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This study assessed undergraduate college students' ability to recognize facilitative responses on the revised Suicide Intervention Response Inventory (SIRI-2) by adopting an empathic mindset. Students were exposed to an imagining prompt, an observing prompt, or no prompt, based on experimental designs in the empathy literature. Empathy was hypothesized to promote recognition of facilitative responses on the SIRI-2 by improving the scores of college students who were untrained in suicide intervention. One hundred seventy six participants, age 18 to 24, volunteered. Participants were randomly assigned to three prompt groups. Participants in the control (i.e., no prompt) group completed the SIRI-2. Participants in the imagining group received a verbal prompt to consider how the suicidal person, described in the SIRI-2, could be feeling and then completed the SIRI-2. Participants in the observing group received a verbal prompt to consider only the information conveyed by the suicidal person and then completed the SIRI-2. One hundred fifty-eight valid test packets were included in the data analysis. A 2 x 3 analysis of variance with gender by experimental prompt conditions was performed on the SIRI-2 scores. Results showed no significant main effect for prompt condition or interaction for gender by prompt condition. A gender difference was obtained with women receiving better SIRI-2 scores than men (better scores on the SIRI-2 are numerically lower scores).

COLLEGE STUDENTS' RESPONSES TO SUICIDAL COMMUNICATIONS USING THE REVISED SUICIDE INTERVENTION RESPONSE INVENTORY

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I would like to thank my professional mentor who provided direction and assistance, and through whose example I discovered a love for the profession I have chosen.

I acknowledge the energy of Kali-Durga, the destroyer and nurturer. May I balance this energy within myself. I acknowledge the energy of Hanumanji, the perfect servant of God. May I be as true a servant as you.

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CHAPTER 1

INTRODUCTION

College students have a high likelihood of arriving on campus with significant mental health and adjustment problems (Dannells & Stuber, 1992; Rickgarn, 1994). In fact, Ofer and Spiro (1987) estimate 20% of each incoming freshman class faces serious psychological disturbance or distress. The rate of suicide, for example, is a major concern (Nelson, Farberow, & Litman, 1988). Suicide among adolescents and young adults is the third leading cause of death (Morrison, 1987; U.S. Bureau of the Census, 1998). The alarming estimation is 400,000 people in this age group may attempt suicide each year (Cantor as cited in Peck, Farberow, & Litman, 1985).

Interrupting the cycle of suicide enhances the odds people will ultimately change their minds about dying. This challenge has special importance to students who are most likely to be the first person suicidal peers will approach for help (Knott & Range, 1998; Lawrence & Ureda, 1990; Mishara, 1982; Murray, 1973; Ross, 1985; Wellman & Wellman, 1986). Appropriate peer reactions can increase the odds suicidal students will receive help and ultimately choose to live (Mishara, 1982; Kalafat & Elias, 1992).

Literature Review

The Suicidal Adolescent and Young Adult

Rickgarn (1994) pointed out the difficulty of determining accurate suicide rates among student groups. For example, statistics of the 15-24 year old age group reflect high school students, graduates and dropouts as well as traditional college students, graduates, dropouts, or those young adults who did not enter college. Racial diversity, nontraditional status, and part-time status were also difficult to delineate. Many schools failed to keep suicide or attempted-suicide statistics fearing a poor reputation. It remains a fact suicide is the third leading cause of death for adolescents and young adults (Department of Health and Human Services, 1985). The rate of suicide deaths per thousand 15-19 year olds was third following homicides and accidents and for 20-24 year olds, suicide ranked third

behind accidents and homicides. Suicide ranked eighth of 10 possible mortality categories (11.3 per 100,000) for death rates by leading cause in the State of Kansas, which approximated the 1978 national ratio for 15-19 year olds (Silver, Goldston, & Silver, 1984).

Suicide as a national problem is well known. In 1980 approximately 27,000 people committed suicide compared with 35,000 more recently (Vital Statistics of the United States, 1994). Pokorny (as cited in Resnik, 1968) believed the total number of suicides would continue to increase beyond the expected population base growth rate, possibly due to the aging of the population and the higher expected number of suicides among the elderly.

General risk factors. Wodarski and Harris (1987) listed depression, stress, peer involvement, and family influences as common risk factors in young adult suicide. Rickgarn (1994) cited familial influences, including history of parental alcohol and substance use, conflict with parents, physical abuse or witnessed physical abuse in the family, incest, sexual abuse and assault, student use of alcohol and substances, student's status as gay or lesbian, and emotional distress, low self-esteem, and depression. Other suicidologists have proposed modeling effects (Chiles, Strosahl, McMurtray, & Linehan, 1985), inadequate defense mechanisms (Taiminen, 1992), disorders in attachment (Kaplan & Worth, 1993), personality typology (Street & Kromrey, 1994), and family system problems (Held & Bellows, 1983) as critical factors influencing suicide in the young adult.

Gender. Stable gender differences in suicidal behavior are also noted. The literature points out more men than women commit suicide, more women than men attempt suicide, and men consistently use more guaranteed lethal means than women (Rosenthal, 1981; Schniedman & Farberow, 1961). Leenaars (as cited in Wass & Neimeyer, 1995) stated the stable ratio of completed suicides has been 3 men to 1 woman

for "many eras" (p. 367). Mishara (1976) cautioned repeated attempts inflate annual statistics. However, Maris (1981) doubted this concern.

Community response. Recognizing suicide as a result of the inability to deal with stress, the U.S. Public Health Objectives were developed to increase recognition and utilization of community resources (Silver et al., 1984). Two goals expected to be reached by the 15-24 year old age group included the ability of 50% of the target population to identify a community agency able to assist in a stressful situation and the ability to identify and contact a prevention hotline. By recognizing and utilizing community resources it was hoped lay people in this vulnerable group could recognize the signs of severe stress and intervene quickly.

The State of California implemented a 5-year evaluation and intervention program for adolescents and young adults age 12 to 20. Respondents listed depression, hopelessness, stress, low self-esteem, family instability and problems with parents as major contributors to suicide. Students themselves reported needing love and support to assist them through a crisis, while their parents thought increased education was the critical factor. Compas and Wagner (1991) noted younger students are greatly affected by stressful family issues, but by the time a student is living at college, familial concerns have diminished. Academic and peer issues then become more bigger stressors for students.

Suicidal students and campus policy. Individuals who threaten suicide are often considered mentally ill (Murphy & Robbins as cited in Resnick, 1968). Distinguishing those students who pose no threat to themselves or the campus community from students who do is an important consideration (Dannells & Stuber, 1992). Capuzinni and Golden (1988) preferred to label such students as handicapped rather than mentally ill. Many institutions developed mandatory psychiatric withdrawal policies (PWP) designed to protect the university community and the student himself or herself from possible harm resulting from any number of psychiatric emergencies. Among Kansas colleges, however,

mandatory PWP policies were seldom found and were less often invoked (Dannells & Stuber, 1992). Instead, Kansas universities have preferred to respond to disturbed students by dismissing them on the basis of behavioral code violations, if any were found (Dr. Pat Wade, personal communication, June 23, 1999). Rickgarn (1994) proposed members of each campus should strive to "be proactive as well as reactive when they meet students who are contemplating or attempting suicide" (p. 229). The literature reminds one confessions of suicidal intent affect many people in the university community. The literature also reminds us it is a myth to consider all suicidal individuals mentally ill (Pokorny as cited in Hoff, 1989).

Suicidal Communications

Seventy-five percent of completed suicides in the general population will communicate their intent beforehand (Pokorny as cited in Resnick, 1968) and from 75% to 80% of completed suicides among college students will warn someone (Rickgarn, 1994). These percentages underscore the danger of taking any suicide threat lightly.

Adult communication of intent and effects on recipients. Researchers accept Robins, Gassner, Kayes, Wilkinson, and Murphy (1959) as authorities for understanding the impact of suicidal communications on the respondent (Bernstein, 1978; Farberow & Schniedman, 1965; Lester, 1997; Modlin, 1971; Rudestam, 1972; Wolk-Wasserman, 1986; and Yessler, Gibbs, & Becker, 1960). For example, Lester (1997) accepted the four reasons why people communicate prior intent as described by Robins et al. (1959). Those reasons included communication of ambivalence to die so death could be prevented, communication of an attempt to prepare the listener for the death, communication of an attempt to threaten or antagonize the listener, and communication of preoccupation with suicide. In their study of 134 consecutive adult suicides, Robins et al. found 69% communicated intent, but less than half of those used direct verbal communication of intent; indirect, behavioral clues were given by most eventual suicides. Spouses were most often the recipients of the message, followed by other relatives, and friends.

Sixty-five per cent of the subjects used multiple means to communicate intent and told different people. Almost 75% had been talking about suicide for one year, and of those, 43% had been talking for less than three months. Robins et al. cautioned that although only a minority of individuals making suicidal communications actually went on to complete the act, responding seriously to all threats was critically important. Three quarters of those who communicated intent were experiencing a serious crisis of recent onset that was most usually communicated directly without being disguised in behavioral clues.

The effects of suicidal communications on recipients was also examined. One-quarter of recipients suspected the communications were ingenuine; others felt "angered and irritated" (p. 728). Many felt anxious, afraid, and helpless to intervene. Most recipients felt responsible for the person "prior to and at the time of the suicide" (p. 732). However, a small number of recipients welcomed the death of the troubled person. Robins et al. stated the recipient's report of events leading up to the suicide was more clinically valuable than reports given by suicidal individuals who survived their attempt.

Regarding the management of fear and sense of threat surrounding the receipt of a suicidal message, Robins et al. noted recipients would change their attitudes toward the message or toward the communicator or change their perception of what was expected in response. For example, recipients often denied the urgency of the message, hoping the person did not mean it. Or, recipients minimized the seriousness of the threat if they had heard it numerous times; becoming habituated to the threat and thus lessening their anxiety. Recipients often denied the person would carry out the threat, denying the person was troubled enough to actually be suicidal. Recipients changed perceptions of their roles in relation to the suicidal person if they did not know how to refer the person for help, or if the person was referred then released back into their hands after an ineffective intervention.

Yessler et al. (1960) proposed type differences between communicators and noncommunicators in an analysis of U.S. Army data on attempted and completed suicide. They found these differences demanded different preventative responses. One hundred cases of completed suicide were compared with 104 cases of attempted suicide from the same time period. Four patterns of suicidal communication were established, two of which were verbal. Those verbal communications included direct communication of intent and implied communication of intent. Implied communication of intent ranged from nearly explicit verbalizations to highly disguised statements whose seriousness was easily misinterpreted. The majority of completed (70%) and attempted (75%) suicides did not communicate intent beforehand. However, some attempters specifically declared intent beforehand. More attempters (27.9%) than completers (17%) made previous threats. As a whole, this study reflected the trend toward noncommunication across all age groups. However, caution must be exercised in generalizing from a military to a college population.

Type and content of verbal communication. Schneidman and Farberow (as cited in Resnik, 1968) categorized suicidal communication into direct verbal communications such as "I am going to commit suicide," "I'm going to end it all," and "I want to die," (p. 371); indirect verbal communications such as "You'd be better off without me," (p. 371); and coded verbal communications. Coded verbal communications were defined as those statements best interpreted as suicidal by significant others who know the patient well. Such communications include "This is the last time I'll be here," or "How does one leave his body to the medical school?" (p. 372). Despite these clear distinctions, the recipient must decide if intent is present or if the person is asking for help not to commit suicide (Maltsberger, 1986).

Wolk-Wasserman (1986) studied the impact of direct vs. indirect suicidal communications on significant others' ambivalence toward 40 adult attempters (ages not reported) who survived to be admitted to the emergency room. Significant others were

defined as "cohabitants or persons in close and continuous contact with, and important to, the patient" (p. 483), which included friends of the patients. Characteristics of these attempters included either neurosis, psychosis, or alcohol/drug dependence or abuse. All of the completers in this study suffered from severe depression and most significant others had a serious psychiatric condition as well. Wolk-Wasserman (1986) noted patients engaged in "protracted indirect verbal communication" (p. 495) for months to years, which was generally fueled by psychic conflict of the suicidal person surrounding the demise of an important relationship.

Conscious ambivalence toward the attempter, especially agonizing over whether to discontinue the relationship with the suicidal partner, was at the core of recipient awareness as well. When this dilemma went unresolved, conscious ambivalence shifted toward aggression and hatred of suicidal partners. Death wishes were verbally expressed and a determined choice not to assist the suicidal person was made, even when witnessing the partner take the overdose of pills.

Responses to suicidal communication depended in part on the personality and experience of the recipient; indeed, all of the individuals in Wolk-Wasserman's (1986) sample recognized the suicidal messages but hoped the threats were not real. Typical behaviors and feelings elicited from recipients' included silence to increased verbal aggression or ambivalence to increased anxiety. Wolk-Wasserman (1986) concluded these behaviors contributed to escalating the suicide attempt. In this light, Rickgarn (1994) suggested college students made indirect threats to test if someone would confront and help them. He suggested students were willing to repeat this process until they found assistance or their hope ran out.

Litman (1964) noted the seriousness of inadequate responding since people who threatened suicide were very likely to carry it out. The tendency to become helpless and immobile in response to threats was explored retrospectively in dream analyses of patients whose spouses or close friends committed suicide. Litman (1964) theorized the

suicidal message was unconsciously perceived, but "conscious recognition of its significance is avoided, denied, and repressed" (p. 282). Although these hypotheses could not be tested, he nevertheless described a plausible, emotional response to a suicidal threat. Litman (1964) astutely recognized the importance of the respondent both knowing appropriate responses to make and having the ability to carry them out.

College Students' Responses to Suicidal Communications

Gender differences in peer responses. Wellman and Wellman (1986) believed the most adaptive response sequence a friend could offer would be to recognize the presence of a suicide problem, take the threat seriously, be willing to lend supportive presence, and quickly involve a trained helper. But many variables intervened from receiving the confession of intent to delivering the troubled student into competent hands. For example, the roles of gender socialization and psychological androgyny on sympathetic reactions toward a suicidal peer were examined. Socialization rendered remarkable differences in gender reactions to suicidal peers, such that women formed closer relationships and were generally more receptive and caring, while men were more aloof, socially facilitative, and superficially competent. A contrasting theory stated people who possessed the personality dynamics of both sexes, known as psychological androgyny, formed closer attachments that favored willingness to help in a suicidal crisis. College students were studied to determine how gender differences impacted attitudes which influenced receptivity toward suicidal friends.

Men and women almost equally (66% and 63%, respectively) said they would try to talk a friend out of suicide, but men and women (38% and 59%, respectively) differed in their willingness to initiate a discussion of suicide with the troubled friend. Wellman and Wellman (1986) expressed concern for the small segment of men who embraced very traditional masculine sex roles and who showed the least openness and receptivity. These men subscribed to myths that suicide occurred suddenly, without warning or communication and before the victim could be dissuaded. Wellman and Wellman (1986)

speculated holding these beliefs justified the decision to withhold assistance. They also took little comfort in the nearly 60% of men who would accept responsibility to help to a suicidal peer, arguing the 40% of men who seemed unwilling to assist was a critical percentage of the population. However, Scheid (1981) found women who adopted an androgynous orientation toward suicidal friends were less effective in suicidal crises, a point not addressed by Wellman and Wellman (1986).

Regarding the difficulty of some young men to respond, Rosenthal (1982) proposed unresolved death anxiety caused higher suicide rates among men, such that young men chose to end their lives rather than learn to manage their death anxiety. Rosenthal (1982) speculated men perhaps believed they were asserting the masculine traits of decisiveness and fearlessness by ending their psychological suffering once and for all. Rosenthal (1982) acknowledged his theories were speculations that had not been confirmed through studies.

White and Stillion (1988) studied gender differences in attitudes and responses elicited by suicidal and non-suicidal target figures as portrayed in vignettes. They noticed women college students reacted with more sympathy toward a suicidal peer and suspected this was because women were generally more sympathetic to people in distress. While women sympathized equally with suicidal and non-suicidal adolescents, men sympathized with non-suicidal adolescent men but less with suicidal adolescent women. Men appeared to stigmatize suicidal men. Mens' sympathy was situation-specific and less enduring. This may explain why men succeed at suicide more often than women. Men completed suicide rather than survive and face condemnation from other men, as well as themselves. Attitudes toward suicidal peers in this population did not necessarily predict helping behavior.

Effects on the recipient. Cowgell (1977) studied the impact a suicide threat had on 83 college women's verbal responses to suicidal peers. She presented two taped versions of a young woman discussing her problems with an interviewer; on one tape she admitted

wanting to kill herself. At various intervals the tape was paused and the participant was asked to respond as if she were speaking directly to the young woman. Participants were rated on their ability to conceive a concrete plan of assistance and the willingness to actually carry it out. Cowgell (1977) discovered a suicide threat significantly raised the recipient's experience of anxiety as measured in physiological, cognitive, mood, and emotional domains. There were no differences between groups on types of helping verbalization nor in the ability to formulate a helping plan. However, participants in the suicide threat group were more likely to use the words "death" or "suicide" in their responses; one-third as many more women used these terms. Thus, the presence of a suicidal threat increased the likelihood the listener would respond by talking openly about death or suicide. However, participants in the suicide admission group predicted a poor outcome of the stimulus person's future. Other reactions included the tendency to deny the suicide threat in order to continue relating as if nothing had happened. Some students were incapable of recovering beyond initial shock such that they did not fully grasp the risk at hand. Thus, some students were ineffective because they were unable to keep their anxiety in perspective. Cowgell (1977) strongly suspected negative responses such as disbelief, skepticism, ignoring, and discounting, were the primary or 'natural' responses, whereas rescuing behaviors, such as inviting open disclosure, were secondary or 'learned' responses.

Mishara (1982) believed effective suicide prevention began with effective responses in pre-crisis situations. In everyday life, friends could change the course of a crisis by their choice of appropriate responses. Mishara (1982) surveyed students to determine what percentage had ever encountered a suicidal peer, whether they took the threat seriously, what was happening in the student's life at the time, how they responded, and whether their response was helpful. A substantial number (59%) acknowledged encountering suicidal peers and admitted initial responses of shock, anger, confusion, and guilt. Situations in the suicidal student's life were categorized as loss-related or non-loss

related. Helping reactions were categorized as open (encouraged talking about the problem) or closed (joked about it, referred them to a professional, ignored the communication). The most helpful responses were seen in the interaction between non-loss related situations and open reactions. For example, a lesser interpersonal loss or crisis was best dealt with by allowing the student to talk openly about the situation. But if the crisis was precipitated by the loss of an important social support such as a parent or significant other, neither open nor closed reactions were helpful. Instead, the student's ability to receive intervention seemed disordered. Mishara (1982) confirmed the tendencies for people to "naturally" react to a suicidal confession with uneasiness. Variations in situations that prompted the suicidal communication required different respondent strategies.

Lawrence and Ureda (1990) studied the importance of peer preparedness to assume a rescuer's role in suicide prevention by questioning if students recognized signs and symptoms of suicidal behavior, if they knew an appropriate, helpful response to make, and if there was an interaction between these two factors and the intention to intervene. They polled 1,131 college freshmen, believing a helpful response would not be forthcoming unless one actually believed the student was suicidal, and one had a sense of what constituted a helpful response. The conviction that a helper's behavior could change the outcome of a suicidal crisis was the catalyst between knowledge of suicide risk and possessing an intervention plan.

Lawrence and Ureda (1990) also found emotional distress significantly impacted the student's self-efficacy to act. They found college freshmen recognized the difference between suicidal and non-suicidal behavior, but only 20% felt capable of directly confronting the friend. Students generally did not know a helpful response outside of distracting the distressed student.

Assessing peer responses to suicidal messages was a complex endeavor. Resnik (1968) noted friends are called upon to assess the seriousness of the threat with relatively

little knowledge of what to look for. This is intriguing and encouraging. Despite the lack of knowledge and intervention training, peers remain in a position to render enormous help and do so despite their inexperience.

Measuring Suicide Intervention at the College Level

College students historically performed poorly on knowledge-of-suicide areas such as lethality (Holmes & Howard, 1980) and recognizing facilitative responses (Neimeyer & MacInnes, 1981) compared to trained professional and community interventionists. Likewise, untrained psychology students scored below crisis trainees in ability to recognize facilitative responses on a test of intervention skills (Neimeyer & Pfeiffer, 1994).

The Suicide Intervention Response Inventory (SIRI; Neimeyer & MacInnes, 1981) was developed to assess paraprofessional and professional recognition of facilitative responses to suicidal crises. It has been validated in settings with undergraduate students, volunteers, crisis line staff, nursing and medical students, and professional therapists. Its utility is that it indicates the individual's ability to respond facilitatively to suicidal clients. Historically, college students have been used in SIRI and SIRI-2 research in order to compare trained interventionists' scores with those of untrained populations who could be expected to score poorly.

The SIRI assesses sensitivity to suicide threats and distinguishes simple reassurance from meaningful intervention (Norton, Durlak, & Richards, 1989). However, the SIRI failed to differentiate higher level skills and was revised (Neimeyer & Bonnelle, 1997). The SIRI and revision, the SIRI-2, are highly correlated and contain the same items and response choices. Scoring on the SIRI is dichotomous, whereas scoring on the SIRI-2 utilizes a dimensional Likert-type rating scale.

SIRI and SIRI-2 in college studies. Earlier studies established the expectation that untrained populations scored poorly on the SIRI (Neimeyer & MacInnes, 1981; Norton et al., 1989). Indeed, the SIRI was recommended for studies with student populations

because such populations never approached the instrument's ceiling, reserving the SIRI-2 for studies with trained populations (Neimeyer & Bonnelle, 1997). However, college students also demonstrated systematic improvement on the SIRI (Abbey, Madsen, & Polland, 1989). Abbey et al. (1989) used the SIRI to determine the effectiveness of instructional methods for a suicide awareness program. Students were pretested with the SIRI before being assigned to a study group, a study-lecture group, or a control group. Student performance confirmed the responsiveness of the instrument to instructional situation. Use of the SIRI to develop undergraduate suicide awareness and intervention programs was felt to lend a new utility to the instrument.

SIRI-2. The revised Suicide Intervention Response Inventory (SIRI-2; Neimeyer & Bonnelle, 1997) represents a scoring revision of the SIRI (Neimeyer & MacInnes, 1981), which was developed in response to an inadequate ceiling. The SIRI was designed to assess counselors' skills in "discriminat(ing) between more and less effective responses in suicide counseling situations" (Neimeyer & Bonnelle, 1997, p. 61). It has been used in research with professionals as well as college undergraduates and high school students (Neimeyer & Bonnelle, 1997). For the purposes of this study, the SIRI-2 may measure college student's ability to engage a suicidal peer in a facilitative relationship by recognizing responses that invite open discussion of the crisis. The SIRI-2 is a Likert-type instrument which presents 25 brief suicidal statements made by hypothetical clients, followed by two possible helper responses. The items reflect direct and indirect statements of suicidality (Norton et al., 1989). Both helper responses are to be rated.

Test-retest reliability refers to the instrument's ability to reflect a stable score upon repeated administrations, when other confounding factors are accounted for. Test-retest reliability on the SIRI-2 was determined for two administrations over a 2 week period. The resulting correlation was highly dependable (Pearson $r = .92$; Neimeyer & Bonnelle, 1997, p. 69). Validity refers to the instrument's ability to describe and predict

the human characteristics in question. SIRI-2 scores were sensitive to levels of suicide intervention education. Discriminant validity for the SIRI-2 indicated no contamination from social desirability, response bias, age, or gender of participants. The SIRI and SIRI-2 were highly correlated (Neimeyer & Bonnelle, 1997).

According to the instructions, participants read the items, which are portrayed as being derived from counseling sessions, and evaluate two response choices for appropriateness of each choice. One choice is facilitative of the helping process while the other is detrimental. Item 14 of the SIRI-2 is discarded, based on the recommendations of the test authors (Neimeyer & Bonnelle, 1997).

The SIRI-2 test instructions state the items were taken from counseling sessions but participants are not specifically instructed to assume the role of a counselor. Participants rate the appropriateness of hypothetical counselor responses on a Likert scale (ranging from +3 Highly appropriate response to -3 Highly inappropriate response). It is possible this instruction increased the face value of the items and response choices on the SIRI-2. The items present individuals from a range of age groups, caution should be used when generalizing results to college populations. However, for the purpose of this study, the SIRI-2 represents a collection of naive and informed responses to suicidal statements, with a dimensional scoring system that may offer a more sensitive rating scale for evaluating the appropriateness of helping responses.

Mean scores obtained by a panel of suicide experts comprise a standard table with which the participant's actual scores are compared. Comparisons are obtained by first determining the absolute difference between the participant's score and the clinical experts' scores. There are 50 possible responses on the SIRI-2, thus 50 differences to calculate. Those 50 differences are then summed to obtain a grand score (Neimeyer, personal communication, August 19, 1999). Lower scores indicate better performance because they deviate less from those of suicide experts (Neimeyer & Bonnelle, 1997). For example, a control group of college undergraduates with no training in suicide

intervention (M = 70.36; SD = 25.76) scored poorer than masters level psychology trainees (M = 47.84; SD = 12.96) (Neimeyer & Bonnelle, 1997, p. 68) on the SIRI-2.

The literature does not address the possibility of improving scores on the SIRI-2 through means other than suicide prevention training. Nor does the literature address using the SIRI-2 to measure effectiveness of helping, if one assumes an empathic mindset regarding a suicidal target person. Such a mindset compromises the quality of help rendered (Inman, Bascue, Kahn, & Shaw, (1994). In contrast, combining attention to suicide knowledge with related interviewing skills would produce the best helpers. However, they did not test whether assuming an empathic mindset alone would prove as detrimental as assuming a strictly informational mindset. Therefore, prompting students to assume an empathic focus with a suicidal target person in order to obtain better scores on the SIRI-2 may be possible. Although one might expect holding a strictly empathic mindset would be as detrimental to assisting a suicidal person as holding a strictly factual mindset, this hypothesis was not tested. The rationale and methodology for testing this hypothesis may be found in the literature on empathic motivation, specifically, in manipulation of mental set via written prompts to imagine or observe hypothetical peers who request help.

Effects of Imagining vs. Observing a Distressed Target Figure

Stotland (1969) studied physiological reactions of male participants to determine conditions under which empathic helping emerged to ascertain whether arousing the participant's ability to place himself in the target person's position would have "predictive value" (p. 289) in helping situations. For example, using three experimental mental sets--imagining oneself in a painful or pleasurable situation, imagining a target person in a painful or pleasurable situation, or observing a target person in a painful or pleasurable situation--were contrasted for measures of vasoconstriction in the hand. Stotland (1969) theorized "imagin[ing] how you yourself would feel" (p. 292) would cause participants to "project" (p. 290) themselves onto the target person and better

understand his experience. Stotland (1969) contrived a painful situation of a bogus heat treatment in which a student confederate acted as if he enjoyed the treatment or felt pain. The confederate sat at the front of a room, with his back toward the participants, and with his face concealed, since it was feared the confederate would not be a convincing enough actor.

Conversely, Stotland (1969) also theorized arousing emotional neutrality by instructing participants to observe a target person's plight would decrease empathy and result in less emotional identification, less arousal of empathy, and less understanding of the person's situation. His "watching" (p. 290) prompt instructed participants to observe the target person closely rather than to imagine how the target person or they themselves would feel. Stotland (1969) found the watching condition, which he felt produced a "superficial" (p. 297) involvement with the target person did not arouse empathy. However when participants imagined themselves in the situation, or even the target person's pain, empathy was aroused. Stotland (1969) noted there were differences in the ways empathy was measured physiologically across these conditions. Nevertheless, he (Stotland, 1969) concluded that "any interpersonal process, symbolic or overt, which causes an individual to imagine himself in another's position would lead him to empathize with the other person" (p. 297) and increase the probability of helping behavior. Stotland (1969) noted participants in the imagine condition where the confederate was perceived as feeling pain accounted for the most vasoconstriction in the participant or the arousal of more empathic regard in the participant. Stotland (1969) concluded superficial instructions to observe without feeling a target person experiencing pain did not arouse empathy.

Subsequent researchers investigating empathic motivation of helping used adaptations of Stotland's (1969) watching and imagining prompts to elicit helping behavior as measured with both physiological and paper and pencil instruments. For example, Coke, Batson, and McDavis (1978) used imagine-set and observe-set

instructions to determine differences in helping responses to a student in crisis. Using a tape-recorded plea for help, along with imagine-prompt and observe-prompt groups participants rated how likely they were to volunteer assistance to a student facing a major life crisis. Results favored increasing empathic responses also increased the motivation to meet the victim's needs. Coke et al. (1978) interpreted the relationship between empathy to helping as containing two possible dynamics: empathy acted as a cognitive factor which provided the helper with information useful in interpreting the victim's needs and empathy acted as a motivator of helping behavior. Coke et al. concluded that raising empathic emotion increased the likelihood of helping behavior no matter whether the helpers were motivated to reduce their experience of unpleasantness at the victim's plight, or whether the helper was acting in a purely altruistic desire to reduce the victim's distress.

Archer, Diaz-Loving, Gollwitzer, Davis, and Foushee (1981) pre-tested participants for levels of empathy then gave participants false galvanic skin response feedback in response to bogus radio broadcasts. The broadcasts were neutral campus announcements or student appeals for help with a crisis situation. Participants evaluated a tape recorded plea after reading a prompt instructing them to imagine how they and the target person would feel in a situation. They concluded empathy was a predictive factor in decisions to help, but social expectations also influenced decisions to help.

Batson, Batson, Slingsby, Harrell, Peekna, and Todd (1991), in a test of the empathic joy hypothesis, attempted to distinguish social rewards versus self-rewards for helping behavior. Empathic joy was defined as helping behavior given in order to share in the target person's good feelings and relief at being helped. They instructed participants via written prompts to remain objective or imagine how the target person's life was affected. They employed a bogus broadcast of campus announcements or a plea for help to adjust to a major life change. Their results failed to confirm the empathic joy

hypothesis, they found no disconfirmation that the arousal of empathy produced an increased desire to help.

Toi and Batson (1982) paired low and high empathy imagine sets with ease of escaping from the helping situation to determine egoistic versus altruistic helping motivation. Participants were given prompts to either imagine the target person's emotional situation or observe as objectively as possible. The experimental stimulus was a taped plea for help or a bogus campus announcement. Results showed participants in the observe-set manipulation only showed a high rate of helping behavior when escape from the plea for help condition was difficult. Toi and Batson (1982) also noted participants who reported subjective distress at the situation displayed egoistic helping whereas those who reported a high awareness of empathy displayed altruistic helping. Toi and Batson (1982) thus concluded empathic emotion as manipulated by the imagine-set condition produced altruistic motivation to help.

Cialdini, Schaller, Houlihan, Arps, and Fultz (1987) sought to understand the contribution of mood to helping behavior in empathically predisposed individuals. Again, low and high empathy instructions were given in conditions that were easy or difficult to escape. Participants then watched a videotape of a student who was being subjected to increasingly strong electric shocks. Personal sadness was found to be a contributing factor with awareness of social approval as an added dimension. A second study confirmed personal sadness as the primary factor which motivated a decision to help.

Dovido, Schroeder, and Allen (1990) used low and high empathy prompt conditions to determine if empathic arousal prior to making a decision to help based on a bogus broadcast would generalize to other situations. Empathically-aroused students responded with more empathy and experienced greater personal distress than observing students. But empathy remained situation-specific: empathic helping did not generalize to other situations.

The above studies generally supported hypotheses that manipulating an empathic mental-set favorably influenced college students' decisions to help a non-suicidal, troubled peer. The above researchers did not ask if arousing empathy in response to a troubled peer would impact the quality of assistance given. The quality of assistance given to a suicidal peer was of interest in the currently-proposed study.

Hypothesis

The purpose of this study was to assess undergraduate college students' ability to recognize facilitative responses on a suicide intervention inventory after exposure to an imagining prompt, an observing prompt, or no prompt. This information was sought to determine whether influencing mental-set was sufficient to improve scores on an intervention skills test that reliably distinguishes levels of helper capability.

Based on the empathy literature cited here, manipulating mental set through imagining prompts has been shown to influence students' willingness to help persons in distress. The literature on peer responses to suicidal friends supports the natural willingness of students to help, although they do not always feel secure. The literature suggests students are insecure because they often do not know if a particular response is adequate. Strengthening one's sense of being able to perform helping behaviors, providing a blueprint for intervention, alleviates this insecurity. The literature generally suggests college students possess high levels of natural empathy. However, is it feasible to train students to put empathy at their conscious disposal when assisting suicidal peers? Or is an empathic mindset, which has much face-value, actually detrimental in assisting suicidal peers? Specifically, I hypothesized college students whose empathic capabilities are aroused will show better performance on the SIRI-2 compared to an experimental group which receives the observing prompt and a control group which will not receive a prompt.

The SIRI-2 is a stable and sensitive instrument measuring paraprofessional and professional knowledge of facilitative responses to suicidal communications. These

responses were favored by a panel of suicide experts and were deemed more open to the troubled person, while responses that appealed to novices were deemed detrimental. The SIRI-2 forces one to rate the suitability of responses throughout a series of vignettes, and may be an appropriate instrument to measure the influence of mental set on recognition of facilitative responses in an untrained sample.

CHAPTER 2

METHOD

Participants

The participants were 158 lower division students (94 women, 64 men) enrolled for the Fall 1999 term at a mid sized Midwestern state university. Students were recruited via a posting on the division bulletin board. The purpose of the study was disclosed as a study about suicide. Students in the 18 through 24 year old category were invited to participate. A question on the demographics form screened students for previous suicide intervention training, which in itself is sufficient to cause better performance on the SIRI-2. Therefore, these students' results were excluded from the study.

Design

The control group consisted of 26 men and 35 women, the Observing group consisted of 15 men and 26 women, and the Imagining group consisted of 23 men and 33 women. At least 15 students were required for each group. Testing was repeated until adequate numbers were obtained.

One independent variable was type of prompt with 3 levels: no prompt, imagining, or observing. The SIRI-2 was not sensitive to gender differences (Neimeyer & Bonnelle, 1997), but it was important to determine if gender sensitivity to type of prompt existed. Therefore, the second independent variable was gender. The dependent variable was the difference between participants' scores for the 50 SIRI-2 items and the scores for the same items given by an expert panel.

Instrumentation

The instruments included an informed consent form (see Appendix A), one of two written prompts (observing prompt, see Appendix B, or imagining prompt, see Appendix C) which preceded the SIRI-2, the revised Suicide Intervention Response Inventory (SIRI-2; Neimeyer & Bonnelle, 1997; see Appendix D), and a demographic form (see

Appendix E). A typed debriefing statement (see Appendix F) was issued as students turned in their packets upon completion.

Prompts. Two written prompts, derived from Toi and Batson's (1982) and Stotland's (1969) written prompts preceded the SIRI-2 in the two experimental groups only. The imagine prompt instructed students to imagine the feelings the suicidal person, as described in the SIRI-2 items, is likely experiencing and the imagined impact on the suicidal person. The observing prompt instructed students to carefully focus only on the information provided by the suicidal person as described in the SIRI-2.

Procedure

Participants were solicited through memos sent to instructors announcing the nature of the study and participant ages sought. Traditional college students ages 18-24 were invited to participate. Sign up sheets announcing the date, time, and location of the session were provided. The test administration occurred at arranged group testing times.

Students in each group were greeted and told by the middle-aged, Caucasian, female experimenter that the study was about suicide. They were asked to imagine being the helper of suicidal people by evaluating statements a potential helper could make. No students declined to participate after the introduction. Students were asked not to discuss the project with their peers to avoid biasing answers of potential participants. Test packets were then distributed. Students were asked to sign, date, and detach the informed consent document and pass it forward. This way, participant anonymity was protected.

Directions for each group were read aloud and clarified when questions arose. Students in the control group were read the verbatim instructions for the SIRI-2. Students in the imagining prompt group were read the prompt (See Appendix B) and the verbatim instructions for the SIRI-2 (See Appendix D). Students in the observing prompt group were read the prompt (See Appendix C) and the verbatim instructions for the SIRI-2. Students in all three groups completed the demographics form lastly. Students were

dismissed upon completion of their test packets and the extra point voucher and debriefing statement were distributed.

CHAPTER 3

RESULTS

A total of 176 students responded to the testing announcements. Three test packets were rejected for students who exceeded the age-range, three were rejected for giving inappropriate, unrelated responses on the demographics questionnaire, two for not following directions in the SIRI-2 ratings, and ten test packets were rejected for prior suicide prevention or intervention training. A total of 158 students (men = 41%, $n = 64$; women = 59%, $n = 94$) were included in the data analysis.

A 2 x 3 ANOVA was employed with gender (men or women) and prompt (no prompt, observing, or imagining) as the independent variables and total SIRI-2 score as the dependent variable. Results of this analysis revealed significance for gender, $F(1, 152) = 7.71$, $p < .01$. The women ($M = 85.95$, $SD = 22.21$) did better than the men ($M = 95.60$, $SD = 21.52$) on the SIRI-2.

There was nonsignificance for prompt, $F(2, 152) = 1.71$, $p = .31$, and the gender by prompt interaction, $F(2, 152) = .43$, $p = .65$. Mean SIRI-2 scores for gender, prompt, and gender by prompt are shown in Table 1. Five percent of the variance in this study was accounted for by gender (Eta squared = .05).

Table 1

Means and Standard Deviations of SIRI-2 by Gender, Prompt, and Gender by Prompt

	Men		
	M	SD	n
Control	96.85	20.97	26
Imagining	93.06	20.88	23
Observing	97.34	24.46	15
Total	95.60	21.52	64

	Women		
	M	SD	n
Control	91.15	26.22	35
Imagining	82.37	19.53	33
Observing	83.48	18.70	26
Total	85.95	22.21	94

	Combined Men and Women		
	M	SD	n
Control	93.58	24.10	61
Imagining	86.76	20.60	56
Observing	88.55	21.76	41
Total	89.86	22.37	158

Note. Lower means indicate better performance. N = 158

CHAPTER 4

DISCUSSION

The purpose of this project was to determine if differences in SIRI-2 performance could be manipulated based on participants adopting either a low or high empathy response set when encountering a hypothetical suicidal person. College students willingly responded to pleas of help (Lawrence & Ureda, 1990; Wellman & Wellman, 1986). Gender differences among college students in response to suicidal peers exist (Wellman & Wellman, 1986; White & Stillion, 1988). Specifically women tend to be sympathetic to suicidal peers of both genders, whereas men withheld sympathy from suicidal peers (White & Stillion, 1988). No age or gender differences when college students were obtained with the SIRI-2 (Neimeyer & Bonnelle, 1997).

SIRI-2 performance could be systematically improved through intervention training (Inman et al., 1994; Neimeyer & Bonnelle, 1997; Neimeyer & MacInnes, 1981; Neimeyer & Pfeiffer, 1994; and Norton et al., 1989). In fact, untrained college students who were exposed to campus intervention education demonstrated improved scores on the SIRI-2 (Abbey, Madsen, & Polland, 1989). Based on these sources, SIRI-2 scores would be less likely to improve except under intervention training conditions.

College students, however, were not assessed for the effects of an empathic mindset on selecting the quality of facilitative responses to a suicidal person. Examples of hypothetical suicidal individuals as well as facilitative versus non-facilitative responses could be found in the SIRI-2. This project hypothesized adopting an empathic orientation toward a hypothetical suicidal person would result in a higher quality of verbal assistance from college students, which would be displayed as improved SIRI-2 performance. Empathy, as an effective cognitive and emotional organizer (Coke et al., 1978; Stotland, 1969) was hypothesized as the factor which would produce a difference between groups.

The arousal of empathy, as manipulated in this study, did not improve SIRI-2 performance. No differences in SIRI-2 performance between prompt groups or the

interaction could be detected. However, a significant gender difference in SIRI-2 scores was found. Women obtained significantly better scores on the SIRI-2 than men, whereas Neimeyer and Bonnelle (1997) obtained no gender difference. These results, however, do tend to support the literature which points out gender differences can be seen in college students' responses to suicidal peers. A valid question to be explored would be why did previous studies fail to find a gender difference when this study did? Could this study have been flawed in producing gender differences that more experienced researchers did not find, or were earlier studies flawed in some way?

Neimeyer and Bonnelle (1997) used older participants (mean age 33) who were nevertheless categorized as introductory psychology students. The present study used 18 to 24 year olds, an age range more traditionally associated with introductory psychology students. This suggests gender may not be the significant factor, rather maturation. What accounts for the smoothing out of scores as participants mature? It is unlikely women lose their natural ability to empathize as they mature. As men mature, do their responses on the SIRI-2 grow to resemble responses made by women? White & Stillion, (1988) state that women respond more sympathetically to troubled peers, choosing affiliating and relationship-building over stigmatizing and judging, which are reactions more common to men. In the present study, women may simply have demonstrated natural competence to relate to troubled individuals. Even though a significant gender difference was found in the present study, it was not strong. Generalization of these findings is discouraged and the likelihood of the above speculations to produce significant results in further studies is very limited.

Determining the degree of responses to prompts may be crucial. For example, Batson et al. (1991) used adjective checklists as post measures to assess prompt effectiveness. This simple follow-up measure would have eliminated a lot of doubt in the present study. In addition, Batson et al. used seemingly more effective prompts than this researcher. Tape recorded or video-taped prompts, in combination with longer, more

detailed scenarios may have made stronger impressions on students. Although the SIRI-2 may have proven inappropriate, this researcher felt frustrated by the literature which depended on "home-made" instruments. The possibility of the SIRI-2 being ill suited to detect effects of the prompts is a strong possibility, regardless of its reliability as an instrument. The scenarios were brief, and students may have had difficulty making effective responses.

The empathy studies cited above used student self-reports of willingness to help troubled peers, which is a different issue than assessing the quality of intervention. Thus, such prompts may have been ineffective in a situation which required more complex judgment.

Additional concerns may include the order in which students encountered prompts and SIRI-2 instructions. It is possible the prompts, which were read first, were disregarded in favor of the SIRI-2 instructions. Conversely, the more difficult SIRI-2 instructions may have caused students to focus on the easier to understand prompts instead.

Future research. Since the SIRI-2 measures complex intervention skills, of which empathy is likely only a part, generalization of these results is not advised. The role of adopting an empathic mindset in organizing effective responses to suicidal persons, as measured on the SIRI-2, remains unanswered by this study. This study may have stretched the practical limits of the prompts. The SIRI-2 may not have been the appropriate instrument for this study. Future researchers may wish to find or create an instrument that is reliable, but that measures the contribution of empathy to facilitative responding to suicidal messages. At any rate, this study should at least be repeated with an effective way to determine whether empathy was aroused. If such a study can prove the arousal of empathy and the SIRI-2 scores remain the same, then finding a more suitable instrument would be the next focus.

This study was suggested by the present researcher's questions after encountering suicidal students in a campus counseling situation while lacking specific training in facilitative responding to suicidal messages. The dilemma of whether to adopt an empathic mindset or an observational one in handling each case was the basis of this project. Perhaps a naive reaction to this dilemma was to develop such an either-or mindset. Results which determine without a doubt whether an empathic or an observational mindset is more facilitative in reality may never be forthcoming. Can this question be practically answered?

Questions posed by the SIRI-2 itself may stimulate some interesting research questions. For example, it seemed the facilitative responses invited or demanded a reaction or answer from the client. Does this place clients under a type of pressure that is actually healthy? One may imagine a suicidal person to be very fragile and to place demands may seem cruel. Or, is this just the medicine needed? What part does applying pressure in keeping the client engaged in the discussion play? Is it wise to empathically couch demands placed on the suicidal client, and does that elicit their decision to abandon suicidal plans or feelings? Again, these questions seem to take an either-or approach to a very complex subject.

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APPENDIX A

Participant Consent Form

Participation Consent Form

Please read this consent form. If you have any questions, ask the experimenter and she will answer the question.

You are invited to participate in a study investigating suicide. You will be allowed ample time to complete the questionnaire.

You will not be identified as a participant in this study. Your answers will remain separate from this signed consent form, therefore your identity cannot be discovered.

Your participation in this study is completely voluntary. Should you decide to terminate your participation, you are welcome to do so at any time with no adverse effects on your class standing.

If you have any questions or comments about this study, please raise your hand.

Thank you for your participation.

I, _____, have read the above information and
(please print name)
and have decided to participate. I understand that my participation is voluntary. I understand I may withdraw at any time without prejudice after signing this form should I decide to discontinue participation in this study.

_____ _____
(Signature of participant) (Date)

THIS PROJECT HAS BEEN APPROVED BY THE EMPORIA STATE UNIVERSITY COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS.

APPENDIX B

Imagining Prompt Instructions

The following questionnaire presents some conversations between a suicidal person and a helper. You are to play the part of the helper. While you are reading each conversation, try to imagine the perspective of the suicidal person, imagining how he or she feels about what is happening and how it has affected his or her life. Try not to concern yourself with attending to all the information presented. Just concentrate on trying to imagine how the person in the example feels.

Now, turn the page and read the instructions.

APPENDIX C

Observing Prompt Instructions

The following questionnaire presents some conversations between a suicidal person and a helper. You are to play the part of the helper. While you are reading each conversation, try to attend carefully to the information presented by the suicidal person. Try to be as objective as possible, carefully attending to all the information the person presents about the situation and about the person. Try not to concern yourself with how the person is feeling. Just concentrate on being objective about the information in each conversation.

Now, turn the page and read the instructions.

APPENDIX D

Revised Suicide Intervention Response Inventory (SIRI-2)

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

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

1. <u>Client:</u> I decided to call in tonight because I really feel like I might do something to myself...I've been thinking about suicide.
   _____ A. You say you're suicidal, but what is it that's *really* bothering you?
   _____ B. Can you tell me more about your suicidal feelings?

2. <u>Client:</u> 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.
   _____ A. Try not to worry so much about it. Everything will be all right.
   _____ B. You must feel pretty lonely and afraid of what might happen.

3. <u>Client:</u> But my thoughts have been so terrible. . . I could never tell them to anybody.
   _____ A. You can tell me. I'm a professional and I have been trained to be objective about these things.
   _____ B. So 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. <u>Client:</u> 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.
   _____ A. It seems like you've been suffering so much that cutting your wrists is the only way you can make the pain go away.
   _____ B. But you're so young, you have so much to live for. How can you think of killing yourself?

CONTINUED

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.
_____ A. So you're wondering if I can understand how you feel.
_____ B. You're not even giving me a chance. I've had a pretty rough life too; you're not the only one who's seen some hard times.

6. Client: My life has been worthless ever since my wife, Emma, died a 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.
_____ 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?
_____ B. It sounds like everything just collapsed around you 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].
_____A. It must be hard for you to talk about what's bothering you.
_____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.
_____ A. See, it really isn't so bad after all. It certainly isn't anything you would think of killing yourself over, is it ?
_____ B. Sometimes talking about problems does make them a bit clearer. I think you realize 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.
_____ A. I'm sorry. I was only trying to help.
_____ B. You sound pretty angry.

10. Client: How could you ever help me? Have you ever wanted to kill yourself?
_____ A. It sounds like you're concerned about whether I can understand and help you.
_____ B. Sure, I've thought about suicide sometimes. But I always found more realistic solutions to my problems.

CONTINUED

11. Client: I don't know . . . this whole thing with my wife really gets me [sobs]. I try so hard to keep from crying . . .

_____ A. Do you think the reason it's hard for you to cry is because you're a man?

_____ 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.

_____ A. Things have gotten so bad, that it's difficult to see any meaning in the things that have happened to you.

_____ 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 . . .

_____ 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.

_____ 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.

_____ A. Okay, but if you keep feeling suicidal, remember you can always call back.

_____ B. All right, but first I want you to promise me you won't do anything to hurt yourself, until you call and talk to me. Will you repeat that promise?

15. Client: Is it really true that many people feel this way? I thought I was the only one who had such dreadful, sinful ideas.

_____ 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.

_____ B. It's 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.

CONTINUED

16. Client: I'm so lonely, so tired [crying]. There just isn't anywhere left to turn.
_____A. You seem so alone, so miserable. have you been feeling suicidal?
_____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 . . .
_____ A. Would it help if I asked questions?
_____ 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!
_____ A. You seem to be somewhat upset.
_____ B. I want you to put down the gun so we can talk.

19. Client: Why should you care about me, anyway?
_____ A. I've been trained to care about people. That's my job.
_____ B. Because I think your death would be a terrible waste, and it concerns me that things are so 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.
_____ A. You must really be angry at him for not being there when you need him most.
_____ 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.
_____ A. It sounds like you're feeling pretty isolated.
_____ B. Why do you think that no one cares about you any more?

22. Client: I tried going to a therapist once before, but it didn't help . . . Nothing I do now will change anything.
_____ A. You've got to look on the bright side! There must be something you can do to make things better, isn't there?
_____ B. Okay, so you're feeling hopeless, like even a therapist couldn't help you. But has anyone else been helpful before--maybe a friend, relative, teacher, or clergyman?

CONTINUED

23. Client: My psychiatrist tells me I have an anxiety neurosis. Do you think that's what's wrong with me?

_____ A. I'd like to know what this means to you, in this present situation. How do you feel about your problem?

_____ 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.

_____ A. That isn't true. There are probably lots of people who care about you if you'd only give them a chance.

_____ B. It must be difficult to find help when it's so hard to trust people.

25. Client: [Voice slurred, unclear over telephone]

_____ A. You sound so tired. Why don't you get some sleep and call me back in the morning.

_____ B. Your voice sounds so sleepy. Have you taken anything?

PLEASE TURN THE PAGE

APPENDIX E

Demographics Questionnaire

Instructions: Please respond to the following questions as honestly as possible. Fill in the blank or circle your selection.

1. What is your gender? Male Female

2. What is your age? _____years.

3. What is your classification? (circle one) FR SO JR SR GRAD

4. Have you ever received any suicide prevention training? YES NO

PLEASE TURN IN YOUR PACKET NOW AND THANK YOU FOR YOUR PARTICIPATION!

APPENDIX F

Debriefing Handout

Thank you for your participation in this study. Your thoughtful responses will assist me to learn more about how to help suicidal people. This study required you to play the role of a helper and respond to statements a suicidal person could make. The questionnaire you answered did not contain any right or wrong answers. The way you as a unique individual responded is valuable in this study.

Please refrain from discussing this testing session with your friends in order not to influence their reactions should they participate in this experiment.

TO: All Graduate Students Who Submit a Thesis or Research Problem/Project as Partial Fulfillment of The Requirements for an Advanced Degree

FROM: Emporia State University University Graduate School

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