gave them each a piece of her daughter’s puzzle and said, “you now have a piece of my daughter’s puzzle—perhaps if we all work to put these pieces together we can come closer to solving the puzzle of suicide.” (Pam Harrington, 2000).

**Theoretical Framework**

My research will be grounded primarily in crisis intervention theory and Bronfenbrenner’s ecological model of social influence, specifically as applied to adolescent suicide by Huda Ayyash-Abdo (2002). Bibliotherapy and existing research on school-based prevention/education programs will also be utilized.

**Crisis**

The core assumptions of Crisis Intervention Theory are spelled out articulately by Gerald Caplan (1964) in his groundbreaking book, *Principles of Preventive Psychiatry*. A crisis is clinically defined as an imbalance between a stressor and the coping resources available to an individual. Caplan explains that when individuals are in a non-crisis state, they maintain a level of homeostasis. He proposed that most of the time, people solve their problems using strategies that they have learned over the course of their lives, habitual coping mechanisms. As long as a person’s stressors are in balance with the internal and external resources available to them, they are able to maintain that level of emotional homeostasis.
People go into crisis, Caplan explains, when events occur that create an imbalance between their stressors and resources. At this point, people’s coping skills are not adequate to resolve the difficulty. People in a crisis state will repeatedly use their existing resources, trying to cope with the situation. As they fail time and time again, their frustration level will increase as they become unstable and their functioning processes become disorganized. Caplan outlines the intense emotions people in crisis frequently experience at this point. These include hopelessness, helplessness, anxiety, fear, anger, grief and shame.

An important concept in crisis theory is the belief that this crisis reaction should not be viewed as a form of pathology but rather as a normal response to a loss or traumatic event. Caplan argues that everyone is vulnerable to this experience of crisis. No matter the extent of resources and coping skills, at some point in their lives, everyone will likely experience a stressor beyond their ability to cope. Yet, Caplan argued that all people have the opportunity to gain strength and additional resources through a crisis situation--if they receive the appropriate kind of help at the right time (Caplan, 1964).

Dr. Marshall Knudson is the Director of the Alachua County Crisis Center and a national leader in suicide prevention. He elaborates on Caplan’s explanation in his lectures on crisis. Knudson describes the four ways in which people typically resolve the chaos and unbearable pain experienced at the height of crisis. Optimally, people will experience growth, resolving their crises by gaining new coping skills. These are the stories of something good coming out of real loss. The next best outcome is for people to return to roughly the same level of functioning they experienced prior to the loss. The loss may leave scars, but one day people feel and act more like their old selves again.
Unfortunately, these two outcomes are not always what occur. Knudson explains that a third possible outcome during a crisis is for people to develop psychopathology or lose aspects of their previous functioning. At other times, and Knudson’s fourth possible outcome, when they cannot find any way to resolve the crisis, for better or worse, people may become suicidal. Unable to see any other escape from the unbearable pain, they may begin to consider killing themselves.

**Crisis Intervention**

Caplan (1964) proposes there is a fairly narrow window in which appropriate and optimal crisis intervention can be achieved. He describes crisis intervention as short-term and goal directed. Caplan notes that peak crises last four to six weeks, after which there will be movement toward psychiatric impairment or growth. Caplan emphasizes that crisis intervention must take place as soon after the loss or traumatic event as possible. Immediate stabilizing of emotional conflicts can help the individual in crisis move through the process of crisis resolution in a healthier manner. Caplan states that people in crisis tend to be more open and willing to accept a helper’s interventions than they are when in a more balanced emotional state. Effective intervention, according to Caplan (1964), includes understanding through listening and acknowledgement of feelings. It is important to allow people in crisis to grieve, scream, cry, shout in anger, and in general to feel their feelings. This acknowledgement of emotions is crucial because it allows the person in crisis to confront the realities of the situation—both the external event and the inner response. It is premature to attempt to problem solve before people in crisis are able to face and begin moving through the emotional chaos of their own response.

Caplan (1964) emphasizes the importance of being direct with people in crisis and avoiding any false reassurances or incorrect information. Facing the reality of a situation allows the individual to begin to make sense of how the event is impacting them. Factual information
and an accurate picture of what they are facing will help the person in crisis approach the trauma from a place of strength. (p.294)

Erich Lindemann is considered the founder of modern crisis intervention and had a significant influence on Caplan. In 1943, Lindemann documented his observations from work with people involved in an infamous fire at the Coconut Grove nightclub in Boston. The Coconut Grove fire occurred on the eve of a Harvard-Yale football game. Four hundred, ninety-one people were killed, and 39 survivors were brought to the Massachusetts General Hospital for treatment of burns. It was with these patients that Lindemann began to observe and document grief reactions. Survivors, families and friends were left in various stages of crisis. Lindemann noticed that as he and his team talked to the patients, in order to develop psychiatric histories, their grief symptoms began to decrease. The summary of his findings on human reaction to loss became the *fundamentals of crisis theory* which serve as a “conceptual framework for preventive psychiatry” (Caplan, 1964, p.10). Lindemann outlines five major characteristics of grief: (a) somatic stress (disruption of normal sleep, loss of appetite), (b) preoccupation with the image of the deceased, (c) guilt (d) hostile reactions, and (e) loss of patterns of conduct (Lindemann, 1944).

Lindemann notes that it is common for people to avoid the intense pain caused by the loss of a loved one and that most people who effectively grieve a loss do so with much effort.

The duration of a grief reaction seems to depend upon the success with which a person does the grief work, namely, emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships. One of the big obstacles to this work seems to be the fact that many patients
try to avoid the intense distress connected with the grief experience and to avoid the expression of emotions necessary for it (p. 143).

These statements create a profile of what a person looks like in a crisis state and acknowledge the difficulty of working through the grief. Often, it is not only the people in crisis who want to distance themselves from the pain, it is often also the people trying to help them. Helpers often move directly into problem-solving to avoid being exposed to the intense emotions of those in crisis.

It is important to understand that Lindemann’s and Caplan’s vision of crisis intervention is not limited to help at the professional level. Their vision of optimal, system-wide prevention includes people in the immediate lives of those in crisis also being able to help those people grieve. It includes preparing those who will be in crisis to understand the value of this kind of everyday support, as well. The goals and methods of The Turning Hour Project are highly consistent with that vision of prevention.

**Bronfenbrenner’s Ecological Model**

Bronfenbrenner’s ecological model (1977, 1979) describes how varying circles of influence impact an individual. His intention in proposing the model is to demonstrate that no one factor should be viewed alone, apart from the others. Bronfenbrenner uses a visual similar to a bulls-eye, placing the individual in the center. Each concentric circle around the individual represents a broader circle of influence: in order, the microsystem, exosystem, and macrosystem. The microsystem includes immediate influences on an individual, such as family and friends. The exosystem encompasses a larger environment surrounding the individual, for example, the neighborhood in which he or she lives. The macrosystem, the outermost layer, represents the larger culture, including the over-arching beliefs and values, which impact how decisions are made within the system.
In 1980, Belsky added a final, inner-most circle to the ecological model, representing individual ontogenic development (Ayyash-Abdo, 2002). This layer includes factors inherent to the individual, for example, psychological characteristics such as the experience of hopelessness. Each of these four layers interacts with the others, thereby, having complex influence on the individual.

**Ayyash Abdo’s Application of the Ecological Model to Suicidal Adolescents**

Huda Ayyash-Abdo (2002) wrote an article, *Adolescent Suicide: An Ecological Approach*, in which she uses Bronfenbrenner’s model as a framework to organize adolescent risk factors for suicide. This model moves the focus beyond the individual, to include a broader, systemic view of the problem. Ayyash-Abdo’s approach provides a foundation from which to begin putting together a more holistic view of the suicidal adolescent, in which various factors influence the individual from multiple levels. Ayyash-Abdo (2002) applies Bronfenbrenner’s model to adolescent suicide risk factors to show that suicide is also a community issue and not only an individual issue. As this paper will elaborate in the next chapter, many of the problem areas highlighted by Ayyash Abdo are specifically addressed by The Turning Hour Project.

**Statement of the Problem**

Kalafat and Elias, (1992) surveyed 325 suburban high school students regarding their knowledge of suicide. Specifically, the researchers wanted to know if this sample population had ever talked to a suicidal peer and, if so, how they had responded. Kalafat and Elias found that 68% of females and 42.5% of males had known of another teen who had talked about or attempted suicide. The majority (63%) of these students took it upon themselves to help the suicidal peer without telling an adult. The results of this study emphasize the need to talk to adolescents, assure them that adults are aware that suicide is an issue for this age group, and teach them basic prevention skills that include involving an adult.
A variety of school-based suicide prevention and education programs have been designed in the past decade. These programs often include a didactic presentation and a discussion. For example, the SOS Suicide Prevention Program provides teachers and counselors with a video that teaches students helpful and hurtful ways to respond to a suicidal individual. The video also interviews persons who have either attempted suicide or lost someone to suicide. A guide is provided to help an adult facilitate the discussion (Aseltine, 2002).

While The Turning Hour Project includes the traditional “do’s and don’ts” of suicide, it offers more as well. The Turning Hour Project offers human connection through the study of literature. The project incorporates discussion about suicide and other real adolescent difficulties into a language arts program. This intervention may evoke more genuine, open engagement with the real struggles in the lives of adolescents. It may also lead to measurable differences in how adolescents understand suicide and their own potential response to a suicidal peer.

Additionally, while teachers, librarians and mental health providers have observed the usefulness of bibliotherapy and their belief that it has a positive impact on the children and adults they work with in educational and therapeutic settings, there is a lack of empirical research in the area of bibliotherapy as a tool that helps people cope with emotional concerns (Corr, 2003-2004).

**Need for the Study**

As suicide continues to be a leading cause of death for adolescents, there is a heightened need for effective strategies in the field of suicide prevention. Research with high school students indicates that teenagers are more likely to confide in each other regarding their own suicidal thoughts and feelings. Research also reveals that adolescents will more typically take it upon themselves to help a suicidal friend rather than seek an adult’s help (Ross, 1985; Kalafat & Elias, 1992; Hennig, Crabtree, & Baum, 1998). These two findings support the need for adolescents to be educated about suicide and suicide prevention. They also show the need for programs that
foster and encourage communication between teenagers and adults about an issue as serious as suicide.

**Purpose of the Study**

The primary purpose of this study was to explore the effectiveness of The Turning Hour Project, as a school-based program. The study compared the impact of this literature based suicide education curriculum and a traditional suicide prevention presentation (made by staff from the Alachua County Crisis Center) on high school students’ knowledge about and attitudes towards suicide. The impact was measured by a questionnaire that addresses knowledge about adolescent suicide warning signs, attitudes towards help-seeking with a suicidal peer, and self efficacy in help-seeking behaviors when approached by a suicidal peer. Students from six high schools in Alachua County (three rural and three urban) participated in this study. The goal of this research was to provide knowledge about ways both to increase the level of suicide awareness in high school students and to increase the likelihood that they will intervene effectively with a suicidal peer. The information gained from this study may be used by suicidologists to develop more effective suicide prevention and education programs for school systems.

**Null Hypotheses**

This is a quasi-experimental study in which data from high school students assigned to two treatment groups (A.C.C.C. lecture plus Turning Hour Project or A.C.C.C. lecture only) were compared to each other and to data from other high school students assigned to a control group. Data was collected for the following: (1) demographic variables; (2) attitudes towards peers with suicidal thoughts; (3) knowledge of suicide intervention concepts; (4) self-reported feelings of adequacy.
The following null hypotheses were investigated:

Ho1: There will be no significant difference in knowledge of suicidal behavior between the groups of students based on their participation in the suicide prevention program.

Ho2: There will be no significant difference in attitudes towards help-seeking and intervening with suicidal peers between the groups of students based on their participation in the suicide prevention program.

Ho3: There will be no significant difference in students’ degree of self-efficacy in suicide related help-seeking behaviors when approached by a suicidal peer between the groups of students based on their participation in the suicide prevention program.

**Definition of Terms**

**Active Listening** is a therapeutic term that describes skilled listening where an individual paraphrases statements made by the person they are listening to, reflects feelings and summarizes what they hear the other person saying. The goal of active listening is to communicate to the other person that their thoughts and feelings are being heard and understood.

**Suicide** is defined as the act of voluntarily terminating one’s own life.

**Suicide Education** is defined as a formal program that teaches individuals about suicide. This includes data on suicide statistics in the United States, explanation of suicide related warning signs, suicide related help-seeking behaviors and local resources for suicidal persons.

A **Suicidal Adolescent** is defined as an individual between the ages of 13-19 who is considering killing him or her self.

**Crisis** is defined as a period of psychological imbalance experienced as a result of a single or multiple stressor(s) that an individual perceives as a threat. During a crisis, individuals realize their coping skills are not adequate to help them regain equilibrium.
Crisis intervention is the process of providing immediate psychological assistance to an individual experiencing a crisis. Crisis intervention involves attending to immediate emotions, acknowledging the full reality of a loss or trauma, and developing short-term goals.

Suicide Prevention is defined as the process by which individuals are educated and trained to recognize and intervene, as appropriate for their given roles, with a suicidal person.

Overview of the Remainder of the Study

The remainder of this study consists of four chapters. Chapter Two is a review of related literature. Chapter Three contains a description of the methodology, subjects, and research design. In Chapter Four, the results of the study are presented. Chapter 5 includes a discussion of the results, conclusions, implications, limitations and recommendations.
CHAPTER 2
REVIEW OF THE LITERATURE

This chapter reviews the professional literature relevant to this study. The review is organized into four major sections: (1) Crisis Intervention Theory, (2) the Ecological Model, Applied to Adolescent Suicide, (3) School-Based Suicide Education/Prevention Programs, and (4) Bibliotherapy.

Crisis Intervention Theory

This elaboration of crisis intervention theory will provide central theoretical support for the validity of the Turning Hour Project. The theory, based largely on the work of Caplan (1964) and Lindemann (1944), proposes that people in crisis should not be viewed as mentally ill, but as having normal reactions to intense loss. Generally, Caplan writes, “a person operates as an individual and as a member of society in certain persistent patterns with minimal self awareness and sense of strain” (1964, p.38). That is, a person who is not in crisis lives with the relative ease of having stressors and resources in balance. It is when the stressors outweigh existing resources that a person goes into a crisis state. Then, the person may be overwhelmed by intense emotion and feel helpless to regain any balance. Crisis intervention helps the person re-stabilize and then find ways to cope with the new stressors (Caplan, 1964).

This model focuses on regularly occurring human dilemmas without resorting to psychopathology as an explanation. It supports respecting people as competent experts in their own lives, but who may need more attention and guidance during times of crisis. Even then, the focus remains on empowering people to resolve their own problems. Crisis intervention steers away from personal interpretations or clinical understandings of other people’s personalities and difficulties. Crisis intervention focuses only on the crisis at hand and whatever must be dealt with immediately.
In crisis intervention, there are two preliminary steps to be taken before problem-solving of external difficulties begins (Young, 1998). The first priority is to attend to the immediate safety of the person in crisis. For example, with a woman who has just been raped, it is important to see if she is safe from her attacker and if she needs immediate medical attention. With a suicidal individual, this first priority is to ensure immediate safety. For a telephone crisis worker this can mean working to see if a gun can be unloaded or pills can be moved out of immediate reach. Crisis intervention focuses on empowerment, emotional experience and individual responsibility, but not at the expense of life or limb. For a student or a teacher, this still means involving a trained responder as soon as possible, to address the potential danger faced by a suicidal adolescent.

After immediate safety is addressed, the next priority is attending to the intense emotions of trauma and loss. In his research of the 1942 Coconut Grove nightclub fire, Lindemann found that survivors of this disaster who developed serious psychopathologies had failed to go through the normal process of grieving. Beyond grieving a death, this basic idea can be applied to anyone who experiences a “serious, sudden loss” (Hoff, 1995, p.11). Individuals who have just experienced a trauma are helped to express their emotions and grieve their loss. Only after this has been done are people naturally ready to participate with a helper in problem-solving. At this point, as they regain contact with their own inner resources, they will often require less additional help.

Crisis intervention theory proposes that a relatively small contribution from a helper can make a significant, long-term difference in another person’s well-being. Although a particular crisis may sometimes be avoided, crisis in general is seen as unavoidable. The psychological crisis is an immense force of change, with the potential to alter a person’s life irrevocably. The
helper takes advantage of this powerful change process and believes that a relatively brief response, made at the right time in the right way, can tip the scales of an individual’s life toward a healthier resolution. The emphasis is on helping individuals resolve crises in such a way that their lives are enriched rather than diminished.

As the Chinese symbol for crisis represents danger and opportunity, the goal of crisis intervention is to avoid the danger and take advantage of the opportunity (Hoff, 1997). Crisis intervention is not therapy. Caplan (1964) states that an individual in crisis may actually rework or expand limited and unhealthy coping responses developed in previous crises. Yet a helper guided by the theory of crisis intervention does not set out purposefully to uncover old wounds or address longstanding symptoms. The focus remains on facing the emotions and difficulties threatening the individual in the moment the crisis is occurring.

While achieving them may be difficult, Crisis Intervention theory presents a simple, elegant set of goals. Crisis intervention is immediate. Crisis theory supports helpers to respond as soon as possible. The earlier people in crisis are able to get help, the better their chances of regaining their pre-existing state of well-being, or even of improving beyond that (Parad & Parad, 1990).

Crisis intervention has been referred to as “emotional first aid” or “psychological triage” (Brock, Sandoval & Lewis, 2001). There is a small window in which individuals will respond most effectively. If this window is missed, crisis intervention is less likely to be helpful. The emotions that a helper works to reflect are once again buried deeply and the strict crisis interventionist is left without tools to reach them.

In 1944, Erich Lindemann published his study of 101 survivors of the Coconut Grove fire. Among these were injured survivors of the fire, their families and family members of
victims killed by the fire. Based on his observations, Lindemann coined the term “grief work.” Essentially, it involves only two goals. 1) To help people in crisis to feel whatever emotions they have to feel in order to move beyond the emotional disorganization and disconnection of the crisis state. 2) To help them take whatever energy was once invested in their lives with those who died (or whatever was lost) and bring it back somehow into the process of living.

Caplan (1964) essentially restates the same process, encouraging the person to face the emotional and tangible realities of the crisis squarely. He encouraged helpers to speak directly about the crisis and avoid false assurances. Arresting the process of grief and loss can lead to psychopathology to more permanent states of disorganization and disconnection. It can also lead to maladaptive coping responses such as substance abuse or withdrawal into social isolation. Therefore, the goal of crisis intervention is to help individuals in distress face intense, potentially crippling emotions and then reengage their resources and the world until they regain their previous balance or even gain a more productive or satisfying balance. Crisis intervention requires helpers to direct the individual in crisis to face reality and make a commitment. The individual must face the emotional devastation of a loss, in order to commit to finding a way back into life without it.

As envisioned by its originators, crisis intervention does not have to be carried out by medical or mental health workers. As a psychiatrist, Caplan (1964) specifically envisioned crisis intervention as a preventive step, whenever possible, to avoid the regression toward over-reliance on expert medical understanding and decision making that can come with medical treatment. Of course Caplan’s concern need not be taken concretely. For instance, treatment for depression may help some individuals regain the ability to face the difficulties in their lives.
Crisis intervention is flexible and expansive. Non-practitioners, such as volunteers, ministers and others can be taught crisis intervention skills (Hoff, 1995). Caplan writes, an individual “does not usually face crisis alone, but is helped or hindered” by the influence of “family….friends …community…even nation” (1964, p. 42). What is most important, he continues, “for maintenance of mental health and avoidance of mental disorder is that the activities of the family or other primary groups be directed to helping the person in crisis deal with” the problem.

Crisis intervention theory provides an essential theoretical basis for understanding the value of The Turning Hour Project. When difficult issues like depression, substance abuse and even suicide are viewed only within the expertise of medical and mental health providers, then students, teachers, family members and others can be kept from participating as fully as possible in addressing the real problems facing adolescents every day. Crisis intervention was originally intended to guide those in the immediate social environments of people in crisis. Caplan (1964) understood professional resources are too scarce. They cannot be present in all those critical moments when a crisis will make or break some individual’s future.

Crisis intervention theory supports the legitimacy of teaching adolescents collectively to face their own problems, work through their own painful emotions—and then also to seek additional help when they need it. It shows how necessary that work is. Crisis intervention theory reframes human loss and trauma—and the suffering that accompanies them—out of strict medical interpretation and back into a broader human understanding.

A quote from Caplan’s (1964) Principals of Preventive Psychiatry specifically demonstrates his appreciation of learning from literary depictions of crisis. Crisis theory, Caplan explains, (in the original, non-inclusive language of the time):
is consonant with the popular views on crisis as a turning point in life development exemplified by the writings of novelists and dramatists. Many plays focus on the reactions of an individual and his personal network in dealing with a temporarily insoluble problem. The even tenor of his life is upset by some unexpected happening, and with the help and sometimes the hindrance of his associates, he is portrayed struggling to find a way out of his predicament. The excitement of the play consists in the difficulty of predicting the outcome and in the identification of the audience with the actors as the tension rises to a climax in confronting the challenges and threats to their fundamental needs without knowing how to deal with them. In many plays the tension stimulates the emergence of unexpected capacities in the characters, and these sharpen the dramatic struggle. Eventually, a series of trial-and-error explorations leads to a resolution of the problem and of the tension. Characteristically, this resolution is polarized as good or bad, and, when the play ends, the central characters have settled down to a new equilibrium in which they are clearly better or worse off than they were when the play started. From our point of view, one of the significant aspects of many modern plays is the implication that the outcome is determined by the choices which the characters make in coping with the situation. (pp.34-35)

Caplan’s view of crisis and this description have a remarkable resonance with the Turning Hour Project and the original goals of its creators—that participants will learn to cope better with their own crises and with those of their peers.

In the Turning Hour Project, students follow Bergin Talbot through her own struggle to discover how she will be able to get past her suicide attempt and return to living a full life. The students are empowered, experientially, to face the painful realities of real crises and dilemmas in their lives. They are empowered to speak directly about divorce, relationships, sexual intimacy, peer rejection and depression and begin making more direct sense of how they can deal with these issues. They are encouraged by the structure of the curriculum to connect with each other, to develop more confidence in their ability to support each other through these difficult struggles. At the same time, they are also encouraged by Bergin’s example. There are times when the magnitude and danger of their crises will require involving expert help from the adult world. In the full context of the Turning Hour Project—including the teachers, counselors and administrators involved in making the project real—the adolescents are given an example that expert adult help can be both protective and empowering.
The Ecological Model, Applied to Adolescent Suicide

In this section, I will elaborate the ecological model as used by Ayyash-Abdo (2002) to address adolescent suicide, including the risk factors she names at each systemic level. I will use her model as a level-by-level guide for understanding the problem of adolescent suicides. I will also weave in research from other authors to flesh out the model.

The ecological approach, Ayyash-Abdo writes, resists the tendency to focus solely “on the adolescent’s personal history, such as depression, hopelessness, substance abuse, etc. and depicts suicide as a result of an interaction among a number of factors (personal, interpersonal, and socio-cultural) that are directly or indirectly related to adolescents” (p. 461, 2002). This systemic view is crucial to the development of suicide education programs in the school system. The focus of these programs should not be based solely on those adolescents who score highest on depression or hopelessness scales or who have previous suicide attempts (although it is critical that we do not lose sight of these children either). Suicide education programs should reach out to every adolescent in order to counteract negative messages or influences that may be at work within the four levels of the universes those adolescents inhabit.

Ontogenic development is the level added by Belsky (1980) to include person-oriented factors in the ecological model. An individual’s historical, medical, and psychological development will interact with influences from the other three layers. In the case of suicide, Ayyash-Abdo (2002) identifies depression, hopelessness and substance abuse as the key risk factors at this level. Another significant risk factor identified by suicidologists and belonging at this level is previous suicide attempts (Watkins and Guiterrez, 2003).

Depression is identified as the strongest and most consistent correlate of adolescent suicidal behavior (Brent et. al, 1992; Shaffer, et. al., 1996; Mazza & Reynold, 1998; Mazza, 2000). Rhode, Lewinsohn and Seeley’s (1994) study, which examined what characteristics that
are present in adolescents’ thinking about suicide, found that a significant number of teens who were contemplating suicide also reported signs of depression. Researchers have linked depression as a major predictor of suicidal ideation (Mazza, 2000; Doan, Roggenbaum, & Lazear, 2003). Depression can interfere with an individual’s thinking to the point where he or she no longer sees or thinks clearly. In this state, a person’s options may seem more limited than they actually are.

Two types of depression have been identified: biological and situational (Opalewski, 2001). Biochemical depression involves changes in the brain structure or brain function. Biochemical depression may be inherited; however, it can also occur in individuals with no family history of depression (The National Institute of Mental Health, 2006). Situational depression occurs when an individual experiences a crisis event such as the loss of a loved one, which causes feelings of deep sadness and hopelessness. Young adults with a parent who dies or who loses any significant relationship in their lives can become depressed to the point where they begin to think suicide is the only way to alleviate the pain.

Depression in teenagers has been found to increase other risk factors such as alcohol and drug abuse, anxiety disorders, decreased interest in academics and extracurricular activities and withdrawal from peers and family (Hess et. al, 2004). Research suggests that as many as 7% of teenagers diagnosed with a major depressive disorder commit suicide (Weismann, et al., 1999).

Clinicians focusing on suicide prevention in the general population have considered hopelessness to be one of the most significant warning signs (Knudson, personal communication). Yet, the empirical study of hopelessness and suicide in younger people is relatively new. According to Ayyash-Abdo (2002), results have been inconsistent. She singles out a study by McLaughlin, Miller and Warwick (1996), who report “hopelessness is a more
powerful predictor of adolescent suicidal behavior than depression” (p. 462). Other researchers (Joiner & Rudd, 1996; Mazza & Reynolds, 1998; Beautrais, Joyce, & Mulder, 1999) have not demonstrated as strong an association between hopelessness and suicide.

Substance abuse has also been identified as a significant risk factor of suicidal ideation in teenagers (Thompson et al., 2002). In a study on the association between adolescent suicide and drug use, Hallfors, et al. (2004) reported a significant increase in depression, suicidal ideation and suicide attempts among teens who used alcohol and drugs, compared to those who abstained from drinking, smoking or other drug use.

The risk of a completed suicide is higher among teens with a history of suicide attempts. “For every completed suicide by youth, it is estimated that 100 to 200 attempts are made. In grades 9 through 12, 8.8% of students attempted suicide in the previous 12 months (6.2% male and 12.2% female)”( American Association of Suicidology, 2004). In their summary of suicidal risk factors in the literature, Watkins and Guttierez, (2003), identify that a history of previous suicide attempts is the strongest predictor of future suicide attempts. Shaffer (1998) asserts, “the risk for future suicide attempts increases twenty-fold with individual’s history of prior attempt” (Harvard—p. 427).

School-based suicide education programs can attend to the ontogenic level by addressing these issues. In general, suicide educators should be aware of the ontogenic risk factors and optimally include discussion and education on depression, hopelessness, substance abuse and suicide attempts. The main character in the Turning Hour makes a suicide attempt. The dialogues with her therapist that follow address depression and loss at length. The Turning Hour Project incorporates significant discussion of the main character’s feelings, including her hopelessness at the time of the attempt, her subsequent struggles and increasing optimism. The curriculum brings ontogenic risk factors into real life discussion within the classroom.
Ayyash-Abdo (2002) indicate that the “most immediate influences on adolescent suicidal behaviors are within the microsystem” (p.462). This level of the microsystem is comprised of those people and environments that are in constant contact with the individual. The microsystem includes family, friends, school and peers.

In her article, Ayyash-Abdo (2002) discusses the impact that family history has on an individual. Research findings suggest that adolescents who have lost a family member to suicide are at greater risk for attempting or completing suicide than adolescents who have not experienced this loss. The American Association of Suicidology explains that youth who repeatedly attempt suicide usually have a history of suicide in their families (American Association of Suicidology, 2004). A recent study (Agerbo et al., 2002) examined risk factors for suicide in adolescents based on data received from the national Danish registry. The researchers found that teen suicide was five times more likely in those individuals who had lost a mother to suicide and twice as likely in those individuals whose father completed suicide. This population-based nested case control study adjusted for parental psychiatric history.

Evidence consistently suggests that there is a connection between suicidal behavior and dysfunctional family origins in general. This may include substance abuse disorders and antisocial behaviors (Agerbo et al., 2002; Brent et al., 1988, 1996; Gould et al., 1996). Other familial events that may affect and increase suicide ideation are parental loss by separation, divorce and a history of physical or sexual abuse during childhood (Agerbo et al., 2002; Brent et al., 1988, 1996; Gould et al., 1996).

Goldman and Beardslee (1999) explain that because adolescents live so intensely within the family matrix any factor that impacts the functioning of the family will have a significant effect on the child. If the family has poor coping skills and does not communicate adequately
about what happens to them, the child incorporates this dysfunction and is at a greater risk for becoming self destructive.

Adolescence is a time where there is a need for intimate relationships among peers with a distancing from parents. Ayyash-Abdo (2002) discusses the changes in this developmental stage. She notes that teens begin to rely on their friends for support and approval more than they do on their parents. Ayyash-Abdo (2002) adds that adolescents begin to share their innermost thoughts and feelings with their friends during this phase of development. Teens often help each other cope with problems or conflicts that arise. Because of this Ayyash-Abdo identifies loneliness as a significant concern during adolescence as well.

Low peer support has been identified as a predictor of depression, conduct problems and substance abuse issues (Ayyash-Abdo, 2002; Beautrais, 2001; Aseltine, Gore, & Colten, 1998). These are all risk factors for adolescent suicide. Teens who attempt suicide have consistently been identified as alienated from their peers or as having experienced a significant loss such as a break-up with a boyfriend or girlfriend (American Association of Suicidology, 2004). In a study examining the effects of perceived peer and family support (Harter et al., 1996), researchers found that those adolescents who felt connected to their families and peers and who believed themselves to be supported by them had a greater sense of self worth and lower levels of suicide ideation. Other studies have shown that those adolescents who lack social support have higher rates of suicide ideation and other self-destructive behaviors (Grholt et al., 2000, Spruijt & de Goede, 1997).

Ayyash-Abdo (2002) noted that research findings link poor academic performance to adolescent suicidal behaviors. There are researchers who have found a correlation between school work and self-destructive behaviors. For instance, Gould, et al., 1996, conducted a study
that investigated the psychosocial risk factors in adolescents who had completed suicide. The researcher performed psychological autopsies of 120 suicides completed by individuals younger than 20 years of age. Problems in school were among the most significant factors found.

At the same time, there are studies which report no clear relationship discovered between poor school performance and suicide ideation. Ayyash-Abdo’s review of the literature suggests an interaction effect between low school performance and other risk factors in the ontogenic or microsystem levels. Together, these predict higher risks of suicide ideation (p. 465). This is consistent with the previous discussion of how an individual’s perception of support from peers and family interacts with other factors to affect suicide risk. The advantage of the ecological model is not only to identify the interaction of adolescent suicide risk factors at various levels, but also to suggest interventions that might address the risk systemically.

School-based suicide education programs can have a significant impact on adolescent difficulties at the microsystem level. The Centers for Disease Control and Prevention (1992) has recommended school personnel be trained in suicide prevention. Goldman and Beardslee (1999) noted that open communication and early identification are crucial in the prevention of suicide. The Turning Hour Project heightens the school staffs’ awareness of adolescent issues and opens a door for connection.

In the same way that the project introduced ontogenic risk factors for discussion in the classroom, it also provides a natural opening for discussion of microsystem issues. In the novel, Bergin Talbot and her therapist talk at length about school performance and relationships with family and peers. One hope for this literature-based approach to suicide education is that it will allow more open and extensive discussion of these issues between teachers and students. Viewing suicide as a multi-faceted, human problem (Shneidman, 1985), this approach may
provide a more natural invitation for discussion than presentations by mental health experts alone.

One aim of the Turning Hour Project is to foster a sense of connection among peers, thereby, reducing the level of loneliness that can occur in adolescence. If peers are able to talk more candidly--inspired by the voices of the characters in *The Turning Hour*--perhaps a number of them will begin to realize they are not alone in their sometimes painful thoughts and feelings.

Ayyash-Abdo (2002) defines the exosystem as the level “of settings in which adolescents do not play a direct role but nevertheless affect them” (p.465). She uses media as an example of a primary example of influence in the exosystem. Ayyash-Abdo cites research that links media coverage of suicide to an increase in suicide rates. High profile suicides have been correlated to increased suicide rates among adolescent populations. Overall, studies have shown that young adults are more sensitive to the effects of the duration and prominence of media coverage of a completed suicide (Gould, 2001; Schmidtke and Schaller, 2000; Stack, 2000).

School-based suicide education programs may these effects of the media through frank conversations led by responsible adults. As an inoculation against thoughtless media coverage, suicide can be de-romanticized. Suicidal teenagers can be reframed, as individuals in great pain. Getting help and finding other ways to relieve the pain can be offered as preferred solutions.

The final level in the ecological approach to suicide is the macrosystem, which Ayyash-Abdo’s (2002) define to include the larger culture influencing the individual. She includes cultural and ethnic differences in the macrosystem. One of the most significant observed macrosystem differences is the higher suicide rate among Caucasians adolescents than among other groups. Ayyash-Abdo focuses on research specifically addressing the difference in suicide
rates between Caucasian and African-American adolescents. She discusses possible reasons for the difference, citing two major conceptual explanations.

The first is internal/external restraint theory proposed by Henry and Short (1954). This theory suggests that Caucasians are more likely to feel guilt and blame themselves for failures, thereby internalizing the cause of their pain. On the other hand, African Americans tend to blame others for their struggles, externalizing their anger and pain and decreasing their likelihood to see suicide as a sensible solution.

The second explanation cited by Ayyash-Abdo for the lower rates of suicide in African American youth is a greater sense of connectedness within the culture. For example, religiosity is highly valued and the church provides a strong social support system. Also, the African American elderly tend to live with their extended families rather than move into retirement communities or nursing homes. This allows them to take a major role in caretaking for the youth in the family. Religion and family connectedness are identified as significant cultural values in the African American community. A greater general sense of communalism encourages individuals to share their concerns and seek help from their support system. These characteristics have been seen as protective factors against suicide.

In general, family cohesion has been reported as a protective factor for suicidal behavior among adolescents (G rholt, et al., 2000). For instance, Harris and Molock (2000) examined the association between family cohesion and suicide by surveying 188 African American psychology students at a historically black college and found that higher levels of family cohesion and family support were associated with lower levels of suicidal behavior. In a longitudinal study of depression and suicidal ideation in adolescents, Garrison, et al., (1991),
surveyed 1,073 middle school students over the course of 3 years and also found that family cohesion was a significant protective factor against suicide.

Goldman and Beardslee (1999) discuss the importance of family support in their chapter on suicide in adolescents. They note that the stressors on families can create a crisis situation in which children are neglected as the focus of parent shifts toward resolving whatever the external concerns may be. For example, if a parent loses a job and the family falls into a financial crisis, the family naturally focuses on ways to pay the bills and survive financially. The focus may be shifted away from the children, significantly, at a time when they need attention the most. This decrease in support and supervision can lead to feelings of hopelessness and helplessness in adolescents.

From this viewpoint, diminished family support can be understood both at the microsystem and macrosystem levels. At the microsystem level, an individual family can provide less support for its members than other families in that culture. At the macrosystem level, within an entire culture, more or less family support can be offered than among other cultures. That level of support can also change over time, for better or worse.

The sociologist Emille Durkheim developed a theory of social integration. His theory proposes that individual psychopathology is actually more a result of social dynamics than of personal, psychological factors. In his book, Suicide, Durkheim (1966) theorizes that suicide is triggered by a general erosion of societal integration.

Caplan’s (1964) focus on the influence of family, friends, the community and the nation—and his intention to increase supportive response at any of these levels—is also consistent with the ecological model. As discussed at a number of points previously, The Turning Hour curriculum provides teens with an opportunity to connect with their classmates, teachers and
school counselors through discussions about the book characters’ choices, literary activities and journal writing. In addition, a letter was sent to parents during the pilot—event before adding the more elaborate consent form required for this study. This was not only for the purpose of informing the parents of the curriculum and that their child would be discussing suicide in the classroom. The letter was also intended to encourage communication between parents and their teens about suicide.

The hope of the project’s creators has been for the community as a whole to engage in more conversations around the issue of suicide, fostering a sense of connectedness and thereby, decreasing the likelihood of suicidal behavior. Impacting genuine macrosystem level change may be an unlikely outcome. Yet, where such change does occur, it is often as a genuine local reality.

The impact of the Turning Hour Project will be measured in very specific ways by this study (that is, knowledge about adolescent suicide warning signs, attitudes towards help-seeking with a suicidal peer, and self efficacy in help-seeking behaviors when approached by a suicidal peer). These are all measures of individual competence. Future studies might also attempt to measure systemic changes directly. However, the ecological model would suggest that efforts to impact the various levels of the system would be the optimal way to bring about individual change, as well.

**Bibliotherapy as a Development Guide**

A review of trends and some differences in approaches to educational bibliotherapy will provide another context for understanding the goals of the Turning Hour Project. Many educators believe literature is an effective tool for helping adolescents cope with life challenges. The characters offer teens a voice through which they can hear their own feelings of anxiety, desperation and emptiness expressed. Books may help teens feel less alone, as they realize
someone else understands and is able to verbalize their own response to a situation (Pardeck & Pardeck, 1993).

Herbert (2000) proposes two categories regarding the use of bibliotherapy: clinical bibliotherapy and developmental bibliotherapy. Clinical bibliotherapy refers to a psychotherapeutic tool used by mental health practitioners in working with their clients. Developmental bibliotherapy refers to the use of literature as a means to help children learn to navigate changes in their lives and develop a repertoire of healthy coping strategies.

Developmental bibliotherapy can be conducted by teachers who are willing to have meaningful discussions about problems in children’s lives. Herbert writes, “one advantage of this approach is that teachers can identify the concerns of their students and address the issues before they become problems, helping the students move through predictable stages of adolescence with knowledge of what to expect and examples of how other teenagers have dealt with the same concerns” (p.2). For the purposes of this paper, bibliotherapy will refer to the developmental bibliotherapy definition.

**More Informational Approaches**

In the literature of this developmental bibliotherapy field, there often appears to be a cognitive emphasis on providing information and helping students learn more concrete solutions to problems. Pardeck (1994) states this perspective fairly clearly as he provides specific goals for educators to follow when offering bibliotherapy:

(a) to provide information about problems, (b) to provide insight into problems, (c) to stimulate discussion about problems, (d) to communicate new values and attitudes, (e) to create an awareness that others have dealt with similar problems, and (f) to provide solutions to problems (p.1).

These goals are guidelines for conducting literature discussions and choosing appropriate books for adolescents to address life events. Through the process of reading the book and
participating in an ongoing discussion, adolescents begin to make sense of their reactions towards a particular topic. As they hear other voices echo their own thoughts and provide new ones, the minds of teens expand to learn healthy ways to cope with stressors.

For example, a book chosen to discuss an issue with adolescents about the death of a friend can provide information about the problem. A book about a friend’s death to cancer might describe a type of cancer and some details about treatment and prognosis. Follow-up discussion of the book creates an opportunity for the teacher or counselor to present still more information. Armed with all this knowledge, teens can begin a meaningful discussion of the problem. This conversation draws in the adolescents, helping them look at the problem through various lenses. By listening to their peers and teacher, teens learn that there is more than one solution to a problem.

Also presented with more cognitive language, Tussing and Valentine (2001) studied the use of bibliotherapy among adolescents whose parents have a mental illness (modeling their research study on a previous study by Sargent, 1985). The authors looked at literature as a potential tool for helping this population cope with their difficult situation. A non-quantitative case-study approach explored which books (published between 1985-1999) might be the best bibliotherapeutic resource for juniors and seniors in High School having a parent with a mental illness. The researchers decided upon books that gave appropriate information and explanations regarding mental illness, accepted surrogate parenting, presented positive coping skills and depicted healthy relationships.

Cartledge and Kiarie (2001) present a model for helping children develop social skills through the use of literature. They encourage teachers to choose simple books with straightforward lessons that carry clear messages regarding problem-solving, gender issues,
diversity and respect. Cartledge and Kiarie’s model describes how to develop a lesson plan to teach a particular social skill. The components of this model include; identifying the skill students are to learn, helping students understand the story concepts, connecting the storyline to the skill and transferring the knowledge of the skill into action (e.g., with role-plays). The authors assert that “social competence is predictive of school and later life success” (p. 47).

Maich and Kean (2004) also encourage the development of social skills through bibliotherapy in their article, “Read Two Books and Write Me in the Morning.” They discuss the changes in society and consequently, a redefining of teachers’ roles. It is their belief that teachers are now charged with character and moral development as well as academic learning. Maich and Kean (2004) observe that children are more willing to talk about themselves and their ideas indirectly. They believe books give children a voice through the experiences of the characters in the story.

More Emotionally Focused Approaches

In this shift toward an emphasis on social skills, the language of some bibliotherapy proponents begins to move away from more definite, informational perspectives toward more fluid, process-oriented understandings. The potential of bibliotherapy to help students work through emotional challenges and find their own solutions to ambiguous dilemmas is suggested. For example, in a discourse on how literature can help gifted children in particular cope with life stressors, Herbert (2000) criticizes the frequently limited treatment of gifted children as one-dimensional. Their intellect is their obvious strength and the focus of the academic curriculum. Herbert writes that gifted children’s emotions are often ignored because the children are perceived as “smart” enough to handle life’s problems and not get into trouble. Herbert sees literature as one means used to alleviate the actual isolation that this population may often feel. Books are a creative and non-threatening way to attend to their emotions and the possibility that
they may face issues similar to other teenagers. Herbert describes literature as creating a balance for gifted teens, between their high intellectual abilities and their high levels of sensitivity (2000).

Herbert describes her experience with bibliotherapy in the classroom this way; “Over the years it has become clear that my student colleagues often use young adult novels as a way of confronting the issues in their young lives. By sharing their concerns… students not only search for solutions within themselves, but through their products, create an avenue for others to join in the therapeutic discussion” (Herbert, 2000, p. 3). With this language, the line between clinical bibliotherapy as a psychotherapeutic tool and developmental bibliotherapy as a means to help children navigate changes in their lives becomes even less clear.

In the last decade, there has been some interest in bibliotherapy as a tool to develop emotional intelligence (Salovey & Sluyter, 1997). This idea may help to clarify the goals of developmental bibliotherapy. It is connected to Daniel Goleman’s best-selling book, Emotional Intelligence (1995). In this book, Goleman expands the traditional definition of intelligence to include emotion. He gives an example of how students who do not score well on the math section of a standardized test may not become mathematicians. However, they may easily succeed in business or politics because of other qualities. Goleman defines these “other characteristics” as emotional intelligence; “abilities such as being able to motivate oneself and persist in the face of frustrations; to control impulse and delay gratification; to regulate one’s moods and keep distress from swamping the ability to think; to empathize and to hope” (p. 34). Following this theory, one can deduce that, in general, children need to develop emotional intelligence in order to navigate life successfully. Although perhaps controversial, general emotional competencies may eventually be considered a staple of classroom learning,
In line with this movement, Tang (2002) studied the effects of a bibliotherapy-based classroom guidance curriculum on children in fourth grade, in a suburban district in Taiwan. Tang used Lazarus and Folkman’s (1984) transactional model of stress as her theoretical framework. Tang notes that in the transactional model of stress, coping is defined as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p.141).

The students read stories that emphasized social-emotional characteristics such as peer relationships and self-worth. After reading aloud, the students were asked to reflect on their reading through several forms of feedback (e.g., role-playing, journal writing, group discussion, creative writing, drawing and individual reflection). The researcher chose to study one class for one full academic year. The researcher and the teacher collaborated to lead the classroom discussions. The researcher mentions that in this year, one of the student’s fathers committed suicide. As a result the teacher, school principal and researcher altered the literature program to include a section called “Live a meaningful life” (p.2).

Three types of information from the students were collected: in-class field notes, semi-structured interviews and portfolios. By using these three forms of feedback, the researcher was able to develop a social-emotional skills training curriculum of twenty topics for teachers to use in their classrooms. Each topic includes a selection of corresponding books, poems and videotapes. Examples of topics developed are as follows; “How to Deal with Your Anger, Be an Active Problem-Solver, Understand Your Parents, To Change or Not to Change” (p.5).
The Turning Hour Project

Like most of the programs reviewed in this section, The Turning Hour Project actually incorporates some focus on helping students develop more tangible coping skills and some focus on helping them work through more ambiguous emotional difficulties.

Taken as a whole—with the traditional suicide presentation--The Turning Hour Project provides definite information concerning warning signs about suicide. It offers at least one definite coping strategy to be learned and incorporate--that is, if you or a friend are considering suicide, get help. At the same time, it emphasizes a process of approaching taboo, emotionally-charged subjects—not so much to be taught straightforward lessons about how to respond or what to believe—but to work through the intense emotions toward some resolution that allows the individual to stay engaged in living.

Bibliotherapy and Empirical Evidence

While the values of bibliotherapy are a widely accepted tool among school communities, there is a dearth of empirical evidence that literature actually helps people cope with emotional concerns, either in educational or therapeutic settings (Corr, 2003-2004). Publications that do exist tend to be more conceptual and theoretical, with a fairly limited empirical basis, at best. In his analysis of adolescent literature regarding bereavement issues, Corr (2003-2004) expresses disappointment at the lack of formal studies that exist in this area. Corr expresses particular disappointment that more emphasis has not been placed on discovering the actual impact of bibliotherapy on participants’ experiences with emotional difficulties.

While there is an unfortunate lack of empirical research in the area of bibliotherapy, teachers, librarians and mental health providers believe bibliotherapy in the classroom is making a difference for the children they work with. The majority of the writings found on this topic observe that bibliotherapy is a useful intervention that quickly engages children and opens a door
for their feelings, thoughts and ideas. Additionally, bibliotherapy does not require the presence of a school counselor. It can be facilitated by an insightful and competent teacher. In a world where school counselors do not have the time or resources to attend to every child equally, teachers who develop a successful bibliotherapy program appear to be giving the children and the school an enormous gift. The current research on The Turning Hour Project will attempt one small step toward providing evidence that bibliotherapy can help students take definite steps toward dealing more effectively with an emotionally difficult issue.

**Suicide Prevention/Education Programs**

Suicide prevention programs gained popularity in the 1980s when the problem of adolescent suicide reached its height. Youth suicide rates had increased over 200% from the 1950s to the late 1970s (American Association of Suicidology, 2004). There were 16,584 reported adolescent suicide deaths (ages 15-19) from 1981-1989 (American Association of Suicidology, 2004). And Garland et al. (1989) reported that the number of schools implementing prevention programs increased from 789 to 1,709 between 1984 and 1986 (Mazza, 1997).

Prevention programs are curriculums developed to reduce risk factors, such as disconnection and peer pressure and to enhance protective factors (i.e. communication and increased self esteem). Kalafat (2003) describes prevention programs as either categorical or general. Categorical programs focus on a specific issue, such as drug use prevention. General prevention programs promote healthy attitudes, which translate into coping strategies to help in many difficult situations.

In 1999, the Prevention Division of the American Association of Suicidology developed guidelines for school-based suicide prevention programs. This division identified 3 types of prevention strategies. These are Universal, Selective, and Indicated.
Universal prevention programs are targeted towards the general student population. These programs intend to develop or enhance the connection between students, their peers and school personnel. Universal programs focus on increasing students’ protective factors. Protective factors included in prevention programs are; “…problem solving ability; contact with caring adults; and a sense of connection with school, family, and community based opportunities to participate and make contributions” (Kalafat, 2003, p.1212). Universal prevention programs develop character building skills or coping skills (AAS Prevention Division, 1999). For example, the Zuni Life Skills Training Program is a program used with the Zuni Pueblo and Cherokee Nation programs for adolescents. The goal of this program is to teach social skills and life competency abilities that are necessary for successful social and academic interactions (Doan et al., 2003).

The AAS guidelines (1999) offer empirically based reasons why universal programs can be effective in the school system. One of these reasons is that suicidal adolescents are more likely to confide in their peers than tell an adult (Kalafat, 1992, Zimmerman, 1994). Additionally, the AAS guidelines report that “as few as 25% of peer confidants tell an adult about their troubled or suicidal peer” (1999). The guideline suggests that research shows connecting a suicidal teen to an adult can serve as a protective factor.

Selective Suicide Prevention programs target students who have not specifically demonstrated suicidality but who may be generally vulnerable, marginalized or at risk. They may have gone through transitions such a changing schools or divorce. These adolescents will have been identified through a screening instrument or communication with parents, school counselors, teachers, other school personnel or their peers. A type of program commonly referred to as “gatekeeper training” is often used to train school personnel to work effectively
with a specific population of children (AAS Prevention Division). For example, Pam Harrington, who lost her 15 year old daughter to suicide in 1997, along with other Suicide Survivors have developed a gatekeeper training, Florida Youth Suicide Prevention Gatekeeper Training Program. This program has been adopted by The Florida Task Force on Suicide Prevention and the National Suicide Prevention Strategy, a government task force, in order to teach teachers, school nurses, school personnel, police officers, mental health care providers, and emergency health care personnel and other adults who interact with young people how to respond to a suicidal teen (The Beth Foundation, Inc. 2002). This training as well as other gatekeeper trainings allows those who come in contact with children to feel more confident in identifying warning signs and responding adequately (Davidson & Range, 1999).

Another type of selective prevention resource offered to students is crisis hotlines. These crisis lines provide twenty-four hour phone counseling to anyone in need. A student who is in crisis or thinking about suicide can anonymously call the hotline and speak to someone who offers care and concern and is trained to listen and discuss possible resources or alternatives to suicide. The AAS prevention guidelines suggest that generally at-risk students may use crisis lines more than other resources.

The third type of suicide prevention program mentioned in the AAS guidelines is Indicated Suicide prevention programs. The goal of this type of program is to specifically target suicidal teens, or teens that have demonstrated specific warning signs of suicide (drug abuse, suicidal thoughts, previous attempts, depression) and to increase their protective factors. Indicated programs are run by professionals trained to screen students. These programs are offered by community-based agencies as well as by school counselors or psychologists (AAS Prevention Division, 1999).
The AAS School-Based Suicide Prevention Guidelines specify a number of requirements for an effective intervention program. The program should have (1) conceptually and empirically grounded goals, (2) clearly articulated and packaged components and (3) appropriate instructional principles. It should be (4) comprehensive—addressing all levels of targeted organization (this means consultation and training should be provided for school personnel as well as students). It should be (5) a good ecological fit—adapting to the specific and multiple contexts in which participants interact, and conforming to context/culture/values of the target population and organization.

**The Turning Hour Project**

The Turning Hour Project addresses all these AAS criteria. This paper has elaborated the conceptual grounding for the goals of this project within three areas—crisis theory, the ecological model and bibliotherapy. General empirical support for these goals has been elaborated throughout the paper. Beyond that, the goal of this research is to provide empirical evidence to support this specific methodology.

The components of the Turning Hour Project are clearly articulated and packaged in the Educators Guide. The instructional principles of the project were developed by a team of experts in Language Arts and Mental Health issues, within the Alachua County School system, and refined in consultation with suicide prevention experts from the Alachua County Crisis Center. The intervention is comprehensive. Before classroom instruction begins, training for participating teachers and guidance counselors is provided by the creators of the Educators Guide and staff of the Alachua County Crisis Center. Parents are also notified that suicide will be discussed in their children’s classroom and provided with resources to learn more about suicide.
The project is adapted to fit the local ecology at multiple levels. While this program is a suicide prevention strategy, it has also been designed to fit educational goals mandated by the public school system in Florida. Educational tasks assessed by the Florida Comprehensive Assessment Tests (FCAT) are specifically addressed in the goals of lesson plans in the Educator’s Guide (Appendix F).

The Turning Hour Project is ecologically adapted in another fairly sophisticated way. The Turning Hour Project works in close conjunction with the local, Alachua County Crisis Center (ACCC). The project provides both students and teachers and guidance counselors with quality information about suicide prevention. It personalizes the existing relationship between the ACCC and the Alachua County Schools. It provides students and staff with information about other local mental health resources and the national suicide prevention hotline. At the same time, the Turning Hour Project addresses suicide through various lenses. It frames suicide as a human problem and prevention as a human response. It is thus able also to draw upon resources from the language arts programs, including the ability of these instructors to engage students in addressing difficult human issues.

The Turning Hour Project incorporates elements of Indicated, Selective and Universal prevention. At the Indicated level, the project reinforces awareness of the existing contract between the Alachua County Schools and the Alachua County Crisis Center—to respond whenever an individual student is identified as suicidal or concerning warning signs are observed. That individual will be referred to the Crisis Center for individual treatment. Training will help teachers understand suicide, know the signs to watch for and have a plan of action if they see that a student is at risk for suicide.
At the Selective level, The Turning Hour Project increases awareness of risk factors that make adolescents vulnerable in general. The project is intended to decrease taboos surrounding many of these difficult issues and to make it more likely that vulnerable students will be able to get support from peers and to be referred to a qualified adult when appropriate. The project is also intended to increase the likelihood that students and teachers and students and parents will talk about these painful issues more freely and genuinely, decreasing the isolation which can intensify crises.

The Turning Hour Project is primarily a Universal prevention program. The previous three sections of this chapter have detailed the coping skills and protective factors that this project is intended to model and strengthen. It is intended, generally, to strengthen connection among students and between students and adults. It is intended to teach a process of navigating taboo subjects and intense emotions, experientially.

There is another, empirically supported school-based prevention project which appears to have share a similar essential philosophy. Aseltine & DeMartino (2004) examined the effectiveness of a school based suicide prevention program called Signs of Suicide (SOS). This program combines a suicide awareness program with a suicide screening tool. Students are taught to recognize the signs of suicide and they are taught specific steps to use when faced with a suicidal peer. The steps are summarized through the acronym- ACT. “First, acknowledge the signs of suicide that others display and take those signs seriously. Next, let that person know that you care and that you want to help. Then, tell a responsible adult” (p.446). The researchers surveyed twenty-one hundred students through the use of self-administered questionnaires three months after the participants received the prevention program and found significantly lower rates
of suicide attempts, greater knowledge and more adaptive attitudes about depression and suicide in the students in the intervention group.

The traditional suicide prevention component of the Turning Hour offers a model of peer based crisis response that is very similar to the three steps of ACT. The most difficult of these steps to teach in a short intervention is probably the second step. The Turning Hour Project is intended to emphasize all three components of this response. But its greatest strength may be its emphasis on caring--on providing students with an increased ability to demonstrate this empathy and understanding.
CHAPTER 3
METHODOLOGY

The purpose of this quasi-experimental study was to determine the effectiveness of the Turning Hour Project, a suicide education program developed for high school students to increase the level of suicide prevention knowledge. Students’ attitudes towards suicidal peers were also examined.

The following topics are covered in this chapter: (1) sample characteristics, (2) variables, (3) instrumentation, (4) null hypotheses, (5) research procedures, (6) data collection and analysis and (7) methodological limitations.

Sample Characteristics

Over 700 surveys were collected for this study. Many of these surveys could not be included in the statistical analysis due to unplanned scheduling changes that were inconsistent with the study design. The analyzed sample consisted of 154 participants (79 male, 73 female with two participants not indicating their gender) with a mean age of 15.58 (SD = 1.15). The sample was primarily Caucasian, 66.4% (N = 101), followed by African American, 14.5% (N = 22), Multiracial, 8.6% (N = 13), Hispanic/Latino 6.6% (N = 10), Other 2.6% (N = 4), Asian American, 0.7% (N = 1), and Native American, 0.7% (N = 1).

Participants were asked to indicate their year in high school, which consisted of primarily 9th graders, 46.1% (N = 71), followed by 10th graders, 30.5% (N = 47), 11th graders, 11.7% (N = 18), and 12th graders, 11.7% (N = 18). The classes ranged from Advanced English to Regular English, all students were required to read The Turning Hour alternating between class time and home.

Three schools are in Gainesville, Florida (Gainesville High School, W. Travis Loften High School and F.W. Buchholz High School) and three are in rural areas of Alachua County
(Newberry High School, Hawthorne High School and Santa Fe High School). Twelve teachers participated in this study along with the students in their classes. Four of these teachers allowed the Crisis Center staff to come into their class and deliver the presentation on suicide prevention (Group 1). Another four taught The Turning Hour as part of their curriculum and had the Crisis Center give their presentation on suicide prevention (Group 2). The last four teachers participated as the control group for this study. The students participating in this study live, primarily, in Alachua County, which is considered a rural county with the exception of Gainesville, Florida. Gainesville is described as an “Urban Fringe of Mid-Size City” by the Public School Review website (Public School Review LLC, 2003).

The schools in Alachua County are racially diverse with primarily African American (29.17%) and Caucasian (62%) populations. The students in these high schools range from upper middle class socioeconomic status to poverty level. Three of the high schools are in Gainesville, Florida, which is commonly referred to as a university town because the main campuses of the University of Florida (UF) reside within the city limits. Approximately fifty thousand students attend the University of Florida and a majority of these live in Gainesville. The high schools within Gainesville, Florida are influenced by the University of Florida in numerous ways. Many of the university’s faculty and staff enroll their children in these schools. Also, the university collaborates with the Alachua County School Board to offer innovative programs to the students. An example of this is UF’s department of Astronomy, who offers a space education program to students of varying grade levels.

Variables

The first independent variable in this study was The Turning Hour school-based suicide education program. A second independent variable in this study was the suicide
prevention/intervention presentation given by a staff member at the Alachua County Crisis Center (ACCC). The following dependent variables were measured by the researcher:

1. Students’ degree of knowledge regarding adolescent suicidal warning signs.
2. Students’ attitudes towards help-seeking and intervening with a suicidal peer.
3. Students’ degree of self-efficacy in help-seeking behaviors when approached by a suicidal peer.

**Warning Signs** are behaviors that researchers have documented in individuals who have completed suicide. An example of a warning sign is giving one’s beloved possessions away. This study attempted to measure the effect of The Turning Hour suicide education curriculum on the students’ recognition of warning signs. In this study, recognition of warning signs was measured by the Lifelines Questionnaire (Kalafat & Elias, 1994).

**Attitudes** towards helping a suicidal peer is defined as an individual’s willingness to listen to their peer and help get them connected to the appropriate resources. As mentioned in chapter 1, studies (e.g., Kalafat & Elias, 1994) have shown that teens are reluctant to tell an adult about their suicidal friend. An emphasis of this program is to facilitate conversation between the students and various adults (teachers, counselors and crisis center staff). This study attempted to measure the students’ attitudes towards help-seeking behavior using the Lifelines Questionnaire (Kalafat & Elias, 1994).

**Self-efficacy** is defined as an individual’s perceived ability to complete a task or perform a behavior successfully. The Turning Hour Project hopes to enhance students’ perceived ability to help suicidal friends in need. The project focuses on teaching students about suicide, communicating directly and honestly and helping teens get help from appropriate resources. This study measured self–efficacy using the Lifelines Questionnaire (Kalafat & Elias, 1994).
Instrumentation

One questionnaire was used for data collection. A personal data sheet was distributed and used to obtain demographic information from the participants. Additionally, a feedback sheet for the students regarding The Turning Hour Project is included with the final survey.

Lifelines Questionnaire

The Lifelines Pre/Post Questionnaire (LQ) (Kalafat & Elias, 1994) is a 30–item, self-reporting instrument that provides quantitative data about high school students’ responses to Lifelines, a school-based suicide awareness program. (Appendix C) This questionnaire was developed by Drs. John Kalafat and Maurice Elias in order to test the efficacy of Lifelines, a suicide prevention program developed by John Kalafat and Maureen Underwood in 1989. Similar to the Turning Hour Project’s central themes, Lifelines’ focus is on increasing students’ knowledge about suicide and promoting positive attitudes toward help-seeking and intervening with suicidal peers. Four domains were assessed in the Lifelines study: knowledge about suicide; attitudes toward suicide, help seeking, and talking about suicide in one’s classes; self reported responses to the awareness of potential suicide in peers; and, reactions to the suicide awareness classes (Kalafat & Elias, 1992). The scale was given to 253 10th grade students in a northeastern community, in the United States, who participated in the Lifelines curriculum. In a report of their findings, Kalafat and Elias describe the development of the Lifelines questionnaire. The authors note that “in order to insure fidelity to the curriculum content and comparability with other studies, items from this questionnaire were drawn from published curriculum assessment instruments (Shaffer, Garland, & Whittle, 1988; Spirito et al., 1988) and from a pool of items developed by the health teachers…” (Kalafat & Elias, 1994, p. 227). The health teachers were the instructors for the Lifelines curriculum and developed items for the suicide awareness classes as they would for any other unit.
The purpose of this study was to determine whether the Turning Hour Project has an impact on high school students’ awareness, attitudes and help-seeking behaviors regarding suicide prevention. The Lifeline questionnaire assesses these three variables.

The items in the Lifeline questionnaire are divided into 5 sections. The first section consists of two scenarios that assess self-reported responses to awareness of potential suicide in peers. These questions ask the students to describe how they would respond to a suicidal peer that confides in them. The responses will reflect the attitudes each participant has towards suicide.

In the following four sections, students are asked to rate on a 5-point summary scale whether they agree or disagree with each item. End points of the scale are 1—Strongly Agree—to 5—Strongly Disagree. Higher values indicate more adaptive attitudes about suicide and help-seeking intervention. The second section is made up of 10 items assessing the students’ self-reported attitudes towards suicide. The third section of the Lifelines questionnaire consists of 8-items that assess the students’ suicidal behavior (warning signs) knowledge. The fourth section consists of 5-items that measure a student’s attitudes towards their self-efficacy and potential resources if they need to seek help for a suicidal friend. Finally, the last section of the questionnaire has 5-items assessing a students’ willingness to seek an adult to help their friend.

The construct validity of the instrument was examined using factor analysis. Based on the factor analysis, the four factor solution explained 49% of the variance. Analyses of the interitem covariances indicate the factors were internally consistent. This measure has shown reliability with Chronbach’s reliability coefficients for each subscale, as follows; Knowledge, 0.89; Attitudes, 0.80; Help seeking, 0.76; Awareness, 0.77 (Kalafat, J. & Gagliano, 1996). Permission from the authors has been obtained to use this scale in this study.
**Personal Data Sheet**

A personal data sheet was distributed to all participants to obtain demographic data.

(Appendix B) The students were asked to give information about their age, school, grade, sex, race and any previous suicide prevention training.

**Null Hypotheses**

The following null hypotheses were investigated:

Ho1: There will be no significant difference in knowledge of suicidal behavior between the groups of students based on their participation in the suicide prevention program.

Ho2: There will be no significant difference in attitudes towards help-seeking and intervening with suicidal peers between the groups of students based on their participation in the suicide prevention program.

Ho3: There will be no significant difference in students’ degree of self-efficacy in suicide related help-seeking behaviors when approached by a suicidal peer between the groups of students based on their participation in the suicide prevention program.

**Research Procedures**

All English teachers and guidance counselors from Alachua County High Schools were invited to participate in the Turning Hour Project. Twelve teachers and their respective guidance counselors agreed to participate in this study. Approximately, 200 High school students participated in the study. Participating teachers and guidance counselors received training on January 19th, from 8:30am-3:00pm, 2006. The training was conducted by Mary Anne Wagner and Diane Heaney.

Mary Anne Wagner is the Supervisor of Language Arts and Reading for Alachua County School Board. She also has a specialist degree in guidance counseling. Ms. Wagner has headed the development of The Turning Hour curriculum and has taught the course several times to gain first hand knowledge of how it can be improved. Diane Heaney is a consultant who supervises
secondary teachers who participate in a practicum related to reading endorsement. She is a former elementary classroom teacher and adult education teacher.

All teachers and guidance counselors who agreed to participate attended the training session prior to beginning The Turning Hour curriculum. Each teacher received a packet including the 8-unit lesson plans, 35 paperback copies of The Turning Hour, an Educator’s curriculum guide, a cover letter describing the study, consent forms for the students and consent forms for the parents. The training session included the following components: introduction to The Turning Hour by the author, Shelley Fraser Mickle, through a video presentation; overview of each lesson plan in The Turning Hour Educator’s guide, instruction on the most effective methods to teach students to journal including discussion on teacher feedback that elicits more developed journal responses; a presentation by the local suicide prevention experts (Alachua County Crisis Center) which discusses the material presented to students and provided teachers with an opportunity to discuss their own concerns or questions regarding adolescent suicide.

Following the training, the teachers’ participating classes were divided into two groups. Group 1, received the suicide intervention/prevention presentation from a staff member of the Alachua County Crisis Center. Group 2 completed The Turning Hour unit and then also received the suicide intervention/prevention presentation. Both groups received the Personal Data Sheet and the Lifelines Questionnaire pretest and posttest. All teachers were visited by the Turning Hour trainers, at least twice, as they facilitated the program in their classrooms.

Suicide prevention programs typically include the information (statistics, warning signs and resources) that was provided by the ACCC staff. The unique piece to this program is The Turning Hour curriculum. The design of this study allowed the researcher to test for significant differences between groups who received only the didactic presentation and those who received
both interactive and didactic interventions. The goal of this design was to see if The Turning Hour curriculum lends power to the suicide intervention presentation or makes the curriculum insignificant.

The Suicide Prevention/Intervention Presentation was conducted by the Alachua County Crisis Center (ACCC) staff members Dana Myers and Alexandra Martinez. Ms. Myers is a licensed Mental Health counselor and a member of the American Association of Suicide Prevention. She is the Training Coordinator for the ACCC and has been with the center for over 10 years. Ms. Martinez is a licensed Marriage and Family therapist. Presently, she is the Project Coordinator for the ACCC. She has worked as a therapist and Child Advocate for 5 years. Both presenters are graduates of the University of Florida’s Counselor Education program.

**Data Collection and Analyses**

The design for the study is shown in Table 3-1. All participating students received a Personal Data Sheet to complete prior to beginning any treatment.

Group 1 received the pretest two weeks prior to the presentation from the Alachua County Crisis Center staff. The purpose of this interval was to create an equal time difference between interventions: 1) the ACCC presentation and 2) the combined ACCC presentation and Turning Hour curriculum. The Alachua County Crisis Center presentation included adolescent suicide statistics, suicidal warning signs, recommended interventions and information about resources in Alachua County. Group 1 received the Posttest immediately following this presentation.

The second treatment group (Group 2) was comprised of those students who attend class with the teachers who agreed to participate as facilitators of The Turning Hour curriculum. Group 2 was given a Pretest on the day they began The Turning Hour Project. Immediately after Group 2 finished the two week unit, they participated in the same presentation given to Group 1
by the same Alachua County Crisis Center staff person. Group 2 completed the Posttest immediately after this presentation was given.

Group 3 served as the control group and did not receive treatment between each survey. Group 3 was asked to complete the survey twice, with time intervals equal to Groups 1 and 2. In order to provide this group with information regarding suicide awareness and prevention, Group 3 participated in a presentation given by a Staff member from the Alachua County Crisis Center after both surveys were completed.

This study made use of a quasi-experimental design in which the investigator was interested in discovering if change over time occurred in students’ knowledge, skills and attitudes regarding suicide prevention while they participated in a suicide prevention course. The course combined didactic information with an interactive language arts program that addressed adolescent suicide. A one-way (treatment versus control) analysis of covariance was used to test for differences between groups, with posttest scores as the dependent variable and the pretest scores as the covariate. The ANCOVA was used to explore the prediction that the difference in responding is specifically related to the addition of the Turning Hour curriculum to the suicide prevention program. For each measure, post hoc multiple comparisons were conducted using the Tukey HSD Significant Difference Test (familiar and common) method to identify significant differences among the treatment groups.
Table 3-1. Outline of Research Design.

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<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Treatment</th>
<th>Test 2</th>
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</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td>O1</td>
<td>A.C.C.C. + 2 week interval</td>
<td>O2</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td>O1</td>
<td>A.C.C.C + T.H.</td>
<td>O2</td>
</tr>
<tr>
<td><strong>Group 3 (Control)</strong></td>
<td>O1</td>
<td></td>
<td>O2</td>
</tr>
</tbody>
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O1=Pretest  O2=Posttest  T.H. = Turning Hour Curriculum (2 week program)
CHAPTER 4
RESULTS

The purpose of this study was to determine the effectiveness of the Turning Hour Project, a suicide prevention/education program developed for high school students to increase the level of suicide prevention knowledge. This quasi-experimental study examined the impact of a 2-week suicide prevention program on high schools students’ awareness of suicide prevention, attitude towards suicidal peers and their willingness to help suicidal peers.

A pre-test-post-test control group design was used. Teachers who agreed to participate had a choice between three group conditions. Groups were developed based on the teachers’ choices. Data were collected from a survey that included a demographic sheet, and an instrument used to assess the effects of the study’s intervention, the Lifelines Questionnaire. All participants completed the demographic data sheet. All participants completed the Lifelines Questionnaire as a pre-test and post-test. Results from the current study are described below.

Preliminary Analyses

Normality

In order to assess the capacity of the data to be in line with the normality assumptions of analysis of covariance (ANCOVA), the skewness and kurtosis of the data was examined. This indicates that the assumptions for normalcy were met. All skewness and kurtosis estimates for the variables fell between 2 and –2 except for the Knowledge subscale on the pretest and posttest, which had a kurtosis value of 3.788 and 4.299, respectively, and the Tell Friend subscale which had a kurtosis value of 2.939 on the pretest.

Additionally, mean differences were conducted between groups (treatment 1, treatment 2 and control group) to make sure there were no differences in pretest scores. Results indicated that there were no significant differences between groups on pretest scores (all ps > .05).
**Measurement Reliability**

In addition, measurement reliabilities for the Lifelines Questionnaire (LQ) pre/posttests were conducted and reliability coefficients appear in Table 4-1. A 2-week test-retest reliability analysis was conducted, correlating pre-test to post-test LQ subscale scores for the control group, with results indicating a moderate magnitude of the coefficients for Help Seeking, \( r = .42 \), and Not Help, \( r = .53 \), however, test-retest reliability for both the Knowledge \( (r = .27) \) and Tell Friend \( (r = .11) \) subscales were in the low-moderate range. Additionally, Cronbach’s coefficient alpha for the LQ subscales of Help Seeking, .70, and Knowledge, .60, were somewhat lower than Kalafat & Elias (1994) findings (.89 and .80 respectively). Reliability findings for the LQ subscales of Not Help, .38 and Tell Friend, -1.74 were substantially lower than Kalafat & Elias (1994) findings (.76 and .77 respectively) and are well below the acceptable range for reliability, which is between .50 - .90 (DeVellis, 1991). Thus, results regarding the Not Help and Tell Friend subscales should be considered with caution in light of the low reliability found on these two subscales in the current study.

**ANCOVA Analyses**

Separate univariate analyses of covariance were conducted along each of the subscales of the LQ (Help Seeking, Knowledge, Not Help, and Tell Friend) with Group (treatment 1, treatment 2, and control group) as the independent variable, posttest scores as the dependent variable, and pretest scores as the covariate in each analysis.

**Hypothesis 1**

The first hypothesis was that both treatment groups (those that received the Crisis Center training and those that received both Crisis Center training and the Turning Hour Project) would show increased levels of knowledge (i.e., teens can’t do very much to prevent teen suicide) as evidenced by higher scores on the knowledge subscale of the LQ. Thus, for the first hypothesis,
a univariate analysis of covariance was conducted to determine if the treatment groups revealed significantly higher scores on the knowledge subscale.

Results from the ANCOVA did not reveal a significant difference between groups along the Knowledge subscale, \( F(2, 122) = 1.39, p > .05 \). This was not in the predicted direction of the hypothesis. One explanation for this finding not being in line with the initial hypothesis could be the fact that there was low test-retest reliability for this subscale and somewhat higher skewness, which may have affected the normality of the distribution.

**Hypothesis 2**

The second hypothesis was that both treatment groups (those that received the Crisis Center training and those that received both Crisis Center training and the Turning Hour Project) would show increased levels of help seeking (It is important to have at least one adult that you can talk to if something is bothering you) as evidenced by higher scores on the Help Seeking subscale of the LQ. Thus, for the second hypothesis, a univariate analysis of covariance was conducted to determine if the treatment groups revealed significantly higher scores on the Help Seeking subscale.

Results from the ANCOVA revealed a significant difference between groups along the Help Seeking subscale, \( F(2, 122) = 7.28, p < .001 \). Follow-up custom hypothesis testing revealed a significant difference between treatment 1 (both crisis center and turning hour training) and treatment 2 (crisis center training only), \( p < .001 \) and the control group, \( p < .019 \). As predicted, the direction of the differences indicated that the treatment 1 group’s scores were higher on the posttest \( (M = 41.87, SD = 5.33) \) than treatment 2 \( (M = 36.71, SD = 6.40) \), and the control group \( (M = 38.71, SD = 5.86) \) when pretest scores were covaried. There was not a significant difference between treatment 2 and control group scores, \( p > .05 \), which was not in the predicted direction.
Hypothesis 3

The third hypothesis was that both treatment groups (those that received the Crisis Center training and those that received both Crisis Center training and the Turning Hour program) would show increased levels of helping a friend who acknowledges suicidal ideation (If someone really wants to kill themselves, there is not much I can do about it) as well as telling a friend if they knew another friend had suicidal ideation (tell another friend about what you notice about your friend), as evidenced by higher scores on the not help and tell friend subscales of the LQ. Thus, for the third hypothesis, two univariate analyses of covariance were conducted to determine if the treatment groups revealed significantly higher scores on the not help and tell friend subscales.

Results from the both ANCOVA did not reveal a significant difference between groups along the not help, $F(2, 140) = 1.25, p > .05$ or the tell friend subscales, $F(2, 139) = 0.30, p > .05$. This was not in the predicted direction of the hypotheses. As suggested earlier, an explanation for this finding not being in line with the initial hypotheses could be the fact that the reliability for these subscales was below standards. Additionally, the kurtosis level for the tell friend subscale was also somewhat higher than usual standards. This will be further discussed in the limitations portion of this study.
CHAPTER 5
DISCUSSION

At the most basic level, the results of this study more broadly show the usefulness of the Turning Hour Project for this population. The most important, tangible goal of this research project was to provide empirical evidence of the value of the Turning Hour Project value to its creators. In the zeitgeist of the school systems and the larger contemporary world, this kind of evidence is all but essential to the acceptance and ongoing use of any methodology.

In this study, student participants in the Turning Hour Project reported a statistically significant higher willingness to seek help—as measured by an established instrument developed for a school-based suicide awareness program—than either those students who received a traditional suicide prevention/intervention presentation or those students in the no-treatment control group. With this evidence, the supporters of the Turning Hour Project will have a strong basis to argue for the ongoing use of this methodology and for its dissemination into wider use in the schools. Given the tremendous face-value richness of the Turning Hour Project, the primary goal of this study has been met.

Of course, there is room and cause for a great deal more research to be done around this intervention. The most immediate pragmatic need would be to replicate this study, strengthening the claim of empirical support. Beyond that, the Turning Hour Project offers a wealth of possibilities to future researchers.

It is encouraging that the Help Seeking scale did yield a significant measured difference. However, talking to teachers who administered the Turning Hour Project, it is apparent that a great deal happened in these classrooms that the Lifelines questionnaire—designed for an entirely different intervention—was never intended to measure. Optimally, researchers could develop
new instruments, aimed to measure what actually appears to be happening in Turning Hour classrooms.

Many of the basic ideas at the heart of this project—spelled out in the first two chapters of this study—would readily lend themselves to measurement. One basic idea is that students talk more freely about taboo topics when they are presented in the framework of literature and the human condition than they do when the same topics are presented in a framework of traditional mental health services delivery. This could be addressed through a rating scale designed for use in direct observations of classroom interactions.

Another idea is that Turning Hour participants will be able to engage their peers more appropriately and effectively because engagement is taught experientially through the project rather than only encouraged didactically in a brief lecture on the value of peer crisis intervention. This could also be measured readily. Participants in the Turning Hour group and other control groups could be engaged in helping skill role plays—without any further training—which could be rated by experienced role play evaluators.

Yet another idea is that the journal component of the project has its own intrinsic value, potentially helping students work through difficult issues and solidifying new coping skills. This could be measured by offering two different versions of the Turning Hour Project—one with the journal component, and another with a more concrete, non-exploratory academic component in its place. Differences between the two groups could be measured, most easily with a self-report rating of the overall value of the Turning Hour experience in helping students address their own personal issues.

Given widespread dissemination of this project, of course, grander measures would also be possible. Are more at-risk individuals actually identified through this program, in the actual
classrooms during the time when the program is administered or in the year that follows? Do the student participants in the Turning Hour Project actually facilitate a larger number of interventions to help their peers during the project or over the course of the following year? Do the student participants themselves demonstrate any higher levels of adaptive or lower levels of maladaptive coping skills in the year that follows the program?

All of these quantitative empirical measures would increase our understanding of the Turning Hour Project. With significant results, they could potentially increase its attractiveness to school personnel. This research would also contribute to the literatures of crisis intervention theory, the ecological model of suicide prevention, bibliotherapy and the general literature of suicide prevention projects.

The richest research of the greatest genuine value to educators and clinicians would be qualitative and systemic in nature. In the end the goals and theoretical aspirations of this project are more process oriented than outcome oriented. The goal, for instance, is not only to make the students speak more often to the adults about their problems. The goal is also help the adults become more worth talking to. It is to make the conversations that happen of more real value. It is to change the very nature of the relationships among the students and between the students and adults in the schools. Whatever their pragmatic, political value--static empirical measures of this change could not provide the same level of understanding and inspiration that are the real potential of the Turning Hour Project.

Limitations and Future Research

Assessing suicidal knowledge and attitudes in high school aged students is a difficult process. Although there are many Suicide Awareness and Prevention programs around the country, there is little empirical research on their effectiveness. Testing adolescents on their knowledge of suicide is considered a taboo issue. As mentioned previously in chapter 1,
adolescents do not typically feel safe giving information to adults. Chapter 2 mentions a study where researchers, Kalafat and Elias (1992), found that 63% of the students tested took it upon themselves to help a suicidal peer without telling an adult; if this statement is consistent throughout the population of teenagers, then it can be assumed that adolescents do not feel safe sharing any kind of compromising information with adults. Thus, the reliability of a survey completed by teenagers may have been decreased by the notion that they will not consistently give accurate and comprehensive information to adults. Additionally, since teachers in a high school setting collected data where there is a high likelihood of teenagers not consistently giving accurate information to adults and not filling out questionnaires completely, the data collection procedure may have compromised the external validity of the current study.

The characteristics of participants in the current study may have compromised the external validity. This study was conducted on a voluntary basis and those who volunteered to participate may have been a biased sample. Rosenthal and Rosnow (1975) suggest that volunteers tend to differ from non-volunteers in behavioral research regarding their level of education, intelligence and desire of social approval.

The original plans for this study included over 700 participants. Many surveys were thrown out of the data collection because they were incomplete. A large number of surveys could not be used due to miscommunications regarding the scheduling of the suicide prevention lecture. These issues resulted in a significantly lower sample size than anticipated for the groups, which may compromise the representativeness of the sample and generalizability of the findings. Testing-effects are another limitation to the external validity of this study such that having a pretest may have sensitized the participants so that they are affected differently by the intervention (Kazdin, 1998).
In addition, the study that validated the instrument, Lifelines Questionnaire (Kalafat & Elias, 1992), was conducted with a relatively small sample and has not been replicated.

Although the design has advantages, it also brings limitations. A true experimental design is not possible because students cannot be randomly assigned to the three groups based on the conditions for participation put forth by the schools. The schools did not require teachers to participate in the project. Therefore, because they agreed to give extra time to this research, teachers who volunteered were asked to choose which group (Group 1, Group 2 or Control Group) they would like to be part of based on their comfort and time commitments. Student participation was dependent on their teacher’s decision. Therefore, there are limitations to the investigator’s ability to claim a causal relationship, even with positive results. Using a quasi-experimental design, this researcher has a responsibility to discuss potential threats to validity.

One possible confound would be the difference between the composition of the classes that receive the two treatments and those that do not, any differences should be described to the degree they can be known. Any high profile event (such as a suicide publicized in the national media) could be expected to affect all the classes in roughly the same ways. However, any event which affected students differently (such as a suicide attempt known only to students in one school or a certain social group with higher membership in a particular treatment group) could create a confound.

As a result of the program, it is quite possible that students talked with other classmates, friends and family members about their participation in the Turning Hour Project and even specifically about suicide. This breaking of the taboo could have been a positive effect of the treatment (much as taking a Selective Serotonin Reuptake Inhibitors—SSRI may have given individuals energy to make desired changes to resolve difficulties in their lives). Yet, students in
the treatment groups could have also talked to schoolmates in the control group, creating a ripple effect, which may have weakened the observed statistical difference between the groups.

Another possible limitation of the study was the design for students to take the same survey twice. This could serve as an advantage because reliability is tested over time with the use of the same instrument. However, this repeated testing could have been a limitation if students experienced impatience, answering the same questions two times, and then filled out the survey less genuinely and accurately.

In addition, internal validity may have been compromised due to history effects (any event occurring in the experiment, other than the independent variable, or outside the experiment that may account for the results, Kazdin, 1998). For example, to some extent students in the treatment groups may have talked with schoolmates in the control group, which may have affected the results. Additionally, testing effects have to be considered as a threat to internal validity in that taking the pretest may have affected participant’s performance on the posttests.

There are also limitations regarding the reliability of the Lifelines questionnaire due to the poor psychometrics that this questionnaire revealed (e.g. test-retest reliability and Chronbach’s Alpha). An item discrimination was run with the descriptive information and the original data was recoded numerous times to determine why the tell a friend and knowledge subscales showed poor reliability. There was no change from the initial reliability reports. One possible explanation is misinterpretation of the question due to poor wording. Another is that each of these items had only three and four questions respectively. Future research should focus on further refining the psychometrics of this survey.

However, in light of these limitations, the findings of the current study still contribute to the literature addressing teen suicide prevention. The current study provides provisional support
for the notion that providing the Turning Hour education program increases teenager help seeking behaviors in regards to suicide prevention.
December 12, 2005

Dear Parents,

I am a doctoral student in the Department of Counselor Education at the University of Florida, conducting research on the usefulness of “The Turning Hour Project” as a suicide awareness/prevention tool for high school students. I will be working under the supervision of Dr. Silvia Echevarria Doan. The purpose of this study is to see if the study of a fiction book that addresses the issue of teen suicide will (1) increase the high school students’ knowledge about suicide as a problem, and (2) increase their willingness to seek adult help for a friend in need. The results of this study may help us understand the usefulness of this project and allow us to continue working toward an effective suicide awareness/prevention tool. With your permission, I would like to ask your child to volunteer for this research, no compensation will be provided for their participation.

Two-thirds of the students participating will study the novel, The Turning Hour, by Shelley Fraser Mickle. The instruction will be provided by your child’s English or Health teacher. (You will be receiving a letter from them as well). The school guidance counselors will also be involved in this project. One-third of the students participating in this study will not study the Turning Hour. All students will receive a forty-five minute talk on suicide awareness and prevention from a staff member of the Alachua County Crisis Center. All the students will be asked to fill out a 30 question survey related to suicide prevention. They will be asked to fill this questionnaire out two times in order to assess their understanding of the material presented.

Your child’s identity will be kept confidential to the extent provided by the law. Results will only be reported in the form of group data. Participation or non-participation in this study will not affect the students’ grades or placement in any of the programs.

You and your child have the right to withdraw consent for your child’s participation at any time with no consequence. The issues discussed in class (suicide, teen despair, relationship issues) are serious and can bring up feelings for your teen. We will be providing information for local resources that can offer help for any concerns that come up as a result of the study. If you have any further questions about this study, please contact me at 352-284-1293, or my faculty advisor, Dr. Doan, at 352-392-0731, ext.237. For questions about your child’s rights as a participant, please contact the Institutional Review Board at 352-392-0433 or irb2@ufl.edu.

Patricia Xirau-Probert

I have read the procedure described above. I voluntarily give consent for my child, ____________________________, to participate in Patricia Xirau-Probert’s study of adolescent suicide awareness/prevention. I have received a copy of this description.

Parent/Guardian ____________________________ Date ____________
APPENDIX B  
PERSONAL DATA SHEET

Personal Data Sheet

The following questions are intended to gather demographic information about the students participating in this research study. You will not be asked to identify yourself by name. Your responses will be reported only in general terms as they relate to relevant variables of interest. Thank you for your participation!

1. Gender: ____ M ____ F

2. Race (check one): ____ African American
   ____ Asian/Pacific Islander
   ____ Caucasian
   ____ Hispanic/Latino/Latina
   ____ Native American
   ____ Mixed
   ____ Other _______________

3. Age: _____

4. Grade: ___ 9th ___ 10th ___ 11th ___ 12th

5. School: ____________________________________________________

6. Have you had peer mediation training?  (Circle one)  Yes No

7. Have you had any training in suicide prevention?  (Circle one) Yes No

8. If you answered yes to question 7, which of the following best describes the type of training you have had. (Circle one)
   Lecture/Presentation in class  Hotline Training  Combined lecture/video

9. Do you know anyone who has attempted or committed suicide? (Circle one) Yes No

10. Has a friend ever confided their suicidal thoughts or attempts to you? (Circle one) Yes No
APPENDIX C
LIFELINES QUESTIONNAIRE AND PROGRAM FEEDBACK FORM

CODE: ______________________________                    Today’s Date:___/____/____

Name of School: _______________________________

Sex: ___ Female ___Male                             Grade in School: _____

Have you read *The Turning Hour*, by Shelley Fraser-Mickle? (Circle one) Yes  No

Situation
A good friend of yours has seemed troubled lately and has begun to keep more and more to
herself. One day you go to see her and she tells you she would like to talk to you about
something, but you must promise to keep it a secret. She seems pretty serious and you value
your friendship with her a lot so you agree not to tell anyone what she has to say. She tells you
that she and everyone else would be better off if she were dead. Then she says, “Sometimes I
think I might as well kill myself”. She smiles and shrugs her shoulders when she says it. She
then reminds you of your promise not to tell anyone. You are the only person she trusts, she
says, and if you tell, she will never forgive you.

How would you respond in this situation?

How concerned would you be?

Very O

Somewhat O

Not very O

Not at all O
Situation

You have a friend at school who has been keeping to himself lately. You know he has trouble at home – his parents are getting divorced and he’s not sure who he will be living with or if there will be enough money for him to go to college. It is Friday and you ask him to go to a party with you but he declines to go.

Later that day in English class, the teacher is reading samples of students’ short essays that she has assigned. She doesn’t identify the writer but one of them is entitled “(Final) Family Decisions” and describes a very important decision that is about to be made by the writers’ parents that will involve whether he will change schools and whether he will be able to go to college. The writer says that he may not go along with his parents’ decision and make one of his own that will resolve things.

You believe that your friend wrote this essay and that you are the only one who knows what he is talking about.

How would you respond in this situation?

How concerned would you be?

Very O

Somewhat O

Not very O

Not at all O
Please fill in the circle that most closely represents what you think about the question.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Teens can’t do very much to prevent teen suicide.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2.</td>
<td>It is important to have at least one adult that you can talk to if something is bothering you.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3.</td>
<td>A friend’s confidence about suicidal feelings should never be broken.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>4.</td>
<td>People should be expected to handle all of their own problems without outside help.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5.</td>
<td>People who are seriously planning to kill themselves don’t want any help.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>6.</td>
<td>If somebody wants to kill themselves, nobody has the right to stop them.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>7.</td>
<td>Teens are at a point in their lives where they should not rely on adults for help with problems.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>8.</td>
<td>It is not a good idea to ask someone if they are thinking about suicide because you may give them the idea to try it.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>9.</td>
<td>My school is prepared to help a student who might be thinking about killing him/herself.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>10.</td>
<td>If a friend came to school in a bad mood and casually mentioned, “my family would be better off without me”, I would encourage him or her to get help from a responsible adult.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Question</td>
<td>Description</td>
<td>True</td>
<td>False</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------</td>
<td>-------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>People who talk about suicide do not commit suicide.</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Giving away prized possessions may be a sign that a student is thinking about suicide.</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>The fact that a person has attempted suicide means that they are not likely to try it again in the future.</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Suicide attempts are rare among good students.</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>If a person seems to feel better after they have been feeling really down or depressed, they are not likely to try to kill themselves.</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Suicide tends to “run in families” – that is, if someone in a kid’s family committed or attempted suicide, that kid is more likely to commit or attempt suicide.</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Males commit suicide more often than females.</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Most teens who try to kill themselves really want to die.</td>
<td>O</td>
<td>O</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For Questions 19 through 23, Please fill in the circle that most closely represents what you think about the question.

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>The best thing to tell a suicidal friend is to “pull yourself together and things will get better”.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>20</td>
<td>If someone really wants to kill themselves, there is not much I can do about it.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>21</td>
<td>I know what officials in my school will do if they learn about a student who is thinking about killing or hurting him/herself.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>22</td>
<td>There is at least one adult in my school that I could confide in about a concern of my own or about a friend’s concern.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>23</td>
<td>If a friend told me that she/he is thinking about killing her/himself, I would not know what to do.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
For question 24 – 28, please fill in the circle next to the sentence that most closely represents how you feel about the question.

If a suicidal friend asked me not to tell anyone, I would:

O Definitely tell someone
O Probably tell someone
O Probably not tell someone
O Definitely not tell someone

If a friend began to lose interest in activities and friends and sometimes said things like s(he) wasn’t much good to anyone, would you:

<table>
<thead>
<tr>
<th></th>
<th>Definitely Would</th>
<th>Probably Would</th>
<th>Probably Would Not</th>
<th>Definitely Would Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Mind your own business and let him/her have his/her privacy.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>b. Ask him/her if something was bothering him/her.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>c. Try to get him/her to go talk to some trusted adult about what’s bothering him/her.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>d. Tell a trusted adult about what you notice about your friend.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>e. Tell another friend about what you notice about your friend.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Which of the above would you be most likely to do? Write the letter of your choice here:_________
If a friend told you s/he was thinking about killing him/herself would you:

<table>
<thead>
<tr>
<th>Option</th>
<th>Definitely Would</th>
<th>Probably Would</th>
<th>Probably Would Not</th>
<th>Definitely Would Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Tell my friend to call a hotline.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>b. Talk to an adult about him/her.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>c. Talk to my friend without getting anyone else’s help.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>d. Get advice from another friend.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>e. Respect his/her privacy &amp; keep it a secret.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Which of the above would you be most likely to do? Write the letter of your choice here: ________

THANK YOU
Suicide Education Feedback

You’re feedback is very important to us.
Please circle the number indicating your answer.

1. Overall, how would you rate your English classes this marking period?
   
<table>
<thead>
<tr>
<th>Interesting</th>
<th>Average</th>
<th>Boring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

2. How would you rate the suicide education classes (Includes The Turning Hour)?
   
<table>
<thead>
<tr>
<th>Interesting</th>
<th>Average</th>
<th>Boring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

3. Did you learn anything new in the suicide education classes?
   
<table>
<thead>
<tr>
<th>A Lot</th>
<th>Average</th>
<th>Nothing</th>
</tr>
</thead>
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3a. If you answered 1 or 2, what did you learn?

4. Was the information presented clearly in the suicide education classes?
   
<table>
<thead>
<tr>
<th>Clear</th>
<th>Average</th>
<th>Unclear</th>
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5. The suicide education classes were
   
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<th>Advanced</th>
<th>About Right</th>
<th>Elementary</th>
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6. How do you think the suicide education program will help you deal with your friends’ problems?
   
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7. How do you think the suicide education program will help you deal with your own problems?
   
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8. The suicide education program was
helpful

1 Helpful 2 Neutral 3 Not Helpful

If you answered 1 or 2, how was it helpful?

If you answered 4 or 5, how was it not helpful?

9. Do you think other high school students in your area should participate
in the same program? Yes No

10. Did you ask any questions or make comments during the suicide awareness program? Yes No

11. If no, why not? (You may circle more than one answer)
   11a. Not enough time
   11b. Nothing to ask/say
   11c. Presenter did not ask for questions or comments
   11d. Everything was covered
   11e. Other

12. Did you miss any of the suicide awareness classes? Yes No
   12a. If yes, how many?

THANK YOU
APPENDIX D
ALACHUA COUNTY CRISIS CENTER SUICIDE PREVENTION PRESENTATION

ADOLESCENT SUICIDE PRESENTATION

Define Terms:
What is suicide attempt?
What is completion?
Who is a Survivor of Suicide?

Stats:
- Each year approx. 12 suicide deaths for every 100,000 adolescents—
- Which means that in an average high school class it is likely that 3 students (2 girls and 1 boy) have either made an attempt or had thoughts of suicide in the last 12 months.
- 60% of teens have reported having suicide ideation
- Adolescent males are 4.8 times more likely than females to complete suicide.
- Know why?? Firearm vs. pills
- Females---more attempts (3-4 times)

⇒ How many of you have been touched by suicide in some way?

⇒ Who commits suicide? How would you describe them?

Profile of Suicidal Teen: Why do people attempt suicide…
I will tell you about one client I have who is constantly thinking about suicide and through my description of her you will recognize suicidal teens that you may have come across.
- Feelings: Hopeless, despair, loss of control, ashamed, unloved
Says in moments of her deepest despair, she feels so much ache and pain as if she is rotting inside and can do nothing about it.
Feels like she doesn’t belong anywhere—no one understands her, she trusts no one to any great extent, in her worst moments she truly believes no one cares, no one loves her and that no one would be impacted by her death--- one of the most dynamic teens I have ever met.
- Thoughts: she thinks—as many suicidal teens do—nothing will ever change…life is not worth living, she grows tired of putting on what she calls her armor just to go through another day of surviving—there is no part of her that feels alive.
In moments of high lethality, she can’t see any other options--- tunnel vision.

Suicide Myths:
- Biggest Myth—that talking about it will cause it to happen
- People “choose” suicide: “Suicide is not chosen, it happens when pain exceeds resources for coping with pain”
Warning signs/Behaviors:
- Depression
- Abusing drugs and alcohol
- Change in sleeping or eating
- Talk about suicide and/or no reason to live
- Preoccupied with death and dying
- Withdraw from friends and social activities
- Recent severe loss—esp. a relationship
- Loss of interest in hobbies, work, school
- School problems/crisis
- Problems in family/crisis
- Legal problems
- Impulsivity
- Loss of interest in personal appearance
- Guilt

Giving away possessions and other final preparations

What helps?:
Question is not, “how do you stop them from killing themselves?” but rather “How do you help them find a way to go on?”

What would be helpful??
- Listen—let them know you care—active listening
- Non-judgmental
- Don’t give advice at first
- Don’t ask a lot of questions, let them tell their story
- Help them feel understood
- Acknowledge suicidal feelings---say them aloud—name all taboos
- Eventually discuss coping skills, resources and strategies to use

What is not helpful?
- “You should feel lucky”
- “You are better than most people”
- You’re smart, good kid”
- “It will all be ok”
- “It is not so bad”
- “Why don’t you just get busy, you’ll feel better”

Lethality Assessment: Balancing these questions with empathic responses to their emotions
⇒ How will you kill yourself?
⇒ When do you think you might kill yourself?
⇒ Where will you kill yourself?
⇒ Means—Do you have the gun/pills/rope?
⇒ Who knows—notify parent or guardian
Resources:

⇒ Alachua County Crisis Center: 24 hour hotline: 264-6789
⇒ Suicide Hotline: 24 hour hotline: 1-800-Suicide
⇒ School Counselors, teachers, other trusted adults
⇒ Meridian Crisis Stabilization Unit (CSU): Suicide Assessments/inpatient treatment: 374-5600
READING GROUP GUIDE

Although a dark subject about a heartbreaking national crisis of 1.3 million teen suicide attempts per year, this novel, in the hands of humorist and NPR Morning Edition commentator, Shelley Fraser Mickle, lifts the reader into the realm of knowing how to nurture and protect resilience. The Turning Hour explores teen despair, weaving the viewpoints of Bergin, a high school senior, with that of her mother, Leslie, to unravel the mystery of why Bergin, in the middle of her senior year, attempts suicide and then struggles to regain a life she can value. Peopled with characters that could live in anyone's neighborhood--two husbands struggling to understand themselves and the women they love, an African-American psychiatrist with a secret of her own, a stepbrother who looks at the world with "amazed" grace, two senior citizen geldings who don't know much about horse whispering but understand a little about cussing, and a pig who lives behind an azalea--this is a mesmerizing novel about beating the blues and learning how to take care of one's own life. (ReadingGroupGuides.com)

The importance of mature, professional adults discussing suicide with teenagers in a positive setting cannot be overstated. Author Mickle wants to save lives. The goal is that this Educator’s Guide can provide assistance to teachers, guidance counselors, ministers, and other helping professionals as they use The Turning Hour in classroom literary study or counseling group bibliotherapy. Most appropriate for high school students and older, the novel should be viewed in the context of that genre, in contrast to the plethora of nonfiction on the subject of teen suicide. This guide is not intended to be a treatise for professionals on the subject of teen suicide; rather, it should be a starting point to facilitate dialogue between adults and teens. The novel’s theme of resilience provides a positive approach to dealing with tough personal issues.
The educators who developed this guide hope that both professionals and students who use these ideas experience the gift of personal growth.

Mary Anne Wagner, Language Arts and Guidance
Rita Page, Language Arts
Linda S. Myrick, Guidance
Marilyn Bishop Shaw, Language Arts
Catherine Berg, Language Arts
Pat Lucas, Technology
Terri Johnson, Technology

A REPRINT FROM TEENREADS.COM

Biography
Shelley Fraser Mickle was born in 1944, and grew up in Arkansas and Tennessee. The mother of two grown children and the wife of a pediatric neurosurgeon, she now lives in Florida on a farm with her three horses, two dogs, one cat, and eight cows. Her first novel, The Queen of October, was a 1989 New York Times Notable Book; her second novel, Replacing Dad, became a CBS movie and is now frequently shown on the Hallmark Channel, starring Mary McDonnell and heartthrob Eric von Detten. Shelley began reading her humorous essays on National Public Radio in 1995, and her collection of some of these was published in 2000, titled The Kids Are Gone; The Dog Is Depressed and Mom's on the Loose. She also writes a weekly newspaper column called "Novel Conversations" which works like a book club.

Interview
March 26, 2002
Teen suicides have reached epidemic numbers in our country, and many parents are at a loss to know why their teenagers feel so hopeless or even how to recognize the signs of depression. Shelley Fraser Mickle, author of The Turning Hour, answers some questions for Teenreads.com’s Kathy Hale on what she discovered in researching her novel and what she hopes her new book will accomplish.

TRC: What inspired you to write a book about teen suicide?

SFM: In 1995, I was over at the beach near St. Augustine, which is near where I live, and I met a woman who said she had read my two novels and felt that she had known me forever. Furthermore, she said she felt that perhaps I could know her in ways no one else could. And she wanted to give me a story she had lived, and encouraged me to do with it as I might. She then proceeded to tell me over the next hour and a half how her child, as a senior in high school, attempted suicide and that something she had unwittingly done had contributed to her child's drastic decision. She then explained that even though it was the darkest time in her family's life, it turned out to be one of the most enriching. For they all emerged in an enlightened kinship. She ended by saying she knew she would never talk about this again, for suicide is such a taboo subject, and yet, so much was learned from this dark time.

Well, I filed this story away. I simply did not want to "go there." I have to admit, though, it was one helluva plot; but still, I didn't want to have to crawl into the dark hole into which that young
adult had fallen--which is what I knew I would have to do in order to write a literary novel. Then one day years later, it occurred to me: If I wrote this story from the point of asking, once someone has made the drastic decision to give up life, then is turned back physically, how does one get back emotionally? In other words, how does one come back to an emotionally vibrant life?

I called around town to find an expert on teen suicide. It turned out the person I was referred to was someone who was getting her Ph.D. while we were raising boys together--carpooling, etc. When I told her what I was thinking about doing--writing a novel about young adult suicide--she said, "My God, Shelley, you've got to do it. You won't believe how many young women and men (of high school and college age) I see in my practice each month who have attempted to end their lives."

The new statistics from the CDC is that one in five high school students each year considers committing suicide, and 1.3 million attempt to end their lives. This is a heartbreaking crisis. So off I went--writing The Turning Hour--because I could not say no to bringing this most pressing story to life.

TRC: Are Bergin and her family based on real people?

SFM: No. As a novelist, all my characters are composites of people I have known. I always have to find myself within them, too. For I can't bring a character to life unless I've had dinner with them, showered with them, taken a long trip and paid our income taxes together! I borrow stories from my friends and family, too, as my Acknowledgments admit. I chose to write the book from a young woman's viewpoint rather than a young man's, because I had just finished writing Replacing Dad, my novel told by a 15-year-old boy and his mother, and I wanted a different challenge. The point is, though, the cultural influences that lead to Bergin's crisis in The Turning Hour are also many of the same pressures for young men.

TRC: Has suicide ever touched your life?

SFM: No, thank goodness. Looking back, however, I realize that a young man I once dated in my twenties committed suicide. If I live a story, I can't write about it. I'm too close, and too emotional. I need that distance. But of course, all literary artists have to understand the emotions of their characters and find them within themselves. That's the way we work.

TRC: In researching your story, did you draw any conclusions about the most prevalent cause of teen suicide?

SFM: Suicide is always a complicated set of events leading to a profound sense of hopelessness. Basically, though, loss is always a part of the set of circumstances that leads to suicide--loss of a relationship or loss of self-worth through humiliation. And then that loss is coupled with isolation. Our literature and media have romanticized too often the act of suicide following the loss of a loved one. Clusters of suicides can result. The depression that leads to suicide creates a distorted sense of reality. That's why the facts leading to a suicide never seem believable. Of course we want to deny that any reason is a good one to end a life. But simply, the person who wants to end their life sees the world in their own very logical but twisted way. It all makes perfect sense to them. And frequently it provides a secret form of having power over what is
uncontrollable. Chemical imbalances seem to always be in play. I recently attended Grand Rounds on Teen Suicide at the University of Florida Medical School, and the chemical imbalances from depression were emphasized. Also disturbing was the statistic that 40% of young adults hospitalized for a suicide attempt drop out of treatment. This is why I think a novel such as The Turning Hour may be able to reach young adults in ways that conventional treatment cannot--and aid in prevention.

**TRC:** Why do you think that so many parents miss the signs of their kids' depression?

**SFM:** Kids are good at hiding their most intimate feelings from their parents because they are at that time in life when they are pulling away from their family and asserting their independence. Frequently in their flight toward independence, communication lines break down. It's a difficult and painful time for both parents and kids because it's nature's way of turning kids into adults--to prepare them to go out into the world on their own. Often, parents forget to listen to their young adults. They forget how to be silent and just spend time doing anything at all with their kids who are in the midst of the struggle to become adults. It's always important for parents to lend their kids their strength and not use it against them. Part of being a good parent is empowering the child.

**TRC:** You capture the depressed personality very well in The Turning Hour. Have you ever had any personal experience with depression?

**SFM:** No one gets out of living their life without knowing something about The Blues. I have not had a personal experience with clinical depression, other than dealing with family members who have suffered from it. A number of years ago, I read an interesting article on depression that indicated some experts believe depression has a chemical basis that at one time aided our primitive ancestors to hibernate when food sources were low. This seems very possible to me—that there could be biological reasons for our moods that they help us survive. Certainly, The Blues have always made me emerge feeling stronger, more clearly focused, and energetic. I like looking at Depression in this positive way. However, I am talking here about ordinary run-of-the-mill Blues, and not clinical depression, which is a complicated medical condition. From what I understand about the chemical basis of clinical depression, it requires diligent and professional treatment that sometimes must be attended to for a life-time. I have always felt, though, that it is these challenges in life which make us who we are. For someone to be diagnosed with clinical depression, seek treatment, continue to monitor and live with their condition, they become heroes in the story of their own lives. These people are smart! I know that the fact that I had polio in 1950, spent most of my childhood in children's hospitals, then in wheelchairs, braces, and crutches has made me on special terms with myself. I would not be who I am without having experienced this and knowing how to take care of myself. I strongly believe that these experiences are like buying strength on the lay-away-plan. We get to pull out the goods, one day. How we wear them is our personal decision.

**TRC:** According to your website, you have a dog named Stella, and so does Bergin. Is that just a coincidence?
SFM: I thought it would be fun to put my dog Stella in the novel. The name of my farm is also Blueberry Hill Farm. I had no ulterior motive other than to be playful. A good friend of mine had a pot belly pig named Spam, too; and I thought that was such a cool name for a pig, he ought to be in the book also.

TRC: Do you think that Leslie's childhood experiences influence how she reacts to the situation with Bergin?

SFM: Most definitely. Children of alcoholics are always quick to deny problems and good at covering them up. Shame is such a strong force in their lives that subconsciously they do all sorts of things to make themselves feel better about the secret they are keeping—that someone in their family is not functioning and cannot be related to in a healthy way.

TRC: When Bergin is hospitalized, Leslie tells her colleagues that she has mono or hepatitis. Do you think that most parents are honest about their children's mental illnesses, or do they choose to hide them?

SFM: You know, parenting can get as competitive as the last lap in a NASCAR race. Being a parent, I can say this with no qualms. I've been there and done that myself, and have also been greatly disturbed by the pressures some parents can put on their kids. Luckily, the powers in the universe tend to even things out for parents--give them one easy-to-raise kid who seems to do everything to society's highest standards. Then they are given one child who makes them know the real values in life—that being a good, kind person who can be steady, loving, and have a humorous outlook on life is worth more than any number of degrees from prestigious colleges or a fat bank account. Furthermore, these are talents no one can buy. So yes, parents tend to hide their children's problems. Then often they wise up and see the value in how difficulties help kids grow, and then they themselves begin growing. It's the parents who don't let their kids teach them things who miss out. These are the ones I feel sorry for.

TRC: What is the one thing you would like teens to learn from reading The Turning Hour?

SFM: Resilience. If there is one thing I want readers of all ages to take away from The Turning Hour it is that life requires patience. Bad weather passes. Don't let our culture dictate to you who or how you should be. Follow your head and hold hands with your heart. Growing up is a tempestuous time. It's supposed to be. You've got to try out all sorts of things and make mistakes. Unlike Bergin, in the beginning of the book, don't ever think anything is hard and fast. Everything changes. The way you feel now won't be the way you feel always. I would also like men to read The Turning Hour so they would see more clearly that their children don't want them to be only providers. Fathers play a crucial role in the emotional life of their children. I don't want The Turning Hour to be seen as only a "Babe Book." And remember, my novel is about Life, not Death. To go through this world, we all have to learn how to take care of our lives.

TRC: What advice would you like to share with parents about dealing with their teenagers?
SFM: Listen. Wait. Be patient. And enjoy them. Lend them your strength, rather than overpower them. And don't try to be a teenager again with them--parents acting like teens make for too many in the house!

TRC: What are you working on now?

SFM: I've got three things going and have to decide which to finish first. One appears to be a nonfiction humor book called Old Wives Tales Told by a Half-Dozen Old Wives. I also have a new novel going, and a memoir. I've lived long enough to almost become interesting--even to myself.

REVIEW OF PROFESSIONAL LITERATURE ON BIBLIOThERAPY

Bibliotherapy is a specific, progressive, planned therapy that includes:

- Identification with the characters-- Situations, or elements of a story, enable the reader to see his or her problem from a different perspective and thus gain hope and catharsis.
- Catharsis-- a tension release that allows the reader to be open to insight and change.
- Insight into one's own motivations and actions allows for a positive change in attitude and behavior.


- Bibliotherapy should not be viewed as a single approach to treatment but rather as an adjunct to other therapies.


- Two types of bibliotherapy are described:

1. “Reactive” bibliotherapy, which is based on the premise that clients’ identification with literary characters similar to themselves is helpful in releasing emotions, gaining new directions in life, and promoting new ways of interacting with others through catharsis, insight or emulating character behaviors.
2. “Interactive” bibliotherapy, in which the processes of growth, change and healing are facilitated by guided discussions of feelings and cognitive responses to the material.

With appropriate guidance from a facilitator, bibliotherapy can benefit students:

- Affectively, by providing an avenue for the release of pent up emotions that may have previously interfered with personal growth and constructive interpersonal relationships.
Behaviorally, by providing characters that may model actions for the reader, including appropriate ways of relating to self and others.

Cognitively, by providing opportunities to learn selective strategies for approaching potential problems and thereby preventing or reducing unwanted stress.

Some important issues to watch for include:

- Participants projecting their own motives onto the characters, thus reinforcing their own perceptions and solutions.
- Participants discounting the actions of characters and thus failing to identify with them or even using them as scapegoats.
- Participant’s failure to recognize oneself in a character, defensiveness, or denial.
- Facilitator’s failure to appropriately pace exploration of issues evoked by the story to the participant’s level or readiness.


Bibliotherapeutic intervention may be undertaken for many reasons:

- to develop self-concept
- to increase understanding of human behavior or motivations
- to foster ones self-appraisal
- to encourage finding interests outside of self
- to relieve emotional or mental pressure
- to show that one is not the first or only person to encounter such a problem
- to show that there is more than one solution to a problem
- to help a person discuss a problem more freely
- to help a person plan a constructive course of action to solve a problem

Basic Procedures:

Motivate the individual(s) with introductory activities.
- Provide time for reading the material.
- Allow incubation time.
- Provide follow-up discussion time, using questions and leads that move participant(s) from literal recall of facts and story through interpretation, application, analysis, synthesis, and evaluation.
- Provide for evaluation of progress by practitioner and by participant(s) and move participant(s) toward closure.

• Bibliotherapy is an intervention for dealing with stressful situations or to enhance self-understanding, using books with a therapeutic content.

The reader should experience:

• Identification – the student should be able to identify with the age and behaviors of the main character and with the events of the story.
• Catharsis – the student then relates to the situation and feels emotional ties with the main character. Through emotional involvement with the main character and the story, the student can experience some relief from emotional stress.
• Insight – by analyzing and developing opinions about the main character and events of the story, a student can develop a deeper understanding of his/her own situation. By exploring alternative behaviors for the main character, the student can develop problem-solving skills.

Counseling Group Guide

Although The Turning Hour can be used effectively in individual counseling, this Guide focuses on group counseling, based on the model outlined in Sridhar and Vaughn’s Bibliotherapy for All (Teaching Exceptional Children, 33,74-82).

Most important is good communication among professionals using The Turning Hour. Guidance counselors should discuss the approach with significant administrators, classroom teachers, and even parents, since the counseling group is focused on sensitive topics such as teen suicide and divorce. Perhaps the best approach is a co-teaching model where the classroom teacher and the counselor work together.

Sridhar and Vaughn outline a four-step process, which provides a flexible framework for counselors and teachers.

Step 1  Getting Ready
• Make sure the book is suitable based on the following criteria:
  • The main character and storyline are relevant to the student.
  • The book is at an appropriate level, developmentally as well as reading.

Step 2  Before Reading
• Give students an introduction to the theme of the book, the major events in it, and the main characters.
• Encourage students to compare their experiences with situations in the book.
• Help students make predictions about the content of the book based on the information given and their own knowledge about people similar to the main characters.

Step 3  During Reading
• Ask questions that help students summarize the text and facilitate their identification with the main character.
• Ask questions about what they might do as the main character, perhaps encouraging them
to collaborate in a process of problem solving.
• For additional ideas, refer to Essay/Discussion Questions, page 21, and Reading Group

**Step 4  After Reading**

• Facilitate deeper discussion, perhaps in smaller groups, about the story and how the
characters felt and what the students themselves might do in situations from the book.

**Use follow-up activities that allow students to express themselves more fully.**

**Creative Writing:**

• A summary of the book from the point of view of someone in the book other than the
main character
• A diary for a character in the story
• A letter from one character to another or from the student to a character
• A different ending for the story
• A “Dear Abby” letter that a character may have written about a situation in the story.

**Art:**

• Create a drawing or collage representing the story, the growth of the main character or a
personal reaction.
• Role-play and discussion:
  • Role-play events in the story.
  • Discuss how the outcome of the story could be changed and how alternative behaviors of
the characters could cause changes in the story.

For additional ideas, refer to Essay/Discussion Question, page 21, and Reading Group

**Chapter Synopses**

The chapter synopses provide a brief explanation of key chapter event. A teacher can use these
synopses as tools for reviewing events or locating scenes in the novel.

**Overview**

Part I of the novel deals principally with the past and builds to an epiphany for both Bergin and
Leslie that answers the question of why Bergin attempted suicide. Part II deals with the present
and future and leads both Bergin and Leslie to epiphanies that answer the question of how they
can go on with their lives.

**Part I**

• Chapter 1 ~ Bergin
  The chapter tells how Bergin had swallowed a bottle of aspirin the first week in December at her
father’s house. The chapter also includes some school background information such as how
Bergin was the captain of the cheerleaders but “defected” to the soccer team.
• Chapter 2 ~ Leslie
  Leslie tells about what she was doing the day the Bergin committed suicide. She was in court
defending a client, Richard Murphy (“Hoot”). She also describes her own parents and growing
up. Included is the childhood story of how her father revived a pet duck. Leslie was at the hospital checking “Hoot” into a rehabilitation program when Bergin arrived at the hospital.

- Chapter 3 ~ Bergin
This chapter shows Bergin in the hospital. Dr. Cone arranges for Bergin’s stepbrother Dylan to describe to Bergin what it was like to find her. Leslie introduces her dad’s second wife Miss Vicky LaTour and describes the day that her dad proposed marriage. Some description of how Bergin perceives her parents is also included.

- Chapter 4 ~ Leslie
Leslie summarizes what life was like growing up with Bergin’s dad Doug Talbot through life’s phases: high school, college, marriage, and Bergin’s birth. She provides a view of Bergin being in the Intensive Care Unit. When asked why she did it, Bergin’s only response was that she wanted Jack.

- Chapter 5 ~ Bergin
Bergin gives her impression of Jack. She tells what she is unable to explain to anyone: the Daddy Juju. Simpson Bates whom Bergin has not seen since middle school visits. Bergin meets “Hoot.”

- Chapter 6 ~ Leslie
The entire family meets in Dr. Cone’s office for a therapy session. Maggie tells about where they live. Bergin explains what a hard year she has had. But Leslie feels that there is something more. Leslie talks about her father’s death as well as meeting and getting to know Jack.

- Chapter 7 ~ Bergin
Bergin talks with Dr. Cone about her relationship with Luke and what life is like on the farm.

- Chapter 8 ~ Leslie
Leslie and Jack put together a swing set on Christmas Eve. Bergin spends the first part of Christmas Day at the farm. Leslie remembers Bergin learning to drive. Leslie takes Bergin to Doug’s house.

- Chapter 9 ~ Leslie
After trying to understand, searching for something that makes sense, trying to grasp that gnawing detail that she cannot remember, Leslie suddenly understands what she has done. When Bergin had asked her mom to tell her dad that she wanted to move back out, Leslie had said that she couldn’t. The epiphany for Leslie was that Bergin had done what she had done to save Leslie from having to confront Doug and to an extent to save Doug as well.

Part II

- Chapter 12 ~ Bergin
Bergin returns home to the farm and goes back to school. She finds the suitcases Leslie had hidden in the barn instead of giving them to Bergin for Christmas. Bergin realizes that things change.

- Chapter 13 ~ Leslie
The family takes a trip to Tallahassee and invites Simpson Bates to go along. Leslie panics when she cannot find Bergin and Simpson at the Native American Powwow. On the way home, they drive by Leslie’s childhood house and visit the grave of her father. Leslie must deal with her perfectionism, her fear of letting Bergin out of her sight, sorting out what she is responsible for, and letting Bergin be her own person. At the graveyard, Leslie realizes how her attitude of devotion to her own father had passed on to Bergin, and she acknowledges to her dead mother how “fraught with danger” mothering is.
• Chapter 14 ~ Bergin
Bergin gets her nose broken during a soccer match and is rushed to the hospital emergency room. Leslie and Bergin go on a horseback ride where Bergin unexpectedly experiences joy while watching an eagle. Bergin learns the lesson that it is all right to make mistakes. Bergin notices that Leslie has a shirt on backwards and has missed several belt loops. Bergin realizes that Leslie is her own person, apart from her mother role, who also has things that she needs to work through.

• Chapter 15 ~ Leslie
Leslie has dinner with Doug. To some degree Leslie is reconciled to Doug. She protects Doug by not explaining why Bergin attempted suicide. Jack decides that the family will dig a swimming hole. Doug wants Bergin to drive with Dylan to see his father in Palm Key.

• Chapter 16 ~ Bergin
On the way to Palm Key, Bergin and Dylan lose a tire and have to be towed home. Dylan and Bergin decide to spend the evening out. When they return to her father’s house Bergin discovers the pictures her father drew of her while she was in the hospital. She begins to feel a sense of reconciliation when she realizes that his was her father’s way of “saving” her.

• Chapter 17 ~ Leslie
Leslie discovers that Dr. Cone had lost a nineteen-year-old son to suicide. Leslie realizes that Bergin is now different and will never be the person she once was. She sees “Hoot” and confirms that Bergin really is doing well.

• Chapter 18 ~ Bergin
Bergin now understands why Luke acted the way he did. Vicky is going to have a baby and name it Elizabeth Bergin. Bergin experiences moments of happiness and is glad to be alive. She looks to the future by considering her college prospects and realizes how much her family needs her.

Essay or Discussion Questions

Choose one of the following themes and trace its development through the novel.

Loss  Resilience  Protection
Guilt  Isolation  Connection

- Explore the different options for the novel’s point of view. Why do you think the author chose first person narrative alternating between Bergin and Leslie? What other point of view do you think would be effective, and how would this different point of view change the story?
- Each pet and each house in this story takes on a symbolic significance for Bergin. Choose either the topic of pets or houses, and explain how they operate as symbols in Bergin’s life.
- There is a difference between the external reality and Bergin’s internal reality. On the surface Bergin had to face breaking up with Luke, not being chosen for the state capital trip, and not being able to tell her father that she couldn’t live at his house. Explain how Bergin interpreted and processed these events internally.
- The novel begins in the winter and ends in the spring; it begins with an attempted death and ends with a birth. Explain how these events symbolically reflect the development of the plot.
• At the end of Chapter 1, Bergin asks, “But how do I get back?” How does Bergin succeed in making it back, and what things in the novel confirm that she does indeed make it back?
• Like many teenagers today, Bergin faces both sexual and cultural pressures. What pressures does Bergin specifically face? Discuss the reality of sexual and cultural pressures that teenagers face in today’s world.
• The author begins with a poem from Emily Dickinson and a quotation from Elie Wiesel. Why do you think the author chose these two, and how do they relate to the story?

Comprehension Check Questions

A sixty-seven question, chapter-by-chapter comprehension check has been devised mainly for younger readers or struggling readers to assist them in following the plot of the novel. The reason is that a reader needs to comprehend and recall the basic components of a story in order to successfully respond to higher level though processes. Older or more advanced students may want to use the questions as a device for staying focused or as a review guide.

Chapter 1
1. On the day that Bergin attempted suicide, she saw a piece of paper float up into the air. How did she interpret that event?
2. What question does Bergin ask at the end of Chapter 1? What do you think she means?

Chapter 2
3. In Chapter 2, how does Leslie describe her mother and father?
4. Why was Leslie already at the hospital when Bergin arrived to the emergency room?
5. At the end of Chapter 2, what does Leslie say she has to know?

Chapter 3
6. Why did the hospital take away Bergin’s clothes?
7. What did Dr. Cone want Dylan to describe to Bergin?
8. Why had Bergin decided that there was no way she was ever going to like Miss Vicky LaTour?

Chapter 4
9. Why did Leslie and Doug get married?
10. What difficulties did Leslie face after Bergin’s birth?
11. What had Bergin written on a slip of paper while she was in the emergency room?
12. What questions end Chapter 4?

Chapter 5
13. What name does Jack like to call Bergin?
14. What was the “Daddy Juju,” and how did Bergin use it?
15. What does Simpson “read” in Bergin’s palms?
16. Whom does Bergin meet while she is on the patio with Simpson?

Chapter 6
17. Which family members attend the therapy session?
18. According to Bergin, what things in her life had made the past year hard?
19. In what ways have Bergin and Leslie tried to protect one another?
20. What questions keep haunting Leslie?
Chapter 7
21. Why did Luke break up with Bergin?
22. According to Dr. Cone, why had Bergin burned herself?

Chapter 8
23. For Leslie, what was even worse than imagining the sheer horror of the act of suicide?
24. What present did Jack give to Leslie?

Chapter 9
25. What decision did Bergin make at the end of the big fight with Leslie?
26. What homework assignment had Dr. Cone given Bergin?
27. What present did Bergin give Dr. Cone?
28. What conversation had Bergin overhead at school?

Chapter 10
29. What reason had Leslie given her coworkers for Bergin being in the hospital?
30. Leslie keeps asking herself what it is that she’s not remembering is. What does Leslie Figure out?

Chapter 11
31. How does Bergin react to her roommate Dee Dee Hamilton?
32. Why didn’t Bergin want to remain in her father’s house?
33. What does Bergin learn about Dr. Cone?

Chapter 12
34. How are things different from how Bergin thought they would be, from how things are in books and movies?
35. What was Bergin’s new homework assignment from Dr. Cone, and what is Bergin to learn from it?
36. How are Bergin and Mr. Whitstruck alike?
37. What did Bergin find in the barn?
38. What question does Bergin have that she doesn’t ask Dr. Cone?

Chapter 13
39. What advice had Dr. Cone given to Leslie?
40. Why did Leslie panic at the Native American Powwow?
41. At what two places did the family stop on the way home?
42. Why did Leslie silently apologize to both her father and her mother?
43. What message does Leslie receive when she is in the courtroom?

Chapter 14
44. What question does Bergin ask that relieves everyone’s tension at the hospital?
45. Describe Bergin and Jack’s ride home from the hospital.
46. While driving home, what feelings does Bergin realize she has towards the hospital?
47. What is it about her mother’s clothing that disturbs Bergin?
48. What do Bergin and Leslie see during their horse ride, and to what feeling does the incident lead Bergin?
49. What is Dr. Cone’s homework assignment, and what is Bergin to learn from it?

Chapter 15
50. Why does Leslie want to talk with Doug?
51. What does Leslie feel will forever connect her with Doug?
52. With what "answers" does Leslie decide to provide Doug?
53. What comment does Doug make about having children?
54. What favor does Doug ask?

**Chapter 16**
55. Why did Bergin say she couldn’t leave with Dylan until Saturday afternoon?
56. What happens to the car on the way to Palm Key?
57. What was the most difficult thing for Bergin to handle that evening?
58. What did Bergin find in her father’s study?
59. How does Bergin feel on her way home from Carl LaTour’s house?

**Chapter 17**
60. After digging up information, what does Leslie learn about Dr. Cone?
61. What has Leslie come to say to Dr. Cone?
62. What truth does Leslie hold onto as she leaves the parking lot?

**Chapter 18**
63. What does Bergin now understand about Luke?
64. How does Bergin see Dr. Cone on a regular basis?
65. How does Bergin feel while she is mowing on the tractor?
66. What news does Miss Vicky have?
67. What is the last paragraph of the book?

**COMPREHENSION CHECK QUESTIONS**

**Answer Key**

**Chapter 1**
1. On the day that Bergin attempted suicide, she saw a piece of paper float up into the air. How did she interpret that event?
   Bergin felt that the paper had spoken to her telling her it was ok to end her life. She saw it as a sign.
2. What question does Bergin ask at the end of Chapter 1? What do you think she means?
   “But how do I get back?”
   Bergin is asking how she is to get past the attempt to end her life and return to living a full life once again.

**Chapter 2**
3. In Chapter 2, how does Leslie describe her mother and father?
   Father-- someone Leslie idolized, stable, caring, dependable, had photographic memory  
   Mother--depressed, slept too much, spent hours ironing in front of the TV, drank wine, would pass out
4. Why was Leslie already at the hospital when Bergin arrived to the emergency room?
   Leslie was checking Hoot into the hospital for an alcohol rehabilitation program.
5. At the end of Chapter 2, what does Leslie say she has to know?
   "Where is my father in Bergin now?"
   "Where is his resilience?"

**Chapter 3**
6. Why did the hospital take away Bergin's clothes?
   Bergin had to earn her clothes back.  
   Having her undressed was the only way that they could trust her.
7. What did Dr. Cone want Dylan to describe to Bergin?
   Dr. Cone wanted Dylan to describe what it was like to find Bergin so that Bergin would
   know how her actions affected others.

8. Why had Bergin decided that there was no way she was ever going to like Miss Vicky
   LaTour?
   Bergin had long ago decided that it would be her alone who would be all the family her
   father would ever need.

Chapter 4

9. Why did Leslie and Doug get married?
   Leslie became pregnant during her senior year in college. A month after graduation, they
   married.

10. What difficulties did Leslie face after Bergin's birth?
    Leslie suffered from postpartum depression. She grieved for and had an understanding of
    her mother for the first time in her life. She couldn't get the hang of being a mother and a
    wife. She felt "crazy and selfish," frustrated, and lonely.

11. What had Bergin written on a slip of paper while she was in the emergency room?
    "I want Jack."

12. What questions end Chapter 4?
    "If we learned what we feared, how could we live? How could we go on, if we found out
    we had been part of very nearly taking from the world this perfect good that, out of our
    youthful love, we had placed here?"

Chapter 5

13. What name does Jack like to call Bergin?
    Starlight with a Crown

14. What was the "Daddy Juju," and how did Bergin use it?
    It began as a round circle that Bergin could draw inside her head. Bergin felt that she had
    an invisible line to her father. It became like a charm, a juju, which she could rub across
    her mind at anytime. It was a connection to her father and the security of his love. She
    used it to hold things together, to keep everything whole, and to have everything make
    sense.

15. What does Simpson "read" in Bergin's palms?
    Bergin has difficulty with relationships and an inability to express affection. She has
    Samaritan lines that Simpson connects to Bergin wanting to be a doctor. She can be prone
    to extravagance, everything has to be her way, and she will most likely be aggressive in
    bed. She is a diehard romantic, idealistic especially in relationships, and depends on
    intuition and spiritual impressions to guide her. She is sensitive and trusting but lacks
    common sense and is easily crushed if romance does not work out.

16. Whom does Bergin meet while she is on the patio with Simpson?
    Bergin meets Richard Murphy (Hoot).

Chapter 6

17. Which family members attend the therapy session?
    The entire family attends: Doug, Dylan, Vicky, Carl, Leslie, Jack, Maggie, and Kirk

18. According to Bergin, what things in her life had made the past year hard?
    Bergin hadn't been chosen for "the student government thing," her boyfriend Luke broke
    up with her, and she has to get into college.
19. In what ways have Bergin and Leslie tried to protect each other?

   When Bergin was younger, Leslie had a difficult time coping after her father's death. Bergin would answer the phone and the door and make excuses for her. Presently, Bergin is trying to protect Leslie from the truth of why she tried to kill herself. While Leslie and Bergin were living alone, Leslie tried to keep everything the same for Bergin so that Bergin would not feel as if her world were changing in any way. She wanted to keep Bergin's world right and never let her down.

20. What questions keep haunting Leslie?

   "How much over the years had Bergin and I kept from each other?"
   "How many times had we hidden our mistakes, our failures, our private fears?"
   "What had we forgotten about each other?"

Chapter 7

21. Why did Luke break up with Bergin?

   Bergin no longer wanted to keep having sex.

22. According to Dr. Cone, why had Bergin burned herself?

   It was easier for Bergin to hurt herself than others.

Chapter 8

23. For Leslie, what was even worse than imagining the sheer horror of the act of suicide?

   What was worse was knowing that Bergin's act of attempted suicide was somehow connected to her. Leslie felt that Bergin was taking the life Leslie had given her and throwing it back as a gift she did not like and would not accept.

24. What present did Jack give to Leslie?

   Jack gave Leslie a wide silver bracelet engraved with the words "Give me Patience, Lord, But hurry."

Chapter 9

25. What decision did Bergin make at the end of the big fight with Leslie?

   Bergin decided to live with her father.

26. What homework assignment had Dr. Cone given Bergin, and what was the purpose of the assignment?

   Bergin was to count all the doors and windows in every room she spends time in and count all the pencils or pens that are lying around. The assignment was to show Bergin that in both her mother's house and her father's house, there are plenty of ways to get out, that she is never really trapped in either place. Also, with a little scrambling, she can always write down what she wants to say even if it is just to herself.

27. What present did Bergin give Dr. Cone?

   Bergin gave Dr. Cone a can of mixed nuts.

28. What conversation had Bergin overheard at school?

   The teacher commented that Bergin had everything and it was time to take her down a peg.

Chapter 10

29. What reason had Leslie given her coworkers for Bergin being in the hospital?

   Leslie told her coworkers that Bergin was sick in the hospital, possibly with hepatitis.

30. Leslie keeps asking herself what it is that she's not remembering. What does Leslie figure out?
Bergin had asked Leslie to tell Doug that she wants to move back out, but Leslie said that she couldn't and told Bergin to tell him.

Chapter 11
31. How does Bergin react to her roommate Dee Dee Hamilton?
   Bergin is kind and sympathetic. She puts together a makeup case for Dee Dee and fixes her hair into a French braid.

32. Why didn't Bergin want to remain in her father's house?
   Bergin felt that her father didn't really see her, that he wasn't interested, that she was disappearing in her father's house, and that her life didn't count. If she told her father how she felt, the last of her Daddy Juju would go.

33. What does Bergin learn about Dr. Cone?
   Bergin realizes that Dr. Cone somewhere along the way had lost something. She knew about loss and the fear of it.

Chapter 12
34. How are things different from how Bergin thought they would be, from how things are in books and movies?
   In movies and books, once a person puts everything out in the open, then he is set free, magically made well, and moves on. Bergin realizes, however, that making it back is not so fast and easy.

35. What was Bergin's new homework assignment from Dr. Cone, and what is Bergin to learn from it?
   The assignment was to make a list of things she has seen that have moved. The point was to learn that the way that she feels now won't be here forever either, that the way she feels now would also change.

36. How are Bergin and Mr. Whitstruck alike?
   Both Bergin and Mr. Whitstruck are viewed as being different. This gives them a sort of freedom because it allows them to do things that others would not be able to do.

37. What did Bergin find in the barn?
   Bergin found the set of suitcases that her mother had bought as a Christmas present.

38. What question does Bergin have that she doesn't ask Dr. Cone?
   "Can't anything last?"

Chapter 13
39. What advice had Dr. Cone given to Leslie?
   Sort out what you are responsible for from whom you are responsible for. Getting her life back is Bergin's job now.

40. Why did Leslie panic at the Native American Powwow?
   She couldn't find Bergin.

41. At what two places did the family stop on the way home?
   They stopped at Leslie's childhood house and her father's gravesite.

42. Why did Leslie silently apologize to both her father and her mother?
   She understands now how "fraught with danger" the job of mothering is.

43. What message does Leslie receive when she is in the courtroom?
   "Call the County Hospital E.R."

Chapter 14
44. What question does Bergin ask that relieves everyone's tension at the hospital?
"Did the goal count?"

45. Describe Bergin and Jack's ride home from the hospital.
   Jack slipped in a homemade tape of "Starlight with a Crown." They listened to it all the way home, neither needing to say anything. They couldn't help but laugh a little at the song.

46. While driving home, what feelings does Bergin realize she has towards the hospital?
   Bergin realizes that the entire time her nose was being worked on, she was aware of being fascinated and had a sense of wanting to spend more time there but not as a patient.

47. What is it about her mother's clothing that disturbs Bergin?
   Leslie had her shirt on backwards, and her belt missed every one of her jean loops but one.

48. What do Bergin and Leslie see during their horse ride, and to what feeling does the incident lead Bergin?
   They see an eagle. As Bergin watches the eagle swooping, diving, circling, and gliding, she feels joy.

49. What is Dr. Cone's homework assignment, and what is Bergin to learn from it?
   The assignment is to intentionally mess up on at least three things and write down what happens as a result. The lesson is to begin feeling that you could make mistakes and everything would still be okay. Bergin wonders if Dr. Cone had given the same assignment to her mother.

Chapter 15

50. Why does Leslie want to talk with Doug?
   Leslie wants to apologize to Doug for the way she had blasted him in the Emergency Room.

51. What does Leslie feel will forever connect her with Doug?
   Leslie is known to Doug in a way that she will never be known to anyone else. They share a history. He knows the memories of her youth, her father, and the joy of Bergin's birth.

52. With what "answers" does Leslie decide to provide Doug?
   He is more important to Bergin than he realizes. Time will make all of this better.

53. What comment does Doug make about having children?
   He is glad that he never had any more children and never intends to have any more.

54. What favor does Doug ask?
   Doug asks if Bergin would drive to Palm Key with Dylan, stay Saturday night, and then drive back with him.

Chapter 16

55. Why did Bergin say she couldn't leave with Dylan until Saturday afternoon?
   Bergin had plans to attend a soccer team car wash.

56. What happens to the car on the way to Palm Key?
   The car had a flat tire. They attempted to change it, but since the lug nuts hadn't been put on tightly enough, the tire rolled off.

57. What was the most difficult thing for Bergin to handle that evening?
   The most difficult thing for Bergin was to stay the entire night in her father's house, the place where she had tried to kill herself.

58. What did Bergin find in her father's study?
Bergin found her father's sketchpad that included pictures of Bergin in the hospital, pictures of her hands, ears, eyes, and arms.

59. How does Bergin feel on her way home from Carl LaTour's house?
   Bergin feels as if she has a crush on something, as if she is falling in love. She realizes that the "crush" is on her own life.

Chapter 17
60. After digging up information, what does Leslie learn about Dr. Cone?
   Dr. Cone had lost a child. At the age of nineteen, her son took his life.
61. What has Leslie come to say to Dr. Cone?
   Leslie wants to thank Dr. Cone for saving Bergin's life.
62. What truth does Leslie hold onto as she leaves the parking lot?
   When Hoot asks Leslie how Bergin is doing, Leslie realizes that the truth is that she is really doing well.

Chapter 18
63. What does Bergin now understand about Luke?
   Bergin understands that Luke hadn't known any other way to respond than to be hurt or to think that Bergin didn't care for him. She understands how a lack of the right words or how silence can twist the way a person sees.
64. How does Bergin see Dr. Cone on a regular basis?
   Bergin volunteers a few afternoons a week in the Discharge Department at the hospital.
65. How does Bergin feel while she is mowing on the tractor?
   The whole time Bergin is riding the tractor she feels happy.
66. What news does Miss Vicky have?
   Miss Vicky is going to have a baby.
67. What is the last paragraph of the book?
   "It's clear. They need me."

Vocabulary
This list is to give teachers guidance when working with younger readers or struggling readers. The teacher may choose to devise activities using this word list or may choose a few key words to use for vocabulary maps. For older or more advanced readers, the teacher may want to use words that deal with theme (such as isolation and resilience)

Part I

Chapter 2
forte
comatose
resilience

Chapter 3
dilapidated
Chapter 4
admonish
discreetly
libidos
incessant
effusive
intricacies
postpartum
dissipated
colic
malady
disheveled
magnitude
impromptu

Chapter 5
sashayed
afflicted

Chapter 6
menagerie
earnestly
authentic
volatile
palpable
inadvertently
amenable
manipulative
buoyant
serenity

Chapter 7
retaliation

Chapter 8
mirth
effulgent
nonplused
exuberance
nemesis

Chapter 10
angst
Simile or Metaphor?

Directions: Read the following examples of figurative language taken from The Turning Hour. Label each as either a simile or a metaphor and identify the two things being compared.

1. The ground was like chewed gum from a recent rain.

2. Before then we were certainly as severed and distant as two clocks keeping time in separate rooms.

3. My dad memorized nursery rhymes the way he ate beer nuts, nonstop and with little effort.

4. Why, why running through my mind like the drip from a broken faucet.

5. He and Dylan were up in this tree standing on a platform-like thing… and it was ramshackled and probably about as sturdy as a loose tooth.

6. I had seen something happen between my mother and my father. Love got smashed, or lost, then died. Murdered, I guess you might say.
1. I can still recall her voice, jazzy and halting like a Latin band heavy with syncopated castanets.

2. At least I know that’s what goes through someone’s mind when they hear that a girl has tried to do a mean two-step with Saint Peter. Or to buy the farm. Or to cash in her chips.

3. The room smelled like chewed wooden pencils and skin on the verge of sweat.

4. My body was a mannequin that I inhabited from eight to two, that I then laid down on the bed to be refueled.

**Simile or Metaphor?**

**KEY**

1. Simile
   - the wet ground – chewed gum
2. Simile
   - a severed and distant relationship – two clocks keeping time in separate rooms
3. Metaphor
   - memorizing nursery rhymes – eating beer nuts
4. Simile
   - the question why – the drip from a broken faucet
5. Simile
   - an unsteady platform – a loose tooth
6. Metaphor
   - parents’ divorce – an act of murder
7. Simile
   - her voice – a Latin band
8. Metaphor
   - attempting suicide – a mean two-step with Saint Peter, buy the farm, cash in her chips
9. Simile
   - the smell of a room – wooden pencil and skin on the verge of sweat
10. Metaphor
    - my body – a mannequin

**Character Study Activities**

- Create a graphic representation of Bergin’s extended family. Be sure to include all three branches of her family.
- Choose one character and create a character map for that character. Include a physical description, the viewpoints of other characters, and at least one direct quotation from the character.
- Matching Characters with Descriptions

**SECTION I**
Directions: Read each quotation, and identify the character that is most likely to be associated with the quotation. You may use a character’s name more than once for an answer. Not all names will be used.

~ Characters~
Bergin Doug Talbot Luke
Leslie Vicky LaTour Simpson Bates
Jack Carl LaTour Richard Murphy (Hoot)
Kirby and Maggie Dylan Dr. Cone
Judge Bergin Carol Ann (coach) Mr. Whitstruck (teacher)
Leslie’s mother

Quotations from the novel:
1. Court is where I am comfortable. Court is where I follow the script that I have been trained to follow, where my anxieties fade, and I can fight like a man.

2. Usually he’d have on Janco jeans, big enough for two, and so long that when he skated, you couldn’t see his feet.

3. He was fifty-eight then, ramrod-straight like the dusty gray-haired cowboys in the movies of my childhood…Judge of nothing when it came to giving himself away.

4. Not one iota…if you know what I mean.

5. He claimed me in the first month of twelfth grade. He was on the football team. A follower in my father’s footsteps.

6. Yep, I got the best of both my mother and my father.

7. He has a buoyant outwardness, funny and high, ready to be “on” at any minute where being on is called for, and yet there’s a deep quiet sadness in the center of him.

8. He was a billboard you drove by everyday: well known, every inch memorized, its message clear and constant, yet existing at a distance.

9. There it was—that sound that was all hers, so explosive it was contagious.

10. Let’s just say, physical beauty is not my forte.

11. All of her nails were painted blue with sprinkly stars on them, and each of her fingers had a ring on it. Even her right thumb…The coolness of her fingers was still like touching ropes of modeling clay, smooth and damp.

12. He can draw about anything.
SECTION II

**Directions:** First, list the characters that were not used as answers in Section I. Then, choose two of those characters, and find a quotation from the novel that you think characterizes each one.

Characters Not Used in Section I

1.  
2.  
3.  
4.  
5.  
6.  

Character and Quotation

1.  

Character and Quotation

2.  

**Matching Characters with Descriptions**

**Answer Key**

Section I

1. Leslie  
2. Dylan  
3. Judge Bergin  
4. Vicky LaTour  
5. Luke  
6. Bergin  
7. Jack  
8. Doug Talbot  
9. Dr. Cone  
10. Leslie  
11. Simpson Bates  
12. Doug Talbot
Section II
1. Kirk and Maggie
2. Leslie’s mother
3. Carl LaTour
4. Carol Ann (coach)
5. Richard Murphy (Hoot)
6. Mr. Whitstruck (teacher)

Reading Group Guide
Shelley Fraser Mickle

The purpose of this Reading Group Guide is to help facilitate discussion of this novel. It was developed personally by the author. Discuss some or all of the points below for a fuller understanding of the story.

1. Of all the relationships that women have, mother-daughter relationships are among the most satisfying and most complicated. Bergin and Leslie have shared many challenges and special times as mother and daughter within their changing family. What makes their relationship typical of most mother-daughter relationships, and what makes it different?

2. Leslie’s father, Judge Bergin, was an extraordinary man—intelligent, warm, imaginative, and loving. In many ways he stepped outside the traditional male role. Do you think his being original and being so much a part of Leslie’s childhood led her to expect too much from the other men in her life? All the men in The Turning Hour are very different, and each relates to women in different ways. What does each of these relationships contribute to Bergin and Leslie’s sense of who they are?

3. Leslie’s mother had trouble with alcohol—which is usually associated with depression by either leading to the alcohol abuse or resulting from it—and Leslie herself experienced postpartum depression, which affected her relationship with her husband. Years later, does it seem that this history of depression affected Bergin and Leslie’s relationship?

4. What were the cultural influences that affected Leslie and Doug’s relationship? Bergin and Luke’s relationship? In what ways do cultural influences enhance relationships? In what ways do they complicate and harm them?

5. Suicide is a complicated issue. In many ways it always seems unbelievable. Yet 500,000 young adults a year attempt suicide, one every 1.5 hours. It is the third leading cause of death of young people in the U.S. Why is it so difficult for us to believe that a young person would want to commit suicide? Would it have been easier to believe that Bergin would have tried to end her life had she been less gifted, less beautiful, less accomplished?

6. Leslie comments on Bergin and her friends by calling them the Black Fabric Generation. Many young people today have publicly stated they feel hopeless. Are there pressures and problems for young people today that were not present in previous generations? Are today’s challenges more difficult to meet than the challenges of the 60s, 50s, etc.?

7. What was Bergin most afraid of losing? How did the loss of the relationship with Luke affect her relationship with her father, and her fears about it?

8. In this book, complicated concepts are explored that really have no one word to fully express them. These ideas and beliefs were what Bergin says were at the root of her reality, i.e., the way she saw the world. For instance, in the epigraph, the poem by Emily Dickinson, a mood
is likened to a certain slant of light. Which were your favorite metaphors and images used to impart meaning to these difficult concepts, and to express the feelings that Bergin was trying to describe?

9. What are the ingredients of Bergin’s resilience? Which of these did she have and where did she get them? Why weren’t these strengths working for her at the beginning of the book?

10. Do the writing styles that convey Leslie and Bergin’s voices also convey their personalities? Do the broken sentences of Bergin’s story enhance the sense of the state of her mind? Does it seem you are closely viewing her world with her, as if indeed you are inside her mind? Is literature perhaps the best art form to capture the way the human mind works?

11. The word “turning” is used metaphorically throughout the book: being turned back physically from death, the darkness Bergin did not know how to turn away from, the fact that Jack was the one she was turning to her darkest hours, etc.” Turning” implies movement and a connection with time. To what and to whom would you predict Bergin would turn in a future difficult time in her life?

The last few chapters of the book are viewed from the present and told in the present tense, rather than the past tense. Why do you think the author chose to tell the story this way?
### Benchmarks

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<tbody>
<tr>
<td>LA.A.1.4.2 Selects and uses strategies to understand words and text, and to make and confirm inferences from what is read, including interpreting diagrams, graphs, and statistical illustrations.</td>
</tr>
<tr>
<td>LA.A.2.4.1 Determines the main idea and identifies relevant details, methods of development, and their effectiveness in a variety of types of written material.</td>
</tr>
<tr>
<td>LA.A.2.4.2 Determines the author’s purpose and point of view and their effects on the text. (Includes LA.A.2.4.5 Identifies devices of persuasion and methods of appeal and their effectiveness.)</td>
</tr>
<tr>
<td>LA.A.2.4.7 Analyzes the validity and reliability of primary source information and uses the information appropriately.</td>
</tr>
<tr>
<td>LA.A.2.2.7 Recognizes the use of comparison and contrast in a text.</td>
</tr>
<tr>
<td>LA.A.2.4.4 Locates, gathers, analyzes, and evaluates written information for a variety of purposes, including research projects, real-world tasks, and self-improvement. (Includes LA.A.2.4.6 Selects and uses appropriate study and research skills and tools according to the type of information being gathered or organized, including almanacs, government publications, microfiche, news sources, and information services.)</td>
</tr>
<tr>
<td>LA.A.2.4.8Synthesizes information from multiple sources to draw conclusions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>course</th>
<th>Text(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA.E.2.2.1 Recognizes the cause-and-effect relationships in literary texts. [Applies to fiction, nonfiction, poetry, and drama.]</td>
<td></td>
</tr>
<tr>
<td>LA.E.2.4.1 Analyzes the effectiveness of complex elements of plot, such as setting, major events, problems, conflicts, resolutions.</td>
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</tbody>
</table>
## Instructional Validity Checklist
### For Writing Benchmarks
#### Assessed on FCAT
##### Grades 9-12

- Indicates Benchmark is tested on FCAT Writing
- Indicates Benchmark is tested on FCAT Reading

<table>
<thead>
<tr>
<th>Benchmarks</th>
<th>Content Reference</th>
<th>Date(s) of Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>L.A.B.1.4.1 - The student selects and uses appropriate prewriting strategies.</td>
<td></td>
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<tr>
<td>L.A.B.1.4.2 - The student drafts and revises writing that has focus, organization, support, and conventions.</td>
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<tr>
<td>L.A.B.1.4.3 - The student produces final documents that have been edited.</td>
<td></td>
<td></td>
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<tr>
<td>L.A.B.2.4.1 - The student writes text and notes that demonstrate comprehension and synthesis of content.</td>
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<td></td>
</tr>
<tr>
<td>L.A.B.2.4.2 - The student organizes information using alphabetical, chronological, and numerical systems.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L.A.B.2.4.3 - The student writes fluently for a variety of audiences and purposes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L.A.B.2.4.4 - The student uses electronic technology to gather information and communicate new knowledge.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DEVELOPED BY: Mary Anne Wagner
LIST OF REFERENCES


Alachua County Crisis Center (ACCC). (2004). *Alachua County Crisis Center Trainee Manual*. Gainesville, FL: Author


Doan, J., Roggenbaum, S., & Lazear, K. (2003). Youth suicide prevention school-based guide-Issue brief 3a: Risk Factors: Risk and protective factors, and warning signs. Tampa, FL: Department of Children and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Series Publication#218-3a)


BIOGRAPHICAL SKETCH

Patricia Xirau-Probert was born in 1972 in Miami, Florida. She is the youngest two daughters, and comes from an extended Cuban family. She earned her B.S. in early childhood education from Spring Hill College in 1994; and her M.Ed., Ed.S. in marriage and family therapy from the University of Florida in 1999.

After graduation, she began working at the Alachua County Crisis Center as a suicide prevention and crisis interventionist. In this role, she worked therapeutically with individuals, couples, and families; trained volunteers to work on the 24-hour crisis lines; and performed outreach services for the county. Patricia presently works at the University of Florida’s College of Dentistry as the Director of Student and Multicultural Affairs.

Patricia is married to Dr. Jim Probert, a psychologist at Student Mental Health in the University of Florida and is the proud mother of two beautiful boys, Dylan and Max.