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Is Suicide Training Sufficient for Psychology Trainees to Respond Appropriately to Suicidal Clients?

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Abstract

This study reports the frequency of suicide training for current psychology trainees. Additionally, the research uses the Suicide Intervention Response Inventory – Second Edition (SIRI-2) to assess psychology trainees' ability to respond appropriately to suicidal clients. This study compares scores on the SIRI-2 between participants who are in pre-internship years of training and those currently in internship or having completed internship training. Finally, this study compares SIRI-2 scores between high training, low training, and no-training groups, as well as the scores of no-training versus training groups. Findings indicate no statistically significant difference in SIRI-2 scores between participants early in their programs and those who received training later in their programs. Also, the study shows no statistically significant difference between scores of high, low, and no-training groups. However, research found a statistically significant difference between no-training and training groups, indicating that any amount of training provided to students could increase their ability to respond appropriately to suicidal clients.

Keywords: suicide; suicide training; psychology training; SIRI–2; training program; suicidal clients

Is Suicide Training Sufficient for Psychology Trainees to Respond Appropriately to Suicidal Clients?

History of Suicide

Sir Thomas Browne first coined the term *suicide* in 1643. The word is believed to derive from the Latin *sui*— of oneself, and *caedere*— to kill, to kill oneself (Palmer, 2008). However, since this time, the definition of suicide has gone through several revisions. Palmer reports on these various definitions, including that of a sociological perspective, "All cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result" (p. 11). Over time, definitions emerged for research purposes, as well as to settle nuances between "parasuicidal" and "attempted suicide" (Palmer, 2008). However, as Bongar (2002) points out, the differences in definitions are helpful from a research perspective, but when suicidal thoughts are brought into a clinical setting, the communication needs to be assessed immediately for risk.

Despite the changes in the definition of suicide throughout history, suicide has been around for ages, from Ancient Egypt, to Greece and Rome (Bongar, 2002). As suicide remained throughout the years, cultural morals dictated the social desirability of the act of suicide. Christianity condemns the act of suicide based on the view of life being a gift from God, whereas Japanese culture often views suicide as an act of bravery or penance (Retterstol, 1993).

Given both the substantial history of suicidal behavior and the mass of research conducted on the phenomenon, it is troubling to see holes in academic and training programs for trainees highly likely to work with suicidal individuals (Bongar & Harmatz, 1991). Over two decades ago, Bongar and Harmatz made inquiries of schools of psychology regarding the amount

of suicide training students receive in their programs. More than ten years later, psychology interns identified similar deficits in their graduate training (Dexter-Mazza & Freeman, 2003).

Purpose of the Study

While studies identify a lack of training in suicide, there is disagreement amongst clinical training directors over whether formal training in managing suicidal clients should come from graduate coursework, graduate-level practicum, internships, supervised postdoctoral work, or socialization (Bongar & Harmatz, 1989). There is often support for the trainee following an encounter of a suicidal client (Knox, Burkard, Jackson, Schaack, & Hess, 2006) in the form of supervision or peer support. However, without proper training, psychology trainees are providing treatment while lacking an important competency to effectively manage suicidal clients. Additionally, this gap in training leaves psychology trainees feeling unprepared when confronted with suicidal clients.

Taking into consideration the literature identifying gaps in the training of psychology students, this study assesses how well psychology trainees appropriately respond to suicidal clients. Using the Suicide Intervention Response Inventory, Second Edition (SIRI-2; Neimeyer and Bonnelle, 1997) and a demographic questionnaire, this study examines the amount of training current psychology trainees receive and how well they respond to suicidal clients when item scores are compared to a panel of suicide experts.

Based on previous research, there is no statistically significant difference expected between scores on the SIRI-2 prior to internship training and scores during internship training; these results identify a lack of suicide training obtained during training years. However, a greater amount of training in suicide will indicate lower scores on the SIRI-2, representing a greater ability to recognize facilitative responses to a suicidal client. This study found that there was no

statistically significant difference in SIRI-2 scores between those participants in pre-internship training and those either currently in internship or having completed internship. Additionally, when comparing those participants with no suicide training, low suicide training, and high suicide training, there was no statistically significant difference, although the results approach significance. Finally, when comparing groups with no suicide training to those with training, there was a statistically significant difference between scores on the SIRI-2.

Literature Review

In 2007, there were 34,598 recorded suicides in the United States, making suicide the 11th leading cause of death for Americans. This statistic does not take into consideration ambiguous circumstances such as single-car accidents or suspicious deaths which may increase that statistic (McIntosh, 2010). In addition to the fatal outcomes of suicides, estimates of suicide attempts range from 864,950 to 1.1 million in 2007 (McIntosh, 2010).

Suicide is not a phenomena limited to the United States. In 1995 about 900,000 suicides were reported worldwide. According to the World Health Organization (WHO; 1999), the number of suicides is projected to increase and by the year 2020 approximately 1.53 million people will successfully complete suicide. Between 10 and 20 times more people will attempt suicide but unsuccessfully complete it. While these figures are not precise, they do provide a frightening picture should nothing be done to prevent suicide. Other trends reported by the WHO (1999) indicate a gradual, yet substantial increase of suicide in males since 1950, whereas there has been only a slight increase with female suicide in the same period.

A psychological autopsy, a process to help ascertain what a client was thinking and feeling prior to the act of suicide, following suicides indicate that more than 90% of individuals who completed suicide had one or more mental health diagnosis (AAS, 2011). About one third

of suicide completers had contact with mental health services within a year of their death, and one in five had contact within their last month (Luoma, Martin, & Pearson, 2002). Diagnoses such as depression, schizophrenia, substance abuse, and conduct disorders in adolescents pose an increased risk of suicide. However, feeling hopeless is a better predictor of suicide than a diagnosis of depression.

Other factors to consider in assessing suicide include culture and religion. In Islamic countries, committing suicide is unacceptable and the total suicide rates are generally very low. Overall, Christian countries have a higher suicide rate than Hindu countries, and largely secular countries have the highest levels of suicide (Palmer, 2008); however, the data does not represent the countries that do not fit neatly into the descriptive analysis. In addition, levels of religiosity, along with socioeconomic factors, should be considered in cultural research (Palmer, 2008).

The impact of suicide is far reaching. Although the act of suicide is generally a solitary act, it leaves family members, social supports, and treatment providers to grieve and try to understand the reasons for the death. Themes of guilt, blame, ostracism, and isolation echo throughout the research on family survivors of suicide (Cerel, Jordan, & Duberstein, 2008). Additionally, therapists experience feelings of shock and sadness immediately following the suicide of a patient (Wurst et al., 2011).

Competency in Practice

Within the practice of mental health, the most common experience for clinicians is encountering a suicidal client in therapy (Schein, 1976). In addition, these encounters are consistently viewed as the most stressful of clinical situations. Not only does the typical practicing psychologist treat an average of five suicidal clients a month, the same psychologists have a one-in-five chance of having a client commit suicide while in treatment (Bongar, 2002).

Kleespies, Smith, and Becker (1990), investigated the incidence, impact, and methods of coping with patient suicide during training years of psychology graduate students. They found one-in-six students had experienced a patient's suicide at some time during their training.

One area in which trainees often feel the need for ongoing support is when dealing with suicidal clients (Kleepsies, Penk, & Forsyth, 1996). It is not possible to know whether a client will be suicidal; therefore, all trainees should be prepared to come in contact with a suicidal patient at one point or another. As mental health professionals, supervision remains a vital support when working with suicidal clients. It is important to receive ongoing supervision throughout training years. This includes practicum experience, internships, and post-doctoral fellowships. Supervision during this time has a dual purpose. Not only does supervision provide much-needed professional support in dealing with difficult client situations, it also provides trainees with feedback regarding practice standards (Sommers-Flanagan & Sommers-Flanagan, 2003).

In an attempt to provide a common framework for the education and training of suicide risk assessment and management, the Suicide Prevention Resource Center [SPRC] (2006) established core competencies for mental health professionals. The competencies include seven broad categories with 24 competencies and the sub-competencies addressing the areas of clinical evaluation, formulation of risk, treatment planning, and management of individuals at risk for suicide.

The American Psychiatric Association (APA) also set forth *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors* (Jacobs & Brewer, 2004). In addition to recommending that direct questions be used in suicide assessment, the guidelines acknowledge that accepting a negative response regarding suicidal ideation may not be enough

to appropriately assess a situation (Jacobs & Brewer, 2004). The guidelines caution about inconsistencies between a patient's presentation and denial of suicidal ideation; these inconsistencies should prompt additional inquiry and collateral sources of information.

In addition to various guidelines set forth, Rudd, Cukrowicz, and Bryan (2008) propose a model for supervision utilizing the core competencies. The tasks of the supervisor in addressing the competency include improving the trainee's self-awareness and understanding of attitudes and values regarding suicide, ensuring the trainee's awareness of facts associated with suicide, and the ongoing monitoring and refinement of skills.

Proposed Suicide Training Programs

If adequate training and clinical practice is to occur, London (1986) first suggests that clinicians more carefully explore the terminology and empirical basis for our current techniques and procedures. The type and form of training in the study of suicide at the graduate and internship level is open to debate. However, competency in managing suicidal patients does not mean informational competence alone (Berman, 1986). Some argue (Inman, Bascue, Kahn, & Shaw, 1984) that knowledge of risk factors and the capacity to respond in an effective way to suicidal clients may be two distinct areas of clinical competency. Therefore, training in suicide must be more than a mechanical distribution of facts and figures; training should involve clinical supervision, as well as didactic training.

One proposed approach for clinicians to use when working with suicidal clients is the Collaborative Assessment and Management of Suicidality (CAMS), developed by Jobes and Drozd (2004). This approach focuses on clinician behavior and their identification, engagement, assessment, conceptualization, treatment planning and management of suicidal clients. CAMS uses a variety of theoretical models, including behavioral, cognitive, psychodynamic,

humanistic, existential, and interpersonal to understand and treat suicidal clients. When creating CAMS, Jobes and Drozd identified an individual's suicidality as a means of coping or problem-solving. With this point-of-view, clinicians should engage with suicidal clients in an empathic and non-judgmental way. Indentifying suicide as a coping strategy for clients helps to form a strong therapeutic alliance necessary for continued treatment.

There are five steps involved in the CAMS approach to suicidal clients. Step 1 is the early identification of suicidality. Identification may be made through a client's self-report or through concerns raised via routine measures used, such as the Outcome Questionnaire 45.2 (Lambert, 2004). Next, using the Suicide Status Form (SSF; Jobes & Drodz, 2004), a collaborative assessment is completed with both the client and the clinician providing information. In Step 3, collaboration continues through the treatment planning process. Here, clinicians work together with the client to identify problems, goals, objectives, and interventions. Subsequent sessions include ongoing clinical tracking of suicide status that involves the completion of the SSF at the beginning of each session. In Step 5, clinical resolution of suicide status is established following three consecutive sessions of no suicidal ideation. Research using the CAMS approach (Jobes & Drodz, 2004), although limited, shows that a collaborative approach between the clinician and the client to understand what it means for the client to be suicidal, and create a treatment experience based on this knowledge, shows a quicker resolution in suicidal thoughts.

If not through formal training, learning how to respond to suicidal clients can also take place within the context of clinical supervision. Juhnke and Hovestadt (1995) feel that it is the responsibility of clinical supervisors to ensure psychology trainees' competency in suicide

assessment. A system, developed by Patterson, Dohn, Bird, and Patterson (1983), provides trainees with direct and prescriptive means of assessing for suicide.

The SAD PERSONS Scale (SPS; Patterson et al., 1983) is an acronym identifying 10 risk factors for suicide assessment including sex, age, depression, previous attempts, ethanol abuse, rational thinking, loss, social supports lacking, organized suicide plan, no spouse, and sickness. Supervisors can use this acronym to prompt trainees to assess suicide risk, based on these literature-identified risk factors. When comparing psychology trainees receiving instruction in SAD PERSONS to those in a control group, those receiving instruction show a greater ability to accurately assess suicide risk (Juhnke & Hovestadt, 1995). This system of assessment demonstrates another method of providing this necessary skill to psychology trainees.

In addition to the content of suicide assessment, Granello (2010) acknowledges that the assessment process is unique to each individual, complex and challenging, an ongoing process, collaborative in nature, and occurring in a cultural context. In addition, those conducting suicide assessments must ask tough questions, should err on the side of caution, take all threats, warning signs, and risk factors seriously, and rely on clinical judgment. Granello also views suicide risk assessment as a form of treatment that tries to uncover the underlying communication, and should be thoroughly documented.

Similarly, Sullivan and Bongar (2009) view suicide assessment as based more on clinical judgment, rather than evidence-based approaches. Reviewing a client's risk factors is only the first step in a comprehensive suicide assessment. In addition to psychiatric diagnosis, "suicide accelerants" show up frequently in patients admitted to the hospital following serious suicide attempts (p. 62). These risk factors include partial insomnia, severe anxiety, depressed mood, panic attacks, and recent loss of close personal relationships. Substance use, firearms access,

medical illness, prior suicide attempts, and current suicidal ideation should all be evaluated during a suicide assessment.

Additional areas of concern that are present at higher rates in suicidal individuals include demographic risk factors, suicidal communication, genetic predisposition, isolation, and lack of protective factors (Sullivan & Bongar, 2009). When attempting to bring even more information into an assessment, several assessment measures can be used, ranging from personality measures (MMPI-2, Rorschach) to self-report inventories (Beck Depression Inventory, Beck Hopelessness Scale, Linehan Reasons for Living Inventory, etc.; Sullivan & Bongar, 2009).

It may be helpful to formulate an individual's risk based on the lethality of the situation. Schwartz and Rogers (2004) present guidelines to use for establishing a client's lethality ranging from "low" to "very" lethal. Clients at the low end of risk present with suicidal ideation, deny intent and plan, and deny past attempts. On the other hand, at the very high end of risk are clients who verbalize suicidal ideation with intent and a concrete plan. Additionally, these individuals have immediate access to means necessary to carry out their plan, as well as a sense of rigidity and feelings of hopelessness. These individuals do not have social supports available and have made previous attempts in the past. Clients may also be somewhere in between these extremes at either a moderate or high lethality risk (Schwartz & Rogers, 2004)

While clinical interviews and standardized measures may prove to be useful, Lovett and Maltsberger (1992) present a psychodynamic approach and conceptualization to suicidal individuals. In addition to mental status exams and client history; dynamic concepts, such as the stability of the client's identity, or proneness to malignant regressions is considered in a psychodynamic formulation.

Five components comprise the psychodynamic case formulation. Clinicians assess the client's response patterns to emotional stress, particularly loss. Also, there should be exploration regarding the client's capacity for tolerating painful emotions. There should be assessment of the client's object relations, both internal and external resources. According to Lovett and Maltsberger (1992), clinicians should work to find an understanding of the client's death fantasies, as "they provide a crucial window into the underlying motives and the dynamic structure of the person's experience of longing for self-destruction" (p. 164). Finally, the psychodynamic formulation gathers information regarding the client's impulsiveness, reality testing, and defenses. Lovett and Maltsberger caution against clinician's counter-transference and subsequent withdrawal from the client. The client may view this rejection as reinforcement of their unconscious wishes. Clinicians are also cautioned against the use of contracts and ultimatums, as this may be experienced by the client as empathic failures (Lovett & Maltsberger, 1992).

Effectiveness of Suicide Training

Fenwick, Vassilas, Carter, and Haque (2004) emphasize the importance of continuing education in the area of suicide risk assessment and management. Fenwick et al. evaluated two methods of providing training in the competency of suicide risk assessment by comparing a full-day workshop on suicide assessment and prevention with a half-day didactic teaching on risk assessment in suicide. Both forms of training led to improvements in assessment skills and in the confidence of the trainees to assess suicide. The improvements established in the post-treatment assessment were sustained at a two-month follow up.

While Fenwick et al. (2004) compared two different forms of training, McNiel et al. (2008) compared a group of psychiatry and psychology trainees who had received training in

suicide risk assessment to similar trainees who had received no training. Participants in the study were measured on their perceived ability to assess and manage suicidal clients, along with being rated on progress notes addressing standards of care in risk assessment of suicide. Prior to the trainings, the two groups did not differ significantly in the hours of prior formal training in suicide risk assessment and management. However, after the training, there was a significant difference in scores between the two groups, indicating an improvement in ability to identify risk and protective factors for suicide in the group who had received training (McNiel et al., 2008).

When comparing undergraduate psychology students, volunteers at a suicide crisis hotline, and graduate students in clinical and counseling psychology, the level of training and experience with suicidal clients positively related to suicide intervention competencies (Neimeyer, Fortner, & Melba, 2001). However, when there was a personal history of suicidality and a belief that suicide is a personal right, these factors were negatively correlated with skills to respond appropriately to suicidal verbalizations (Neimeyer et al., 2001).

Researchers in Belgium (Scheerder, Reynders, Andriessen, & Van Adenhove, 2010) and Italy (Palmieri et al., 2008) have confirmed that specific training in suicide assessment and intervention is rare. Regardless of discipline, the ability of subjects to respond appropriately to suicidal clients increases significantly when suicide training is provided to health care professionals. It is evident through research that training of some sort, whether it is a short lecture or a full-day workshop, demonstrates an improvement in a trainee's ability to assess suicide risk.

In addition to an increased ability to respond appropriately to suicidal clients, Oordt, Jobes, Fonseca, and Schmidt (2009) identify several additional advantages of suicide training. Active duty Air Force mental health professionals were trained through a continuing education

program on assessing and managing suicidal behavior. At a six- month follow-up, practitioners reported increased confidence in assessing suicide risk and increased confidence in managing suicidal patients (Oordt et al., 2009). Clinicians also reported changing suicide care practices and clinic policies following the training.

Absence of Suicide Training

Despite consistent research indicating the effectiveness of suicide training on professional skill development, training programs continue to lack training and education in working effectively with suicidal clients. Juhnke and Hovestadt (1995) suggest that training programs believe suicide assessment and management skills will be gained through clinical experience, rather than didactic training.

In 1993, Kleepsies, Penk, and Forsyth surveyed 292 psychology interns. The numbers showed that 96.9% of the group surveyed had experienced a patient with some sort of suicidal behavior or ideation while in training. Within the same group, 29.1% reported treating a patient who had made a suicide attempt, while 11.3% had a patient who actually completed suicide during their training years. The greatest amount of support following the experience of a suicidal patient was sought through supervision (Kleepsies et al., 1993). Subjects found discussing and reviewing the case in supervision moderately to very helpful. While subjects found supervision following treatment with a suicidal client helpful, areas of deficit included education and training in suicide. While over half of the subjects received some form of didactic instructions, it was described as minimal.

Bongar and Harmatz (1989) first endeavored to collect empirical data on what the traditional graduate training programs in clinical psychology were doing to provide formal didactic and clinical training on the treatment of the suicidal patient. A comprehensive

questionnaire was sent to the Director of Clinical Training for every member department of the Council of University Directors of Clinical Psychology Programs (CUDCPP) and over half of the programs responded that they offered no formal training (courses, seminars, etc.) in the study of suicide (Bongar & Harmatz, 1991). When training was provided, it was mostly incorporated into other courses. When Bongar and Harmatz (1991) asked training directors where clinical psychologists should primarily get their formal training in managing suicidal patients, 22.8% responded graduate course work, 43.5% responded practicum as part of graduate training, 37% responded internship, 9.8% believed it should occur during supervised post-doctoral experience, and 14.1% believed training in the study of suicide should occur in socialization.

Even when combining the training efforts of the National Council of Schools of Professional Psychology (NCSPP) training programs with the CUDCP, only 40% of all graduate programs in clinical psychology reported offering formal training in the study of suicide (Bongar & Harmatz, 1991). Taking into consideration APA ethics code to practice with boundaries of competence, and APA's Committee on Professional Standards (COPS) of the Board of Professional Affairs (BPA) stating the need for psychologists to manage problems of suicide competently (Bongar, 1992), it is clear that formal graduate training in the study of suicide is a necessary part of graduate training.

Despite the recommendations of Bongar and Harmatz (1989), statistics remained relatively unchanged years later. In 2003, pre-doctoral psychology interns identified the prevalence of working with suicidal clients and the amount of formal training received in managing these clients (Dexter-Mazza & Freeman, 2003). While nearly every subject indicated they had treated at least one suicidal client during their training, only half reported receiving formal training through their training program.

Contrasted with the lack of suicide training in clinical psychology training programs is the training provided in psychiatry residency programs. Of those programs surveyed by Ellis, Dickey, and Jones (1998), 94% reported some form of didactic training in the treatment of suicidal patients. However, there was considerable variability in specific forms of training, and course offerings drop off considerably as training intensity, formality, and narrowness of focus on suicide increase. The greatest number of programs offer suicide-related training in contexts less specifically devoted to the topic of suicide such as therapy supervision, seminars on general topics, and case conferences. While the great majority of residency programs do provide some form of training and individual supervision in assessment and treatment of suicidal patients, such training may often be relatively superficial in nature. Whereas more than 90% of the programs report that the topic is covered in clinical supervision or seminars and journal clubs, only about one-fourth of the programs report training in the form of skill building workshops devoted specifically to suicide assessment and intervention (Ellis et al., 1998).

The issue of what constitutes adequate training is a problematic one for psychology and for core mental health disciplines. For example, Berman and Cohen-Sandler (1982) noted that fewer than one in four psychiatrists and psychologists in the Washington, D.C. area, who average eleven years in independent practice, have had any post-residency/graduate school training in suicide assessment (Bongar, 1992).

In a more recent look at psychiatry training programs, Melton and Coverdale (2009) asked chief residents to describe how suicide care was taught by choosing from a list of six possibilities. The study found that grand rounds and case conferences were the most common teaching methods utilized, whereas quality assurance meetings, including morbidity and

mortality conferences, were utilized by less than half of the responding programs and the majority of teaching occurred in the first two years of the programs.

After reviewing the literature identifying gaps in suicide training for psychology students, as well as the effectiveness of training, this study has two goals. First, this study examined the amount of training psychology students currently receive regarding suicide. And secondly, it assessed if psychology trainees are being prepared by training programs to respond appropriately to suicidal clients.

Methods

The purpose of this study was to examine psychology trainees' clinical and academic experience in responding to suicidal clients. Subjects were asked to identify demographic information including type of doctoral program, if the trainee had suicide training prior to enrolling in their academic program, approximately how many hours of training in suicide they received, their current internship status and type of suicide training that occurred. Finally, subjects' ability in responding to suicidal clients was measured using the Suicide Intervention Response Inventory, Second Edition (SIRI-2; Neimeyer & Bonnelle, 1997).

Recruitment

Participants for this study were psychology doctoral trainees, in varying levels of training including pre-interns, currents interns, and those who completed internship training. Participants were from clinical, counseling, and educational psychology programs. Based on Cohen (1992), the minimum number of participants necessary for a large effect size at $\alpha = .05$ is 91 participants.

A letter stating (a) who is conducting the study, (b) why the subject is chosen to participate, (c) the time commitment, (d) potential risks and benefits, (e) confidentiality of the information, and (f) explanation of the voluntary nature of the study (Rudestam & Newton,

2007) was provided electronically to members of NCSPP, as well as APPIC internship training directors to disseminate to students. The letter also contained the website for trainees to access the online, confidential survey.

Measures

A questionnaire (see Appendix A) consisting of demographic information, in addition to the SIRI-2, was presented to the subjects.

Subjects identified their current doctoral program as clinical, counseling, or educational psychology. Additionally, subjects identified their anticipated degree as Psy.D. or Ph.D. Subjects identified their current internship status as pre-internship, current intern, or completed-internship. Subjects identified if he or she received training in suicide prior to their enrollment in their academic program. Subjects reported the approximate hours of training he or she received in the study of suicide training. Additionally, participants identified their training as formal or informal. If formal, they identified the type of training as: class/workshop, lecture, required reading, or seminar/journal club (Ellis et al., 1998).

Finally, subjects completed the SIRI-2 in order to assess the individual's ability to respond appropriately to suicidal clients. Subjects' responses to "helper" replies were compared to responses given by a panel of experts on suicide. Prior to administering the SIRI-2, a pilot distribution was conducted in order to estimate a time commitment for the participants resulting in an average of 10 minutes to complete the questionnaire.

The first edition of the Suicide Intervention Response Inventory (SIRI) is a self -administered questionnaire to assess the ability of subjects to recognize appropriate responses to suicidal clients (Neimeyer & Bonnelle, 1997). The measure is comprised of 25 items representing a series of excerpts from counseling sessions. Each excerpt expresses a client

concern regarding some aspect of the situation he or she faces followed by two possible "helper" responses to the client's remark.

In the SIRI, subjects were asked to respond to the more appropriate helper reply. The respondent's total SIRI score was calculated based on the total number of correct responses. In the first edition of this measure, scores were interpreted as the extent to which subjects could discriminate between more and less effective responses to suicidal clients. However, the primary criticism of the original SIRI concerned the ceiling effect with highly skilled trainees. This effect was demonstrated by Neimeyer and MacInnes (1981) when untrained psychology students, crisis line trainees, and highly experienced crisis counselors scored 72%, 83%, and 97% correct, respectively. Although the instrument discriminates between various training levels, the tendency of highly trained groups to score in the upper limit may leave little room to demonstrate the impact of advanced training in suicide intervention among more highly trained subjects.

The revised inventory (SIRI-2), presents the subjects with the same hypothetical client remarks as the SIRI. However, the scoring for SIRI-2 introduces a 7-point Likert scale of responses to the two helper responses. Subjects in this study rated each response in terms of how appropriate or inappropriate they felt the reply is to the client's comment. Ratings for SIRI-2 range from -3 to +3, where -3 represents a highly inappropriate response to the clients remark, 0 represents neither appropriate, not inappropriate, and +3 represents a highly appropriate response.

Sample questions from Neimeyer and Bonnelle (1997) include:

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

_____ *Helper A:* You say you´re suicidal, but what is it that´s *really* bothering you?

_____*Helper B:* Can you tell me more about your suicidal feelings?

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

_____ *Helper A:* It seems like you´ve been suffering so much that cutting your wrists is the only way you can make the pain go away.

_____ *Helper B:* But you ´re so young, you have so much to live for. How can you think of killing yourself?

Client: I really need help… It´s just…{voice breaks: silence}

_____ *Helper A:* It must be hard for you to talk about what´s bothering you.

_____ *Helper B:* Go on, I´m here to listen to you talk.

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 for activities with their friends. But nothing seems to interest me. Life is just a bore…

_____ *Helper A:* Considering all you have going for you, your problems can´t be all that serious. Try to focus more on the positive aspects of your situation.

_____ *Helper B:* So even though things seem to be going well at one level, life still seems pretty depressing, even if it´s hard to say exactly why.

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

_____ *Helper A:* No, there are many people who suffer from mental illness. But with appropriate treatment by a qualified physician, some of these patients can be cured.

_____ *Helper B:* It is true. You're not the only one who has suicidal thoughts. And you can be helped to get through this crisis, just as others have been.

Subjects' scores on the SIRI-2 were compared to mean response scores of a panel of suicidology experts. The differences between the subjects' response rating for each item and the mean rating of the expert group were calculated. The total score in the end represented the total discrepancy between the individual and the expert ratings across the items. Therefore, larger scores represent less competence in recognizing appropriate responses to suicidal client.

After restructuring the scoring system, Neimeyer and Bonnelle (1997) compared a group of counselor trainees enrolled in a masters' level crisis intervention class and students from an introductory psychology class who had no training in suicide intervention or related topics. In addition to the SIRI-2, and a background information questionnaire administered to both groups of participants, counselor trainees were administered the Marlowe-Crowne Social Desirability Scale to evaluate the discriminant validity in terms of independence from social desirability effects.

Looking at construct validity, Neimeyer and Bonnelle (1997) performed an analysis of variance of scores obtained by master's level trainees pre- and post-suicide intervention training. When administering the original SIRI, no training effect was detected. However, scores on the SIRI-2 showed a significant improvement following education in suicide intervention. As with the original SIRI, the SIRI-2 was uncontaminated by a social desirability response bias, as reflected in the lack of association with the Marlowe-Crowne Social Desirability Scale. Finally, controls were administered the SIRI-2 on two separate occasions over a two-week period to examine test-retest reliability. The revised scoring procedure resulted in a Pearson correlation, $r = .92$, $p < .001$ (Neimeyer & Bonnelle, 1997).

When examining internal consistency of the SIRI-2, Neimeyer and Bonnelle (1997) found adequate internal consistency with coefficient alphas of .90 and .93 at Time 1 (pretesting) and Time 2 (post-testing), respectively. Additionally, the test-retest reliability for the revised scoring format was demonstrated by calculating Pearson correlations. The revised scoring procedure resulted in a substantially higher correlation than the first edition, $r = .92$, $p < .001$ (Neimeyer & Bonnelle, 1997).

Results

Participant Demographics

Demographic data of the sample are presented in Table 1. The sample group included 170 psychology doctoral trainees. Thirty-three people (19%) did not complete the survey in its entirety and were excluded from further analyses.

Table 1

Sample Group Demographics

Current Degree Program	N	%
Clinical	124	91
Counseling	5	3
Educational	8	6
Degree	**N**	**%**
Psy. D.	102	75
Ph. D.	35	25
Current Internship Status	**N**	**%**
Pre-Internship	67	49
Current Intern	64	47
Completed Internship	6	4

A majority of the participants were Clinical Psychology (91%), Psy.D. (75%) students. There was nearly an even split between students in pre-internship years (49%) and those that are either current interns or completed internship (51% total).

Table 2 presents the frequency data indicating participants' experience in suicide training.

Table 2

Suicide Training

Previous Suicide Training	N	%
Yes	48	35
No	89	65
Type of Training	**N**	**%**
Formal	101	73
Informal	29	22
None	6	4
Both	1	1
Mode of Training	**N**	**%**
Class/Workshop	85	62
Lecture	67	49
Reading	57	42
Seminar/Journal Club	19	14
Other	6	4

Hours of Training Reported	N	Range	Mean	SD
	135	0-200	22.03	34.39

A majority of participants did not receive training (65%) in suicide prior to their current academic program. Additionally, some participants (4%) report receiving no training in suicide at this point in their training program. However, a majority of the participants (74%) report receiving formal training in suicide with most training (62%) occurring in a class/workshop.

Participants reported hours of training between zero and 200 hours, with $M = 22.03$ and $SD = 34.39$ creating a wide range of hours spent in suicide training.

Research Question One

Do psychology trainees receive more training in suicide as they progress through their training programs?

Based on previous research (Fenwick et al., 2004; Neimeyer et al., 2001; Palmieri et al., 2008; Scheeder et al., 2010), lower scores on the SIRI-2 indicate an increased ability to respond appropriately to suicidal clients and are associated with increased training in suicide. An ANOVA, whose results are presented in Table 3, was used to establish differences in SIRI-2 scores between participants in early years of an academic and training program (pre-internship years) and those later in their training program (currently in their pre-doctoral internship or completed internship training).

Table 3

Training Years ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	16.33	1	16.33	.178	.674
Within Groups	12382.97	135	91.73		
Total	12399.29	136			

When comparing SIRI-2 scores for participants early in their academic and training years to participants late in their academic and training years, there is no statistically significant difference between the groups, F (1, 135) = .178, p = .674.

Research Question Two

Are psychology trainees with more hours of training in suicide better at responding to suicidal clients?

Participants were divided into groups based on the reported number of hours devoted to suicide training (high suicide training ≥ 9 hours, low suicide training ≤ 8 hours, and no hours of training). Scores on the SIRI-2 were again used to determine participant ability to respond appropriately to suicidal clients. An ANOVA, whose results are presented in Table 4, was employed to identify differences in SIRI-2 scores between groups.

Table 4

Hours of Training ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	519.84	2	259.92	2.95	.06
Within Groups	11640.47	132	88.16		
Total	12160.31	134			

When comparing SIRI-2 scores for participants with no training, low training, and high training, based on the numbers of hours reported, there is no statistically significance difference between groups, F (2, 132) = 2.95, p = .06, though the result approaches significance. However, when comparing participants with no reported training and those that report training in suicide, there is a statistically significant difference between groups, F (1, 135) = 4.79, p = .030. Table 5 presents the data for groups with no suicide training versus some training in suicide.

Table 5

Training and No Training ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	424.54	1	424.54	4.79	.03
Within Groups	11974.75	135	88.70		
Total	12399.29	136			

Discussion

Over 20 years ago, researchers first ventured to identify the extent of suicide training that was provided to psychology students. Although nearly every student encountered a suicidal client during their training years, only one-third to one-half of students received training in working with suicidal clients. Given the continued increase in suicides throughout the world, suicide remains a necessary area of training for those entering the field of psychology. This study identified the frequency of suicide training for current psychology students. The research utilized the SIRI-2 to assess participants' ability to respond appropriately to suicidal clients and compared scores to evaluate suicide training within training programs. These data support the idea that everyone should have some amount of training in suicide.

Research Implications

Overall, a greater number of psychology trainees today report receiving training in suicide than in the past. Ninety-three percent of trainees either entered their program with previous training in suicide, have received training during their program, or both. Students report training in a variety of modalities. Some students report class work in suicide, journal clubs, integration in coursework, and workshops. Others identify suicide training as a part of a training

curriculum for crisis work or research related to suicide. Students also receive informal training in suicide through supervision.

Although the researchers hypothesized that those in later years of training would demonstrate an increased ability to respond appropriately to suicidal clients than those in early years of training, there were no statistically significant differences between the two groups' scores on the SIRI-2. Although these results were unexpected, they are not surprising given the research (Fenwick et al., 2008; McNiel et al., 2008) which indicates varying amounts of training in suicide increases a person's ability to respond appropriately to suicidal clients.

Similarly, although there was no significant difference noted between groups of no training, low training, and high training, there was a significant difference between scores on the SIRI-2 of participants with no training in suicide compared to those with training in suicide. While the research did not demonstrate significant differences when groups were broken down into more discrete groupings, it repeatedly confirmed that training in suicide resulted in lower scores on the SIRI-2, indicating an increased ability to respond appropriately to suicidal clients.

Limitations of Research

Demographics. Results of this study may not be reliable given the reliance on participants to report their hours of training rather than identify the amount of training provided by programs. There should be caution in extrapolating findings to training programs. Thirty-five percent of participants reportedly received training in suicide prior to their current program. In reporting hours of training, participants did not specify if this included training prior to their program or if training occurred in the context of their program. Given that training programs were not the respondents, as was the case in past research (Bongar & Harmatz, 1991), the amount and type of training provided by programs remains unclear.

In the study, participants identified various aspects of their academic programs (e.g., degree program, program of study); however, they did not identify specific programs. It is uncertain the number of different programs represented in the respondents. It is possible that programs emphasizing training in suicide are over-represented in the respondents and the study may lack information from respondents in programs without suicide training. This lack of information leads to difficulty in generalizing the findings to all psychology trainees.

Use of the SIRI-2. The current study utilizes scores on the SIRI-2 to assess how well participants respond to suicidal clients; however, it is unclear how well scores on the SIRI-2 translate into clinical practice. Previous research utilized additional information when assessing participants' ability to respond to suicidal clients, including reviewing session notes and identifying participants' level of confidence. This study relied on only one measure to deduce conclusions and makes it difficult to infer participants' interactions with clients.

There are definite limitations in solely using the SIRI-2 to measure and extrapolate ability of participants to respond appropriately to suicidal clients. Previous research utilized the measure to establish change in pre- versus post- suicide training by comparing scores on the SIRI-2 (Fenwick et al., 2004; Palmieri et al., 2008; Scheerder et al., 2010). However, when utilizing the measure to ascertain a participant's ability, it fails to consider the unique aspects of suicide assessment such as those presented by Granello (2010). The SIRI-2 uses the consensus of six suicidology experts to determine appropriate responses, but fails to account for factors such as the therapeutic relationship and client individuality.

Although the SIRI-2 evolved from dichotomous responses to those that allow for greater variability in responses, there remains a sense that the expert's responses are the best response for the client. Question 12 represents a question that created great variability in responses from

participants and client response to the intervention would likely depend greatly on a client's individual beliefs.

Neimeyer and Bonnelle's (1997) question reads:

> Client: How can I believe in God anymore? No God would ever let this happen to me; I've never done anything to deserve what's happened.
>
> Helper A: Things have gotten so bad, that it's difficult to see any meaning in the things that have happened to you.
>
> Helper B: Well, God works in mysterious ways. Maybe this is His way of testing your faith. (pp. 77-78)

The suicidology experts view the second response as a "highly inappropriate response." However, this does not take into consideration an individual's beliefs. A client's reaction to the above responses will probably depend largely on his or her religious beliefs and the therapist knowing the client well enough will see the response as appropriate or inappropriate based on this knowledge.

Despite the growth in the number of participants identified as having received training in suicide, there is considerable variability in the hours reported and scores on the SIRI-2. This may be normal variability or may represent shortcomings in the measure used. From a personal perspective, responses on the SIRI-2 resulting in elevated scores seem to represent statements that would be highly unlikely for any respondent to choose, regardless of training. Also, it seems more difficult to distinguish between differences in scores for those respondents with experience working with suicidal clients.

Recommendations for Future Research

The primary focus in the current research was on suicide training provided in academic

and training programs. However, individual changes in ability to appropriately respond to suicidal clients were not examined in the current study. It may be helpful to examine individual participant development throughout academic and training programs in order to assess how well programs provide training in suicide. Also, it could benefit the area of suicide training to examine any additional individual or program characteristics that correlate with lower scores on the SIRI-2 in order to integrate those characteristics in suicide training.

Given the repeated confirmation that suicide training increases an individual's ability to respond appropriately to suicidal clients, it seems important to identify programs that are not providing training and encourage programs to introduce the training. In order to introduce the most useful training to students, future research could help identify differences in effectiveness between various formats of training. For example, researchers could explore if there are differences in effectiveness between seminars related to suicide training, integrating suicide training throughout coursework, or providing readings to students.

Personal Reflections

Throughout this process I could not help but reflect on both my own training in suicide and my experiences with suicidal clients that led to my interest in this topic. Despite having completed educational requirements and nearly completed my pre-doctoral internship, I do not feel adequately trained in suicide. There has been training included in small sections of coursework, brief organizational trainings, and informally in supervision following sessions with suicidal clients. I feel competent in my ability to do the appropriate paperwork and ask the standard questions (plan, intent, means, etc.). However, I do not feel my training prepared me in ways to conceptualize suicide in treatment, individualize treatment, and work collaboratively with the client as suggested by Jobes and Drozd (2004).

It was fulfilling to see that a greater percentage of participants report receiving suicide training than in past research. However, there continues to be great variability in the training provided, as well as participants' scores on the SIRI-2. My hope for the future of the field is to have more consistent and ongoing training in both academic and training programs throughout trainees' experiences. Given the anxiety associated with treating suicidal clients, having consistent conversations and support may help prepare trainees, as well as increase trainee confidence when confronted with a suicidal client.

Given the high prevalence (McIntosh, 2007) of completed suicide and suicide attempts, ongoing training is imperative. As Inman et al., (1984) point out; training in suicide is multi -faceted and should involve clinical supervision and didactic training, in addition to standard facts and figures. I propose that this training begin in the academic setting with empirical data laying the groundwork for understanding the importance of suicide training. Prior to trainees having practical experience, academic programs should provide students with a multi-layered look at suicide, including terminology and empirical data, risk factors and protective factors, and suicide within a cultural context (Palmer, 2008).

As trainees progress through their academic program, they should gain a comfort in asking clients about suicidal ideation, intent, and plan. They should be aware that clients may not be honest about their report and trainees should be prepared to question inconsistencies and utilize other sources for information. Prior to clinical experience, this comfort can be developed through reviewing case vignettes and participation in role plays.

Through personal experience, I realized that training sites have specific protocols to follow should a client attempt or commit suicide. This may include a chart review, review of progress notes, and interviews with treatment providers. There seems to be an unspoken standard

of care for which reviewers look. However, training programs may fail to explicitly identify this standard of care. Each training program should develop a specific document which identifies their standard of care, ways to assess for suicide risk, a decision-making process to follow, strategies for managing suicidal clients, appropriate documentation to use, and ways of coordinating continued care (Cukrowicz, Wingate, Driscoll, & Joiner, 2004; Oordt, 1996).

In addition to an explicit standard of care, training programs should also provide ongoing didactic training. At times, training programs front load trainees with didactics and agency trainings (Melton & Coverdale, 2009) and fail to provide any review for the information as the training progresses. This review could take place in formal seminars, journal clubs, or in clinical supervision with ongoing dialogue regarding clients who are at higher risk for suicide.

Currently academic and training programs do not seem to appreciate the complex factors and emotionality involved in suicide. Suicide is an act that leaves those involved with many questions, most of which go unanswered. Given the impact suicide has, it is important to be as proactive as possible, rather than focusing on postvention responses. After reviewing this paper, my hope is that academic programs and training programs will note the multitude intervention points possible for suicide training and incorporate these suggestions into their training.

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Appendix A

Electronic Questionnaire

Demographic Information

- Current program: Clinical Psychology
  Counseling Psychology
  Educational Psychology
  Psy. D.
  Ph. D.
  Ed. D.
- Current internship status: pre-internship, current intern, post-internship
- Did you receive training in suicide prior to your enrolling in your academic program
- Approximately how many hours of training in suicide have you received
- Was training formal or informal:
- If formal, what type of training: class/workshop, lecture, required reading, seminar/journal club

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 record a rating from -3 to +3, corresponding to the chart below. Be sure to respond to each item and try not to leave any blanks.

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

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

_____ *Helper A:* You say you´re suicidal, but what is it that´s *really* bothering you?
_____*Helper B:* Can you tell me more about your suicidal feelings?

2. Client: And now my health is going downhill too, on top of all the rest. Without my husband around to care for me anymore, it just seems like the end of the world.

_____ *Helper A:* Try not to worry so much about it. Everything will be all right.
_____ *Helper B:* You must feel pretty lonely and afraid of what might happen.

3. Client: But my thoughts have been so terrible…. I could never tell them to anybody.

_____ *Helper A:* You can tell me. I´m a paraprofessional, and have been trained to be objective about these things.

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

_____ *Helper A:* It seems like you´ve been suffering so much that cutting your wrists is the only way you can make the pain go away.
_____ *Helper B:* But you´re so young, you have so much to live for. How can you think of killing yourself?

5. Client: What are you anyway? Are you a doctor? How do you know what I´ve been going through? You´ve probably always had it pretty soft.

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

6. Client: My life has been worthless ever since my wife, Emma, died four years ago. The kids are grown and married now, and I´ve been retired from my job at the railroad for some time. It just seems that I´d be better off dead.

_____ *Helper A:* But try to think of what Emma would want for you. She´d want you to continue leading a productive life, wouldn´t she?
_____ *Helper B:* It sounds like everything just collapsed around you when Emma died. … But what has happened recently to make things even worse, to make you think that dying is the only way out?

7. Client: I really need help.… It´s just….{voice breaks: silence}

_____ *Helper A:* It must be hard for you to talk about what´s bothering you.
_____ *Helper B:* Go on, I´m here to listen to you talk.

8. Client: When you sum up my problem like that, it makes it seem less confusing and not so scary.

_____ *Helper A:* See, it really isn´t so bad after all. It certainly isn´t anything you would think of killing yourself over, is it?
_____ *Helper B:* Sometimes talking about problems does make them a bit clearer. I think you 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.

_____ *Helper A: I ´*m sorry. I was only trying to help.
_____ *Helper B:* You sound pretty angry.

10. Client: How could you ever help me? Have you ever wanted to kill yourself?

_____ *Helper A:* It sounds like you ´re concerned about whether I can understand and help you.
_____ *Helper B:* Sure, I´ve thought about suicide sometimes. But I always found more realistic solutions to my problems.

11. Client: I don´t know… this whole thing with my wife really gets to me {sobs}. I try so hard to keep from crying….

_____ *Helper A:* Do you think that the reason it´s hard for you to cry is because you´re a man?
_____ *Helper B:* With all the hurt you´re feeling, it must be impossible to hold those tears in.

12. Client: How can I believe in God anymore? No God would ever let this happen to me; I´ve never done anything to deserve what´s happened.

_____ *Helper A:* Things have gotten so bad, that it´s difficult to see any meaning in the things that have happened to you.
_____ *Helper B:* Well, God works in mysterious ways. Maybe this is His way of testing your faith.

13. Client: I don´t know why I´m calling you. My family is financially well off, and my husband spends plenty of time with me, even though he has a successful law career. Even my kids have been doing well. They get good marks at school and have lots of free time activities with their friends. But nothing seems to interest me. Life is just a bore ….

_____ *Helper A:* Considering all you have going for you, your problems can´t be all that serious. Try to focus more on the positive aspects of your situation.
_____ *Helper B:* So even though things seem to be going well at one level, life still seems pretty depressing, even if it´s hard to say exactly why.

14. Client: I have to hang up now. My mother´s coming home soon and I don´t want her to know I´ve been talking to you.

_____ *Helper A:* Okay, but if you keep feeling suicidal, remember you can always call back.
_____ *Helper B:* All right, but first I want you to promise me you won´t do anything 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.

_____ *Helper A:* No, there are many people who suffer from mental illness. But with appropriate treatment by a qualified physician, some of these patients can be cured.
_____ *Helper B:* It is true. You´re not the only one who has suicidal thoughts. And you can be helped to get through this crisis, just as others have been.

16. Client: I´m so lonely, so tired {crying}. There just isn´t anywhere left to turn.

_____ *Helper A:* You seem so alone, so miserable. Have you been feeling suicidal?
_____ *Helper B:* Come on now. Things can´t be all that bad.

17. Client: {Over telephone} It´s hard to talk here, with all these people ….

_____ *Helper A:* Would it help if I asked questions?
_____ *Helper B:* Why don´t you call back some other time when you can talk more easily?

18. Client: I have a gun pointed at my head right now, and if you don´t help me, I´m going to pull the trigger!

_____ *Helper A:* You seem to be somewhat upset.
_____ *Helper B:* I want you to put down the gun so we can talk.

19. Client: Why should you care about me, anyway?

_____ *Helper A:* I´ve been trained to care about people. That´s my job.
_____ *Helper B:* Because I think your death would be a terrible waste, and it concerns me that things are so that you are considering suicide. You need help to get through this critical period.

20. Client: I really hate my father! He´s never shown any love for me, just complete disregard.

_____ *Helper A:* You must really be angry at him for not being there when you need him most.
_____ *Helper B:* You shouldn´t feel that way. After all, he is your father, and he deserves some respect.

21. Client: I don´t think there´s really anyone who cares whether I´m alive or dead.

_____ *Helper A:* It sounds like you´re feeling pretty isolated.
_____ *Helper B:* Why do you think that no one cares about you anymore?

22. Client: I tried going to a therapist once before, but it didn´t help… nothing I do now will change anything.

_____ *Helper A:* You´ve got to look on the bright side! There must be something you can do to make things better isn´t there?
_____ *Helper B:* Okay, so you´re feeling hopeless, like even a therapist couldn´t help you. But has anyone else been helpful before – maybe a friend, relative, teacher, or clergyman?

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

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

_____ *Helper B:* I´m not sure I agree with that diagnosis. Maybe you should seek out some psychological testing, just to be certain.

24. Client: I can´t talk to anybody about my situation. Everyone is against me.

_____ *Helper A:* That isn´t true. There are probably lots of people who care about you if you´d only give them a chance.
_____ *Helper B:* It must be difficult to find help when it´s so hard to trust people.

25. Client: {Voice slurred, unclear over telephone}

_____ *Helper A:* You sound so tired. Why don´t you get some sleep and call back in the morning?
_____ *Helper B:* Your voice sounds so sleepy. Have you taken anything?