Lethality Assessment Analogue: A Behavioral Measure for Evaluating the Suicide Intervention Competency of Crisis Hotline Volunteers

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LETHALITY ASSESSMENT ANALOGUE: A BEHAVIORAL MEASURE FOR EVALUATING THE SUICIDE INTERVENTION COMPETENCY OF CRISIS HOTLINE VOLUNTEERS

BY

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THESIS

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Abstract

The need for behavioral evaluations of volunteers performing hotline crisis work led to the development of the Lethality Assessment (LA) Analogue. This measure is designed to evaluate the competence of hotline volunteers in performing the specific crisis intervention skill of Lethality Assessment. This skill is the ability of the volunteers to assess suicide risk in a caller. The specific procedures used in the development of the LA Analogue and preliminary validation data on its use are reported. The development stages of the LA Analogue were the following: (a) operationally defining the skill to be assessed, (b) the formulation of a case summary and caller script based on the skill to be assessed, (c) the formulation of a performance rating scale, (d) the standardization of instructions given to the hotline volunteers being assessed and simulators performing the script, and (e) training and evaluation of simulators.

The construct validity of the LA Analogue was evaluated by assessing a group of hotline volunteers beginning a training program at a crisis intervention center. As expected, LA Analogue scores for hotline volunteers increased significantly following specific
training in Lethality Assessment with control group scores showing no significant change over the same interval of time, \( t(25) = 4.50, p < .0005 \), one-tailed. In addition, a comparison between the significance levels of the LA Analogue and two other instruments measuring a similar attribute, the Suicide Intervention Response Inventory (SIRI) and the Test for Evaluation of Training in Suicide Prevention (SP Test), showed the LA Analogue to be significantly superior to the other two instruments in measuring training effect, LA Analogue \( p < .0005 \), SIRI \( p < .005 \), and SP Test \( p < .05 \), one-tailed. High reliability was demonstrated for the rating system used, .95 to 1.00. The expected correlation between the LA Analogue, SIRI, and SP Test was not found. It is speculated that this lack of correlation may be due to the instruments assessing different levels (performance vs. cognitive) of the same construct (McGee, 1974) and the correlation coefficient's sensitivity to a small range of scores (Pfeiffer & Olson, 1981). For further validation and resolution of this lack of correlation, additional work employing a larger sample size is needed.
The formulation of the LA Analogue has several implications for the advancement of assessment in suicide prevention and hotline crisis intervention training. The availability of a consistent behavioral assessment procedure will enable centers to compare the performance of their volunteers. With other methods of assessment in which the presenting stimulus is not controlled, comparisons would be inappropriate for the reason that volunteers are being assessed in response to different caller variables. An additional advancement is the LA Analogue's focus in measuring a skill specific to crisis intervention. In the area of training, the LA Analogue also provides the volunteer with an experiential learning experience in which he or she is directly confronted with the anxieties, fears, and rewards associated with being a hotline crisis worker.

The LA Analogue and applications of its design will contribute to the advancement of assessment of hotline crisis intervention skills.
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To my extraordinary, incredible family who offered me their constant support and most importantly, believed in me when I did not ---- I LOVE YOU.

...and most specially I would like to thank a little girl who long ago had a dream, perservered, and made it come true.
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Introduction

In the movement for telephone hotline crisis intervention and suicide prevention services, the volunteer non-professional has consistently played a central role. The volunteer's significance in the development and continual evolution of suicide prevention services is summarized by McGee and Jennings (1973) who stated that had the volunteer non-professional been found unacceptable, the programs could not have survived and multiplied as they have. It has been the demonstration of the effectiveness of the non-professional volunteer that has brought about the continual growth of suicide prevention services in this country. With this growth and the increasing numbers of volunteers working in suicide prevention centers, the need has arisen for more valid and reliable measures of volunteer performance. This need is for the development of empirically based assessment tools that are direct, behavioral evaluations of volunteer performance. In the search for more valid and reliable measures, it was found that the behavioral analogue assessment tool provides the best method for the systematic evaluation of how well volunteers perform...
the behaviors expected of them (France, 1975; Williamson, Goldberg, & Packard, 1973).

In this study, an attempt has been made to apply this finding to the formulation of a standardized analogue assessment tool, where the presenting stimulus was controlled and maintained constant resulting in a consistent assessment situation. The Lethality Assessment (LA) Analogue measures a skill which is essential to the effectiveness of the telephone hotline volunteer. This skill is the ability of the volunteer to assess lethality or suicide risk in a caller. Learning how to accurately assess lethality has been considered a difficult skill to learn and evaluate due to its complexity in clinical judgment. Yet it is essential for paraprofessionals to be competent in this area before beginning to work on the hotline phones. It was the unavailability of a behavioral measure capable of evaluating the competence of hotline volunteers in lethality assessment, and therefore the opportunity to apply the principles of behavioral assessment, that prompted the development of this instrument. Not only will this instrument fulfill the need for a more valid and reliable measure, but its stages of development will provide the guidelines for the formulation of other measures.
The LA Analogue's development and preliminary validation will be reported. The LA Analogue's stages of development consist of: (a) operationally defining the skill to be assessed, (b) the formulation of a case summary and suicidal caller script based on the skill to be assessed, (c) the formulation of a performance rating scale, (d) the standardization of instructions given to the hotline volunteers being assessed and those instructions given to the simulators performing the suicidal caller script, and (e) the training and evaluation of the simulators performing the suicidal script. These stages are consistent with the behavioral approach to assessment (Goldfried & D'Zurilla, 1969). For determining the LA Analogue's construct validity, the appropriateness of the operational definition was tested in addition to the LA Analogue's correlation with established instruments (Goldfried & Linehan, 1977). Overall in this study an attempt was made to develop an empirically based, standardized assessment tool capable of fulfilling the need for behavioral evaluations of hotline volunteer performance.

The formulation of this behavioral instrument has several implications for the advancement of assessment in crisis intervention. A particular advancement is seen in the availability of a standardized evaluation procedure that would enable centers to compare the per-
formance of their volunteers with that of other centers. In addition, information regarding the competence of the training staff would be available, offering an additional check (Lester, 1973, p. 283). A previous attempt to standardize an assessment tool is seen in The Fowler Technical Effectiveness (TE) Scale (Fowler & McGee, 1973, p. 291) which rates the hotline volunteer's performance in the ability to perform those tasks that he/she has been explicitly trained to perform, and which the center recognizes as the fundamental duties of the worker performing the telephone crisis intervention function. Even though the scale provides a standard for performance criteria, certain methodological problems are apparent with its use. One of these is the inability of the scale to control the presenting stimulus and maintain caller variables constant, which results in volunteers responding to different caller variables. In addition, the scale items on lethality assessment do not provide the information needed for an accurate assessment of suicide risk, which is considered a fundamental and necessary skill of all hotline volunteers. Moreover, the scale is to be used to rate volunteer performance in response to actual calls. On the other hand, the LA Analogue measure is devised to be used in response to a simulated caller, which would give the
volunteer the opportunity to rehearse his or her skills previous to dealing with an actual caller.

Another contribution of the LA Analogue is its focus on measuring skills that are specific to crisis situations. Typically the assessment tools used have sought to measure features that are characteristics of helping communications in general rather than those that might be specific to any particular crisis situation (Neimeyer & MacInnes, 1981). Two of the instruments that have been used in assessing the competence of hotline volunteers have been the Truax Stage Rating Scales and the Lister Component Rating Scales (Knickerbocker & McGee, 1973). These scales assess what has been referred to as the Clinical Effectiveness of the volunteer (i.e. empathy, warmth, and genuineness) which is their ability to create the necessary therapeutic condition. Even though these characteristics necessary for a therapeutic relationship occupy a significant place in the volunteer's level of competency, the specific skills of crisis intervention need to be directly addressed. The hotline volunteer working with people in crisis is functioning within a crisis intervention model which requires a specific group of skills and approach (Dixon, 1979). Their ability to deal with a variety of crisis situations, e.g. rape, sudden physical illness, divorce, suicide, death, etc. is seen as crucial and assessment
tools specifically designed to assess these skills are necessary. The LA Analogue not only offers a focus on the specific evaluation of competency in lethality assessment but also offers the guidelines necessary for the formulation of other instruments designed to assess skills specific to crisis situations.

**Traditional Assessment Procedure**

The systematic observation of volunteers in the role of crisis intervention telephone workers began with the work of Knickerbocker and McGee (1973). They were interested in investigating what they called the Clinical Effectiveness of the hotline volunteer. In their study 65 volunteers and 27 professional trainees or professional practitioners in a suicide crisis intervention center were rated on the Truax Stage Rating Scales and Lister's Component Rating Scales of accurate empathy, warmth, and genuineness. Previously taped telephone conversation segments, each of three minutes duration, were used in the study. These taped segments were screened and judged by the experimenters "as involving a crisis of sufficient intensity such that therapeutic conditions would be offered appropriately" (p. 303). Their findings revealed that over the telephone, non-professional volunteers offered significantly higher levels of warmth, empathy and total conditions
than professionals. Though confounding issues can be raised regarding the use of screened tape recorded segments, the study did offer objective data by using research rating scales to measure the clinical skills of the lay volunteer on the telephone.

Further research in the area of assessing the performance of telephone crisis intervention workers was conducted by Fowler and McGee (1973) who devised The Fowler Technical Effectiveness (TE) Scale. This scale focuses upon the technical aspects of the counselor's performance and is designed to measure the extent to which workers perform the basic functions of: (a) securing the communication, (b) assessing the caller's condition, and (c) forming a plan of action. The TE Scale consists of nine items used to rate telephone performance. The performance data is gathered from either listening to the volunteer's responses to the caller, monitoring the call on a speaker phone, or listening to a tape recorded call. In validity studies conducted by the author, the scale demonstrated high interrater reliability and a high degree of confidence when used by one rater. Several criticisms of the scale were discussed previously, one of these being its ineffectiveness in evaluating the volunteer's competence in lethality assessments. Major variables to be considered in making accurate assessments of short- and
long-term suicide risk have been omitted from the scale, e.g. age of the caller, drug abuse, history of emotional or psychological disturbance, etc. These major variables or target areas will be discussed in detail in subsequent paragraphs. The TE Scale also fails to operationally define the skills it is measuring. One of the items for example asks, "Did the volunteer communicate that he is willing to help?" and the Scoring Criterion for this item states, "This question may be answered on the basis of affect and/or content" (p. 291). This example illustrates the ambiguity present in some of the items and in their scoring criteria. The need for and demonstration of operationally defined hotline volunteer behaviors will be discussed in the development of the LA Analogue measure.

A test for the evaluation of suicide prevention training is reported in Lois L. Tompson's (1973/1974) doctoral dissertation. The Test for Evaluation of Training in Suicide Prevention (SP Test) was devised by the Los Angeles Suicide prevention Center (1972) for evaluating the attitude, information and skill at rating suicide risk of their hotline volunteers. It includes important statistical data, commonly held myths, and other information needed for effective confirmation of issues involved in dealing with suicidal individuals. The test also includes some sample cases to rate for
suicidal risk. The test has a multiple choice format with 43 items, reliability and validity studies have not been reported in the literature. The **Test for Evaluation of Training in Suicide Prevention** is seen as a possibly useful measurement tool for evaluating the knowledge acquired through didactic instruction in suicide prevention.

In more recent research, Némeyer and Maclnnes (1981) have devised the **Suicide Intervention Response Inventory** (SIRI). These researchers saw the need for measurement tools capable of assessing the competence of volunteers when presented with specific crisis situations. They state that effective intervention in certain crisis situations requires additional skills from those characteristic of helping communications in general. The SIRI is designed to measure the volunteer's competence in discriminating between facilitative and non-facilitative responses to a suicidal caller. The SIRI includes 25 items each of which consists of an initial client remark followed by two helper responses, one of which is facilitative from the standpoint of crisis theory, while the other is non-facilitative. The instructions for the questionnaire are to select the most appropriate response. The results of a preliminary validation study performed by the authors suggest the SIRI represents an internally consistent and reliable
index of a volunteer's capability to select an appropriate response to a suicidal caller. The authors cite the fact that the SIRI measures skills at recognizing facilitative responses, not producing them, and therefore its relationship to more direct evaluations of volunteer effectiveness is needed.

**Behavioral Assessment Procedures**

A behavioral assessment procedure for evaluating hotline volunteers was proposed by Williamson, Goldberg, and Packard (1973) who advocate the use of simulated calls. This analogue procedure provides a standardized caller simulation in which it is possible to maintain caller variables relatively constant, and the experimenter retains control over the type of situation the volunteer is requested to deal with. In this type of assessment the volunteer responds to stimuli that simulate those found in actual caller situations. Used in the assessment of hotline volunteers, an analogue situation will involve the presentation of a standardized caller simulation and the subsequent evaluation of the volunteer's response to the call. The recommended format for developing the instrument consists of five parts: (a) instruction booklet, (b) case summary, (c) caller script, (d) response tabulation sheet, and (e) scoring and summary sheet. Once the instrument is
conceptualized, the initial task involves training the simulator. When practice sessions indicate sufficient consistency and mastery of the caller to be simulated, the simulator calls the hotline and presents the chief complaint. In subsequent dialogue, conducted by the volunteer, the simulator responds as directed in the caller script. After the call is completed, the volunteer's performance is scored and recorded on the scoring and summary sheet along with any recommendations.

Applications of this proposed method of evaluation are found in the following studies which utilized simulated calls. In the study by Bleach and Claiborn (1974) simulated problem calls were used to examine the counseling and information-giving skills of hotline services. It is reported that problem calls were designed to reflect those commonly experienced by hotlines and included pregnancy, loneliness, parent difficulties, and drug related problems. Standardized answers were prepared for those questions that were most likely to be asked by hotline workers. The simulators were six female undergraduate students who were trained to role play as callers and the calls were tape recorded for subsequent evaluation. The data gathered supported the researchers' hypothesis concerning differences among hotlines based on the counseling scales used. Morgan
and King (1975) also utilized simulated crisis calls to assess the listener effectiveness of volunteer telephone counselors. The simulated calls used were all performed by a female simulator who presented to each listener one of five problems. Each of the simulator crisis calls concerned one of the following areas: (a) parent-child difficulties, (b) problem pregnancy, (c) marital conflict, (d) loneliness and depression, and (e) academic difficulties. Each volunteer was informed of the call and that the simulator would be a co-worker. It is reported that calls were approximately ten minutes in length and were audiotaped by the simulator. Taped calls were then presented to three raters for evaluation. Results in this study indicated high interrater reliability for the scale used.

In other research, Hart and King (1979) used simulated calls to investigate the relative contributions of selection and training to volunteer competence. In their study, five female callers presented simulated crisis calls to hotline volunteers. The calls concerned a problem with the caller's boyfriend and had a depressive affect. The researchers report that the scripts used described the content of the call and the affect to be presented in outline form. The same call was used three times during the study which allowed the subjects to anticipate what would be required of them, creating a
practice effect factor. Results of the study revealed training to be a more significant variable than selection in determining a volunteer's level of functioning. Uhlemann, Hearn and Evans (1980) employed what they termed pseudocalls in their investigation of programmed learning applied to the training of hotline workers. A male graduate student and his wife acted as pseudoclients. The calls to each volunteer were twenty minutes in length and were audiotaped for further analysis. It is reported that the roles employed by the pseudoclients were randomly determined for each volunteer, and that pseudocalls were not distinguished from other calls. The primary implication of the study was that both traditional microtraining and a modified programmed-learning procedure can be used to train volunteers.

In the majority of studies previously reported, insufficient information was provided in the areas of: (a) operational definitions of skills to be assessed, (b) development of caller scripts, (c) training of simulators, (d) duration of calls, and (e) attempts made to standardize the calls. This lack of information, on the step-by-step development of these analogues, makes replication and application of their methods very difficult. In addition, methodological problems and confounding factors were also apparent. These problems
include the use of only one simulator to perform all simulations or the use of same sex simulators, both confounding the type of call with simulator's personality (France, 1975, p. 207). Also continued monitoring of simulator performance, which is essential for maintaining experimental control and accuracy of simulation, was not reported in most of the studies. Instead of evaluating short calls in their entirety, which is considered a better method (France, p. 206) in most cases very brief segments were selected for evaluation. The use of single raters and expert judges, in addition to unreported reliabilities of ratings, are all seen as additional limitations in a number of the studies reported. All of these specific areas of concern have been addressed in this study's development of the LA Analogue.

**Lethality Assessment**

Due to the high probability of receiving a call from a potentially suicidal caller, a critical area of training at a suicide prevention center involves the training in recognition and evaluation of lethality or suicide potential. This high probability results from the availability of a twenty-four hour hotline, offering the distressed individual help when most other services are not available. Today this training becomes even
more crucial with the increasing rate of suicides among young people. The rate of suicide has increased over 250% among young women 15 to 24 and over 300% among young men in the same age group and suicide has maintained its ranking as one of the ten leading causes of death in the United States with over 27,000 people committing suicide annually (Hendin, 1982, p. 19). In addition, thousands of others will also experience periods of suicidal ideations or exhibit forms of self-destructive behavior. With this alarming evidence, there is no doubt that suicide is a grave community problem requiring the special attention of all community services and particularly that of suicide prevention centers. The special training of hotline volunteers in recognizing and evaluating the suicide potential in a caller is seen as an important step towards confronting this problem.

The accurate assessment of lethality has been considered a difficult task due to the complexity of clinical judgment. It involves the assessment of several major signs which are weighted according to their value in predicting suicide risk. The method of judging suicide risk from telephone interactions with suicidal callers was developed by the staff at the Los Angeles Suicide Prevention Center (LASPC) and consists of evaluating the caller on several criteria or target
areas and assigning a suicide lethality rating (Brown & Sheran, 1972). As reported by Brown and Sheran, in a review of research on suicide predictive signs, the criteria for the prediction of suicide were first specified by Litman and Farberow (1961). Subsequently these criteria were converted into a suicide potentiality scale. Following research on the unreliability of the scale, Farberow, Heilig, and Litman (1968) reformulated the criteria into a detailed description of nine general predictive categories or signs to be implemented in making lethality judgments: (a) age and sex, (b) suicide plan, (c) stress, (d) symptoms, (e) resources, (f) lifestyle, (g) communication aspects, (h) reactions of significant others, and (i) medical status. Brown and Sheran report that research on the reliability and validity of suicide lethality judgments based on these categories has been positive. The following are descriptions of the nine predictive categories, that were formulated by Farberow et al. (1968), to be used as the criteria for assessing suicide potential:

1. Age and sex: Both statistics and experience have indicated that the suicide rate for committed suicide rises with increasing age, and that men are more likely to kill themselves than women. A communication from an older male tends to be most dangerous; from a young female, least dangerous. Young people do kill themselves, even if the original aim may be to manipulate and control other people and not to die. Age and sex thus offer a general framework for evaluating the
suicidal situation, but each case requires further individual appraisal, in which the criteria which follow are most useful.

2. Suicide plan: This is probably the most significant of the criteria of suicide potentiality. Three main elements should be considered in appraising the suicide plan. These are (a) the lethality of the proposed method, (b) availability of the means, and (c) specificity of the details. A method involving a gun or jumping or hanging is of higher lethality than one which depends on the use of pills or wrist cutting. If the gun is at hand, the threat of its use must be taken more seriously than when the person talks about shooting himself but has no gun immediately available. In addition, if the person indicates by many specific details that he has spent time and made preparations, such as changing a will, writing notes, collecting pills, bought a gun, and set a time, the seriousness of the suicidal risk rises markedly.

Another factor in the rating of the suicide plan arises when the details are obviously bizarre. Further evaluation of the plan will depend in large degree upon the patient's psychiatric diagnosis. A psychotic person with the idea of suicide is a high risk and may make a bizarre attempt as a result of psychotic ideation.

3. Stress: Information about the precipitating stress usually is obtained in answer to the question, "Why are you calling at this time?" Typically precipitating stresses are losses, such as: loss of a loved person by death, divorce, or separation; loss of job, money, prestige or status; loss of health through sickness, surgery, or accident; threat of prosecution, criminal involvement, or exposure, etc. Sometimes increased anxiety and tension appear as a result of success, such as promotion on the job and increased responsibilities. Stress must always be evaluated from the patients' point of view and not from the worker's or society's point of view. What might be considered minimal stress by a worker might be felt as severe for the patient. The relationship noted between stress
and symptoms (next criterion) is useful in evaluating prognosis. In general, if stress and symptoms are great, the action response of the worker must be high. In contrast, if symptoms are severe, but stress is low, either the story may be incomplete or the person is chronically unstable and will give a history of prior similar crises in his life.

4. Symptoms: Suicidal symptoms occur in many different psychological states. Among the most common are depression, psychosis, and agitation. Evidence of a severe depressive state may be elicited with questions about sleep disorder, loss of appetite, weight loss, social withdrawal, loss of interest, apathy and despondency, severe feelings of hopelessness and helplessness, and feelings of physical and psychological exhaustion. Psychotic states will be characterized by delusions, hallucinations, loss of contact or disorientation, or highly unusual ideas and experiences. Agitated states will show tension, anxiety, guilt, shame, poor impulse control and feelings of rage, anger, hostility, and revenge. Of most significance is the state of agitated depression in which the person may feel that he is unable to tolerate the pressure of his feelings and anxieties and exhibits marked tension, fearfulness, restlessness, and pressure of speech. The patient feels he must act in some direction in order to obtain some relief from his feelings. Alcoholics, homosexuals, and drug addicts tend to be high suicidal risks.

5. Resources: The patient's environmental resources are often critical in determining whether or not the patient will live. Inquiry should be for resources which can be used to support him through the severe suicidal crisis. These may consist of family, relatives, close friends, physicians or clergymen. If the patient is already in contact with a therapeutic agency or a professional therapist, the first consideration should be the possibility of referral back to the therapist or agency. Another resource may be the patient's work, especially when it provides him with self-esteem and gratifying relationships. Related to this is the patient's financial status which may influence the availability and location of immediate physical and psychological care.
Sometimes the patient and family try to keep the suicidal situation a secret, or even to deny its existence. As a general rule this attempt at secrecy and denial must be vigorously counteracted and the suicidal situation dealt with openly and frankly. A general principle is that it is usually better both for the worker and for the patient when the responsibility for a suicidal patient is shared by as many people as possible. This gives the patient the feeling he lacks, that others are interested and ready to help him. Where there are no apparent sources of support, the situation should be considered more ominous. The same evaluation may be applied when resources are available but have become exhausted or hostile, as when family and friends have turned away and now refuse to be concerned with the suicidal patient. In most cases people respond to crises and will help if given an opportunity to do so.

6. Life style: This criterion of the person's general functioning refers to a stable versus an unstable style of life, and includes an evaluation of the suicidal behavior of the patient as acute or chronic. The stable person will report a consistent work history, stable marital and family relationships, and no history of prior suicidal behavior. If serious attempts were made in the past, the current suicidal situation may usually be rated more dangerous. The unstable personality may include severe character disorders, borderline psychotics, and persons with repeated difficulties in main areas of life functioning, such as interpersonal relationships and employment. Acute suicidal behavior may be found in either a stable or an unstable personality; chronic suicidal behavior is found only in an unstable person. With stable persons undergoing a suicidal crisis, usually in reaction to a specific stress, the worker should be highly responsive, active, and invested. With unstable persons, the worker generally should be slower and more thoughtful, reminding the caller that he has weathered similar crises in the past. The main goal will be to help him through another crisis, to restore order, and to help him stay in an interpersonal relationship with a stable person or resource.
7. Communication aspects: The communication aspects of the suicidal situation are revealing. The most important question is whether or not communication still exists between the suicidal person and other people. The most alarming signal is when communication with the suicidal person has been completely severed. This can be an indication to the worker that the suicidal person has lost hope in any possibility of rescuing activity.

The form of communication may be significant. In type, the communication may be either verbal or indirect. A serious problem in the suicidal situation occurs when the person engages in non-verbal and indirect communication. These "action communications" imply that the interchange between the suicidal person and others around him is unclear and frequently raises the probability of acting out of the suicidal impulses. In addition, if the recipient of the communication tends to deny the existence of things which upset him, it may be very difficult for him to appreciate or even recognize the suicidal nature of the communications. In general, one of the primary goals of the worker is to open up and clarify the communications among all who are involved.

The content of the communications may be directed to one or more significant persons in his environment with accusations, expressions of hostility, blame, and implied and overt demands for changes in behavior and feelings on the part of the others. Other communications may express feelings of guilt, inadequacy, worthlessness, or indications of strong anxiety and tension. When the communication is directed to specific persons, the reactions of these persons are important in the evaluation of the suicidal danger. The reactions are detailed in the following section.

8. Reactions of significant other: The significant other may be judged by the worker either as non-helpful, or even injurious, in the situation and therefore no possible assistance for the patient; or he may be seen as helpful and a significant resource for rescue. The non-helpful significant others either reject the patient or deny the suicidal behavior itself and withdraw both psychologically and physically from continued
communication. The significant other may resent the increased demands, the insistence on gratification of dependency needs, the dictum to change his behavior. In other cases, one may see helpless, indecisive, and ambivalent behavior on the part of the significant other and the strong feeling that he does not know what the next step is and has given up. This latter reaction of hopelessness gives the suicidal person the feeling that aid is not available from a previously dependable source and may increase the patient's own feelings of hopelessness.

By contrast, a helpful reaction from the significant other is one in which the significant other recognizes the communication, is aware of the problem that needs to be dealt with, and seeks help for the patient. This is an indication to the patient that his communications are being attended to and that someone is doing something to provide help for him.

9. Medical status: The medical situation of the patient may reveal additional important information for evaluating the suicidal potentiality. The patient, for example, may be suffering from a chronic, debilitating illness, which has involved considerable change in self-image and self-concept. For persons with chronic illness, the relationship with their physician, their family, or a hospital will be of most importance. It is a positive sign if the patient continues to see these as resources for help.

The patient may be suffering from ungrounded fears of a fatal illness, such as cancer or brain tumor, and indicate a preoccupation with death and dying. There may be a history of many repeated unsuccessful experiences with doctors or a pattern of failure in previous therapy. These symptoms are of importance because of their possible effect on the significant others and doctors, exhausting them as resources for the patient.

In general, no single criterion need be alarming, with the possible exception of the one: having a very lethal and specific plan for suicide. Rather, the evaluation of suicidal potential should be based on the general pattern
of all the above criteria within the individual case. (pp. 5-9)

More recently the Los Angeles Suicide Prevention Center (LASPC) has reorganized the nine general predictive categories in the Evaluation of Suicide/Emergency Risk check list (LASPC, 1984—see Appendix A). This check list is currently being implemented in the center's telephone service training program. In this revision, the original categories have been simplified and regrouped. Its simplification involves the listing and description of factors in a concise format, making it more accessible for quick referencing. The predictive factors in the check list have also been regrouped into two groups, those that correspond to Suicide Risk and those that correspond to Emergency Risk. This breakdown of lethality assessment into evaluations of Suicide Risk and Emergency Risk provides a clear distinction between short-term and long-term risk. This lethality assessment check list was used as the basis for the formulation and development of the LA Analogue.

The first stage in the development of the LA Analogue consisted of operationally defining the skill to be evaluated, lethality assessment. This was accomplished by using the factors outlined in the Evaluation of Suicide/Emergency Risk check list. Following this stage, a Case Summary and Suicidal Caller Script were
formulated by investigating the typical profiles of suicidal persons calling suicide prevention hotlines and consulting with professionals in the field of suicidology. For the purpose of eliminating the possibility of a confounding variable, a female and male version of the case summary and script was composed. It was also decided that the case summary and script would be simplified by only containing information corresponding to the predictive factors outlined in the check list. Simulators were then trained to perform the scripts and a Performance Rating Scale was used to evaluate the volunteers' competence in assessing the simulated suicidal caller. Throughout the LA Analogue's development and implementation, an attempt was made to standardize instructions, simulations, and performance ratings. The specific procedures used will be discussed in the Procedure section of this paper.

For the purpose of obtaining correlational data the LA Analogue was compared to two other instruments: the Suicide Intervention Response Inventory and the Test for Evaluation of Training in Suicide Prevention. These instruments were designed to assess volunteer knowledge or information in hotline suicide intervention. They are of the paper-and-pencil format and unlike the LA Analogue do not measure actual volunteer behavior. They were select-
ed for their focus on the specific area of hotline suicide intervention.

Statement of the Research Problem

After a review of current assessment methodologies used in evaluating the competence of volunteers performing hotline crisis intervention work, a need was found for the development of empirically based assessment tools providing direct, behavioral evaluations of volunteer performance. Moreover, it was found that assessment tools designed to measure skills that are specific to crisis intervention are needed.

In response to these needs, a standardized analogue assessment tool was developed. The Lethality Assessment (LA) Analogue was designed to measure the competence of hotline volunteers in performing the specific crisis intervention skill of assessing lethality in a caller. The instrument's stages of development and preliminary validation will be reported. As indicated by Goldfried and Linehan (1977), who state it is essential that greater emphasis be put on reporting the full details of specific assessment procedures, the specific details of the LA Analogue's development will be reported. Particular emphasis will be placed on reporting standardization procedures and content and criterion-related validity. For establishing construct validity the method described by
Goldfried and Linehan was used. According to these researchers the concept of construct validity refers to "the validity of a particular assessment procedure as an appropriate operational definition of a specified construct" and "the construct validity of a behavioral measure may be reflected by its ability to change as a function of a given experimental manipulation" (p. 29). They offer as examples the decrease in observed disruptive behavior following the institution of a token reinforcement program and the increase of anxiety on a given measure following threat of shock as offering evidence of construct validity, in the former of the observational code and in the latter of the anxiety measure. In determining the LA Analogue's construct validity, its ability to measure improvements in volunteer performance after lethality assessment training (experimental manipulation) was evaluated. It was hypothesized that LA Analogue performance scores for hotline volunteers would increase after specific training in lethality assessment. The control group was expected to show no significant increase in scores over the same interval of time. For further evidence of construct validity the LA Analogue's correlation with two other instruments measuring a similar attribute, the Suicide Intervention Response Inventory (SIRI) and the Test for Evaluation of Training in Suicide Prevention (SP Test), was investigated. It
was expected that the LA Analogue would correlate significantly with the SIRI and SP Test at pre and post training intervals.
Method

Subjects

Hotline volunteers. The hotline volunteers who participated in the study consisted of a new group of volunteers beginning a training program for hotline crisis work at We Care, Inc., Crisis Intervention Center in Orlando, Florida. The group consisted of 15 volunteers, 9 women and 6 men. The women were of ages ranging from 25 to 62 with educations ranging from high school graduates to college graduates. The men were of ages ranging from 19 to 60 with educations ranging from high school graduates to college graduates.

Control group. The control group was composed of 12 hospital volunteers from a local hospital who agreed to participate in the study. The group included 9 women and 3 men, of ages ranging from 19 to 62 with high school to college educations.

Simulators. The simulators who portrayed the suicidal caller were 5 university students. The group consisted of 2 women and 3 men.

Raters. The two raters in the study were university students without prior experience in the field of
suicidology who were specifically trained to perform the task of rating volunteer performance. Training involved an average of five hours per rater. The same raters were also trained to assess simulation accuracy.

Materials

**Lethality Assessment (LA) Analogue.** The LA Analogue is being introduced as an empirically based behavioral assessment tool designed to measure the competence of hotline volunteers in performing the specific crisis intervention skill of assessing lethality in a caller. A detailed description of the instrument is included in the Procedure section of this paper. (Appendix B)

**Suicide Intervention Response Inventory (SIRI).** The SIRI (Neimeyer & MacInnes, 1981) is a self-administered questionnaire designed to measure volunteer competence in discriminating between facilitative and non-facilitative responses to a suicidal caller. The SIRI includes 25 items each of which consists of an initial client remark followed by two helper responses, one of which is facilitative from the standpoint of crisis theory, while the other is non-facilitative. The instructions for the questionnaire are to select the most appropriate response. (Appendix C)

The results of a preliminary validation study by the authors suggest the SIRI represents an internally
consistent and reliable index of a volunteer's capability to select an appropriate response to a suicidal caller.

Test for Evaluation of Training in Suicide Prevention (SP Test). The SP Test was devised by the Los Angeles Suicide Prevention Center (1972) for evaluating the attitude, information and skill of their hotline volunteers in dealing with a suicidal caller. This test includes important statistical data, commonly held myths, and other information needed for effective confrontation of issues involved in dealing with suicidal individuals. The test has a multiple choice format with 43 items. (Appendix D)

Design and Procedure

In developing the Lethality Assessment (LA) Analogue, a combination of the characteristics of role-play and enactment analogues were used (Nay, 1977). Also used in it's development were adaptations of the guidelines offered by Williamson et al. (1973) in the use of simulation for evaluating the competence of telephone counselors. As indicated by Goldfried and Linehan (1977), who state it is essential that greater emphasis be put on reporting the full details of
specific assessment procedures, the specific stages of the LA Analogue's development will be reported. The following are the stages of the LA Analogue's development:

1. **Operational definition of Lethality Assessment.** The predictive factors outlined in the Evaluation of Suicide/Emergency Risk check list (see Appendix A) were used in operationally defining Lethality Assessment. The skill of performing an accurate lethality assessment was defined as the hotline volunteer's ability to acquire from the simulated caller the information outlined in the predictive factors check list.

2. **Case Summary and Suicidal Caller Script.** The Case Summary and Suicidal Caller Script were developed after investigating the profiles of suicidal persons calling hotlines and consulting with professionals in the field of suicidology. A female and male version of the Case Summary and Script was composed to eliminate the possibility of a confounding variable. The female and male version differ only in the planned method of suicide (overdose of pills vs. gun) and history of drugs abused (tranquilizers vs. alcohol). These differences tend to be gender specific and provide a more accurate
simulation. It was also decided that the Case Summary and Script would be simplified by only containing information corresponding to the predictive factors.

The Case Summary is a condensed description of the caller and it facilitates a more reliable and accurate simulation by helping the simulator understand the caller (Williamson, et al., 1973). The following is the Case Summary used:

A female/male calls the hotline. She/He complains that she/he is very depressed, feels lonely and thinks that no one is interested in her/him. She/He mentions that she/he feels as if her/his life were over since her/his husband/wife died and that there is no point in continuing to live.

The content of the Suicidal Caller Script was composed with the use of transcripts from actual calls and information acquired from experienced hotline volunteers. The Script provides the simulator with the caller's Initial Statement and with simulator responses to give in response to subsequent volunteer inquiries. It is divided into three sections: (a) Item Category, (b) Question and/or Statement, and (c) Simulator Response. The Item Category section categorizes volunteer inquiries corresponding to specific predictive factors. It's purpose is to familiarize the simulator with the specific categories and alert him or her to those inquiries requiring a Simulator Response. In the Question
and/or Statement section each factor in the Item Category is translated into a sample dialogue lead. These same leads are based on the typical styles volunteers use in acquiring information from a caller. The Simulator Response section provides the simulator with specific responses to be given when the volunteer makes an inquiry which corresponds to the predictive factors. Those inquiries which do not correspond with the predictive factors outlined in the Item Category section are considered a Non-Target Item and are given a neutral response, i.e. "I don't know", "I don't want to talk about it", and silence (see Appendix B).

3. **Performance Rating Scale.** A rating scale was formulated to be used in evaluating volunteer performance in conducting Lethality Assessments. The scale is based on the operational definition given for Lethality Assessment and therefore evaluates the volunteer's ability to acquire information regarding the predictive factors outlined in the Evaluation of Suicide/Emergency Risk check list. The scale is composed of 23 items that describe specific volunteer inquiries which a rater, listening to an audiotaped recording of the simulated call, checks when they occur. The two raters used were trained in recognizing volunteer inquiries that required a check. Rating of actual simulations were begun when
raters had achieved an interrater reliability of at least .95. In subsequent intermittent reliability assessment, agreement between raters was between 95 and 100 percent. The total number of items checked was the score used as a performance index to evaluate the volunteer (see Appendix B).

4. **Standardization of instructions.** Standard instructions were given to all volunteers explaining in detail their task prior to participating in the simulation. The instructions were given to decrease ambiguity and provide a framework for the volunteer. The instructions informed the volunteer of the following: (a) definition of Suicide Risk and Emergency Risk, (b) the maximum 10 minutes allotted time, (c) their choice to stop the call when they thought sufficient information had been acquired, (d) that their ability as a counselor was not being evaluated and their primary task was to gather specific information, and (e) that the experimenter would return to the phone once the simulation was completed (see Appendix B). These instructions were read by the experimenter and given to each volunteer and control subject prior to the simulation. Instructions given to the simulators were in written form and attached to the Case Summary and Script. Its primary purpose was to provide specific information regarding the task
of performing the simulation. These instructions were discussed with the simulators prior to training.

5. Training and evaluation of simulators. The simulators were trained to perform the Suicidal Caller Script in a standard manner to assure that each volunteer and control group subject would be exposed to the same stimuli, maintaining simulation variables constant. The following steps were taken in training of simulators: (a) the Instructions for Simulators were discussed, (b) experimenter modeled appropriate simulator behaviors based on Script, (c) practice sessions were conducted in which the experimenter and simulator rehearsed and role-played the suicidal caller and the hotline volunteer, (d) the Simulation Evaluation Scale was used to evaluate audiotape recordings of practice sessions (see Appendix B), (e) practice sessions were continued until simulator achieved sufficient accuracy in performing the Script, sufficient accuracy was defined as achieving less than two "0" (incorrect responses) in a rated practice session; and (f) simulator performance was periodically monitored by evaluating the recordings of actual simulations conducted. If inconsistencies were found at this time, practice sessions were reinstated and continued until accuracy was regained. Interrater reliability in evaluating simulation
accuracy was between .95 and 1.00.

Pretraining period. During the pretraining period the hotline volunteers were given consent forms to sign (see Appendix E) and were administered the SIRI and SP Test during their individual initial interview with the crisis intervention center. At this time they were informed of the LA Analogue and were given a written information sheet of the procedure; which required their signature, day and time when they preferred to receive the call and the telephone number where they would be reached. Additional information regarding the simulation was not given. All volunteers were evaluated during a week's time, the time and day varied with each volunteer. Simulators were scheduled to perform the Script at different times during the week depending on their availability.

Control group participants were also given consent forms to sign during this time and the information necessary for conducting the LA Analogue was obtained. Control group subjects were only requested to respond to the LA Analogue. All control group evaluations were conducted within the same period of time hotline volunteers were evaluated.

The following procedure was implemented in conducting the simulation:
1. The experimenter telephoned each volunteer at the predetermined day and time and read the information provided in the Instructions to Hotline Volunteers sheet. At this time a telephone tape recording device was turned on for recording the simulation and the experimenter began to time the call.

2. The simulator gave the Initial Statement and proceeded by responding to the volunteer according to the Suicidal Caller Script.

3. At the 10 minutes allotted time the experimenter stopped the call and informed the volunteer that the time was up. At this time the experimenter asked the volunteer to assess the caller's Suicide Risk and Emergency Risk. This was requested for the purpose of giving the volunteer an opportunity to discuss his or her impressions and anxieties regarding the call and to offer closure to the call. The experimenter did not answer questions at this time and informed the volunteer that additional information would be given after the posttraining simulation.

4. The tape recording of the simulation was evaluated at a later date by one of the two raters previously trained. The Performance Rating Scale was used for this evaluation.

Posttraining period. Following specific Lethality Assessment training, in which the predictive factors
outlined in the Evaluation of Suicide/Emergency Risk check list were discussed, the hotline volunteers were readministered the SIRI, SP Test, and the LA Analogue. Procedures implemented during the pretraining period were once again followed in the posttraining period. The control group was reevaluated during the same period of time.
Results

The data collected for analyzing the construct validity of the LA Analogue consisted of: (a) hotline volunteer pretraining scores for the SIRI, SP Test and LA Analogue; (b) hotline volunteer posttraining scores for the SIRI, SP Test and LA Analogue; (c) control group scores for the LA Analogue at the pretraining period, and (d) control group scores for the LA Analogue at the posttraining period. A pretest-posttest control group design was used and the data was analyzed using a one-tail \( t \)-test on gain scores (Robinson, 1976). The procedure involved subtracting each subject's pretest score from the post-test score, the difference being a gain score. Each gain score was then treated as a raw score for each subject, and a \( t \)-test was carried out using the same formula employed with randomized two group designs.

Results from the one tail \( t \) test performed on the data showed as predicted a significant increase in LA Analogue scores for hotline volunteers after training in Lethality Assessment, \( t(25) = 4.50, p < .0005 \), one-tailed. As can be seen in Table 1, the difference between the two groups' gain scores was visibly apparent. The mean
### Table 1

**LA Analogue Gain Scores for Hotline Volunteers and Control Group**

<table>
<thead>
<tr>
<th>Gain Score</th>
<th>Hotline Volunteer</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>-3</td>
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<tr>
<td></td>
<td>3</td>
<td>1</td>
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<td>3</td>
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<td>6</td>
<td>0</td>
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<td>7</td>
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<td>0</td>
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<tr>
<td></td>
<td>6</td>
<td>0</td>
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<td></td>
<td>1</td>
<td>-1</td>
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<tr>
<td></td>
<td>10</td>
<td>M = 0</td>
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<tr>
<td></td>
<td>5</td>
<td></td>
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<td></td>
<td>2</td>
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</tr>
</tbody>
</table>

**M = 4.47**

**Note.** A pretest-postest control group design was used in which each gain score is treated as a raw score and a *t*-test was carried out using the same formula employed with randomized two group designs.

^aLethality Assessment Analogue

* _t(25) = 4.50, P < .0005, one-tailed.*
gain score for the hotline volunteers was 4.47 and the mean gain score for the control group was 0. The within group sum of squares used in calculating the t value was 113.74 for the hotline volunteers and 18 for the control group.

Hotline volunteer pre and posttraining scores were also analyzed for the SIRI and SP Test. Results from one tail t tests on repeated measures showed significant increases in posttraining scores for these two instruments, SIRI $t(14)= 3.26, p<.005$, one-tailed, and SP Test $t(14)= 2.05, p<.05$, one-tailed.

For additional analysis of construct validity the LA Analogue's correlation with the SIRI and SP Test was tested. A Pearson product-moment correlation revealed no significant relation between the LA Analogue, SIRI$^a$, and SP$^b$ Test, pretraining scores $r^a = -.01$, $r^b = .02$, posttraining scores $r^a = -.05$, $r^b = .29$, N.S. .

The formula described by Kazdin (1980) was used for estimating interrater reliability. With this procedure, reliability consists of the number of behaviors that observers agree upon divided by agreements plus disagreements and multiplied by 100. Three reliability checks were conducted: (a) before data was gathered, (b) midway through data collection, and (c) at the end of data collection. The ratings ranged from .95 to 1.00 for both volunteer performance and simulation accuracy.
Discussion

As hypothesized LA Analogue scores for hotline volunteers increased significantly following specific training in Lethality Assessment with control group scores showing no significant change over the same interval of time. In addition a comparison between the significance levels of the LA Analogue, SIRI, and SP Test showed the LA Analogue to be significantly superior to the other two instruments in measuring training effect. These preliminary findings of the LA Analogue's construct validity suggest the LA Analogue offers an appropriate operational definition for the construct Lethality Assessment and is capable of measuring behavioral improvements in volunteer performance. These findings also suggest the LA Analogue may be more sensitive than the SIRI and SP Test in measuring the skills learned by volunteers in suicide prevention centers.

The expected correlation between the LA Analogue, SIRI, and SP Test was not found. It is speculated that this finding may be due to the instruments assessing different levels (performance vs. cognitive) of the same construct. While the LA Analogue is a behavioral mea-
sure assessing volunteers at a performance level the SIRI and SP Test are paper-and-pencil measures that assess volunteer knowledge at a cognitive level. Supporting this view is McGee's (1974) report that centers using multiple choice quizzes to measure volunteer knowledge acquired through training, discontinued this assessment procedure when it was discovered that "test scores bore no relationship to workers' performance on the job" (p. 111). Therefore, this discrepancy between the instrument's assessment focus is seen as a possible explanation for the lack of correlation found. In addition, the study's small sample size may also be an explanation for the lack of correlation found. Small sample designs with a small range of scores generally show weaker relationships as a result of the correlation coefficient's sensitivity to the range of scores (Pfeiffer & Olson, 1981).

As discussed previously the behavioral analogue assessment procedure, originally proposed by Williamson et al. (1973) and found to be the best method for the systematic evaluation of hotline volunteers, has been applied in a number of studies investigating volunteer competence (Bleach & Claiborn, 1974; Hart & King, 1979; Morgan & King, 1975; Uhlemann, Hearn & Evans, 1980). As in the present study's LA Analogue, these studies also employed simulated calls as behavioral assessment tools.
for evaluating the competence of hotline volunteers. Most were interested in evaluating general counseling skills and used established rating scales for evaluating volunteer performance in response to simulations. In the majority of the studies insufficient information was reported on the step-by-step development of the analogues used and general assumptions were made on the adequacy of the procedures. This lack of information makes replication, and therefore application of the specific procedures used, very difficult. In addition the assumptions made on the validity and reliability of the assessment procedures, as being adequate measures, also presents a problem. In response to these problems Goldfried and Linehan (1977) have stated that since the consequences of specific variations in behavioral assessment procedures are not known, greater emphasis is needed in reporting the full details of assessment procedures. They also suggest researchers investigate the validity and reliability of behavioral procedures used. These suggestions have been applied in this study's development of the LA Analogue, where the focus has been in reporting the full details of the systematic development of a behavioral assessment tool and in providing preliminary validation data on its use. In the systematic approach employed in developing the LA Analogue, the instrument's construct, content, and
criterion-related validity were emphasized. Construct validity, as already discussed in the beginning of this section, involved analyzing the appropriateness of the operational definition for Lethality Assessment. It was the conceptualization of this operational definition which formed the basis for the actual development of the measure itself (behavioral-analytic approach discussed in Goldfried & D'Zurilla, 1979). In controlling for content and criterion-related validity a representative sample of a suicidal caller situation was created. For further investigation of criterion-related validity the contrived analogue situation needs to be directly compared with naturalistic observations of actual suicidal callers.

To determine the reliability of the rating system used in evaluating volunteer performance and simulation accuracy, interrater reliability was investigated. Internal consistency and test-retest reliability assessments were not performed in this preliminary study. In the area of method variance, as described by Campbell and Fiske (1959), sources of error attributable to the measurement procedure itself need investigation. In this study the related issue of reactivity was addressed. To minimize reactivity effects standardized instructions were given to all participants. Further
investigation in reliability and of possible reactivity problems is needed.

The formulation of the LA Analogue as a standardized behavioral assessment tool has several implications for the advancement of assessment in suicide prevention and hotline crisis intervention training. Traditionally, established assessment tools have been used to measure skills that are characteristic of facilitative helping communications in general. Even though these general therapeutic skills are significant in evaluating a hotline volunteer's level of competency, the specific skills of crisis intervention, particularly in suicide prevention, need to be directly addressed and assessment tools specifically designed to assess these skills are necessary. The LA Analogue not only offers an assessment tool designed to evaluate volunteer competence in the skill of Lethality Assessment but also offers the guidelines necessary for the formulation of other instruments designed to assess skills specific to crisis situations. These guidelines discussed previously are: (a) operationally defining the skill to be assessed, (b) the formulation of a case summary and caller script based on the skill to be assessed, (c) the formulation of a performance rating scale, (d) the standardization of instructions given to the hotline volunteers being
assessed and simulators performing the caller script, and (e) training and evaluation of simulators.

Another advancement offered by the LA Analogue is its availability as a standardized behavioral evaluation procedure whose consistent assessment situation would enable centers to compare the performance of their volunteers. With other methods of assessment in which the presenting stimulus is not controlled, volunteers are assessed in response to different caller variables. As a result of these inconsistencies comparisons of volunteer performance would be inappropriate. With this method centers will be able to compare the performance of their volunteers which would encourage the development of common performance criteria and consistent training programs. Used in the training of volunteers the standardized caller situation presented by the LA Analogue would also ensure consistent training exposure.

The LA Analogue's focus in directly evaluating behaviors is closely related to the experiential approach to training. In experiential training, trainees are given the opportunity to develop and practice their skills through direct learning experiences. The LA Analogue provides this kind of direct learning experience by giving the volunteer the opportunity to respond to a simulated suicidal caller where he or she can practice and rehearse new skills. In this learning
experience they are directly confronted with the anxieties and rewards associated with being a hotline crisis worker. They can confront and overcome their fears of not knowing what to say and test their ways of interacting with a person in crisis. The feedback volunteers receive from these experiences have proven to be very beneficial. A proponent of this method, McGee (1974) states, "what the volunteers need most is the chance to practice their native sensitivities [and]... must be given the chance to role-play telephone answering, interviewing, and caring for people in crisis" (p. 219). He believes, "such feedback of their own performance is more valuable than all the published literature on crisis theory and suicidology" (p. 220). Used in conjunction with experiential training programs the LA Analogue can provide volunteers with the opportunity to rehearse their skills in responding to a simulated suicidal caller prior to dealing with an actual crisis situation.

This study has introduced and provided preliminary validation data for an empirically based, behavioral assessment tool designed to measure the competence of trained hotline volunteers in performing the specific crisis intervention skill of Lethality Assessment. The specific procedures used in the LA Analogue's development have been reported and offered as guidelines for
the formulation of other instruments designed to assess skills specific to crisis intervention and suicide prevention. It is believed the LA Analogue and applications of its design will contribute to the advancement of assessment in hotline crisis intervention. However, additional validation work remains to be done, specifically those employing larger sample sizes.
Appendix A

Evaluation of Suicide/Emergency Risk

Suicide Risk

This is an assessment of the probability that the person will die by suicide within the next two years. This is not a fixed measure, it changes with time.

Factors to Consider

1. **Age.** Generally speaking, as age increases so does the risk of suicide, especially for males. However, the high rate for males in the 20 - 29 age bracket must be kept in mind.

2. **Sex.** Two-thirds of all suicides are males.

3. **Previous suicidal history.** Suicide risk increases if there is a history of suicide attempts, especially near lethal attempts. The longer the suicidal history, the greater the risk.

4. **Character and lifestyle.** Important high-risk indicators are:
   - Alcoholism
   - Drug Abuse
   - History of mental illness
   - Living alone
   - Refusing help (super-independent attitude)

5. **Feeling states.** Some of the feeling states that can be indicators of high risk are:
   - Depression
   - Anxiety and/or panic
   - Helplessness, hopelessness, and despair
   - Confusion and/or bizarreness

6. **Resources available.** Generally, the more resources that the person has on his own, the lower the risk. Some of the resources are:
   - Family
   - Friends
Professionals (physicians, therapists, etc.)
Money
Job

7. Significant losses. Significant losses can raise the lethality rating. Some losses are:
   Death of a loved one
   Divorce or separation
   Loss of job or money
   Loss of self-esteem or status

EMERGENCY RISK

This is an evaluation of how close a person is to making a suicide attempt within the next 24 hours.

Factors to Consider

1. Definite plan. Has the person decided how they are going to kill themselves?

2. Availability of means. Do they have or can they readily obtain the means by which they are going to kill themselves?

3. Lethality. How lethal is the method they are going to use? Such as the difference between using a gun and using an overdose of aspirin.

4. Time set. Have they set a time when they are going to make the attempt?

5. Opportunity for intervention. What is the possibility of rescue after the attempt has started? gun vs. overdose. Have they isolated themselves or are they reachable for rescue?

If the person has thought out all of these factors and has definite answers, the risk is high.

ALSO, HAVING SOME/OR MOST OF THE FACTORS LISTED UNDER SUICIDE RISK ON FRONT SIDE OF THIS PAPER. THE MORE FACTORS THAT APPLY THE HIGHER THE RISK.

Note. Reproduced with permission from the Los Angeles Suicide Prevention Center.
Appendix B

Lethality Assessment Analogue
Instructions to Simulators

1. You will be asked to simulate a suicidal person calling the hotline. You will be expected to perform the simulation in a very standard manner so that every volunteer will be exposed to the same stimuli. Your tone of voice, hesitations, etc., will need to be the same every time the simulation is performed.

2. A Case Summary is provided which contains general information regarding the person you will be portraying. This information will give you an overall picture of the person and will help in your effort to provide an accurate simulation.

3. The Script which has been provided will be your primary guideline in performing the simulation. It contains sample key Questions and/or Statements to be given by the volunteer and the Simulator Response you are to give when they occur. It is critically important that you follow these responses exactly so that every volunteer will be exposed to the same stimuli.

4. The volunteer will be called at a predetermined time and day and will be informed of the call. The experimenter will first give the volunteer specific instructions. Each volunteer will have 10 minutes to respond to the call and will also have the option of ending the call before the 10 minutes allotted time. Once the 10 minutes are up, the experimenter will once again speak to the volunteer before terminating the call.

5. The interaction will be tape recorded for future evaluation of volunteer performance.
Simulation Evaluation Scale

Instructions to Raters

You will listen to tape recording of a simulator performing the suicide call. Your task will be to check ("✓") Simulator Responses that are correct and do not deviate significantly from the script. In order for a Simulator Response to be correct, the key word or phrases underlined need to be included in the response. Incorrect responses, or those in which the underlined key word or phrase is omitted, are to be marked with a zero ("0").
<table>
<thead>
<tr>
<th>Item Category</th>
<th>Question and/or Statement</th>
<th>Simulator Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>&quot;How old are you?&quot;</td>
<td>Silence 1 rating</td>
</tr>
<tr>
<td>Question pertaining to age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling States</td>
<td>&quot;You sound very depressed and down right now.&quot;</td>
<td>&quot;I feel very depressed, there's nothing left to do.&quot; 2 rating</td>
</tr>
<tr>
<td>Acknowledgement of depression, helplessness, hopelessness. Any reference made to the the callers feelings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant Losses</td>
<td>&quot;What's happened in your life recently to bring about this depression?&quot;</td>
<td>&quot;My life has been meaningless ever since my wife/husband died. It just seems that I would be better off dead.&quot; 3 rating</td>
</tr>
</tbody>
</table>
Item Category
- Resources Available

Question re: people available help caller; neighbors, friends, family, etc.

Question re: professionals, involved with caller, psychologist, therapist, doctor, etc.

- Character and Life Style

Question re: caller's past experience with depression. Trying to gather information pertaining to a history of emotional or psychological disturbances.

Question re: drinking. (Specific question as to amount of alcohol consumed, how long the caller has been drinking, etc. fall in NON-TARGET area).

Question and/or Statement
"Have you talked to a family member or a friend about how you feel?" "Have you a neighbor you can talk to?"

Simulator Response
"I'm all alone. I don't have anyone, my wife/husband was all I had."
4 rating

"Do you see a therapist?"

"No, I don't."
5 rating

"Have you been this depressed before?"

"Yes, I've been treated for depression before, nothing's ever helped."
6 rating

"Do you drink?"

"No" or "No, I don't drink." (female caller)

"Yes" or "Yes, I drink." (male caller)
7 rating
<table>
<thead>
<tr>
<th>Item Category</th>
<th>Question and/or Statement</th>
<th>Simulator Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgement of Suicidal Thoughts</td>
<td>&quot;Are you using drugs?&quot;</td>
<td>&quot;Yes, tranquilizers.&quot; (female caller)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;No&quot; (male caller)</td>
</tr>
<tr>
<td>Volunteerdirectly asks if caller is thinking of ending their life.</td>
<td>&quot;Do you live alone?&quot;</td>
<td>&quot;Yes&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Yes&quot;</td>
</tr>
<tr>
<td>Previous Suicidal History</td>
<td>&quot;Are you thinking of ending your life, of committing suicide?&quot;</td>
<td>&quot;Yes, there's no point in continuing to live. I'm going to end my life.&quot;</td>
</tr>
<tr>
<td>Prior suicidal behavior -- general questions.</td>
<td>&quot;Have you wanted to kill yourself in the past?&quot;, &quot;Have you had these thoughts before?&quot;</td>
<td>&quot;Yes, I've had these thoughts before and have done awful things.&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;11 rating&quot;</td>
</tr>
</tbody>
</table>
**Item Category**  
Specific question. re: past suicidal behavior.

**Question and/or Statement**  
"Tell me about your past suicide thoughts."

**Simulator Response**  
"I was feeling very depressed and I took an overdose of sleeping pills one time. There were other times, I just kept trying. Once, I took all the pills I could find in the house."

(female caller)

"I've tried to shoot myself."

(male caller)

12 rating

**- Definite Plan**  
Question pertaining to a plan.

"You've talked about ending your life, I wonder if you would like to share with me what you intend to do?"

"Well, I've thought about it for a long time and I'm going to use tranquilizers and sleeping pills."

(female caller)
<table>
<thead>
<tr>
<th>Item Category</th>
<th>Question and/or Statement</th>
<th>Simulator Response</th>
</tr>
</thead>
</table>
| - Availability of Means | "What do you intend to do?"  
"Do you have a plan?" | "Well, I've thought about it for a longtime and I've decided to shoot myself."  
(male caller) |
| Specific question re: the means the caller plans to use. | "Do you have the means, by which you intend to end your life?" | "Yes, I have tranquilizers and sleeping pills."  
(female caller) |
| - Time Set | "Have you decided when you are going to end your life?" | "Right after I talk to you. You will be the last person I talk to."  
(15 rating) |
Item Category
- Opportunity for Intervention

Question re: where the caller is.

Question and/or Statement
"Where are you?"
"Where do you live?"

Simulator Response
"I don't want to tell you where I live."

rating

TOTAL: "✓ " ______ "0" ______

Instructions to Hotline Volunteers

1. You will be asked to respond to a simulated suicide call.

2. Your task will be to gather all information necessary to predict Suicide Risk and Emergency Risk.

   Suicide Risk is a long-term assessment of the probability that the person will die by suicide within the next 2 years.

   Emergency Risk is a short-term assessment of the probability that the person will die by suicide within the next 24 hours.

3. You will have 10 minutes to speak to the caller and you may stop the call at any time you think you have gathered sufficient information. Remember that your task is to acquire information from the caller that will help you predict Suicide Risk and Emergency Risk.

4. Your ability to be a counselor to the caller will not be evaluated, your task is to gather specific information.

5. The experimenter will return to the phone once the simulation has been completed.
A female calls the hotline. She complains that she is very depressed, feels lonely and thinks that no one is interested in her. She mentions that she feels as if her life were over since her husband died and that there is no point in continuing to live.

Suicidal Caller Script

Initial Statement
"There's no point in continuing. No one cares, I'm so lonely."

Key Simulator Responses to Specific Volunteer Questions and/or Statements.

<table>
<thead>
<tr>
<th>Item Category</th>
<th>Question and/or Statement</th>
<th>Simulator Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>&quot;How old are you?&quot;</td>
<td>(1) silence</td>
</tr>
<tr>
<td>Feeling States</td>
<td>&quot;You sound very depressed and down right now.&quot;</td>
<td>(2) &quot;I feel very depressed, there's nothing left to do.&quot;</td>
</tr>
</tbody>
</table>

Acknowledgement of depression, helplessness or hopelessness. Any reference made to callers feelings.
Item Category
- Significant Losses

Question about what is happening in the caller's environment.

- Resources Available

Question re: people available to help caller: neighbors, friends, family, etc.

Question re: professionals involved with caller; psychologist, therapist, doctor, etc.

- Character and Life Style

Question re: caller's past experience with depression. Trying to gather information pertaining to history of emotional or psychological disturbances.

Question and/or Statement
"What's happened in your life recently to bring about this depression?"

Simulator Response
(3) "My life has been meaningless ever since my husband died. It just seems that I would be better off dead."

(4) "I'm all alone. I don't have anyone, my husband was all I had."

(5) "No, I don't."

(6) "Yes, I've been treated for depression before, nothing's ever helped."

(7) "No, I don't drink."

(8) "Yes, tranquilizers."
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<thead>
<tr>
<th>Item Category</th>
<th>Question and/or Statement</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgement of Suicidal Thoughts</td>
<td>&quot;Do you live alone?&quot;</td>
<td>(9) &quot;Yes&quot;</td>
</tr>
<tr>
<td>Volunteer directly asks if caller is thinking of ending her life.</td>
<td>&quot;Are you thinking of ending your life, of committing suicide?&quot;</td>
<td>(10) &quot;Yes, there is no point in continuing to live. I'm going to end my life.&quot;</td>
</tr>
<tr>
<td>Previous Suicidal History</td>
<td>&quot;Have you had these thoughts before?&quot;</td>
<td>(11) &quot;Yes, I've had these thoughts before, and have done awful things.&quot;</td>
</tr>
<tr>
<td>General questions re: prior suicidal behavior.</td>
<td>&quot;Have you wanted to kill yourself in the past?&quot;</td>
<td></td>
</tr>
<tr>
<td>Specific question re: past suicidal behavior.</td>
<td>&quot;Tell me about your past suicidal thoughts.&quot;</td>
<td>(12) &quot;I was feeling very depressed and I took an overdose of sleeping pills one time. There were other times, I just kept trying. Once I took all the pills I could find in the house.&quot;</td>
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</table>
Item Category

- Definite Plan

Question pertaining to a plan.

- Availability of Means

Specific question re: the means the caller plans to use.

- Time Set

When does the caller plan to do this.

- Opportunity for Intervention

Question re: where the caller is.

Question and/or Statement

"You've talked about ending your life, I wonder if you would like to share with me what you intend to do?"
"Do you have a plan?"

Simulator Response

(13) "Well, I've thought about it for a long time and I'm going to use tranquilizers and sleeping pills."

(14) "Yes, I have tranquilizers and sleeping pills."

(15) "Right after I talk to you. You will be the last person I talk to."

(16) "I don't want to tell you where I live."
<table>
<thead>
<tr>
<th>Item Category</th>
<th>Question and/or Statement</th>
<th>Simulator Response</th>
</tr>
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<tbody>
<tr>
<td>- NON-TARGET AREAS</td>
<td>All other inquiries</td>
<td>(17) Respond with a neutral statement, &quot;I don't know&quot;, &quot;I don't want to talk about it&quot;, and silence.</td>
</tr>
</tbody>
</table>
A male calls the hotline. He complains that he is very depressed, feels lonely and thinks that no one is interested in him. He mentions that he feels as if his life were over since his wife died and that there is no point in continuing to live.

Suicidal Caller Script

Initial Statement

"There's no point in continuing. No one cares, I'm so lonely."

Key Simulator Responses to Specific Volunteer Questions and/or Statements.

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<tr>
<td>- Age</td>
<td>&quot;How old are you?&quot;</td>
<td>(1) silence</td>
</tr>
<tr>
<td>Question pertaining to age.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| - Feeling States    | "You sound very depressed and down right now."
<p>| Acknowledgement of depression, helplessness, or hopelessness. | (2) &quot;I feel very depressed, there's nothing left to do.&quot; |</p>
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<tr>
<td>- Significant Losses</td>
<td>&quot;What's happened in your life recently to bring about this depression?&quot;</td>
<td>(3) &quot;My life has been meaningless ever since my wife died. It just seems that I would be better off dead.&quot;</td>
</tr>
<tr>
<td>- Resources Available</td>
<td>&quot;Have you talked to a family member or a friend about how you feel?&quot; &quot;Do you have a neighbor you can talk to?&quot;</td>
<td>(4) &quot;I'm all alone I don't have anyone, my wife was all I had.&quot;</td>
</tr>
<tr>
<td>- Character and Life Style</td>
<td>&quot;Have you been this depressed before?&quot; &quot;Do you drink?&quot; &quot;Are you using drugs?&quot;</td>
<td>(5) &quot;No, I don't.&quot;</td>
</tr>
<tr>
<td>Question re: people available to help caller: neighbors, friends, family, etc.</td>
<td></td>
<td>(6) &quot;Yes, I've been treated for depression before, nothing's ever helped.&quot;</td>
</tr>
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<td>Question re: professionals involved with caller; psychologist, therapist, doctor, etc.</td>
<td></td>
<td>(7) &quot;Yes&quot; or &quot;Yes, I drink.&quot;</td>
</tr>
<tr>
<td>Question re: caller's past experience with depression. Trying to gather information pertaining to history of emotional or psychological disturbances.</td>
<td></td>
<td>(8) &quot;No&quot;</td>
</tr>
<tr>
<td>Item Category</td>
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</tr>
<tr>
<td>-----------------------------------------------</td>
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<td>(12) &quot;I've tried to shoot myself.&quot;</td>
</tr>
<tr>
<td>- Definite Plan</td>
<td>&quot;You've talked about ending your life, I wonder if you would like to share with me what you intend to do?&quot;</td>
<td>(13) &quot;Well, I've thought about it for a long time and I've decided to shoot myself.&quot;</td>
</tr>
<tr>
<td>Question pertaining to a plan.</td>
<td>&quot;Do you have a plan?&quot;</td>
<td></td>
</tr>
<tr>
<td>- Availability of Means</td>
<td>&quot;Do you have the means (e.g. gun, pills), by which you intend to end your life?&quot;</td>
<td>(14) &quot;Yes, I have a gun.&quot;</td>
</tr>
<tr>
<td>Item Category</td>
<td>Question and/or Statement</td>
<td>Simulator Response</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>- Time Set</td>
<td>&quot;Have you decided when you are going to end your life?&quot;</td>
<td>(15) &quot;Right after I talk to you. You will be the last person I talk to.&quot;</td>
</tr>
<tr>
<td></td>
<td>Question re: where the caller is.</td>
<td>(16) &quot;I don't want to tell you where I live.&quot;</td>
</tr>
<tr>
<td></td>
<td>All other inquiries</td>
<td>(17) Respond with a neutral statement,&quot;I don't know&quot;, &quot;I don't want to talk about it&quot;, and silence.</td>
</tr>
</tbody>
</table>
Performance Rating Scale

The volunteer requested information from the following areas. (Mark with a "✓")

SUICIDE RISK TARGET AREAS

Identifying Information
1. Age
2. Sex _Given_

Feeling States
3. Any reference made to caller's feelings
4. Depression (helplessness, hopelessness, despair)
5. Anxiety or panic
6. Confusion and/or bizarreness

Significant Losses (precipitating event)
7. General questioning regarding what is happening in the caller's environment
8. Have you experienced a loss?

Resources Available
9. Family, friends, neighbors, etc.
10. Professionals; e.g. therapists, counselors, etc.
11. Money
   Do you have the money to seek professional help?
12. Job
   Do you have a job?

Character and Lifestyle
13. History of emotional or psychological disturbances
14. Alcoholism
   Do you drink?
15. Drug use
   Are you using drugs?
16. Living alone
Do you live alone, do you have someone to talk to?

Acknowledgement of Suicidal Thoughts

17. Confronts caller regarding suicidal thoughts

Suicidal History

18. Previous suicidal behavior (General)
Have you had these thoughts before?

19. Previous suicidal behavior (Specific)
Tell me about your past suicide thoughts. What did you do?

EMERGENCY RISK TARGET AREAS

20. Definite plan
You've talked about ending your life, I wonder if you would like to share with me what you intend to do?

21. Availability of means
(Specific questions regarding the means the caller plans to use.)
Do you have the means, e.g. pills, gun, etc. by which you intend to end your life?

22. Time set
Have you decided when you are going to do this?

23. Opportunity for intervention
Where are you?
Where do you live?

TOTAL TARGET AREAS CHECKED
PREDICTABLE SUICIDE RISK
EMERGENCY RISK
Appendix C

Suicide Intervention Response Inventory

The following items represent a series of excerpts from counseling sessions. Each excerpt begins with an expression, by the client concerning some aspect of the situation he/she faces, followed by two possible helper responses to the client's remark. You are to select that response which you feel is the more appropriate reply to the client's comment, recording either "A" or "B" to the left of the item to indicate your preferred response. Be sure to select only one response per item, and try not to leave any item blank.

1. 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: I'd like to hear more about your suicidal feelings.

2. 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 alright.
   Helper B: You must feel pretty lonely and afraid of what might happen.

3. 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.

4. Client: No one can understand the kind of pain I've been going through. Sometimes I just feel like I have to hurt myself, so I cut my wrists.

Helper A: You've been suffering so much that cutting your wrists seems to be 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.

5. 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: You're wondering if I can understand how you feel.

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

6. Client: My life has been meaningless 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 when Emma died... But what has 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 very difficult 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:** Well, I think it's still pretty frightening, even though talking about it makes it a bit clearer. I think you realized how dangerous your suicidal feelings were, and 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:** 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 solutions 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 gotten 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 intentional or unintentional to hurt yourself, until you call and talk to me. Will you repeat the promise?
15. **Client:** Is that 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 at him for not being there when you need him most.

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. It just makes me feel so isolated.

Helper A: No one seems concerned about you anymore, and that leaves you pretty alone. Can you tell me more about how that makes you feel to be so 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: You feel like nothing you do is important, and that a therapist can't help you. Hasn't 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 that 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 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?

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Suicide Intervention Response Inventory

Scoring Key

1. B
2. B
3. B
4. A
5. A
6. B
7. A
8. B
9. B
10. A
11. B
12. A
13. B
14. B
15. B
16. A
17. A
18. B
19. B
20. A
21. A

22. B
23. A
24. B
25. B
Appendix D

Test For Evaluation Of Training
In Suicide Prevention

Instructions: Select the best answer to each question.

SECTION 1:

1. Most suicides
   a. occur without communication of intent.
   b. occur after the person has called a suicide prevention center.
   c. occur usually after the person has communicated his intent to some friend or relative.
   d. occur without warning to anyone.

2. A person who was at one time suicidal
   a. should always be considered suicidal.
   b. will never be suicidal again after he has received help the first time.
   c. is a higher risk than someone who has never been suicidal.
   d. will again become suicidal when subjected to stress.

3. Which of the following indicates that the risk of suicide is reduced following a suicidal crisis?
   a. Patient is less depressed and appears to feel better.
   b. Successful (accepted) referral to an appropriate resource.
   c. Family and friends rallying around to help patient.
   d. All of the above.

4. Suicidal tendencies are
   a. inherited, run in families.
   b. influenced by response of others.
   c. stronger among rich.
d. stronger in poor people.

5. Patients in a mental hospital
   a. are a high suicide risk group.
   b. often commit suicide in the hospital.
   c. should be considered suicidal.
   d. have no significant traits as far as suicide.

6. The role of communication in a suicide might be summarized as follows:
   a. People who feel suicidal will not let others know how they feel.
   b. People who talk about suicide are not likely to commit suicide.
   c. Blocked or unclear interpersonal communication contributes to suicide.
   d. None of the above.

7. Suicidal people are
   a. mentally ill.
   b. depressed.
   c. trying to get help for themselves.
   d. it is impossible to generalize to this extent.

8. Suicidal people who are alcoholics and drunk
   a. can generally be treated as a low risk group.
   b. need special patience because they might be very lethal.
   c. should be advised to sober up before seeking help.
   d. will no longer be suicidal when they stop drinking.

9. A man is a greater suicide risk if he
   a. is an alcoholic.
   b. lives alone.
   c. is in psychotherapy.
   d. fits both "a" and "b" above.
   e. fits "a", "b", and "c" above.

10. A man should be considered a low suicide risk
    a. if he is an alcoholic with no current suicide plan.
b. if he has a history of suicide threats but has never attempted suicide.
c. if he is under thirty years of age and has no current suicide plan.
d. none of the above.

11. A young woman who threatens to slash her wrists is most likely

a. manipulating others.
b. a low suicide risk.
c. a high suicide risk.
d. a masochist.

12. Which of the following is least related to suicide risk?

b. The suicide of a same sex parent.
c. Ethnic background.
d. Prior suicidal episodes.
e. Lethality of the current suicide plan.

SECTION 2:

1. Suicide is

a. the major cause of death among adolescents.
b. not a significant cause of death in the United States.
c. among the first ten causes of death in the United States.
d. more prevalent among college students than non-college youth.

2. Regarding suicide rate in different countries

a. the United States has one of the highest rates.
b. rates are mostly determined by accuracy of reporting.
c. Japan has the highest reported rate.
d. Communist countries have high rates.

3. Urban areas

a. have lower suicide rates than isolated rural areas.
b. generally have higher suicide rates than rural areas.
c. have high rates due to crowded conditions.

4. Regarding sex differences in suicide, generally
a. men threaten suicide more often than women.
b. men attempt suicide more often than women.
c. men commit suicide more often than women.
d. the rates are about equal.

5. Regarding age-sex differences in suicide rates
a. young women have a very high suicide rate.
b. older men have the highest suicide rate.
c. older women have the lowest suicide rate.
d. young men have a high but rapidly dropping suicide rate.

6. All of the following groups have high suicide rates except
a. alcoholics.
b. psychotics.
c. blacks.
d. males over sixty years of age.

7. Suicide attempt rates are highest among
a. older women.
b. young women.
c. older men.
d. young men.

SECTION 3:

1. Suicidal people
a. are fully intent on dying.
b. usually have a great deal of ambivalence about dying.
c. are mentally ill and are unable to tell right from wrong.

2. Suicide attempts may be
a. manipulations but should be taken seriously.
b. signs of a weak character.
c. manipulations and should be ignored.
3. If you tell members of the family about a person's suicide attempt
   a. it will upset them and make them unable to help.
   b. they will usually deny the problem and be uncooperative.
   c. they will interfere in the proper care of the suicidal person.
   d. they will usually be concerned and want to help.

4. If you think a patient may be suicidal
   a. discuss it openly with him.
   b. don't say anything and the symptoms will pass.
   c. call his bluff.
   d. treat the matter with extreme delicacy, avoiding mention of suicide.

5. Suicidal behavior is best understood as
   a. a manipulation.
   b. giving up.
   c. a cry for help.
   d. an indication that a person is feeling sorry for himself.
   e. mental illness.

6. Predominant feelings of most suicidal persons are
   a. hostility and aggression.
   b. dependency.
   c. helplessness and hopelessness.
   d. self-pity.

7. If someone is in a suicidal crisis
   a. he should usually be hospitalized.
   b. nothing can be done during the crisis except offer sympathy and wait for the crisis to end.
   c. he will benefit from active intervention during the crisis.
   d. intensive psychotherapy is the way to resolve the crisis.

8. Which of the following is a clue of suicidal intentions?
a. giving away personal belongings.
b. marked change in behavior.
c. repeated accidents.
d. all of the above.

9. Persons who have long histories of suicide attempts
   a. rarely go on to commit suicide.
   b. become less suicidal through their chronic acting out.
   c. are serious long-term risks.
   d. are usually attention seekers.

10. If a person who has a stable life history becomes suicidal
   a. it is an indication of emotional collapse.
   b. he may have been putting up a good front all along.
   c. it is probably not a serious risk because he has emotional strength.
   d. he is usually responding to a current serious stress.
   e. it is usually the beginning of a chronic way of dealing with problems.

SECTION 4:
While taking calls at a suicide prevention center:

1. If a suicidal person is willing to seek professional help
   a. you should give him three or four reputable referrals where he could receive such help.
   b. you should give him the number of his local chapter of the American Medical Association to call for a referral.
   c. you should encourage this attitude and let him use his initiative and independence to find a therapist.
   d. you should make what you consider to be the one best referral for him and help him to make an appointment.

2. If it is established that someone has taken an overdose of some medication the important thing is
a. to find out what kind and how many of the pills were taken, and get the person to the hospital.
b. to have him stay on the phone with you until some definite symptoms occur.
c. to find out which doctor prescribed the medication.
d. to call a doctor to evaluate the effect of the drug used.

3. If a patient who is in therapy calls the suicide prevention center and complains about his therapist
   a. you should refer him to another therapist.
   b. you should try to act as a temporary therapist for him while trying to straighten out things with the regular therapist.
   c. you should refer the patient back to his own therapist and try to contact the therapist yourself.
   d. you should ignore this "red herring" and ask the patient why he really called.

4. A man calls who says he is going to commit suicide with a gun and he has the gun right there and intends to use it now. You should
   a. tell him you refuse to talk to him until he at least unloads the gun.
   b. find out where he is, then call the police because other people's lives are endangered.
   c. try to engage him in conversation and work to get him to agree to disarm the gun.
   d. call his bluff because 99% of this type of threat are only attention-getting devises.

5. If a woman calls about her husband, who sounds like a high suicidal risk
   a. you should offer to call him.
   b. have her tell him she called and ask him to call you.
   c. give them an appointment, and see them together.
   d. both "b" and "c".
SECTION 5:

Instructions: Read the following four items and place them in rank order in terms of the highest risk. For example, place a "1" next to the item you consider the most serious risk, a "2" next to the next most serious risk, etc. In each case, a person calls and the following information is revealed.

A. Thirty pills available and the date and place of suicide planned.

B. Man has a plan to shoot himself, but the gun is not available as yet, nor have the date and place for suicide been planned.

C. Young woman threatens to cut wrists while talking on the phone.

D. Man has bought a hose which he plans to attach to his car to commit suicide; date and place not yet planned.
SECTION 6:

Instructions: Rate the following five cases for suicide lethality on a scale from 1 to 9. (1 is low and 9 high.) Make two ratings on each case, based on time; the current period (next to twelve months), and a lifelong routine (likelihood that patient will die by suicide in the future).

RATINGS:

No. 1

<table>
<thead>
<tr>
<th>12 months</th>
<th>Lifelong</th>
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<tbody>
<tr>
<td>Sex:</td>
<td>Female</td>
</tr>
<tr>
<td>Age:</td>
<td>22</td>
</tr>
<tr>
<td>Stress:</td>
<td>Living alone.</td>
</tr>
<tr>
<td>Symptoms:</td>
<td>In past: depression, alienation, and hallucinations in form of imaginary characters.</td>
</tr>
<tr>
<td>Suicide plan:</td>
<td>Called to &quot;offer information (about self) that may be of interest (to us) in our work.&quot;</td>
</tr>
<tr>
<td>Prior Suicidal Behavior:</td>
<td>Seven years ago took 24 Nembutal, plus other pills. Left note. Dressed well in nightgown.</td>
</tr>
<tr>
<td>Resources:</td>
<td>Divorced, no children, living alone, student.</td>
</tr>
<tr>
<td>No. 2</td>
<td>12 months</td>
</tr>
<tr>
<td>-------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifelong</td>
<td>Stress:</td>
</tr>
<tr>
<td></td>
<td>Symptoms:</td>
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<td></td>
<td>Suicide Plan:</td>
</tr>
<tr>
<td></td>
<td>Prior Suicidal Behavior:</td>
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<table>
<thead>
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<td></td>
<td>Age:</td>
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<tr>
<td>Lifelong</td>
<td>Stress:</td>
<td>Lost wife, business debt of $3,000. Can't have kids.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symptoms:</td>
<td>Drinking. Last night felt like a failure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suicide Plan:</td>
<td>Use gun or CO from car.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prior Suicidal Behavior:</td>
<td>Last night had a gun. Notified friend who called police. Also, last night attached hose to tail pipe and into car. Suicide attempt eight months ago - drunk, with gun.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resources:</td>
<td>Separated, divorce in progress, two children, unemployed, has friend.</td>
<td></td>
</tr>
<tr>
<td>No. 4</td>
<td>12 months</td>
<td>Sex:</td>
<td>Male</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>Age:</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>_____</td>
<td>Stress:</td>
<td></td>
<td>Nothing means anything. Feels that something is going to happen.</td>
</tr>
<tr>
<td>_____</td>
<td>Prior Suicidal Behavior:</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>_____</td>
<td>Resources:</td>
<td>Married, two children 10 and 12, employed.</td>
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</table>

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<th>12 months</th>
<th>Sex:</th>
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<td></td>
<td>Age:</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>_____</td>
<td>Stress:</td>
<td></td>
<td>Marital problems; a week ago her child swallowed lye and was hospitalized.</td>
</tr>
<tr>
<td>Lifelong</td>
<td>Symptoms:</td>
<td></td>
<td>Sounded very depressed and unhappy.</td>
</tr>
<tr>
<td>_____</td>
<td>Suicide Plan:</td>
<td>Patient has stomach pumped and is hospitalized following ingestion of 12 Dristan tablets.</td>
<td></td>
</tr>
<tr>
<td>_____</td>
<td>Prior Suicidal Behavior:</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>_____</td>
<td>Resources:</td>
<td>Married, marital problems; a child; doctor concerned and seeking help.</td>
<td></td>
</tr>
</tbody>
</table>
Test For Evaluation Of Training In Suicide Prevention

Scoring Key

SECTION 1

1. c
2. c
3. d
4. b
5. a
6. b
7. d
8. b
9. d
10. c
11. b
12. c

SECTION 2

1. c
2. c
3. c
4. c
5. b
6. c
7. b

SECTION 3

1. b
2. a
3. d
4. a
5. c
6. c
7. c
8. d
9. c
10. d

SECTION 4

1. d
2. a
3. c
4. c
5. d

SECTION 5

A. 1
B. 3
C. 4
D. 2

SECTION 6

1. 12 mos. ______ Lifelong_____
2. 12 mos. ______ Lifelong_____
3. 12 mos. ______ Lifelong_____
4. 12 mos. ______ Lifelong_____
5. 12 mos. ______ Lifelong_____

(not available)
Appendix E

Consent Forms
General Consent Form

I understand that I am being asked to participate in research investigating the competence of volunteers working in a suicide intervention center. This will involve completing two multiple choice questionnaires dealing with suicide issues and participating in a simulated standardized situation of a suicide call.

I will not be personally identified in any way in the research. If I desire any feedback on the experiment, it will be provided by the experimenter.

Date________________ Signature__________________________
Consent Form

Simulation of Suicide Call

I agree to respond to a simulated suicide call. The experimenter and a trained simulator will call me during a predetermined time and day, at which time instructions will be provided and I will be asked to respond to the call. I understand that the call will be tape recorded by the experimenter for the purpose of evaluating my skills in Suicide Intervention. Once the tape is evaluated its contents will be erased and I will not be personally identified in the research.

Day of the week appropriate for call____________________
Time of the day____________________________________
Phone Number_______________________________________

Date_______________ Signature_______________________
Consent Form

Control Group

I understand that I am being asked to participate in research investigating the competence of volunteers working in a suicide intervention center. This will involve participating in a Control Group, which will not receive training in Suicide Intervention, and comparing my performance with that of trained hotline volunteers. I agree to respond to a simulated suicide call. The experimenter and a trained simulator will call me during a predetermined time and day, at which time instructions will be provided and I will be asked to respond to the call. I understand that the call will be tape recorded by the experimenter for the purpose of evaluating my skills in Suicide Intervention. Once the tape is evaluated it's content will be erased and I will not be personally identified in the research.

Day of the week appropriate for call____________________
Time of the day____________________________________
Phone Number_______________________________________

Date_____________ Signature_________________________
Consent Form

Simulators

I understand that I am being asked to participate in research investigating the competence of volunteers working in a Suicide Intervention Center. This will involve being trained to simulate a suicidal person calling the hotline. I will be following a script provided by the experimenter. When my training is completed I will be asked to perform the simulation for Hotline Volunteers and volunteers working in a local hospital. The simulation will be performed over the telephone, the volunteers being informed of the call, and the interaction will be tape recorded by the experimenter for evaluation. I will not be personally identified in any way in the research. If I desire any feedback on the study, it will be provided by the experimenter.

Date________________ Signature__________________________
References


