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The Training and Evaluation of Crisis Line Volunteers in Suicide Prevention

Susan Jean Groat
Western Michigan University

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THE TRAINING AND EVALUATION
OF CRISIS LINE VOLUNTEERS
IN SUICIDE PREVENTION

by

Susan Jean Groat

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Master of Arts

Western Michigan University
Kalamazoo, Michigan
December 1975
ACKNOWLEDGEMENTS

In writing this thesis, I have benefited from the encouragement, advice, and constructive criticism of Professors Kathleen Lockhart, Frederick Gault, and Malcolm Robertson. My thanks go to them, as to the many interested in suicide prevention, who have given much needed help. The intellectual and professional training experienced under the supervision of the Department of Psychology has been a rewarding and stimulating experience. The responsibility for what is written here is solely my own despite the advice and encouragement received from those already mentioned.

Susan Jean Groat
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REVIEW OF THE LITERATURE

With the creation of the Los Angeles Suicide Prevention Center came the development of modern community crisis intervention. The LASPC was established in 1958 by the National Institute of Mental Health for the purpose of research on suicidal behavior. Increase of demand on staff time for clinical and research duties led to the use of closely supervised non-professional volunteers as crisis phone workers during the day (McCloskey, 1973). Trainees and graduate students took over the majority of patient contact by 1970 while the professional staff devoted their time to training activities by serving as supervisors and consultants of trainees. The professional staff also did research. The research covered a broad range of topics related to suicide and crisis intervention; examples of such research topics are the treatment of the chronic suicidal person and the prediction of suicide potentials (Farberow, 1970).

Pretzel (1970), who did most of the research in the training of volunteers at the LASPC, described the training and evaluation normally used as follows: The training was divided into three parts. Part I entailed giving trainees a didactic background in preliminary personality theory, theoretical concepts on suicide and self-destruction, letha-
lity assessment, intervention techniques, and the use of community resources. Practicum time entailed listening to tapes, role play, and case discussion. Part II entailed the trainee's taking calls under close supervision and then discussing the handling of the call with the supervisor. Part III consisted of weekly meetings of volunteers for the purpose of additional inservice training on theory and techniques. Pretzel's description suggests that except for the close supervision and personal evaluation in part II of the training and, despite the emphasis on research at the Los Angeles based center, there is no regular evaluation of volunteers beyond that of interviews and the Minnesota Multiphasic Personality Inventory administration during the process of selecting the volunteers.

The innovative Los Angeles Suicide Prevention Center set the pattern. The report of the successful use of volunteers along with the rapid development of community crisis intervention centers during the late 1960's and early 1970's resulted in a rapidly expanded use of volunteers in para-professional duties such as phone intervention. Regretfully, as the following descriptive examples reveal, many crisis centers, in developing their own training programs, adopted and adapted the negative as well as the positive aspects of the LASPC program. The positive training and close supervision aspects were adopted as well as the negative global, subjective evaluation procedure (McGee, 1971). The LASPC
researchers, however, were aware that thorough training evaluation was lacking. Heilig (1970) stated that research on evaluation by the following means was proposed for future concern: Written materials to evaluate training in terms of content such as those used in schools were to be developed as well as methods to evaluate clinical performance. The latter could be done by preparing written sample materials on which professional staff consensus is available. Comparison between the professional's and trainee's evaluation would be possible. Another method would be to have experienced clinicians evaluate the trainees subjectively.

Brockopp & Yasser (1970) described in detail the training and evaluation techniques used by the Erie County SPCS; the description, when paired with those of the Tuscaloosa Community Crisis Intervention Center (1973) and the Ottawa County Crisis Intervention Center (1974), gives an indication of recent developments in training and evaluation. The Erie County procedure was described as follows in 1970: Training entailed a description of the role of the volunteer and a confrontation of the volunteer's fears and expectations in handling crisis calls. Lecture-discussions were included on communication theory, the use of the phone as a therapeutic instrument, crisis intervention theory, suicide and suicide lethality, and resource and referral techniques. Experiential training included role play, presentation and discussion of models of therapeutic interviews, practice in completing
intake sheets, and observation of trained volunteers on duty.
Evaluation consisted of a review and criticism by his super-
visor on all calls handled during the first two six-hour
shifts worked (taping of all calls was a requirement). Mon-
itoring continued and after every two, six hour shifts an
evaluation would be done on a sample of calls.

The Tuscaloosa Community procedure was described as
follows by Stern in 1973: A reading, discussion, and critique
of the training manual which contained the basic theory and
procedural information made up the didactic part of the train-
ing program. Sensitivity training was included to foster
group cohesiveness. Role play, observation of experienced
volunteers, and the handling of crisis calls under supervision
followed by critiquing was also done. The role play and
crisis call critique served as the screening, evaluative
procedure. The demographic information regarding the length
of the call was also used in the evaluation as Stern assumed a
longer call would suggest the volunteer knew how to draw out
the caller, offer alternative suggestions, etc. The value of
this type of evaluation is open to debate.

The Ottawa County procedure was described as follows by
Pfeiffer in 1974: Information on suicide, depression, handling
feelings of anger and resentment, the art of referral and
using community resources, crisis theory and crisis counseling,
the mechanics of emergency services, plus a variety of crisis
problems such as drugs and venereal disease made up the didac-
tic portion of the training program. Experiential exercises consisted of role play, practice in giving and receiving feedback, and empathic listening. Evaluation included an assessment by the trainees themselves as to whether the training objectives had been achieved. Three trainers made independent evaluations of the trainees on fourteen traits and/or abilities that affect phone crisis intervention at the beginning, in the middle, and at the end of the training class.

A review of the methods of suicide-crisis intervention centers suggested that training of volunteers typically included basic concepts related to crisis intervention and suicide, recognition and evaluation of suicidal lethality, the use of the telephone and telephone techniques, and mobilization of resources and referral. Training techniques generally included a combination of lecture, discussion, role play, phone work while under supervision, and observation of staff during working hours. Other less commonly used techniques according to the McCord & Packwood survey of 253 crisis centers (1973) were sensitivity training, listening to tapes, and films. None of the techniques listed above were used by half of the reporting centers; the most common procedure, discussion, was used by only forty per cent of the centers and this was for an average of only six hours of the fifty hours devoted to training. Answering the phone under supervision and observing the staff during working hours, which were used by 33 and 32 per cent of the centers respectively,
accounted for the greatest average number of training hours -- at least nine hours each. A review of the training evaluation methods suggested that subjective techniques such as staff consensus, inpractice supervisory evaluation, and a critical review of taped calls were the most commonly used techniques.

A major weakness in the training format of many centers is an over-emphasis of the didactic training technique in training volunteers. Trainers use the traditional teaching methods of lecture and discussion and emphasize fact over application of information. Berman (1973) suggested that the ideal balance between the informational and skill training requirements are often overlooked. Those training programs which did include listening or empathy exercises used only role play or used sensitivity training as an adjunctive aspect of training. For example, sensitivity training was incorporated into the program merely to foster rapport among the volunteers quickly (Stern, 1973), not to aid the volunteer in developing his interactive, therapeutic skills.

Perino (1972) found integrated techniques of training consistently superior to lecture techniques with volunteers on the following five criterion measures: (1) Affective Sensitivity Scale, (2) two basic scales of the Personal Orientation Inventory, (3) Discrimination Index, (4) Traux Accurate Empathy Index, and (5) an achievement test.

There is a need for evaluation of training programs and intervention programs; this is reflected in standards set by
the regulatory boards across the nation. An example of this is the standard of the San Francisco Bay Area Suicide Prevention Centers (Motto, 1969, p.37) whose program evaluation standards reads as follows: "A formal evaluation must be carried out at least every two years as to goals, methods, and effectiveness of SPC program." The evaluation required actually refers only to program evaluation, but the requirement of training evaluation can be logically assumed as training effectiveness is a component of program effectiveness.

The importance of evaluation is further emphasized by the fact that governments require an account of program effectiveness before they will grant further money toward an agency's support.

A weakness indicated in the training evaluation literature was that volunteers were only rarely asked for their evaluation of the training program. The lack of inclusion might be due to the author's exclusion of the topic from analysis. Fisher's recommendation (1973) of the inclusion of the volunteer's own reactions to the effect and adequacy of the training program in the survey report, however, suggests that often the worker's evaluation is not sought. Fisher found that the workers desired more role playing, response technique exercises and information, detailed information on resources, and observation and feedback by the staff of the volunteer's handling of the calls. This evidence supports Berman's statement that training programs often lack experi-
ential relevance.

Berman (1973) also criticized many evaluation formats for using global criteria in which the objectives were not operationally defined. The use of a single, inexplicitly stated criterion in evaluation of a complicated set of tasks reduces the utility of the evaluation feedback information. Berman questioned whether any statement of effectiveness of the training, and the program as a whole, could be stated if the goals themselves were vaguely stated. The Ottawa County study (Pfeiffer, 1974) was the only study reviewed that indicated that training objectives had been written and evaluated. A scarcity of literature describing individual training programs and their evaluations in detail might explain this disappointing result. The Heilig (1970) article was one of the few surveyed that clearly indicated objective evaluation of the volunteers and training could be done. Notably, even Heilig's proposal for program evaluation was hypothetical.

The subjective critiques used as the means of evaluating trainees were often done with actual calls received by the center; therefore, the confidentiality of the caller became an issue of contention in training evaluation. The importance of confidentiality was reflected by its inclusion, for example, in the Bay Area standards as a concern, a concern on a par with qualifications of the staff. The minimal training standards also required an inclusion of ethical considerations with an emphasis on confidentiality (Motto, 1969). The Fisher (1973)
report on the survey of crisis prevention centers reiterated the confidentiality problem of taping calls for training or evaluative purposes; only eight per cent of the centers taped calls. Fisher also reported that the American Association of Suicidology presented a position paper against the use of tape recordings unless the caller was immediately informed and confidentiality of the tapes was maintained.

Confidentiality considerations, which make the current training evaluation procedures used by agency staff questionable, cause further complications when professionals outside the agency do the training evaluation. A multiple criterion approach, or use of more than one criterion to test or evaluate the training program by a professional outside the agency was an extremely difficult task due to the confidentiality requirement. Nelson & Grunebaum (1972, p. 1362) suggested, however, that "ethical pitfalls (could) be avoided by careful planning of experimental procedure" when they did research on the ethical follow-up studies. Careful planning of training evaluation could also be done. This training program was developed with consideration of the volunteer's reaction to the training and with an experiential as well as didactic focus in mind. The evaluative procedure used took into consideration research findings that indicated that judgmental policy equations obtained from judges of suicide lethality were equivalent for all conditions no matter how natural or contrived the conditions. This research suggested that stim-
ulation of calls and call information could be done effectively and correctly in analyzing training effectiveness (Brown, 1974). The use of contrived conditions would circumvent any ethical difficulties.

Dilley & Bowers' (1973) technique of offering taped problem samples and having the trainee listen to and evaluate the call could also be adapted for ethical training evaluation by an outsider. The critique of the trainee's helpfulness and concern for the client could be measured by a panel of carefully selected professionals and non-professionals individually. Dilley & Bowers' data suggested that there is not a significant difference in professionals' and non-professionals' ratings when the summary data, rather than the individual judgmental decisions within the evaluative task, were considered. The use of a written test plus practical tests adapting the above procedures should enable a valid evaluation of the training program despite confidentiality requirements.

The major purpose of this study was to research the development and evaluation of a training program by a professional not directly affiliated with the crisis intervention center concerned, despite the ethical procedural difficulties inherent in doing the evaluation. The training and evaluation procedures used for evaluation by those within the agency were surveyed so that effective techniques could be adapted for use in the "outsider" study. Those criticisms
commonly directed toward crisis intervention agencies evaluated by "insiders" were also taken under consideration so that errors could be avoided. A multiple criterion was used which included both subjective and objective evaluation. The objective was to evaluate the volunteers' ability to assess suicidal lethality, do preliminary evaluation of effectiveness in handling the suicidal crisis over the phone, and to increase the volunteers' confidence in their ability to handle suicidal calls effectively. All the evaluations were done or supervised by a professional not affiliated with the agency except for the purpose of training and evaluating a group of volunteers on suicide prevention. Developing procedures enabling evaluation of the training program by an "outsider" would enable comparison between agencies and aid in speeding the utilization of techniques found effective. A commonality in the evaluating procedure would foster a commonality in training procedures.
METHOD

Subjects

The subjects were nine volunteers and two staff of a telephone crisis intervention center located in Kalamazoo, Michigan. Most of the subjects were volunteers who had already had their initial crisis service training and had worked on the phone lines. All subjects volunteered. They learned of the inservice training class through a poster in the phone room and two notices in the weekly newsletter. The poster included a sheet which volunteers interested in being experimental subjects could sign to indicate their interest. Five volunteers and two staff were in the experimental group. The four control subjects volunteered to participate in the evaluation after receiving a phone call asking if they would be willing to do so. All crisis line workers who had not agreed to participating as an experimental subject received a call. Assignment to groups was not random due to the resistance predicted by the agency staff if this were done.

Apparatus

A survey form was devised and given to all volunteers to be completed. This form contained items concerning the
proposed content of the inservice training class on suicide prevention. The topics were included in a questionnaire because they were often mentioned in already existing training programs or concerned controversial information or corrected deficits in current training as indicated in interviews and the literature on suicide prevention. A sample of the survey form is included as Appendix A.

The training program necessitated the use or development of certain training materials. Three audiocassettes illustrating suicidal calls were used as samples of how such crisis calls could be handled. The response sheets that go with them aided training also. An audiocassette player was used to play the tapes. The tapes and response sheets were obtained from the Charles Press Publishers, Inc. A sample of the training format is included in Appendix B.

All the evaluative materials were especially devised for the inservice training class described in this study. The evaluation included the use of the following materials:

(1) A self-evaluation questionnaire.
(2) A test in which clues of suicide potentiality had to be identified.
(3) A test in which selection of pertinent facts and the assessment of suicide potentiality was required on three literature based cases presented on an audiocassette.
(4) A test in which the volunteers were to respond to and assess the suicide potentiality indicated in four literature based cases presented both audially and visually.

The evaluative material developed is included in Appendix C.
Procedure

The procedure entailed a series of steps to assure effective planning, presentation, and comparative evaluation of the training class.

Planning

A thorough reading of the literature, interviewing of the Directors of the Ottawa County, Michigan and Chicago-Read-Mental Health Centers' crisis lines, and interviewing of the suicide trainer and a volunteer were done. The information from these sources was incorporated into a questionnaire of proposed training segments that was given to all volunteers. The questionnaire enabled the volunteers to indicate their interest in and the utility of the proposed training segments. This questionnaire was to insure the involvement and cooperation of the volunteers. A copy of the questionnaire developed is included as Appendix A.

Objectives of the training class based on the questionnaire were devised so that the necessary evaluation materials could be planned. The class objectives were as follows:

(1) Significantly increase the volunteer's self-confidence in his ability to correctly handle suicidal callers.
(2) Significantly increase the volunteer's ability to identify clues for suicide potentiality.
(3) Significantly increase the volunteer's ability to respond effectively and helpfully to the suicidal caller.
(4) Significantly increase the volunteer's ability to correctly assess suicide potentiality.

Significant increase referred to a significant difference in
the means between pre- and post-training scores and evaluations. The significance of tenure differences in degree of improvement were also planned as part of the evaluation of training effects.

Evaluation

The self-selected volunteers were evaluated on the above objectives by a series of short, especially devised tests and a self-evaluation questionnaire immediately before the training class and two weeks after the training class. The evaluation began at nine on a Saturday morning. Before administering any tests or the questionnaire, the experimenter explained that the evaluation materials were devised to determine the effectiveness of the training, not the individual members. The subjects were encouraged to respond frankly on the various items so that any changes in responses due to training could be correctly assessed.

The questionnaire which included seven self-evaluation questions and a general written self-evaluation comment was administered first. This assured that responses would not be influenced by the difficulty or easiness of the tests but only by their opinion of self-confidence in handling suicidal calls. The subjects were allowed fifteen minutes to complete the questionnaire. After ten minutes, they were asked if they were done. If all were not finished, an additional five minutes were allowed for completion.
The first subtest required the subjects to indicate which of the twenty items were clues for suicide potentiality. The items were selected because of their presence on the Suicide Potentiality Scale developed by the Los Angeles Suicide Prevention Center or myths concerning suicide which suggested the item might mistakenly be considered a clue. Five minutes were allowed for completion of this subtest.

The second subtest consisted of a series of three case histories recorded on an audiotape. All three cases were adapted from *A Panorama of Suicide* by Niswander, Casey, and Humphrey (1973). The subjects were required to indicate whether suicide potentiality was low, moderate, or high and to list as many of the significant details they thought important that they would normally use in assessing potentiality and devising a treatment plan. The subjects had ten minutes to complete the two tasks on each of the three cases. Three experts or persons who were either directors of a crisis line, had extensive experience working with suicidal callers, or had done extensive reading on suicide potentiality determined the correct rating of the suicide potentiality in the cases independently. The scoring base of all three experts was the Los Angeles Center's Suicide Potentiality Scale. The scoring of selection and notation of pertinent details was done by simply counting the number of details listed that were significant. Significance was indicated through the presence of similar details on the LASPC Suicide Potentiality
Scale.

The third subtest consisted of a series of four case histories recorded on an audiocassette. The histories were also printed on the answer form. Three of the cases were adapted from A Panorama of Suicide by Niswander, Casey, and Humphrey (1973). The fourth case was adapted from The Realization of Death by Weisman (1974). The subjects were required to indicate the degree of suicide potentiality. Correctness was determined as indicated for the preceding subtest. The second task entailed the subjects writing what their response to the caller would be and the things that came to mind while listening to the caller. Three judges independently rated these responses after listening to the tapes, identifying themselves with the caller, and reading the response the test taker made. The judges rated the subject's understanding of and care for the caller on a 5-point scale and the helpfulness on a 4-point scale. The judges were a previously suicidal person, a mental health professional who also worked as a crisis line volunteer, and a non-suicidal adult. Fifteen to twenty minutes were allowed for each case. After the initial fifteen minutes, the subjects were asked if they had finished the task. If anyone had not, an additional five minutes were allowed for task completion.

Training

Fifteen minutes after the tests were completed the train-
ing class began. The order of the training was as follows:

(1) Role of volunteer and volunteer's limitations (lecture and discussion).
(2) General information on suicide (lecture and discussion).
(3) Experiential exercises.
(4) Assessment of suicide potentiality (lecture, discussion, and hand-out).
(5) Three training audiotapes.
(6) Techniques for handling manipulative and repeat callers (lecture and hand-out).

Appendix B includes a detailed description of the information and sources of the training materials. Training ended at five in the afternoon; there was an hour break for lunch and two fifteen minute breaks.

Post-training evaluation

Appendix C includes a copy of the evaluative questions and subtests and answer sheets used. Administration of the follow-up tests two weeks after the training class was as described above for the initial administration. In each case the evaluative questionnaire included information concerning the amount and degree of experience as a volunteer and handler of suicidal calls at the crisis center. Each subject was assigned a number so that the identity of the test taker was unknown when the scoring was done. The follow-up test number was assigned randomly in the order of arrival for completing the follow-up test beginning with the number plus one of the last pretest subject. At the conclusion of the second testing, all subjects were given an opportunity to evaluate the training and evaluation procedures.
RESULTS

Treatment Effects on Testing

Differences between the pre- and posttest scores were analyzed for both the control and experimental groups. The analysis, using t tests, was done on the five subtests both individually and collectively. Significant findings existed with only the experimental subjects, who participated in a training program on information and skills included in the various subtests. These significant findings were found with subtests 1 and 2 and the composite of all five subtests at either the .05 and .01 level. Significant findings were not found with the control subjects who did not participate in training, but merely underwent testing twice. Table 1 indicates the degree of change between the mean scores of the two testings.

A two-by-two analysis of variance with unweighted means was used to test for significance in the difference scores as affected by tenure and treatment group effects. Difference scores were derived by subtracting the posttest score from the pretest score so that comparison of treatment effects would be possible with non-randomly assigned subjects. The analyses were carried out on the five subtests individually and collectively. Significant differences were not found at

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the .05 level between subjects with seven or more months tenure and subjects with less than seven months tenure as a volunteer at a crisis center. Seven months was used as the cut-off point because the Kalamazoo volunteers' tenure was generally either of two to six months or of two or three years duration. Seven months was a central and logical cut-off point.

Despite the lack of significant tenure effects, a significant difference due to treatment effects did result. A significant F value was obtained at the .05 level between the difference scores of the experimental and control subjects on subtest 3, rating of suicide potential. Table 2 lists the findings of the analysis of variance across the five subtests for tenure and treatment effects.

Intercorrelations of Results of Tests

Significant correlations were not found among the five subtests. Four of the subtests evaluated a distinct skill in handling and evaluating suicidal calls and one of the subtests entailed self-evaluation of effectiveness in handling the suicidal call. Table 3 indicates the percentage score each subject achieved on the five subtests individually and collectively. The scores on both the pre- and post-tests are indicated separately by a test number and the letter "E" (experimental subject designation) or letter "C" (control subject designation) in Table 3. The original scores were converted to a scale of one-hundred with one-
Table I

$t$ test Results for Significant Differences because of Treatment Effects on Experimental and Control Subjects

<table>
<thead>
<tr>
<th>Tests</th>
<th>Experimental</th>
<th>Control</th>
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<tbody>
<tr>
<td>1. Self Rating</td>
<td>3.75*</td>
<td>.675</td>
</tr>
<tr>
<td>2. Suicide Clues</td>
<td>2.76*</td>
<td>1.0</td>
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<tr>
<td>3. Suicide Potential</td>
<td>.795</td>
<td>.509</td>
</tr>
<tr>
<td>4. Pertinent Clues</td>
<td>1.216</td>
<td>.859</td>
</tr>
<tr>
<td>5. Call Handling</td>
<td>.285</td>
<td>.827</td>
</tr>
<tr>
<td>All Tests</td>
<td>3.928**</td>
<td>1.143</td>
</tr>
</tbody>
</table>

$df = 6$  
$df = 3$

*two-tailed, $p < .05$

**two-tailed, $p < .01$
Table II

Two-by-Two Analysis of Variance with Unweighted Means F Values Difference Scores between Pre- and Posttest Results across Treatment and Tenure

<table>
<thead>
<tr>
<th>Tests</th>
<th>1 Treatment</th>
<th>2 Tenure</th>
<th>Treatment X Tenure</th>
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<tbody>
<tr>
<td>1. Self Rating</td>
<td>.2619</td>
<td>.0864</td>
<td>0.0</td>
</tr>
<tr>
<td>2. Suicide Clues</td>
<td>4.487</td>
<td>1.381</td>
<td>4.019</td>
</tr>
<tr>
<td>4. Pertinent Clues</td>
<td>.0001</td>
<td>.1178</td>
<td>.0477</td>
</tr>
<tr>
<td>5. Call Handling</td>
<td>.7271</td>
<td>.4726</td>
<td>1.174</td>
</tr>
<tr>
<td>All Tests</td>
<td>1.239</td>
<td>.287</td>
<td>.0742</td>
</tr>
</tbody>
</table>

* p < .05
hundred as the highest possible score. Table 3 also indicates the inter-correlation of the five subtests.

Training Inclusion Questionnaire

Analysis of the planning questionnaire results supported the decision to include all of the training activities listed on the questionnaire. The analyses were carried out on an interest and utilitarian basis. The means were determined on all activities across those volunteers that completed the questionnaire; approximately one-fourth or twelve of the volunteers responded. The means ranged from 3.2 to 4.4 on the interest scale and from 3.1 to 4.1 on the utility scale. On a scale of one to five with one as low and five as high value, the interest and utility ratings were moderate to high moderate. Utilitarian ratings were slightly lower than the interest ratings.
Table III

Percentage of Total Possible Correct on Suicide Tests and their Correlations with one another

<table>
<thead>
<tr>
<th>Test Results</th>
<th>1 Self Rating</th>
<th>2 Suicide Clues</th>
<th>3 Suicide Potential</th>
<th>4 Pertinent Call Clues</th>
<th>5 Handling</th>
<th>Total</th>
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<tr>
<td><strong>PRE</strong></td>
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*two-tailed, p < .05
E = Experimental subject
C = Control subject

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DISCUSSION

Evaluation of the scores provided evidence that training results in changes on tests especially devised to determine volunteers' skills and confidence in handling suicide calls. The change is not significant on all tests, but does indicate a significant increase in self-confidence, ability to identify suicide clues, and an overall ability to handle suicide calls after training. A significant improvement or change might not occur on each individual subtest but the change may approach significance. When averaged with those changes that are significant, results approaching significance may make the composite results of the five subtests significant. The pattern of no significant change in any of the tests for the control group supports the conclusion that change occurred because of training and not because of a second exposure to the test.

Comparison between the scores of the experimental and control subjects on the pre- and posttest was not possible due to the non-random assignment of subjects to the experimental and control groups. Equivalence of the subjects in the two groups is questionable as assignment to groups was done by the subjects themselves. However, a two-by-two analysis of variance enabled evaluation of tenure and treatment effects by analyzing the differences between the pre- and
posttest scores across these factors. Significant tenure effects were not found for any of the subtests or the composite of the subtests. This negative finding suggests tenure need not be a consideration when determining the ideal time to administer the training and testing program. It is particularly important to note that, when averaged across subjects, tenure differences were not found in how volunteers rate themselves on confidence and suicide call handling. Ordinarily this finding would suggest tenure does not significantly effect self-confidence. However, the Kalamazoo crisis line volunteers' experience with suicide calls is limited. Of the approximately 550 crisis calls received a month at the crisis center, only twenty pertain to suicide. Limited experience with suicide calls despite tenure variations may explain the non-significant findings.

The comparison between the treatment groups difference scores resulted in a significant finding at the .05 level on Test 3, correct judgment of suicide potential. Scores of both treatment groups improved, but the greater improvement in the control group's mean score merits explanation. Probable cause of the control group improvement is found in the patterning of the individual scores. Several of the experimental subject's posttest scores did not differ from the pretest scores, whereas the control subjects had large score changes in both directions. In fact, the control subjects' difference scores had a 58-point variation. A small sample
size in both treatment groups, particularly the control group, when paired with several extreme scores results in a group mean which may not reflect the true patterning of scores. A partial explanation of the experimental subjects' inattention during training and the resultant small change in scores may be found in the challenge of the utility of assessing suicide potential. Lack of significant differences between the control and experimental groups on the other four subtests and on the composite of the subtests suggests the mean change of the scores on those tests are similar.

Lack of correlation of test scores to each other suggests each test might measure a separate aspect of working effectively with a suicidal caller. Notably, even the self-confidence rating did not correlate significantly with the other tests. This would suggest that no one aspect of dealing with a suicidal caller predominates in determining whether a person feels confident in handling such a call. General informational background and past training seem most pertinent in determining confidence level, however, because the experimental subjects who received additional information and training significantly improved their self-confidence ratings.

The discussion of strengths and weaknesses by the subjects clarified the results of the experiment. The most outspoken criticisms of the testing format concerned the necessity of retesting and of including audio test materials that had little or no tonal variation and affect. The first of these criticisms explains, in part, the poor attendance for
the second testing. The criticism was based on the premise that the control subjects gained nothing through taking the test a second time. There was an attrition of experimental subjects from eleven to seven; the number of control subjects decreased from fourteen to four. The sizable control subject attrition, particularly, related to the flat tonal affect aspect of some of the test items. Explanations of the importance of content as well as affect did not change the attitudes of some of the control subjects toward the test material. Some of the control subjects repeated this criticism several times during the initial testing. Resistance to content emphasis during the inservice training may have occurred due to affect emphasis during the initial training of the Kalamazoo crisis line volunteers. Difference in emphasis may have contributed to the attrition. If attrition had been less extreme, the results of the significance tests would have been more meaningful as extremely high or low scores would have had less effect on the significance of the \( t \) and \( F \) tests.

An important variable in this experiment was the attitude of the subjects toward the training materials. A repeated questioning of the necessity to determine suicide potentiality during the training suggests that a questionnaire technique will not necessarily result in correct attitudinal feedback. Those participating in the training may differ significantly from those that respond to the questionnaire. The comparative non-involvement of those responding to the
questionnaire may result in favorable ratings which would not result otherwise. It is important to impress these volunteers of the necessity for accurate assessment and complete cooperation in every stage of the development, training, and assessment of the suicide training program. Cooperative involvement of the agency's staff and volunteers is a necessity. Cooperation may be facilitated if the initial evaluation of the training and evaluation technique is done by a professional affiliated to the agency in question.

The results suggest that volunteers of a crisis line can be evaluated by a written test format but that there are several problems involved in such a procedure. There may be effects on the scores because of training, but a group size of ten or more in both control and experimental groups would be preferred to determine this training effect. The groups should preferably be of equivalent size. Equivalent group size would insure comparative degrees of freedom, and even with small samples equivalence of interpretive meaning would be more assured. Random assignment of subjects to groups is a necessity if accurate evaluation of between group treatment effects is to be done. The experimenter must have complete control over research procedure so that compromise of research standards would be minimized.

The training preceding the posttest should be thorough and unhurried so that all information may be stated explicitly in the manner preferred by the trainer. A carefully paced
training schedule would increase the probability that all material included on the test was covered thoroughly. The schedule would insure a more effective measure of the test's worth as a determiner of the volunteer's skill and information level. The unhurried schedule would also increase the probability of greater rapport between the volunteers and the trainer and, thus, decrease and/or minimize attitudinal effects on the results. The development and inclusion of an attitudinal scale towards the major test premises with a breakdown of the ratings by tenure, self-confidence, and training could be included to determine the relationships of the variances of these measures. The worth of the written assessment procedure must be retested several times and correlated with the assessment of the training and/or professional staff at several agencies before its worth and utility as an assessment device is assured.

It is important to obtain feedback on the effectiveness of the assistance obtained from the crisis line by those that have used it, the client population. Appendix C contains evidence which suggests the client may have higher standards of service than the volunteer. The volunteer may tend to overrate his empathy and effectiveness.

The principle criticism of the training program made by the experimental subjects concerned the content of call emphasis. A smooth blending of procedural techniques and practice with the information could make the informational
emphasis less obvious. Instead of offering the information orally, a greater emphasis should be placed on utilizing written hand-outs. Usage of hand-outs enables economical information highlighting procedures which increase the opportunity for trainees to participate by offering their own ideas and opinions. Participation of the trainees could be increased by asking opinion questions which could be discussed and/or debated.

One question worthy of debate within the Kalamazoo crisis center inservice class was the role of affect assessment in handling suicide calls. The Kalamazoo center's emphasis on the importance of affect, as evidenced in their training program, is a possible bias source on the subtest requiring assessment of suicide risk. A brief inclusion of the role of affect, as well as information, may mediate the bias effect for an agency with a similar training history.

The worth of the training package would be increased by an addition of information and technique on practices particular to each individual agency. Such additions might include referral and definition of the agency's service policy which, although important, cannot be defined in a training package developed outside that agency. Oversights of the program package could be pinpointed by the inclusion of an evaluation of the training by the trainees in discussion or written format. Successful adaptations to correct the faults could, therefore, be facilitated. The training pack-
age includes the information needed to facilitate the successful and confident handling of suicide calls, but the communication of such information and techniques must be refined to increase participation of the trainees. Motivation of the subjects during training must be improved so that attention and learning is improved; a slight modification of the teaching technique may aid in improving motivation.

Keller (1968) offers several general training suggestions which, with the suggestions offered in the preceding paragraph, could be adapted to improve the inservice instruction. Use of short quizzes after a unit on suicide information or technique could encourage attention as well as assess readiness for other less basic training segments. Perhaps material such as the experiential exercises, which trainees find highly entertaining and informative, could be earned by passing quizzes on materials and information less readily understood and appreciated. If inservice training is offered in weekly meetings, a unit of training and a readiness, attention insuring quiz could be administered at the meeting. Content and format of the next meeting could depend on the current meeting's quiz results. Keller's technique of quizzing and earning unit lessons would insure attention and foster more effective training.
BIBLIOGRAPHY


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APPENDIX A

Suicide Training Class Questionnaire
Suicide Training Class Questionnaire

Duration of time as crisis line volunteer ____________

Approximate number of suicide calls you have personally handled ____________

Although I have interviewed several of the staff and volunteers, I wish the class to be as beneficial as possible to the volunteers for which it is planned. Therefore, I would appreciate it if each volunteer would complete the questionnaire which aids me in evaluating what material should be covered in the inservice training.

There are two evaluative questions for each proposed topical subject. The first enables me to determine your interest in the topic and the second enables me to determine the degree of value or aid the topic will be in your volunteer work.

1. Training record with five recordings of actual suicidal-operator phone conversations and analysis of the calls that will enable the class to experience and learn some phone techniques that highly experienced workers have used with suicidal callers (and suggest some techniques you may want to incorporate).

   1  2  3  4  5
   low interest  moderate interest  high interest

   1  2  3  4  5
   low utility   moderate utility  high utility

2. Information concerning assessment of suicidal potentiality by past history and characteristics of caller.

   1  2  3  4  5
   low interest  moderate interest  high interest

   1  2  3  4  5
   low utility   moderate utility  high utility
3. Volunteers in class role play several times how they believe a suicidal person feels while another volunteer role plays as the operator who received the crisis call.

   1  2  3  4  5
low interest moderate interest high interest

   1  2  3  4  5
low utility moderate utility high utility

4. General information concerning suicide -- its prevalence, characteristics, forms, myths, etc.

   1  2  3  4  5
low interest moderate interest high interest

   1  2  3  4  5
low utility moderate utility high utility

5. Role and limitations of volunteer in handling suicidal callers.

   1  2  3  4  5
low interest moderate interest high interest

   1  2  3  4  5
low utility moderate utility high utility

6. Currently there is some question as to the success of crisis suicide prevention. Some information concerning this controversy -- who does or does not use the crisis center and why or why not -- could be related.

   1  2  3  4  5
low interest moderate interest high interest

   1  2  3  4  5
low utility moderate utility high utility

7. Description of techniques for testing out suicidal intention.

   1  2  3  4  5
low interest moderate interest high interest

   1  2  3  4  5
low utility moderate utility high utility
8. Techniques for handling manipulative and repeat suicidal callers.

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Describe and evaluate any other topics related to suicide that you feel would be helpful or interesting that I did not include on the questionnaire on the back of the sheet.

The class would probably be more beneficial to the volunteers if an interested, willing volunteer would help me explain the practical applications of the information, etc. If interested in helping, please give your name and number (phone) below. One or two short meetings before the class will be necessary.

--- After completing the questionnaire, please put it into Jared's mail folder. Thank you for your help. Hope to see you in class.

Susan Groat
APPENDIX B

Training Class Information
ROLE AND LIMITATIONS OF THE VOLUNTEER

The volunteer phone worker has an important role in the therapeutic community; he is the resource person, the contact person, of the individual in crisis who in his emotional discomfort feels abandoned and in need of reassurance. The caller's ambivalence must be swayed so that the desire for life dominates (Fisher, 1973). One of the major advantages of crisis centers is that they offer easy access to counseling services when other mental health agencies are closed — at night and on weekends. It is the phone volunteer who makes this service possible as he can provide inexpensive service that will often succeed in getting the caller through the initial crisis. Without the volunteer, there would not be enough manpower to man the phone lines.

Pfeiffer, the director of a crisis intervention service, in a recent interview (1975) described the role of phone volunteers in Ottawa County, Michigan as follows: "They are professional crisis counselors for they are the most qualified persons in their community to service the phones. They are better than professional, paid mental health workers and police because they are unpaid and, thus, are less threatening. There is less stigma in contracting the volunteer than the professional so more people will call. The volunteer must demonstrate effectiveness and follow the ethical standards of the professional but also must come across as a friend."
over the phone, a friend who listens and empathizes."

Some might question why actual friends and family of the suicidal person could not sway the caller in favor of life. The answer is that they, the friends and family, are too close to the caller emotionally. The situations which make suicide seem feasible to the suicidal caller most likely involve the friends and family directly. The proposed helpers, themselves, are emotionally uncomfortable and anxious. They are unable to respond with the comfort and support the suicidal person needs. The trained volunteer, although empathetic, can retain the emotional distance required if he is to objectively listen, evaluate, and plan a treatment course either by suggesting an alternative coping technique to suicide or referring the caller (Fisher, 1973).

Brockopp (1970) of the Erie SPCS emphasizes the necessity of retaining an objective, professional, therapeutic approach to phone work, of not allowing the call to degenerate into a friendly conversation. He warns volunteers to be aware of the conversational trend, especially when dealing with a chronic caller or a caller who has talked with them before. The conversational call must be avoided for the following reasons: (1) It reduces the probability the therapist will be objective. (2) Any confrontation will be in terms of personalities and not the caller's confrontation of self with his own thoughts and behaviors. (3) Conversation
may reduce anxiety but not encourage a therapeutic change. (4) The crisis center is supposed to be a place in which therapy occurs; the inexperienced caller may develop misconceptions about therapy which would slow progress when actually in a therapeutic situation. As McCloskey states (1973), it is important for the volunteer to be aware that ritualized handling of calls may be more harmful to the callers than not receiving any help at all. The volunteer has the task of maintaining a personalized, empathetic phone relationship in which objective listening, assessing, and planning may occur.

Sebolt (1973) goes beyond describing the volunteer's role as one of making quick and accurate assessments of suicidal risk and of making resources available. The role is also nontraditional in that problems are solved together by mutual agreement without the volunteer-therapist adopting a "follow me and do as I say" attitude with the caller. The phone volunteer also serves as an active, involved living example for the caller. He reflects the emotions that the caller reveals to him but also expresses his own feelings in a controlled manner; the volunteer reflects reality. Any personal experiences which relate directly to what the caller related may be shared and serve as an example as to how the volunteer coped in a similar situation. The volunteer's technique, his own feelings of security and confidence as reflected in his voice and words, serve as examples
to the caller of calm handling of problems. The volunteer's openness in expressing his fillings and ideas encourages an equivalent openness on the caller's part. The volunteer is also aggressive, especially with the suicidal caller, who may require direction if he is to survive the crisis. To be most effective, the volunteer should be flexible, able to adapt quickly to differences in various caller's reactions and to adapt himself to the pace of each caller.

Suicidal situations involve a caller's debate within himself between the choices of life or death. It is natural for the volunteer who is aware of the import of his role with the caller to become anxious. He becomes concerned as to whether he is competent enough to handle the crisis situation correctly. The concern can be almost entirely relieved by having thorough training in suicidal theory and methods. The other major reducer of anxiety is practice or actual experience with suicidal calls. The volunteer should combat the excessive anxiety by recalling the following points of Frederick and Resnick (1970): (1) "(He) must realize that no treatment . . . guarantees the patient against suicide;" and (2) "must maintain his equanimity by reminding himself that death is inevitable for everyone . . . " (p. 105). Furthermore, when wondering if the call was handled correctly or if he should blame himself for the death of the suicidal caller, the phone volunteer should remember that if nothing had been ventured, nothing could have been gained. The volunteer must,
at least, make an attempt to help; if he does not, he definitely is a failure as a crisis phone worker (Schulman, 1972).
Sources for information on the volunteer's role and limitations were as follows:


GENERAL INFORMATION OF SUICIDE

Suicide is a broader range problem than even its statistics suggest. The best of the statistics from a number standpoint state that suicide is the tenth leading cause of death in the United States. The definition states that "Psychologically, suicide can be viewed as escape behavior resulting from the interaction of the individual's inner emotional makeup with external stress or extreme social pressure." (Reese, 1972, p.220). The definition like the statistic, seems to be exact, but if one examines the implications, vagueness as to the magnitude of the problem is discovered. The escape behavior referred to is self-destruction. This terminology is the crux in defining the scope of suicide in the United States. Self-destruction could include not only self-inflicted bullet wounds, but also drug overdoses, alcoholism, accidents, or any act which negates life-continuing action.

Because it is an action against life, one might assume that suicide is an act contemplated and carried out predominately by the adults in situations of undue stress. This is not the case; suicide occurs more frequently in those below age twenty-five than one might suppose. Suicide is reported as occurring rarely between the ages of five and fourteen. Between the ages of fifteen and nineteen, the death rate jumps from 1 per 200,000 to 4 per 100,000 deaths. Between
age twenty and twenty-four, the latter figures doubles to 8 per 100,000, only 3 per 100,000 short of the national suicide rate of 11 per 100,000 for all ages. When one considers that youth die less from illness than the older population, it becomes evident that the younger population significantly participates in suicidal activity. The suicidal statistics are significant because other causes of death occur less frequently in the younger population (Berg, 1972).

Further evidence of the prominence of suicide in youthful death is revealed in the ranking of suicide as a leading cause of death. Suicide is the third most common cause of death for those between the ages of fifteen and nineteen with only accidents and cancer causing more death (Yahraes, 1972). Suicide is the second leading cause of death for college students; only accidents lead to a greater number of deaths (Knight, 1968).

The method of death through suicide varies with sex and age. Statistics collected by the Bureau of Vital and Health Statistics during the years 1950 to 1964 reveal that firearms and explosives are used as the means of death in 48% of all suicides. The following are the other three most frequent means of suicide in descending order: Hanging and strangulation, poisoning and drugs (usually barbituates), and gas fumes. Generally, it is found that males use the violent means of death; one explanation for this is that males are stronger physically. Females use the less violent means from which
rescue is more likely. Karen Westenkow (1972) suggests that beauty is a concern for females even in death and this influences the means of death. These sexual differences in method of suicide do not hold true for those who commit suicide under the age of fourteen. It is only after puberty and sexual identification of behaviors that adolescents follow the adults in choosing a method of suicide seemingly related to their sex identification (Winickoff & Resnik, 1972). This suggests to me that factors related to sex role identification, such as strength or concern over beauty, determine the means of death in suicide.

Suicidologists suggest that the under-reporting of suicide may be as high as 200% (Berg, 1972). Kiell, as reported by Levition in an article (1972), suggests "hidden suicide" may result because families deny that the deaths are suicide. Instead, the families perceive the death as accidental so they can avoid the stigma and guilt of suicide. The coroner, himself, can have difficulty in determining whether death is accidental or suicidal because motive after-the-fact is not always unequivocally understood unless an obvious sign like a suicide note is left by the deceased. New York health officials further support the hypothesis that accidents can, in reality, be suicides by making the following estimates: 10% of all fatal traffic accidents and 15% of all home accidents (usually poisoning) are suicide attempts.

Further study and theorization complicates the matter of
determining the extent of suicide; when defined as self-destructive behavior, suicide can include victim-precipitated homicide. There is ample evidence that murder occurs in which the victim, per reports from witnesses and defendants, first started the aggressive assault with the murder weapon and then provokes the defendant into killing him with the weapon. One example of this may be when the husband starts a fight with his wife, threatens her with a knife, has the wife gain possession of the knife, and then obliges the wife by slapping her after she says, "One more slap and I'll stick you with this knife." In the victim-precipitated homicide, the victim commits suicide by having another person do the act after he sets up the situation. Usually, the person who commits suicide in this manner is a member of the lower class which considers physical aggression normal acting out behavior. He utilizes that pattern of aggressive acting out to accomplish his suicide and to arrange that the murderer, who is treating him in such a way that death is desirable, gets punished by society and he, the victim, accomplishes his goal of dying (Wolfgang, 1968).

Victim-precipitated homicide is only one example of a method of dying included in suicide when suicide is defined as self-destructive behavior. A classification system of the role an individual plays in his death may help clarify the extent of suicide. Death can be broadly classified as either intentioned, unintentioned, and subintended. Intentioned
death is death in which the individual plays a direct and conscious role in his own demise; this is the classification the general population would state includes all those who commit suicide. Most easily identified is the death-seeker who after a life-versus-death debate decides he wishes death and acts upon this wish. Another example of intentioned death is that of the death-initiator who knows that he will die soon (whether in prison on death row or in the hospital of terminal illness) and wishes to dominate, not surrender to death, by initiating it himself. The death-ignorer is the person intent on death who kills himself while denying the finality of death. He believes that he will transcend death and start an afterlife. The last type of person intent on death is the death-darer who disregards his lack of skill and does a dangerous act despite his very low probability of survival. In summary, the four types of intentioned death are those of the death-seeker, death-initiator, and death-darer (Shneidman, 1972).

The unintentioned and subintended death probably are not considered related to suicide by the layperson, but they are correct in this assumption only in regards to unintentioned death. The two prominent types of unintentioned death in which the decedant plays no role in effecting his death are the death-postponer and death-disdainer. The death-postponer is the typical adult who believes death will come but hopes it will be decades away in the future. The typical
child is a death-disdainer who believes the cessation of all vital processes has nothing to do with him; he will live forever (Shneidman, 1972).

In contrast to unintentioned death, subintended death or the unconscious hastening or one's demise is suicide related. There is the death-chancer, very similar to the death-darer, who gambles with death but has a greater likelihood of surviving. This person may be somewhat skilled, for example, in stunt driving and do tricks which entail a chance of death if concentration, automechanisms, etc. are not one-hundred per cent accurate. The death-hastener neglects his physical health by having a hectic life style or not following a doctor's orders; he could, if he tried, prolong life indefinitely but prefers to pursue Epicurean delights. The death-capitulator is rare in our society among the highly educated, in that, the capitulator psychologically wills his own demise by believing in another person's power to effect his death. The death-experimenter does not consciously seek death but does seek the sleep or befogged state caused by death or alcohol that is not totally unlike death. Self-destructive behaviors include a wide range of activity that leads to death; identifying the person desiring his demise is as complicated as defining self-destructive or suicidal behavior (Shneidman, 1972).

Further examples or descriptions of people with a life style that disguises a subintended suicidal behavior pattern are the addict (death-experimenter or death-hastener) and the
accident prone individual (death-chancer or death-darer). The addict, particularly the drug or alcohol addict, may wish to be in a state resembling death. When depressed or in a state of emotional upset, he will take the drug to calm him and escape from life's troubles. If he continues to use drugs as an emotional crutch, he may eventually take an overdose with fatal results. The coroner may state the death was caused by an accidental overdose, but this is a euphenistic way of stating it. Alcohol dependency may cause death through accidents and general neglect of body needs as well as alcohol related physical illnesses such as cirrhosis of the liver. Overeating and overworking are other forms of addiction that may be hidden suicide. In both of these cases, neglect of body health and care may lead to death by heart attacks, etc. The hidden suicide aspect may be relevant if the addictive behavior continues despite warnings for health reasons from doctors. The accident-proneness or repetitive courting of disaster may indicate suicidal tendencies when behaviors like drunk driving and self-poisoning persist. Usually such a pattern would start at an early age with the child using the accidental injury as a way of getting attention from parents; it is a reaction to pathological conditions in the home (Meerloo, 1968).

There are many traditional beliefs concerning suicide, its causes, and its management which are myths rather than fact (Pokorny, 1968). A brief statement concerning these myths and their flaws is relevant as these misconceptions
may lower the effectiveness of the volunteer when he interacts with the suicidal caller.

Common myths about suicide in general are as follows:

(1) People who talk about suicide won't commit suicide. Evidence indicates that 60 to 80% of those who commit suicide communicate their intent to others. A person's sudden ceasing to talk about suicide is also noteworthy as this may indicate he is about to take action on his threats. (2) Suicide happens without warning. The suicidal person indicates his inclination. The statement may be subtle and indirect, but if asked, he will confirm the tendency. Asking a person if he is suicidal will not make him so if he is not already suicidal. The suicidal person communicates the tendency to people in the following order: spouse, relative, friend, job associate, and physician. (3) The suicide rate is rising steadily. If population statistics are considered, one finds that there are more older people than there were before. It is the older population that makes up the majority of the age population that commits suicide. (4) Suicide and attempted suicide are in the same class of behavior. Various suicidologists stress that there is a difference and that these differences are significant. The majority of the attempts are young, female, and use the less lethal methods, whereas three times more males commit suicide and are older. These successful suicides use lethal methods from which there is only slight chance of rescue due to the time and location of the attempt.
The lethal attempt is less reversible if rescue is attempted (Westenkow, 1972). Moreover, the suicidal attempter outnumbers the suicide committer in adolescence by a ratio varying from 7:1 to 50:1 and only one in ten who attempts suicide later dies in a suicide attempt (Seiden, 1972).

Myths can be divided into the social, psychological, and biological categories. Common social myths are as follows: (1) Suicide involves only a specific class of people. Suicide is democratic and occurs in those who are uninvolved in society regardless of class level. (2) Good circumstances prevent suicide. An example that contradicts this statement is the fact that in the military suicide and suicide attempts are more common with officers than with enlisted men. Also, studies show that suicide is very common with professionals; a notable group is doctors. (3) Suicide can be fully explained by sociological factors. Actually, social factors combine with the individual's psychological traits to determine how that individual will handle stress. Example: A wife may consider suicide when her husband, who did everything for her, dies if she is an insecure person and society supports strong emotional reaction by women at death and supports their dependency on males. (4) In the United States more suicides are Protestant than Catholic. It is not religious affiliation which indicates if suicide is more likely to occur but the depth of belief. This myth is an outgrowth of misconceptions based on Durkheim's social theory of suicide. Specifically, Durkheim's egoistic suicide classifica-
tion would suggest that, because the Catholic Church exerts greater control over its members through its governing body, fewer Catholics than Protestants would commit suicide.

Several psychological myths of suicide causation are as follows: (1) Motives or causes of suicide are readily established. Motives may seem obvious when recent history is quickly surveyed, but actually the recent event is merely a trigger; it is the last event in a long chain of build-up events. (2) Suicide occurs in a single disease, depression. Although depression is the commonest "disease" and is found in many suicides, other diseases or classifications also include suicide. In fact, all psychiatric classifications occasionally include suicide as a concern. (3) Suicide is a "crazy act". There are cases in which suicide is acceptable such as in war; the oriental disembowelment ceremony is another example of socially condoned suicide. Suicide may also be decided upon after a long history of upsets as a defensive, adaptive move. Another indication that suicide is not necessarily a crazy act is that it occurs in depressives and schizophrenics when they have begun to improve.

A major biological myth of suicide causation is that suicidal tendencies are inherited. Although it is true that suicide can run in families, this is not true due to inheritance of traits and weaknesses, but rather is due to the socialization process and the later family members adopting a self-fulfilling prophecy, fatalistic attitude. Dr. Pokorny
(1968) reports that he knows of no cases when both members of a set of twins committed suicide. Also, Lester (1972) reports that the etiology of suicide is very complex so it is unlikely that twins experience exactly the same factors.

Several myths about management of suicidal persons are as follows: (1) Improvement in a suicidal person means the danger is over. Reports have repeatedly stated that a sizable percentage of psychiatric discharged patients commit suicide within ninety days of discharge. The suicidal act requires an energy drive which often is not significantly built up until improvement, which leads to release from the hospital, occurs. (2) Patients under a doctor's care are not suicidal risks. Statistical data reveals that 40% of the suicides and 60% of the attempters saw a doctor within six months preceding the act. Often the doctor does not take the time to learn the psychological factors of the illness that brought the patient to him or is unaware of the possible psychological significance of the client's behavior and/or illness. (3) Patients in hospitals, especially mental hospitals, are not a risk. Hospitals are locations where emotional upsets are common; one must be alert to the possibility of suicide to prevent it. In mental hospitals, the suicide rate is three to five times greater than that of the general population.

There are some laypeople who would question the ethics of suicide prevention and treatment. Primarily, ethical considerations arise in those few cases that the suicidal
person is apparently in full possession of his faculties, and situational circumstances make the decision a "rational" one. Suicidologists question that a person is ever rational when he concludes the debate in favor of death. Shneidman (1972) defends prevention activities because suicide is resolved upon after debate, that is, the decision is based upon ambivalence and the act is impulsive. Furthermore, the effect of suicide upon the survivors and the community is such that grief and resentment for the suicide cannot be worked through, but rather continues and festers.

Three type of rational suicides found in the United States can be examined to evaluate the suicidal person's rationale (Pretzel, 1972). The absence of disruptive emotional factors on the individual who sacrifices himself for a good cause (religious martyr, military hero) cannot be assumed automatically. His rationality can be assumed only after an in depth appraisal of his emotional development and psychiatric symptomatology. The person who commits suicide in reaction to what seems a hopeless and painful situation such as terminal illness, also, cannot be automatically assumed rational. The degree of "hopelessness" in the situation may be questionable, in that the suicidal person's emotional attitude may cloud the philosophical reality by overestimating the hopelessness of the situation. Finally, there is the Epicurean who considers life worthless because it is no longer pleasurable. An in depth examination as to why life is no
longer pleasurable may reveal unresolved grief reactions which, once resolved, would allow him to experience satisfaction. Even in the "rational" suicide the freedom from emotional distortion is questionable and, thus, allows the therapist to question whether the suicide is rational.
Sources for general information on suicide were as follows:


EXPERIENTIAL EXERCISES

Three exercises were done so that the volunteers would be more aware of their feelings when experiencing transition, being creative, or thinking about death. The premise of each exercise was that through their own feelings and thoughts about these three topics they could effectively learn how to respond to the suicidal caller. Volunteers would be aware of the discomfort and relief of transition and creativity. They would be aware of their own attitudes toward death and, through sharing attitudes, be aware of differences and similarities. Self-awareness in the three situations would help foster empathetic interaction with the suicidal caller. Also, awareness of one’s personal feelings may be used to help effective interaction by revealing the volunteer’s strong anti-death attitudes.

Each exercise was introduced with a brief statement of the premise of that exercise. Volunteers were then asked to recall a time of change, etc. After thinking or writing their responses, the volunteers shared their feelings, conflicts, etc. Those responses shared were written on a blackboard to enable comparison of responses and analysis of trends.
The exercises were based on those found in the following source:

Suicidal people are not so much seeking death as they are seeking an answer to the problems of life. This fact is reflected in research done by Bell as reported by Fisher (1973) which showed that eight people out of ten directly or indirectly communicate a need for help. Farberow's theme of a cry for help further emphasizes this premise. The person who calls a suicide prevention center, because he called, has increased his expected suicide rate to 100 times that of the ordinary American. The fact that he called is a partial screening. The volunteer, however, must evaluate the information to determine the acuteness and severity of the risk.

A report on suicide potentiality work done at the LASPC states that "the most important cues (in determining suicidal potentiality) were suicidal plan, age, and prior suicidal behavior." (Litman, et al, unpublished). My intention in these next minutes is to describe in detail some clues which may be gained in phone conversation and aid in assessing suicide potentiality. These clues may be verbal, behavioral, or situational, but all may be gotten through a careful interviewing and evaluation process. In handling the call, Frederick and resnick (1970) state that the presence or absence of the suicidal plan and the availability of resources are the most im-
portant volunteer planning bits.

Communication of his need for companionship, for another's interest and concern in his welfare, is relayed to others before the suicidal attempt. The suicide intent is not always communicated directly in words like "If things continue this way, I'll kill myself." Intent is also communicated by a cessation of planning activity for the future. A sudden concern with putting his affairs in order, of arranging his burial, is highly suggestive of suicidal intent if this activity is paired with the appearance of other suicidal symptoms such as depression (Wahlquist & Pack, 1972). There are differences in the purpose of the communication as well as the method of suicide intent communication. Communication of suicide intent may be a cry from the isolation of loneliness for help, a method of manipulating the significant adults or friends to act in a caring manner, or even a form of punishment by making significant adult feel guilty that such an extreme measure is necessary. Adolescent girls are more likely to use suicidal behavior as a manipulative communication technique than males (Seiden, 1972).

If one examines the suicide statistics (Danto, 1971) there is evidence that men are three times more likely to commit suicide than women, but women are three times more likely to attempt suicide. An age increases, the woman's likelihood of dying also increases. Suicidal risk increases when there is a history of attempts and chances are greater
that the older woman has made previous attempts. With the male, older age, again, indicates greater risk than does younger age. The importance of age and sex factors are indicated in the ratings given them by the LASPC's Suicidal Potentiality Scale (taken from Wahlquist & Pack article, 1972). The greater likelihood of severity of older male attempts in comparison with older female attempts is indicated by the 7-9 or high risk rating for the former versus the 5-7 or moderate risk for the latter. Only at the young ages of 15 to 34 years are males and females equally likely to die in an attempt; this is true despite the women's greater number of attempts at this age.

Another area of consideration in determining suicide potentiality is symptomatic behavior. One of the most obvious symptoms is severe depressive behavior. The depressed adult has certain symptoms of a physiological, psychological, and social nature that are easily identified. Physiologically, the depressed adult may have a sleep disorder, a loss of appetite, constipation, headaches, and fatigue. Psychologically, there is a loss of energy and initiative, absence of interest in previously enjoyed activity, sadness, guilt feelings, low self-esteem, and an overriding feeling of hopelessness and helpfulness. Socially, the adult has withdrawn and isolated himself from others. The depressed adult has noticeably and obviously changed his behavior patterns and, thus eases his identification (Wahlquist & Pack, 1972).
A multitude of stress situations can cause adult depression and consideration of suicide. Most often these stress situations can be readily identified and summarized after allowing for sex role differences. The most common stress situations that lead to suicidal behavior in men are a lack of success in job, marriage and home life, debt difficulties, and authority or law difficulties. Women attempt or commit suicide because of failure in home and family life or, more generally, because of problems relating to the men in their lives. The suicidal adult considers death because of his extreme sensitivity to failure in the role he assimilates as his own. Generally rigid in his approach to problem resolution, the adult suicide considers death the only alternative after standard procedure fails to resolve the stress producing (Yahraes, 1972).

Identification of the depressed, suicidal child or adolescent is more complicated than similar adult identification. Specifically, the adolescent or child has a greater number of ways of expressing his depression. Superficially, the suicidal youth may seem as happy and untroubled as his non-suicidal peers, for adolescence is a troubled period of reconciling the combination of child and adult behavior expectations to significant adults. A closer, more in depth examination of the suicidal adolescent’s history reveals there is a reason for grief or functional depression. The older adolescent may, indeed, express his depression overtly with the same symptomat-
tology as an adult. Younger adolescents and children act out their depression in ways that mask the depression, by manipulative expression in that the child after suffering a severe insult and wishing death learns by chance that threatening suicide results in attention and gratification. The child learns by manipulation to get secondary gains that make the situation more bearable. Depression may also be masked by hostility. The child is continually faced with rejection and becomes angry with the rejecting person. He acts out his anger by destructive and aggressive acts which, in turn, increases the rejecting behavior of the person from whom he desires comfort and love. Depression may also be masked by denial or a constant euphoric reaction to whatever happens regardless of the inappropriateness of such behavior to the situation. The euphoric child's depression cannot be positively diagnosed until such behavior occurs inappropriately. Depression may also be associated with withdrawal and fantasy. Like the adolescent or child that denies his depression, the child who lives in a fantasy world blocks out the depressing situation by substituting a pleasanter world. Through fantasy, the child imagines the world he would prefer to compensate for the real world. The child's depression may be overtly expressed in behavior which would be classified as sociopathic, delinquent, manic, or schizophrenic (Faux & Rowley, 1972). The adult's behavior may also adapt some of the characteristics of the suicidal child or adolescent, in that, he too may be disoriented and have delusions or may
express his emotional state in anger, hostility, or revenge.

Some other symptoms that should be evaluated when determining suicide potentiality is whether or not there is a feeling of helplessness, hopelessness, or exhaustion. Such a state might be evidenced by statements like "What's the use, everything will go wrong anyway" or "I am just too tired to try anymore. All I get is bruises." Such negativism when paired with other symptoms can be suggestive of high suicide potentiality. It must be remembered that apathy and withdrawal, which are indicative of depression, might be indicated by similar negative statements and actions.

Any habits that suggest a person has poor control of himself, that his behavior may control him rather than vice versa has some risk of suicide. Gambling, alcoholism, and drug addiction are some of the more prominent behaviors of which to be aware in determining suicidal risk as their presence suggests moderate to high suicide risk. The alcoholic whose drinking has resulted in the loss of job or home, and caused tension in the home may behave rashly without consideration of the results in an attempt to atone for his past behavior. The major concern is that his compulsion may hinder his reasoning abilities and, thus, may increase the chance of suicidal behavior. Poor impulses control or poor judgment as indicated by past behavior (Mintz, 1968) can also indicate a moderate suicide risk. For example, a person who states he frequently has temper tantrums or quits a job he dislikes without regard
to how he will pay his bills has a history suggesting that he might commit suicide impulsively. The intended manipulatory suicide gesture might also result in death instead of rescue because of misplanning.

Some of the stresses which can lead to suicidal action such as loss of loved one or of job or prestige have already been described. These stresses indicate a moderate to high likelihood of suicide. It is important to note that any change in the person's life situation may lead to suicide. any change causes concern about meeting the expectations of oneself and others in that new situation. Generally, there is greater risk of suicide if the change is a negative one like loss of job rather than a positive one like promotion.

Another factor to be considered when evaluating suicide potentiality is whether the call was initiated due to a chronic or acute onset of symptoms (Frederick & Resnik, 1970). Generally, both an increase or recurrence of long term symptoms and a sudden onset of symptoms are indicative of suicidal danger. However, with the acute onset, the action must be more immediate; whereas, with the chronic onset, the immediate danger is less but the remediation must be long term.

Another category useful in determining the immediacy and lethality of the suicidal intent is the degree of suicidal plan specificity. If the plan is specific as to time, place, and method and there is only a slight chance of rescue, there
is a high probability the person is sincere when he states he wants to die. He will do so unless immediate action is taken to reduce the stress. A vague plan of low lethality or a highly improbable plan for committing suicide does not require as drastic and immediate preventive action. The methods used vary in lethality; for example, hanging or shooting is more likely to result in death than taking pills. All could result in death, but miscalculation and rescue is more likely in the latter case. Taking pills would result in a less immediate death. In evaluating suicidal potentiality, it is important to rate any previous suicide attempts. There is a tendancy for the lethality of the attempts to increase. The attempter learned that the previous attempts were discounted as not being serious or did not get the attention desired. Progressive attempts may escalate in severity. Even the bizarre plan must not be discounted entirely, as the psychotic may implement the more realistic part of the plan. The volunteer must listen for sounds of pain that may accompany the description of the plan and indicate its partial verity (Danto, 1971).

The number and kind of resources available to the suicidal person aid the volunteer in evaluating suicidal potentiality. Generally, the greater the number and kinds of resources, i.e., family, friends, supportive professional help, economic, life and work security, the lower the risk of suicide. It is when there are no supports that the risk is high. Moderate risk exists when support is available but
unwilling (family and friends exist, but will not help) or when there is a financial problem. It is interesting to note that availability of professional help from sources other than the crisis line is less indicative of low suicide potentiality than is the availability of support from friends and family. The depth of the relationship is the decisive difference.

Another category of use in predicting suicide is the degree and kind of prior suicide behavior. Previous attempts of high lethality suggest the current problem is severe; often the lethality of the attempts increases when the prior attempts did not result in the desired guilt and/or cherishing behavior from the significant others. A history of prior low lethality attempts requires carefully considered action by the volunteer. An increase of the lethality of the attempts is not uncommon. The least lethal history of prior suicidal behavior possible is that of a history of repeated threats and depressions for action has never actually been taken.

The medical status of the caller can also aid the volunteer in assessing suicidal potentiality. Generally, the most serious risk in the medical category indicates moderate risk; this is when there is a chronic debilitating disease or repeated unsuccessful experiences with doctors and therapy. There is less risk if the illnesses are psychosomatic or are chronic minor illnesses. Suicidal action might occur with illness due to the chronic, severe pain, concern about
changed physical appearance or function, feared shifts in personal and social relationships because of the illness' after-effects, a fear of death, or a fear of cancer. Often depression may occur as a result of the disease and its effects (Dorpat, Anderson & Ripley, 1968).

Communication aspects also are important clues in determining suicidal potentiality. Overall prognosis is better if the caller has kept lines of communication open to others around him. If he has rejected all communication, there is a moderate to high potentiality of suicide. Direction and purpose of the communication are also important in assessing suicidal risk. If the purpose of the suicide is to express shame, guilt, or the worthlessness of self, there is greater risk than if the goal is to manipulate the behavior of others. The manipulator wants to cause the others to change their normal way of responding to him; the suicidal person is still influenced by reinforcers outside himself.

The communication aspect of suicide is suggestive of the extreme sense of isolation experienced by the suicidal person and the role of the other as a causative and preventative agent. For example, a young child may identify with the parent who died and/or committed suicide. He may feel guilty and responsible for the death. The guilt and identification when paired with the depression may lead the child to the conclusion that suicide or death is an answer to problems confronted in life. If a parent commits suicide,
the child may also, and his method may be identical to that of his parent. The relationships that the adolescent has with significant others in home and school may compound, by their lack of depth, the problems created by his unstable environment. The adolescent may feel that he must face the unpredictable future alone without companionship and guidance. The difference between the attempter who failed and the one that succeeded is the "failure" had a relationship with someone who cared (Seiden, 1972).

Evaluating the reaction of significant others is also helpful in determining suicidal potentiality. It is important to note the relationship between the suicidal person and significant others. It may be that just as a wife may encourage the husband's drinking and dependency, she also directly encourages his suicidal behavior. Such a tendency should be determined during the call as referral in cases judged less severe overall may be made to the significant other. If the significant other's behavior indicates a punishing or rejecting attitude or denial of the caller's need for help, prognosis of suicide is moderately high in this category. Lack of concern or decisiveness and helplessness on the part of the significant other indicates a moderate risk. There is a low risk if the significant other admits a feeling of concern and a desire to help.

A person's attitude toward death is another significant clue in evaluating suicidal potentiality. The concept of
death and the person's attitude toward death is, in part, developmental and, in part, indicative of the emotional state of the person. It is doubtful that any child under ten intends to die even if he does attempt suicide for he does not view death as final. Because death is not considered permanent, the attempt may be more lethal than he intended. Under the age of five, death is denied and considered similar to sleep. Between the ages of five and nine, death is personified and is seen as applicable only to others, not to oneself. The older child begins to comprehend death as final cessation and develops a fear of death apparent in nonsuicidal adolescents and adults (Seiden, 1972). There is a difference between the suicidal and nonsuicidal person's comprehension of death. The suicidal person does not fear death but rather idealizes it as leading to a continued, better existence. Death becomes a pleasurable goal that is made even more attractive in that the present existence is lonely and difficult. The lack of fear as the standard protective measure enables the depressed, isolated person to contemplate death without guilt (Dorpat, 1972).

Some practical techniques in further assessing suicidal risk exist. One technique is determining the degree of planning the caller does for the future and his extent of interest in maintaining his physical well being in the present. For example, if the caller continues to plan for next week's PTA meeting, suicidal risk is low. Verbal confirmation that
such practical necessities such as eating and sleeping continues also reduces suicidal risk. Another clue in determining risk is the extent to which the caller is willing to help himself. Willingness to communicate the reasons he considers suicide and to cooperate with the referral agencies and significant others indicates this. The stated method of proposed self-injury can be validated through careful listening and questioning by the volunteer. This is particularly true if the intended means of injury is a gun or pills. These can be identified by naming the caller's and manufacturer's name or describing the pills. Such information is generally given by the caller without questioning as he wants to impress the volunteer with the sincerity of his threat. Vagueness, particularly after questioning, diminishes the caller's credibility. Often, clicking or shooting the gun occurs during the call to emphasize the plea for help; audible signs like this can support the caller's proclaimed suicidal action (Danto, 1971).

A volunteer should be aware that a suicide potentiality scale is merely a device to aid the volunteer. Reason and careful assessment is still necessary. A routine, non-thinking use of a scale is of little help in assessing the caller's suicidal potentiality.
Sources for information on assessing suicide potentiality were as follows:

Danto, B.L. Assessment of the suicidal person in the telephone interview. Bulletin of Suicidology, Fall 1971, 48-56.


CHRONIC AND MANIPULATIVE CALLER TECHNIQUES

The manipulative caller is not acting out of character when he tries to influence, to control the behaviors of others around him through his suicide threatening call. Manipulation is a "specific and integral part of the ways by which these patients deal with their emotional problems." (Sifneos, 1966, p. 529). The manipulator by his direct action avoids having insight into the reasons for his problems. Immediate release from anxiety is his goal and direct manipulative action is his means of achieving this. Sifneos (1966) estimates that 65% of the suicide attempters in this experience are manipulators. They use the suicidal threat as a means, for example, to force a boyfriend to marry them, to get their own way. Sifneos' statistics and description of attempters as manipulators suggest that many of the suicidal callers that contact a crisis center are manipulators; it is the attempter who is more apt to contact the center. The manipulator—attempter rarely dies in an attempt for most arrange their environment so that they will be rescued during the attempt. If they die, it will be because of an error in anatomy or a miscalculation in timing a rescuer's arrival. Once the manipulator has made an attempt, he is apt to make repeat attempts because of the technique's effectiveness as a powerful control over others.
The crisis counselor must be aware that a caller may try to manipulate. A brief discussion concerning how he relates to others should reveal that manipulation is often used as a method of interpersonal interaction. When talking with the manipulative caller, it is important to determine the reason for the action (whether it is to absolve him of blame, set stage for presenting another problem, or to prepare others for a death). In the latter case, the danger of death is much greater than in the other cases. Even when death is not originally intended, death may occur as perturbation with the problem increases and the impulsive manipulator loses control (Danto, 1971).

Several methods that can be used by the counselor when dealing with the manipulative caller are as follows (Sifneos, 1966): (1) When conversing with the manipulative caller be on the alert for any sensivities. For example, if he is vain about his looks, remind him that a suicide attempt may mutilate him. This may stop him from making further attempts. Cause anxiety or concern about something of importance to him so that the appeal of the attempt as a controlling device is diminished. (2) The manipulator is usually self-centered and hedonistically interested in enjoying life. Pointing out that manipulation does not permit the full capacity of enjoying the companionship of others may cause him to reconsider his ways. Manipulation requires the manipulator to be on a constant alert so he can use "the golden opportunity". 

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There is not ease and relaxation in the fellowship of others.

(3) Emphasizing the seriousness of the attempt and the need for therapy might also be effective if the urging is done subtly. (4) Dr. Pribyl (1974) of Chicago-Read-Mental Health Center encourages a procedure of confronting the caller with his behavior and urging the client to decide for himself, when given options, what he will do. The client is told that he alone must take responsibility for his death if he opts for suicide.

Danto (1971) suggests that the manipulative and chronic caller are less worrisome than other callers, but reminds volunteers that "every gun is assumed loaded until proven otherwise." The chronic caller is frequently suicidal and often gives marriage and alcohol problems as the reason for calling. The majority of the chronic callers (85%) in the Farberow, Sneidman, Litman, Wold, Heilig, and Kramer (1966) study had been in treatment previously but had exhausted the facilities of the agency. They were not sick enough to require hospitalization but did require structure and a constant source of emotional gratification. Brockopp (1970) criticizes many of the calls of the chronic callers as being merely conversation. The caller requests a particular volunteer, often giving the reason that the volunteer already knows his history. The calls, because they become routine, do not involve a challenge of the caller's behavior and rationale but rather consist of the volunteer's acceptance of what the
caller does and says. The accepting pattern evolves, in part, because the volunteer ceases to plan therapeutic action.

Fisher's book (1973) includes a list of responses that might be effective with chronic callers (Brockopp, p. 61). Some of them are as follows: (1) Determine whether the caller is in therapy or contacts other phone services so that these services may be contacted and a uniform approach may be planned. (2) Do not underestimate the suicide risk of chronic callers. (3) Be aware that the chronic caller needs a trusting, supportive relationship and that his dependency may have exhausted his own resources of emotional support from family and friends. (4) Urge the chronic caller to mobilize his own resources and develop his own means of self-support. (5) If the problem seems overwhelming to the caller, have him focus on one basic aspect. Taking one problem at a time makes complex problems manageable. (6) Help the chronic caller get in contact with other lonely people in the community so that they may give emotional support and comfort to one another. (7) Attempt to have the caller who needs companionship and support gain this through ways that will not tie up crisis phones. For example, if older, have the caller gain support through the Golden Age Club, through letter exchange, or through calling the chronic caller during a slow period.

Pfeiffer (1975) of the Ottawa County crisis service does not believe that repeat callers are automatically undesirable.
The intervention process as done in that agency involves several steps for successful completion. Three or four calls may be needed before the problem is effectively resolved. When the caller, however, is abusing the service and not using the call to resolve problems, confronting the caller is advised. The volunteers tell the caller he is accomplishing nothing, give him options to the problem, and have him make decisions. Whenever a call is handled, the volunteer is to guide the caller toward more adaptive alternatives. The decisions, however, are the caller's responsibility. Only when suicidal risk or danger to life is high does the volunteer become more assertive in guiding behavior.
Sources for the information on chronic and manipulative caller techniques were as follows:


Danto, B.L. Assessment of the suicidal person in the telephone interview. Bulletin of Suicidology, Fall 1971, 48-56.


UTILITY AND SUCCESS OF SUICIDE PREVENTION-CRISIS CENTERS

Some professionals in the field of suicide prevention such as Doctor Teicher of Los Angeles as reported in a recent newspaper (1974) have stated "that suicide prevention centers 'don't work' for children or adults and funds could be better spent ..." The basis of such criticism must be explored. Teicher explained that adolescents who commit suicide do not call crisis centers. Their decision is a rational one based on a long history of unstable home life, often including a history of suicide in the family. For them, years of experience show that life does not offer realistic hope for change. If the adolescents are to be helped, it must be by a person whom these adolescents "can form a steady attachment to, in whom the child can confide and trust and talk to." Such a person might be his minister or school counselor, not an anonymous voice on the phone.

Success of the suicide prevention-crisis centers can also be questioned with other populations; the older male, who statistics suggest accomplishes suicide rather than attempts suicide, is one such population. That is, it is questionable whether centers even receive calls from those individuals with the greatest suicide risk. The success of the centers with those having chronic as well as acute problems with living also requires discussion.
Wold (1970) describes a study in which the characteristics of 26,000 callers were analyzed and estimates that 1% of the LASPC patients go on to commit suicide after the call. Characteristics of the populations which call the center and those that later kill themselves were compared and reveal the following differences: Those that committed suicide had a median age of 43 years compared with the age of 34 for callers, 64% of those that killed themselves were men compared with 34% of the callers, 40% of those that killed themselves had repeat marriages compared with 19% of the callers, 51% of the suicides lived alone with 32% of the callers, 88% of the suicides had a chronic problem compared with 72% of the callers, 45% of the suicides had high acute lethality ratings compared with 19% of the callers, 92% of the suicides were depressed compared with 80% of the callers, 31% of the suicides were influenced by another's suicide compared with 11% of the callers. Another study (Murphy, Wetzel, Swallow, and McClure, 1969) in which the characteristics of those that called on their own behalf were described also indicates that the characteristics of the callers resembles those of the suicide attempter, not the committer of suicide. It is important to note that one per cent of those that call did later commit suicide, that a small per cent of those that call are commiters.

Litman, Wold, and Graham (unpublished) report further detail on populations with which the crisis centers are ef-
fective, namely those in a state of acute crisis. They, however, also report some utility and success with even the chronically suicidal, but the achievement is more temporary. The crisis intervention model is effective for those in acute crisis who previously had a stable adjustment and have only recently experienced stress. The center aids them through the period of stress and helps them determine effective coping techniques. The center also helps the chronic suicide whose history consists of a gradual exhaustion of resources by enabling him to control the recurrent threat, to survive one more of a series of suicidal threats, to postpone the suicide. Mintz's data (1966) based on twenty follow-up studies done with persons who attempted suicide to attest whether they later killed themselves supports the temporary rescue of chronic thesis. Two per cent had died after eight months or a year whereas ten to twelve per cent had died after eighteen years. Wilkins (1966), however, reports that the centers do help when he gives the findings of a follow-up study done with 300 high risk suicide cases. Three years after initial center contact, he found that six per cent had killed themselves, eight per cent had made additional attempts, 31% still had suicidal thoughts, and the rest no longer had a suicidal problem.

Various techniques have been suggested by researchers to evaluate the effectiveness of suicide prevention centers. One, determining the population that calls the center, has
already been described in detail. Generally, the evidence suggests that the caller is ambivalent, a gesturer, an attempter rather than a committer of suicide. The caller belongs to a different population. Lester (1971) states that data from Los Angeles area indicate that 98% of the completed suicides had not called the center. Another technique proposed for evaluating the effectiveness of the centers is determining the effect of the center's efforts on the suicide rate in that community. Lester reports of a study by Weiner in which the suicide rates in communities with centers were compared with those in communities without centers. He found no change effect between cities. Los Angeles, a city with a center, experienced a significant increase in suicide rate. Despite the negative result, one must remember that comparative statistics between cities may be misleading because of differences in the death classification systems and inquest requirements between cities. Haughton (1968) discusses whether the centers save lives as follows: Workers in crisis centers can and do specify individual cases in which lives were saved after the center was contacted. He reminds us, however, that tools to ascertain whether these people would have died without contact are not available. In summary, Haughton stresses that regardless of whether or not lives are saved the centers do provide worthwhile services.

Pribyl (1974) supports Haughton's thesis when he states that crisis centers are effective. They are effective from
a cost standpoint alone. Hospitalization, which is the alternative means of handling a crisis person unless his personal doctor is there to say it is unnecessary, is expensive. Effective handling of just one person a month without hospitalization would equal the expense of the crisis program. Effective handling of more than one person a month without hospitalization being required is a savings.

Another means of determining the center's effectiveness is assessing referral success. An example of such statistics are those of the study on persons calling on their own behalf (Murphy, Wetzel, Swallow, and McClure, 1969). Eighty-six percent were referred for medical or psychiatric care. An almost equal number of those referred followed and did not follow the advice. It is important to note that referral failure occurred consistently when referral was made to the doctor instead of the crisis center if that referral was to be successful.

Some of the positive aspects of crisis services referred to in general by Haughton earlier and stated specifically by Fisher (1973) are as follows: The centers provide an agency service based on the premise that communication, when a person is in crisis, is necessary and lines to help must be open and obviously available. Crisis lines help ease the manpower shortages by providing easily assessible service to a large number of people while using few professionable staff. Such centers not only save lives, but more generally help
people cope with problems of living. Crisis centers also provide service "around the clock". Statistics at one center (Farberow, et al, 1966) show that 65% of the calls made at night as compared to 38% of the calls made during the day were made by the suicidal individuals themselves. During the day, the calls are made by concerned others, i.e., 23% family, 10% friends, and 31% professionals. At night, when other helping agencies are closed the suicidal individual turns to the crisis center for help.
Sources for information on the effectiveness of suicide prevention centers were as follows:


Litman, R.E., Wold, I., & Graham, N.K. Beyond emergency services. Unpublished article, Suicide Prevention Center, Los Angeles, California.


ROLE PLAY

In order to increase transfer of the techniques and information presented in this class, role playing will occur at intervals throughout the day. The number done will depend on time factors, but those done will relate directly to information and techniques presented. The information given is very general so that the volunteers participating may draw on the information given them in the class but not feel bound by many details. The information as to the history will be given only to the person role playing the caller. As this is a role play of a phone interaction, the "caller" and the "volunteer" face opposite directions so that the clues are auditory and not visual.

-After presentation of general handling tape "Gloria" and information on assessing suicide potentiality:

Woman of 35, previous history of suicide attempt by taking overdose of pills, despondent because of husband divorcing her.

-After second training tape with teenage girl, "Maryjo":

Man of 45, alcoholic history, unstable job and family history, thinking of suicide because of overall failure history.

-After manipulative and repeat callers information:

Woman of 21, had slashed wrists before, relationship with boyfriend threatened, few close friends.
After "Jack Dugan" training tape on violent methods:

Man of 35, failure in work and marriage when compared with brother (as constantly was), second wife committed suicide, has feelings of paranoia, getting affairs in order, has gun.

Role play was not included in the actual training class because of time requirements. The volunteers felt they had sufficient role play experience in pre-service training. The above is included in the training material to serve as a guide in how such training could be done.
Sources for role play were as follows:

Role 1:


Role 2:


Role 3:


Role 4:

APPENDIX C

Evaluation Materials, Answer Key, and the Analysis
SELF EVALUATION

Duration of time as a crisis line volunteer ____________

Approximate number of suicide calls you have personally handled ____________

Circle the appropriate number, the number that most closely indicates the answer appropriate in describing you, the crisis volunteer.

1. If I were working at the service and got a call in which the caller was threatening to shoot himself, my immediate reaction would be:

2. After I got more information from the suicidal caller, my reaction would be:

3. If I had to make an assessment of a caller's suicide potentiality, my assessment of the task's difficulty for me would be:

4. If someone asked me to explain or describe how a person with a high probability of committing suicide views the world and his role in it to determine if I can identify with that person, I would find the task:

5. If I learned one of the suicidal callers that I had talked to committed suicide, my reaction would be:
   1. Guilt, I am inadequate, 2. Ask, why me? 3. Wish I knew more, 4. Think it was a very difficult call, 5. Think I did all that was possible.

6. If someone called and I had to determine their intention to act on their threat of suicide, I would think the task's difficulty for me would be:

7. If a person called who I had determined to be manipulative and suicidal, I would assess the task of effectively handling that call to be:


Given the task of describing in a few sentences my overall evaluation of myself as a handler of suicidal calls, I would say:
CLUES FOR SUICIDE POTENTIALITY

Circle the number of the item if it is a clue for suicide potentiality when taken into consideration with the total set of facts known about the caller.

1. Religious affiliation
2. Age
3. Addict
4. Spouse just died
5. Depressed
6. Twin considering suicide
7. Sex
8. Social class
9. Job promotion
10. Disorientation
11. Life history
12. Previous attempts occurred
13. Wife is defensive when asked to relate how she reacts toward the client
14. Month of the year
15. Communications of anger directed outward
16. Has unsuccessful experience with doctors
17. Change in environment
18. Weather (cloudy or sunny)
19. Homosexual
20. Sleep disorder
MEMORY FOR SIGNIFICANT DETAILS OF CASE HISTORY
AND
RATING SUICIDE POTENTIALITY

(oral only)

Case 1 - Lydia Graham Bickford, adapted from A Panorama of Suicide, p. 91-95, by Niswander, Casey, and Humphrey.

"I am thirty-three, have one sister and two brothers, and grew up in an orphanage because my parents separated when I was little. I married young; in fact, I had my first child when I was only fifteen. But, it didn't last. I married again, this time to a man fifteen years older than me. He was domineering and like a father to me.

I trained to be a practical nurse, but despite this achievement, I became an alcoholic. Eventually, I whipped this problem, but by this time my second husband had divorced me and was seeking custody of the children. Despite my resistance, he gained custody. After that, I just drifted from job to job.

I attempted suicide a couple of times while married to my second husband - by taking pills. In fact, I still use pills regularly to help me sleep and relax. I married again and have a good marriage, but my second husband married again too. His wife can't manage our children so they came to me. But finances were tight and my second husband wanted to avoid legal trouble. The kids returned to him. I am torn and undecided as to whether it would be better if I stayed with my husband or went to live with my second husband and his wife so that I could take care of my children."

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Case 2 - Janet Frederick, adapted from A Panorama of Suicide, p. 37-44, by Niswander, Casey, and Humphrey.

"I am fifty-one and the third of five siblings. Our home life was stable and dominated by my father. If anyone were to describe me, they'd probably say that I'm shy, but stubborn. In fact, my sister describes me by saying that I "would cut off my nose to spite my face." I rather describe myself as quiet, proud, and organized. I want to nursing school for a short time but quit because I became homesick. Instead of nursing, I worked for a phone company for twenty years. I never married but stayed at home with my parents.

I don't worry myself about how others treat me, but I must be perfect. There is no reason I should make mistakes. If things go wrong, I simply withdraw. When I was thirty, I moved in with my sister's family. I also requested night work at the phone company. I'd gotten one of those embarrassing psychosomatic diseases and thought "It might help." I soon quit my job and moved back in with my parents. During the next couple of years, I changed jobs three or four times. I even worked with my sister once, but we never talked; I was too shy. I hardly talked to anybody and they didn't talk to me. I guess I am inferior. My parents died around that time too.

Things got to be too much for me and I admitted myself to the state hospital. I lived, after released, in the family house by myself. It was lonely. Eventually, I got a chance for a job in a hospital. Despite the fact that I like to garden, I decided not to this year. Things just don't work out for me. I bet that I'll make a mess of the job and it's my last chance."
Case 3 - Howard Jessop, adapted from A Panorama of Suicide, p. 13-17, by Niswander, Casey, and Humphrey.

"I'm fifteen and am the third kid of five. People disagree as to what I'm really like. My mother thinks of me as happy and interested in sharing with others, especially my blind friend who lives down the road. Mom realizes that one of my problems is school; the teachers just don't understand me. Dad scared me some, he can be mean on occasion and is sometimes drunk. He isn't around much as he often is away working on a construction job. Dad thinks that I have a temper and am impulsive because I once hit a friend and later regretted it.

One time when Dad was away a couple of years back (he was gone four months), Mom had "visitors", if you know what I mean. They would not have been there if Dad had been home. Things really fell apart then - my sister also got pregnant and married some guy who wasn't the father.

I don't like school. I just don't fit in with the other kids there. I sometimes think that I am a little dumb. One thing I do know, I can't read and am always having trouble with the assignments. I guess that is why I act up and get sent to the principal's office all the time. My counselor at school is probably one of the few there who even begins to understand me. He knows, I want to read better.

I use to be active at church and I really liked it. I even fit in, but my father called it quits because I'm needed on the farm. It seems like I am alone a lot and don't have much chance to know other kids."
MEMORY FOR SIGNIFICANT DETAILS OF CASE HISTORY
AND
RATING SUICIDE POTENTIALITY

Case _____

Potentiality of suicide: Mark with circle around the correct degree of suicide potentiality.

Low Moderate High

Clues pertinent in assessment, significant details of case history remembered, are as follows:
HELPFULNESS AND EFFECTIVENESS OF RESPONSES
AND
RATING SUICIDE POTENTIALITY
(oral and written)

Case 1 - Albert Boyd, adapted from A Panorama of Suicide, p. 27-30, by Niswander, Casey, and Humphrey.

"I am twenty years old and come from a big family; I'm the sixth of ten children. School was okay. I guess my teachers would say that I was an average student. But, I only finished grade school. If my parents were asked to describe me, they would say that though I have a bad temper and get into a lot of fights, I minded them well.

After quitting school, I worked as a laborer for a while. The job was a bust though so I quit after two months and got another job. That job worked out better so I stayed there 'til I joined the army. Just about the time I went in, my sister attempted suicide. Don' ask me why! I won't say.

I like the service fine and am glad and proud to be serving my country. Got a leave eventually and it was great being at home again. Only problem is, transportation back to the base was fouled up royally because of a blizzard and a ticket agent's mistake with my plane ticket. I had to return home.

Getting money for another ticket is a real hassle. The first time they gave a cost estimate they were low by a bunch; it cost twice as much! Dad said that he'd lend me the money, but I said no. Mom called the Red Cross and told them my problem. They said that I should turn myself in at one of their offices. Just ignored this. Holidays were coming so I decided to stay. Now, I'm mixed up about whether I should wait 'til the MP's get me or turn myself in. I'm not sure that I could stand being in a stockade. Maybe I'm better off dead. What should I do?
Mark with a circle around the correct degree of suicide potentiality:

Low          Moderate          High

My response to this caller would be as follows:
Case 1 - Helpfulness and effectiveness of responses continued

Things that came to mind while listening to this caller were as follows:
"I'm fifty-five and the youngest of three. Home was a good place to be when I was growing up. We were very close and we still keep in touch by phone or letters and occasional visits. School was no problem. I did average work and had lots of friends. In fact, I even dated my future wife all through high school. When I graduated, the war was still going so I enlisted. Although dating all that time, I didn't marry 'til I was twenty-six. I made the military my career 'til I retired, but even then I worked for a while as a civilian working in the accounting division at the base.

If anyone were to describe me, they'd probably say that I'm a hard working, meticulous man, but a good sport and fun to be around. I'm also ambitious. I've always wanted to have a business of my own. So I saved some money and borrowed the rest, several thousand, from my mother. I finally started my restaurant!

One bad thing about it though, my wife wasn't for my starting this grand venture at all. In fact, she fought it tooth and nail. She seems to think we'll lose all our money. She's always been that way - a worrier. She's even been to the clinic for counseling about it and got a prescription to calm her.

I put many hours into getting the restaurant ready, working twelve to eighteen hours a day and planning every detail. I don't tell anybody my troubles; why should I, they have enough of their own. My wife is the last person I would go to with a problem. The way it is, she is the worrier and I'm the problem solver. I like to be the adviser, the one who solves the problems. So that I can think my best, I plan everything, don't lose my temper, and stay away from smoke and drink. I take care of everything.

My son's a bright boy, in the Honor's Society and everything. I'm teaching him the business. I know both he and my wife look up to me and depend on me.

The restaurant's open now and business is slow. It has me worried, I owe Mom so much money. What if it does fail? I already am working a long day and my family is too. What if it fails? What should I do?"
Circle correct degree of suicide potentiality:

Low        Moderate        High

My response to this caller would be as follows:
Case 2 - Helpfulness and effectiveness of responses continued

Things that came to mind while listening to this caller were as follows:
Case 3 - Alicia Dupuis, adapted from A Panorama of Suicide, p. 109-111, by Niswander, Casey, and Humphrey.

"I come from a hard-working farm family. The third of ten children, I had a lot of responsibilities at home and quit school after completing sixth grade. I remember getting up at four in the morning to do the wash because my mother was doing poorly. I did not get married until I was almost forty, but my husband says he married into such a close, hard-working family.

I am proud to say that I'm a church-going Catholic; I go to mass several times a week. But my children, they're another thing altogether. They only go once a week. I think people would say that I'm a good homemaker, wife, and mother. I always try to keep my home spotless and I give my husband and children what they need or want.

Some people might think me eccentric just because I go out of my way to save money. I believe in taking advantage of sales though. As for me, I don't need anything so I don't buy anything for myself. No, the money goes for education and the best sports, radio, etc., equipment. Things for my husband and my children. I do admit though that I hate the idea of being without money. The thought gives me the shakes.

I like to go visiting, but only if my husband goes with me. I don't like to go out alone. Sometimes things begin to bother me, to worry me. If this happens, I talk with my best friend or get busy so I can't think about it. I'd never let anybody tell my husband how things get to me; I must be cheerful for him.

In the last couple of years, I've been having health problems. It all started when I lost those twenty-five pounds by taking diet pills. Then I had an ulcer. Now, I think I have cancer. It seems that I'm always taking some kind of pill or having pain. Then to make the bad worse, the "change" occurred. I feel so miserable. What should I do?"

Circle correct degree of suicide potentiality:

Low Moderate High

My response to this caller would be as follows:
Case 3 - Helpfulness and effectiveness of responses continued

Things that came to mind while listening to this caller were as follows:
Case 4 - "Marie Smith", adapted from The Realization of Death, p. 93-94, by Weisman.

"I'm fifty-eight years old and though some might call me an old has been, I feel that trying to continue as one has started is important. My family life was happy. As a youngster, I remember endless hours of reading and bickering with my sister, she's dead now, about whose turn it was to do the dishes. We were a close family.

Both my sister and I never married. In fact, we lived together in the same house 'til she died of cancer last year. I support myself by teaching school and continue to do so despite my own health problems.

Shortly after my sister died, I noticed a lump on my own breast. I went to the doctor right away, but he said that there was nothing to worry about. What with my sister's death and all, I didn't trust him. I went to another doctor. He confirmed my suspicion. I had cancer. The treatment was extensive surgery. I felt unsure about what to do... health problems make everything so uncertain. But, I finally decided to continue as I started. I continued to teach. It is exhausting.

Those radiation treatments make me so tired and to make it worse, no one seems to care. The doctors and technicians treat me like a piece of meat and so does my superintendent. All of the sudden, he transferred me to a new school where I don't know anyone. Do you think that's fair? Why should he transfer me? What should I do?"

Circle correct degree of suicide potentiality:

Low    Moderate    High

My response to this caller would be as follows:
Case 4 - Helpfulness and effectiveness of responses continued

Things that came to mind while listening to this caller were as follows:
SELF EVALUATION: No set answers required.

CLUES FOR SUICIDE POTENTIALITY: Circle numbers 2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 15, 16, 17, 19, and 20.

MEMORY FOR SIGNIFICANT DETAILS OF CASE HISTORY and RATING SUICIDE POTENTIALITY:

Case 1 - Potentiality is moderate.
Pertinent clues are as follows: Age, unstable childhood, divorce repeated pattern, alcoholism, lost of loved ones (custody struggle), drift job to job, previous suicide attempts (pills), still uses pills, good marriage now, finances tight, and indecision.

Case 2 - Potentiality is high.
Pertinent clues are as follows: Age, home stable, very stubborn, homesick - dependent, never married, self not important, must be perfect, withdraw when things go wrong, psychosomatic illness, changed jobs frequently, lonely, admitted to state hospital, not plan for future, hopeless - last chance, and loss of parents.

Case 3 - Potentiality is moderate.
Pertinent clues are as follows: Age, school problems, not understood by significant others, father ignores - alcoholic, disorganized home life, poor temper control, don't fit in - outsider, lonely, and inferior.

HELPFULNESS AND EFFECTIVENESS OF RESPONSES and RATING SUICIDE POTENTIALITY:

Case 1 - Potentiality is moderate.
No set assessment; judges determine effectiveness rating on each case of each volunteer individually.

Case 2 - Potentiality is moderate.
No set assessment; judges determine effectiveness rating.

Case 3 - Potentiality is moderate.
No set assessment; judges determine effectiveness rating.

Case 4 - Potentiality is moderate.
No set assessment; judges determine effectiveness rating.

For statistical information of judge determined ratings see the next pages.
ANALYSIS OF INDEPENDENT RATER CORRELATION

Two of the tests required independent rating of responses by judges to determine the correctness of the subjects' responses. Test 3, which required the subjects to rate the suicide potentiality as indicated in the seven cases, was one such test. The following table indicates the variability of the ratings of the three judges under a description of each judge's exposure to suicide information. The table also indicates the mean rating of each judge and the correlation of the three judges' mean ratings. Correlation of all three judges' ratings were significant; each judge rated the suicide potentiality similarly.

The correlations on the judges' ratings of suicide potentiality, using the Los Angeles Suicide Potentiality Scale as a base, suggest that the scale did equalize any differences that might have occurred otherwise. Despite differences in exposure to suicidal people and information ranging from reading and study of suicide to actual handling of crisis calls, the assessment of suicide potentiality is highly correlated for all three judges. The procedure of having judges independently rate suicide potentiality using the scale as a guide provides a reliable measure of suicide potentiality.

Three other judges with varying exposure to suicide and
## Summary of Lethality Ratings

<table>
<thead>
<tr>
<th>Judges</th>
<th>1 Director</th>
<th>2 Director &amp; Call Handler</th>
<th>3 Reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lydia</td>
<td>Moderate (2)</td>
<td>Moderate (2)</td>
<td>High Mod. (2)</td>
</tr>
<tr>
<td>Janet</td>
<td>Low High (3)</td>
<td>Low High (3)</td>
<td>Low High (3)</td>
</tr>
<tr>
<td>Howard</td>
<td>Low Mod. (2)</td>
<td>Moderate (2)</td>
<td>Low Mod. (2)</td>
</tr>
<tr>
<td>Albert</td>
<td>Moderate (2)</td>
<td>Low Mod. (2)</td>
<td>Low Mod. (2)</td>
</tr>
<tr>
<td>Arthur</td>
<td>Moderate (2)</td>
<td>Moderate (2)</td>
<td>Moderate (2)</td>
</tr>
<tr>
<td>Alicia</td>
<td>Low (1*7)</td>
<td>Moderate (2)</td>
<td>Moderate (2)</td>
</tr>
<tr>
<td>Marie</td>
<td>High Mod. (2)</td>
<td>High Mod. (2)</td>
<td>Low Mod. (2)</td>
</tr>
</tbody>
</table>

Mean: 2 2.14 2.14

Rank: Low = 1; Moderate = 2; High = 3.

Correlations: Judge 1 to Judge 2 \( r = .77^* \)
Judge 1 to Judge 3 \( r = .77^* \)
Judge 2 to Judge 3 \( r = 1.00^* \)

*two-tailed, \( p < .05 \)
suicide information rated the responses of the subjects for empathy and effectiveness on subtest 5 on four cases independently. Mean ratings of each judge on each subject are given in the second table. A subject score is the mean score across all subjects and correlations of the judges' ratings are also indicated in the table. The only significant correlation between the mean score across all subjects was that of the nonsuicidal and previously suicidal judges. The rating of the mental health professional-crisis line volunteer did not correlate significantly with the ratings of the judges selected from the patient and nonprofessional subgroups.

The correlations of independent ratings of suicide call handling by judges of variable exposure to suicidal activity and people do not support the findings of Dilley and Bowers (1973). The professional-crisis line volunteer's and the non-professional's rating of effectiveness and empathy do not correlate significantly. The previously suicidal and nonsuicidal adult do correlate significantly, but the professional's rating is higher than that of the nonprofessional. This finding suggests that the professional and/or volunteer may tend to overrate his empathy and helpfulness. The lay person may have higher standards of service than does the professional.
**Correlation of Ratings of Subjects by Judges on Suicide Call Handling (Test 5)**

<table>
<thead>
<tr>
<th>Judges</th>
<th>1 Nonsuicidal Adult</th>
<th>2 Mental Health Profess. Crisis Line Volunteer</th>
<th>3 Previously Suic. Adult</th>
</tr>
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<td>Subj.</td>
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<tr>
<td>1</td>
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<td>112.5</td>
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Correlations:  
Judge 1 to Judge 2 \( r = .24 \)  
Judge 1 to Judge 3 \( r = .62* \)  
Judge 2 to Judge 3 \( r = .05 \)

*two-tailed, \( p < .05 \)