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**AN EVALUATION OF A METHOD OF
SUICIDE ASSESSMENT TRAINING**

by

Gerald A. Juhnke

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
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and Counseling Psychology

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AN EVALUATION OF A METHOD OF SUICIDE ASSESSMENT TRAINING

Gerald A. Juhnke, Ed.D.

Western Michigan University, 1991

This quasi-experimental study used a Randomized Groups, Posttest-only Design, to determine if significant differences between three groups existed in their: (a) ability to accurately assess high- and low-risk clients, (b) ability to accurately assign clinical actions, and (c) self-reported confidence to accurately assess suicide risk and assign clinical actions. The 59 volunteer subjects who participated in the study were master's level counselors-in-training enrolled in a counseling prepractica training course within a Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited counselor education and counseling psychology department of a large Midwestern university. Two of the three groups were experimental (i.e., the SAD PERSONS Suicide Assessment Scale [Patterson, Dohn, Bird, & Patterson, 1983] Live Lecture Group [SAD-Live Group] and the SAD PERSONS Suicide Assessment Scale Videotape Instruction Group [SAD-Video Group]). These groups were exposed to a suicide assessment aid designed to assess suicide risk and assign clinical interventions.

The SAD-Live Group and SAD-Video Group components were identical in content but different in format. The SAD-Video Group received only videotaped instruction and later observed the presenter assessing the presence of risk factors and assigning clinical actions based upon two videotaped vignettes.

The SAD-Live Group received live lecture and later participated with the lecturer in assessing the presence of 10 risk factors and assigning clinical actions based upon two videotaped vignettes. The third group (i.e., the Transference-Countertransference Control Group [Control Group]) received a videotaped lecture regarding transference and countertransference within the therapeutic relationship.

The findings from this study indicated that: (a) counselors-in-training who received SAD-Video Group instruction made suicide assessments which corresponded more closely to three expert psychiatrists' assessments, (b) counselors-in-training who received SAD-Video Group instruction assigned clinical actions which corresponded more closely to three expert psychiatrists' recommendations, and (c) counselors-in-training who demonstrated superior client risk assessment and clinical recommendation abilities felt no more confident or qualified than their counterparts who did not perform as well. It was concluded from these results that SAD-Video Group instruction was more effective than either SAD-Live Group training or Control Group training in helping master's level prepractica counselors-in-training more accurately assess suicide risk and more accurately assign clinical recommendations.

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Gerald A. Juhnke

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CHAPTER I

INTRODUCTION

The famous Russian writer, Count Leo Nikolaevich Tolstoy, stated in a letter to a friend in 1898, "The possibility of killing one's self is a safety valve. Having it, man has no right to say life is unbearable" (Seldes, 1985, p. 421). Today's current statistics, however, bear out the grim fact that many Americans believe suicide is the answer to life's miseries and seemingly intolerable feelings instead of the "safety valve" Tolstoy implied. Unfortunately, for those who commit suicide the permanency of its "cure" may be worse than the perceived intolerable inflictions they would otherwise endure.

Across all age groups in the United States (U.S.) suicide is the eighth leading cause of deaths annually (National Center for Health Statistics [NCHS], 1990). Approximately 83 persons kill themselves each day within the U.S. (McIntosh, 1991). McIntosh suggests that on average one person within the U.S. commits suicide every 17.3 minutes. Official records by NCHS (1990) indicate that 30,796 Americans died of suicide in 1988. The frequency of such suicidal behavior, however, is often not fully realized or readily apparent because information regarding suicide attempts is not compiled at the national level. McIntosh (1991), for example, reports that for every suicide completion there are between 8 and 20 suicide attempts. He suggests between 240,000 and 600,000

suicide attempts occur annually. Berman (1975) estimates that the annual number of suicide attempts is two to eight times the yearly total of legally certified suicides. This estimate would suggest that between 61,592 and 246,368 suicide attempts were made in the year 1988.

Over five million living Americans have attempted suicide at some time in their lives (McIntosh, 1991; Wekstein, 1979). Between 1970 and 1980 more than 300,000 persons died from suicide in the United States; this number is higher than the total number of American deaths related to all world wars (Peck, Farberow, & Litman, 1985). Suicide is the second leading cause of death among American young people ages 15-24 with approximately 13.7 young Americans committing suicide daily (NCHS, 1986). Such numbers constitute a 300% increase in the suicide rate for this specific age group alone over the last 20 years (Shaffer & Fisher, 1981). Brody (1986) indicates that approximately 400,000 teenagers attempt suicide annually. However, Cantor (1987) suggests that only 5,200 of these suicide attempts, otherwise known as parasuicides, result in actual fatalities.

Data compiled by NCHS (1990) further suggest that all American populations are not at equal risk. White males, for example, had the highest number of certified suicides for the year 1988 with 24,078 deaths indicated as being a direct result of suicide. This population alone accounted for 79% of the certifiable suicides that year. White females during this same time period ranked second with 6,320 certifiable suicides. African-American youths between the ages of 15 and 24 are also noted as being at significant risk; suicide is the third leading cause

of death within this specific population behind deaths resulting from homicides and accidents (NCHS, 1986). Concomitantly, NCHS (1990) reports persons living within the Mountain States of Nevada, New Mexico, Arizona, Colorado, Montana, Idaho and Wyoming have the highest rate of suicide when compared to other U.S. geographic regions (e.g., Pacific, South Atlantic, New England, Middle Atlantic, etc.).

Besides those who choose to end their lives, many family members and friends are adversely affected by suicide and suicide attempts. In 1972 Shneidman estimated that an additional 200,000 family members experienced the emotional trauma and stigma related to the suicide of a loved one each year. McIntosh (1991) states, "Each suicide intimately affects at least 6 other people (estimate)" (p. 10). Given the total number of U.S. deaths certified as resulting from suicide in 1988, McIntosh's estimate suggests that nearly 185,000 persons within the U.S. experienced the effects of another's suicide during that year. Studies further indicate that these survivors of suicide are themselves at higher risk for suicide and emotional problems (American Association of Suicidology [AAS], 1990).

Osterweis, Solomon and Green (1984) report that family survivors of suicide face a most difficult form of bereavement. Danto and Kutscher (1977) indicate that bereavement reactions to a family member's suicide often induce increased feelings of shame, guilt and anger. Their research suggests that survivors have a proclivity towards greater risk of emotional and physical difficulties than the general population at large.

The actual toll of human lives lost due to suicide may be higher than those suicides actually reported. The veracity of suicide rates has long been suspect as underreported or inaccurate (MacKinnon, 1977; Sainsbury, 1983; Sainsbury & Jenkins, 1982; Warshauer & Monk, 1978; Wekstein, 1979). The true number of deaths by suicide is suspected to be far greater than that compiled by the NCHS. Allen (1984) believes nearly 50,000 Americans die annually of suicide. Farberow, MacKinnon, and Nelson (1977) support Allen's position by arguing that investigations often, if not always, lack the true intent of the deceased's actions and his or her predeath thoughts.

Prevention through a thorough assessment seems the logical key to reducing suicides, especially given the fact that remediation is impossible for those who complete the act of self-induced annihilation (Motto, 1991; Patterson, Dohn, Bird, & Patterson, 1983). Shneidman (1986) reports that clues regarding suicide are present in approximately 80% of all suicidal deaths and that suicidal people commonly indicate their intent to end their lives. Therefore, Shneidman argues that the primary prevention strategy for suicide prevention is professional education related to suicide. One possible method in accomplishing this would be through adequate assessment training of mental health professionals and laypersons (Maris, 1991; Motto, 1991). Neimeyer and Diamond (1983) contend that the majority of suicides "could be foreseen and perhaps averted" (p. 562), suggesting that persons could intervene if they learned how to estimate immediate suicide risk. This position appears to be supported by trainers of medical and

non-medical mental health providers who have devised suicide assessment aids or suicide assessment training programs (Golden, 1978; Patterson et al., 1983). The argument for increased suicide assessment training seems even more logical when one understands that the overwhelming majority of suicidal persons desperately desire to live and frequently give definite warnings regarding their intentions to take their lives (AAS, 1990).

However, Berman (1986) reports that on average, no more than 1/2 day's formal education is given to the topic of suicidology by any of the mental health disciplines. Berman (1986) states:

Our own survey of over 300 training directors of psychiatric residency, clinical psychology, clinical social work and psychiatric nursing programs ... found training in suicidology is expected to occur (please note my use of the passive tense) through clinical experience with suicidal patients (as cases arise) and supervision. (p. 9)

Berman (1986) continues, indicating that current research, however, has suggested that "increased clinical professional experience per se has no relationship to increased ability to recognize suicide lethality factors" (p. 9).

Bongar and Harmatz (1989) indicate that training in the management of suicidal patients is both important and feasible. Bongar and Harmatz's (1989) survey of 115 members of the Council of University Directors of Clinical Psychology Programs reports that 57% of the programs participating in the survey "offered no formal training in the study of suicide" (p. 211). Bongar and Harmatz (1989) hypothesize:

Therefore, one possible explanation for why training programs do not have

a formal training sequence in the study of suicide may be a by-product of the day-to-day clinical lives of faculty. Specifically, the typical academic clinical psychologist and the average health service provider in psychology may in fact be seeing different populations in their professional practice and supervision (e.g., the selected client populations of the typical university psychological services center). (p. 211)

Citing Tyler and Clark's (1987) study, Bongar and Harmatz (1989) report "there exist basic differences between academic and practicing clinicians with respect to the professional activities that they perform and prefer to perform" (p. 211).

Other possible reasons for this paucity of formal graduate school training in suicidology may be related to: (a) lack of clinical faculty who themselves have had sufficient formal training and experience in suicidology, suicide assessment or emergency psychotherapy; (b) lack of available department funds to create a specialty course in suicidology, suicide assessment or emergency psychotherapy; (c) lack of available classroom or laboratory space within departments to establish such specialized training; (d) liability concerns related to proper instruction of students involved in such a course; (e) a distorted perception that either students will not encounter suicidal crises or that suicidal behavior is a medical emergency vis-a-vis a mental health emergency; or (f) some department faculty may be unaware of the available resources related to specific training in suicidology.

In an attempt to insure that medical students are sufficiently trained in suicidology prior to their clinical experience, Patterson et al. (1983) created the SAD PERSONS Suicide Assessment Scale. They believed that a key component in suicide assessment training was teaching mental health professionals how to

evaluate current suicide risk in those presenting for services during a clinical interview or mental status examination. Patterson et al. demonstrated that the SAD PERSONS Suicide Assessment Scale can significantly aid medical students in accurately identifying degrees of client risk. They reported that because SAD PERSONS was a brief acronym, it was easily memorized and facilitated clinicians in conducting a thoughtful and mentally organized risk assessment procedure.

The current scale is based upon 10 major risk factors identified in the literature (i.e., sex, age, depression, previous attempt, ethanol abuse, rational thinking loss, social supports lacking, organized plan, no spouse, and sickness). The client is given one point for each of the 10 factors identified or perceived present by the clinician. Recommended clinical treatment is indicated by the total number of factors compiled. This proposed clinical recommendation can then be used in conjunction with the mental health professional's clinical perceptions and other available aids (e.g., consultation with a senior level clinician, psychosocial history as provided by family and friends, psychological testing, etc.) to create an anticipated safe and minimally restricting plan of action.

As early as 1970, Berger (1970) and Onder (1970) suggested that videotaped training was a useful instructional tool. Videotaped training programs have been designed to increase students' skills in a variety of areas (Iverson, 1986; Kaczkowski & Fenton, 1985) ranging from the facilitation of groups to conducting direct clinical interviews. It has also been useful in supplementing existing curricula (Harbison, 1989). Researchers in counselor education suggest that: (a)

self-instructional videotaped programs are effective in teaching counseling skills (Hum, Calder, & Zingle, 1981); (b) written, audio and video models of self-instructional learning related to counselor training demonstrated no significant differences in effectiveness (Robinson, Froehle, & Kurpius, 1979); and (c) graduate level counseling students exposed to videotaped models of instruction did not significantly differ in their performance from those who had received other types of instruction (Peters, Cormier, & Cormier, 1978). Others suggest that medical students have found videotaped models of teaching highly beneficial to their clinical education (Jackson & Pinkerton, 1983), and that medical students exposed to different types of instructional methods (i.e., live lecture and videotaped lecture) found both to be effective and worthwhile (Pohl, Lewis, Niccolini, & Rubenstein, 1982).

For example, Golden (1978) developed a self-instructional videotape program for teaching suicide assessment to medical students. Golden's (1978) research regarding the program suggests "that students exposed to the treatment did score significantly higher ($\alpha=.05$) on four of the seven criteria used to determine the effectiveness of the program" (p. 45). His research implies that some skills necessary for accurate suicide assessment may be learned via self-instructional videotape. A program such as Golden's may be useful in augmenting existing master's level training and course work, especially in suicide assessment.

Statement of the Problem

The problem of this investigation was evaluating the effects of a standardized suicide assessment training model upon master's level students enrolled in a prepractica counselor training course within a Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited counselor education and counseling psychology department of a large Midwestern university. Of major concern was knowledge of 10 primary suicide risk factors cited by Patterson et al. (1983) as the ability to: identify said risk factors, make appropriate clinical recommendations from a SAD PERSONS Suicide Assessment Scale score, and determine the relative effects of live lecture vis-a-vis videotaped instruction of the SAD PERSONS Suicide Assessment Scale. Lastly, the study investigated the subjects' self-confidence related to assessing suicide risk in clients and students who present for services.

Purpose of the Study

The primary purpose of this study was two-fold: (1) to investigate possible cause-and-effect relationships, as evidenced by the existence of significant Assessment Scale training (i.e., experimental groups) compared to those not receiving such instruction (i.e., the Transference-Countertransference Control Group [Control Group]; and (2) to manipulate the method of training used (i.e., SAD PERSONS Suicide Assessment Scale Live Lecture Group [SAD-Live

Group] vis-a-vis SAD PERSONS Suicide Assessment Scale Videotaped Instruction Group [SAD-Video Group]) to compare efficacy. Specifically, the following purposes were included:

1. To determine whether there is a significant difference in ability to more accurately assess high-risk clients and low-risk clients portrayed within videotaped vignettes between master's level counselors-in-training who received SAD PERSONS Suicide Assessment Scale training through one of the two experimental groups (i.e., SAD-Live Group or SAD-Video Group), and counselors-in-training who participated in the Control Group; and to determine if significant differences related to differentiation exist between the two experimental groups, as measured by Likert Scale scores.

2. To determine whether there is a significant difference in ability to assign more accurate clinical actions for persons portrayed as being high- or low-risk within videotaped vignettes between master's level counselors-in-training who received SAD PERSONS Suicide Assessment Scale training through one of the two experimental groups (i.e., SAD-Live Group or SAD-Video Group), and counselors-in-training who participated in the Control Group; and to determine if significant differences related to proposed clinical actions exist between the two experimental groups, as measured by subject self-reported, multiple-option responses.

3. To determine if there is a significant difference between master's level counselors-in-training who received SAD-Live Group training and those who

received SAD-Video Group instruction in their abilities to accurately assess both high- and low-risk clients by means of the SAD PERSONS Suicide Assessment Scale as measured by Likert Scale scores.

4. To determine whether there is a significant difference in subject self-reported confidence in ability to accurately assess clients' and students' risk of suicide between master's level counselors-in-training who: (a) received SAD-Live Group training and those who received SAD-Video Group instruction; and (b) received one of the two SAD PERSONS Suicide Assessment Scale experimental training groups and those counselors-in-training who participated in the Control Group as measured by subject self-reported, multiple-option responses.

5. To determine whether there is a significant difference between SAD PERSONS Suicide Assessment Scale Scores for high-risk clients and low-risk clients portrayed within videotaped vignettes given by master's level counselors-in-training who received SAD PERSONS Suicide Assessment Scale training through one of the two experimental groups (i.e., SAD-Live Group or SAD-Video Group), and SAD PERSONS Suicide Assessment Scale scores given by three experienced psychiatrists who observed the same videotaped vignettes and assigned the scores recommended and used as correct in Patterson's et al. (1983) study, as measured by Likert Scale scores.

6. To determine whether there is a significant difference between proposed clinical actions for high-risk clients and low-risk clients portrayed within videotaped vignettes given by master's level counselors-in-training who received

SAD PERSONS Suicide Assessment Scale training through one of the two experimental groups (i.e., SAD-Live Group or SAD-Video Group), and proposed clinical actions given by three experience psychiatrists who observed the same videotaped vignettes and assigned the clinical actions recommended and used as correct in Patterson's et al. (1983) study, as measured by subject self-reported, multiple-option responses.

Significance of the Study

As the eighth leading cause of U.S. deaths annually (NCHS, 1990), the human costs related to lost American lives seems relatively obvious. However, heightened concern regarding the need for increased suicide assessment training of mental health professionals appears increasingly more logical given research which suggests: (a) psychologists providing direct care have a greater than 1-in-5 risk of having a client commit suicide during the clinician's career (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988); (b) potential for suicide attempts and suicide completions are significantly higher for those in mental health treatment vis-a-vis the general population at large (Nekanda-Trepka, Bishop, & Blackburn, 1983); (c) of all mental health emergencies, suicidal behavior is the most frequently encountered by mental health professionals (Schein, 1976); (d) therapists who experience the death of a client from suicide suffer intense feelings of isolation, guilt and loss of professional esteem (Michalik, 1988); and (e) suicidal crises have been identified by clinicians as one of their worst fears (Birtchnell, 1983;

Deutsch, 1984). Such studies strongly imply that further suicide assessment training may not only benefit clients, their families and friends, but mental health providers as well.

Concomitantly, most entry level counselors attain initial employment in schools or community agency settings (Hollis & Wantz, 1986) where interactions with those belonging to one or more high-risk groups commonly occur (e.g., those ages 15-24, those who lack other significant treatment resource availability, those who are experiencing confusion or psychological distress, etc.). Beginning counselors with little field experience are especially in need of suicide assessment training. Increasing financial constraints upon schools and community agencies by federal, state and local governments may have significant effects upon the mental health profession (Berman, Kisch, Deleon, & Cummings, 1987; Cummings, 1979). Cummings (1979, 1988) suggests that such funding constraints would probably reduce available monies for clinical supervision by mental health care providers. He suggests this will probably lead to increasing client case loads of mental health care providers which may allow less time for client-provider contact (Cummings, 1979, 1988). It seems reasonable then that mental health care providers should receive suicide assessment training to function adequately in a therapeutic delivery system which is likely to demand more independent clinical functioning and accurate clinical judgement with diminished support from advanced degreed or senior level supervisors.

Due to the relative low cost of purchasing or producing a videotaped

program and wide availability of videocassette recorders (VCR's), it would seem that university administrators and faculty would find videotaped suicide assessment training programs a viable and cost effective option. Such relatively inexpensive instruction would likely be increasingly useful if department faculties or funds were stretched to their limits. A videotape component specifically designed to supplement classroom course work related to basic counseling techniques appears to be a cost effective way to insure a minimum standard of counselor training and skills pertaining to suicide assessment.

It would further seem reasonable to anticipate that clinical supervisors and agency administrators would perceive as beneficial suicide assessment instruction as part of a student's formal graduate level training program. Such training would likely develop skills that may reduce possible liability issues related to failing to estimate significant suicide risk in a client presenting for services and likely encourage mental health providers to provide a more comprehensive delivery service. Finally, a videotaped supplementary suicide assessment component could be used occasionally to sharpen mental health providers' skills either as a review or to generate in-house training of newly hired staff and interns.

The present study, then, sought to determine efficacy of the SAD PERSONS Suicide Assessment Scale upon master's level counselors-in-training. The intent was to aid the students' developing judgement so they could more effectively perform their clinical duties, even in the face of possible diminishing direct clinical supervision and support from more advance degreed or senior level

clinicians. The findings of this research should aid counselor educators in objectively determining whether the SAD PERSONS Suicide Assessment Scale via live lecture or videotaped instruction is helpful in promoting skill development related to assessment of high- and low-risk clients and accurately proposed clinical actions.

Statement of the Null Hypotheses

Seven null hypotheses and 12 null sub-hypotheses were investigated in this study. The hypotheses examined the effects of SAD PERSONS Suicide Assessment Scale training upon master's level counselor education, counseling psychology students enrolled in a prepractica counselor training course related to: (a) assessment of high- and low-risk clients through identification of 10 primary suicide risk factors as cited by Patterson et al. (1983), (b) ability to make accurate clinical dispositions and interventions based upon a client's clinical presentation, and (c) confidence of subjects in adequately assessing the immediate risk of suicide for clients or students who present for services. Additionally, hypotheses examined the efficacy of specific training methods (i.e., SAD-Live Group training in comparison with SAD-Video Group instruction) used in presenting the SAD PERSONS Suicide Assessment Scale to master's level counselor education, counseling psychology students enrolled in a prepractica counselor training course. The following hypotheses are stated in null form:

Null Hypothesis 1: Subjects who participate in the research experiment will

not demonstrate significantly different suicide risk assessments of a videotaped vignette of a low-risk client, as measured by Likert Scale scores.

Null Sub-hypothesis 1.1: Subjects who received SAD-Live Group training will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a low-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by Likert Scale scores.

Null Sub-hypothesis 1.2: Subjects who received SAD-Video Group instruction will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a low-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by Likert Scale scores.

Null Sub-hypothesis 1.3: Subjects who received SAD-Video Group instruction will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a low-risk client in comparison with those subjects who received SAD-Live Group training, as measured by Likert Scale scores.

Null Hypothesis 2: Subjects who participate in the research experiment will not assign significantly different clinical interventions of a videotaped vignette of a low-risk client, as measured by self-reported, multiple-option responses.

Null Sub-hypothesis 2.1: Subjects who received SAD-Live Group training will not assign significantly different clinical interventions of a videotaped vignette of a low-risk client in comparison with those subjects who did not receive SAD

PERSONS Suicide Assessment Scale training, as measured by self-reported, multiple-option responses.

Null Sub-hypothesis 2.2: Subjects who received SAD-Video Group instruction will not assign significantly different clinical interventions of a videotaped vignette of a low-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by self-reported, multiple-option responses.

Null Sub-hypothesis 2.3: Subjects who received SAD-Video Group instruction will not assign significantly different clinical interventions of a videotaped vignette of a low-risk client in comparison with those subjects who received SAD-Live Group training, as measured by self-reported, multiple-option responses.

Null Hypothesis 3: Subjects who participate in the research experiment will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a high-risk client, as measured by Likert Scale scores.

Null Sub-hypothesis 3.1: Subjects who received SAD-Live Group training will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a high-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by Likert Scale scores.

Null Sub-hypothesis 3.2: Subjects who received SAD-Video Group instruction will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a high-risk client in comparison with those subjects who

did not receive SAD PERSONS Suicide Assessment Scale training, as measured by Likert Scale scores.

Null Sub-hypothesis 3.3: Subjects who received SAD-Video Group instruction will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a high-risk client in comparison with those subjects who received SAD-Live Group training, as measured by Likert Scale scores.

Null Hypothesis 4: Subjects who participate in the research experiment will not assign significantly different clinical interventions of a videotaped vignette of a high-risk client, as measured by self-reported, multiple-option responses.

Null Sub-hypothesis 4.1: Subjects who received SAD-Live Group training will not assign significantly different clinical interventions of a videotaped vignette of a high-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by self-reported, multiple-option responses.

Null Sub-hypothesis 4.2: Subjects who received SAD-Video Group instruction will not assign significantly different clinical interventions of a videotaped vignette of a high-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by self-reported, multiple-option responses.

Null Sub-hypothesis 4.3: Subjects who received SAD-Video Group instruction will not assign significantly different clinical interventions of a videotaped vignette of a high-risk client in comparison with those subjects who did not

receive SAD-Live Group training, as measured by self-reported, multiple-option responses.

Null Hypothesis 5: There will be no significant difference in self-reported confidence to adequately assess the immediate risk of client or student suicide among subjects, as measured by self-reported, multiple-option responses.

Null Hypothesis 6: Subjects who participated in either experimental group (i.e., SAD-Live Group or SAD-Video Group) will not differ significantly in SAD PERSONS Suicide Assessment Scale scores given to high- and low-risk videotaped clients when compared to scores given by three experienced psychiatrists who observed the same videotaped vignettes and assigned the clinical actions recommended and used as correct in Patterson's et al. (1983) study.

Null Hypothesis 7: Subjects who participated in either experimental group (i.e., SAD-Live Group or SAD-Video Group) will not differ significantly in proposed clinical actions given to high- and low-risk videotaped clients compared to proposed clinical actions given by three experienced psychiatrists who observed the same videotaped vignettes and assigned the clinical actions recommended and used as correct in Patterson's et al. (1983) study.

Definition of Terms

The following definitions apply to this study:

Suicide means "a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue

for which the suicide is perceived as the best solution" (Shneidman, 1985, p. 203); simply stated suicide is the intentional act of killing oneself.

Suicide assessment within this study implies less precision than suicide prediction and is used because the term prediction means to make known beforehand; assessment assumes that one is never 100% positive that a client will or will not commit suicide (Maris, 1991). Therefore, suicide assessment herein means to predict the risk of suicide vis-a-vis the suicide itself (Motto, 1991).

High-risk indicates persons who were judged by a panel of three experienced psychiatrists to be in significant and immediate danger of attempting suicide.

Low-risk indicates persons who were judged by a panel of three experienced psychiatrists as not being in significant and immediate danger of attempting suicide.

Parasuicide and suicide attempt are synonymous terms within this dissertation and indicate a nonfatal suicide act which was either intentionally or unintentionally nonfatal.

Self-instructional videotape indicates a videotape which is designed to adequately train mental health providers in a specific skill (i.e., a self-instructional videotape used to adequately train counselors in the proper use of the SAD PERSONS Suicide Assessment Scale).

Delimitations of the Study

This research was specifically developed for and conducted with master's

level counseling students enrolled in a single department of counselor education and counseling psychology and, therefore, may not be applicable to other mental health providers (i.e., clinical social workers, psychiatric nurses, clinical psychologists, marriage and family therapists, etc.) or other mental health training programs. Concomitantly, the study was restricted to one Midwestern university and conducted during the winter semester.

Limitations of the Study

Attrition occurred during the study; therefore, all students within the prepractica counseling course did not participate. Some were absent during the specific day of the research. Others perceived it not in their best interest to participate. Because of such attrition, the results of the study may be influenced in some unknown way. Concomitantly, some subjects failed to complete all questions on the instrument used to obtain subject self-reported responses. Other subjects may have misinterpreted questions used to obtain self-reported responses. Finally, it is noted that the instrument used to measure the dependent variables was not tested for reliability or validity. In view of the preceding limitations, generalizations are limited to the sample studied and may not be relevant to all counselors-in-training.

Assumptions of the Study

For the purposes of this study, the following basic assumptions were made:

1. The SAD PERSONS Suicide Assessment Scale identified 10 primary suicide risk factors that accurately assess immediate suicide risk.
2. The SAD PERSONS Suicide Assessment Scale aided in proposing accurate clinical interventions related to the client's presenting degree of suicide risk.
3. The SAD PERSONS Suicide Assessment Scale aided clinicians attempting to structure a thorough and systematic suicide assessment interview.
4. Adequate suicide assessment training was important for master's level community agency counselors, school counselors, student personnel services workers and counseling psychologists.
5. All respondents in the study participated willingly and honestly.

Summary of the Study

The study has compared differences between master's level counseling students who received specialized SAD PERSONS Suicide Assessment Scale training by means of either SAD-Live Group training or SAD-Video Group instruction to those who have not received such training. The study has compared the abilities of these counselors-in-training to accurately assess high- and low-risk clients and students. Concomitantly, it has compared the abilities of these subjects to assign clinical actions for those identified somewhere along a continuum of immediate risk. This research further compared methods of instruction to determine if one method is suggested as being significantly superior in helping counselors-in-training identify those at risk or assign accurate clinical actions.

The study compared self-reported levels of confidence in suicide assessment related to training and method received. The subjects, instruments, procedures, and data analysis have been described.

Organization of the Remainder of the Study

Related literature is reviewed in Chapter II, and methods of procedures are described in Chapter III. Data are analyzed in Chapter IV; findings, conclusions, and recommendations are summarized in Chapter V.

CHAPTER II

REVIEW OF RELATED LITERATURE AND RESEARCH

Client suicide has long been a concern to mental health professionals. More recently, however, the topic of suicide and its effects upon American society has gained increased public attention as evidenced through major feature articles in the New York Times and Los Angeles Times newspapers (Brody, 1986; Cantor, 1987). In response to this problem, there have been increased efforts by suicidologists to engender awareness of the frequency of suicide and the need for increased suicide assessment training for mental health professionals. This chapter reviews three areas important to suicide prevention and clinical training: (1) suicide prediction vis-a-vis suicide assessment, (2) training of mental health professionals in suicide assessment, and (3) the efficacy of videotaped training.

The purpose of this literature review is twofold: (1) to investigate suicide risk assessment and clinical training of mental health professionals related to appropriately interacting with those who present with suicidal behaviors or ideation, and (2) to investigate the use of videotaped training components. This investigation of research literature will provide clarification between suicide prediction and suicide assessment. Existing research data regarding current training of students within formal graduate school education in suicidology will be discussed and summarized. Possible benefits as suggested by researchers related to

such training paradigms and possible concerns will also be examined. Other research regarding videotaped training programs will be reviewed, including videotape training within other disciplines (e.g., medicine, psychiatry, special education, pharmacology, etc.). This review will provide information regarding various videotape training usage within formal education and indicated benefits.

Prediction and Assessment of Suicide

Hatton and Valente (1984) state, "Determining the prediction of suicide risk is one of the major objectives in suicide prevention and is also a major problem area fraught with conflict" (pp. 62-63). They report that the vast majority of suicidologists are unable to agree how to identify suicide risk and suggest that most research regarding suicide assessment can be challenged due either to its lack of validity or reliability. Biro and Lazic (1988), Lettieri (1974) and Maltsberger (1988) cite similar difficulties related to suicide prediction, with MacKinnon and Farberow (1976) claiming "it is unlikely to predict a future suicide beyond a 20% level of efficiency" (p. 86).

The reliable prediction of suicide is further questioned by Balon (1987), who reports that accurate prediction is impossible. Despite his assertion, however, he unequivocally states suicide prediction is essential for suicide prevention and treatment. He indicates that the vast majority of research literature deals with demographic predictors, and contends that such predictors fail to accurately assess whether an individual will commit suicide. According to Balon, the etiology of

suicide is likely multifactorial. He implies it foolhardy for researchers to search for single factors which might or might not suggest a client is at risk of suicide. Balon (1987) states, "Suicide is the end result of a process, not a process itself. ... Like most complex behavior, suicide appears to have multiple determinants" (p. 236). He believes even if one uses biological, psychological and demographic variables to predict suicide, the results will most probably be imprecise.

Lettieri (1974) also views suicide risk prediction resulting from demographic or psychological variables as being difficult and frequently inaccurate. He implies that often those who attempt to use such demographic or psychological variables to predict suicide follow a "classical British empiricist notion of straight line or historical cause and effect relations" (Lettieri, 1974, p. 235). Such a paradigm does not adequately address the reciprocal influences of the suicidal client's interactions with his or her immediate environment and the effects of the evaluatee's interpersonal relationships, according to Lettieri. He suggests that methods which identify high-risk criteria falsely imply a static, non-changing system.

Motto (1977), however, implies that specific high-risk indicators or factors can help identify those who may be at greater risk of suicide. He argues that more accurate suicide prediction depends increasingly upon defining precise sub-populations to which assessment instruments can be more adequately applied. He used a wide range of psychological and psychosocial data obtained from 3,006 psychiatric inpatients hospitalized due to a depressive or suicidal state. Each of these subjects was interviewed at length to obtain necessary information related to

specific high-risk indicators. The results of his research supported some previously thought-to-be high-risk questions that were anticipated to indicate those who might be at greater risk (e.g., items which asked about topics such as prior psychiatric hospitalization, unsatisfactory results of prior efforts to obtain help, etc.).

Using these identified items, Motto (1977) was able to discriminate between those who were dismissed from inpatient hospitalization and committed suicide within 2 years from those who were dismissed and did not commit suicide at the .0005 level of confidence. From this information, Motto, Heilbron, and Juster (1985) created a paper-and-pencil scale from 15 variables believed to be significant predictors of suicidal outcome. All except two of these risk predictors were found in previous risk-assessment instruments.

Maris (1991) reports the term suicide prediction is a misnomer which incorrectly implies one can accurately identify all those who will successfully commit suicide. He contends that one may become disillusioned and cynical regarding the concept of suicide prediction and may begin to feel that "only suicide 'predicts' suicide" (Maris, 1991, p. 1). He states, "Prediction literally means to make known beforehand or to foretell. Suicide prediction has a kind of 'zero-sum' quality to it. One either 'gets it right or not'" (Maris, 1991, p. 2).

The term suicide assessment, according to Maris (1991), is more accurate. He believes it reflects a quality of imprecision that most suicidologists acknowledge along some type of suicide risk continuum or in degrees of estimated risk.

Assessment, then, implies something much different than prediction. Maris suggests that empirical approaches to suicide assessment (e.g., suicide prediction scales, suicide check lists, prediction variables and psychological tests, etc.) in conjunction with appropriate clinical judgment create a better assessment strategy than either component solely by itself.

Motto (1991) claims it ironic that even if clinicians could perfectly predict which clients would successfully commit suicide through some type of predictive instrument that the clinicians would not recognize it. Such prediction could not be validated by its critical outcome criterion; clinicians would be ethically and morally obligated to intervene to prevent a client's suicide and therefore be unable to prove that without intervention the client would have successfully completed suicide. Motto (1991) states:

After the crisis we could have no way of knowing with certainty whether the person would have suicided or not. Even if we accepted the reality that people are not either 0% or 100% likely to suicide, and developed a perfect scale to estimate degree of risk, we would still be unable to validate it in individual cases. (p. 88)

He suggests that an eclectic approach to suicide assessment is best and believes that some form of direct inquiry about the client's suicidal intent is imperative in assessing risk.

Motto (1991) indicates that since clinicians are unable to predict suicide, they need to evaluate known and observed data by both subjective and objective measures. Such an evaluation will create a measurement of estimation regarding suicide risk: "We can thus predict the risk of suicide rather than the suicide itself"

(Motto, 1991, p. 83). He indicates that the use of a carefully constructed empirical risk scale can suggest to a clinician the degree of danger for those within certain identified populations. This in combination with a clinical interview will give the clinician an indication of whether the client's pain tolerance is so close to being exceeded that an environmentally restrictive intervention is warranted.

According to Motto (1991), the final summation of suicide assessment gives the clinician only an estimation of risk and is commonly indicated in somewhat nebulous terminology (i.e., low, moderate, or high risk). Motto (1991) states:

Uncomfortable as it is, we have no realistic choice but to deal in levels of risk, which can vary from day to day or hour to hour, subject to the influence of numerous uncontrollable and unpredictable events. To try to predict more than the risk that is present at a given time, or the risk that would be present under specific circumstances, is an unrealistic goal that can lead to frustration and discouragement. This tone has crept into the risk assessment literature to some extent in the form of questioning the value of efforts in this direction. (p. 84)

Motto cautions clinicians not to become excessively discouraged related to some researchers' pessimism regarding an inability to provide perfectly accurate suicide prediction. He concludes by reminding clinicians that even if perfect suicide assessment were possible, it would not necessarily insure positive safety. Placing clients deemed to be at high risk in a restricted environment (i.e., a psychiatric hospital or crisis housing) may not prevent their suicide while in the restrictive environment or inhibit suicide once they are released.

Differences in Suicide Assessment Training

A study comparing suicide risk assessment skills of clinical psychologist trainees and psychiatry residents has suggested that the semistructured clinical interviews of psychologist trainees proved more accurate in identifying the seriousness of parasuicides (Burstein, Adams, & Giffen, 1973). In this study 5 psychology and 4 psychiatry residents in a county hospital emergency room evaluated 102 patients admitted due to suicide attempts. Trainees rated each client according to 3 scales: (1) a 7-point scale reflecting the patient's conscious expectation of living or dying as a result of his or her attempt, (2) a 4-point scale reflecting the seriousness of the attempt, and (3) a 4-point scale reflecting the likelihood that the patient would attempt suicide again.

These ratings were based upon individual clinical interviews with clients in which trainees attempted to obtain a psychosocial history from the client. The trainees' scale scores were then compared to those of a senior clinician. The researchers reported that psychology trainees regularly outperformed their psychiatric resident counterparts. Burstein et al. (1973) reported "important questions are raised about the conventions of psychiatric training" (p. 793). They concluded stating:

The role of the semistructured interview in facilitating the psychologists' performance seems important. Deliberately and systematically collecting parallel information on successive patients offered them a more stable, more structured experiential field in which to learn. The use of such training aids contrast sharply to the sink-or-swim tactics of many psychiatric residencies and suggest that more planful teaching approaches might yield good results

(Burstein et al., 1973, p. 793).

Arguing that the best intervention for suicide is prevention through a prompt, systematic and thorough assessment, Patterson et al. (1983) identified 10 major risk factors from existing research and created the SAD PERSONS Suicide Assessment Scale. The scale encourages the interviewer to gather demographic data and to obtain a thorough psychosocial history through a semistructured interview as suggested by Burstein et al. (1973). Concomitantly, it uses direct inquiry about the client's suicidal intent via therapist-engendered questions related to the existence of an organized suicide plan, something which was strongly advocated by Motto (1991). Clinicians can use the easily memorized acronym SAD PERSONS to aid them in identifying the 10 literature-identified risk factors in their clients (i.e., sex, age, depression, previous attempt, ethanol abuse, rational thinking loss, social supports lacking, organized plan, no spouse, and sickness). One point is scored for each factor perceived as applicable to the client presenting for treatment. Total scores can range from 0 (suggesting very little risk of suicide) to 10 (suggesting very high risk of suicide). Patterson et al. (1983) devised guidelines for clinical actions according to scale scores (Table 1).

These researchers then taught a group of 36 third-year medical students in psychiatry at a major Southeastern U.S. university the SAD PERSONS Suicide Assessment Scale during a lecture on emergency psychiatry. A control group of 21 third-year medical students in psychiatry at the same university received "basically the same lecture but without the acronym" (Patterson et al., 1983,

Table 1

Total Points Proposed Clinical Action

Score	Action
0 to 2	Send home with follow up
3 to 4	Close follow up; consider hospitalization
5 to 6	Strongly consider hospitalization, depending on confidence in the follow-up arrangement
7 to 10	Hospitalize or commit

p. 348). One week later, each group viewed two video-vignettes and were requested to assess the risk of suicide potential with each identified client in the corresponding vignette. Both videotaped vignettes had been independently prejudged by three psychiatrists who each had significant clinical experience and were faculty members within the university's department of psychiatry.

Using a simple t test to determine significance in the first videotaped vignette between the treatment group which had received specialized training in the use of the SAD PERSONS Suicide Assessment Scale and the control group which received no specialized training, the researchers found a significant difference ($p < .01$) in perception of suicide risk between the two groups. The control group tended to rate the client in the first videotaped vignette as more seriously suicidal than the treatment group. Concomitantly, in the second

videotaped vignette, the control group again tended to rate the client as more seriously suicidal ($p < .01$). In both cases, the treatment group assessed the risk of suicide by the client similarly to the expert psychiatry faculty members.

In general, Patterson et al. (1983) report that the treatment group was more conservative than the control group, "therefore, they would tend to hospitalize only those persons judged to be at high risk" (p. 349). They continued by suggesting that those who did not receive the SAD PERSONS Suicide Assessment Scale training tended to rate both clients within the video-vignettes at greater risk. Medical students who did not receive the SAD PERSONS Suicide Assessment Scale training, according to Patterson et al., may be less able to differentiate between high- and low-risk clients. This may lead to needless hospitalizations of low-risk persons who may otherwise be adequately treated on an outpatient basis.

In summary of this section, the above cited research suggests: (a) the use of semi-structured clinical interviews are effective in assessing the seriousness of parasuicides (Burstein et al., 1973), and (b) specialized suicide assessment training is helpful in assessing suicide risk and can aid mental health providers in proposing appropriate treatment (Patterson et al., 1983). Concomitantly, the research implies those who receive specialized suicide assessment training tend to provide a more thoughtful and thorough assessment (Burstein et al., 1973; Patterson et al., 1983).

Lack of Formal Graduate School Training in Suicidology

Berman (1986) conducted a survey of over 300 training directors regarding the formal education and training of psychiatrists, psychologists, social workers and psychiatric nurses in suicidology. He found "on average, no more than 1/2 day's formal education is given to the topic of suicidology by any of the mental health disciplines" (Berman, 1986, p. 9). His research findings were later indirectly supported by Bongar and Harmatz (1989) and Juhnke (1991).

Bongar and Harmatz (1989) surveyed 115 clinical training directors that were members of the Council of University Directors of Clinical Psychology Programs. They found only 35% of the directors responding to the survey indicated their departments offered any formal training in the study of suicide. Respondents further indicated that if suicide training occurred within these departments it usually was indirectly offered as part of another course. Bongar and Harmatz (1989) report "directors of clinical training saw the study of suicide as a relatively important element in graduate training in clinical psychology" (p. 211).

Juhnke's (1991) survey also suggested a lack of suicide training within formal graduate course work. He conducted a survey of master's level counseling students who had completed at least one practica and were entering their field practica experience. These students were enrolled in one of four different counseling departments, each located in a different geographic region (e.g., North, South,

East and West) within the continental U.S.

While generalizations from Juhnke's (1991) study are impeded due to a limited number of subjects ($N=37$) and nonrandom assignment of surveys, Juhnke made some tentative observations. His survey suggests a lack of formal academic preparation regarding suicide and suicide assessment within master's level clinical mental health and community agency counseling programs. Over 41% of survey respondents indicated total absence of suicide assessment training, while 22% reported only two or more of their academic courses adequately addressed the topic of suicide. Concomitantly, 76% of the respondents denied the availability of graduate courses or seminars specifically devoted to suicidology. Last, all except two of those who responded to an open ended question (89%) in Juhnke's (1991) survey implied a need for increased suicide assessment training in their master's programs (e.g., "My master's level practica were inadequate in teaching suicide assessment--the topic was neglected. ... it is much needed"; "suicide should be more aggressively addressed and explored. It is critical for us as counselors to have strengths in these areas, which I feel are lacking" [p. 3]; etc.).

Berman (1986) reports that while "increased clinical professional experience per se has no relationship to increased ability to recognize suicide lethality factors" (p. 9), most of the 300 training directors surveyed still expected training in suicidology to occur through the students' clinical experience. This might suggest that even those who do receive increased experience related to suicide assessment as a result of field practica or internships may not benefit as fully as

those who receive specialized suicide assessment training prior to such clinical experiences.

Holmes and Howard (1980), for example, tested 180 persons, each of who primarily identified himself or herself with one of six groups (i.e., nonpsychiatrist physicians, psychiatrists, doctoral-level clinical or counseling psychologists, master's-level social workers, ministers and lower division college students). Thirty subjects participated in each group. The college students served as the control group. Subjects within the professional groups had two or more years of clinical or pastoral experience. Each participant completed a four-option, multiple-choice test composed of 13 questions. Each question was based on risk factors of the Suicide Potential Rating Scale. The tests were scored for the total number of correct responses and a one-way analysis of variance was performed to determine if there existed any differences in ability between the six groups to identify a person who is at risk of suicide. Years of experience alone did not increase the subject's ability to recognize suicide lethality factors. This conclusion was based on two primary points: (1) the sample of ministers had the second highest number of experienced members (i.e., 11 of the ministers had 15 or more years of direct pastoral care experience), yet their mean number of correct responses was not statistically significant when compared to the control group; and (2) the sample of psychologists had the least number of experienced persons, yet they achieved a higher mean score than either the social workers or ministers. The results of this research further indicated: (a) physicians and psychiatrists

scored significantly higher in correct responses than did the other four groups, (b) there was no significant differences in the number of correct responses between physicians and psychiatrists, (c) social workers scored significantly higher than ministers and students, and (d) there was no significant difference between scores by ministers and college students.

Videotaped Instruction and Self-Instructional Training Modules

Videotaped instruction has been successfully used in a variety of fields. Stone, Wolraich, and Hillerbrand (1988) created a videotape training program for special education teachers which resulted in a reduction of the teachers' anxiety related to specific topic areas (i.e., a student's need for extended schooling in the summer, behavioral problems of a minority student, a teacher's request for the parents to allow the school to perform a formal psychological evaluation of their child, etc.). Chandler (1989) developed an instructional videotape to aid third-year pharmacy students in conducting a medication interview with older adults. She compared pretest scores which were obtained immediately before an instructional videotape to posttest scores which were obtained immediately following the videotaped instruction. The pre- and posttest questions "were identical in content and consisted of 10 true/false questions dealing with the purpose of the medication interview, and special considerations for the older patient" (Chandler, 1989, p. 381). She used a t test to demonstrate significant improvement in pre- and posttest scores.

Medical educators have also demonstrated that videotaped instruction is an effective and useful teaching method. They have reported that videotape teaching has become an increasingly important method of instruction over the past two decades (Jackson & Pinkerton, 1983; Kaufman & Kaufman, 1983; Mason, Barkley, Kappelman, Carter, & Beachy, 1988; Meyerson, Wachtel, & Thornton, 1977; Pearn & Nixon, 1980; Sox, Marton, Higgins, & Hickman, 1984; Verby, David, & Marshall, 1979). Jackson and Pinkerton's (1983) survey of medical residents at the University of Connecticut indicated that 75% of those students interviewed believed videotaped teaching was beneficial to their clinical education. An additional 20% reported videotaped teaching as moderately beneficial. Their research suggests that interest in videotaped training is greatest during the first year of residency and declines somewhat in the following years. Concomitantly, self-reported responses by their subjects indicate that "videotape instruction is most effective in teaching the behavioral aspects of physician-patient encounters" (p. 435).

Mason et al. (1988) developed and implemented a self-instructional videotape on communication and interviewing skills for fourth-year medical students. These researchers randomly selected 60 subjects and randomly assigned students to one of three experimental groups or a control group. Group One viewed the self-instructional videotape; Group Two viewed the self-instructional tape, critiqued themselves according to a preintervention videotape and were assigned workbook lessons; Group Three self-critiqued their preintervention videotape and

were assigned workbook lessons; and Group Four, the control group, did not participate in any of the educational interventions and received no other instruction in communication skills.

The researchers compared scores between the four groups and determined through statistical analysis that a self-instruction videotape can significantly improve medical students' interviewing skills. Kaufman and Kaufman (1983) also demonstrated that videotaped instruction is effective in teaching specialty topics to medical students. They imply that medical schools can financially benefit from creating videotaped programs that reduce direct faculty time related to more redundant forms of instruction.

Sox et al. (1984) used videotape instruction in providing high quality training in areas for which there was a limited supply of expert educators. They compared tutored videotape instruction (TVI) to live lectures and found no statistically significant differences between the TVI groups and the live instruction groups. They concluded that videotaped instruction using the format of one non-expert (i.e., a student or teaching assistant who had successfully completed the course, etc.) who was familiar with the materials to be presented on the videotape within a small group of students was as effective as live lecture.

To determine the viability of videotape instruction of the mental status examination, Pohl et al. (1982) randomly split 43 students in their second year of medical school into one of two groups: (1) live lecture or (2) videotaped lecture. The researchers used a 34-question, multiple-choice examination to determine the

achievement level of each of the groups. Students were also given a feedback questionnaire which asked if the training sessions were outstanding, worthwhile or not worthwhile, and whether the sessions were enjoyable or whether a different format would be suggested.

Pohl et al. (1982) state, "In general, students tended to feel that all forms of teaching the MSE [mental status examination] were worthwhile and enjoyable and resulted in a learning experience" (p. 628). They reported no significant difference between the mean scores of either the live lecture or videotaped lecture group. The researchers do indicate that the videotaped group did slightly better than the live lecture group, "but the differences were so small that analysis of variance did not yield an overall significant difference among posttest scores" (Pohl et al., 1982, p. 628).

Specialized videotape training in the topic area of suicide assessment has also been proven effective within medical education. Golden (1978) developed a self-instructional videotaped suicide assessment program and compared it to a traditional model of suicide assessment training which included textbook readings, occasional lectures with case presentations and supervised clinical exposure to suicidal or potentially suicidal patients. His sample was comprised of 120 third-year students at a major university located in the Southcentral U.S. Golden divided the subjects into a control group which received the traditional model of suicide assessment training and an experimental group which received the self-instructional videotapes related to suicide assessment. Both groups received pre-

and posttests. The control and experimental groups were tested at the same times with pretests being administered the first day of the students' rotation and posttests administered during the last week of the semester.

Golden (1978) states that each test included: (a) "a ten-question multiple-choice test relating to the clinical aspects of suicide evaluation," (b) "a five-minute videotaped interview with a potentially suicidal patient in which the student was asked to evaluate the suicide potential of the patient viewed and to provide an appropriate disposition," and (c) requests regarding the students' responses "to a question that asked them to rate how secure they felt in doing an evaluation" (p. 33). Golden's results indicated that students who viewed the self-instructional videotape on suicide assessment in comparison with the control group which received traditional forms of instruction did significantly better in: (a) specific tests of knowledge relating to suicide assessment; (b) their ability to do a complete suicide evaluation, and (c) demonstrating in-depth awareness of the feeling-tone of the interview, the patient's suicidal planning and the patient's strengths. Concomitantly, self-report by students who received the self-instructional videotape further indicated that the self-instructional format was highly valued.

Social workers and counselor educators also suggest that videotaped instructional programming is an effective teaching method and have made recommendations regarding the creation of instructional videotapes (Brown, 1977; Iverson, 1986; Thayer, 1977; Winborn, Hinds, & Stewart, 1971). Thayer (1977)

indicates that the use of videotaped instructional mini-lectures, role-play situations and skill-practice sessions within counseling is meeting previously unmet needs. Thayer (1977) further states counseling students "can obtain exposure to numerous problems before practicum by using simulation materials on videotape" (p. 217). Kaczkowski and Fenton (1985) imply that instructional videotapes can be effectively used to simulate small group behaviors and teach counseling group leaders how to respond accordingly. Stone and Vance (1976) report that prerecorded videotaped training facilitated improvement in empathic communications.

Further, development and implementation of self-instructional counselor training models have been advocated by Cormier and Cormier (1976). They suggest that more traditional forms of counselor education (i.e., lecturing, reading and discussion) must be integrated with simulated problem solving activities and self-managed instruction to encourage students to attain increased counselor competency. They imply that individualized self-instructional components within specific contained topic areas can help student learners attain acceptable levels of performance within specific training areas (i.e., suicide assessment training, assertiveness training, etc.).

Brown (1977) implied that videotaped training within counselor education will become frequently more common as videotape technology improves and as instructional videotapes become more readily available. He believed videotape training films were useful in helping students acquire effective counseling skills and behaviors. Appropriate modeling of counseling behaviors within instructional

videotapes by a skilled practitioner is recommended by Brown.

Bandura's social learning theory best explains why videotaped presentations are effective, according to Brown (1977). He suggests that student observers "acquire mainly symbolic representations of modeled events rather than specific stimulus-response associations" (Brown, 1977, p. 131). He reports that the modeling phenomena of students who view videotaped instruction is governed by three variables. Each variable is reportedly interrelated. Attention, the first variable, refers to what students hear and see during the instructional videotape. This includes both specific behaviors demonstrated by actors or counselors within the videotape as well as the context in which such behaviors occurred (i.e., office, classroom, etc.). The second variable, retention, is what student observers comprehend or retain from viewing the videotape. Brown argues that students cannot repeat modeled behavior if they have no memory of the modeled event. Action, the final variable, refers to providing positive incentives for students appropriately repeating the modeled behaviors.

Brown (1977) believes that positive incentives demonstrated in the presence of other student observers following the viewing of videotaped instruction encourage students in two ways. First, they create incentive for those who demonstrate the modeled behavior to continue such behaviors. Second, when such positive reinforcements are witnessed by other student observers, it encourages them to repeat the modeled behaviors in a similar manner.

Hum et al. (1981) created nearly identical 52-minute self-instructional taped

(i.e., audiotape or videotape) programs which modeled empathy and reflection of feelings. The result of their research suggested that "the self-instructional tape program is an effective procedure for teaching counselling skills" (Hum et al., 1981, p. 185). They further state:

One important implication arising from this study is that a systematic self-instructional, training tape program is effective in teaching the counselling skill of reflection. A self-instructional training tape program based on modeling principles, simulation, role-practice, and an instructional manual is perhaps as effective as a lecture presentation of similar material. Thus, the advantage of this method is that it can free the instructor or supervisor for other teaching duties. (Hum et al., 1981, pp. 190-191)

The authors randomly assigned 104 senior education students to one of five groups (i.e., Language Laboratory Audio Group [LLA], Language Laboratory Video and Audio Group [LLV], Audiotape Recorder Group [ATR], Lecture-Discussion Group [LDG] or No-Treatment Control Group). Before the beginning of the training tapes and lecture, each subject--except those within the control group--received instructions via a written manual. These instructions directed subjects to listen to and/or observe counselors modeling how to respond to a client's feelings. After obtaining their instructions, participants were told to observe and/or listen to the training tape and imagine they were the counselor in the vignette.

Each self-instructional tape (i.e., audiotape or videotape) "contained the narrator's instructions, excerpts of three professional model counselors, and the series of clients presenting problem statements" (Hum et al., 1981, p. 188). After the completion of the experimental treatment, all subjects interviewed five high

school students. Prior to the introduction of each subject to their randomly assigned high school students, both research subjects and high school students were given printed cards. The research subjects' cards read:

As part of your learning experience, you will have the opportunity to interview high school students who have volunteered to talk to someone in the helping professions. The length of this interview will be approximately 20 minutes. Therefore, it is necessary for you to interact with your volunteer client immediately upon entering the counselling office. During the interview you should attempt to explore those areas which are of personal concern to your client. (Hum et al., 1981, p. 189)

Cards for the high school students stated:

You will be participating in a research project involving university students who are studying in the helping professions, and who are interested in developing their interviewing skills. You will be seeing him or her for approximately 20 minutes. You should go into the office and interact with him as if he were your counselor. It would be helpful if you could begin the interview by talking about something of personal concern to you or of something which has troubled you in the past. You are free to discuss any subject that concerns you. (Hum et al., 1981, p. 189)

After the sessions began, two-minute segments from the beginning, middle and ending phases of the interview were extracted. These segments were rated according to the Standard Communication Index, a test designed to assess a person's level of empathic communication. An analysis of variance indicated significant differences between the groups. The researchers then used the Scheff's test to compare treatment means. This statistical analysis indicated the experimental groups when compared to the single control group significantly differed on both the Accurate Empathy Scale and the Standard Communication Index. Concomitantly, Hum et al. (1991) stated, "No significant differences were found

between subjects in the audiotape recorder group (ATR) and the language video and audio group (LLV) and the lecture-discussion group (LDM)" (p. 190). Their results suggest that self-instructional tape programs are as effective as traditional lecture in teaching some counseling skills related to empathy.

In another study (Robinson et al., 1979) of the possible efficacy in self-instructional learning, 44 counseling students enrolled in a master's program were randomly assigned to one of three treatment groups (i.e., written, videotape and audiotape). Subjects within the videotaped group observed a modeling videotape. Those within the written group read the printed sound track of the modeled videotape while subjects within the audiotape group listened to the audio portion of the videotape with no visible video picture. The researchers concluded there were no significant differences among written, videotaped or audiotaped models of instruction. In more recent research Robinson, Kurpius and Froehle's (1981) results supported their previous findings and again determined there was no statistically significant differences in scores between students who received written and video training models.

Results from a 1978 experiment by Peters et al. indicate there were no statistically significant differences in basic counseling skill acquisition between the following models of instruction: (a) written and video models, (b) role-play practice, (c) peer feedback, and (d) role-play remediation practice. The researchers randomly assigned 40 graduate students enrolled in a basic counseling skills course to one of the four previously mentioned training modalities. Subjects in

the written and videotaped model read a 14-page handout which described the appropriate manner in which to develop counseling goals. They also reviewed a 15-minute videotape of a counselor modeling the use of the written model to develop counseling goals with a client. Subjects in the second group received the same training in the written and videotaped model, and role-play practice model, and further participated in a 15-minute practice role-play interview to demonstrate goal development within counseling. The third group, which received the written and videotaped model and practice with feedback, also received the 14-page written handout and observed the 15-minute videotape. In addition, these subjects were randomly assigned to triads for practice and feedback by other persons within the triad. Lastly, the fourth group which received written and videotaped model, practice, feedback and remediation practice received all conditions described in the previous group. They also were given an opportunity for one 15-minute remediation practice after receiving feedback from their first role-play. Peters et al. (1978) reported, "There is no reason to conclude that the four training groups differed significantly from one another" (p. 236).

Stone (1975) reported that consistent use of low fidelity simulation procedures (i.e., instructional manuals and audiotapes) results in the least effective counselor skill training. He implies that counselor educators need to use high fidelity models of instruction (i.e., videotapes, lectures and role-playing) which most likely capture and maintain students' attention.

Chapter Summarization

Literature contained within this review suggests suicide assessment by means of both empirical approaches and clinical judgement aids mental health care providers in better classifying a client's immediate suicide risk along a continuum of estimation (Maris, 1991; Motto, 1991). Accurate suicide prediction, however, is most probably imprecise and questionable at best (Balon, 1987; Biro & Lazic, 1988; Lettieri, 1974; MacKinnon & Farberow, 1976; Maltzberger, 1988). The articles further imply that a structured clinical interview which also directly inquires about the client's suicide intent is essential to accurate risk assessment (Burstein et al., 1973; Motto, 1991). Concomitantly, some studies suggest those who receive specialized training in assessing client suicide risk demonstrate increased accuracy in their assessment when compared to those who do not receive such training (Golden, 1978; Patterson et al., 1983).

Survey results suggest students in mental health and community agency counseling, as well as other mental health disciplines, receive limited suicide assessment training within formal graduate school education (Berman, 1986; Bongar & Harmatz, 1989; Juhnke, 1991). This reportedly occurs despite some students indicating a desire for further training in suicide assessment. Berman (1986) states despite clinical training experiences which are expected to increase the student's skills in suicide assessment, there is evidence that suggests increased clinical experiences and supervision alone may not improve the student's suicide

risk assessment skills.

Lastly, it is noted that several articles within this chapter report positive results related to videotaped training for students (Chandler, 1989; Golden, 1978; Stone et al., 1988). This seems especially true for medical educators. Many suggest that videotaped teaching has become an increasingly important and effective method of instruction, and a useful tool (Jackson & Pinkerton, 1983; Kaufman & Kaufman, 1983; Mason et al., 1988; Meyerson et al., 1977; Pearn & Nixon, 1980; Sox et al., 1984; Verby et al., 1979).

CHAPTER III

RESEARCH DESIGN AND PROCEDURES

This chapter describes the procedures employed in the study. Descriptive summaries are divided into seven sections: method and research design, description of the subjects, description of the treatment, instrumentation, field procedures, data collection, and analysis of the data.

Method and Research Design

The study was a quasi-experimental study, using a Randomized Groups, Posttest-only Design (Hopkins, 1980). The two experimental groups and the single control group were assumed to be equivalent on the basis of random assignment of subjects to each of the three groups and random assignment of a single, specific treatment to each individual group. Such random assignment of subjects and treatments "assures that initial differences between groups are attributable only to chance and that differences will follow the laws of probability" (Hopkins, 1980, p. 354). Therefore, identified significant differences are probably attributed to the type of training received (i.e., SAD PERSONS Suicide Assessment Scale [Patterson et al., 1983] training vis-a-vis transference-countertransference training) or the method used to convey the lecture materials (i.e., live lecture vis-a-vis videotaped instruction).

The two identified independent variables in this research were: (1) type of lecture received by students (i.e., SAD PERSONS Suicide Assessment Scale training or transference-countertransference training), and (2) method in which training occurred (i.e., SAD PERSONS Suicide Assessment Scale Live Lecture Group [SAD-Live Group] or SAD PERSONS Suicide Assessment Scale Videotaped Instruction Group [SAD-Video Group]). The Transference-Countertransference Control Group (Control Group) received the regular, prepractica counselor training course specifically designed to teach interviewing and counseling skills related to the counseling relationship. The two experimental groups received the regular, prepractica counselor training course specifically designed to teach interviewing and counseling skills related to the counseling relationship. In addition, the two experimental groups further obtained instruction in the use of the SAD PERSONS Suicide Assessment Scale to aid in identifying 10-primary risk factors as cited by Patterson et al. (1983) as being associated with persons at risk of suicide and to aid in proposing appropriate clinical actions.

Questions from Patterson's et al. (1983) original experiment were altered to eliminate medical jargon. The revised questions were then used to measure dependent variables which include: (a) perception of suicide risk of a low-risk client, (b) clinical actions proposed for a low-risk client, (c) perception of suicide risk of a high-risk client, (d) clinical actions proposed for a high-risk client, (e) ability to accurately determine a SAD PERSONS Suicide Assessment Scale score for persons portrayed in two videotaped vignettes, and (f) perception of counselor

confidence in adequately assessing suicide risk in clients and students who present for services.

Description of the Subjects

The subjects who participated in the study were master's level counselors-in-training enrolled in a counseling prepractica training course in the Department of Counselor Education and Counseling Psychology at Western Michigan University, Kalamazoo. All participating subjects were volunteers, who were randomly assigned to one of three groups. From the original pool of 63 subjects, 59 (94%) participated in the research. This sample included 25 males (42%) and 34 females (58%). The Control Group consisted of 20 subjects which included 8 males and 12 females. The SAD-Live Group consisted of 19 subjects which included 9 males and 10 females. The SAD-Video Group consisted of 20 subjects which included 8 males and 12 females.

Description of the Treatment

Subjects were enrolled Winter Semester, 1991, in Western Michigan University's Department of Counselor Education and Counseling Psychology's regular, prepractica counselor training course specifically designed to teach interviewing and counseling skills. Each of the three sections of the prepractica training course was taught by a different faculty member. All training related to this study was conducted during regularly scheduled class time and participants

received approximately one hour of specialized training. Each section of the prepractica counselor training course was scheduled for a different day of the week (i.e., Wednesday, Friday and Saturday) and all training related to this study was completed within a four-day period (i.e., Wednesday through Saturday). Since each of the three sections of the prepractica counselor training course was divided into three groups (i.e., SAD-Live Group, SAD-Video Group and Control Group), a similar number of students from each section participated in all groups (i.e., n 's = 19, 20, and 20), thus, assuring that initial differences existing between all three groups were attributable to chance. Appropriate statistical analyses which took into account the unequal group sizes were employed.

A videotaped instructional training component on suicide and the SAD PERSONS Suicide Assessment Scale was created to aid viewers in using the scale to assess persons at risk of suicide and to assign accurate clinical actions. The component included statistical and demographic data related to suicides and parasuicides occurring within the U.S. each year. It continued by summarizing research which suggests: (a) the number of family members and friends affected by an individual's suicide or parasuicide; (b) survivors of another's suicide are at greater risk of emotional and physical illness; (c) survivors often face a most difficult form of bereavement, frequently accompanied by significant feelings of guilt and/or shame; (d) suicidal persons often give specific warning signals which can alert mental health professionals of possible suicide risk; (e) psychologists providing direct care to clients have a greater than 1-in-5 risk of having a client

die due to suicide during the clinician's career; (f) potential for suicide attempts and suicide completions are significantly higher for those in mental health treatment vis-a-vis the general population at large; (g) of all mental health emergencies, suicidal behavior is the most frequently encountered by mental health professionals; (h) therapists who suffer the death of a client from suicide often suffer intense feelings of isolation, guilt and loss of professional esteem; and (i) suicidal crises are reported to be many clinicians' worst fear. The component further warned subjects against relying solely upon the SAD PERSONS Suicide Assessment Scale in assessing suicide risk. Subjects were also warned against developing clinical disposition based wholly upon the SAD PERSONS Suicide Assessment Scale's proposed clinical recommendations. Participants were informed of standardized psychological tests and specialty tests which should be used in conjunction with the SAD PERSONS Suicide Assessment Scale. Clinical supervision and professional peer consultation was further advocated when assessing persons who may be at risk of suicide and when developing appropriate treatment plans. The history of the SAD PERSONS Suicide Assessment Scale and the reasons for its development followed. Specific instructions related to the instrument's use was then followed by two videotaped vignettes. One vignette portrayed a high-risk client, the other vignette portrayed a low-risk client. After each vignette, the videotaped instructor repeated the step-by-step procedure of implementing and completing the SAD PERSONS Suicide Assessment Scale for each corresponding client. He then discussed the SAD PERSONS Suicide Assessment Scale score

the viewer should have obtained and the corresponding risk assessment and clinical action defined by the aid.

A second training component identical in content areas to the above mentioned videotaped component was created. It was designed to be presented during a live lecture on suicide and the SAD PERSONS Suicide Assessment Scale. This SAD-Live Group component integrated the videotaped vignettes of high- and low-risk clients used in the videotaped instruction component, but was different in format because it allowed an opportunity for subjects to participate with the lecturer in: (a) assessing the presence of the 10 specific risk factors related to each videotaped vignette client, and (b) prescribing appropriate clinical action as recommended by the SAD PERSONS Suicide Assessment Scale. The Control Group received no suicide assessment training, but instead observed a videotaped training component related to the topic of transference and countertransference within the counseling relationship.

Instrumentation

The instrument used to measure perceptions of suicide risk, accurate clinical actions and accurate SAD PERSONS Suicide Assessment Scale scores for clients portrayed within videotaped vignettes, and evaluate personal confidence related to adequately assessing suicide risk in clients and students who present for services, was the Videovignette Data Scoring Sheet (VDSS). This instrument was specifically designed for use within the study. The VDSS included modified

questions from Patterson's et al. (1983) original experiment and two additional questions related to confidence in assessing suicide risk and identification of the number of graduate counselor education, counseling psychology courses completed by participating subjects. Examination of the questions within the SAD PERSONS Suicide Assessment Scale and the VDSS lead to the conclusion that a measure of face validating seems to be established, because all questions directly relate to client self-report. Furthermore, data reported by Patterson et al. (1983) suggest concurrent validity between the treatment group's mean suicide assessment score and recommended clinical action when compared to mean assessment scores and clinical recommendations obtained by a panel of three expert psychiatrists. Concomitantly, the VDSS demonstrates adequate reliability. A Cronback's alpha Coefficient of reliability was calculated to be .77.

The VDSS is composed of 8 items. It includes two Likert Scale questions (i.e., survey items 1A and 2A) designed to test each subject's assessment of suicide risk based upon two different videotaped assessment interviews. During each videotaped interview the therapist obtains the client's psychosocial history and participants view the corresponding client's clinical presentation. Subjects then rate the portrayed client along a 10-point continuum from very unlikely to commit suicide (score of zero) to very likely to commit suicide (score of 10). Two self-reported, multiple-option questions designed to test the appropriateness of each subject's proposed clinical actions (i.e., survey items 1B and 2B) are also included in the VDSS. Participants in the study chose one of four options related

to a proposed clinical action for each client. Options increase in the degree of recommended clinical interaction with the client and move from a least restrictive environment (i.e., send home with follow-up as suicide is unlikely) to a restrictive environment (i.e., definitely hospitalize or commit).

Subjects who participated in one of the two experimental groups also received two Likert Scale questions (i.e., survey items 1A and 2B) designed to test each subject's skill in using the SAD PERSONS Suicide Assessment Scale. They summed the number of suicide risk factors identified by Patterson et al. (1983) which they perceived present in the individual presenting for clinical services within the videotaped vignette and circled the corresponding SAD PERSONS Suicide Assessment Scale score somewhere along a continuum indicating little-risk of suicide (one) to high-risk of suicide (10). Concomitantly, the VDSS included one multiple-choice question (i.e., survey item 3) designed to allow subjects to self-report their perceived confidence in adequately assessing the risk of client suicide and a final Likert Scale question (i.e., survey item 4) designed to identify the number of completed graduate level counselor education, counseling psychology courses.

Field Procedures

In the fall of 1990 instructors who would be teaching a master's level pre-practica counselor training course during Winter Semester 1991 within the Department of Counselor Education and Counseling Psychology at Western.

Michigan University were contacted to determine their interest in having students participate in a study related to suicide assessment training via the SAD PERSONS Suicide Assessment Scale. All instructors agreed to allow the primary researcher use of a single class period within each course section for the study, with an option to return to discuss the experiment and/or complete training during the individual section's next regularly scheduled class meeting. Students enrolled in these sections were informed of their opportunity to participate as a volunteer within the study during their course orientation and through written notification within their course syllabi. Prior to the implementation of the study, students were informed by this researcher that participation was totally voluntary and that participation or nonparticipation within the study would not positively or negatively affect course grades. Concomitantly, it was indicated that responses given would be anonymous and confidential. An Informed Consent Form which reiterated the voluntary nature of participation and confidentiality was then distributed among students within their respective course sections. Participating subjects signed the Informed Consent Forms in duplicate, retaining one copy for their personal records and returning the other copy to the researcher. Students not desiring to participate were allowed to either stay to observe the training or were free to leave.

Random assignment of both subjects to groups and treatments to groups was used within this study. The process of subject random assignment for each course section began when individual course section rosters were obtained and

names appearing in alphabetical order were numbered consecutively (i.e., 1, 2, 3, 4, ...). Later, a coin was flipped onto a printed random assignment table. Starting where the coin came to rest, this researcher proceeded down the printed columns until he identified a number corresponding to a number assigned to a specific subject within that section. This process was repeated until the first third of the subjects identified from section one were assigned to Group A, the second third were assigned to Group B and remaining section one subjects not previously selected were assigned to Group C. Participants were assigned only to one of the three groups. Each of the three groups (i.e., Group A, Group B and Group C) was then randomly assigned to one of two experimental groups (i.e., SAD-Live Group and SAD-Video Group) or the single Control Group by numbering each of the three groups (i.e., Group A was assigned number 1, Group B was assigned number 2, etc.), flipping a coin onto a printed random assignment table and proceeding down the columns until the first corresponding number was found. This group was then assigned the live lecture component of the SAD PERSONS Suicide Assessment Scale (i.e., SAD-Live Group). The next identified group was assigned the videotaped instruction component of the SAD PERSONS Suicide Assessment Scale (i.e., SAD-Video Group), and the last identified group was assigned the transference-countertransference training (i.e., Control Group). This process was repeated for the second and third sections of the prepractica counselor training course.

Data Collection

Data were obtained during regularly scheduled class periods. This collection occurred within the specific course section's normal classroom. The instrument was administered by the author. Students' names were not used; required identification for groups was accomplished by references entered on the instrument and through collection of the instrument by groups. Testing was completed by April 6, 1991.

Analysis of the Data

To test Null Hypotheses 1, 2, 3, 4, 5, 6 and 7 (including Null Sub-hypotheses 1.1-4.3) of this study, ANOVA's were computed to determine whether any statistically significant differences existed between the three groups (i.e., SAD-Live Group, SAD-Video Group and Control Group). When an ANOVA indicated that significant differences existed between groups, Tukey's Tests were used to identify specific groups which were statistically different. Null Hypotheses 6 and 7 were analyzed by means of t tests to determine whether any statistically significant differences existed between group mean scores and the expert scores considered to be accurate constants. The level of significance for rejection of each of the hypotheses was set at $p < .05$.

Summary

The VDSS was used to: (a) measure subjects' perception of suicide risk in clients portrayed in two videotaped vignettes; (b) measure subjects' perceptions of accurate clinical actions for clients portrayed in two videotaped vignettes; (c) measure the experimental groups' skills in determining an appropriate SAD PERSONS Suicide Assessment Scale Score for clients portrayed within two videotaped vignettes; (d) evaluate personal confidence of subjects related to adequately assessing suicide risk in clients or students who present for services; and (e) learn the number of graduate level counselor education, counseling psychology courses completed. Subjects within the two experimental groups received training in the use of the SAD PERSONS Suicide Assessment Scale. Those who participated in the Control Group received specialized training related to transference-countertransference within the therapeutic relationship. Data were collected by means of a Randomized Groups, Posttest-only Design. The data were analyzed to determine if possible cause-and-effect relationships, as evidenced by the existence of significant statistical difference between subjects exposed to SAD PERSONS Suicide Assessment Training Scale (i.e., SAD-Live Group or SAD-Video Group) and those not receiving such instruction (i.e., the Control Group), existed, and to determine if the method of training used (i.e., SAD-Live Group vis-a-vis SAD-Video Group) significantly altered efficacy.

CHAPTER IV

ANALYSIS AND PRESENTATION OF DATA

Introduction

This chapter reports the analysis of data pertaining to evaluating the effects of SAD PERSONS Suicide Assessment Scale (Patterson et al., 1983) training on the ability of master's level counselors-in-training to: (a) assess high-risk and low-risk clients, (b) assign accurate clinical actions for high-risk and low-risk clients, (c) engender self-reported confidence in adequately assessing clients and students for suicide risk, and (d) accurately assign a SAD PERSONS Suicide Assessment Scale score to clients portrayed during a videotaped clinical interview. Comparisons were made between a SAD PERSONS Suicide Assessment Scale Live Lecture Group (SAD-Live Group), a SAD PERSONS Suicide Assessment Scale Videotaped Instruction Group (SAD-Video Group) and a Transference-Countertransference Control Group (Control Group).

Analyses of the hypotheses will be presented in three sections. The first two sections will report the findings from Null Hypotheses 1, 2, 3 and 4. These hypotheses were tested by ANOVA's; the corresponding sub-hypotheses were analyzed by Tukey's Test. The final section will report the findings from Null Hypotheses 5, 6 and 7. These hypotheses were tested by ANOVA's or independent t tests which compared a normal group with corresponding expert responses.

These expert scores were treated as a constant. The dependent variables were the individual groups' scores (i.e., SAD-Live Group or SAD-Video Group). All hypotheses were stated in null form with the level of significance for rejection of the null hypotheses set at $p < .05$.

Null Hypotheses 1 and 2

Null Hypothesis 1 stated that subjects who participate in the research experiment will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a low-risk client, as measured by Likert Scale scores. This hypothesis was tested by means of an ANOVA. As reported in Table 2, the F value obtained for Null Hypothesis 1 was 14.15, which was significant at the $p < .01$ level. A significant difference was obtained between the three groups (i.e., SAD-Live Group, SAD-Video Group and Control Group) relevant to suicide risk assessment of a low-risk client, therefore, Null Hypothesis 1 was rejected. Subsequent comparisons using Tukey's Test are discussed under analysis of Null Sub-hypotheses 1.1, 1.2, and 1.3.

Analysis of Null Sub-hypothesis 1.1

Null Sub-hypothesis 1.1 stated that subjects who received SAD-Live Group training will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a low-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by

Table 2

Summary of Analysis-of-Variance: Comparison of the Means
of Three Groups' Perceptions for a Low-Risk Client

Source	<u>SS</u>	<u>dF</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between	102.37	2	51.19	14.15	<.01*
Within	<u>202.51</u>	<u>56</u>	3.62		
Total	304.88	58			

*Significant at the .01 level.

Likert Scale scores. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 1.1. The mean scores were 3.21 for the SAD-Live Group and 6.40 for the Control Group. Analysis using Tukey's Test revealed the SAD-Live Group statistically differed from the Control Group at the $p = <.05$ level. Therefore, Null Sub-hypothesis 1.1 was rejected. Master's level counselors-in-training who received SAD-Live Group training demonstrated a lower mean score than participants who did not receive such specialized suicide assessment training. This lower mean score suggests that the SAD-Live Group assessed the low-risk client more accurately than the Control group.

Analysis of Null Sub-hypothesis 1.2

Null Sub-hypothesis 1.2 stated that subjects who received SAD-Video Group

instruction will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a low-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment training, as measured by Likert Scale scores. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 1.2. The mean scores were 4.35 for the SAD-Video Group and 6.40 for the Control Group. Analysis using Tukey's Test revealed the SAD-Video Group statistically differed from the Control Group which received no SAD PERSONS Suicide Assessment Scale training at the $p < .05$ level. Therefore, Null Sub-hypothesis 1.2 was rejected. Thus, master's level counselors-in-training who received SAD-Video Group instruction demonstrated a lower mean score than participants who did not receive such specialized suicide assessment scale training. This lower score suggests that the SAD-Video Group assessed the low-risk client more accurately than the Control Group.

Analysis of Null Sub-hypothesis 1.3

Null Sub-hypothesis 1.3 stated that subjects who received SAD-Video Group instruction will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a low-risk client in comparison with those subjects who received SAD-Live Group training, as measured by Likert Scale scores. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 1.3. The mean scores were 4.35 for the SAD-Video Group and 3.21 for the SAD-Live Group. Analysis using Tukey's Test failed to reveal any statistically

significant difference between the SAD-Live Group and SAD-Video Group at the $p < .05$ level. Therefore, Null Sub-hypothesis 1.3 was not rejected. Master's level counselors-in-training who received SAD-Video Group instruction demonstrated no significant difference in assessing a low-risk client than participants who received SAD-Live Group training.

As reported above, Null Hypothesis 1 was rejected (a difference in suicide risk assessment was found related to a low-risk client). Null Sub-hypotheses 1.1 through 1.3 were concerned with any differences discovered within Null Hypothesis 1 relative to specific comparisons between each of the three groups. Analyses using Tukey's Test indicated: (a) subjects who received SAD-Live Group training assigned a lower mean suicide risk score when viewing a low-risk videotaped client than participants who did not receive such specialized suicide assessment training, (b) subjects who received SAD-Video Group instruction assigned a lower mean suicide risk score when viewing a low-risk videotaped client than participants who did not receive such specialized suicide assessment scale training, and (c) subjects who received SAD-Video Group instruction demonstrated no significant difference in assessing a low-risk client than participants who received SAD-Live Group training.

Null Hypothesis 2 stated that subjects who participate in the research experiment will not assign significantly different clinical interventions of a videotaped vignette of a low-risk client, as measured by self-reported, multiple-option responses. This hypothesis was tested by means of an ANOVA. As reported in

Table 3, the F value obtained for Null Hypothesis 2 was 11.82, which was significant at the $p = <.01$ level. A significant difference was obtained between the three groups (i.e., SAD-Live Group, SAD-Video Group and Control Group) relevant to clinical interventions of a low-risk client. Therefore, Null Hypothesis 2 was rejected. Subsequent comparisons by means of Tukey's Test are discussed under analysis of Null Sub-hypotheses 2.1, 2.2 and 2.3.

Table 3

Summary of Analysis-of-Variance: Comparison of the Means of Three Groups' Proposed Clinical Actions for a Low-Risk Client

Source	<u>SS</u>	<u>dF</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between	8.31	2	4.16	11.82	<.01*
Within	<u>19.69</u>	<u>56</u>	.35		
Total	28.00	58			

*Significant at the .01 level.

Analysis of Null Sub-hypothesis 2.1

Null Sub-hypothesis 2.1 stated that subjects who received SAD-Live Group training will not assign significantly different clinical interventions of a videotaped vignette of a low-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by self-reported, multiple-option responses. Post hoc comparisons by means of Tukey's Test were

used to analyze Null Sub-hypothesis 2.1. The mean scores were 1.53 for the SAD-Live Group and 2.45 for the Control Group. Analysis using Tukey's Test revealed the SAD-Live Group statistically differed from the Control Group which received no SAD PERSONS Suicide Assessment Scale training at the $p < .05$ level. Therefore, Null Sub-hypothesis 2.1 was rejected. Thus, master's level counselors-in-training who received SAD-Live Group training more accurately proposed significantly less aggressive clinical intervention than those who did not receive such specialized SAD PERSONS Suicide Assessment Scale training.

Analysis of Null Sub-hypothesis 2.2

Null Sub-hypothesis 2.2 stated subjects who received SAD-Video Group instruction will not assign significantly different clinical interventions of a videotaped vignette of a low-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by self-reported, multiple-option responses. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 2.2. The mean scores were 2.00 for the SAD-Video Group and 2.45 for the Control Group. Analysis using Tukey's Test did not reveal any statistically significant differences between the SAD-Video Group and the Control Group which received no SAD PERSONS Suicide Assessment Scale training at the $p < .05$ level; therefore, Null Sub-hypothesis 2.2 was not rejected. Thus, master's level counselors-in-training who received SAD-Video Group instruction did not assign significantly different

clinical interventions for a low-risk client when compared to those who received no specialized SAD PERSONS Suicide Assessment Scale training.

Analysis of Null Sub-hypothesis 2.3

Null Sub-hypothesis 2.3 stated that subjects who received SAD-Video Group instruction will not assign significantly different clinical interventions of a videotaped vignette of a low-risk client in comparison with those subjects who received SAD-Live Group training, as measured by self-reported, multiple-option responses. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 2.3. The mean scores were 2.00 for the SAD-Video Group and 1.53 for the SAD-Live Group. Analysis using Tukey's Test revealed the SAD-Video Group statistically differed from the SAD-Live Group at the $p = < .05$ level; therefore, Null Sub-hypothesis 2.3 was rejected. Thus, master's level counselors-in-training who received SAD-Video Group instruction assigned more accurate and aggressive clinical interventions (i.e., close monitoring of the client and consideration of inpatient psychiatric hospitalization) than those who received SAD-Live Group training.

As reported above, Null Hypothesis 2 was rejected (a difference was found in proposed clinical action plans related to a low-risk client). Null Sub-hypotheses 2.1 through 2.3 were concerned with any differences discovered within Null Hypothesis 2 relative to specific comparisons between each of the three groups. Analyses using Tukey's Test indicated: (a) subjects who received SAD-Live

Group training proposed significantly less aggressive clinical intervention than those who did not receive such specialized SAD PERSONS Suicide Assessment Scale training, (b) subjects who received SAD-Video Group instruction did not assign significantly different clinical interventions for a low-risk client when compared to those who received no specialized SAD PERSONS Suicide Assessment Scale training, and (c) subjects who received SAD-Video Group instruction proposed significantly more aggressive clinical interventions than those who received SAD-Live Group training.

Null Hypotheses 3 and 4

Null Hypothesis 3 stated that subjects who participate in the research experiment will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a high-risk client, as measured by Likert Scale scores. This hypothesis was tested by means of an ANOVA. As reported in Table 4, the F value obtained for Null Hypothesis 3 was 23.61, which was significant at the $p < .01$ level. A significant difference was obtained among the three groups (i.e., SAD-Live Group, SAD-Video Group and Control Group) relevant to suicide risk assessment of a high-risk client. Therefore, Null Hypothesis 3 was rejected. Subsequent comparisons by means of Tukey's Test are discussed under analysis of Null Sub-hypotheses 3.1, 3.2 and 3.3.

Table 4

Summary of Analysis-of-Variance: Comparison of the Means
of Three Groups' Perceptions for a High-Risk Client

Source	<u>SS</u>	<u>dF</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between	115.08	2	57.54	23.61	<.01*
Within	<u>136.45</u>	<u>56</u>	2.44		
Total	251.53	58			

*Significant at the .01 level.

Analysis of Null Sub-hypothesis 3.1

Null Sub-hypothesis 3.1 stated that subjects who received SAD-Live Group training will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a high-risk client in comparison with those who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by Likert Scale scores. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 3.1. The mean scores were 5.05 for the SAD-Live Group and 8.45 for the Control Group. Analysis using Tukey's Test revealed the SAD-Live Group statistically differed from the Control Group which received no SAD PERSONS Suicide Assessment Scale training at the $p = <.05$ level. Therefore, Null Sub-hypothesis 3.1 was rejected. Master's level counselors-in-training who received SAD-Live Group training demonstrated a lower mean score than

participants who did not receive such specialized suicide assessment training. This lower score suggests that the SAD-Live Group assessed the high-risk client more accurately than the Control Group.

Analysis of Null Sub-hypothesis 3.2

Null Sub-hypothesis 3.2 stated that subjects who received SAD-Video Group instruction will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a high-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by Likert Scale scores. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 3.2. The mean scores were 6.35 for the SAD-Video Group and 8.45 for the Control Group. Analysis using Tukey's Test revealed the SAD-Video Group statistically differed from the Control Group which received no SAD PERSONS Suicide Assessment Scale training at the $p < .05$ level. Therefore, Null Sub-hypothesis 3.2 was rejected. Thus, master's level counselors-in-training who received SAD-Video Group instruction demonstrated a lower mean score than participants who did not receive such specialized suicide assessment scale training. This lower score suggests that the SAD-Video Group assessed the high-risk client more accurately than the Control Group.

Analysis of Null Sub-hypothesis 3.3

Null Sub-hypothesis 3.3 stated that subjects who received SAD-Video Group

instruction will not demonstrate significantly different suicide risk assessments of a videotaped vignette of a high-risk client in comparison with those subjects who received SAD-Live Group training, as measured by Likert Scale scores. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 3.3. The mean scores were 6.35 for the SAD-Video Group and 5.05 for the SAD-Live Group. Analysis using Tukey's Test revealed the SAD-Video Group statistically differed from the SAD-Live Group at the $p < .05$ level. Therefore, Null Sub-hypothesis 3.3 was rejected. Thus, master's level counselors-in-training who received SAD-Video Group instruction assessed high-risk clients at a greater risk of suicide than those who received SAD-Live Group training. This higher score suggests that the SAD-Video Group assessed the high-risk client more accurately than the SAD-Live Group.

As reported above, Null Hypothesis 3 was rejected (a difference was found in suicide risk assessment related to a high-risk client). Null Sub-hypotheses 3.1 through 3.3 were concerned with any differences discovered within Null Hypothesis 3 relative to specific comparisons between each of the three groups. Analyses using Tukey's Test indicated: (a) subjects who received SAD-Live Group training assigned a lower mean suicide risk score when viewing a high-risk videotaped client than counselors-in-training who did not receive such specialized suicide assessment training, (b) subjects who received SAD-Video Group instruction assigned a lower mean suicide risk score when viewing a high-risk videotaped client than counselors-in-training who did not receive such specialized suicide

assessment scale training, and (c) subjects who received SAD-Video Group instruction assessed high-risk clients at a greater risk of suicide than those who received SAD-Live Group training.

Null Hypothesis 4 stated that subjects who participate in the research experiment will not assign significantly different clinical interventions of a videotaped vignette of a high-risk client, as measured by self-reported, multiple-option responses. This hypothesis was tested by means of an ANOVA. As reported in Table 5, the F value obtained for Null Hypothesis 4 was 5.01, which was significant at the $p < .01$ level. A significant difference was obtained among the three groups (i.e., SAD-Live Group, SAD-Video Group and Control Group) relevant to clinical interventions of a high-risk client. Therefore, Null Hypothesis 4 was rejected. Subsequent comparisons by means of Tukey's Test are discussed under analysis of Null Sub-hypotheses 4.1, 4.2 and 4.3.

Table 5

Summary of Analysis-of-Variance: Comparison of the Means of Three Groups' Proposed Clinical Actions for a High-Risk Client

Source	<u>SS</u>	<u>dF</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between	4.70	2	2.35	5.01	<.01*
Within	<u>26.28</u>	<u>56</u>	.47		
Total	30.98	58			

*Significant at the .01 level.

Analysis of Null Sub-hypothesis 4.1

Null Sub-hypothesis 4.1 stated that subjects who received SAD-Live Group training will not assign significantly different clinical interventions of a videotaped vignette of a high-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by self-reported, multiple-option responses. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 4.1. The means scores were 2.74 for the SAD-Live Group and 3.40 for the Control Group. Analysis using Tukey's Test revealed a significant difference between the SAD-Live Group and the Control Group at the $p < .05$ level. Therefore, Null Sub-hypothesis 4.1 was rejected. Master's level counselors-in-training who received SAD-Live Group training more accurately assigned significantly less aggressive clinical interventions (i.e., they did not advocate psychiatric inpatient hospitalization) than did those not receiving such specialized SAD PERSONS Suicide Assessment Scale training.

Analysis of Null Sub-hypothesis 4.2

Subjects who received SAD-Video Group instruction will not assign significantly different clinical interventions of a videotaped vignette of a high-risk client in comparison with those subjects who did not receive SAD PERSONS Suicide Assessment Scale training, as measured by self-reported, multiple-option responses. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 4.2. The mean scores were 2.90 for the SAD-Video Group

and 3.40 for the Control Group. Analysis using Tukey's Test failed to reveal any statistically significant differences between the SAD-Video Group and the Control Group which received no SAD PERSONS Suicide Assessment Scale training at the $p < .05$ level. Therefore, Null Sub-hypothesis 4.2 failed to be rejected. Master's level counselors-in-training who received SAD-Video Group instruction did not assign significantly different clinical interventions for a high-risk client than those who received no specialized SAD PERSONS Suicide Assessment Scale training.

Analysis of Null Sub-hypothesis 4.3

Null Sub-hypothesis 4.3 stated subjects who received SAD-Video Group instruction will not assign significantly different clinical interventions of a videotaped vignette of a high-risk client in comparison with those subjects who received SAD-Live Group training, as measured by self-reported, multiple-option responses. Post hoc comparisons by means of Tukey's Test were used to analyze Null Sub-hypothesis 4.3. The mean scores were 2.90 for the SAD-Video Group and 2.74 for the SAD-Live Group. Analysis using Tukey's Test failed to reveal any statistically significant differences between these two groups. Therefore, Null Sub-hypothesis 4.3 was not rejected. Master's level counselors-in-training who received SAD-Video Group instruction did not assign significantly different clinical interventions for a high-risk client when compared to those who received SAD-Live Group training.

As stated above, Null Hypothesis 4 was rejected (a difference was found in proposed clinical action related to a high-risk client). Null Sub-hypotheses 4.1 through 4.3 were concerned with any differences discovered within Null Hypothesis 4 relative to specific comparisons between each of the three groups. Analyses using Tukey's Test indicated: (a) subjects who received SAD-Live Group training proposed significantly less aggressive clinical interventions than those who did not receive such specialized SAD PERSONS Suicide Assessment Scale training, (b) subjects who received SAD-Video Group instruction did not assign significantly different clinical interventions for a high-risk client when compared to those who received no specialized SAD PERSONS Suicide Assessment Scale training, and (c) subjects who received SAD-Video Group instruction did not assign significantly different clinical interventions for a high-risk client when compared to those who received SAD-Live Group training.

Null Hypotheses 5, 6 and 7

Null Hypothesis 5 stated that there will be no significant difference in self-reported confidence to adequately assess the immediate risk of client or student suicide among subjects, as measured by self-reported, multiple-option choices. This hypothesis was tested by means of an ANOVA (Table 5). The F value obtained for Null Hypothesis 5 was .35, which was not significant at the $p = <.05$ level ($p < .70$). As reported in Table 6, the mean scores for the SAD-Live Group, the SAD-Video Group and the Control Group were 2.63, 2.67 and 2.80, respec-

Table 6

Summary of Analysis-of-Variance: Comparison of the Means of Three Groups' Self-Reported Confidence to Assess Suicide Risk

Source	<u>SS</u>	<u>dF</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between	.31	2	.15	.35	<.70
Within	<u>23.62</u>	<u>54</u>	.44		
Total	23.93	56			

tively. A significant difference was not obtained among the three groups relevant to confidence in ability to adequately assess immediate risk of client or student suicide. Therefore, Null Hypothesis 5 was not rejected.

Null Hypothesis 6 stated that subjects who participated in either experimental group (i.e., SAD-Live Group or SAD-Video Group) will not differ significantly in SAD PERSONS Suicide Assessment Scale scores given to high- and low-risk videotaped clients when compared to scores given by three experienced psychiatrists who observed the same videotaped vignettes and assigned the clinical actions recommended and used as correct in Patterson's et al. (1983) study. This hypothesis was tested by t tests comparing group means to the expert scores which were considered a constant. The t value obtained for the comparison between the SAD-Live Group ($\bar{X}=2.84$) and the constant score given by the three experienced psychiatrists ($\bar{X}=3.00$) was -1 for the low-risk client, which did not reveal any

statistically significant differences between these groups at the $p < .05$ level ($p = .33$). The t value obtained for the comparison between the SAD-Video Group ($\bar{X} = 3.50$) and the constant score given by the three experienced psychiatrists ($\bar{X} = 3.00$) was 1.81 for the low-risk client, which also did not reveal any statistically significant differences between these groups at the $p < .05$ level ($p = .09$).

However, the t value obtained for the comparison between the SAD-Live Group ($\bar{X} = 4.58$) and the constant score given by the three experienced psychiatrists ($\bar{X} = 5.00$) was -3.02 for the high-risk client, which revealed a significant difference between these groups at the $p < .01$ level ($p = .0073$). The t value obtained for the comparison between the SAD-Video Group ($\bar{X} = 5.15$) and the constant score given by the three experienced psychiatrists ($\bar{X} = 5.00$) was .65 for the high-risk client, which did not reveal any statistically significant difference between these groups at the $p < .05$ level. Because those receiving SAD-Live Group training reported the high-risk client as less of a danger to himself than the experienced psychiatrists at a significant level, Null Hypothesis 6 was rejected.

Null Hypothesis 7 stated that subjects who participated in either experimental group (i.e., SAD-Live Group or SAD-Video Group) will not differ significantly in proposed clinical actions given to high- and low-risk videotaped clients compared to proposed clinical actions given by three experienced psychiatrists who observed the same videotaped vignettes and assigned the clinical actions recommended and used as correct in Patterson's et al. (1983) study. This

hypothesis was tested by t tests comparing group means to the expert scores which were considered a constant. The t value obtained for the comparison between the SAD-Live Group ($\bar{X}=1.53$) and the constant score given by the three experienced psychiatrists ($\bar{X}=2.00$) was -4.02 for the low-risk client. This revealed a significant difference between these groups at the $p < .01$ level ($p = .0008$). The t value obtained for the comparison between the SAD-Video Group ($\bar{X}=2.00$) and the constant score given by the three experienced psychiatrists ($\bar{X}=2.00$) was $.00$ for the low-risk client, which did not reveal any statistically significant differences between these groups at the $p < .05$ level ($p = 1.00$). The t value obtained for the comparison between the SAD-Live Group ($\bar{X}=2.74$) and the constant score given by the three experienced psychiatrists ($\bar{X}=3.00$) was -2.54 for the high-risk client, which revealed a significant difference between these groups at the $p < .05$ level ($p = .021$). The t value obtained for the comparison between the SAD-Video Group ($\bar{X}=3.00$) and the constant score given by the three experienced psychiatrists ($\bar{X}=3.00$) was $.00$ for the high-risk client, which failed to reveal any statistically significant differences between these groups at the $p < .05$ level. Because those receiving SAD-Live Group training proposed significantly less aggressive clinical intervention than the experienced psychiatrist, Null Hypothesis 7 was rejected.

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

This chapter is divided into four sections. The first section consists of a brief summary of the study, the second discusses the findings and the third presents conclusions and implications drawn from the findings. The fourth section consists of recommendations for future research.

Summary

The purpose of this study was to investigate possible cause-and-effect relationships between subjects exposed to SAD PERSONS Suicide Assessment Scale (Patterson et al., 1983) training and those not receiving such instruction, and to manipulate the method of training used to compare efficacy. Fifty-nine master's level counselors-in-training in the Department of Counselor Education and Counseling Psychology at Western Michigan University who were enrolled in a prepractica counselor training class were randomly assigned to one of three groups. Each group was then randomly assigned to one of the two experimental treatments (i.e., SAD PERSONS Suicide Assessment Scale Live Lecture Group [SAD-Live Group] or SAD PERSONS Suicide Assessment Scale Videotaped Instruction Group [SAD-Video Group]) or a nontreatment control group (i.e., Transference-Countertransference Control Group [Control Group]).

During regularly scheduled class times participating subjects received approximately one hour of specialized training related to their specific group assignment (i.e., SAD-Live Group, SAD-Video Group or Control Group). At the completion of their training all subjects observed two videotaped vignettes. The first vignette portrayed a client assessed to be at low-risk of suicide. The second vignette portrayed a client assessed to be at high-risk of suicide. At the conclusion of each videotaped vignette, subjects were asked to complete the VDSS. Questions contained within the VDSS included: (a) the subject's assessment of the suicide risk presented by the client in each specific videotaped vignette, (b) the subject's proposed clinical actions for each client portrayed within the identified videotaped vignette, (c) the subject's confidence in assessing suicide risk, and (d) the number of completed graduate level counselor education and counseling psychology courses completed by the participant. Subjects who participated in one of the two experimental groups were further asked to report the individual SAD PERSONS Suicide Assessment Scale score they had given the identified client within each videotaped vignette.

The study was a quasi-experimental study, using a Randomized Groups, Posttest-only Design. Null Hypotheses 1, 2, 3, 4 and 5 were tested by ANOVA's and Null Sub-hypothesis 1.1 through 4.3 were analyzed by means of Tukey's Test. Null Hypotheses 6 and 7 were tested by means of t tests which compared group means to the expert scores which were considered a constant. The level of significance for rejection of each of the null hypotheses was set at $p < .05$.

Findings

Seven null hypotheses and 12 null sub-hypotheses were developed to investigate possible effects related to SAD PERSONS Suicide Assessment Scale training upon counselors-in-training and to compare efficacy of the instructional methods used (i.e., SAD-Live Group or SAD-Video Group). The findings of these null hypotheses and null sub-hypotheses are summarized in this section.

1. Null Hypothesis 1 compared mean scores of the SAD-Live Group, the SAD-Video Group and the Control Group. Statistical analysis by means of an ANOVA revealed a significant difference among the three groups' abilities to assess suicide risk of a low-risk client. Thus, Null Hypothesis 1 was rejected. Post hoc comparisons by Tukey's Test in Null Sub-hypotheses 1.1 through 1.3 revealed: (a) counselors-in-training who received SAD PERSONS Suicide Assessment Scale training assessed the low-risk client to be in less immediate danger of suicide than those who received no suicide assessment training, and (b) those participating in either experimental group did not significantly differ in their assessment skill.

2. Null Hypothesis 2 compared mean scores regarding proposed clinical actions of the SAD-Live Group, SAD-Video Group and Control Group. Statistical analysis by means of an ANOVA revealed a significant difference. Thus, Null Hypothesis 2 was rejected. Post hoc comparisons by Tukey's Test in Null Sub-hypotheses 2.1 through 2.3 revealed that the group receiving SAD-Live Group

training proposed significantly less aggressive clinical interventions of a low-risk client than the group which received no such SAD PERSONS Suicide Assessment Scale training. Concomitantly, it was noted that master's level counselors-in-training who received SAD-Video Group instruction proposed significantly more aggressive clinical interventions than those who received SAD-Live Group training. Lastly, no significant difference in proposed clinical actions for a low-risk subject was noted between the SAD-Video Group and Control Group.

3. Null Hypothesis 3 compared mean scores of the SAD-Live Group, SAD-Video Group and Control Group. Statistical analysis by means of an ANOVA revealed a significant difference among the three groups' abilities to accurately assess suicide risk of a high-risk client. Thus, Null Hypothesis 3 was rejected. Post hoc comparisons by Tukey's Test in Null Sub-hypotheses 3.1 through 3.3 revealed that groups which received SAD PERSONS Suicide Assessment Scale training assessed a high-risk client to be in less danger of suicide than those who received no specialized suicide assessment training. Concomitantly, the SAD-Video Group assessed the high-risk client to be at greater risk of suicide than the SAD-Live Group.

4. Null Hypothesis 4 compared mean scores regarding proposed clinical actions of the SAD-Live Group, SAD-Video Group and Control Group. Statistical analysis by means of an ANOVA revealed a significant difference among the three groups. Thus, Null Hypothesis 4 was rejected. Post hoc comparisons by Tukey's Test in Null Sub-hypotheses 4.1 through 4.3 revealed that the SAD-Live

Group proposed significantly less aggressive clinical interventions for a high-risk client than the Control Group. It was further noted that: (a) counselors-in-training who received SAD-Video Group instruction did not assign significantly different clinical interventions for a high-risk client than the Control Group, and (b) no difference in proposed clinical intervention for counselors-in-training was noted for those who participated in either SAD-Live Group or SAD-Video Group.

5. Null Hypothesis 5 compared mean scores regarding self-reported confidence in assessing suicide risk among the SAD-Live Group, SAD-Video Group and Control Group. Statistical analysis by means of an ANOVA revealed no statistically significant differences among the mean scores of these groups. Thus, Null Hypothesis 5 failed to be rejected. Counselors-in-training who participated in the study reported themselves to be average to above average in their assessment skill confidence.

6. Null Hypothesis 6 compared mean scale scores of the SAD-Live Group and SAD-Video Group with expert scores. Statistical analysis using t tests in which validation data sets were compared with corresponding expert scores treated as a constant revealed that a significant difference among the groups related to SAD PERSONS Suicide Assessment Scale scores was found. Therefore, Null Hypothesis 6 was rejected. Counselors-in-training who received SAD-Video Group instruction corresponded more closely to the experts' assessment scores than those who participated in the other experimental group.

7. Null Hypothesis 7 compared proposed clinical action group mean scores of the SAD-Live Group and the SAD-Video Group with intervention scores determined by three expert psychiatrists. Statistical analysis using t tests in which validation data sets were compared with corresponding expert proposed clinical action scores treated as a constant revealed that a significant difference among the groups existed. Therefore, Null Hypothesis 7 was rejected. The proposed clinical intervention scores of counselors-in-training who received SAD-Video Group instruction corresponded more closely to the experts' proposed clinical actions than counselors-in-training who participated in the SAD-Live Group.

Conclusions and Implications

The results of this study appear to warrant the following conclusions and implications:

1. Based on a comparison of the two experimental groups, the results suggest that counselors-in-training who received SAD-Video Group instruction made suicide assessments and proposed clinical actions which corresponded more closely to the experts. Conversely, those who received SAD-Live Group training assessed the high-risk client at lower-risk of suicide than the experts. The SAD-Live Group also proposed significantly less aggressive clinical interventions for the high-risk client than the experts. Overall the assessments and interventions of the SAD-Live Group did not parallel the experts as well as the SAD-Video Group.

A possible explanation for such significant differences is that despite having

the same curriculum, the format for delivery of the content to each of the experimental groups was somewhat different. The SAD-Live Group was given the opportunity to verbally interact with the lecturer in: (a) assessing the presence of the 10 specified risk factors related to the two practice videotaped vignette clients, and (b) prescribing accurate clinical actions as recommended by the SAD PERSONS Suicide Assessment Scale for clients portrayed within the vignettes. Such group interactions within the live lecture format might have fostered confusion within the group discussion resulting from students expressing perceived reasons for a risk factor's inclusion or exclusion in the corresponding SAD PERSONS Suicide Assessment Scale score. Perhaps the group receiving only videotaped instruction focused solely upon the correct risk factors identified as accurate and present within each practice videotaped vignette, whereas those receiving live lecture may have heard other participants within their group argue for the inappropriate inclusion or exclusion of a risk factor.

A factor which may have contributed to the differences between the two experimental groups' abilities to more closely replicate the experts' SAD PERSONS Suicide Assessment Scale scores and proposed clinical actions was the instructor's more formal, business-like manner within the videotaped instruction component. The live lecture was presented in a more spontaneous and, perhaps, entertaining manner. The possible entertaining qualities of the live lecture may have overshadowed some of the more salient points of the SAD PERSONS Suicide Assessment Scale training, therefore, adversely affecting subjects within

the group receiving live lecture.

Another possible explanation for the differences between the two groups may be that the pace of the videotaped component was slower than the live lecture component. Several participants within the SAD-Live Group initiated questions related to the specific inclusion or exclusion of certain risk factors within the SAD PERSONS Suicide Assessment Scale scores. While these questions warranted direct responses and brief explanations, they reduced available lecture time and incited the lecturer to quicken his pace of progression through the training. These hurried behaviors may have affected the presentation, thus, adversely affected the skill acquisition of the group receiving live lecture.

The author notes the results of this study validate the efficacy of videotaped instruction supporting claims by other mental health researchers. Golden (1978) found that junior medical students who observed a self-instructional videotaped program on suicide assessment demonstrated greater knowledge related to suicide assessment on a ten-question, multiple-choice test than those who had received traditional live lecture instruction, case presentations and textbook readings related to suicide assessment. Pohl et al. (1982) found that trainees receiving videotaped instruction alone scored higher on a 34 question, multiple-choice test related to the mental health status examination than subjects receiving live lecture only. Despite the fact that the differences in Pohl's et al. (1982) research were not great enough to yield significant differences among posttest scores, it did demonstrate that videotaped instruction can be as effective as traditional live

lecture alone.

2. Based on a comparison among all three groups, the results suggest that counselors-in-training who participated in the SAD PERSONS Suicide Assessment Scale training tended to rate high- and low-risk clients as less of an immediate danger of suicide than those who did not participate in such training. Therefore, counselors-in-training who participated in either of the experimental groups would more likely encourage hospitalization for those with immediate and significant risk. The increased accuracy of making high- and low-risk assessments and subsequent recommendations for clinical intervention will reduce the number of unnecessary hospitalizations of low-risk clients, while encouraging hospitalization for those truly in need. These results support Patterson's et al. (1983) findings. As indicated earlier, they reported that third-year medical students who received SAD PERSONS Suicide Assessment Scale training tended to rate high- and low-risk clients more accurately than those who did not receive such training.

Except for the SAD-Live Group's single instance of evaluating a high-risk client as less of a danger to self than the experts, the results of the current research imply that the semi-structured, systematic, assessment interview encouraged by the SAD PERSONS Suicide Assessment Scale aided counselors-in-training to more accurately evaluate the videotaped clients. A possible explanation of this result may be related to increased understanding of the broader continuum of estimated risk. Such an increased understanding of the risk continuum likely suggests a greater number of intervals between a high-risk client whose con-

dition warrants immediate hospitalization and a low-risk client who most likely can be treated effectively outside of a restrictive environment. Conversely, trainees who do not receive suicide assessment training may attempt to make assessments and proposed clinical interventions based upon a perceived forced-choice dichotomy of the client being suicidal or not.

3. Irrespective of the actual assessment and intervention scores, trainees perceived themselves as possessing average to slightly above average suicide assessment skills. The results imply that those who received videotaped or live training did not perceive their abilities to be significantly inferior or significantly superior compared to others. Notwithstanding data which demonstrates superior client risk assessment ability in the SAD-Video Group, those trainees felt no more confident or qualified than their counterparts who did not receive such instruction.

It is possible that the extreme brevity of the suicide assessment training experience did not permit adequate time for trainees to integrate their newly acquired knowledge and skills into their emerging professional repertoire. Also, scores were not reported to trainees before they responded to the posttest question regarding perceived level of confidence in assessing risk. Had scores been reported earlier one might expect that the perceived level of confidence would have been higher. Since reported levels of confidence fall between average and slightly above average within the experimental groups, one might assume that trainees remain cautious and view SAD PERSONS Suicide Assessment Scale

scores as an aid vis-a-vis an answer to suicide assessment and clinical intervention.

Recommendations

The results of this study led to the following recommendations:

1. In order to support or verify these findings, it is recommended that a replication of the study be performed with a different sample of counselors-in-training who are enrolled in a counseling prepractica course.
2. A longitudinal study should be conducted with the current participants to determine if: (a) those who received the SAD PERSONS Suicide Assessment Scale training continue to use the scale in their professional practice when making suicide assessments, (b) those who received SAD PERSONS Suicide Assessment Scale training via live lecture and videotaped instruction are perceived by their immediate clinical supervisors as adequately able to make accurate suicide risk assessments and assign accurate clinical interventions.
3. Continued research with and refinement of the SAD PERSONS Suicide Assessment Scale appears indicated and of value. Further study may continue to validate the scale as a useful clinical tool that can aid mental health providers in the suicide assessment process. One possible study might include professionals trained in the use of the scale assessing clients who were currently hospitalized as a result of suicide attempts. These scores could then be compared to scores of persons from the general-population-at-large to determine if significant differences are suggested.

Appendix A
Human Subjects Review Board
Letter of Approval



WESTERN MICHIGAN UNIVERSITY

Date: January 30, 1991

To: Gerald A. Juhnke

From: Mary Anne Bunda, Chair

Mary Anne Bunda

Re: HSIRB Project Number 90-09-02

This letter will serve as confirmation that the changes in your research protocol, "Evaluation of a Method of Suicide Assessment Training," were received by the HSIRB on January 28, 1991.

The changes are acceptable, and your protocol continues to be approved.

xc: Alan J. Hovestadt, CECP

Appendix B
Videovignette Data Scoring Sheet

VideoVignette Data Scoring Sheet
Page One

1. Client Number One:

A) Based on my evaluation of client number one's history and clinical presentation, I feel his/her risk for suicide is:
(Circle Only One of the Following Numbers)

Very Unlikely	0 1 2 3 4 5 6 7 8 9 10	Very Likely
------------------	--	----------------

B) Circle the appropriate clinical action you would propose for this client.
(Circle Only One Response)

- a) Send home with follow-up as suicide is unlikely
- b) Consider hospitalization but may send home if close follow-up is arranged
- c) Strongly consider hospitalization depending on my confidence in follow up arrangements
- d) Definitely hospitalize or commit

Only Groups A & B complete the questions in the box below. If you were in group C, do not complete questions in the box. Group C, please, wait for further instructions.

Only if you were in either Group A or Group B should you respond to BOTH questions within this box:

a) Please add up the total number of SAD PERSONS points you would have given client number ONE and CIRCLE that total number of points below.

1 2 3 4 5 6 7 8 9 10
--

b) Please circle the Group you were in:

b1) I participated in GROUP A

b2) I participated in Group B

STOP. Do not proceed until further instructions are given. Thank You.

VideoVignette Data Scoring Sheet
Page Two

2. Client Number Two:

A) Based on my evaluation of client number two's history and clinical presentation, I feel his/her risk for suicide is:
(Circle Only One of the Following Numbers)

Very Unlikely	0 1 2 3 4 5 6 7 8 9 10	Very Likely
------------------	--	----------------

B) Circle the appropriate clinical action you would propose for this client.
(Circle Only One Response)

- a) Send home with follow-up as suicide is unlikely
- b) Consider hospitalization but may send home if close follow-up is arranged
- c) Strongly consider hospitalization depending on my confidence in follow up arrangements
- d) Definitely hospitalize or commit

Only Groups A & B complete the questions in the box below. If you were in group C, do not complete questions in the box. Group C, please, wait for further instructions.

Only if you were in either Group A or Group B should you respond to **BOTH** questions within this box:

a) Please add up the total number of SAD PERSONS points you would have given client number TWO and CIRCLE that total number of points below.

1 2 3 4 5 6 7 8 9 10
--

b) Please circle the type of SAD PERSONS training you received below:

b1) I participated in GROUP A

b2) I participated in GROUP B

STOP. Do not proceed until further instructions are given. **Thank You.**

**VideoVignette Data Scoring Sheet
Page Three**

3. When comparing my own level of confidence in adequately assessing the risk of client suicide to others with similar amounts of completed academic and clinical experience, I feel (Circle One Response)
- a) Significantly more able than most
 - b) Above average
 - c) Average
 - d) Below average
 - e) Significantly less able than most

4. Circle the number of CECP courses you have COMPLETED.

1 2 3 4 5 6 7 8 9 10 or More

Please remain seated until dismissed. **Thank you** for your help.

Appendix C

Approval Letter From Dr. William M. Patterson Granting Permission to Use the SAD PERSONS Suicide Assessment Scale

William M. Patterson, M.D.
6869 5th Avenue South
Birmingham, AL 35212


May 30, 1990

Alan J. Hovestadt, Ed. D.
Professor and Chair
Department of Counselor Education And
Counseling Psychology
3102 Sangren Hall
Western Michigan University
Kalamazoo, MI 49008-3899

Dear Dr. Hovestadt:

Understanding that you are Gerald A. Juhnke's Doctoral Committee Chair, as well as Chair of Western Michigan University's Department of Counselor Education and Counseling Psychology, I am writing to inform you that I have hereby granted permission to Gerald A. Juhnke for the use of the SAD PERSONS Suicide Assessment Scale in his research and dissertation endeavors

Sincerely,



William M. Patterson, M.D.

Appendix D
Informed Consent Form

Informed Consent Form

The purpose of this research experiment is to determine if specific professional counselor development training components impact students' perceptions. Volunteers will receive approximately 3 hours of training relevant to their development as a professional counselor.

It is anticipated that subjects will attain a significant increase in their counseling knowledge and skills, especially, as these relate to the counselor-client interview interaction. No significant identifiable or foreseeable physical, psychological or social risks are anticipated. Participation in this professional development component is voluntary; grades will not be positively or negatively affected by ones' participation or non-participation. Any written responses submitted during this professional training component will be confidential and anonymous.

Please forward any questions or concerns you might have to Gerald A. Juhnke (616) 940-0434. Should difficulties be encountered that you believe Jerry can not adequately resolve to your satisfaction, please, contact Dr. Alan Hovestadt, Chairperson of the Department of Counselor Education and Counseling Psychology (616) 387-5100.

I have read this informed consent form and agree to the above stated terms.

Signed_____ Dated_____

**Gerald A. Juhnke, M.A.
CECP Doctoral Student
2107 Ridgecrest SE #12
Grand Rapids, MI 49506
(616) 940-0434**

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