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Not all of those likely to counsel potential suicide victims are equally qualified to do so. How do the competency levels of various professional groups rate?

Recognizing Suicide Lethality Factors: Who is Competent?

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INTRODUCTION

Suicide and the threat of suicide remain important mental health issues for all health service providers. Farberow and Litman (Note 1) have estimated that five percent or fewer of individuals threatening suicide are unequivocally certain that they want to die. The remaining 95% are at least ambivalent about their wishes to die. They represent a group potentially receptive to intervention by mental health professionals.

Who the potential suicide victim (initially) turns to for help and how capable that person is in recognizing the signs of potential suicide are critical issues not fully addressed by recent research. Snyder (1971) found that suicidal persons are most likely to turn to family, friends, physicians, the clergy, psychiatrists, social workers, and lawyers in that order. However, the training of those individuals typically sought out for help may be inadequate. Pretzel (1970) and Anderson (1972) report that ministers are not given sufficient training in recognizing the signs of potential suicide. Motto (1969), Fawcett (1973), and Dorport and Ripley (1974) report that physicians are also believed to lack adequate training. Prokorny (1970) assessed the ability of resident psychiatrists ability to recognize the signs of a potentially suicidal individual and reported discouraging results. In general, these results suggest that the individuals sought after for help by individuals contemplating suicide may be inadequately trained to identify the signs of potential suicide.

A more recent study (Holmes & Howard, 1980) has attempted to assess various professional's ability to recognize the signs of potential suicide (lethality factors). Using the Thirteen Questions on Successful Suicide, Holmes and Howard attempted to discover who among psychiatrists, psychologists, physicians, social workers, ministers, and college students were most able to identify lethality factors. The study reported a clear ordering of the group. Physicians and psychiatrists had the highest mean scores followed by psychologists, social workers, ministers, and college students. This current study represents a partial replica of the Holmes and Howard research, controlling for potentially significant variables which were originally uncontrolled and extending the study to include the responses of masters level counselors. The variables to be controlled included: length of experience in profession, experience with suicidal individuals, and amount of training in the recognition of suicide lethality factors.

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METHOD

Subject

This study employed physicians, doctoral level clinical or counseling psychologists, masters level counselors, masters level social workers, ministers, and lower division college students. Masters level counselors were added because, along with social workers, they form the majority primary mental health care services at various mental health agencies in the state of Oklahoma where the survey was conducted.

All were directly involved in professional care of clients. Students were enrolled in an undergraduate class at the University of Oklahoma.

Instruments

The Thirteen Questions on Successful Suicide (TQSS) and the Survey of Professional Experiences with Suicidal clients served as the dependent measures.

The TQSS utilized a four-choice, multiple-choice format requiring the respondents to circle the correct answer. This survey is an adaptation of the Suicide Potential Rating Scale which attempts to assess an individual's ability to recognize signs of a potentially suicidal person. Recognition of the following factors, which have been found to be related to clients who attempt suicide (Coleman, 1964; Litman & Farberow, 1961; Farberow, 1980), was assessed: effective plan; prior attempts; isolation from friends and family; disruption of interpersonal relationships; depression, anxiety and helplessness; immediate stress; chronic illness; marital status; not communicating; alcoholism; acute onset of symptoms; having recently seen a physician; and, male over 50 years of age. For example, the first question was: "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. The sixth question was: 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 done; (c) has a definite plan of how it will be done; (d) appears very confused about how it will actually be done. These factors were used in instrument construction because of the empirical research supporting them. The instrument was used because of its previous use in the Holmes & Howard (1980) study and the researchers belief that it adequately assessed the recognition of signs of suicide lethality as indicated in the literature.

The Survey of Professional Experiences with Suicidal clients (SPESC) was developed by the researchers. Respondents were requested to answer five questions concerning the following: years of experience as a counselor; personal experience with suicide or attempts among family, friends, community, etc.; professional contact with suicide or attempts among clients; special training in recognition of suicide lethality signs in clients; and the expression of a need for additional training. Responses to the last four questions were presented in a yes/no format.

RESULTS

The TQSS mean score was found to be significantly lower for physicians in the current study (7.48) than in Holmes and Howard (1980) (9.20). However, other means were quite consistent with those in the previous study: for psychologists, 7.9 in present study, 7.53 in previous study: for psychologists, 7.9 in present study, 7.53 in previous study; for social workers, 6.6 in present study, 6.23 in previous study; and, for ministers 5.1 in present study and 5.33 in previous study.

Each test was scored for the number of correct responses. The mean number of correct responses (out of 13 possible) and the results of Tukey's Test Comparisons Between Groups are presented in Table I. As the data reveals there were found to be no significant differences in the number of correct responses by physicians, psychologists, and counselors, but all three groups scored significantly higher than all of the other groups. Social Workers scored significantly higher than ministers, and ministers scored significantly higher than college students.

An analysis of the data by years of experience (regardless of profession) was also performed. Professionals with 0-2 years experience (n = 23) obtained a mean score of 6.68 correct responses; those with 2-5 years experience (n = 33) obtained a mean score of 9.26 correct responses; those with 5-10 years experience (n = 16) obtained a mean score of 11.83 correct responses; those with 10-15 years experience (n = 17) scored 6.2 as the mean of correct responses; while those with 15+ years of experience (n = 11) scored 6.66 as the mean of correct responses. Specific comparisons using Tukey's test revealed that the group with 5-10 years were most knowledgeable in recognizing suicidal signs as measured by the TQSS questionnaire. The results showed a progressive improvement in professionals with 0-10 years experience and then a sharp drop after this period.

The information collected from the questionnaire offers possible explanations for the above differences and similarities among groups. All groups, except ministers, had had some contact with suicide in their personal lives: 72% of the physicians; 66% of the psychologists; 62% of the counselors; 58% of the social workers. Ministers also reported the lowest incidence of professional contact with clientele dealing with suicidal tendencies (21%). This was significantly different from the physicians 81%, psychologists 88%, counselors 82%, and the social workers 100%.

According to Table II, approximately 50% of all psychologists, social workers, and counselors had experienced specific training in recognizing and working with suicidal clients. Twenty-seven percent of the physicians reported these experiences while only 16% of the ministers had. However, the extent of professional exposures of training seems to have a mixed effect on the expressed need of additional training. Psychologists, counselors and social workers reported a higher desire for additional training: 77%, 85%, and 83% respectively. Sixty-three percent of the physicians reported a desire for additional training. However, in spite of the low exposure to suicide, both personally and professionally, only 31% of the ministers reported a desire for this experience.

DISCUSSION

Recognizing the need for additional data we will proceed to make some tentative remarks about our research. First of all, our results conflict with previous study (Holmes and Howard, 1979) on two points. They found a significant difference between the physicians and psychologists, where we found no significant difference among physicians, psychologists, and masters level counselors. This could be accounted for by the relatively small N which will be rectified as our research progresses. However, this remains to be seen. Results also conflict in that Holmes & Howard found a progressive increase in knowledge as professional experience increases. The present data show that those who were in the 5-10 year range of experience scored the highest, while those with more experience had a drastic drop in scores. This could open the door for speculation about reasons for this occurrence.

We also found from our additional questionnaire that ministers were distinguished from the other professionals by their general lack of personal contact with suicide, as well as limited relevant professional contact (21%). This may explain the low mean score as well as their lower expressed need (31%) to increase their amount of knowledge about the topic. The data also show that those who have had the most exposure to suicide, personally and professionally, are those who feel the strongest desire for additional information.

As scores were compared initially the results appear to decrease the urge for professional competition by showing that the three major areas are relatively equally competent in recognizing factors that may result in potential suicide. However, the fact remains that approximately 50% of psychologists, counselors, and social workers received training in this area with physicians trailing at 27%. This seems to be reflected in the general overall low mean scores relative to the number of items on the questionnaire. The highest score of 7.9 is only 60.7% of the entire test. If this had occurred in any academic setting an evaluation of failing would have surely been assigned! This study hopefully shows the urgency of programs training future mental health care providers in reevaluating current instruction related to the recognition of suicide lethality in order to train a more effective, helping professional.

TABLE I
Results of Tukey's Test Comparisons Between Groups

	Group	1	2	3	4	5	6
1.	Physicians N = 22		.42	.13	* .88	*2.38	*1.58
2.	Psychologists N = 14			.29	*1.3	*2.8	*2.0
3.	Counselors N = 33				*1.01	*2.51	*1.7
4.	Social Workers N = 12					*1.5	* .7
5.	Ministers N = 19						* .8
6.	Students N = 27						
MEANS OF CORRECT #		7.48	7.9	7.61	6.6	5.1	5.9

*significant difference $p < .01$

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TABLE II

	(n) YEARS EXPERIENCE					Personal Contact		Professional Contact		Training?		Need?	
PROFESSION	0-2	2-5	5-10	10-15	15+	YES	NO	YES	NO	YES	NO	YES	NO
PHYSICIANS X = 7.48	2	4	3	7	5	72%	28%	81%	19%	27%	73%	63%	37%
PSYCHOLOGISTS X = 7.9	2	4	5	3	0	66%	34%	88%	12%	55%	45%	77%	23%
COUNSELORS X = 7.6	13	16	4	0	0	62%	38%	82%	18%	55%	45%	85%	15%
SOCIAL WORKERS X = 6.6	4	1	2	4	1	58%	42%	100%	0%	50%	50%	83%	17%
PSYCHOMINISTERS X = 5.1	2	8	2	3	4	0%	100%	21%	79%	16%	84%	31%	69%
TOTAL	23	33	16	17	11								

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