Crisis Intervention, 1969, Volume 1, Issue 1

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EDITORIAL NOTE

The staff of the SPCS of Buffalo believes that there is a need to develop a method by which the ideas and programs of the more than 100 suicide prevention centers in the United Stated can be shared. The history of suicide prevention centers is very short and the process of development and the programs of each center differ greatly. Yet all are designed to reach a very special individual and to do so primarily through telephone contact. If we can share the ideas and programs which we have developed through the difficult and arduous process of experience, we can learn from each other's successes and mistakes and, having a greater fund of experiences at our disposal, improve the quality of service to the individual in need.

With this goal in mind, we have established a new bi-monthly bulletin CRISIS INTERVENTION: The Bulletin Of The Suicide Prevention And Crisis Service Of Buffalo, New York. Each issue will be concerned with 3 major areas:

(I) Programs of suicide prevention centers,
(II) Clinical aspects of crisis intervention and suicide prevention, and,
(III) Current issues and research in suicidology and crisis intervention.

We would welcome receiving contributions of any type; letters, comment, descriptions of new and planned programs, case notes, and articles about research into suicide and crises. We are especially interested in hearing from other suicide prevention centers.

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NEW PROGRAMS

A Brief View of the History and Services of the Suicide Prevention and Crisis Service

Gene W. Brockopp, Ph, D., Erie County SPCS.

In April of 1966, at the request of the Mental Health Association and the Psychological Association of Western New York, the Community Welfare Council appointed a committee to determine the need for a Suicide Prevention Service in Erie County. Peter F. Ragan, M. D., Executive Vice-President of the State University of New York at Buffalo was appointed chairman of the group and Miss Mary Champlin of the Community Welfare Council served as the executive staff member. During the next year, the committee collected information on various suicide centers in the United States and Europe and on the need for such a service in the Erie County community. In this process, they interviewed all the agencies in Erie County which dealt with individuals who might be suicidal. Each agency was queried regarding its knowledge of the extent of the problem and how it might best be handled. Almost unanimously, they felt that there was a need for a new service in Erie County which would focus on this critical area.

In March of 1967, the committee presented a thoroughly documented plan for a Suicide Prevention and Crisis Service to the Community Welfare Council. This plan was subsequently adopted by them and presented to the public in a public meeting. A committee, with Charles C. Victor, a local businessman as chairman, was formed and discussions were held with the Erie County Mental Health Department regarding establishing and financing this new agency. The Commissioner of Mental Health, James Warde, M.D. was enthusiastic about the proposed program and agreed to support the development of the service as a contract agency of the Erie County Mental Health Department. Initially, a budget of $50,000 was allotted for this service in the Mental Health Department budget. In April of 1968, a nation-wide search was begun for an Executive Director to head the organization and, in July of 1968, Dr. Gene Brockopp, a Fellow in Psychiatry (suicidology) at Johns Hopkins Medical School was appointed to this position by the Board of Directors.

Initially, it was felt that the agency should develop an emergency telephone service, use volunteers, have a limited clinical program and initiate some research into the problem of suicide. After analyzing the community, its needs, the present mental health programs in the area and then discussing the potential value of various programs with the Commissioner of Mental Health, it was decided that the agency should have broader purposes and concerns in the area of emergency mental health services. The Service was therefore designed to be an innovative unit which would explore new methods of treatment and handling people in emotional crises through a variety of therapeutic services. It would also provide training and educative programs in crisis intervention and have a comprehensive research program undergirding the whole service.

To accomplish this, the Service was organized around three major functions: (1) The Crisis Clinic of Erie County; (2) Institute for Training in Crisis intervention; and, (3) The Center for the Study of Personal and Social Disorders. Each of these areas was to be headed by a Director, who would function with the Executive Director in administering the agency. These three services will be briefly discussed.

The Erie County Crisis Clinic, under the interim direction of Gene W. Brockopp, Ph. D., maintains a 24-hour emergency service available to all individuals in the community. This

service is available either through telephone contact (854-1966) or by the individual presenting himself at the clinic. In either case, consultation, therapy or assistance is given to the individual immediately upon request or within a very short period of time. During the day the telephones are manned by the professional or counseling staff of the center; during the evening and through the night, the telephones are manned by a cadre of trained individuals ranging from housewives to nurses, social workers and psychologists who are specifically trained by the center to perform this vital function. The clinic also sees individuals in crisis on a face-to-face basis through maintaining a short-term intensive psychotherapy program which uses both group and individual modes.

The institute for Training in Crisis Intervention, under the direction of Nancy Bourne, ACSW, is concerned with educating and training both community and professional groups in the techniques of crisis intervention and in assisting them to provide these services through their own agencies. High priority is given to the training of non-professional people at the center. Presently, five individuals, selected from the community, having no professional background, are being given specialized professional training to enable them to function as highly trained counselors in the field of crisis intervention. Continuous training programs are being given for new members of our night watch staff and in addition, training programs of a seminar or workshop type have been given to specific groups in the community, including other agencies, social workers, nurses, the police department, counselors, teachers and psychiatrists.

The third task of the Center is to provide systematic research in the area of crisis intervention and suicide prevention. This is accomplished through the Center for the Study of Personal and Social Disorders under the direction of David Lester, Ph. D. The types of calls that are received are continually analyzed as well as the changes in the type of calls over the period of time that the center has been in operation. Investigations into completed suicides in Erie County have been begun as well as the types of patients and problems that are being seen in the clinic. Research projects are being designed to measure the effectiveness of the center's operation and look into the type of center that should be developed in the community in order to meet the specific needs of the community. Programs for the future include research into the disrupting factors in the community and interplay between the social settings and the individual's aggressive behaviors.

To accomplish these varied tasks, the service is staffed by four different types of individuals: (1) Professionally-trained individuals who operate out of most mental health disciplines (including psychology, social work psychiatry, nursing and ministry), individuals who, by training and experience, are qualified to work in a center of this nature; (2) trained non-professional people who are selected from the Erie County community and who are trained by the center staff to be counselors and who will be placed in other community agencies in Erie County after they are trained; (3) Clinical Associates who are trained to answer the telephones at nights or on weekends and who vary in background from high school graduates to mental health professionals; (4) Befrienders or non-professional individuals who live in the community and who are called on by members of the staff to provide personal contact and support for individuals in crises.

The staff of the center consists of six professional staff members, five non-professional counselors, an administrative assistant, three secretaries, two part-time psychiatric consultants, a part-time social work consultant, a part-time nursing consultant, and forty clinical associates. A board of 26 directors selected to represent the business, general public and professional community, and elected by a membership corporation, operate the service as a contract agency of

Erie County Mental Health Department. The funds for its operation are received entirely from County and State tax monies with the budget for 1969 being $200,000.00. The center is located in a downtown office building in a suite of 18 offices, teaching and therapy rooms.

The center began telephone operation on November 12, 1968. To date, (Oct. 14, 1969) 7,300 calls have been received from over 3,700 individuals in various types of suicidal or emotional crises. Approximately 1,000 calls a month are now handled at the center. In addition, approximately 175 people have been seen at the Center in short-term intensive psychotherapy.

As a result of the first six months of operation and the analyses of the calls received at the center, a number of changes in the center and its programs have been proposed. Two additional phone numbers, one under the heading of Programs of Living and one under the term of Teenage Problem Service are being placed into operation. It is expected that separate telephone numbers under these headings will facilitate the movement of individuals in emotional crisis to the center through eliminating the need for them to come in under the term "suicidal." It is also proposed that the center develop an outreach program into the community, visiting all-night restaurants, bars, eating places, recreation centers, etc., allowing people who frequent these places to have access to counselors. An intensive daycare center, as an alternative to hospitalization, has also been proposed for next year. This unit would be built on a non-medical model, utilizing community resources and attempting to work with the inter- and intra-personal emotional problems in terms of the individual's social milieu.

In summary, the center is designed to provide a specialized crisis and suicide emergency service in the Erie County community and to assist both present and developing community agencies to take over this function as part of their operation. Through the development of an outstanding clinic service, a model of how this can be accomplished and how new methods of intervention can prevent suicide and emotional crisis is being developed.

Through research, the causes of emotional and suicidal crisis are being investigated and new ways to cope with them are being evaluated. Through education and consultation, the development of emergency mental health services in both existing and developing mental health clinics is being fostered, and both the public and the profession are being educated regarding emergency mental health services and psychological first-aid.

It is anticipated that other agencies in the community having a broader therapeutic base than the Center will begin to take over these specialized services as part of their operation in the future.

This Center is therefore programmed to go out of existence as soon as these community agencies are able and willing to provide these services throughout the area. It is hoped that this can be accomplished within a period of five to seven years when a system of community mental health centers, in concert with existing agencies, will be ready to provide the complete range of mental health services for all individuals in Erie County.

ARTICLES

Characteristics of Those Who Call the Suicide Prevention and Crisis Service of Buffalo[1]

David Lester Ph. D. Erie County SPCS.

The Suicide Prevention and Crisis Service of Buffalo has already become one of the busiest suicide prevention centers in the United States. In August, 1969 the center received 449 calls from new patients, 552 calls from patients who had already made one contact with the center, and 835 incompleted calls (that is, calls in which the caller hangs up, makes some obscene comment, says that he has a wrong number, etc.) For comparison, the Suicide Prevention Service of Ancora State Hospital in Hammonton, New Jersey, received 160 serious calls in its first eleven months of operation and the daily rate leveled off to 2-3 per day. (Brunt, et al., 1968). At the Erie County Suicide Prevention and Crisis Service (which, of course, serves a larger population) the daily rate is 20-40 calls and the number is rising steadily.

Between the date of opening, October 31st and February 13th, 1969, a total of 626 new patients made contact with the center via the telephone. This paper will describe the characteristics of this population.

When a patient calls the center, the counselor attempts to collect some data about the patient and his problem and to write this down on a specially designed form. Of course, since the handling of the patient's problem is the primary function of the counselor (and not data collection) information is often not obtained on many of the patients. If information is not available, the counselor is asked to guess the race and the age of the patient.

The Typical Patient[2]

The modal caller was female (69.6% of the callers to the center were female), aged 35-44 years of age, was single (44.9% of the callers were single and 35.0% were married), was not living alone, was white, identified himself (only 34.7% of the callers to the center remained anonymous), and was employed (29.2% of the callers were employed) or a housewife (29.7% of the callers were housewives).

There was a tendency for there to be more calls on Wednesdays and fewer on Sundays but this difference did not approach statistical significance (on a chi-square test, $X^2 = 9.98$, df = 6). The least busy time for calls was between 4 A.M. and 8 A.M. and the busiest time was from noon to 4 P.M. However, the calls received were evenly distributed over the day with the exception of the very early morning.

In 23.2% of the calls, the caller claimed to be calling about some other person who was in crisis. In the remaining 76.8% of the calls, the caller was the patient. The majority of the problems were concerned with interpersonal problems and the majority of these problems concerned the spouse. Only 7 calls were traced and these were in cases where the counselor deemed it necessary to send aid to the patient. Forty-four patients were seen subsequently at the center out of 82 patients for whom appointments were made.

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[1] The research assistant for this paper was Kitty Priebe.

[2] The following percentages were computed for those patients for whom the necessary information was available.

Of the calls, only 14.8% had a presenting problem of suicidal preoccupation (as listed by the counselor). However, in the course of the telephone contact 21.3% of the patients reported having made one or more suicide attempts in the past, a further 12.8% reported having threatened suicide, and 17.9% reported having thought about suicide in the past. Each patient is supposed to be rated by the counselor on a simple 5-point rating scale for the degree of suicidal risk. Of the 225 patients who were rated on this scale by the counselors, 20.0% received the highest rating for suicidal risk.

Anonymous Callers

Many of the callers to s suicide prevention center refuse to identify themselves. Tabachnick and Klugman (1965) compared a small sample of anonymous callers with a sample of patients who did identify themselves. They found that the anonymous callers presented problems concerned with being manipulated more than the callers who identified themselves. The anonymous callers seemed more intent on irritating the counselor than in receiving help and this often alienated the counselor which in turn made the caller more defensive. The anonymous callers were offered more office interviews than those callers who identified themselves but they were less likely to accept these appointments. Tabachnick and Klugman noted that the anonymous callers were older, more often psychotic, more often male, and more often living alone than those callers who identified themselves.

For those calling the Erie County Suicide Prevention And Crisis Service, the anonymous callers did not differ from the callers who identified themselves in sex ($X^2 = 0.90$, df = 1)[3] or in race ($X^2 = 0.00$, df = 1) They were significantly more likely to be single ($X^2 = 19.10$, df = 1, $p = 0.01$) and they were significantly younger ($p = 0.01$). They were more likely to be calling for themselves than on behalf of someone else ($X^2 = 30.55$, df = 1, $p < 0.01$). They were less likely to have children ($X^2 = 14.35$, df = 1, $p < 0.01$) and more likely to be students ($X^2 = 7.25$, df =1, $p < 0.01$). They were not more likely to be under the influence of alcohol or drugs while on the telephone ($X^2 = 1.87$, df = 1).

They did not differ from those who identified themselves in the suicidal risk assigned to them by the counselors or in presenting the problem of suicidal preoccupation to the counselor ($X^2 = 0.00$, df = 1). They did not differ in suicidal history. They tended more often to be calling for information about the service ($X^2 = 8.88$, df 1, $p<0.01$).

These results are not very reliable since less information was available about the anonymous callers than for those who did identify themselves. Obviously, if they are withholding their name, they may very well withhold other information also. However, it can be seen that the anonymous callers in Buffalo differ considerably from those in Los Angeles as described by Tabachnick and Klugman. For example, in Los Angeles they were older than callers who identified themselves, whereas in Buffalo they were younger.

In Buffalo, the impression is that the anonymous callers are young, single, often still students, who do not want to commit themselves to making a direct appeal for therapeutic help. They call to ask for information and perhaps they are still deciding whether to ask for help. It is a very important part of a counselor's task not to react with hostility and frustration to anonymous

[3] Where a X^2 value is given in parentheses, the statistical test used was the chi-square test. Where only a significance value is given the test used was the Kolmogorov-Smirnov two-sample test (Siegel, 1956).

callers (the tendency noted by Tabachnick and Klugman) for, if they are handled correctly, they may be encouraged to make use of the service and so receive the aid that they need.

Callers With A History Of Suicide Attempts

Among the sample of callers to the center were 168 patients who reported no history of suicidal preoccupation and a sample of 68 patients who reported having attempted suicide at least once in the past. These two groups of patients did not differ in sex ($X^2 = 0.09$, df = 1), age, current marital status, whether they had children or not ($X^2 = 0.03$, df = 1), whether they were living alone or with others ($X^2 = 1.96$, df = 1), race ($X^2 = 0.00$, df = 1), whether they remained anonymous or not ($X^2 = 0.11$, df =1), or employment status.

However, the two groups did differ in presenting problem and psychological state during the call. The former suicides were more likely to be under the influence of alcohol or drugs while calling ($X^2 = 18.49$, df = 1, $p < 0.01$), were more likely to be currently alcoholics or drug addicts ($X^2 = 10.91$, df = 1, $p<0.01$), and more likely to have had previous psychiatric hospitalization ($X^2 = 27.51$, df = 1, $p < 0.01$).

None of the patients without a history of suicidal preoccupation presented a problem that was characterized as suicidal by the counselor. The counselors rated the patients with a history of suicidal behavior as greater suicidal risks than those without a suicidal history ($p < 0.01$).

Those patients with a history of suicidal attempts were less likely to have their problem resolved over the telephone ($X^2 = 5.44$, df = 1, $p< 0.05$). However, there was no difference between the groups in whether they were handled solely by the center (the patient calls back or visits the center) or in whether they were referred to some other community agency for treatment or advice ($X^2 = 1.98$, df =1). There was no difference in the proportion of patients seen at the center ($X^2 = 0.02$, df = 1).

This appears to indicate that patients with a history of suicidal attempts were rarely handled solely by means of the one telephone call. They frequently ended the telephone contact by hanging up and they were frequently referred to the center for further contact or to some other agency. This presumably reflects the fact that they were more disturbed and were presenting more serious problems than the average caller.

The general trend of these results is that the patient with a history of suicide attempts did not differ from those who reported no history of suicidal preoccupation on simple demographic variables. The differences lay in their history of psychiatric health and in their emotional state while on the telephone. This finding is of interest in that many scales devised to assess suicidal risk using personal data include items related to demographic variables (Lester, 1970). As yet, the center has not identified a sufficiently large enough sample of patients who have attempted or completed suicide after calling the center so that a predictor of future suicidal actions can be devised. However, when this is done it will be of interest to examine whether the potentially suicidal callers in Buffalo will be predicted with the aid of demographic variables or not.

Callers Rated As Suicidal Risks

There were 23 patients rated with maximum suicidal risk. For the most part the differences between the high-risk group and a low risk group resemble the pattern of differences between those with a history of suicide attempts and those with no history of suicidal

preoccupation. What is of special interest here is what the counselors did with the patients who were rated with maximum suicidal risk.

Although there was a tendency for the more suicidal patients to hang up more, for their problems to be less resolved over the telephone, and for a greater proportion of them to be given an appointment at the center for short-term crisis intervention, these differences were not statistically significant. On the whole, therefore, the patients rated with maximum suicidal risk were disposed of in roughly the same manner as those with minimum suicidal risk.

It is difficult to determine whether this state of affairs is desirable or not from this evidence. It may reflect mature clinical judgment on the part of the counselors in recognizing the difference between a potential completed suicide and the individual who frequently threatens and attempts suicide (but never lethally). On the hand it may reflect misjudgment on the part of the counselors. More detailed evidence is required before an adequate evaluation can be made.

This illustrates the importance in a growing and busy center of constant monitoring of the clinical aspects of the program by the research staff. The feedback that is generated can be of enormous help in revising the training of counselors and in modifying the practices of the center.

Summary

This paper has described some of the characteristics of the patients calling the Erie County Suicide Prevention and Crisis Service. The modal caller was described and differences between anonymous and non-anonymous callers and between suicidal and non-suicidal callers were examined.

References

Brunt, H. H., Rotov, M., and Glenn, T. A suicide prevention center in a public mental hospital, Ment. Hyg., 1968,52, 254-262.

Kaphan, M., and Litman, R. E. Telephone appraisal of 100 sucidal emergencies, Amer. J. Psychother., 1962, 61, 591-599.

Lester, D. Attempts to predict suicidal risk with psychological tests. Psychol. Bull., 1970, in press.

Siegel, S. Nonparametric statistics for the behavioral sciences. New York: McGraw-Hill, 1956.

Tabachnick, N., and Klugman, D. J. No name: a study of anonymous suicidal telephone calls, Psychiat., 1965, 28, 79-87.

CASES

The Masturbator

Gene W. Brockopp, Ph.D. and David Lester, Ph.D. Erie County SPCS

After a few days of working at a Suicide and Crisis Service, answering calls from people in various types of difficulties and crises, the telephone therapist learns to respond to most problems with a type of "concerned objectivity." Yet some problems seem to tap a system of responses which generally is not therapeutic and leaves the therapist with a feeling of hurt, anger, or uselessness. One of the situations which probably does this more than any other is the call from a male who seems to use the services of the center for the sole purpose of masturbating to the voice of a female. For example, a few months ago, the following note was entered into our case file:

> A man masturbating while saying: "Talk to me. Don't leave me". I was not able to locate his file but felt he had called before. As he became more excited he became more verbal with remarks like "Open your legs." I terminated call by suggesting he call back when he had finished to discuss why he needs a stranger rather than a friend at this time.

Over the past few months, this type of phone call has been received about three times a week.

The problems associated with this type of call can be divided into three categories: first, how to develop an appropriate treatment plan for this type of caller; second, how to deal with the feelings of the telephone therapist who receives the call; and third, the effect of this type of call on the service the agency is to perform in the community at large. It should be noted that these problems are not unique to calls from masturbators, but are associated with any type of difficult call that a telephone service receives. For example, females may call the center and act seductively to a male counselor, callers may arouse hostility and anger in counselors by the difficult problems they present, or callers who by their unwillingness to work with the telephone therapist evoke in them the feelings of inadequacy. Certainly the call from a person who is actively suicidal will raise the anxiety of the telephone therapist and may make it more difficult for him to react appropriately to the crisis situation.

Yet the masturbator does, perhaps, require special attention because his calls not only have a very disrupting effect on counselors by arousing very strong negative emotions in them which may result in their inadequate handling of the call but also because the aroused emotions generally have a negative effect on the handling of subsequent calls made by individuals with other types of problems.

From our analysis of the calls received at the center, there appears to be two types of masturbating callers. One type will discuss a problem which may or may not be fictional and, either the counselor will suspect that the caller is masturbating and confront him with this, or the patient himself will admit to masturbating. To this type of person, the counselors have reported feeling "useless" or "ineffectual," and, afterwards, "furious at putting in hard work to no end."[4] The second type of caller merely breathes heavily and says words like: "talk to me," "don't leave

[4] These are the responses of female phone therapists. Our experience with this type of caller is that he will hang up whenever a male answers the phone.

me," "please let me finish," and so on. He may hang up frequently and then call back immediately.[5] To this type of person who does not allow the counselor to establish a relationship that can be seen by her as possibly therapeutic, the counselor reports feeling "used," sexually exploited," "angry," "uptight," or "disgusted." These feelings are intensified if the counselor is alone at the center at night. Often the counselor feels that she can handle the situation intellectually, but not emotionally.

Without question, the therapist's feelings of anger, hostility, or disgust will interfere with the handling of this type of call. In most cases the counselor is responding to her own feelings rather than to the patient's problem. It appears that this may be a result of the counselor's attitudes toward "deviant" sexual behavior, her inability to know what a therapeutic response would be, or a combination of both. If the problem is the result of the counselor's attitude toward this type of behavior, it should be dealt with on an individual basis between her and her supervisor. The discussion would, of course, extend beyond the particular case of the masturbator to cover such issues as the counselor's attitudes towards sexual behavior in general and the feelings aroused when the counselor feels inadequate in the handling of a patient call. From our discussions with telephone counselors, it appears that their inability to respond therapeutically to the masturbator is a result of a lack of specific knowledge on the handling of this type of call combined with the intense emotional feelings of being "used" incorrectly by the caller. It is to these two issues that we would like to address ourselves.

Before discussing the possible handling of the masturbator, it might be well to discuss the philosophy of the telephone service. The unique feature of telephone therapy is its ability to respond immediately to individuals in difficulty on their own basis, with anonymity, and with the control remaining with the patient. In this type of therapy situation more than any other, the therapist is at a distinct disadvantage in that he does not have personal face-to-face knowledge of his patient. He has minimal clues with which to work and he must accept the fact that the patient has as much (possibly more) control of the situation as he does. It, therefore, is necessary for him to move into the problem situation on the patient's own bases, and only on the patient's bases.[6] If he does not do this, he may lose the patient, probably irretrievably, since in many cases he has no knowledge of the person's name, address, or phone number. It would, therefore, seem imperative that the axiom of meeting patients "where they are" would become the basic guideline for working with all types of difficult calls.

With this as a background we would like to list five possible approaches to handling the masturbator, in the hope that these suggestions would not only aid the counselor in a practical way when receiving such a call but also make alternative behaviors available to her so that she may feel more adequate in handling this type of caller.

1. The counselor can respond by saying nothing or with controlled silence.
2. The counselor can communicate her disgust to the caller and/or hang up.
3. The counselor can try to be accepting, but point out that the caller has a problem, that he could benefit from counseling, psychotherapy, or from seeing someone and talking about his problem, and then hang up.
4. The counselor could try to establish a minimal relationship with the masturbator, urge him to call her back after he has finished masturbating.

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[5] On one occasion as many as 22 calls have been received from such an individual in the space of two hours.

[6] We would like to emphasize that we are speaking here about the development of a relationship and not about the subsequent therapeutic movements.

5. The counselor can stay with the caller, allow herself to be used if necessary, with the hope that the relationship can move from this level to one in which she can be more therapeutic to the person calling.

It appears to the authors that the first two approaches are at odds with the concept of a telephone service devoted to rendering therapeutic assistance to individuals in the community. Both of them either reject the patient overtly or communicate non-acceptance of the patient by the therapist. Without acceptance of the patient, regardless of his behavior or feelings, a therapeutic relationship is most difficult, if not impossible to establish. It could be argued however, that a strong negative response on the part of the counselor might negatively reinforce the behavior and cause it to extinguish. In a controlled therapy situation, this may take place. On the telephone, however, a more likely occurrence would be the calling of another person by the masturbator until he had obtained the verbal assistance of a female to complete his task. Mere rejection of the behavior by the therapist would appear to be of value only in allaying some of the therapist's feeling.

Response No. 3 is better but since many of the callers do not see masturbation as a problem, they may not see any reason for coming in for a face-to-face discussion. Indeed, it is most unlikely that this type of exchange will take place, for this person is unlikely to make himself known to the therapist. Also, this approach rejects, but to a lesser extent, the use of a telephone as a means of aiding the individual. However, if the counselor has personal concerns in handling such a call, this approach is probably the best for her to take.

Response No. 4 requires more acceptance of the patient by the counselor, but the chances of the person calling back after he has finished masturbating are probably slight. An extension of this approach would be for the counselor to suggest other stimuli for the masturbator to use to achieve sexual gratification in a more private manner, such as television, radio, or records. This may reduce the negative social aspects of the patient's behavior, but will also decrease the possibility of his receiving appropriate help.

Response No. 5 is clearly the best, in that the therapist is responding in a way that will maximize the chances for developing a relationship with the patient which may later be used for therapeutic purposes. It should be emphasized here, that acceptance of the person does not imply the reinforcing of the behavior or the condoning of it. It means tolerating the condition while attempting to develop a more honest, trusting relationship with the patient. The counselor of course must be careful not to be too seductive or encouraging. Conversely, she also must not be too confrontative to the patient. To ask the person why he is masturbating may be too difficult a question for him to answer and impose too much distance between him, the counselor and his present behavior. The focus of the counselor should be on the affective relationship and the value of it for the patient. Perhaps the patient is lonely and depressed or is having difficulty in developing socially desirable relationships. Focusing on these areas may facilitate establishment of a more sustained and positive therapeutic relationship and may facilitate the patient's visit to a therapist if the relationship moves to a point where trust can be established between the patient and the counselor. Also focusing on the purpose or goal of the behavior seems to be more appropriate and less threatening than an attempt to discover the underlying genesis of the behavior. The patient can be asked what he feels his behavior is achieving for him, how he feels calling achieves this end for him, and how he sees his own behavior.

To use this last approach, the counselor must be aware of her own feelings in responding to this type of patient but keep them in the background. She must recognize that her approach to

him must be one that meets him at the level of his needs, with the covert intent that, if a relationship of trust can be established, the patient may look at his behavior in a more positive and therapeutic manner. Recognition must be given to the fact that this may never be achieved – that the patient may simply use the therapist for his own end without any therapeutic movement on his part. Even though this may take place, and the therapeutic relationship may be misused, we feel that the counselor on the telephone cannot set demands which might be appropriate when counseling a person on a face-to-face basis. Therefore, we feel that, if a person can only relate on the telephone through masturbating, it is necessary to meet the person at this level, not to demand that he change his behavior, but hope that, in the process of being used by him in this way, in the present, a therapeutic movement can be made in the future.

NEWS AND NOTES

Research at the Erie County SPCS

The research staff has been occupied with looking at characteristics of the callers to the SPCS and in writing articles for publication. Some recent articles are:

Lester, D. The anti-suicides pill. JAMA 1969, 208, 1908. It was noted that attempted suicides occur most often in women during the premenstrual and bleeding phase of the menstrual cycle whereas successful acts occur during the ovulation phase. It was suggested that it may be that the birth-control pill will reduce the suicide rate in women by changing the hormone balance during the ovulation phase of the menstrual cycle.

Lester, D. Suicidal behavior in men and women. Mental Hygiene, 1969, 53,340-345. Differences in the suicidal behavior of men and women were discussed and reasons for these differences suggested.

Collett, Lora-Jean, & Lester, D. The fear of death and the fear of dying. Journal of Psychology, 1969, 72, 179-181. A test to measure the fear of death was devised, with separate subscales to measure fear of death of self, fear of death of others, fear of dying of self, and fear of dying of others.

Lester, D. Suicide as a positive act. Psychology, 1969, 6, 43-48. The view of writers who believe that suicidal behavior may not have always deleterious effects on the individual are reviewed.

Lester, D. Fetal suicide. JAMA, 1969, 209, 1367. The report of a case of a fetus committing suicide is questioned but is used to test available concepts used in writing on suicide death.

Crisis Intervention For Counselors

The staff of the SPCS of Buffalo is offering a course for counselors through the Continuing Education Division of the State University of New York. Twenty-one individuals including school counselors, social workers, rehabilitation specialists and clergymen are enrolled in this course, which meets for five two-hour sessions. The purpose of the course is to broaden and upgrade the skills of counselors in crisis intervention by alerting them to the methods and techniques available to the counselors in handling crisis situations. Opportunities are given during the course for individuals to role play, develop interviewing skills, listen to taped materials and work with some practical aspects of crisis intervention. Five major topic areas are included in the format of the course.

1. The theory of crisis intervention and short-term therapy.
2. Practical considerations in crisis intervention.
3. The use of the telephone in crisis intervention and the concept of lethality in suicidal behavior.
4. Working with adolescents in crisis.
5. Modes of therapy in crisis intervention.

Four staff members are teaching the course: Nancy Bourne, A.C.S.W., Gene Brockopp, Ph. D., Marcia Schlenker, M. S. W., Allen Yasser, Ph. D. It is expected that the course will be offered again in the spring semester of next year.