AN ABSTRACT OF THE THESIS OF

John F. Gilbert for the Degree of Master of Science

in Psychology presented on December 17, 1982

Title: THE RECOGNITION OF SUICIDE LETHALITY FACTORS BY MASTERS AND DOCTORAL LEVEL CLINICAL PSYCHOLOGISTS

Abstract approved: Cooper B. Holmes

This study was an investigation of the ability of masters and doctoral level clinical psychologists to recognize several factors indicative of suicide lethality.

Suicide lethality factors employed in this study were obtained directly from the Suicide Potential Rating Scale. The scale consists of ten factors that were empirically derived and developed by the Los Angeles Suicide Prevention Center. These factors were found by the personnel at the Suicide Prevention Center to differentiate successfully lethal from non-lethal attempters.

The subjects in the study (43 masters level psychologists and 30 doctoral level psychologists) completed a thirteen item, four-alternative, multiple-choice questionnaire based on the factors from the Suicide Potential Rating Scale. Analysis of variance revealed that

there was no main effect for years of professional experience and type of degree and no significant interaction effect (i.e., there was no significant difference in the ability of the experimental groups to recognize suicide signs). Specific comparisons are also presented and analyzed. Possible reasons for the results of the study are discussed.

THE RECOGNITION OF SUICIDE LETHALITY FACTORS BY MASTERS AND DOCTORAL LEVEL PSYCHOLOGISTS

A Thesis

Presented to

The Department of Psychology

EMPORIA STATE UNIVERSITY

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

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by

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December, 1982

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ACKNOWLEDGEMENTS

The author of this thesis wishes to express his gratitude and respect to Dr. Cooper B. Holmes, my advisor, for his willingness to share his professional expertise and knowledge. Without his beneficial advice and counsel this study could not have been completed.

I would also like to express a word of thanks to Dr. Jeffrey H. Bair and Dr. David Dungan for serving on my thesis committee. Their professional judgements and constructive criticisms were most helpful in preparing the final draft.

My gratitude must also be extended to Dr. Ray G. Heath for his friendship, continuous support and generous assistance during my graduate level studies.

Special recognition should be extended to my siblings, Richard C. Gilbert and Theodore J. Gilbert and Ellen Ann Farrar, for providing me with the impetus needed to undertake and complete my college level studies. A sincere word of thanks should also be extended to Cindy Lynn Phillips. Her friendship, love and unique individuality has made life's successes more pleasurable and it's defeats a little more palatable.

Finally, I am most grateful to my mother for her love, support and understanding during my many years of study.

CONTENTS

CHAPTER 1

INTRODUCTION

Suicide, defined as the act or instance of intentionally killing oneself, should be a primary concern of all health and mental health professionals. Various research studies have been conducted on the ability of several professional and non-professional groups to recognize empirically derived factors indicative of the suicidal person (e.g., physicians, psychiatrists, doctoral psychologists, social workers, counselors, clergymen, psychiatric nursing assistants, first year medical students, and college students). Since a substantial number of the professional staff in the community mental health centers of our country are composed of masters level psychologists it is evident that the researchers have not dealt with a large and important group of persons who come in contact with the suicidal individual. The present study is an attempt to rectify this situation by conducting an investigation into the ability of masters level psychologists versus doctoral level psychologists to recognize suicide signs (see chapter two).

Upon reviewing the Vital Statistics of the United States for the last available ten year period (1969 to 1978) it was found that on the average suicide claimed the lives of 26,000 persons annually. Furthermore, for many years suicide has been ranked among the top ten causes of death by the United States Department of Health and Human Services. Statistics on attempted suicides are not officially kept by our federal government, thus it is hard to procure an accurate figure. However,

Farberow and Shneidman (1965) found that the most widely accepted estimate on attempted suicides is around six times the number of committed suicides. Practitioners in the field of mental health have essentially operated in the dark by relying upon theories and hypothesis in order to discern and identify potential suicidal persons.

It is safe to assert that health and mental health professionals have met with relatively little success in the diagnosis and management of the suicidal individual. Thus, in the past decade or so there has been a resurgence of interest in the recognition and treatment of the suicidal patient. This has prompted researchers in the field of suicidology to assemble a list of factors or characteristics of lethal suicide attempters. One such attempt has been the Suicide Potential Rating Scale (Litman and Farberow, 1965). The review that follows presents the items on that scale and the research supporting their importance in predicting suicide.

AGE, SEX AND MARITAL STATUS:

Researchers of suicidology determined the factors of age, sex and marital status correlate with suicidal behavior. Cohen, Motto and Seidan (1966) studied 193 persons who had been hospitalized after making a suicide attempt. The authors rated the subjects on twenty-two factors thought to be indicative of suicide. Results of the follow-up study showed that fourteen factors landed in the predicted direction. Of these, age, sex and marital status were found to be valid prognostic factors in predicting suicidal behavior. The high risk groups were males, persons advanced in age (especially persons 45 years of age and older), and those persons who are separated, divorced or widowed.

Tuckman and Youngman (1963a) conducted a study using data from police reports on 1,112 persons who attempted suicide. Their findings were consistent with the Cohen, Motto, and Seidan study in as much the factors of age and sex were found to be significant indicators of suicide. Results showed that persons forty-five years or older, and men were in the high-risk group, whereas women and persons under forty-five were in the low-risk group. Other findings indicated that the females attempted suicide five times more often than the males, but males were more likely to succeed.

In a second study by Tuckman and Youngman (1963b) it was determined that the marital status factor was a statistically significant indicator of lethality potential. The high-risk group was composed of separated, divorced or widowed persons, whereas the low-risk group was made up of single or married persons.

In another study conducted by Tuckman and Youngman (1968) they developed a scale for assessing suicide risk. Using data from the previous studies, eighteen factors were investigated. Seventeen factors were retained on empirical grounds since they could show a differentiation in suicide rate between high and low-risk categories. The authors computed the suicide rate per 1,000 population among 3,800 attempted suicides studied. The results of this study provided further evidence for the factors of age, sex and marital status as related to suicide. Once again the high-risk categories were men rather than women; 45 years of age or older; and separated, divorced, or widowed. In a follow-up study of 886 serious attempters Rosen (1970) concluded that there was no appreciable difference in the suicidal behavior of men and women. Nevertheless, he did find supportive data for the age and marital status

factors in connection with suicide. The high-risk groups were persons over forty years of age and those who are separated or widowed.

In a review of the literature conducted by Davis (1968), it was consistently found that females attempt suicide at a greater frequency than do men and that men commit suicide more often than women. For both committed and attempted suicide, men were found to be older and tended to use more violent and lethal methods. Lester (1969) in his literature review corroborated these findings on the suicidal behavior of men and women. Yap (1958) in his study on suicide in Hong Kong found that Chinese men completed suicide more often than women, whereas females attempted suicide nearly twice as often as men do. Spalt and Weisbuch (1972) found support for the age factor in their retrospective and analytical study of eighteen suicides, eighteen matched controls, and thirty random controls. The authors noted a distinctive increase in suicides for the age group from forty-one to fifty. Seventy-five percent of Tuckman and Lavell's (1958) 742 successful suicides were men.

In a study conducted by Gardner, Bahn, and Mack (1964) on the cumulative psychiatric case register of Monroe County, New York, with specific reference to the older population (55 years old and above) it was found in the three year period of 1960 to 1962 that the completed suicide rates were higher for males (13.8%) than for females (6.0%). A particularly high rate of suicide was noted for males 65 years of age and over. However, in reference to attempted suicide rates for persons age 55 and below the inverse was observed, with females attempting suicide twice as often as males. Furthermore, the successful suicides were found to be over 55 years of age and either single, divorced, separated or widowed. Dorpat and Ripley (1974) reported in their review that men outnumber

women two to one in completed suicides, thus supporting the sex factor in the favor of the men as being indicative of high suicide potential. The authors noted that the mean age of those who attempt suicide is in the early 30's age range. In contrast, the mean age for those who commit suicide is around age 50. The marital status factor was also found to be indicative of greater suicide risk. Once again the high-risk groups are separated, divorced, or widowed persons.

Modlin (1971) in his review of the literature reported that social data, which are usually available to the professional, indicates that risk of suicide rapidly increases with age, and is particularly high after age 45, especially for men. His findings indicated that three of four suicides are successfully completed by men, whereas three of four unsuccessful attempts are by women. The incidence of suicide increases further among those individuals who are either divorced, widowed or live alone.

Miskimins, DeCook, Wilson, Maley, and Dean (1967) conducted a research study that utilized matched pairs. The experimental group consisted of 17 patients who had committed suicide while in a psychiatric hospital. The control group consisted of non-suicidal patients who were matched with the experimental group on the basis of several demographic variables. Upon analyzing the data the authors empirically derived 20 items that formed the Suicide Potential Scale (SPS). Age, sex and marital status were found to be statistically significant factors that proved to be valid indicators of suicide potential. The high-risk groups were males, most notably males between the ages of 40 to 60.

Wold (1970) reviewed and analyzed the accumulated records on more than 26,000 persons who had contacted the Los Angeles Suicide Prevention Center. After reviewing this large amount of data, he selected a random sample of 984 non-suicide cases (SPC patients). A second sample of forty-two individuals who committed suicide were then selected (patient-suicides). Results of the study showed that only one-third of the SPC patients were men, whereas sixty-four percent of the patient-suicides were men. The patient-suicides tended to be older than the SPC patients. In short, the general patient population tended to be younger and mostly women, whereas the successful suicides tended to be men and older. Concerning marital status factor there was no significant difference between the two samples.

Litman (1970) in his follow-up study of 238 randomly selected Suicide Prevention Center patients matched with a random sample of 50 committed suicides, found that sixty percent of the lethal suicides were men. Further analysis of the data demonstrated support for the age and sex factors involved in suicide potential. Comparisons of the samples indicated that the 238 Suicide Prevention Center patients were more youthful and contained a higher percentage of women, whereas the committed suicide group tended to be older and had more male members (sixty percent were men).

Farberow and Shneidman (1965) conducted a comparative study of persons who attempted suicide and those who committed suicide in Los Angeles County during the year 1957. The results showed males to be disproportionately higher than females for committed suicides (70% males, 30% females), whereas females outnumbered males two to one in attempted suicides. In short, males attempted suicide less frequently than females,

however, males sucessfully completed suicide more often than did females. In respect to the age variable, both sexes had a modal age of forty-two in the committed suicide group; however, in the attempted suicide group the peak occured at age twenty-seven for females and age thirty-two for males. The authors noted for persons in the 60 and above age range that although attempts are fairly rare, successful suicides appear to be commonplace. The ratio of committed versus attempted for this age range is four to one. Thus, the older the individual, if he is contemplating suicide the consequences of his suicidal behavior becomes extremely lethal. It is of interest to note that even in upper age groups, eighty and above, that males kill themselves more often than do females. In this study married persons contributed proportionately less than their share to both suicide attempts and commits. However, the divorced, separated and widowed groups contributed proportionately more than their share to the successful suicide group.

RACE:

The demographic variable of race has been considered, for quite some time, to be an important factor in determining suicide potential. Many researchers have found the race factor to be highly significant in helping to determine the lethality of a suicidal individual. Farberow and Shneidman (1965) in their research study on suicide in Los Angeles County, found that out of every ten persons who committed suicide nine were white. Blacks accounted for only three percent of the committed suicides. The findings for the attempted suicides also showed a high proportion of whites, although it was slightly lower than the committed suicides. However, blacks attempted suicide more often than they committed it.

In a study of 1,112 consecutive suicide attempts by persons 18 years and over, Tuckman and Youngman (1963a) concluded that whites were in a higher risk group than nonwhites. In a study by Tuckman and Youngman (1968), they used the entire sample of the original 1963 study, which consisted of 3,800 consecutive suicide attempts by persons age 18 and over. A follow-up study was then conducted on the entire sample to determine the number of persons who subsequently committed suicide. The data revealed that 48 individuals went on to successfully complete suicide. The 3,800 cases were then classified into high and low-risk groups. Statistical analysis of the data showed the race factor to be significant in differentiating high and low-risk suicides. Results showed that whites made up the high-risk category, whereas the low-risk category consisted of nonwhites.

Modlin (1971) concluded in his review of the literature that the suicide rate for the white population is four to six times higher than that of the black population. In a review of the literature conducted by Dorpat and Ripley (1974) it was ascertained that the whites had a greater suicide risk. In a study of 193 hospitalized suicide attempters, Cohen et al. (1966) found the race factor to be a valid prognostic factor in predicting high-risk suicides. In this study, Caucasians constituted the high-risk category.

In contrast to the previously mentioned studies, Wenz (1978) administered a Suicide Potential Scale to a stratified sample of persons in the city of Flint, Michigan. The purpose of the study was to ascertain whether high suicide potential is more indicative of the white population or the black population. Statistical analysis of the data displayed no appreciable difference in the scores for both races within the total

sample population. Nevertheless, blacks did score slightly lower in suicide potential than did whites, but the difference was considerably smaller in comparison to the previous studies on suicide potential. Wenz concluded that economic status rather than race appeared to be a more valid factor in the determining of suicidal potential.

HELPLESSNESS/HOPELESSNESS, ANXIETY, DEPRESSION AND ALCOHOLISM:

The psychological variables of helplessness/hopelessness, anxiety and depression have been determined by many researchers to correlate highly with suicide potential. Of the aforementioned variables, depression appears to be the most significant in predicting suicide lethality, nevertheless not all suicides are depressed. In addition, alcoholism also correlates to a significant degree with suicide. In a progress report on the Los Angeles Suicide Prevention Center, Litman, Shneidman and Farberow (1961) found high suicide potentiality to be particularly associated with severe depression, anxiety and alcoholism.

Golden (1978) in his clinical model of suicide assessment pointed out that both direct and indirect communications of feelings of hopelessness and/or depression are serious signs of suicide potential. A history of alcoholism was considered by the author to be another danger signal of suicide lethality. In his review of training in suicide prevention, Heilig (1970) felt that expressions of helplessness and hopelessness were important variables in delineating serious or successful attempters from non-serious ones. Litman (1966) in his assessment of the acutely suicidal patient found severe depression and feelings of helplessness/hopelessness to be serious danger signals in the patients he dealt with.

In Fawcett's (1973) review of studies on completed suicides he found that nearly all of the subjects demonstrated a diagnosable psychiatric

illness. Clinical depression, alcoholism and schizophrenia were the most common diagnoses. Fawcett concluded that suicidal persons tend to emphasize vague physical symptoms which often cover up a depressive state. Litman (1970) in his follow-up study of 238 Suicide Prevention Center patients matched with 50 committed suicides found that depression was the major psychological symptom for both groups. Alcoholism, another factor associated with suicide, was more prevalent in the committed suicide group.

Wold (1970) in his study of 26,000 SPC patients found that ninety-two percent of the forty-two completed suicides were seen as clinically depressed prior to taking their lives. In this study thirty-one percent of the successful suicide group were alcoholics. Cohen et al. (1966) in their study of 193 hospitalized attempters found alcoholism to be a valid prognostic factor in predicting suicide. The findings of Rosen's (1970) study indicated a significant difference between the serious and non-serious attempters. The serious attempters were found to be more depressed than the non-serious counterparts.

Modlin (1971) in his literature review cited a study on successful suicides in which depression was the major factor involved in half of the cases studied. Modlin noted that other indicators of a potential suicide may be feelings of helplessness and hopelessness, anxiety and feelings of worthlessness. Furthermore, he found that chronic alcoholism may also be an indicator of high-risk suicide potential.

Dorpat and Ripley (1960) conducted a study of 114 successful suicides. Their findings indicated that all of the subjects displayed clinical symptoms of depression. Many of the subjects had a clinical diagnosis of depression while the remaining subjects suffered from a

depressive mood. It is interesting to note that further findings indicated that the common diagnosis in the forty to sixty age range was alcoholism. In a literature review by Dorpat and Ripley (1974) the authors concluded that if an attitude of helplessness or hopelessness is present in depressed patients the risk of suicide increases dramatically. In a review of suicide rating scales, Engelsmann and Anath (1981) found that persons with high risk suicide potentiality tend to display the psychological symptoms of anxiety and depression.

Tuckman and Youngman (1963b) in their study of suicide risk groups among 1,112 attempted suicides found that nervousness and alcoholism were characteristic of high-risk suicidal persons. Tuckman and Youngman (1968) found support for their earlier conclusions in a follow-up study of 3,800 attempters. Results indicated that nervousness and alcoholism were more prevalent in the high-risk group. Gardner et al. (1964) found that seventeen percent of their successful suicides had a history of alcoholism. Tuckman and Lavell (1958) found similar figures in their study of 742 successfuls.

Chynoweth, Tonge and Armstrong (1980) in their retrospective, psychosocial study on 135 consecutive suicides found that a depressive illness was a major contributing factor in fifty-five percent of the suicides. Miskimins et al. (1967) in a study of seventeen successful suicide patients matched with seventeen non-suicidal patients found the psychiatric characteristic of depression to be a valid factor in the predicting of those individuals who would subsequently commit suicide. In a follow-up study conducted by Miskimins and Wilson (1969) fifteen committed suicides were compared with thirty randomly selected non-suicidal patients. Results indicated that the variable of depression

was found to be highly effective in differentiating suicidal persons from non-suicidal persons, thus, providing further evidence for the psychological variable of depression as a valid factor in helping mental health professionals determine suicide potentiality.

Conte and Plutchik (1974) in their study of thirty attempters and thirty matched controls administered the subjects a Personal Information Form designed to elicit clinical data. Results showed that the suicidal patients scored significantly higher on the depression related items. Barraclough, Bunch, Nelson and Sainsbury (1974) in their study of one hundred successful suicides noted that eighty-five percent suffered from depression and/or alcoholism. Farberow and McEvoy (1966) studied forty-three successful suicides and forty-three similarly diagnosed controls and found that the successful suicides were characterized by markedly higher levels of depression and anxiety.

Motto (1969) in his literature review of completed suicides found alcoholism and depression to correlate highly with the more serious and successful suicides. In a study conducted by Beck, Kovacs and Weissman (1979) on ninety patients who were hospitalized for suicidal ruminations, it is worth noting that the majority of the patients received a primary diagnosis of depression.

Wilkins (1970) in his follow-up study of persons who called the Chicago Suicide Prevention Center found that over half of those who subsequently committed suicide were alcoholics. He concluded that alcoholism should be considered a long-term as well as immediate agent for suicide. Ten percent of Tuckman and Lavell's (1958) 742 successful suicides were reported to have had a history of alcoholism.

THE PRESENCE OF AN IMMEDIATE STRESS:

A factor considered by many researchers to be indicative of serious suicide lethality is the presence of an immediate stress. For example, the death of a loved one, losing one's job, or some other crisis in one's life would constitute an immediate stress. Many studies have gathered a great deal of data in support of this factor under a variety of research conditions. Several of the available studies are mentioned in this section of the text. In his review of the literature, Litman (1966) found that if the suicidal crisis is a reaction to an overwhelming, sudden stress the chances for a lethal attempt increase. Conte and Plutchik (1974) found a significantly greater percentage of their suicidal patients reported that a sudden stress occurred just prior to their serious attempt. Farberow and Reynolds (1971) conducted a study on seventy cases of completed suicide. The cases were randomly selected from the completed male suicide records of neuropsychiatric patients at a Veterans Administration Research Unit. A total of 500 cases were reviewed of which fifty were classified as clearly dyadic, that is, the crisis was precipitated by disruption of interpersonal relations, and twenty cases were classified as nondyadic (control group). The findings indicated that the dyadic suicide group showed a markedly disordered pattern in social relationships. Further findings showed that a majority of the subjects in the dyadic group were either suppressed or rejected by significant others when they were young and many were extremely dependent in a number of areas. Results of the study demonstrated support for the immediate stress factor as an important indicator of suicide lethality.

Wold (1970) found that immediate stress was present in forty-four percent of the forty-two successful suicides that he studied. In a

study of 193 suicide attempters, Cohen et al. (1966) found that the suffering of a recent loss was considered to be a valid prognostic factor whether the loss was real, threatened or fantasized. Miskimins and Wilson (1969) also found recent loss to be of prognostic value.

Rosen (1970) concluded that patients who had recently separated from or suffered a death of a loved one had a high rate of serious suicide attempts. In his review of the Los Angeles Suicide Prevention Center's assessment methods, Heilig (1970) concluded that the presence of immediate stress was foremost in callers who were successful or serious suicide attempters. Spalt and Weisbuch (1972) found similar results in their retrospective, analytical study of suicides in Jessamine County, Kentucky from 1963 to 1967. Results demonstrated that the immediate stress involved in the loss of a loved one was one of several factors that correlated most significantly with high-risk suicide potential.

Mikawa (1973) in his analysis of suicidal behavior concluded that persons who commit or attempt suicide are involved in various modes of coping with the stressful situations. Litman (1970) in his comparative study of 238 suicidal cases and fifty completed suicides found fifty percent of the successful suicides were under immediate stress prior to killing themselves.

ACUTENESS OF SYMPTOM ONSET:

Suicidal symptoms of an acute nature are most often extremely stressful to an individual and can lead to a fatal terminus. Acuteness of symptom onset is regarded by researchers in the field of suicidology to be a valid factor in prognosticating suicide lethality. Wold (1970) in his comparative study of 984 non-suicide Suicide Prevention Center patients and forty-two patients who subsequently committed suicide

found that forty-four percent of the suicided group had experienced an acute stress. Litman (1966) in his review of the literature found that about five percent of the successful suicides are a result of an acute stress such as a blind panic reaction in an individual's life situation. Rounsaville and Weissman (1980) found that their serious attempters encountered an acute stress in their lives when a fatal suicide attempt claimed the life of an individual close to them. Analogous findings were obtained by Peck (1965) in his study of successful suicides. Litman (1970) in his follow-up study of 238 non-suicide Suicide Prevention Center patients matched with fifty committed suicides found that most of the suicides were non-chronic in their problems and fifty percent had experienced an acute stress prior to their lethal attempt.

DEFINITE PLAN OR METHOD OF COMMITTING SUICIDE:

If an individual has a definite plan or has chosen one of the more lethal methods the effectiveness of the suicidal behavior increases quite rapidly. Farberow and Shneidman (1965) noted that the degree of lethality is directly related to the method of suicide. For example, if the suicidal individual proposes to kill himself by aspirin ingestion, cold pills, or slow acting sleeping pills then the effectiveness for suicide decreases, whereas the effectiveness increases if the patient proposes to use a gun against himself, jump from high places, or ingest large amounts of fast acting sleeping pills, such as pentobarbital or secobarbital. The lethality of suicidal behavior increases drastically if the individual has a definite plan to commit suicide, i.e., he has selected a specific time and place. Studies dealing with this variable are somewhat sparse, nevertheless the studies

that are available provide strong evidence in support of this factor. Wollersheim (1974) in a study on the assessment of suicide lethality, stated that a primary indicator of lethality in a suicidal client focuses on the degree to which the client has or is considering plans for carrying out suicide. It appears evident when the individual moves the suicidal rumination out of the fantasy stage and into the realistic planning stage that he becomes a more serious suicide risk.

Golden (1978) in his clinical model of suicide assessment came to essentially the same conclusions. He stated in his study that "the degree of suicide planning the patient has done is one of the most reliable indicators of true suicidal intent" (p. 1224). A specific and highly detailed suicide plan such as, deciding upon a time of day, a place and making out a will would indicate high-risk suicide intent. Vague generalizations such as, "Oh maybe someday I'll jump off a bridge," would indicate less seriousness of intent. Cohen et al. (1966) and Tuckman and Youngman (1963b, 1968) also found method of suicide to be of prognostic value.

SOCIAL ISOLATION:

The variable of social isolation is considered by many researchers in the field of suicidology to be helpful in predicting the lethality of a suicidal individual. In essence, when a suicidal individual is socially isolated from friends and relatives the probability for a fatal suicide attempt increases substantially. Engelsmann and Ananth (1981) in their review of the development and current state of suicide rating scales found that persons with high risk suicide potentiality tend to be socially isolated. In her review of the literature Trout (1980)

concluded that social isolation appears to be related to suicidal behavior in a direct and fundamental way.

Rosen (1970) in his epidemiological study and follow-up of 886 patients found the factor of social isolation to be statistically significant in predicting individuals with a lethal potential for suicide. In his study on suicide in London, England, Sainsbury (1956) found that the suicide rate was directly related to social isolation. Spalt and Weisbuch (1972) in their analytical study of suicides in Jessamine County, Kentucky, found social isolation to be characteristic of the eighteen lethals. In their psychosocial study on suicide in Brisbane, Australia, Chynoweth et al. (1980) concluded that social isolation or loss appeared to have contributed to the suicide risk of the 135 successful suicides investigated. Kehoe and Abbott (1975) in their study on suicide in the Yukon Territory found that more than half of the successful suicides occurred in the socially isolated, "loner type" individual with a history of poor social adjustment and no family ties.

Farberow and McEvoy (1966) in their study of suicide among patients with diagnosis of anxiety reaction or depressive reaction found social isolation to be a discriminating clue in forecasting successful attempts. Wold (1970) in his large scale study of 26,000 SPC patients found fifty-one percent of the successful suicides were isolated from social contacts.

Modlin (1971) in his review of the literature concluded that the factor of social isolation is a paramount feature in the composite picture of a maximum risk suicidal individual. Gardner et al. (1964) in their study on suicide in the aging found supportive data for this contention. Upon analyzing the sociological data of the groups

(successful suicides under 55 and over 55 years of age) the authors noted that the over 55 group was living either alone or in social isolation. Tuckman and Youngman (1963b) in their analytical study of 1,112 attempted suicides found nearly seventy-two percent of the high-risk attempters to be isolated. A considerably larger study by Tuckman and Youngman (1968), on 3,800 attempted suicides, found supportive data inasmuch as forty-eight percent of the high-risk group were living alone. Litman (1966) found the factor of complete social isolation to be a special indicator of suicide lethality.

Litman et al. (1961) in their review of the Los Angeles SPC patients found persons with strong interpersonal relationships demonstrate a low potential for suicide. In comparison, individuals who had demonstrated a moderate potentiality for suicide, the authors noted, had strong but disturbed or ambivalent interpersonal relationships (whereas individuals with high suicide potentiality were not intimately involved with others in their environment). Bock (1972), in his nine year study on 188 suicides in a retirement community, found social isolation to be the major factor involved. The author suggested social ties tend to counteract the isolation of the elderly widowed which in turn can significantly reduce their chances for potential lethal suicidal behavior. These findings were consistent with the above mentioned study inasmuch as social contacts help negate potential lethality.

HISTORY OF PRIOR ATTEMPTS:

In the not-too-distant past the factor of prior suicide attempts was thought to be a non-indicator of suicide potential lethality. It was a widely held belief that persons who attempt suicide don't subsequently complete a successful suicide. However, an enormous amount of research

data has proven this to be nothing but a myth. In point of fact a history of prior attempts is probably the most significant factor in predicting an individual's potential for succeeding in a subsequent suicide attempt. In their review of studies that reported how many persons in the completed suicide sample were known to have previously attempted suicide, Dorpat and Ripley (1967) found that the estimates ranged from 8.6 percent to 62.5 percent. In their study of 114 successful suicides, Dorpat and Ripley (1960) found that nearly thirty-five percent had made a previous suicide attempt.

Seager and Flood (1965) in their study of 325 successful suicides found that sixteen percent had made a previous suicide attempt. Similar figures were obtained by Tuckman and Youngman (1963b) in their sample of 1,112 attempters, insofar as twenty-two percent of the high-risk group had a prior suicide attempt. In their follow-up study of 3,800 attempters, Tuckman and Youngman (1968) found that twenty-five percent of the high-risk group had a prior attempt. Kehoe and Abbott (1975) found that fifty-two percent of their nineteen lethals had made a previous attempt.

Farberow and Shneidman (1955) analyzed the anamnestic and psychiatric data of 128 hospitalized patients at a Veterans Administration neuropsychiatric hospital. The subjects were separated into groups according to the lethality of their suicidal behavior. The sample was broken into four distinct groups with thirty-two patients each. The groups were attempted, threatened, committed suicide and a control group of non-suicides. Findings indicated that seventy-five percent of the completed suicide subjects had previously attempted or threatened suicide. Approximately fifty percent of the completers had successfully committed suicide within ninety days of having passed the crucial point

and after they appeared to be back on the road to recovery. The authors concluded that the most dangerous suicidal patient is one with a history of prior attempts or threats, and that the professionals and relatives involved with the patient should be alert and watchful for at least three months during the incipient phase of recovery.

Farberow and McEvoy (1966) conducted a comparative, analytical study of forty-three successful suicides matched with forty-three non-suicidal controls. Results indicated that a history of suicidal behavior, i.e., threats, ruminations and attempts, was significantly more common in the successful suicides than in the controls. The conclusions were consistent with the above mentioned study inasmuch as it was found that a history of prior suicidal behavior is an important indicator of suicide potential.

In their investigation of the personality and background characteristics of thirty suicidal mental patients and thirty matched controls, Conte and Plutchik (1974) found that seventy-three percent of the suicidal group attempted suicide previously. Thus, the authors concluded as did Tuckman and Youngman (1963a) that persons who have a history of prior attempts are at a much higher risk to subsequently complete suicide.

Of the forty-two successfuls in Wold's (1970) study, sixty percent had a history of prior suicide attempts. In another study, Litman (1970) found in his fifty lethal attempters thirty percent had a history of prior attempts. Davis (1967) found that one-third of the committed suicides he studied had attempted suicide prior to the fatal attempt. Cohen et al. (1966) found the factor of previous suicide attempts to be a valid prognostic factor in predicting lethality. Modlin (1971), and Engelsmann and Anath (1981) in their reviews of the literature found

that a history of prior attempts was the most obvious and useful behavioral clue in predicting suicide. Thus, the corroborative data in the aforementioned studies holds strong implications that a history of prior attempts is a critical factor in determining the lethality of a suicidal individual.

PRESENCE OF ILLNESS OR UNSUCCESSFUL MEDICAL TREATMENT:

The next variable in the lethality scale is the presence of a long-term physical illness and/or unsuccessful medical treatment or relations with a medical doctor. In his assessment of acutely suicidal patients Litman (1966) found that of the persons who committed suicide, seventy-five percent had seen a physician within six months prior to ending their lives. The author suggested that the average physician encounters a half a dozen suicidal patients a year and will have ten to twelve patients complete suicide during his medical career. Tuckman and Youngman (1963b) found that fourteen percent of their high-risk attempters were under the care of a physician within six months of their deaths and eighteen percent were known to be in poor physical health. Tuckman and Youngman (1968) substantiated their previous findings in a larger study of 3,800 attempters. The results showed that fourteen percent were physically ill and seventeen percent consulted a physician within six months prior to their serious attempt.

In their study of 114 suicides, Dorpat and Ripley (1960) found that fifty-one percent suffered from a serious medical illness and eighty-seven percent were under medical supervision at the time of their death. Results of a study conducted by Seager and Flood (1965) revealed that twenty percent of their 325 completed suicides showed evidence of physical ill health. One-third of Chynoweth's et al. (1980) 135 successful

suicides contacted a doctor shortly before their death and fifty-two percent demonstrated a physical illness. Corroborative data were obtained by Vail (1959) insofar as forty-eight percent of his 152 lethals had been under some form of treatment by a physician. Motto (1969) in a review of the literature found that from sixteen to sixty percent of the individuals who completed suicide had visited a medical doctor within thirty days prior to their death. Similar figures were obtained by Fawcett (1973) in his review, inasmuch as forty to seventy-five percent had consulted a physician within six months prior to their suicide. The author concluded that an estimated four thousand persons a year consult their physician within one week prior to their fatal act. In their assessment of physicians' knowledge of suicide, Rockwell and O'Brien (1973) suggested that possibly as many as ten percent of all persons who end their lives by their own hand consult a physician on the day of or shortly prior to their suicide.

In a study of men sixty years of age and older who committed suicide in Maricopa County, Arizona, Miller (1977) found that one-third of his thirty lethal attempters had suicided within one week of seeing their physician and seventy-six percent did so within one month of their lethal act. Supportive data were obtained by Barraclough et al. (1974) in their retrospective study of one hundred successful suicides. The results revealed that eighty percent were seeing a physician at the time of their suicide.

Modlin (1971), in his literature review, concluded that three-fourths of all persons who commit suicide see their physician within four months prior to their fatal attempts. He suggested that many pre-suicidal persons make indirect suicidal communications to their physician under the

semblance of vague physical complaints. In their study of equivocal suicides who were eventually certified as having suicided, Litman, Curphey, Shneidman, Farberow and Tabachnick (1963) found that the committed suicides were more closely associated with physicians than were their non-suicide counterparts. It was noted that most of the suicide group had visited a physician within the last six months of their lives.

Golden (1978) in his clinical model of suicide assessment deduced that a chronic debilitating illness or major surgical procedure can alter an individual's self-concept which in turn can precipitate a serious suicide attempt. Litman (1970), and Farberow and McEvoy (1966) found that physical illness was more characteristic of the lethal attempters than their non-lethal counterparts. Tuckman and Lavell (1958) found eighteen percent of their 742 suicides had suffered from a chronic physical illness.

LACK OF COMMUNICATION WITH RELATIVES:

The ninth factor seen as helpful in delineating lethal from non-lethal attempters is the lack of communication with relatives, if they exist. The inverse of the preceeding statement is considered equally as important (i.e, failure on the part of the relative to communicate with the potentially suicidal person). In her case analysis of twenty-five suicides, Miller (1970) found that all of the suicidal individuals lacked genuine intimate relationships. The author suggested if no close communication, distortion of communication, or no real concern exists between the suicidal patient and relatives or friends the chance for a successful suicide attempt increases. Heilig (1970) found lack of communication with others to be a critical indicator of lethality in the suicidal individual. Changes in the family unit (i.e., lack of support,

understanding or acceptance of the family, no communication with relatives or negative changes in a marital relationship), were determined by Farberow and McEvoy (1966) to be a discriminating clue in predicting suicide lethality. Gardner et al. (1964) in their study on suicide in the aging, found that the over fifty-five group tended not to see friends or relatives on a regular basis.

REJECTION BY A SIGNIFICANT OTHER:

The last factor in the scale of suicide lethality is rejection by a significant other person. A significant other person may be a close friend, relative or spouse who is deemed important by the individual. If the individual is rejected by the "significant other" it can cause an acute state of disarray in the individual's life situation and the likelihood for a lethal suicide attempt is noticeably increased. In her case analysis of twenty-five suicidal mental patients, Miller (1970) found that when the significant other terminated or withdrew his or her interpersonal contact, the chance for a lethal suicide attempt increased. Peck (1965) and Heilig (1970) corroborated this conclusion in their reviews.

Hatten (1964) studied twenty suicidal persons who were involved emotionally with twenty non-suicidal spouses. Results of the investigation revealed that the significant other played a major precipitating role in the suicidal behavior of the suicidally inclined individual. Farberow and McEvoy (1966) in their analytical study of eighty-six Veterans Hospital patients (forty-three suicides and forty-three controls) found that rejection by or negative changes in the relationship with a significant other were more characteristic of those who suicided. Farberow and Reynolds (1971) in their examination of seventy cases of

completed suicide among male veterans (fifty dyadic and twenty controls) found that the dyadic suicide group demonstrated more disordered social relationships and more often had a significant other who rejected or suppressed them.

Moss and Hamilton (1965), in their study of fifty consecutive cases of attempted suicide found that ninety-five percent of the individuals had experienced a loss of a loved one by death or some other means. In their examination into the significant other relationships of serious suicide attempters, Rounsaville and Weissman (1980) found that the rejected individual attempted suicide within a month of the significant other's suicide and usually used a similar method. Tuckman, Youngman and Bleiberg (1962) investigated 1,112 consecutive attempted suicides from April 1959 to April 1961. Of those persons who gave a cause for the attempt, results showed that married individuals reported disturbed family relations to be the precipitating factor in the attempt, whereas single persons reported an unhappy love affair as the precipitating circumstance. Tuckman and Lavell (1958) in their five year study on suicide in the city of Philadelphia found that forty-five percent of their 742 successful suicides had disturbed family relationships prior to the fatal act.

Litman et al. (1961) in their review of the patients and data at the Los Angeles Suicide Prevention Center concluded that low lethality suicidal individuals tend to have immature and manipulative interpersonal relationships. Furthermore, when the key person (significant other) in the dyad rejects the suicidal individual the chances for a successful suicidal mode of action are raised significantly. Cohen et al. (1966) found certain aspects of the signficant other variable (real, threatened

or fantasied loss of a love object) to be of prognostic value in predicting suicide lethality. Spalt and Weissbuch (1972) found that separation, divorce or even death in a spousal relationship can be interpreted as a rejection by the remaining partner.

With an estimated quarter of a million individuals successfully completing the act of suicide in the United States during the years 1969 to 1978 (last available ten year period) and a projected number of attempted suicides six times the committed rate (one and a half million) it is evident that professionals in the field of mental health are exposed nearly everyday to suicide-prone individuals. It seems safe to assert that mental health professionals are repeatedly forced to make snap decisions on whether a client is potentially suicidal. Thus, they must be circumspective of and well versed on the signs of potential lethality of the suicidal individual. Moreover, the question arises as to whether the signs of potential lethality, however well-rooted and circulated throughout the literature of suicidology, are recognizable by practicing clinicians who must make decisions concerning the precariousness of a intervention with the suicidal patient. The little available evidence shows some thought provoking results. In a study by Pokorny (1960) on forty-four patients who subsequently committed suicide, a question was posed to seventeen staff and resident psychiatrists regarding characteristics of the suicidal individual. Results revealed the subjects could not agree on one factor considered important in determining suicide lethality.

Steele (1975) investigated the ability of first year medical students to recognize suicide potential. The subjects were asked to fill out a brief rating form after viewing a videotaped interview of a woman

who had recently made a serious suicide attempt. Results showed that sixty-eight percent of the subjects saw suicide as the present illness, whereas the remaining subjects saw the problem as "matrydom", "anger", "isolation", or "hysteria". Holmes and Howard (1980) studied the recognition of suicide lethality factors by various professional groups and college students, and found that the most obvious result of the study was the clear ordering of the professional groups. The result showed that physicians and psychiatrists were equal in the recognition of suicide lethality factors. Moreover, physicians and psychiatrists scored significantly higher in recognizing suicide signs than all the remaining professional groups in the study. Psychologists (doctoral level) were significantly better (i.e., higher mean score of correct responses) than social workers, ministers and college students; whereas social workers were more accurate than ministers and college students. There were no significant differences in the ability of ministers and college students to recognizing suicide signs. In essence, years of experience and degree of psychological training correlated with the professional's ability to recognize signs of suicide. Using the thirteen item Suicide Lethality Questionnaire, Bascue, Inman and Kahn (1982) studied the recognition of suicidal risk factors by psychiatric nursing assistants. Results showed that psychiatric nursing assistant's recognition of suicide signs were slightly above that of the ministers and college students and significantly less that the mental health professionals and the physicians in Holmes and Howard's study.

Holmes and Wurtz (1981) conducted a study on counselors' recognition of factors of suicide lethality utilizing the Suicide Lethality Questionnaire constructed and employed by Holmes and Howard (1980) in their

study of health and mental health professionals. Results revealed that counselor's recognition of signs of suicide scores equalled those of social workers and ministers in the aforementioned study. Results were consistent with Holmes and Howard in that the recognition of suicide signs is related to experience and degree of psychological training.

CHAPTER 2

METHOD

The present study was an investigation of the ability of selected mental health professionals to recognize a list of factors contained in the Suicide Prevention Rating Scale. This study selected samples of masters and doctoral level psychologists working in a clinical setting. For the purpose of this study a clinical setting was defined as a community mental health center.

Subjects

The subjects for this study were selected from two distinct populations: masters and doctoral level psychologists. The experimental groups consisted of forty-three masters level and thirty doctoral level psychologists currently employed by various mental health centers of Kansas. In order to remain compatible with the original study (Holmes and Howard, 1980) all subjects were required to have at least two years of professional experience. The subjects were grouped on the basis of years of experience and type of degree held. The researcher obtained a comprehensive list of psychologists and their employment addresses by contacting, via telephone, all the Community Mental Health Centers in the state of Kansas. Of the thirty centers in the state twenty-seven center granted my request for a list of psychologists on their staffs. Franklin County Mental Health Clinic was excluded from the study due to the fact that no psychologists were currently employed at that particular time. The administrative directors for the Northeast Kansas Mental Health and

Guidance Center and the Sedgwick County Department of Mental Health declined to participate in the experiment. The names and employment addresses of one hundred and fifty-six psychologists were obtained through this procedure. Of these prospective subjects, eighty-five individuals held a masters degree in psychology and seventy-one individuals held a doctoral degree in psychology. Prospective subjects for the experimental groups were asked to participate by responding to a multiple-choice questionnaire concerning suicide lethality factors of the Suicide Prevention Rating Scale. The subjects were also asked to respond to all thirteen items by marking the correct answer among four alternatives and to do so without consulting outside sources before completing the task.

Instrument

The instrument was a thirteen item four choice, multiple-choice examination which consisted of two single-spaced typewritten pages of eight and a half by eleven inches. The first page contained the directions which stated, "Please delimit clearly by circling the letter of the response that you think to be the correct answer for each question." Preceding the instructions there were spaces for occupational designation and two categories for years of experience. The occupational experience categories included the levels of two to ten years and ten years or more. The questionnaire instrument was obtained from Cooper B. Holmes and Michael Haward and authorization was granted by them for the usage of the Suicide Lethality Questionnaire in this study. The authors constructed the instrument so only one of the responses for each question corresponds to one of the Suicide Prevention Rating Scale factors. The instrument has been presented in Appendix, p. 47.

Procedure

The experimental groups were mailed the instrument and returned it upon completion by return mail. A letter of introduction describing the proposed research, instructions for completing and returning the instrument, and a self-addressed, stamped envelope were enclosed with the Suicide Lethality Scale questionnaires. Before the questionnaires were mailed out it was arbitrarily determined by the researcher that at least thirty valid questionnaires were needed from each professional group in order to effect the study. A period of three weeks was allowed for the prospective subjects to return the instrument, before an alternative plan was to have been implemented. Nevertheless, more than the proposed number of subjects returned the instrument prior to the end of the specified time period, thus the alternative plan was abandoned. Ninety-five questionnaires were returned to the researcher. Of these, seventy-three questionnaires were found to be of a valid nature and the remaining twenty-two were found to be invalid for one of several reasons (i.e., subject failed to respond to all thirteen items, subject failed to delimit type of degree held, or subject failed to delimit number of years of experience). In reference to the valid questionnaires received, forty-three were masters level psychologists and thirty were doctoral level psychologists.

CHAPTER 3

RESULTS

Each usable test (questionnaire) was scored for the number of correct responses. There was a maximum of thirteen and a minimum zero possible. Table 1 presents the sample sizes, means and standard deviations of correct responses according to years of experience and degree. These data were subjected to a random effects, 2 X 2 unweighted means analysis of variance. The analysis of variance revealed that there was no main effect for years of experience and type of degree, and no significant interaction effect, as shown in Table 2.

Although the ANOVA showed no significant differences, thus negating the need for individual comparisons, in order to present these results in a clearer, simplified form each returned test from the subjects in the experimental groups was also classified according to professional status (type of degree held), regardless of experience. The two classifications of professional status were: master's level psychologists and doctoral level psychologists. An analysis by type of degree was performed via a t-test. Psychologists with a masters degree (n = 43) obtained a mean score of 7.74 correct responses (SD = 2.53). Professionals with a doctoral degree (n = 30) obtained a mean score of 8.30 correct responses (SD = 1.80). A statistical analysis of these data yielded a t of 1.031, df = 71, $p > .05$.

The data were further analyzed by categorizing the subjects according to years of professional experience, regardless of professional

Table 1

The Sample Sizes, Means and Standard Deviations of Correct Responses According to Degree and Years of Experience

	Doctoral Level (Over 10 years)	Doctoral Level (2 to 10 years)	Masters Level (Over 10 years)	Masters Level (2 to 10 years)
Number of Subjects	8	22	15	28
Mean	7.875	8.455	8.600	7.286
Standard Deviation	1.536	1.827	1.583	2.776

Table 2

Analysis of Variance of Number of Correct Responses By Type of Degree and Years of Experience

Source	Sum of Squares	Degrees of Freedom	Mean Squares	F	p
Experience	1.98	1	1.98	0.40	NS
Type of Degree	0.72	1	0.72	0.14	NS
Interaction	13.15	1	13.15	2.62	NS
Within Cells	345.64	69	5.01		
Total	361.49	72	20.86		

status (type of degree held). The two categories of years of professional experience were: two to ten years and ten or more years. These data were also analyzed by using a *t*-test. Professionals with two to ten years of experience (n = 50) attained a mean score of 7.80 correct responses (SD = 2.49). Professionals with ten or more years experience (n = 23) attained a mean score of 8.34 correct responses (SD = 1.64). The critical value obtained from a *t*-test was not significant at the .05 level of significance (t = 0.959, df = 71, $p > .05$).

The results of this study revealed that there was no significant difference in the responses of the professional status groups (i.e., masters and doctoral level psychologists), regardless of experience. Moreover, there was no significant difference in the responses by experience (i.e., two to ten years and ten or more years of experience), regardless of professional status.

CHAPTER 4

DISCUSSION

The purpose of this study was to investigate the ability of masters and doctoral level psychologists to recognize and identify the lethality factors contained in the Suicide Lethality Rating Scale. The results of a statistical analysis imposed on the data revealed that there was no significant difference between the experimental groups' ability to recognize suicide signs.

Before discussing the results of this study it would be appropriate to mention that the authors of the original study, Holmes and Howard (1980), noted four important points that would apply to this study as well. First, although the lethality factors studied here are specific, they are well researched and can be found in almost any undergraduate abnormal psychology textbook. Second, there are other important signs of suicide potential that the lethality scale fails to deal with (e.g., preoccupation with death). Specifically, the latter point applies to this study because some of the subjects (i.e., psychologists) may have worked exclusively with children or adolescents. Since the signs of suicide for adolescents (e.g., McCulloch, Phillip and Carstairs, 1967, noted school absenteeism and juvenile delinquency; and Finch, Poznanski and Waggoner, 1971, found that adolescents tend to display the somatic equivalents of depression such as insomnia, fatigue, loss of appetite or more frequently complain of an inability to concentrate, instead of verbalizing their depressed feeling like most adults do) are somewhat different than the signs

indicative of adult suicide. Other psychologists in the experimental groups may have been solely involved in administrative duties. Third, if the findings were a result of a bias effect it would have inflated the scores of the persons studied because only the more confident psychologist would have consented to complete the instrument. Fourth, since the Suicide Prevention Rating Scale lacked definite criteria (i.e., what score constitutes a "good" score), Holmes and Howard (1980), noted that until replication and expansion is performed firm statements could not be made on how well a group performed or would perform in another setting.

It should be noted that certain aspects of the data were consistent with the previous research. For instance, a t-test was conducted on the data obtained on the doctoral psychologists in the original study and the doctoral psychologists in this study. Professionals with a doctoral degree (n = 30) in the Holmes and Howard study attained a mean score of 7.53 correct responses (SD = 2.35). The doctoral degree subjects in this study (n = 30) attained a mean score of 8.30 correct responses (SD = 1.80). The critical value obtained from the t-test was not significant at the .05 level of significance (t = 0.442, df = 58, $p > .05$). Moreover, Holmes and Howard (1980), found that after excluding the physicians and the psychiatrists from their sample the level of recognition of the suicidal signs studied corresponded directly to the amount of formal psychological training each professional group would have had (i.e., doctoral psychologists were more trained than social workers, who were more trained than ministers). Thus, it would hold true that the formal psychological training received by masters level psychologists would enable them to score significantly better than the other professionals studied (i.e., social workers and ministers) and comparable to other

professionals within the field of psychology (e.g., doctoral psychologists).

The most striking result of this study is the lack of a significant difference between masters and doctoral psychologists' ability to recognize suicide signs. A possible reason for this could be that, in relation to suicide signs, there may be little or no differences in the training of masters and doctoral level psychologists (i.e., doctoral degree programs may not stress the recognition of suicide signs sufficiently more than masters degree programs).

Another interesting aspect of this study dealt with the lack of a significant difference between the years of experience variable used in the study. As the previous research (Holmes and Howard 1980, Holmes and Wurtz 1981) pointed out, experience was found to be an important factor in successfully recognizing signs of suicide. In contrast, the results of this study revealed that there was no significant difference between the groups in reference to years of experience. This may stem from the fact that the author of this study did not ask for specific years of experience (i.e., an exact mean for years of experience could not be computed). That is, the group means of the subjects in the two categories of experience (2 to 10 years and 10 or more years) used in this study may have been extremely close together. Thus, by failing to duplicate the Holmes and Howard years of experience variable it may have caused the results of the statistical analysis to be biased. The subjects used in this study were only psychologists from the state of Kansas, nonetheless it is reasonable to assume that the results are applicable to other psychologists (i.e., masters versus doctoral psychologists in recognizing suicide signs). It

should be noted that this study does not show that masters level psychologists are equal to doctoral level psychologists in other areas of psychological expertise (e.g., the diagnosis of mental illness), it simply showed that in reference to this specific topic, recognition of suicide signs, there was no significant difference.

RECOMMENDATIONS

Based on the results of this study, the following specific suggestions are recommended to persons interested in furthering the research dealing with the recognition of suicide lethality factors by professionals.

1. The study should be replicated by another individual in order to refute, support or clarify the findings of this study.

2. The years of experience variable should be broken down to match the years of experience variable in the original study, Holmes and Howard (1980). This factor could be statistically significant.

3. Future studies should be conducted using the same experimental groups studied here but in different settings (e.g., masters and doctoral psychologists working in state mental hospitals or doctoral psychologists working in private practice).

4. Future studies should be conducted in different states to determine if the findings of this study hold constant across various geographic localities.

In conclusion, one general recommendation should be noted. The educational programs in the field of psychology and other related disciplines should focus more on increasing the professional's ability to

recognize and readily identify the characteristics associated with suicide lethality, such as the ones employed in this study. Further, it is felt by this author that research into the recognition of suicide signs is as important as life itself and it is hoped that this study will help stimulate further inquiries into this relatively unexplored area. Moreover, I am hopeful that in the near future the practicing clinician will have an accurate frame of reference from which to work when dealing with the suicidal individual.

REFERENCES

REFERENCES

Barraclough, B., Bunch, J., Nelson, B., & Sainsbury, P. A hundred cases of suicide: Clinical aspects. British Journal of Psychiatry, 1974, 75, 355-373.

Bascue, L. O., Inman, D. J., & Kahn, W. J. Recognition of suicidal lethality factors by psychiatric nursing assistants. Psychological Reports, 1982, 51, 197-198.

Beck, A. T., Kovacs, M., & Weissman, A. Assessment of suicidal ideation. Journal of Consulting and Clinical Psychology, 1979, 47, 341-352.

Bock, E. W. Aging and suicide: The significance of marital, kinship and alternative relations. Family Coordinator, 1972, 21, 71-79.

Chynoweth, R., Tonge, J. I., & Armstrong, J. Suicide in Brisbane: A retrospective psychosocial study. Australian and New Zealand Journal of Psychiatry, 1980, 14, 37-45.

Cohen, E., Motto, J., & Seiden, F. An instrument for evaluating suicide potential. American Journal of Psychiatry, 1966, 122, 886-891.

Conte, H. R., & Plutchik, R. Personality and background characteristics of suicidal mental patients. Journal of Psychiatric Research, 1974, 10, 181-188.

Davis, F. B. The relationship between suicide and attempted suicide. Psychiatric Quarterly, 1967, 91, 752-765.

Davis, F. B. Sex differences in suicide and attempted suicide. Diseases of the Nervous System, 1968, 29, 193-194.

Dorpat, T. L., & Ripley, H. S. A study of suicide in the Seattle area. Comprehensive Psychiatry, 1960, 1, 349-359.

Dorpat, T. L., & Ripley, H. S. The relationship between attempted suicide and committed suicide. Comprehensive Psychiatry, 1968, 8, 74-79.

Engelsmann, F., & Ananth, J. Suicide rating scales. Psychiatric Journal of the University of Ottawa, 1981, 6, 47-51.

Farberow, N. L., & McEvoy, T. I. Suicide in patients with a diagnosis of anxiety reaction in general medical and surgical hospitals. Journal of Abnormal Psychology, 1966, 71, 287-299.

Farberow, N. L., & Reynolds, D. K. Dyadic crisis suicides in mental hospital patients. Journal of Abnormal Psychology, 1971, 88, 77-85.

Farberow, N. L., & Shneidman, E. S. Attempted, threatened and completed suicide. Journal of Abnormal Psychology, 1955, 20, 230.

Fawcett, J. Seeing the skull beneath the skin: Recognition and management of the suicidal patient. Journal of Research and Training, 1973, 1, 5-8.

Finch, S. M., Poznanski, E. D., & Waggoner, R. W. Adolescent suicide. Springfield, Ill.: Thomas, 1971.

Gardner, E. A., Bahn, A. K., & Mack, M. Suicide and psychiatric care in the aging. Archives of General Psychiatry, 1964, 10, 547-553.

Golden, K. M. Suicide assessment: A clinical model. The Journal of Family Practice, 1978, 6, 1221-1229.

Hatten, J. V. Precipitating role of discordant interpersonal relationships in suicidal behavior (Doctoral dissertation, University of Houston, 1964). Dissertation Abstracts, 1964, 25, 1335-1336.

Heilig, S. M. Training in suicide prevention. Bulletin of Suicidology, 1970, 6, 41-44.

Holmes, C. B., & Howard, M. E. Recognition of suicide lethality factors by physicians, mental health professionals, ministers and college students. Journal of Consulting and Clinical Psychology, 1980, 48, 383-387.

Holmes, C. B., & Wurtz, P. J. Counselor's recognition of factors in lethality of suicide. Psychological Reports, 1981, 49, 183-186.

Kehoe, J. P., & Abbot, A. P. Suicide and attempted suicide in the Yukon territory. Canadian Psychiatric Association Journal, 1975, 20, 15-23.

Lester, D. Suicidal behavior in men and women. Mental Hygiene, 1969, 8, 340-345.

Litman, R. Acutely suicidal patients: Management in general medical practice. California Medicine, 1966, 109, 168-174.

Litman, R. Suicide prevention center patients: A follow-up study. Bulletin of Suicidology, 1970, 6, 12-17.

Litman, R., Curphey, T., Shneidman, E. S., Farberow, N. L., & Tabachnick, N. Investigations of equivocal suicides. Journal of the American Medical Association, 1963, 184, 924-929.

Litman, R., & Farberow, N. L. The emergency evaluation of self-destructive potentiality. In E. S. Shneidman & N. L. Farberow (Eds.), The cry for help. New York: McGraw-Hill, 1965.

Litman, R., Shneidman, E. S., & Farberow, N. L. Los Angeles suicide prevention center. American Journal of Psychiatry, 1961, 97, 1084-1087.

McCulloch, J. W., Philip, A. E., & Carstairs, G. M. Ecology of suicidal behavior. British Journal of Psychiatry, 1967, 9, 30-36.

Mikawa, J. K. An alternative to current analysis of suicidal behavior. Psychological Reports, 1973, 3, 323-330.

Miller, D. H. Suicidal careers: Case analysis of suicidal mental patients. Social Work, 1970, 15, 27-36.

Miller, M. The physician and the older suicidal patient. The Journal of Family Practice, 1977, 5, 1028-1029.

Miskimins, W. M., DeCook, R., Wilson, L. T., Maley, R. F., & Dean, R. A. Prediction of suicide in a psychiatric hospital. Journal of Clinical Psychology, 1967, 33, 296-301.

Miskimins, W. M., & Wilson, L. T. Revised suicide potential scale. Journal of Consulting and Clinical Psychology, 1969, 33, 258.

Modlin, H. C. Cues and clues to suicide. Menninger Perspective, 1971, 2, 2-5.

Moss, L. M., & Hamilton, D. M. The psychotherapy of the suicidal patient. American Journal of Psychiatry, 1956, 112, 814-820.

Motto, J. A. Toward suicide prevention in medical practice. Journal of the American Medical Association, 1969, 210, 1229-1232.

Peck, M. C. Relation of suicidal behavior to characteristics of significant other (Doctoral dissertation, University of Portland, Oregon, 1965). American Doctoral Dissertations, 1965, 10, 199.

Porkorny, A. Characteristics of forty-four patients who subsequently committed suicide. Archives of General Psychiatry, 1960, 2, 314-323.

Rockwell, D. A., & O'Brien, W. Physicians' knowledge and attitudes about suicide. Journal of the American Medical Association, 1973, 225, 1347-1349.

Rosen, D. H. The serious suicide attempt: Epidemiological and follow-up study of 886 patients. American Journal of Psychiatry, 1970, 127, 764-770.

Rounsaville, B. J., & Weissman, M. M. A note on suicidal behavior among intimates. Suicide and Life-Threatening Behavior, 1980, 10, 24-28.

Sainsbury, P. Suicide in London: An ecological study. New York: Basic Books, 1956.

Seager, C. P., & Flood, R. A. Suicide in Bristol. British Journal of Psychiatry, 1965, 111, 919-932.

Shneidman, E. S., & Farberow, N. L. Statistical comparisons between attempted and committed suicides. In E. S. Shneidman & N. L. Farberow (Eds.), The cry for help. New York: McGraw-Hill, 1965.

Spalt, L., & Weisbuch, J. B. Suicide: An epidemiologic study. Diseases of the Nervous System, 1972, 33, 23-29.

Steele, T. E. Evaluation of first-year medical students' ability to recognize suicide potential. Journal of Medical Education, 1975, 50, 203-205.

Trout, D. L. The role of social isolation in suicide. Suicide and Life-Threatening Behavior, 1980, 10, 10-29.

Tuckman, J., & Lavell, M. Study of suicide in Philadelphia. Public Health Report, 1958, 73, 547-554.

Tuckman, J., Youngman, W. F., & Bleiburg, B. M. Attempted suicide by adults. Public Health Report, 1962, 77, 605-614.

Tuckman, J., & Youngman, W. F. Suicide risk among persons attempting suicide. Public Health Report, 1963a, 128, 585-587.

Tuckman, J., & Youngman, W. F. Identifying suicide risk groups among attempted suicides. Public Health Report, 1963b, 128, 763-766.

Tuckman, J., & Youngman, W. F. A scale for assessing suicide risk of attempted suicides. Journal of Clinical Psychology, 1968, 24, 17-19.

Vail, D. J. Suicide and medical responsibility. American Journal of Psychiatry, 1959, 115, 1006-1010.

Wenz, F. V. Suicide-related experiences among blacks: An empirical test of a suicide potential scale. Omega: Journal of Death and Dying, 1978, 9, 183-191.

Wilkins, J. A. A follow-up study of those who called a suicide prevention center. American Journal of Psychiatry, 1970, 127, 155-167.

Wold, C. I. Characteristics of 26,000 suicide prevention center patients. Bulletin of Suicidology, 1970, 6, 24-28.

Wollersheim, J. P. The assessment of suicide potentiality via interview methods. Psychotherapy: Theory, Research and Practice, 1974, 9, 222-225.

Yap, P. M. Suicide in Hong Kong. Journal of Mental Science, 1958, 104, 266-301.

APPENDIX

EMPORIA STATE UNIVERSITY

THIRTEEN QUESTIONS ON SUCCESSFUL SUICIDE
(Cooper B. Holmes - Michael E. Howard)

ur Profession: Psychologist-Masters Level Years Experience: 2-10 years
(Circle one) Psychologist-Doctoral Level (Circle one) Over 10 years

STRUCTIONS: Please delimit clearly by circling the letter of the response that you think to be the correct answer for each question.

Persons who are most likely to succeed in committing suicide are:
A. female and under 50 years of age.
B. female and over 50 years of age.
C. male and under 50 years of age.
D. male and over 50 years of age.

Successful suicidals are most often characterized by:
A. depression, hopelessness and helplessness, but not anxiety symptoms such as sleep disturbance.
B. depression, hopelessness and helplessness, as well as anxiety symptoms such as sleep disturbance.
C. no visible signs of either depression or anxiety.
D. anxiety symptoms, but very seldom showing signs of depression.

A great percentage of successful suicides involve persons who are:
A. married.
B. single.
C. widowed, separated or divorced.
D. any of the above categories, since there is no significant difference in marital relationships.

In regard to current pressures affecting persons at the time they make a suicide attempt:
A. persons under the effects of an immediate stress are most likely to succeed.
B. persons under an immediate stress are not likely at that time to succeed.
C. the factor of immediate stress is not critical in determining the lethality of a suicide attempt.
D. none of the above are correct

Regarding the onset of suicidal symptoms in a person's behavior:
A. a gradually-developing group of symptoms indicates that the person is more likely to commit suicide.
B. a relatively quick onset of symptoms is the most dangerous sign of a successful suicide attempt.
C. very little evidence has been found to indicate any correlation between onset of symptoms and suicide lethality.
D. both gradual and quick onset of symptoms of suicide are equally dangerous for successful suicide.

A potentially-suicidal individual is more likely to succeed in the attempt if that person:
A. has no idea how he or she will actually do it.
B. is afraid to think of how the actual attempt will be made.
C. has a definite plan of how it will be done.
D. appears very confused about actually how it will be done.

Likelihood of successful suicide is greatest when:
A. a person continues social contacts as if nothing is wrong.
B. a person is very gregarious with a variety of social contacts.
C. a person is socially isolated from friends and relatives.
D. a person keeps in contact with relatives but is isolated from friends and recent acquaintances.

With regard to alcoholics and homosexuals, the suicide rate is:
A. higher than the national average.
B. lower than the national average.
C. the same as the national average.
D. higher for alcoholics and lower for homosexuals compared to the national average.

A person has the highest potential for successful suicide if:
A. there is no previous history of suicide attempts.
B. there is a history of previous suicide attempts.
C. there is no history of previous attempts but some suicidal thoughts have been present.
D. the person has never contemplated suicide.

. The most dangerously suicidal individual with regard to medical history is an individual who:
A. has never had physical complaints or seen a doctor.
B. has a long history of chronic illness but doesn't believe in doctors.
C. has a long history of chronic illness and many visits to physicians during this period.
D. has had no physical complaints but sees a doctor occasionally for checkups with rigid regularity.

. If relatives exist, a dangerously suicidal person would likely:
A. not be in communication with them.
B. see them often, trying to communicate with them.
C. keep in communicatin with them but only from a distance, like writing or calling them on the phone.
D. none of the above, since there is no significant difference.

. An individual would be more likely to be an imminent suicide victim if:
A. there is a significant other person who was extremely important to that individual and who was trying in vain to help.
B. there is a significant other person who rejects the individual.
C. the month is February.
D. none of the above is statistically significant.

. A critical factor in determining the lethality of a potentially-suicidal person is if that person:
A. has never seen a physician.
B. is a member of the middle socioeconomic class.
C. is a young, caucasian female.
D. has seen a physician within the last six months.