

**Knowledge of Suicide Intervention Skills:  
Do Crisis Line Volunteers and Clergy Differ?**

by

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## ABSTRACT

This study extends previous research on suicide intervention skills to include clergy. Two constructs are studied, the knowledge of suicide intervention counselling skills, as measured by the Suicide Intervention Response Inventory – 2 (SIRI-2) (Neimeyer & Bonnelle, 1997), and recognition of suicide lethality, as measured by the Recognizing Suicide Lethality (RSL) test (Holmes & Howard, 1980). These two instruments were administered to 42 crisis line volunteers, 30 clergy and 26 non-counselling graduate students. The expectation that crisis line volunteers would score significantly better than the other groups on each instrument is not confirmed. The volunteers scored significantly higher on the RSL than the graduate students,  $t(61) = 2.00, p < .05$ . Unexpectedly the clergy SIRI-2 score is comparable to master's level counselling students in Neimeyer & Bonnelle's (1997) study. The hypothesis that experience and training in suicide intervention skills will correlate with SIRI-2 performance is not confirmed. The expectation that more experience will be related to RSL scores is not confirmed. Although global measures of experience and training do not show consistent associations with SIRI-2 and RSL some significant correlations emerge for some occupational subgroups and some specific measures. Past research of various psychological constructs regarding suicide and counselling has shown that many people utilize clergy as counsellors, yet clergy may not always be adequately knowledgeable. In this sample clergy knowledge is not significantly less than the crisis line volunteers. Further research to assess training and preparedness of contemporary clergy for suicide intervention and general counselling is required since they are a key care-giving resource in most communities.

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## CHAPTER 1: INTRODUCTION

*Purpose of the Study*

Who encounters persons considering suicide? Friends, peers, family members, teachers and clergy are often the first to observe someone feeling suicidal. Persons contemplating taking his/her life may or may not express their suicidal ideas to any of these persons, but some of their behaviors may indicate their intent. However, the people in these roles may not recognize suicidal intent or may be unaware of suicide intervention techniques. Knowledge of these skills are important considering that Statistics Canada reported that 3,968 Canadian deaths were known suicides in 1995 (Colombo et al., 1997). The following years numbered 3,941 known suicides in 1996 and 3,681 suicide deaths in 1997, which was a suicide rate of 13.2 and 12.3 per 100,000 in respective years (Statistics Canada, n.d.). Generally, those with suicidal intent do not initially approach mental health and medical professionals or paraprofessionals (i.e. crisis line volunteers) specifically trained in crisis intervention techniques. Usually the first line action rests with those closest to the person.

Neimeyer and Pfeiffer (1994a, b) summarized 15 years of research on suicide intervention counseling skills and the most common errors made by suicide interventionists. The research included published studies on the occupational groups that historically encounter potential suicide victims. The groups included medical doctors, nurses, medical students, teachers, crisis line workers, psychologists, psychiatrists, social workers and counsellors. One occupational group that was not represented was clergy, a profession defined by regular, intimate involvement with people.

The purpose of this study was to extend the suicide intervention research to specifically include clergy. This study furthered the research of suicide intervention competencies. Specifically, the knowledge of recognizing suicide lethality and the awareness of suicide intervention counseling skills was explored. This was accomplished by conducting a comparison

between crisis line volunteers, an occupational group trained in suicide intervention skills, clergy and non-counselling graduate students, a group not involved in the care taking profession.

This study extended the research regarding suicide interventionists' attitude toward death that encompassed more than just personal anxiety about death.

### *Rationale*

At the time of this research, no published empirical study had reported on the clergy's awareness of skills needed to help an individual contemplating suicide using both the particular instruments utilized in this research. Therefore, this study extended the research by quantitatively surveying the clergy for knowledge of suicide intervention skills.

Crisis line volunteers are an occupational group that have on average more frequent contact with persons feeling suicidal than the majority of the population. Also telephone crisis centers provide training specific to suicide intervention. Therefore, for this level of training and experience they were chosen as a study group. Non-counseling graduate students were chosen to represent a similar peer group as clergy, considering average age, life experience, level of education and professionalism. For comparison purposes this group represented an educated segment of the general population that are not in the mental health profession or in the social services occupations. Hence it was expected that they would not have a great deal of experience with suicidal persons nor been trained specifically in suicide intervention skills.

It has been suggested that an important component for effective crisis care giving is the ability to recognize signs of suicide lethality (Botsis, 1997; Kral & Sakinofsky, 1994; Pallis, 1997; Shneidman & Madelkorn, 1970; Slaby, 1998). Hence, this research included a survey to measure the awareness of specific indicators that increase the likelihood that someone is feeling suicidal. Suicide research and theory has suggested that counselling someone feeling suicidal requires knowledge of some approaches different than a typical counselling interaction, such as an interventionist acting more directive and immediate (Farberow, Helig & Parad, 1990).

Therefore, this study employed an instrument to tap the participants' knowledge of counseling

skills. The lethality recognition and suicide counseling skills are two constructs that can be measured separately since they have been previously shown to be divergent variables (Inman, Bascue, Kahn & Shaw, 1984).

Finally, a third area of consideration was death attitude. This study extended the research by using a different death attitude instrument than what had been previously used in suicide interventionist research. Death anxiety is a predictor variable that has been considered when measuring differing elements, which may hinder or enhance suicide interventionists counseling skill knowledge (Lester, 1971; Neimeyer & Dingemans, 1980; Neimeyer & Neimeyer, 1984). This study utilized an instrument that explores an overall death attitude that includes neutral feelings toward death, acceptance of death and death anxiety. Since past research has not measured all these areas of death attitude with this study's intervention constructs, exploring these other aspects of death attitude extended the research.

#### *Approach*

Two instruments have been used numerous times during the last 25 years to study knowledge of counseling skills and recognizing lethality particular to suicide. The former has been measured by Neimeyer and MacInnes' (1981) instrument the Suicide Intervention Response Inventory (SIRI) and more recently by the revised version the Suicide Intervention Response Inventory – 2 (SIRI-2) (Neimeyer & Bonnelle, 1997) (see Appendix A). The latter has been measured by Holmes and Howard's (1980) test the Recognizing Suicide Lethality (RSL) (see Appendix B). Therefore, to build on the previous research this project utilized these two instruments to quantitatively measure the suicide intervention skill constructs. The death attitude dimensions were measured with Wong, Reker and Gesser's (1994) scale the Death Attitude Profile-Revised (DAP-R) (see Appendix C).

#### *Suicide Defined*

Suicide has been defined in different ways in the literature. Durkheim (1897/1951) defined suicide as a term that should be “applied to all cases of death resulting directly or

indirectly from a positive or negative act of the victim himself, which he knows will produce this result” (p. 44). The indirect negative actions that end in death, such as a person refusing to take nourishment, or indirect positive actions such as an assisted death includes physician assisted deaths and living wills. Yet, actions that also result in death such as a political martyr or a soldier who knowingly goes to his or her death to save others is not deemed a suicide. Hence, the act of renouncing life does not always constitute suicide. In our society, an act of suicide appears to be defined by a person's motivation to knowingly end his or her life as.

For the purpose of this research, suicide was defined as an individual that knowingly commits an act, which results in his or her death. Shneidman (1985) stated that a motivation for suicide is “a combined movement toward cessation of consciousness and as a movement away from intolerable emotion, unendurable pain, unacceptable anguish” (p. 124).

Each individual determines whether the pain they experience is unbearable. Shneidman (1993/1996) has coined this psychological state a *psycheache*. This combination of pain and the stress of unmet psychological needs precipitate the desperate search for a solution. Some persons decide that the pain is too much and death is the solution. Hence, the goal is simply to end their pain and death is viewed as the sole solution.

The death option, according to Durkheim's (1897/1951) definition, is assumed to be the desired result a person seeks with his or her action. Yet the person thinking of suicide may not fully comprehend and understand all that death entails. However as stated above, rather than death being the goal many suicidologists have agreed that it appears that the goal in suicide is to stop the pain (Kral & Sakinofsky, 1994; Leenaars, 1994; Shneidman, 1985, 1993). Those expecting suicide to free them from pain appear to have an inability to realize that in death he or she will no longer be a cognizant “I”. Shneidman (1985) explained this confused self-attribution concerning death.

It is a confusion about the self, a fallacious identification. It is a psycho-semantic fallacy that may well occur whenever an individual thinks about his own death,

inasmuch as an individual has great difficulty really imagining his own complete cessation, for even as he thinks about it he imagines himself as a spectator-survivor in a world after his death....“I will be cried over”... he is in a maelstrom of semantic confusion, for the “I” that he is talking about will no longer exist to receive those experiences. (p. 138)

Therefore, this suicide discussion is confined to persons who are actively seeking to end their life as a cessation of psychological pain. Hence, it does not include physician-assisted deaths or living wills.

Predicting human behaviour is difficult. Slaby (1998) cited studies that have found that standardized scales are limited in determining suicidality. Slaby concluded from his review of risk factors that “Clinical parameters reflecting histories of hopelessness, previous self-destructive behaviour and impulsive behaviour are better” (p. 45), than solely immediate presenting symptoms. Prediction instruments have been found to account for only a small portion of the variance in any predictive process. Beck, Brown, Steer, Dahlsgaard and Grisham (1999) found that numerous measures used over the years to predict eventual suicide had fairly low sensitivity rates. Beck et al. (1999) reported that the clinical scales he and colleagues had developed to assess hopelessness and suicidal ideation are best utilized over time with full case histories. However, the cost and consequences of not trying to predict may be greater than, and outweigh, the difficulty of attempting to predict suicidality. This study did not attempt to answer the predictability of suicide debate, but rather was based in the traditional theory that recognizing specific static and dynamic factors found to be historically related to completed suicides could contribute to early intervention.

#### *Death Attitude Defined*

This study explored death attitude as measured by the DAP-R. For this research, the following is a working definition of death attitude. Thanatologists, philosophers and theologians have studied humankind’s attitude toward death for centuries. These attitudes have been given

various terms to better define elements of a person's views and feelings toward death. These terms include death anxiety, the threat of death, death acceptance, death concern and the fear of death (Tomer, 1994). This study explored not only anxiety about death but also the acceptance of death. Therefore, a term that encompasses both elements without the connotation of either approach is death attitude.

A few limitations for this study were that only adult death attitude was addressed since suicide interventionists are adults. Secondly, death attitude was a descriptor for the suicide interventionist not the person feeling suicidal. Thirdly, the death attitude construct was limited to an approach to death as an overall belief system, not when someone is coping with the knowledge or threat of immediate personal death.

The following thesis presents a review of the psychological research and theory concerning the two constructs, awareness of suicide lethality and intervention counseling skills. Then the occupational groups and death attitude are reviewed in connection with suicide intervention. After these reviews the hypotheses are discussed. The third chapter discusses the study's methodology, including sample size, the canvassing procedures, and the quantitative instruments. Then in the following chapter the results are presented and finally a discussion with implications and further research suggestions are given. Lastly, references and appendices of the three instruments, the letter to subjects, and the informed consent form are included.

## CHAPTER 2: LITERATURE REVIEW

The following psychology research review describes suicide within the sphere of suicide intervention counselling skills and recognition of suicide lethality. Included within this circle are the specific occupational groups, experience, training, death attitude, and demographic factors in relation to the described suicide constructs.

First, overall suicide prevention is presented. Then the theoretical and empirical suicide research is detailed. Next, the definition of suicide lethality with the researched dynamic and static lethality indicators are given. Then the last half of this chapter is devoted to reviewing research of the aforementioned predictor variables in relation to this study's research constructs.

### *Suicide Prevention and Intervention Defined*

The overall concept of suicide prevention is to intervene at some point in the process of an individual's path toward killing him/herself. This is accomplished on different levels from societal to the individual. Hence, steps can be taken to change the "cultural and/or social conditions that lead to suicide" (Stillion & McDowell, 1998, p. 199), for instance, by the establishment of crisis centres in a community. Overall education and involvement with families, schools, and society is considered primary prevention.

Interpersonal interaction with someone that is in crisis and assessed to be overtly suicidal includes direct treatment and is referred to as suicide intervention or secondary prevention. For simplicity, the term suicide intervention will be used throughout this paper. Finally, postvention is working with the survivors of a suicide victim, including family, friends and groups such as classmates. The focus of this study was on the techniques and knowledge required for intervening when a person is feeling suicidal. Therefore this review is limited to theoretical and empirical material pertaining to direct suicide intervention.

### *Theoretical and Empirical Suicide Profile*

Suicide intervention theory and guidelines have developed from empirical research and case history profiles of persons who have attempted suicide and/or died from suicide. Shneidman

(1985; see also Shneidman & Madelkorn, 1970; Shneidman, 1990/1991,1993/1996) has suggested that persons who are suicidal usually present with some common cognitive, emotional and psychological patterns regardless of age. Shneidman identified that cognitive motives and states include but are not limited to the following: (a) an attempt is being made to find a solution; (b) a goal is to stop awareness or consciousness; (c) an ambivalent cognitive state exists wanting both death and life; (d) escape is desired; (e) and the decision/act is an attempt to communicate pain and intention. Persons considering suicide tend to be in a perceptually limited cognitive state, which leads to constricted thinking. The person with this tunnel vision considers death or life in pain as his or her only possible future. Eventually he or she may zero in on suicide as the only option between these two possibilities (Botsis, 1997; Kral & Sakinofsky, 1994; Leenaars, 1994; Shneidman, 1985, 1990, 1996). The risk appears greatest when the limited option for pain reduction is only suicide (Slaby, 1998).

The affective states may include depression, anxiety and hopelessness (Beck, Kovacs & Weissman, 1975/1996; Botsis, 1997; Kral & Sakinofsky, 1994; Shneidman, 1985; Slaby, 1998). Hopelessness is defined by not only despair about present circumstances but also a negative outlook for the future (Beck et al., 1975/1996). Beck, et al. (1975/1996) completed research on close to 400 suicide attempters and found that hopelessness was more highly correlated with suicidal intent than clinical depression. Since then hopelessness, more than depression, has continued to be seen as a significant dynamic indicator for high suicide risk (Beck, Brown & Steer, 1989; Botsis, 1997; Beck et al., 1999; Slaby, 1998). Slaby (1998) reported findings that individuals suffering from a depressive episode are at the highest risk for suicide as he or she is coming out of the depression or beginning treatment (Pallis, 1997). This appears to occur because the person's energy level is better yet hopelessness and depressed affect remains (Slaby, 1998).

Another predominant emotional state is the combination of anxiety with the feelings of hopelessness. It has been found that in an agitated state of anxiety or during a panic attack is when many individuals complete an act of suicide (Botsis, 1997).

According to Shneidman (1993/1996) a common psychological state, which acts as a stimulus toward a decision for suicide, is unbearable psychological pain or *psycheache*. Shneidman has also suggested that the stress of unmet psychological needs, such as the lack of self-worthiness, belonging and purpose, are often present. Finally, Shneidman (1985, 1990) has reported that an individual's decision or act of suicide is usually consistent with “lifelong coping patterns” such as the capacity to handle psychological pain, dichotomous thinking, and limited problem solving capabilities. Botsis (1997) concurred with Shneidman that among suicide attempters there tends to be an inability to use coping skills, e.g., minimization, alternative solution generation and blaming as coping skills. Hence, they may respond extremely reactionary to stressful life events and be unable to cope effectively. These findings highlight that throughout crisis intervention literature a situation is deemed to be a crisis by the individual person's perception (Botsis, 1997; Leenaars, 1994; Shneidman, 1985). Of course, a history of even one past suicide attempt is a powerful indication of an individual's coping patterns and another suicide lethality indicator (Botsis, 1997; Maltsberger, 1988/1996; Pallis, 1997).

#### *Risk Assessment Theory – Recognizing Lethality*

It has been suggested that the first step in suicide intervention is to assess whether a person is at risk for committing suicide. Determining both lethality and perturbation levels (Kral & Sakinofsky, 1994; Shneidman, 1985) assesses a person's present risk for a suicide attempt. Risk assessment has been considered crucial for discovering the probability of a suicide attempt. This probability, called lethality, is the intent to choose suicide as the best course of action (Kral & Sakinofsky, 1994) and may be rated from low, medium to high (Leenaars, 1994). The second concept of suicide assessment refers to the subjective emotional state of the person and can include varying degrees of “upset, disturbance, tension, anguish, turmoil, discomfort, dread, hopelessness, or other excessive psychological pain” (Kral & Sakinofsky, 1994, p. 24). This emotional state is called perturbation.

The perturbation level that a person can tolerate is subjective. A high level of perturbation often pushes the level of lethality higher (Kral & Sakinofsky, 1994; Leenaars, 1994; Shneidman, 1985, 1990). Lethality increases as the person regards suicide to be the only possible way to alleviate a subjectively unbearable level of psychological pain and perturbation (Kral & Sakinofsky, 1994; Shneidman, 1993). However, it is important to note that a person may be highly distressed and agitated yet have a low level of lethality because no suicidal thoughts or ideation are present. Leenaars (1994) described the importance of assessing both elements with the following.

It is lethality, not perturbation that kills. All sorts of people are highly perturbed but are not suicidal. Perturbation is often relatively easy to assess; lethality is not. When intervening with highly lethal people, one must stay alert to both concepts. In practice, the two may be difficult to differentiate, because lethal states are likely associated with high perturbation (although the converse is not necessarily true). (p. 46)

Now a look at more dynamic and static variables that appear to increase risk among vulnerable groups compared to the general population are listed. Asking an individual whether suicide is an option and also if death is the person's only option effectively explores the person's level of constricted thinking (Kral & Sakinofsky, 1994). A study by Paluszny, Davenport and Kim (1991) determined that the level of constricted thinking is proportionally related to the degree of probability for a suicide attempt. To inquire about intent, one may ask the individual if he/she has a plan for killing him/herself (Kral & Sakinofsky, 1994). A detailed plan that includes, for instance, how, when, where, who would discover them and ways to avoid being stopped all point toward high lethality. Another key lethality component is the individual's access to means of killing him/herself, such as firearms, potentially lethal medication and/or access to a vehicle. The particular method discussed may also indicate higher lethality since some of the leading

means of suicidal death include firearms, gassing, hanging and jumping (La Greca, 1988). An easy accessibility to lethal means may indicate a higher risk of a suicide attempt. A quick onset of symptoms has been believed to indicate higher lethality, hence a need for intervention. Yet the prognosis is better than chronic, repetitive self-destructive behaviour (Litman & Farberow, 1970).

An individual diagnosed with at least one mental illness is at a higher risk for suicide than individuals without a diagnosis. Since the 1950's mental illness has been named as a common denominator in completed suicides (Robins, Murphy, Wilkinson, Gassner & Keyes, 1959/1996). Botsis' (1997) review of more recent empirical studies still reported that "around 95% of individuals who commit suicide suffer from at least one mental illness" (p. 129). It is important that caregivers remember that alcohol and substance abuse are considered a mental illness. Often a dual diagnosis of substance and/or alcohol abuse with an affective disorder is present in many that commit suicide (Botsis, 1997). Slaby (1998) cited numerous studies that brain chemistry appears to be a significant factor in suicides. Slaby stated that "suicide appears at this time to be linked to decreased serotonin in the brain" (p. 46). With the following statement Slaby also argued that a person's physiological state is a key component in suicide.

Most often, it is the result of a pharmacologically sensitive proclivity to impulsive self-harm; it may also be the manifestation of a medical disorder that alters perception and/or enhances impulsivity (e.g., Alzheimer's disease, epilepsy) or of drug intoxication.

Although sometimes psychosocial or existential forces converge to impel a person to commit suicide, the drive for self-preservation is so great...few choose to die rather than live unless biological factors are also involved. (p. 48)

High lethality may also be evident when many psychosocial risk factors are present. These include static environmental factors, especially among younger age groups, such as criminality, unemployment and early exposure to violence in a peer group or neighbourhood (Botsis, 1997). Litman and Farberow (1970) reported that recent losses of either loved ones or financial status may also place a person at high lethality. The literature showed that a combination

of specific personal social factors could increase a person's lethality risk. These included being single, divorced, separated or widowed, living alone, poverty, (Botsis, 1997; Pallis, 1997) and/or living in urban areas (Pallis, 1997). Past life events that have increased the risk of possible suicide included dysfunctional family of origin, history of family mental illness and/ or suicides, adolescent substance abuse, and social isolation as a youth (Botsis, 1997; Pallis, 1997). Also, a homosexual lifestyle coupled with societal stigma have been evidenced among completed youth suicides (Slaby, 1998).

Among the general population chronic or terminal physical illness has been a high risk factor (Litman & Farberow, 1970; Pallis, 1997). This information related to reports that a recent visit, six months or less, to a physician have been indicators of suicide lethality (Holmes & Howard, 1980; Shneidman & Madelkorn, 1970; Slaby, 1998).

Finally, the number of completed and reported suicides have shown that males have been more likely to suicide than females (Botsis, 1997; Lester, 1991; Litman & Farberow, 1970; Pallis, 1997; Statistics Canada, 2003; National Center for Health Statistics [NCHS], 1996 [as cited in Famigheti et al., 1998]). In the U.S. a higher suicide rate has been found among elderly men (Leenaars & Lester, 1995). However, Canadian statistics have not placed only the elderly population at the highest risk. The Canadian youth suicide rate has been rising (Lester, 1991). The 1988 Canadian suicide rates placed younger males between the ages of 15 and 34 at a fairly equal risk per 100,000 as the elder males over 55 years of age (Leenaars & Lester, 1995). The years following Leenaars and Lester's (1995) report the 1996 and 1997 Statistics Canada reports indicated that males between the ages of 15 and 24 had a higher known suicide rate than males over 65 years of age (Statistics Canada, 2003). These reported rates for males over 65 years of age in Canada still placed them in a vulnerable group for suicide.

Evidence of particular lethality indicators may rate an individual higher than other risk factors. Yet, it is the summation of many lethality indicators that determines that an individual is at high risk. The presence of only one or two static or dynamic factors should not be assessed as

high risk, especially without an indication of intent. Botsis (1997) reported that 80% of persons diagnosed with depression and 90% of persons diagnosed with schizophrenia eventually die a natural death. Hence, an individual should not be rated as high risk solely because of a diagnosed mental illness. However, the combination of constricted thinking and a suicide plan with available means places an individual at a higher risk even without other prominent indicators. Each person and situation needs to be assessed by present symptoms and case history with ongoing evaluation.

In summary, the aforementioned lethality indicators each need to be queried in risk assessment because the suicidal act is multi-determinant. Below is a list summarizing the possible indicators reviewed above, which include but are not limited to the following for the U.S. and Canada: (a) constricted thinking; (b) feelings of hopelessness, depression, anxiety or panic attacks; (c) poor coping skills, such as a lack of minimization, problem solving, and appropriate boundaries; (d) a past suicide attempt; (e) a suicide plan; (f) accessibility to lethal means; (g) quick onset of dynamic symptoms; (h) mental illness diagnosis; (i) unemployment; (j) exposure to violence at a young age; (k) criminality; (l) recent crisis event or loss; (m) marital status of single, divorced, widowed or separated; (n) living alone; (o) poverty and/or city dwelling; (p) family history of mental illness and/or suicides, adolescent alcohol and/or substance abuse; (q) social isolation; (r) being gay lesbian or bi-sexual; (s) recent publicized or peer group suicide; (t) terminal or chronic physical ailment; (u) a recent visit to a physician; (v) being male; (w) more specifically in the U.S. male over 55 years of age, in Canada male between 15-29 and over 65 years of age are at equal risk.

#### *Suicide Intervention Counseling Skill Theory*

The previous descriptions of the emotional, cognitive, psychological, physiological and social states of someone suicidal provide interventionists an understanding of a suicidal person's present world. Suicide intervention's overall goal is “to keep the person alive” (Leenaars, 1994, p. 46). Lester (1997) argued that counsellors should not presume that a client’s suicidal intent is

irrational. Therefore, Lester stated a case that a client's suicide option should be explored and the counsellor should not try to dissuade the suicidal act but rather work toward a dignified death if that is the client's choice. However, for the purpose of this paper the following counseling skills are based on the former goal, to preserve life. Therefore, the relationship between the interventionist and the suicidal person is different than regular therapeutic interplay. Regardless of a counsellor/psychologist's theoretical leanings the nature of suicide intervention demands that the interventionist take a more directive and active role. Farberow, Helig and Parad (1989) outlined guidelines for counseling someone feeling suicidal; Frankish (1994) succinctly summarizes these as follows:

- Directly explore suicidal thoughts,
- Assess suicide risk,
- Attempt to diffuse the potential for lethality,
- Encourage social connection,
- Implement behavioural contracting,
- Seek consultative support,
- Make appropriate referrals,
- Take suicidal gestures seriously, and
- Remember the healing power of therapeutic availability. (p. 35)

Establishing rapport is the first step toward accomplishing this treatment plan. This is essential even during a crisis line telephone conversation. Therefore, a non-judgmental, caring attitude is the best approach. Leenaars (1994) wrote about the least helpful approaches that “. . . it is neither useful nor wise to respond to an individual in an acute suicidal crisis with punishment, moral persuasion, or confrontation. The most effective way to help is to assuage the anguish of the trauma, thereby reducing the perturbation.” (p. 51). The key is to engage the individual in a human relationship.

Again, each person perceives the relative severity of his/her situation and determines the extent of the circumstances as a crisis. Hence, understanding and working with that individual's view is necessary, rather than a patronizing response such as "it's really not so bad". Engaging with the individual and not hiding behind a professional stance (Neimeyer & Pfeiffer, 1994b) is important, because an intervention goal that Leenaars (1994) has promoted is to help an individual become emotionally reconnected with the world. A caring human interaction begins to facilitate this goal.

After inquiring about suicidal ideation and plans the level of lethality may be determined to be low, medium or high. When high lethality is determined the next step is to work toward making the person safe. For instance, if the person has readily lethal means available, attempt to eliminate those means. This may include telling the person for instance, to pour the drugs or poison down the drain, illicit the help of family members, persons in the home or neighbours near the individual to take firearms away from them. Establishing a support network is needed to implement some of these interventions.

The motives, cognitive and affective states and reasoning abilities of highly lethal clients is important to understand because these aspects work together to move a person toward suicide but also provide avenues for a care giver to intervene. For instance, at the extreme point of unendurable psycheache the resulting tunnel vision only allows the individual to focus on stopping the pain hence losing the capability of implementing a larger range of coping skills, such as seeking alternative solutions. Therefore, once the person is safe it is essential to help them generate alternatives to suicide (Kral & Sakinofsky, 1994; Leenaars, 1994; Shneidman, 1985). Leenaars (1994) said that to help keep the person alive "the professional actively works to increase the patient's psychological sense of possible choices" (p. 46).

A suggested approach is to meet the person in his or her emotional pain, rather than ignore, trivialize or react indifferently to the individual (Leenaars, 1994; Shneidman, 1970, 1985, 1990) to thereby help alleviate the particular "frustrated psychological needs" (Shneidman,

1993/1996, p. 635). Hence, statements that patronize, invalidate or avoid the individual's pain are not helpful (Neimeyer & Pfeiffer, 1994b). As stated earlier, a person close to committing suicide is often anxious and agitated. Through the years Shneidman has reiterated that a key to decreasing lethality levels is to address and reduce perturbation levels. Therefore, it is important to remember that “elevated perturbation fuels elevated lethality” (Leenaars, 1994, p. 5; see also Shneidman, 1985). Hence, Leenaars (1994) explained a simple rule of thumb with this concept in mind “reduce the level of perturbation, and the level of lethality will come down with it” (p. 52). This is often accomplished with Leenaar's plan to “reduce the anguish, tension and pain” (p. 51).

Appropriate referrals are essential (Sullender & Maloney, 1990), consultation with colleagues (Shneidman, 1985), enlisting the support of family, friends, teachers, clergy and possible hospitalization (Kral & Sakinofsky, 1994; Leenaars, 1994). Once the immediate emergency is alleviated ongoing treatment is important (Leenaars, 1994). Many interventionists develop a behavioural plan with the individual. This may include going to the emergency room for hospital admittance or agreeing to call the interventionist later that day and the next few days until the next appointment, usually less than a week. Some therapists ask the people to write out an agreement or verbally contract to not harm him/herself until the next appointment. Many times this contract includes an agreed upon action plan to call specific people, crisis lines, the interventionist and/or go to hospital emergency before taking action.

Though an initial suicide crisis has been averted it is essential to continue to reassess suicide lethality. This is because suicidal ideation is neither static nor linear. Many different lethality indicators are static factors that will not change, such as being divorced, male and between the ages of 15 and 34. However, dynamic factors are ones that an individual can change such as learning coping skills to better adjust to his circumstance. Static factors are often more stable in prediction of overall risk but dynamic factors are more helpful in isolating when the risk increases or decreases. The emotional and psychological dynamic factors tend to ebb and flow in the process of recovery hence continuous suicide assessment is crucial.

The above outlines the major points of a suicide intervention plan. Now to summarize the interviewing skills necessary to implement a treatment plan with a suicidal individual include but are not limited to the following: (a) believe the individual's intent to be serious; (b) seek to understand the person's subjective interpretation of his/her pain; (c) accept the person's assessment of the severity of his/her crisis; (d) respond openly, unafraid to discuss intense emotions; (e) actively listen; (f) help identify emotions by reflective and empathic feedback; (g) explore suicidal thoughts; (h) assess level of suicide lethality and perturbation; (i) inquire about precipitating events; (j) be directive to manage the emergency; (k) accept their solution as a result of their constricted thinking, but as an interventionist do not be limited by narrow thinking (Leenaars, 1994); (l) engage them in creating a specific plan of action (Leenaars, 1994, Neimeyer & Pfeiffer, 1994b); (m) offer hope; (n) focus on the client's individuality thus avoiding stereotypic responses (Neimeyer & Pfeiffer, 1994b); (o) an act of suicide be non-judgmental and respond with care; and through all of these skills engage in a human relationship with the person.

#### *Predictor Variables*

Now to address the different predictor variables this study considered in relation to the previously described intervention constructs. First, an overview of each of the chosen occupational groups is given.

*Crisis Line Volunteers.* The literature has a great deal of research regarding crisis line paraprofessionals, especially in connection with the crisis centers' effectiveness to prevent suicide (Frankish, 1994; Neimeyer & Pfeiffer, 1994a). These studies included determining historical trends of suicide in communities with crisis centers; number of successful suicides that had at one point contacted a crisis center; evaluating the skills of the paraprofessionals volunteering at the centers (Neimeyer & MacInnes, 1981); and assessing the effectiveness of crisis center training programs. Overall, Frankish (1994) reported that the research showed "a very mixed picture" (p. 35) of suicide centers' impact on suicide reduction. Neimeyer and Pfeiffer (1994a) had come to similar conclusions when analyzing research regarding suicide and crisis centers. They found

that the evidence had been primarily correlational and could have been interpreted as due to societal changes.

However, this study's interest is on how well the crisis line volunteers respond in a suicide intervention, through both recognizing lethality and knowledge of intervention counseling skills. Different studies have explored these constructs and found that compared to other health care professionals (e.g., psychiatrists, psychologists and physicians) the crisis line workers have ranked third on recognizing lethality as measured by the RSL scale and better than groups that were not health care professionals (Domino & Swain, 1986; Swain & Domino, 1985).

Crisis line paraprofessionals have been assessed on the variable of suicide intervention counseling skills by different methods. Neimeyer and Pfeiffer (1994a) reviewed the research methods used over the last 30 years. They reported that role-plays; observer rated simulated crisis calls; audio tapes of crisis simulations with a list of possible responses; and the SIRI, a pen and paper instrument, have all been implemented. Neimeyer and Pfeiffer (1994a) concluded that the studies from the early 1970's had suggested that more training was necessary to "increase the counsellors' facilitative responsiveness" (p.138) and that experience had been shown to develop this particular skill.

Crisis line volunteers with previous experience, even after training, have performed better than other crisis line workers and practicum teachers on the SIRI (Cotton & Range, 1992). Also crisis workers have appeared to significantly improve their counseling skills after training (Neimeyer & MacInnes, 1981).

*Clergy.* The literature regarding clergy and counseling and pastoral counseling appeared to present two slightly different streams of religious caring for the community. Since the 1980's there has been an increase of pastoral counselling training. The training is a master's level education that incorporates a strong emphasis on psychotherapy theory and supervision with theological integration (Danylchuk, 1992; Giblin & Stark-Dykema, 1992). Frequently laypersons rather than ordained ministers attend these master-level programs. Then they are hired in church

settings as pastoral counsellors (Giblin & Stark-Dykema, 1992). However, this study was focused on the traditional pastoral caregiver, an ordained minister who counsels people in his/her role as church clergy. The traditional definition of pastoral counseling is that ministers provide short-term counseling in areas also seen by mental health professionals, such as marital, death, etc. (Danylchuk, 1992). The following reports on ministers that may or may not have been trained as professional pastoral counsellors, but are pastoring a religious congregation.

Clergy groups have reported handling various counselling issues. The conclusion has been that this occupational group is a community mental health resource (Weaver & Koenig, 1996; Wylie, 1984). Wylie's (1984) study showed that the most frequent counselling areas included marital, substance use, patient counseling, aging and death education. Weaver and Koenig (1996) review of the literature reported that clergy were counseling crisis situations and that "depression is either the most frequent or very nearly the most frequent presenting problem among people seeking their help" (p.498). The Gallup Organization (1992) survey (as cited in Weaver & Koenig, 1996) reported that the elderly approached clergy rather than mental health or medical professionals when a friend was considering suicide.

Regardless of age, people seek out help from clergy. And pastors were said to be "most often called upon for counsel during times of crisis when depression and suicidal thoughts may have their origins" (Weaver & Koenig, 1996, p. 496). Domino's (1990) review of studies in the 1980's showed that clergy were consulted for problems before mental health professionals. However, a study showed that a group of clergy's knowledge of abnormal psychology ranked below undergraduate psychology students (Domino, 1990).

Weaver and Koenig (1996) also reviewed some 1980's studies, which had reported that many clergy had believed they were inadequately prepared to provide health counseling and admitted a need for further training, specific to depression and suicide prevention skills (see also Wylie, 1984). The clergy had been reported to spend up to 9.5 hours per week counselling and logging similar hours as members of the American Psychological Association (Weaver &

Koenig, 1996). Therefore, considering time spent counseling and the breadth of mental health issues that clergy encountered it appeared important to identify the level of clergy's knowledge of suicide intervention.

The literature showed that clergy's ability to recognize lethality was not as robust as mental health and medical professionals (Domino & Swain, 1986; Holmes & Howard, 1980; Swain & Domino, 1985). Other studies compared occupational group scores on the RSL to Holmes and Howard (1980) findings and consistently ranked clergy below mental health and medical professionals (Bascue, Inman & Kahn, 1982; Domino, 1985; Holmes & Wurtz, 1981). Leane and Schute (1998) compared the ability to recognize suicide lethality between high school teachers and clergy using the RSL and found no significant difference between groups. Both the teachers and the clergy groups scored a mean of only 5 which is less than half of the questions answered correctly (Leane & Schute, 1998). However, the RSL did not have an established criterion to determine acceptable knowledge of lethality indicators (Holmes & Howard, 1980).

As far as this author was aware there had been no empirical studies published that assess clergy's knowledge of counseling skills with someone feeling suicidal, especially as measured by the SIRI or SIRI-2.

*Non-Counseling Graduate Students.* Also, non-counseling graduate students have not been surveyed in suicide intervention counseling skills or knowledge of suicide lethality research.

The past research had shown that the crisis line professionals have generally scored well on both the SIRI-2 and the RSL compared to other health professionals and better than occupations unrelated to health care. Empirical data concerning clergy had been limited to recognizing suicide lethality, and showed the groups' mean RSL scores at best to have been just over 50% correct on the RSL test. The non-counseling graduate students had not been included in an empirical study for these constructs.

*Experience and Training.* The literature showed that specific experience and training in suicide intervention appeared most prevalent in crisis line workers than in either the clergy or the

non-counselling graduate student. The literature suggested that the combination of experience and training in suicide intervention had been shown to have a positive relationship with overall performance on the SIRI and/or the RSL instruments. Past studies had revealed that crisis line volunteers' overall performance on recognizing suicide lethality and knowledge of suicide intervention skills had ranked similar with mental health professionals and better than non-mental health occupational groups.

In past studies experience, regardless of occupation, had shown a positive impact on recognizing suicide lethality (Holmes & Howard, 1980; Holmes & Wurtz, 1981). Years of experience appeared to have had more impact on the stated criterion variables than actual number of hours spent counseling per week (Holmes & Wurtz, 1981). These results on experience and the RSL had not been replicated (Holmes & Gilbert, 1983 as cited in Range & Knot, 1997). Therefore, subjects with more experience may have had an edge on recognizing suicidal intentions. More experience had been seen to also have an effect on better SIRI scores (Cotton & Range, 1992; Neimeyer & Diamond, 1983; Neimeyer & MacInnes, 1981).

Past research had not always included a suicide training variable on recognizing suicide lethality. Leane and Schute (1998) had surprisingly found that suicide intervention training was not significant in recognizing suicide lethality. However, some research had shown that training often times shows improvement on scores of the SIRI and SIRI-2 when measuring awareness of suicide intervention counseling skills (Cotton & Range, 1992; Neimeyer & Bonnelle, 1997; Neimeyer & MacInnes, 1981). Accordingly, the crisis line volunteers appeared to have received the most suicide intervention training than the general population.

*Death Attitude.* As far as this author could determine, research had not been published on the specific relationship between death attitude and recognizing suicide lethality. However, the literature provided studies measuring crisis death anxiety levels. The focus appeared to have been whether personal fears of death and dying were more prevalent among crisis line volunteers and if there was any impact on the awareness of suicide intervention counseling skills. The studies

were inconclusive. Lester (1971) reported no statistical difference on death anxiety between crisis center workers and non-crisis center workers. Neimeyer and Dingemans (1980) had found higher scores on death anxiety among crisis center workers. Later, Neimeyer and Neimeyer (1984) showed no relationship between death attitude and awareness of suicide intervention counseling skills. Hence, the specific death attitude as measured by the DAP-R, which encompasses both anxiety and acceptance of death, had not been studied on awareness of either suicide intervention skill constructs.

*Demographics.* The demographic variables of gender, age and ethnicity have had no correlational significance in past studies on recognizing suicide lethality (Bascue et al., 1982; Domino & Swain, 1985; Holmes & Howard, 1980; Holmes & Wurtz, 1981; Leane & Shute, 1998). Demographic variables have not had a relationship to awareness of suicide intervention counseling skill constructs (Cotton & Range, 1992; Inman et al, 1984; Neimeyer & Bonnelle, 1997; Neimeyer & Hartley, 1986; Neimeyer & MacInnes, 1981). The one exception was Neimeyer and Diamond's (1983) study that found female medical students scored significantly higher on the SIRI scale.

Religiosity had been studied more in relation to attitude toward suicide (Domino, 1985; Domino & Miller, 1992; Leane & Shute, 1998; Swain & Domino, 1985) than in relation to this study's two criterion variables. Finally, no relationship had been found between knowing a suicide victim and recognizing suicide lethality (Leane & Shute, 1998). Similarly, the research had not reported the impact of religiosity on awareness of suicide intervention skills. Hence, overall demographics have appeared to have no conclusive relationship on either suicide intervention skill construct.

### *Hypotheses*

*First Hypothesis.* The first hypothesis explored was based on the past research conclusion that the crisis line volunteers generally ranked comparable to other health professionals and better than occupations unrelated to health care on the two suicide intervention constructs. Thus, it was

tentatively stated that the crisis line volunteers would perform significantly better than the clergy and non-counselling graduate student occupational groups on each of the criterion variables, recognition of suicide lethality as measured by the RSL and knowledge of suicide intervention counseling skills as measured by SIRI-2.

This hypothesis was also theoretically based on an expectation that as a group the crisis line volunteers would possess more specific training and experience with suicide intervention skills than either the clergy or the graduate students. The literature suggested that experience and training in suicide intervention was shown to have a relationship with better overall performance on the RSL and both SIRI versions.

Though reasoning for a planned comparison between these occupational groups was not based solely on the literature this study was extending the SIRI-2 instrument to a new occupational group of clergy not previously studied. Therefore, based on the theoretical stance of research itself it would be conceptually feasible to have proposed a tentative expectation of significant findings when looking at the whole of previous empirical data.

*Second Hypothesis.* The second hypothesis looked at the relationships of experience and training with the knowledge of suicide intervention counselling skills. Although the subjects were chosen as different occupational groups for comparison in the first hypothesis there was an expected homogeneity of the subject pool as a whole in regards to a fairly standard distribution of amount of experience and training.

In order to make the measure of experience and training more robust several questions were used to tap into each construct. This hypothesis was in two parts so as to explore the full impact of each of these predictor variables on the SIRI-2 performance. The first part was that more experience would have a significant relationship across all participants on the criterion variable of knowledge of suicide intervention counselling skills as measured by performance on the SIRI-2. Experience was measured by occupational experience, professional and non-professional counselling experience, amount of time working as crisis line volunteer or minister,

average time spent counselling per week, frequency of counselling suicidal persons, and the latest interaction with someone feeling suicidal.

Past research showed that subjects with more experience appeared to recognize suicidal intentions, regardless of occupation, better than those with less experience. Therefore, to extend the research with the SIRI-2 this hypothesis was based on the theory of research itself to explore the relationship of experience with the suicide counseling skill construct.

Secondly, we predicted that as training increased, as measured by attendance at a suicide intervention course and/or a crisis intervention course, hours of training, and education level that performance on knowledge of suicide counseling skills, as measured by the SIRI-2 would improve. This question was an extension of the research on the relationship of training to the knowledge of suicide intervention counseling skills.

*Third Hypothesis.* The third hypothesis dealt with recognizing suicide lethality. It stated that more experience, as measured by the same factors mentioned above would have a significant relationship across all participants on the criterion variable of recognizing suicide lethality as measured by better performance on the RSL. This hypothesis was proposed as an extension of the research on the RSL, since the experience predictor variable had previously mixed conclusions.

*Fourth Research Question.* The past death attitude research in suicide intervention focused only on anxiety toward death, hence, we planned to explore relationships between death attitude as measured by the five sub-scales of the DAP-R, which included more accepting attitudes toward death and the two suicide intervention skill constructs. The fourth research question stated that relationships between death attitude as measured specifically by the five sub-scales of the DAP-R on both constructs of RSL and SIRI-2 would be explored.

## CHAPTER 3: METHOD

*Participants*

The participants for this study included already existing groups from the specific occupational groups. The sample of 98 participants consisted of 42 crisis line volunteers, 30 clergy, and 26 non-counseling graduate students. A minimum of 25 subjects per group and an ideal of 50 per group with a minimum overall total of 75 subjects were the intended sample size.

Crisis line volunteers from two 24-hour crisis line centres voluntarily participated in the study from Richmond and Surrey, B.C. The Richmond crisis line (CHEMO) and the Surrey crisis line program directors were both approached through telephone calls and personal contacts. Each reviewed the survey package and agreed to a non-compulsory participation by the volunteers. At CHEMO 50 survey packages were given to the volunteer coordinator. All survey packages included an introductory letter (see Appendixes D, E, F for letters specific to each group), consent form (see Appendix G), a demographic survey (see Appendixes H), the SIRI-2 (see Appendix A), the RSL (see Appendix B), the DAP-R (see Appendix C) and a stamped return envelope addressed to the researcher. The coordinator randomly gave packages to the English-speaking volunteers in their mail files with a CHEMO cover letter reiterating the survey's voluntary nature. The Surrey centre's director gave the researcher permission to attend one of their monthly meetings to request participation in this research. At that meeting approximately 80 survey packages were distributed. From the 130 packages distributed to crisis line volunteers 42 were received for a 32% return rate. Secondly, clergy from the Vancouver, B.C., Lower Mainland and surrounding areas were approached. Twenty area churches were contacted by telephone, personal visits and interchurch meetings and 58 packages were distributed to pastors. A 52% return rate of 30 clergy members represented various Protestant denominations. Thirdly, the non-counseling graduate student participants were obtained primarily from three of Trinity Western University graduate programs, religion and ethics, leadership and religious studies. The appropriate dean of each program gave permission to contact the students. All of the master's of leadership students

were first contacted by a general e-mail request to participate in the study. Those interested replied via e-mail and then 15 survey packages were mailed. The 28 religion and ethics and religious studies students each received survey packages in their university mail. The researcher attended a few religion and ethics classes and distributed 26 surveys. A few respondents were also obtained from five surveys distributed through a personal contact in the Western Washington University's master of education program. From the 74 packages distributed to non-counselling graduate students 26 were received for a 35% return rate. In total 262 surveys were distributed and a 37% return rate was obtained.

The sample was half male, although the crisis line volunteer group was 81% female.

Table 1 presents the participants' basic demographics.

As previously mentioned, three different pen and paper response instruments were used for this study. The research tests' strengths, limitations and appropriateness follows. Then a discussion of the demographic survey compiled by the researcher is given.

#### *Suicide Intervention Response Inventory - Revised (SIRI-2)*

The original SIRI was developed to fill a need in assessing the competency and effectiveness of crisis center training programs. As earlier described, crisis line volunteers have been assessed on the variable of suicide intervention counseling skills by different methods. Neimeyer & MacInnes (1981) describe the SIRI as "designed to measure a care-giver's competence in discriminating between facilitative and non-facilitative responses to the suicidal client" (p. 176). Therefore, the strength of this test is that the correct facilitative responses are based on the most effective theoretical and empirical crisis intervention techniques.

Another primary advantage of the SIRI scale was the convenient administration. The instrument was a self-administered 25-item questionnaire. Each item gave a possible comment a person presenting with suicidal risk may say. These comments were based on the theoretical profile of a person feeling suicidal and ranged from expressions of hopelessness to

Table 1

*Demographic variables*

Background variable	Volunteers n = (42)	Clergy n = (30)	Students n = (26)	All subjects N = (98)
Age	33	46	36	38
Gender <sup>a</sup>	17 %	90%	58%	50%
Years of education	15	17	18	17
Experience (months)				
Occupational	30	207		102
Professional counselling	5	196	55	63
Non-professional counselling	36	179	91	92
Suicide intervention training hours	28	4	8	22

*Note.* All returned surveys were used and missing data was handled with pair wise deletion. The numbers presented in the table are all means except for gender.

Gender<sup>a</sup> percentage of males.

possessing a firearm. Following the comment were two possible interventionist replies, one of which was more facilitative to the person in crisis. The original SIRI was a forced choice format, the participant would choose the better reply and then the number of correct answers was a respondent's total score. Hence, a higher score reflected more awareness of appropriate suicide intervention counseling skills.

However, studies revealed that a ceiling effect occurred because the instrument was unable to discern improvements after advanced training among highly trained professionals (Cotton & Range, 1992; Neimeyer & Bonnelle, 1997; Neimeyer & MacInnes, 1981; Neimeyer & Pfeiffer, 1994a). Suggestions were noted to change the instrument from a forced choice format to a rating style format (Cotton & Range, 1992; Neimeyer & Bonnelle, 1997; Neimeyer & MacInnes, 1981; Neimeyer & Pfeiffer, 1994a).

Therefore, Neimeyer and Bonnelle (1997) presented a revised SIRI format. The new SIRI-2 included the same 25 crisis statements and 50 replies but the respondent now rated each reply on a seven-point Likert scale where +3 indicated a highly appropriate response and -3 a highly inappropriate response. The SIRI-2 has shown a higher sensitivity in pre and posttests,  $F(1,31) = 30.65, p < .001$ , among participants with advanced suicide intervention training than the SIRI,  $F(1,31) = 2.55, p = .115$ , hence the ceiling effect was minimized (Neimeyer & Bonnelle, 1997).

Neimeyer and Bonnelle (1997) published criterion scores for the SIRI-2. These scores were based on the mean scores of a panel of seven expert thanatologists and suicidologists. Hence, with the nature of the negative scores in a Likert scale, and that the total scores "represent discrepancies from criterion scores of expert panelists" (Neimeyer & Bonnelle, 1997, p. 68) a lower score on the SIRI-2 suggested that the respondent better understands the counselling skills necessary to help someone feeling suicidal.

A caveat to the following reliability and validity standards for the SIRI-2 is that due to the recent publication of the revised instrument few published studies have replicated Neimeyer

and Bonnelle's (1997) findings. However, numerous studies have utilized the original forced choice SIRI instrument since 1981 (Cotton & Range, 1992; Inman, et al, 1984; Neimeyer & Bonnelle, 1997; Neimeyer & Diamond, 1983; Neimeyer & Hartley, 1986; Neimeyer & MacInnes, 1981; Neimeyer & Neimeyer, 1984; Neimeyer & Oppenheimer, 1983). The following details that the SIRI and the SIRI-2 have been shown to possess strong reliability, construct validity, discriminant validity, and convergent validity, hence internal stability.

*SIRI-2 Reliability.* The reliability of an instrument is statistically measured by how well it performs over time. Ideally, when no intervention, specific to the construct, has occurred an individual should obtain the same score each time he or she takes the test. Statistically, the reliability of an instrument is best estimated from a coefficient alpha produced in test-retest studies. The preliminary findings on the SIRI-2 showed stronger internal consistency with coefficient alphas of .90 at pretesting and .93 at posttesting than the original SIRI coefficient alphas of .78 at pretesting and .85 at posttesting (Neimeyer & Bonnelle, 1997). Neimeyer and Bonnelle (1997) reported test-retest reliability  $r = .79, p < .001$  for SIRI and  $r = .92, p < .001$  for SIRI-2. For this study there the internal consistency measured with a coefficient alpha of .81.

Both instruments have appeared to be unrelated to age and gender variables (Cotton & Range, 1992; Neimeyer & Bonnelle, 1997; Neimeyer & MacInnes, 1981).

*Correlation of the two SIRI Versions.* Though the scoring format has changed on the SIRI the items have stayed the same. However, item 14 was not utilized since the expert panelists were unable to “distinguish clearly between the theoretically more and less facilitative responses” (Neimeyer & Bonnelle, 1997, p. 81). The two versions’ overall scores should correlate since the content is unchanged. As expected strong correlations between the SIRI and the SIRI-2 have also been found with pretesting coefficients of  $r = -.88, p < .001$  and posttesting  $r = -.84, p < .001$  (Neimeyer & Bonnelle, 1997).

*SIRI Construct Validity.* When choosing a psychometric measure it is important to determine how well the instrument assesses the chosen construct. Therefore, it is necessary to

report how well the SIRI and SIRI-2 measure the intended construct, knowledge of suicide counseling skills. This ability of a scale is called the construct validity. The original SIRI was demonstrated to possess construct validity in known group comparisons between veteran crisis counsellors, less experienced crisis volunteers and undergraduate psychology students (Neimeyer & MacInnes, 1981). The more experienced and trained veteran counsellors scored significantly higher than the less experienced volunteers and the university students.

A few years later, Neimeyer and Diamond (1983) again demonstrated the ability of the SIRI to accurately assess this construct by finding significant differences between first and third year medical students' scores on the SIRI. Cotton and Range (1992) tested the SIRI's construct validity with student teachers and crisis intervention volunteer trainees. As expected, the scores before training were not significantly different between groups. Only those few crisis volunteers with previous experience showed significantly higher scores. However, the construct validity was not as strongly replicated as previous studies because of the small number of trained caregivers.

As earlier stated the SIRI was formulated as a means to assess suicide intervention paraprofessionals' competency. Therefore, a logical step would be to administer the SIRI after suicide prevention training to assess not only the trainee's progress but also assess the efficacy of the training program. Conducting an experimental manipulation in a repeated measures design is another means of establishing psychometric instrument's construct validity. Therefore, some of the previous studies used repeated measures that explored the instrument's sensitivity to detect skill improvement after training (Cotton & Range, 1992; Neimeyer & MacInnes, 1981).

Neimeyer and MacInnes (1981) showed results that the trained groups compared to the untrained control groups had significant improvements in scores. Cotton and Range (1992) replicated these findings.

*SIRI Convergent Validity.* Suicide intervention skills are not the same as non-crisis counseling skills in that they are more directive, action oriented and assertive (Leenaars, 1994). However, the counseling skills required with suicidal persons are thought to be a subset of

psychotherapeutic counseling skills. Hence, SIRI results should correlate with tests for overall counseling skills; such a correlation would demonstrate convergent validity. Therefore, Neimeyer and MacInnes (1981) studied the SIRI's convergent validity by administering both the SIRI and a global counseling skill instrument, the Counseling Skills Evaluation (CSE) by Wolf and Wolf (1974) (as cited in Neimeyer & MacInnes, 1981) to crisis intervention trainees. Neimeyer and MacInnes (1981) interpreted modest correlations as evidence that the two instruments measure a counseling skills construct, but "assess different facets of counseling ability" (p.178). A further study with crisis line volunteer applicants replicated significant correlational findings between the CSE and SIRI,  $r = .60$ ,  $p < .0001$  (Neimeyer & Oppenheimer, 1983).

*SIRI Discriminant Validity.* The SIRI has, through replicated findings and use in various studies, demonstrated the ability to discriminate between groups with varying suicide intervention experience and training (Cotton & Range, 1992; Inman et al, 1984; Neimeyer & Bonnelle, 1997; Neimeyer & Diamond, 1983; Neimeyer & Hartley, 1986; Neimeyer & MacInnes, 1981; Neimeyer & Neimeyer, 1984; Neimeyer & Oppenheimer, 1983). The SIRI-2 demonstrated discriminant ability between trained and untrained university students (Neimeyer & Bonnelle, 1997). Range and Knot (1997) note that the SIRI had discriminant validity by its ability to measure the specific construct of knowledge of suicide counselling skills unrelated to other suicide and death constructs. As was earlier reviewed the counseling knowledge appears unrelated to ethical opinions of suicide (Neimeyer & Diamond, 1983), death anxiety (Neimeyer & Neimeyer, 1984) and the knowledge of recognizing suicide lethality (Inman et al., 1984).

*SIRI Factor Analysis.* The SIRI instrument has not been shown to possess strong factorial structures regarding the recurring facilitative themes (Cotton & Range, 1992). Originally, Neimeyer and Hartley (1986) computed a factor analysis on the SIRI results of 457 crisis intervention center staff. Four factors emerged, which were identified by Neimeyer and Hartley (1986) with the following descriptors, "elaboration of the complaint, exploration of suicidality, involvement, and reflection of negative feelings" (p.442). A caveat to these possible skill sets was

that the study's participants were primarily novice paraprofessionals and the SIRI scores typically change after training and years of experience (Cotton & Range, 1992; Neimeyer & Diamond, 1983; Neimeyer and MacInnes, 1981). Also, some of the loadings within the different factors were low, therefore possibly not very stable.

Though the SIRI-2 has some limitations, such as unconfirmed factor strength the other weaknesses are inherent in the type of instrument, a self-administered pen and paper questionnaire. Also, awareness of counseling skills with persons feeling suicidal is difficult to measure with any type of study or instrument. Knowing a facilitative response does not necessarily mean that a person will be helpful in the crisis situation. Yet as Range and Knot (1997) report the "SIRI is unique in focusing on measuring how one handles a suicidal communication" (Suicide Intervention Response Inventory section, ¶ 6). However, the strengths of the SIRI-2 outweighed the instrument's limitations for the purposes of this study. As previously stated the SIRI-2 carried strong construct validity, discriminant validity, reliability, and convergent validity with the original SIRI version. Also, the theoretical basis of the test has not changed since the instrument was developed and has shown an ability to effectively measure the awareness of suicidal intervention counseling skills between various groups in numerous previous studies.

#### *Recognizing Suicide Lethality Scale (RSL)*

The RSL is a 13 question multiple-choice test with four possible answers each. The test was developed to gauge how well professionals who encounter suicidal persons were able to recognize the various indicators of high suicide risk. Holmes and Howard (1980) based the RSL questions on 10 factors reported by Litman and Farberow (1961) (as cited in Holmes & Howard, 1980) as relevant for indicating high suicide lethality when found in context with each other. Litman and Farberow (1970) reiterated these high-risk indicators for assessing clients that were based on empirical research for that time. The previous chapter reviewed the more recent supporting research for the RSL risk factors.

*RSL Validity.* Range and Knot (1997) reported that validity has been evidenced in the past research results that mental health professionals have scored significantly higher than non-mental health professionals, such as ministers and college students. Subjects with more years of experience scored better than those with less experience (Holmes & Howard, 1980; Holmes & Wurtz, 1981). Yet the Holmes and Gilbert (1983) study (as cited in Range & Knot, 1997) did not reproduce these results. Hence, validity for the scale bears a mixed conclusion. The construct validity of the RSL may be somewhat questionable since through the years the highest reported group mean was only 74% correct (Domino & Swain, 1985/86).

Some of the individual items could appear to have no relevance to suicide lethality when seen out of a crisis context. For instance, the RSL question number 13 states “A critical factor in determining the lethality of a potentially suicidal person” with the four choices: “1) has never seen a physician, 2) is a member of the middle socioeconomic class, 3) is a young Caucasian female, 4) has seen a physician within the last six months”. The correct response was number 4, that the person has seen a physician in the last six months. This may indicate high lethality potential when seen in context with other lethality factors. Also, this fact becomes more important when the nature of the doctor visit is established, for instance, a recent diagnosis of a fatal or severe prolonged illness. Therefore, to strengthen this aspect of the instrument the test was presented with the following directions:

When answering the following questions please make your responses to individual questions in the context that a person is presenting signs of high suicide lethality. Please circle the letter indicating the answer that is most correct for each question. (see Appendix B)

One of the instrument’s overall weaknesses was that the suicide risk factors are based on U.S. vital statistics and research; hence it may not be broadly used in countries with differing statistics. The following RSL question dealt with age, and gender.

1). Persons who are most likely to succeed in committing suicide are:

1. female and under 50 years of age.
2. female and over 50 years of age.
3. male and under 50 years of age
4. male and over 50 years of age

U.S. statistics make number 4 the correct answer. As stated earlier this did not reflect Canadian vital statistics, because both male age groups under and over 50 years of age were at similar risk. Therefore, since this study was conducted with primarily Canadian subjects the responses were changed to Canadian suicide death statistics. At the time the surveys were distributed the 1996 and 1997 Canadian statistics were unavailable; hence the correct answer with the age breakdown was based on the available literature. The revised question, with number 3 as the correct answer, appeared as follows:

1) Persons who are most likely to succeed in committing suicide are:

1. female and under 50 years
2. female and over 50 years of age
3. male and between the ages 15-25 or over 65 years of age
4. Black male and over 50 years of age (see Appendix B)

The benefit of this instrument was that a working knowledge of suicide risk factors was assessed and that clergy and crisis line volunteers have been studied in the past using the RSL. Therefore, this study would help to build the validity of the instrument if similar results concerning clergy and crisis line volunteers were reproduced. Also, the RSL appeared to be the only scale available to measure an interventionist's knowledge of suicide lethality.

*Death Attitude Profile – Revised (DAP-R)*

Now the last instrument in this study was the DAP-R. An aspect of this study was to explore whether an interventionist's death attitude affects his/her knowledge of suicide intervention skills. As stated earlier, previous studies regarding death attitude have not been correlated to this construct. However, the previous research did not include instruments

measuring positive beliefs about death. Hence, to extend the research to include other dimensions of death attitude the DAP-R was used.

Many of the death scales outlined in Lonetto and Templer's (1986) book *Death Anxiety* such as Collett-Lester Fear of Death Scale (1969); Templer's (1970) Death Anxiety Scale; Kreiger, Epting, and Leitner's (1974) Threat Index; and Hoelter's (1979) Multidimensional Fear of Death Scale measured only fear and/or anxiety about death and a low score was assumed to represent death acceptance or positive feelings about death. As Neimeyer (1997-8) pointed out the DAP-R assessed the "form and function of death acceptance" (p. 106) rather than an interpretation that someone with low death anxiety scores was comfortable with death. Therefore, the breadth of different attitudes toward death in the DAP-R was a strong advantage for using it.

This study required a death attitude instrument that measured an individual's personal attitudes towards their own death, not the death of others. Hence, the DAP-R was more appropriate than the often-used Collett-Lester Fear of Death Scale (1969) (as cited in Lonetto & Templer, 1986), which includes scales on fears regarding other's death and other's dying process.

The DAP-R was a self-administered pen and paper questionnaire with 32 statements. Each belief statement required the subject to respond with one of seven responses from strongly agree to strongly disagree.

*DAP-R Factor Analysis.* The DAP-R contained five death attitude dimensions being measured. Wong et al. (1994) succinctly described the original four dimensions of the DAP (Gesser, Wong & Reker, 1987-88) as

- (a) Fear of Death/Dying (negative thoughts and feelings about the state of death and process of dying),
- (b) Approach Acceptance (the view of death as a gateway to a happy afterlife),
- (c) Escape Acceptance (the view of death as escape from a painful existence, and
- (d) Neutral Acceptance (the view of death as a reality that is neither feared nor welcomed. (p. 127 - 128)

The newer DAP-R included seven items for an added Death Avoidance sub-scale, which Wong et al. described as “a person avoids thinking or talking about death in order to reduce death anxiety” (p.128). Wong et al. suggested that when an individual may have a great deal of fear regarding death he/she ameliorates the worry and anxiety about death by avoiding consciously thinking about his/her death. A factor analysis was performed on the responses from 300 subjects showing that the five dimensions were fairly independent and the majority of the statements per dimension showed internal consistency within the factors (Wong et al., 1994).

*DAP-R Reliability.* Both the alpha coefficients and the test-retest reliability performed were presented on the individual scales and not the overall instrument. The alpha coefficients ranged from a low of .65 for the Neutral Acceptance subscale and .97 for the Approach Acceptance subscale. The test-retest reliability ranged from a low of .61 on the Death Avoidance subscale to a high of .95 on Approach Acceptance (Wong et al., 1994). Viewed all together the DAP-R scales possessed good to very good reliability. The internal consistency for this study was an alpha of .73.

*DAP-R Convergent and Discriminant Validity.* Wong et al. (1994) tested the convergent and discriminant validity of the DAP-R by correlating responses from Templer's (1970) Death Anxiety Scale and two subscales of Hooper and Spilka's (1970) Death Perspective Scale, death as an afterlife of reward and indifference toward death subscales; and the semantic differential measure. As expected the specific dimensions of the DAP-R held significant appropriate correlations with each of the other measures, for instance DAP-R's Fear of Death dimension correlated positively with Templer's (1970) Death Anxiety Scale, and the DAP-R's Neutral Acceptance dimension held a positive relationship with the Hooper and Spilka's (1970) subscale of indifference toward death on the Death Perspective Scale. Therefore, Wong et al. concluded that DAP-R's five dimensions possessed very good convergent and discriminant validity.

A limitation to the DAP-R was that the instrument had not been as widely used in the literature as some of the older, more established scales. Since its' relative new emergence into the

field compared to scales from the early 1970's, further reliability and validity studies have not been published for the DAP-R. However, the DAP-R has been recognized to offer an added dimension of measuring death acceptance that other scales do not provide (Neimeyer, 1997-8) that will further death attitude research.

The DAP-R also reflected different death attitudes between different age groups especially between young (18-29 years of age) and the old (60-90 years of age) (Wong et al., 1994). Wong et al. also found significant gender differences where the men scored higher on the Death Avoidance dimension, and women scored higher on the Approach and Escape Acceptance dimensions. This may have been a possible limitation to using the DAP-R in this study. However, the significant age and gender differences might have yielded some rich data.

For this study's purposes, after considering both the DAP-R's strengths and the possible limitations it was the best death attitude instrument available.

#### *Demographic Survey*

Finally, a few comments on the demographic survey. A demographic survey was specifically developed for this research to include all the aspects of experience and training. To tailor the demographic survey for each occupational group specific questions regarding occupation were presented i.e. "How long have you worked as a minister in years and months?" Hence, the demographic questionnaire had three versions (see Appendix H).

The demographic survey opened with a reiteration that the results would not be used to assess a participant's competency. A restriction was stated that if the respondent has known someone or worked with someone who had committed suicide in the last three months they were asked to not complete the survey. Suicide is an emotionally sensitive issue and this restriction was made so as to avoid causing any undue emotional strain on a potential participant who may have counseled or known someone who had very recently died from suicide.

Age, gender, marital status and education were queried but economic status was not included considering the hypotheses explored.

Religiosity was measured from three demographic survey questions. The questions tried to assess a respondents' view of his/her spirituality by whether they associated themselves with a specific religion or belief system, how often they attended religious/spiritual services and how he/she compared themselves to others. These questions addressed personal perspective, commitment to specific faith and behaviour.

Specific questions were presented regarding experience and training broken down into the aspects previously stated for these predictor variables.

## CHAPTER 4: RESULTS

A quick overview of the participating 98 respondents' performance follows. The overall RSL average was 54% correct (see Table 2). The SIRI-2 overall average score was  $M = 48.56$ ,  $SD = 14.82$  (see Table 2). Remember a lower score reflects a better performance. No correlation was found between the SIRI-2 and the RSL  $r(79) = -.040$ ,  $p > .05$ .

The overall means for the DAP-R five sub-scales were as follows: Fear of Death  $M = 21.06$ ,  $SD = 8.33$ ; Death Avoidance  $M = 12.86$ ,  $SD = 6.63$ ; Neutral Acceptance  $M = 28.03$ ,  $SD = 4.03$ ; Approach Acceptance  $M = 52.97$ ,  $SD = 13.14$ ; and Escape Acceptance  $M = 19.41$ ,  $SD = 7.03$ . The five sub-scales' intercorrelations are found on Table 3. The following provides the statistical results for each hypothesis.

*First Hypothesis*

The first hypothesis was that the crisis line volunteers would score significantly higher than the clergy and non-counselling graduate student occupational groups on the RSL and SIRI-2. This hypothesis was not completely confirmed. The crisis line volunteer RSL group scores ( $M = 7.51$ ,  $SD = 2.01$ ) were higher than the clergy group scores ( $M = 6.78$ ,  $SD = 2.15$ ) and the graduate student group scores ( $M = 6.46$ ,  $SD = 2.14$ ). The RSL planned comparison between crisis volunteers and clergy was non-significant  $t(62) = .140$ ,  $p > .05$ , one-tailed. There was a significant difference between volunteers and graduate students  $t(61) = .200$ ,  $p < .05$ , one-tailed. Unexpectedly the clergy's mean on the SIRI-2 ( $M = 45.62$ ,  $SD = 14.40$ ) was slightly lower, reflecting a better performance, than the crisis line volunteers ( $M = 47.56$ ,  $SD = 14.03$ ) and the graduate students ( $M = 53.2$ ,  $SD = 15.96$ ) although not statistically significant. The SIRI-2 planned comparison for volunteers and clergy was non-significant  $t(61) = .53$ ,  $p > .05$ , one-tailed and comparison between volunteers and graduate students was also non-significant  $t(60) = 1.42$ ,  $p > .05$ , one-tailed.

Table 2

*RSL & SIRI-2 Means*

Instrument	Volunteers		Clergy		Students		All Participants	
	<i>n</i> = (42)		<i>n</i> = (30)		<i>n</i> = (26)		<i>N</i> = (98)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
RSL	7.51	2.01	6.78	2.15	6.46	2.14	6.99	2.12
SIRI-2	47.56	14.03	45.62	14.4	53.2	15.9	48.56	14.82

*Note.* Lower SIRI-2 score indicates better performance. Missing data handled by pair wise deletion.

Table 3

*DAP-R Sub-scale Intercorrelations*

Subscale	1	2	3	4	5
1. Fear of Death	—	.42**	-.07	-.43**	-.27*
2. Death Avoidance		—	.02	-.19	-.11
3. Neutral Acceptance			—	-.11	-.20
4. Approach Acceptance				—	.41**
5. Escape Acceptance					—

*Note.* *n*'s vary from 84 to 92.

\* $p < .05$ , two-tailed. \*\* $p < .01$ , two-tailed.

*Second Hypothesis*

The two-part second hypothesis dealt with all participants' performance on the SIRI-2 in relation to more experience and more training. This hypothesis regarding experience held true for the crisis volunteer subgroup but not the entire sample. Experience, measured by the number of months working as a crisis line volunteer, was shown to have a correlation with SIRI-2 performance with a somewhat moderate strength relationship,  $r(36) = -.31, p < .05$ , one-tailed (see Table 4). More training for the entire subject pool, measured by having attended a crisis intervention course, showed a correlation of weak effect size,  $r(85) = -.22, p < .05$ , one-tailed (see Table 4). This course attendance pattern was consistent within all groups.

*Third Hypothesis*

The third hypothesis explored whether more experience had a relationship with RSL performance for all participants. Some measures showed relationships in this third hypothesis but not experience as a whole. More experience for the entire sample, measured by latest interaction with a person feeling suicidal,  $r(85) = .21, p < .05$ , one-tailed and time spent counseling per week,  $r(87) = .28, p < .01$ , one-tailed correlated positively, yet with weak effect sizes with RSL scores. Also, the clergy subgroup had a somewhat moderate effect size for experience as measured by months working as a minister and RSL scores,  $r(24) = .34, p < .05$ , one-tailed.

Post hoc analysis was performed on the relationship between training and RSL. Contrary to previous research results where no significant relationship was found, this study revealed a weak strength relationship for the combined groups between attendance at a suicide course and scores on the RSL with a correlation of  $r(88) = .22, p < .05$ , two-tailed (see Table 4). See Tables 5 and 6 for the self-reported experience and training.

*Fourth Research Question*

No relationships were detected between death attitude and the two suicide intervention constructs (see Table 7).

Table 4

*Correlations of Experience and Training Variables with SIRI-2 & RSL*

	SIRI-2		RSL	
	<i>r</i>	<i>n<sup>a</sup></i>	<i>r</i>	<i>n<sup>a</sup></i>
<b>Experience</b>				
Latest suicide interaction	-.10	84	.21*	87
Counseling hrs./week	-.12	86	.28**	89
Volunteer experience	-.31*	38	-.19	37
Clergy experience	.08	25	.34*	26
<b>Training</b>				
Course attendance				
Suicide intervention	-.11	86	.22 <sup>†</sup>	90
Crisis training	-.22*	87	.14	90

*Note:* Low score on SIRI-2 equal better performance. Non-significant correlations on the remaining five experience and two training measures not reported here.

*n<sup>a</sup>* column includes whole sample and subsample sizes.

\* $p < .05$ , one-tailed. \*\* $p < .01$ , one-tailed. <sup>†</sup> $p < .05$ , two-tailed.

*Post Hoc Analyses*

The entire subject pool's demographics were explored with each of the criterion variables. An ANOVA revealed a significant relationship between gender and the RSL scores  $F(1, 88) 4.32, p < .05$ . The subgroup distribution of gender, where 80% of the volunteers were female and 90% of the clergy were male, may have made gender a confounding variable with occupation (see Tables 1 and 8).

*Summary*

Overall the hypotheses were not confirmed for the sample as a whole. The comparison groups were preexisting occupational groups, hence training and experience were uncontrolled variables. Some significant results were obtained in the subgroups for the relationships between experience and training and the intervention constructs. The sample size was 98 with the combined three groups. This subject pool was substantially less than needed to provide the conventional level of 80% power. Hence, power was low and a moderate effect size may not have become significant in this data set. There were a sufficient number of significant findings to rule out that the correlations may have been an effect of sampling error.

Table 5

*Counselling Experience*

Experience	Volunteers	Clergy	Students
<b>Counselling hrs/week</b>			
None	2%	3%	46%
1-3	17%	63%	39%
3-5	62%	17%	8%
5-10	17%	10%	-
Over 10	2%	7%	4%
<b>Suicide counselling frequency</b>			
1 x every 2 years	2%	27%	31%
1 x/year	2%	20%	8%
1 x /6 months	10%	17%	8%
1 x /2-3 months	17%	20%	12%
1 x/month	10%	7%	-
2-3 x/month	36%	-	8%
1 x/week	12%	-	-
2-3 x/week	2%	-	-
> 3x/week	2%	-	4%
<b>Last suicidal interaction</b>			
> one year ago	7%	23%	5%
Within last year	5%	27%	8%
6 months ago	7%	3%	8%
3 months ago	17%	10%	19%
Last month	31%	20%	8%
Last week	31%	13%	

Table 6

*Suicide and Crisis Intervention Training*

Course attendance	Volunteers	Clergy	Students	All Subjects
Suicide intervention	71%	13%	19%	40%
Crisis training	86%	20%	31%	51%

Table 7

*DAP-R Correlations with RSL & SIRI-2*

DAP-R Subscale	RSL		SIRI-2	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
Fear of Death	-.11	.334	-.12	.300
Death Avoidance	-.12	.260	-.05	.628
Neutral Acceptance	-.00	.979	.11	.335
Approach to Death	.05	.648	.02	.887
Escape Acceptance	.05	.679	.01	.957

Table 8

*RSL & SIRI-2 Means by Gender*

Gender	RSL		SIRI-2	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Female	7.44	2.27	46.38	13.56
Male	6.53	1.87	50.84	15.98

## CHAPTER 5: DISCUSSION

This study examines whether the clergy, a prominent community resource, are as knowledgeable about suicide intervention skills as are crisis line volunteers, a specialised intervention resource. Some things to consider in this discussion of primarily non-significant results are instrument validity, statistical power, and occupational groups' background. The RSL instrument may not be a strong indicator of the lethality recognition construct, yet at the time of this research it was the only one of its kind. The low power due to a small sample size means we may be missing moderate effect sizes. The participants are not from a specific training institution and or have the same level of experience level the sample represents varied aspects of the predictor variables. Considering these potential confounds and low effect sizes the following discussion should be considered to be tentative suggestions that need to be confirmed by replications of this study.

The first hypothesis showed non-significant differences between the crisis line volunteer group and the clergy group on both the SIRI-2 and the RSL. This may indicate that each of these groups has similar working knowledge of both skill sets, responding to someone feeling suicidal and recognising suicide lethality. The similar scores may also reflect that only the participants that felt confident in their knowledge returned the surveys. Also, participants may have referred to outside sources while answering the surveys since the study was conducted outside of a controlled setting. Both of these possibilities may have led to sampling errors for these particular groups. The following discussion of suicide intervention overlaps both constructs but for clarity the SIRI-2 results will be discussed first and then the RSL results.

This study is an extension of research on suicide counselling skills since clergy have not appeared in a published study concerning this construct, especially as measured by the SIRI-2. Past research on clergy groups have reported low performance rankings on suicide intervention constructs when compared with other occupational groups (Domino & Swain, 1986; Holmes & Howard, 1980; Leane & Shute, 1998; Swain & Domino, 1985), knowledge of psychology

(Domino, 1990), and self-reports of insufficient counselling training (Weaver & Koenig, 1996; Wylie, 1984). Considering these past showings it is interesting that this clergy group ranks first among these three groups on SIRI-2 performance, although not significantly. These clergy and crisis line volunteer SIRI-2 scores, ( $M = 45.62$ ,  $SD = 14.4$  and  $M = 47.56$ ,  $SD = 14.03$ ) respectively, are similar to the scores of master's level counselling students ( $M = 47.84$ ,  $SD = 12.96$ ) (Neimeyer and Bonnelle, 1997).

If these results were to be replicated with larger samples and since the SIRI-2 has shown strong construct validity the following could be concluded. Most congregational pastors cultivate strong people skills through the years as they care for their congregation and community. The majority of this clergy group report spending an average of one to three hours counselling per week. Their people skills may include emotionally sensitive, non-judgemental approaches that are also fundamental techniques for addressing someone feeling suicidal. Working experience with distressed individuals may also translate into a working knowledge of facilitative responses to someone in a dynamic suicidal state.

There was no confirmation for the second hypothesis since there were no global correlations for either experience or training and the SIRI-2. Experience and training do not appear to enhance knowledge of suicide counselling skills for relatively knowledgeable care-giving groups.

Now on to discuss the RSL. This volunteer group's RSL score was significantly better than the graduate student comparison group which helps support the overall interpretation that this group does know more about suicide risk, as they should. The broader question is how knowledgeable are these two groups overall in comparison to the same occupational groups previously studied.

The crisis line volunteers' actual RSL mean scores ( $M = 7.51$ ,  $SD = 2.01$ ) are not as high as previously reported scores among the crisis interventionist occupational group. The crisis interventionist group ranked third in two studies with an  $M = 9.05$ ,  $SD = 1.26$  (Domino & Swain,

1985-86) and  $M = 8.75$ ,  $SD = 1.68$  (Swain & Domino, 1985) among medical, mental health professionals and clergy.

This study's clergy group  $M = 6.78$ ,  $SD = 2.15$  is not as low as previously researched clergy groups. As earlier stated the clergy have been compared with medical and mental health professionals. A clergy group previously ranked fifth ( $M = 5.33$ ,  $SD = 1.83$ ) where the physicians had the highest  $M = 9.37$ ,  $SD = 1.40$  and the college students the lowest  $M = 5.23$ ,  $SD = .81$  (Holmes & Howard, 1980). In two other studies clergy ranked last with  $M = 5.77$ ,  $SD = 1.49$  (Domino & Swain, 1985-86), and  $M = 6.42$ ,  $SD = 1.56$  (Swain & Domino, 1985). Leane and Shute (1998) reported that the teacher and clergy group they studied had "a mean score of around 5" (p.170). Clergy of different faiths and denominations were studied by Domino (1985) and the scores ranged from  $M = 4.82$ ,  $SD = 1.39$  to  $M = 6.40$ ,  $SD = 1.88$  by non-traditional ministers and Catholic priests respectively.

This study fails to replicate past RSL studies since the crisis line volunteers have lower scores than past volunteer groups. Yet the clergy group score has neither substantially higher nor lower scores than past clergy groups. Thus, no significant difference between volunteers and clergy is seen. The volunteer group reports the most access to specific suicide training but their relatively low scores may be attributed to the changing content of lethality indicators through the years. The clergy report less specific suicide training, and thus may be less impacted by changing lethality indicators, hence the scores did not change. We may hypothesize that one possibility for the lower volunteer scores is that the RSL may be out of date, especially in light of the replicated low scores of the clergy. It is possible that these crisis line volunteers are relatively less knowledgeable on the RSL content than previous groups but there is no systematic reason to believe this.

High suicide risk lethality levels are also recognised by states of perturbation (Kral & Sakinofsky, 1994; Leenaars, 1994; Shneidman, 1985, 1990). Persons experienced in working with distressed individuals may readily recognise these dynamic, general distress indicators. The

non-significant findings may be due to the general distress factors being transparent and that one may not require specific suicide intervention training to identify the distress factors related to suicide lethality. This could possibly be interpreted that this clergy group has a similar working knowledge of suicide lethality factors, as do these crisis line volunteers when taking into account the dynamic risk indicators. Further research that examines suicide training content and its relationship to recognising suicide lethality would be beneficial.

More experience has had previously mixed conclusions on RSL performance (Range & Knot, 1997). This study did not replicate past studies where years of experience had a positive impact on RSL scores regardless of occupation (Holmes & Howard, 1980; Holmes & Wurtz, 1981). Years of experience had a somewhat moderate effect size with the RSL for the clergy subgroup only,  $r(24) = .34, p < .05$ , one-tailed. Unlike Holmes and Wurtz's (1981) study the number of hours spent counselling per week is related to recognising lethality with a somewhat moderate relationship,  $r(87) = .28, p < .01$ , one-tailed. This study assessed a new experience measure, the latest interaction with persons feeling suicidal, and found a barely moderate effect size,  $r(85) = .21, p < .05$ , one-tailed. This could account for the crisis line volunteers' significant difference with the graduate students since the percentages for each of these experience factors were highest among this volunteer group.

Unlike previous RSL findings more training, (Leane & Shute, 1998) as specifically measured by attendance at a suicide intervention course, had a somewhat medium strength positive relationship with RSL scores. In this case, the crisis line volunteer group's higher scores than the graduate students may be a result of specific training on risk factors since the volunteers report the highest attendance at a suicide intervention course. It is important in suicide risk assessment to understand empirically identified psychological constructs. Recognising suicidal indicators is usually a speciality area requiring attention to specific features and demographic information. Many risk factors are static in nature and specific knowledge of these factors is useful in determining suicide lethality risk levels. Hence, those who have received this specific

suicide information would be more likely to recognise these static risk indicators. The researcher was not privy to the suicide/crisis intervention training content that any of the groups received.

These results may be masked by small sample sizes. If, for instance, there were 200 per group and distinct significant performance rankings were seen we might be able to match the different experience and training measures in each group, hence more effectively teasing out the differential effects of occupation.

The finding that gender related to RSL scores may be indicative of the group configurations since 80% of the crisis line volunteers were female. Gender may be confounded with occupation and this result may be a reflection of occupational differences rather than gender differences.

A possible reason for non-significant group differences could be simply that suicide and suicide intervention has been more publicised to the general public since many of these studies were published twenty-five years ago. Hence, the general population may have a better understanding of suicide and suicide profiles. One reason for this speculation is that the non-counselling graduate students, who were chosen to represent an educated sample of the general public, did not score significantly different than the other groups on the SIRI-2. It is interesting to note that a small percentage of the graduate students had participated in non-professional counselling roles, counselled suicidal people and taken crisis courses, which may have skewed the graduate student group's overall performance. However this group may be reflective of the general population.

Although no relationships were found with the suicide intervention skills and death attitude it is informative to note that, as past research has shown, death anxiety is not related to knowledge of these constructs. And acceptance and approach attitudes toward death as seen by the dimensions of the DAP-R also appear to have no impact on these constructs.

### *Further Research and Implications*

Since this is the first time clergy have been assessed with the SIRI-2 it is important to do further research to determine if these results can be replicated. A study exploring different pastoral training programs specific to suicide intervention skills would be informative. More empirical research of clergy's readiness to deal with all counselling issues is important since they represent a care-giving resource for most communities.

The recognition of suicide lethality is a difficult construct to measure, especially with a pen and paper instrument. Although each suicidal situation needs to be uniquely assessed there is some merit to the static and dynamic factors that have been empirically found through the years. Across these groups just over half of the answers were correctly identified on the RSL, which is similar to past studies (Domino, 1985; Inman, et al, 1984; Leane & Shute, 1998). The highest mean score ever reported was by psychiatrists with only 74% correct (Domino & Swain, 1985-86). Therefore, developing an instrument that better assesses this suicide intervention skill and discriminate between groups would be helpful in suicide intervention research and training.

Regardless of the reasons for these results, it is encouraging to note that this clergy group possess a working knowledge for counselling someone feeling suicidal. If these results were to be replicated with larger samples, given the way they compare with previous research, we could make more conclusive statements. If the lack of significance between clergy and crisis line volunteers were replicated the conclusion would be that the skill level has shifted and that clergy are more capable in this area than previously indicated. The professional implications are that the clergy are an existing resource for interdisciplinary team approach to helping those feeling suicidal.

### *Conclusion*

This study provides preliminary evidence suggesting that contemporary clergy may possess sufficient counselling skills for suicide intervention but may not be able to recognise subtle signs of lethality. As with any assessments cautious interpretation is best. Knowing a

facilitative response or signs of suicidality does not necessarily mean that a person will be helpful in a crisis situation. The somewhat moderate effect sizes seen on some experience and training measures should be cautiously interpreted, due to small sample sizes and need to be replicated. This is especially a caution for the results of the RSL since the instrument's validity is questionable. If replicated, it appears that the clergy's people skills translate to knowing facilitative responses when someone is speaking specifically of suicide intent. Assessing this clergy group for knowledge of suicide counselling skills extends the scope of the SIRI-2 to include a new occupational group. Until further studies replicate these results that clergy perform comparable to crisis line volunteers and master's level counselling students these SIRI-2 scores should be cautiously interpreted. Considering clergy are regarded by much of the public as a care-giving profession continued empirical research including this group's effectiveness and competencies is needed. The clergy are an important element in a community team approach to address mental health and general well being. The mental health profession would do well to consider clergy as a viable resource for helping individuals feeling suicidal.

## REFERENCES

- Bascue, L. O., Inman, D. J., & Kahn, W. J. (1982). Recognition of suicidal lethality factors by psychiatric nursing assistants. *Psychological Reports, 51*, 197-198.
- Beck, A. T., Brown, G. K., & Steer, R. A. (1989). Prediction of eventual suicide in psychiatric inpatients by clinical ratings of hopelessness. *Journal of Consulting and Clinical Psychology, 57*, 309-310.
- Beck, A. T., Brown, G. K., Steer, R. A., Dahlsgaard, K. K., & Grisham, J. R. (1999). Suicide ideation at its worst point: a predictor of eventual suicide in psychiatric outpatients. *Suicide and Life-Threatening Behaviour, 29*, 1-9.
- Beck, A. T., Kovacs, M., & Weissman, A. (1996). Hopelessness and suicidal behaviour. In J. T. Maltzberger & M. J. Goldblatt (Eds.). *Essential papers on suicide*. (pp. 331-341). New York: University Press. (Reprinted from *Journal of the American Medical Association, 234*, 1146-1149, 1975).
- Botsis, A. J. (1997). Suicidal behaviour: risk and protective factors. In A. J. Botsis, C. R. Soldatos, & C. N. Stefanis (Eds.). *Suicide: biopsychosocial approaches*. (pp.129-146). Amsterdam: Elsevier Science B.V.
- Colombo, J. R. et al. (Eds.). (1997). *The 1998 Canadian global almanac*. Toronto, Ontario, Canada: MacMillan.
- Cotton, C. R., & Range, L. M. (1992). Reliability and validity of the suicide intervention response inventory. *Death Studies, 16*, 79-86.
- Danylchuk, L. S. (1992). The pastoral counsellor as mental health professional: a comparison of the training of AAPC fellow pastoral counsellors and licensed clinical social workers. [Electronic version]. *Journal of Pastoral Care, 46*(4), 382-392.
- Dew, M. A., Bromet, E. J., Brent, D., & Greenhouse, J. B. (1987). A quantitative literature review of the effectiveness of suicide prevention centers. *Journal of Consulting and Clinical Psychology, 55*, 239-244.

- Domino, G. (1985). Clergy's attitudes toward suicide and recognition of suicide lethality. *Death Studies, 9*, 187-199.
- Domino, G. (1990). Clergy's knowledge of psychopathology. *Journal of Psychology and Theology, 18*, 32-39.
- Domino, G., & Miller, K. (1992). Religiosity and attitudes toward suicide. *Omega, 25*, 271-282.
- Domino, G., & Swain, B. J. (1985-6). Recognition of suicide lethality and attitudes toward suicide in mental health professionals. *Omega, 16*, 301-308.
- Durkheim, E. (1951). *Suicide a study in sociology*. (J. A. Spaulding & G. Simpson, Trans.). Glencoe, IL: Free Press. (Original work published 1897)
- Famighetti, R. et al. (Ed.). (1998). *The world almanac and book of facts 1999*. Mahwah, NJ: Primedia Annual report for the year 1996 source: National Center for Health Statistics, U.S. Dept. of Health & Human Services.
- Farberow, N. L., Helig, S. M., & Parad, H. J. (1990). The suicide prevention center: Concepts and clinical functions. In H. Parad & L. Parad (Eds.). *Crisis intervention book 2. The practitioner's sourcebook for brief therapy*. (pp. 251-274). Milwaukee, WI: Family Service America.
- Frankish, C. J. (1994). Crisis centers and their role in treatment: Suicide prevention versus health promotion. In A. A. Leenaars, J. T. Maltzberger, & R. A. Neimeyer (Eds.). *Treatment of suicidal people*. (pp. 33-43). Washington, DC: Taylor & Francis.
- Gesser, G. Wong, P. T. P., & Reker, G. T. (1987). Death attitudes across the life-span: The development and validation of the Death Attitude Profile (DAP). *Omega, 18*, 109-124.
- Giblin, P., & Stark-Dykema, J. (1992). Master's-level pastoral counseling training [Electronic version]. *Journal of Pastoral Care, 46*, 361-372.

- Holmes, C. B., & Howard, M. E. (1980). Recognition of suicide lethality factors by physicians, mental health professionals, ministers, and college students. *Journal of Consulting and Clinical Psychology, 48*, 383-387.
- Holmes, C. B., & Wurtz, P. J. (1981). Counsellor's recognition of factors in lethality of suicide. *Psychological Reports, 49*, 183-186.
- Inman, D. J., Bascue, L. O., Kahn, W. J., & Shaw, P. A. (1984). The relationship between suicide knowledge and suicide interviewing skills. *Death Education, 8*, 179-184.
- Kral, M. J., & Sakinofsky, I. (1994). A clinical model for suicide risk assessment. In A. A. Leenaars, J. T. Maltzberger, & R. A. Neimeyer (Eds.). *Treatment of suicidal people*. (pp. 19-31). Washington, DC: Taylor & Francis.
- Leane, W., & Shute, R. (1998). Youth suicide: the knowledge and attitudes of Australian teachers and clergy. *Suicide and Life-Threatening Behaviour, 28*, 165-173.
- Leenaars, A. A. (1994). Crisis intervention with highly lethal suicidal people. In A. A. Leenaars, J. T. Maltzberger, & R. A. Neimeyer (Eds.). *Treatment of suicidal people*. (pp. 45-59). Washington, DC: Taylor & Francis.
- Leenaars, A. A., & Lester, D. (1995). The changing suicide pattern in Canadian adolescents and youth, compared to their American counterparts [Electronic version]. *Adolescence, 30*, 539-548.
- La Greca, A. J. (1988). Suicide: prevalence, theories, and prevention. In H. Wass, F. M. Berardo, & R. A. Neimeyer (Eds.). *Dying: Facing the facts*. (pp. 229-255). Washington, D.C.: Hemisphere.
- Lester, D. (1971). Attitudes toward death held by staff of a suicide prevention center. *Psychological Reports, 28*, 650.
- Lester, D. (1991). Suicide across the life-span a look at international trends. A. A. Leenaars (Ed.). *Life span perspectives of suicide, time-lines in the suicide process*. (pp. 71-80). New York: Plenum Press.

- Lester, D. (1997). Counseling the suicidal person in the modern age. In A. J. Botsis, C. R. Soldatos, & C. N. Stefanis (Eds.). *Suicide: Biopsychosocial approaches*. (pp.193-200). Amsterdam: Elsevier Science B. V.
- Litman, R. E., & Farberow, N. L. (1970). Emergency evaluation of suicidal potential. In E. S. Shneidman, N. L. Farberow, & R. E. Litman (Eds.). *The psychology of suicide*. (pp. 259-272). New York: Science House.
- Lonetto, R. & Templer, D. I. (1986). *Death Anxiety*. Washington, DC: Hemisphere.
- Maltsberger, J. T. (1996). Suicide danger: Clinical estimation and decision. In J. T. Maltsberger & M. J. Goldblatt (Eds.). *Essential papers on suicide*. (pp.574-583). New York: University Press. (Reprinted from *Suicide and Life-Threatening Behaviour*, 18, (1988), 47-54).
- Neimeyer, R. A. (1994). The threat index and related methods. In R. A. Neimeyer (Ed.). *Death anxiety handbook: Research, instrumentation, and application*. (pp. 61-97). Washington, DC: Taylor & Francis.
- Neimeyer, R. A. (1997-98). Special article: Death anxiety research: The state of the art. *Omega*, 36, 97-120.
- Neimeyer, R. A., & Bonnelle, K. (1997). The suicide intervention response inventory: A revision and validation. *Death Studies*, 21, 19-83.
- Neimeyer, R. A., & Diamond, R. J. (1983). Suicide management skills and the medical student. *Journal of Medical Education* 58, 562-567.
- Neimeyer, R. A., & Dingemans, R. M. A. (1980-81). Death orientation in the suicide intervention worker. *Omega*, 11, 15-23.
- Neimeyer, R. A., & Hartley, R. E. (1986). Factorial structure of the suicide intervention response inventory. *Suicide and Life-Threatening Behaviour*, 16, 434-447.

- Neimeyer, R. A., & MacInnes, W. D. (1981). Assessing paraprofessional competence with the suicide intervention response inventory. *Journal of Counseling Psychology, 28*, 176-179.
- Neimeyer, R. A., & Neimeyer, G. J. (1984). Death anxiety and counseling skill in the suicide interventionist. *Suicide and Life-Threatening Behaviour, 14*, 126-131.
- Neimeyer, R. A., & Oppenheimer, B. (1983). Concurrent and predictive validity of the suicide intervention response inventory. *Psychological Reports, 52*, 594.
- Neimeyer, R. A., & Pfeiffer, A. M. (1994a). Evaluation of suicide intervention effectiveness. *Death Studies, 18*, 131-166.
- Neimeyer, R. A., & Pfeiffer, A. M. (1994b). The ten most common errors of suicide interventionists. In A. A. Leenaars, J. T. Maltzberger, & R. A. Neimeyer (Eds.). *Treatment of suicidal people*. (pp. 207-224). Washington, DC: Taylor & Francis.
- Pallis, D. J. (1997). Clinical problems in assessing suicide risk. In A. J. Botsis, C. R. Soldatos, & C. N. Stefanis (Eds.). *Suicide: Biopsychosocial approaches*. (pp.167-175). Amsterdam: Elsevier Science B. V.
- Paluszny, M., Davenport, C., & Kim, W. J. (1991). Suicide attempts and ideation: Adolescents evaluated on a pediatric ward [Electronic version]. *Adolescence, 26*, 209-216.
- Range, L. M., & Knot, E. C. (1997). Twenty suicide assessment instruments: Evaluation and recommendations [Electronic version]. *Death Studies, 21*, 25-59.
- Richman, J. (1994). Psychotherapy with older suicidal adults. In A. A. Leenaars, J. T. Maltzberger, & R. A. Neimeyer (Eds.). *Treatment of suicidal people*. (pp. 101-113). Washington, DC: Taylor & Francis.

- Robins, E., Murphy, G. E., Wilkinson, R. H., Gassner, S., & Kayes, J. (1996). Some clinical considerations in the prevention of suicide based on a study of one hundred thirty-four successful suicides. In J. T. Maltzberger & M. J. Goldblatt (Eds.). *Essential papers on suicide*. (pp.142-159). New York: University Press. (Reprinted from *American Journal of Public Health*, 49, (1959), 888-899)
- Shneidman, E. S. (1985). *Definition of suicide*. New York: John Wiley & Sons.
- Shneidman, E.S. (1990). The commonalties of suicide across the life span. In A. A. Leenaars (Ed.). (1991). *Life span perspectives of suicide; time-lines in the suicide process*. (pp. 39-52). New York: Plenum Press.
- Shneidman, E. (1996). Psychotherapy with suicidal patients. In J. T. Maltzberger & M. J. Goldblatt (Eds.). *Essential papers on suicide*. (pp.417-426). New York: University Press. (Reprinted from *Specialized techniques in individual psychotherapy*, pp. 305-313, by T. B. Karasu & L. Bellak (Eds.). (1980), New York: Brunner/Mazel.)
- Shneidman, E. S. (1996). Suicide as psycheache. In J. T. Maltzberg & M. J. Goldblatt (Eds.). *Essential papers on suicide*. (pp. 633-638). New York: University Press. (Reprinted from *Journal of Nervous and Mental Diseases*, 18, (1993), 147-149)
- Shneidman, E. S., & Madelkorn, P. (1970). How to prevent suicide. In E. S. Shneidman, N. L. Farberow, & R.E. Litman (Eds.). *The psychology of suicide*. (pp.125-140).
- Slaby, A. E. (1998). Outpatient management of suicidal patients. In B. Bongar, A. L. Berman, R. W. Maris, M. M. Silverman, E. A. Harris, & W. L. Packman (Eds.). *Risk management with suicidal patients*. (pp. 34-64). New York: Guilford Press.
- Statistics Canada, Health Statistics Division. Suicides, and suicide rate, by sex, by age group. (n.d.). Retrieved March 4, 2003, from <http://www.statcan.ca/english/Pgdb/health01.htm>.

- Stillion, J. M., & McDowell, E. E. (1996). *Suicide across the life span, premature exits* (2nd ed.). Washington, D C: Taylor & Francis.
- Sullender, R. S., & Maloney, H. N. (1990). Should clergy counsel suicidal persons? *The Journal of Pastoral Care, XLIV*, 203-211.
- Swain, B. J., & Domino, G. (1985). Attitudes toward suicide among mental health professionals. *Death Studies, 9*, 455-468.
- Tomer, A. (1994). Death anxiety in adult life-theoretical perspectives. In R. A. Neimeyer *Death anxiety handbook: research, instrumentation, and application*. (pp.3-28). Washington, DC: Taylor & Francis.
- The Holy Bible, New International Version* (1973, 1978, 1984). Grand Rapids, Michigan: Zondervan Publishing House.
- Weaver, A. J., & Koenig, H. G. (1996). Elderly suicide, mental health professionals, and the clergy: A need for clinical collaboration, training, and research. *Death Studies, 20*, 495-508.
- Wong, P. T. P., Reker, G. T., & Gesser, G. (1994). Death attitude profile-revised: a multi-dimensional measure of attitudes toward death. In R. A. Neimeyer (Ed.). *Death anxiety handbook: research, instrumentation, and application*. (pp. 121-148). Washington, DC: Taylor & Francis.
- Wylie, W. E. (1984). Health counseling competencies needed by the minister. *Journal of Religion and Health, 23*, 237-249.

## APPENDIX A: SIRI-2

## Suicide Intervention Response Inventory (Form 2)

The following items represent a series of excerpts from counselling sessions. Each excerpt begins with an expression by the client concerning some aspect of the situation he or she faces, followed by two possible helper responses to the client's remark.

You are to rate *each* response in terms of how appropriate or inappropriate you feel the reply is to the client's comment. In the blank, you should record a rating from -3 to +3, corresponding to the chart below. Be sure to respond to each item and try not to leave any blanks.

+3: Highly appropriate response.	-1: Marginally inappropriate response
+2: Appropriate response	-2: Inappropriate response
+1: Marginally appropriate response	-3: Highly inappropriate response
0: Neither appropriate nor inappropriate	

- Client: I decided to call in tonight because I really feel like I might do something to myself...I've been thinking about suicide.

\_\_\_\_\_ Helper A: You say you're suicidal, but what is it that's really bothering you?

\_\_\_\_\_ Helper B: Can you tell me more about your suicidal feelings?
- Client: And now my health is going downhill too, on top of all the rest. Without my husband around to care for me anymore, it just seems like the end of the world.

\_\_\_\_\_ Helper A: Try not to worry so much about it. Everything will be all right.

\_\_\_\_\_ Helper B: You must feel pretty lonely and afraid of what might happen.
- Client: But my thoughts have been so terrible...I could never tell them to anybody.

\_\_\_\_\_ Helper A: You can tell me. I'm a professional, and have been trained to be objective about these things.

\_\_\_\_\_ Helper B: Some of your ideas seem so frightening to you that you imagine other people would be shocked to know you are thinking such things.
- Client: No one can understand the kind of pain I've been through. Sometimes I just feel like I have to hurt myself, so I cut my wrists.

\_\_\_\_\_ Helper A: It seems like you've been suffering so much that cutting our wrists is the only way you can make the pain go away.

\_\_\_\_\_ Helper B: But you're so young, you have so much to live for. How can you think of killing yourself?
- Client: What are you anyway? Are you a doctor? How do you know what I've been going through? You've probably always had it pretty soft.

\_\_\_\_\_ Helper A: So you are wondering if I can understand how you feel.

\_\_\_\_\_ Helper B: You're not even giving me a chance. I've had a pretty rough life too; you're not the only one who's seen some hard times.

6. Client: My life has been worthless ever since my wife, Emma, died four years ago. The kids are grown and married now, and I've been retired from my job at the railroad for some time. It just seems that I'd be better off dead.
- \_\_\_\_\_ Helper A: But try to think of what Emma would want for you. She'd want you to continue leading a productive life, wouldn't she?
- \_\_\_\_\_ Helper B: It sounds like everything just collapsed around you when Emma died...But what happened recently to make things even worse, to make you think that dying is the only way out?
7. Client: I really need help...it's just...[voice breaks; silence]
- \_\_\_\_\_ Helper A: It must be hard for you to talk about what's bothering you.
- \_\_\_\_\_ Helper B: Go on, I'm here to listen to you talk.
8. Client: When you sum up my problem like that, it makes it seem less confusing and not so scary.
- \_\_\_\_\_ Helper A: See, it really isn't so bad after all. It certainly isn't anything you would think of killing yourself over, is it?
- \_\_\_\_\_ Helper B: Sometimes talking about problems does make them a bit clearer. I think you realise how dangerous your suicidal feelings were, that's why you decided to contact me.
9. Client: You were supposed to help me, but you've only made things worse.
- \_\_\_\_\_ Helper A: I'm sorry. I was only trying to help.
- \_\_\_\_\_ Helper B: You sound pretty angry.
10. Client: How could you ever help me? Have you ever wanted to kill yourself?
- \_\_\_\_\_ Helper A: It sounds like you're concerned about whether I can understand and help you.
- \_\_\_\_\_ Helper B: Sure, I've thought about suicide sometimes. But I always found more realistic solution to my problems.
11. Client: I don't know.... This whole thing with my wife really gets to me. [Sobs] I try so hard to keep from crying.
- \_\_\_\_\_ Helper A: Do you think that the reason it's hard for you to cry is because you're a man.
- \_\_\_\_\_ Helper B: With all the hurt you're feeling it must be impossible to hold those tears in.
12. Client: How can I believe in God anymore? No god would ever let this happen to me; I've never done anything to deserve what's happened.
- \_\_\_\_\_ Helper A: Things have rotten so bad, that it's difficult to see any meaning in the things that have happened to you.
- \_\_\_\_\_ Helper B: Well, God works in mysterious ways. Maybe this is His way of testing your faith.

13. Client: I don't know why I'm calling you. My family is financially well off, and my husband spends plenty of time with me, even though he has a successful law career. Even my kids have been doing well. They get good marks at school and have lots of free time activities with their friends. But nothing seems to interest me. Life is just a bore...
- \_\_\_\_\_ Helper A: Considering all you have going for you, your problems can't be all that serious. Try to focus more on the positive aspects of your situation.
- \_\_\_\_\_ Helper B: So even though things seem to be going well at one level, life still seems pretty depressing, even if it's hard to say exactly why.
14. Client: I have to hang up now. My mother's coming home soon and I don't want her to know I've been talking to you.
- \_\_\_\_\_ Helper A: Okay, but if you keep feeling suicidal, remember you can always call back.
- \_\_\_\_\_ Helper B: All right, but first I want you to promise me you won't do anything to hurt yourself, until you call back and talk to me. Will you repeat that promise?
15. Client: Is it really true, that many people feel this way. I thought I was the only one who had such dreadful, sinful ideas.
- \_\_\_\_\_ Helper A: No, there are many people who suffer from mental illness. But with appropriate treatment by a qualified physician, some of these patients can be cured.
- \_\_\_\_\_ Helper B: It is true. You're not the only one who has suicidal thoughts. And you can be helped to get through this crisis, just as others have been.
16. Client: I'm so lonely, so tired. [crying] There just isn't anywhere left to turn.
- \_\_\_\_\_ Helper A: You seem so alone, so miserable. Have you been feeling suicidal?
- \_\_\_\_\_ Helper B: Come on now. Things can't be all that bad.
17. Client: [over telephone] it's hard to talk here with all these people.
- \_\_\_\_\_ Helper A: Would it help if I asked questions?
- \_\_\_\_\_ Helper B: Why don't you call back some other time when you can talk more easily.
18. Client: I have a gun pointed at my head right now, and if you don't help me. I'm going to pull the trigger.
- \_\_\_\_\_ Helper A: You seem to be somewhat upset.
- \_\_\_\_\_ Helper B: I want you to put down the gun so we can talk.

19. Client: Why should you care about me, anyway?
- \_\_\_\_\_ Helper A: I've been trained to care about people. That's my job.
- \_\_\_\_\_ Helper B: Because I think your death would be a terrible waste, and it concerns me that things are so bad that you are considering suicide. You need help to get through this critical period.
20. Client: I really hate my father! He's never shown any love for me, just complete disregard.
- \_\_\_\_\_ Helper A: You must really be angry with him for not being there when you need him.
- \_\_\_\_\_ Helper B: You shouldn't feel that way. After all, he is your father, and he deserves some respect.
21. Client: I don't think there's really anyone who cares whether I'm alive or dead.
- \_\_\_\_\_ Helper A: It sounds like you're feeling pretty isolated.
- \_\_\_\_\_ Helper B: Why do you think that no one cares about you anymore?
22. Client: I tried going to a therapist once before, but it didn't help.... Nothing I do now will change anything.
- \_\_\_\_\_ Helper A: You've got to look on the bright side! There must be something you can do to make things better, isn't there?
- \_\_\_\_\_ Helper B: Okay, so you're feeling hopeless, like even a therapist couldn't help you. But has anyone else been helpful before – maybe a friend, relative, teacher or clergyman?
23. Client: My psychiatrist tells me I have an anxiety neurosis. Do you think that's what's wrong with me?
- \_\_\_\_\_ Helper A: I'd like to know what this means to you, in this present situation. How do you feel about your problem?
- \_\_\_\_\_ Helper B: I'm not sure I agree with that diagnosis. Maybe you should seek out some psychological testing, just to be certain.
24. Client: I can't talk to anybody about my situation. Everyone is against me.
- \_\_\_\_\_ Helper A: That isn't true. There are probably lots of people who care about you if you'd only give them a chance.
- \_\_\_\_\_ Helper B: It must be difficult to find help when it's so hard to trust people.
25. Client: [Voice is slurred, unclear over telephone]
- \_\_\_\_\_ Helper A: You sound so tired. Why don't you get some sleep and call back in the morning?
- \_\_\_\_\_ Helper B: Your voice sounds so sleepy. Have you taken anything?

## APPENDIX B: RECOGNIZING SUICIDE LETHALITY

## Thirteen Questions on Successful Suicide

When answering the following questions please make your responses to individual questions in the context that a person is presenting signs of high suicide lethality. Please circle the letter indicating the answer that is most correct for each question.

1. Persons who are most likely to succeed in committing suicide are:
  1. female and under 50 years of age
  2. female and over 50 years of age
  3. male and between the age of 15-25 or over 65 years of age
  4. Black male and over 50 years of age
  
2. Successful suicidals are most often characterized by:
  1. depression, hopelessness and helplessness, but not anxiety symptoms such as sleep disturbance
  2. depression, hopelessness and helplessness, as well as anxiety symptoms such as sleep disturbance
  3. no visible signs of either depression or anxiety
  4. anxiety symptoms, but very seldom showing signs of depression
  
3. A great percentage of successful suicides involve persons who are:
  1. married
  2. single
  3. widowed, separated or divorced
  4. any of the above categories, since there is not significant difference in marital relationships.
  
4. In regard to current pressures affecting persons at the time they make a suicide attempt:
  1. Persons under the effects of an immediate stress are most likely to succeed.
  2. persons under an immediate stress are not likely at that time to succeed
  3. the factor of immediate stress is not critical in determining the lethality of a suicide attempt
  4. none of the above are correct
  
5. Regarding the onset of suicidal symptoms in a person's behaviour:
  1. a gradually developing group of symptoms indicates that the person is more likely to commit suicide
  2. a relatively quick onset of symptoms is the most dangerous sign of a successful suicide attempt
  3. very little evidence has been found to indicate any correlation between onset of symptoms and suicide lethality
  4. both gradual and quick onset of symptoms of suicide are equally dangerous for successful suicide
  
6. A potentially suicidal individual is more likely to succeed in the attempt if that person:
  1. has no idea how he or she will actually do it
  2. is afraid to think of how the actual attempt will be made
  3. has a definite plan of how it will be done.
  4. appears very confused about actually how it will be done

7. Likelihood of successful suicide is greater when:
  1. a person continues social contacts as if nothing is wrong
  2. a person is very gregarious with a variety of social contacts
  3. a person is socially isolated from friends and relatives
  4. a person keeps in contact with relatives but is isolated from friends and recent acquaintances.
  
8. With regard to alcoholics and gay/lesbian people the suicide rate is:
  1. higher than the national average
  2. lower than the national average
  3. the same as the national average
  4. higher for alcoholics and lower for homosexuals compared to the national average
  
9. A person has the highest potential for successful suicide if:
  1. there is no previous history of suicide attempts
  2. there is a history of previous suicide attempts
  3. there is no history of previous attempts but some suicidal thoughts have been present
  4. the person has never contemplated suicide
  
10. The most dangerously suicidal individual with regard to medical history is an individual who:
  1. has never had physical complaints or seen a doctor
  2. has a long history of chronic illness but doesn't believe in doctors
  3. has a long history of chronic illness and many visits to physicians during this period
  4. has had no physical complaints but sees a doctor occasionally for checkups with rigid regularity
  
11. If relatives exist, a dangerously suicidal person would likely:
  1. not be in communication with them
  2. see them often, trying to communicate with them
  3. keep in communication with them but only from a distance, like writing or calling them on the phone
  4. none of the above, since there is no significant difference
  
12. An individual would be more likely to be an imminent suicide victim if:
  1. there is a significant other person who was extremely important to that individual and who was trying in vain to help
  2. there is a significant other person who rejects the individual
  3. the month is February
  4. none of the above is statistically significant
  
13. A critical factor in determining the lethality of a potentially suicidal person is if that person:
  1. has never seen a physician
  2. is a member of the middle socioeconomic class
  3. is a young Caucasian female
  4. has seen a physician within the last six months

APPENDIX C: DAP-R  
Death Attitude Profile - Revised

This questionnaire contains a number of statements related to different attitudes toward death. Read each statement carefully, and then indicate the extent to which you agree or disagree by circling one of the following:

SA = strongly agree	MD = moderately disagree
A = agree	D = disagree
MA = moderately agree	SD = strongly disagree
U = undecided	

If you strongly agreed with a statement you would circle SA. If you strongly disagreed you would circle SD. If you are undecided, circle U. However, try to use the "undecided" category sparingly.

**Please note that the scale run both from strongly agree to strongly disagree and from strongly disagree to strongly agree.**

It is important that you work through the statements and answer each one. Many of the statements will seem alike, but all are necessary to show slight differences in attitudes.

1. Death is no doubt a grim experience.  
SD    D    MD    U    MA    A    SA
2. The prospect of my own death arouses anxiety in me.  
SA    A    MA    U    MD    D    SD
3. I avoid death thoughts at all costs  
SA    A    MA    U    MD    D    SD
4. I believe that I will be in heaven after I die.  
SD    D    MD    U    MA    A    SA
5. Death will bring an end to all my troubles.  
SD    D    MD    U    MA    A    SA
6. Death should be viewed as a natural, undeniable and unavoidable event.  
SA    A    MA    U    MD    D    SD
7. I am disturbed by the finality of death.  
SA    A    MA    U    MD    D    SD
8. Death is an entrance to a place of ultimate satisfaction.  
SD    D    MD    U    MA    A    SA
9. Death provides an escape from this terrible world.  
SA    A    MA    U    MD    D    SD
10. Whenever the thought of death enters my mind I try to push it away.  
SD    D    MD    U    MA    A    SA
11. Death is deliverance from pain and suffering.  
SD    D    MD    U    MA    A    SA

12. I always try not to think about death  
SA A MA U MD D SD
13. I believe that heaven will be a much better place than this world.  
SA A MA U MD D SD
14. Death is a natural aspect of life.  
SA A MA U MD D SD
15. Death is a union with God and eternal bliss.  
SD D MD U MA A SA
16. Death brings a promise of a new and glorious life.  
SA A MA U MD D SD
17. I would neither fear death nor welcome it.  
SA A MA U MD D SD
18. I have an intense fear of death.  
SD D MD U MA A SA
19. I avoid thinking about death altogether.  
SD D MD U MA A SA
20. The subject of life after death troubles me greatly.  
SA A MA U MD D SD
21. The fact that death will mean the end of everything as I know it frightens me.  
SA A MA U MD D SD
22. I look forward to a reunion with my loved ones after I die.  
SD D MD U MA A SA
23. I view death as a relief from earthly suffering.  
SA A MA U MD D SD
24. Death is simply a part of the process of life.  
SA A MA U MD D SD
25. I see death as a passage to an eternal and blessed place.  
SA A MA U MD D SD
26. I try to have nothing to do with the subject of death.  
SD D MD U MA A SA
27. Death offers a wonderful release of the soul.  
SD D MD U MA A SA
28. One thing that gives me comfort in facing death is my belief in the afterlife.  
SD D MD U MA A SA

29. I see death as a relief from the burden of this life.

SD D MD U MA A SA

30. Death is neither good nor bad.

SA A MA U MD D SD

31. I look forward to life after death.

SA A MA U MD D SD

32. The uncertainty of not knowing what happens after death worries me.

SD D MD U MA A SA

APPENDIX D: CRISIS LINE VOLUNTEER INTRODUCTION LETTER

February 1, 2001

Christine B. Royal  
TWU Research Project  
15911 Humberside Avenue  
Surrey, B.C. V4P 3A2

Dear Crisis Line Volunteer,

Thank you for considering participation in my research thesis, a study on suicide intervention. The goal of this research is to compare different groups' ability to recognize suicide lethality and knowledge of intervention skills. This study's results may be used to potentially create suicide intervention training programs. Your participation will help further the research and hopefully increase effectiveness in suicide intervention.

Enclosed please find a survey package with a self-addressed envelope. The first section is a demographic survey, then two separate questionnaires regarding suicide, and lastly a questionnaire about attitudes toward death. Please complete all the questions without consulting anyone and return it to me in the supplied envelope. The survey takes approximately 30 minutes to complete. All information and answers will be kept anonymous and confidential.

Thank you in advance for your time and attention to this study. If you wish to have further information regarding the results of this study, or if you want to discuss any questions arising from your participation in this research please contact me at (604) 531-2526 or e-mail to [bahnsen@agape.twu.ca](mailto:bahnsen@agape.twu.ca). You may also contact my thesis supervisor, Dr. Will Reimer at (604) 852-0061 or e-mail to [reimer.will@home.com](mailto:reimer.will@home.com).

Sincerely,

Christine B. Royal, M. A. Cand.

APPENDIX E: CLERGY INTRODUCTION LETTER

February 1, 2001

Christine B. Royal  
TWU Research Project  
15911 Humberside Avenue  
Surrey, B.C. V4P 3A2

Dear Pastor,

Thank you for considering participation in my research thesis, a study on suicide intervention. The goal of this research is to compare different groups' ability to recognize suicide lethality and knowledge of intervention skills. This study's results may be used to potentially create suicide intervention training programs. Your participation will help further the research and hopefully increase effectiveness in suicide intervention.

Enclosed please find a survey package with a self-addressed envelope. The first section is a demographic survey, then two separate questionnaires regarding suicide, and lastly a questionnaire about attitudes toward death. Please complete all the questions without consulting anyone and return it to me in the supplied envelope. The survey takes approximately 30 minutes to complete. All information and answers will be kept anonymous and confidential.

Thank you in advance for your time and attention to this study. If you wish to have further information regarding the results of this study, or if you want to discuss any questions arising from your participation in this research please contact me at (604) 531-2526 or e-mail to [bahnsen@agape.twu.ca](mailto:bahnsen@agape.twu.ca). You may also contact my thesis supervisor, Dr. Will Reimer at (604) 852-0061 or e-mail to [reimer.will@home.com](mailto:reimer.will@home.com).

Sincerely,

Christine B. Royal, M. A. Cand.

APPENDIX F: GRADUATE STUDENT INTRODUCTION LETTER

February 1, 2001

Christine B. Royal  
TWU Research Project  
15911 Humberside Avenue  
Surrey, B.C. V4P 3A2

Dear Graduate Student,

Thank you for considering participation in my research thesis, a study on suicide intervention. The goal of this research is to compare different groups' ability to recognize suicide lethality and knowledge of intervention skills. This study's results may be used to potentially create suicide intervention training programs. Your participation will help further the research and hopefully increase effectiveness in suicide intervention.

Enclosed please find a survey package with a self-addressed envelope. The first section is a demographic survey, then two separate questionnaires regarding suicide, and lastly a questionnaire about attitudes toward death. Please complete all the questions without consulting anyone and return it to me in the supplied envelope. The survey takes approximately 30 minutes to complete. All information and answers will be kept anonymous and confidential.

Thank you in advance for your time and attention to this study. If you wish to have further information regarding the results of this study, or if you want to discuss any questions arising from your participation in this research please contact me at (604) 531-2526 or e-mail to [bahnsen@agape.twu.ca](mailto:bahnsen@agape.twu.ca). You may also contact my thesis supervisor, Dr. Will Reimer at (604) 852-0061 or e-mail to [reimer.will@home.com](mailto:reimer.will@home.com).

Sincerely,

Christine B. Royal, M. A. Cand.

APPENDIX G: CONSENT FORM  
SUICIDE INTERVENTION PREPAREDNESS CONSENT FORM

The information obtained from these questionnaires will be used only for the purposes of research described in the cover letter.

All information will be anonymous and confidential. The results will not be used to assess any participants' individual competency, commitment or status as a paraprofessional, student or clergy. Rather the results will be analysed as group data.

Please note that your participation in this study is voluntary. If at any time you choose to withdraw by not completing the questionnaires you are welcome to do so.

Please sign the below statement to indicate consent to participate in this study:

I have read and understood the description of this study and I willingly consent to participate.

Participant's Signature \_\_\_\_\_

Please note: This consent form will be kept separate from the completed questionnaires.

APPENDIX H: DEMOGRAPHIC SURVEY

The following questionnaires are an anonymous confidential survey assessing suicide knowledge. The goal of this study is to develop effective suicide intervention training programs for different occupational groups. The results will in no way be used to assess your personal status, commitment or competency as a volunteer, student or staff.

*If you have known someone or worked with someone in the last 3 months who has committed suicide please do not complete this survey.*

**Please fill in the blanks and/or circle the appropriate responses for each question.**

Age: \_\_\_\_\_

Gender: Male Female

Marital Status: Single Divorced Married Widowed

What is your citizenship? \_\_\_\_\_

In what country were you born? \_\_\_\_\_

In what country were you raised? \_\_\_\_\_

In what country do you currently reside? \_\_\_\_\_

What is your ethnic/cultural background? \_\_\_\_\_

Religious denomination, order or faith: \_\_\_\_\_

My religious/spiritual beliefs are very important to me: (please circle one)

Strongly Agree Agree Disagree Strongly Disagree

I consider myself to be more religious/spiritual than most persons of my faith:

Strongly Agree Agree Disagree Strongly disagree

How often do you attend a religious service of your faith? (please circle one)

Once a year 2 or 3 times per year Once a month Weekly Other \_\_\_\_\_

What is the current highest educational degree you have earned? (please circle one)

Grade 12 College certificate Trade certificate  
University Master's PhD Other \_\_\_\_\_

In what field? \_\_\_\_\_

How many years of post high school education have you completed? \_\_\_\_\_

Have you ever interacted with someone feeling suicidal? Yes No

Have you ever taken a crisis intervention course? Yes No

If yes, how long ago \_\_\_\_\_

Have you had any formal training in suicide intervention/prevention? Yes No

If yes how long ago? \_\_\_\_\_

What type of institution provided the training? \_\_\_\_\_

How many hours of suicide intervention training have you completed? \_\_\_\_\_

NOTE: The following four questions do not appear on every survey package, only those questions specific to the indicated group: A)clergy; B)crisis line volunteers; C) graduate students

A)Please indicate the number of *years and months* have you been working full time as a minister? \_\_\_\_\_

B)Please indicate how many *years & months* you have been a crisis volunteer or worked in crisis intervention. \_\_\_\_\_

C)Please indicate the graduate degree you will earn at the end of your schooling. \_\_\_\_\_

C)What professional field do you plan to use your degree? \_\_\_\_\_

How many *years & months* of experience do you have in professionally counselling others?

\_\_\_\_\_

How many *years & months* experience do you have in counselling others non-professionally, i.e. Lay or peer counselling? \_\_\_\_\_

When was the last time you interacted with someone feeling suicidal: (please circle one)

Last week

Last month

Up to 3 months ago

Up to 6 months ago

Within the last year

If more than a year ago, please indicate how long ago \_\_\_\_\_

On average how many hours per week do you spend counselling people, either in person or over the phone?

None            1 to 3 hours    3 to 5 hours    5 to 10 hours    over 10 hours

On average how often do you interact with someone feeling suicidal?

Once a week

Two to three times a week

More than three times a week

Once a month

2 or 3 times per month

Once every 2 to 3 months

Once every 6 months

Once a year

Once every 2 years

Have you ever counselled someone who has subsequently completed a suicide? Yes No

If yes, how long ago was this event? \_\_\_\_\_

Were you counselling the person at the time of their death? Yes No

How many persons have you personally known who have committed suicide? \_\_\_\_\_

Please indicate the type(s) of relationship(s) you had with the individual(s)?

Close family member

Close friend

Distant relative

Acquaintance

Member of your school/church/work but not an acquaintance