Crisis Intervention, 1970, Volume 2, Issue 1

CONTENTS

INFORMATION FOR CONTRIBUTORS

CRISIS INTERVENTION is intended to facilitate communication on

(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.

CRISIS INTERVENTION is published six times per year. It is sent free of charge to Suicide Prevention Centers.

Manuscripts should be double-spaced and conform to the publication manual of the American Psychological Association. Send manuscripts to: Dr David Lester or Dr. Gene Brockopp, Suicide Prevention and Crisis Service, Suite 405, 560 Main Street, Buffalo, New York, 14202.

GUEST EDITORIAL

Current Directions for Suicide Prevention and Crisis Intervention

Calvin J. Fredrick, Ph. D.
Assistant Chief, Center for Studies of Suicide Prevention, NIMH

Not only in the field of crisis intervention and suicide prevention but in the entire mental health field today, broad, new, creative and innovative services comprise the present watchword. The emphasis is away from traditional approaches to treatment and in the direction of reaching larger groups of society which heretofore have received little attention. Many of these groups have become high risk groups, such as Indians, professional groups, college students, and the aged. Methods to do effective research and provide realistic and practical treatment is a sine qua non.

The study of so-called "psychological equivalents" of suicide also warrant further attention and expansion. Example of these areas are: alcoholism and its relationship to self-assaultive behavior; heavy smoking in persons with respiratory disorders; violent behavior among minority groups which invariably leads to self-destruction; and reckless auto driving. Clinically and anecdotally, the evidence points in the direction of a great deal of suicidal behavior in these areas of activity.

Any clinic should ideally be a community clinic designed to meet the needs of the area it serves as fully as possible. Unfortunately, this has not often been the case. Suicide prevention and crisis intervention clinics can lead the way in this endeavor more effectively than older and more traditional clinics have done in the past. They should not wait but be in the vanguard of future mental health development.

PROGRAMS

Seven Predictions for Suicide Prevention in the Seventies[1]

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

Less than two decades ago the first suicide prevention center was opened in the United States. Today such centers play such a vital role in our array or mental health services that it is difficult to imagine that this specialized center, devoted to helping individuals in suicidal or other severe emotional crises, is such a relatively recent innovation. In its short, exciting history the suicide prevention center has radically changed, incorporating many new ideas and discarding those that did not prove useful. In this short paper I would like to take a look at the future of suicide prevention centers in the United States and try to explore the future of this movement and to outline some of the concepts I believe will be a part of the center of the future.

To understand the future direction that Suicide Prevention Services may take in this country, it is necessary to go back and look at the history of this movement to see the changes that have taken place in its development and in the models it has produced. Since its history is short, this is quite easy. In fact one can look at suicide prevention in terms of two ten-year

[1] A speech given by Dr. Brockopp at the 2nd Annual Meeting of the SPCS of Buffalo, New York (January 22, 1970).

periods of time. Each of these periods had specific characteristics, and each was necessary for the subsequent stage to develop.

In 1949 modern suicide prevention services in our country were begun largely by fortuitous circumstances. In November of that year one of the psychologists on the staff of the Los Angeles Veterans Administration Hospital descended into the basement of the Los Angeles Coroner's office to obtain information on two ex-patients who had committed suicide and discovered a file of several hundred suicide notes. The notes intrigued him and his colleague and the suicide research team of Shneidman and Farberow was born. Their work stimulated interest in the study of suicide as a psycho-social phenomenon and resulted in the development of suicide prevention services in the United States.

The next few years were busy ones for this team as they began to study and analyze suicidal behavior and outline methods for working with the suicidal person. In 1955 they received the first of a series of Federal (NIMH), grants to continue their work and in 1958, again with Federal funding, they broadened the scope of their activities, establishing the Los Angeles Suicide Prevention Center, which was at that time the only center in the country concerned with the clinical, educational, and research aspects of suicide.

By the end of the 1950's, suicide prevention services in the United States were almost completely centered in Los Angeles, with the model being a separate, defined agency which observed the suicide phenomenon, worked with patients who were suicidal, and trained other individuals to function in this specialized area. It was staffed almost entirely by professionals, and it was completely supported by federal funds.

In the decade of the 60's suicide prevention in the United States underwent a number of radical changes. Most of these were a result of proliferation of this type of service. Whereas in 1960 the number of the centers in the United States could be listed on one hand, by 1970 over 130 centers dealing with suicide and crises had been established throughout the United States. Along with expansion came the exploration of different types of suicide prevention services. In some cities they were combined with state mental hospitals. In other places, nurses in the psychiatric wards instituted a 24-hour telephone service. In other areas, groups of professional people provided 24-hour emergency telephone service. Obviously, with only the Los Angeles Center training professionals in this area, there were not enough trained people to man all of these centers, so the centers began to spring up all over the country manned largely by volunteers who had little or no training in this area but who had the desire to provide a helping relationship to a person in a potentially serious situation. In the suicide prevention center, the non-professional volunteer found himself in a position where he could possibly be instrumental in intervening in the life and death problems of other people.

In almost all of the centers a 24-hour telephone service was the only means by which suicidal individuals could contact a helping person. In a few areas, groups of individual banded together and formed a type of night-flight team which would go out into the homes of the suicidal person or into the community.

While other areas of the country were exploring different methods of clinical services, the Los Angeles center was heavily involved with producing clinical research on the treatment and care of the suicidal individual and in developing a theoretical concept of the suicidal act. These data, together with the action research produced by the various centers indicated that these centers could not limit themselves to responding to suicidal crises, for individuals with a full

range of problems would call a center to obtain immediate assistance, almost regardless of the quality of that assistance or the name of the center they were calling.

The suicide prevention movement in the 60's began with the idea of offering assistance to a specialized population - the suicidal person - but, by the latter part of the 60's, it had moved to a broader crisis orientation, with an increasing number of centers working with people in crisis rather than focusing only on suicide prevention.

In the 60's, changes were also seen in the financing of the suicide center. The model of federal funding in Los Angeles was not extended to other areas of the country and local communities began to provide funding for suicide and crisis services from their own local area. Very few of the services were supported by public money. Most of them depended on private funds, contributions, local community chests, or United Funds.

By the end of the 1960's suicide prevention services had radically changed. The concept of suicide prevention was extended to include all types of crises. There was a dramatic expansion of the service throughout the United States. Centers were manned by volunteers, in many cases without any type of professional support or assistance, and the movement was largely supported by voluntary funds.

With this as a base for suicide prevention services in the seventies, what is the direction that these centers will take in the next ten years and what type of model of suicide prevention can we expect to see by the end of this decade? I believe the following seven ideas will be central to suicide prevention services in the seventies.

1. *Exploration of new methods for finding people in crises and for bringing them into a network of assistance.*

Most suicide prevention and crises centers still rely on the receptive use of the telephone as a primary means of reaching individuals in crisis. Although this is probably the most common means of impersonal communication in our society, at our center we are painfully aware that many individuals do not use the telephone in crisis or are reluctant to use this type of communication when seeking help. We need to explore new means of reaching individuals in crisis. Somehow we must use communication networks that exist in a community by which individuals make known their needs and, in some cases, express their suicidal intentions. What these are we do not know, yet we know that they will be quite different for a prominent businessman, a well-known physician, or a person on Skid Row. We also know that none of these people is likely to use a telephone service to seek help. Therefore we must somehow re-define our services so that we are most accessible to them through being an intrinsic part of their helping network. At this time the only guidelines we have is that, when we being to explore new methods of finding people with problems, we will need to explore new ways by which to make our service known, be more active with high risk populations, move more into the community, and separate ourselves from the institutional setting and the passive use of the telephone.

2. *There will be changes in the pattern of patient care at suicide and crisis centers.*

At the present time, most suicide and crisis centers deal with patients through using the crisis intervention model, that is, a type of short-term, intensive therapeutic intervention for the individual at the time of his crisis, during which an attempt is made to assist the person to regain his former personal and interpersonal pattern of behavior. Although this concept is theoretically

sound and appears to work in some cases, there is growing evidence that individuals who find themselves in suicidal or other types of crises need a more long-term type of help or help of a different nature, which provides a more substantial base on which they can depend for a longer period of time, possibly for a major part of their lives, in order to maintain themselves and perform a useful function in the community. What the final development in the area will be is difficult to see, but it appears that the model of the future will be one of individual patient care and planning with the active support and intervention of helping people over a long period of time, rather than application of a broad theoretical frame of reference such as crisis therapy for suicidal patients.

3. *The marriage of the volunteer and professional into a team of mental health associates.*

Suicide prevention began with professional staff. Like many professionals, Shneidman and Farberow were initially concerned about allowing the non-professional to work with suicidal individuals. They felt that only the professional could take this responsibility. In the 60's non-professional volunteers began to work in suicide prevention, largely because of a scarcity of interested professional personnel. Very quickly, however, largely as a self-protective device, the concept developed in these groups that *only* the non-professional person, especially the one who had made a suicidal gesture, could really understand the suicide process. Now that this defensiveness has been partly worked through by both professionals and non-professionals, we may see in the seventies the integration of individuals from both groups into a closely knit team of specially trained individuals who will combine their skills and talents in a way which will assist the patient to receive the best help for his specific problems and increase both the quality and scope of services for the person in a suicidal crisis. By the end of the 1970's, we should see completely integrated staffs in which the differences between the trained non-professional and the professional staff member are seen only in terms of the scope of the things that they can do and not in terms of their expertise or the areas in which they function.

4. *Exploration and innovation of new mental health services.*

Suicide and crisis centers have been known throughout their short history as services that have developed new methods of providing mental health services to people. This idea will continue and may in the final analysis be their most important contribution to the mental health field. Suicide centers are very pragmatic in orientation. When a person is at the point of deciding the question of life or death, almost anything that needs to be done is done to maintain the psycho-physical integrity of the individual. The willingness of the center to use anything that is appropriate for the patient in terms of his needs, rather than to pre-define the needs of the individual in terms of the therapist's approach to the problem has resulted in our rethinking what is appropriate for a therapist to do and what type of services we should have for people in crisis. What will happen in this area in the 1970's is difficult to say but it appears that the expansion of the significant-other concept into the concept of the significant group, the development of the concept of *problems of living* to cover most of what is now called *psychiatric problems*, and increased emphasis on working with the "gatekeepers" in the community, that is, people like schoolteachers, clergymen, physicians and policemen, who have contact with people in crisis and who must deal with crisis situations as they arise, will be among the major developments of the 70's and will be harbingers of a radically different approach to what we today call mental health problems.

5. *The suicide prevention centers in the 70's will be funded by a combination of community and state money.*

Neither the 1950 movement of federal funding nor the 60's concept of funding through voluntary agencies and contributions was adequate to provide a sufficient base for the development of this type of service. As the centers become more professionally acceptable and accountable to the community, the move toward public funding will increase.

6. Postvention will take on increased importance.

The work with the families of individuals who complete suicide or the families of individuals with other types of severe emotional crises will become increasingly important in the 1970's. In the 50's and 60's emphasis was given to *prevention* through development research which attempted to locate the suicidal individual and to *intervention* through an attempt to try and relieve the crisis situation through the immediacy and the 24-hour availability of trained telephone therapists. In the 70's we will focus on the families of individuals in crisis. We now recognize that a person who makes a suicide attempt or who commits suicide (or indeed any individual in crisis) is affected in his act by those who surround him and that he deeply affects them. When, for example, suicide does take place, the scars that it leaves in the family and significant friends are profound and require the assistance of people who are specifically trained to work in this type of situation. If the crisis of the individual is non-lethal, the reoccurrence of this event in his life largely depends on the relationship he has with others in this environment and the support that they give him or refuse to give him at some future time. We are beginning to realize that, just as work in the intervention requires special training, the person who works in this reconstructive area will also need to be specially trained to perform this function.

7. Integration of suicide prevention into the broader community mental health service.

It was evident throughout the 1960's that the base of suicide prevention had to be expanded to include all crises in order to be a useful service in most communities. Today it appears that suicide prevention and crisis services, except in a few large metropolitan areas, must be integrated into the broader concept of mental health services as part of their functioning. We now see suicide as merely one type of crisis, severe and final though it may be, yet one that fits into the pattern of mental health services and therefore must be integrated into them. In some areas of the country this will be difficult to achieve for many suicide prevention centers are presently operating as separate little "fiefdoms" with little or no contract with the main body of professional services in the community. Yet, unless the movement into broader mental health services takes place, the centers will eventually die as a result of a lack of both community and professional support. By 1975 it will be clear that as a separate entity the suicide prevention and crisis center is no longer viable. In their place we will see a broad range of community mental health services designed to reach people in various types of crisis including suicide in an immediate and effective way. They will utilize the skills and techniques developed in the suicide prevention centers and, building on these, provide a range of services that will allow the person to receive the type of assistance that he needs in terms of this particular problem or condition.

In conclusion, it may be a strange thing for an Executive Director of a new organization to say, but I would hope that there will not be a tenth annual meeting of this organization. I would hope that by 1980 and, if possible, before that time, the Suicide Prevention and Crisis Service, Inc. would cease to exist as an organization and as an entity in Erie County. If it does not, I fear it will be because the organization is engaged either overtly or covertly in building a rigid, self-sustaining, self-supporting, monolithic system, which on the surface appears to be performing the specialized function of preventing suicides but which in reality is concerned with maintaining itself.

Of all the agencies in the world, a dynamic and pragmatic concept such as a suicide prevention center should not be allowed to die simply because of tired blood or through the strangulation of bureaucratization. When an organization such as this has performed its function in a community, that is, has served as a catalytic unit in the development of broader community mental health centers, and has provided within those centers the range of activities that it, by itself, had previously provided for the community, it would seem only fitting and proper that the center should be allowed to go out of existence, so that the process of fresh, new, dynamic and innovative approaches to mental health problems can remain alive or be reborn under the aegis of a new organization which will be committed to goals similar to those which suicide prevention centers have been committed, to isolate, define, understand, and meet the needs of a lonely, detached, despairing and hopeless segment of humanity, and thereby be instrumental in their search for a more meaningful and richer existence.

The Pueblo Suicide Prevention Center

William F. Griglak, M. A., Pueblo Suicide Prevention Center

In early 1967, Dr. Franklin Osberg, Director of Admissions at Colorado State Hospital, Pueblo, Colorado, became aware of a significant behavioral pattern evidenced by patients being admitted to the State Hospital. Many of these people, in the course of the admitting interview, spoke about suicidal thoughts, gestures, attempts, escape fantasies, etc. Armed with this information, Dr. Osberg began a very thorough and serious study of suicidology, reading extensively as well as making personal visits to a number of the existing centers.

After steeping himself in knowledge about and feasibility of Suicide Prevention Center, Dr. Osberg began to “buttonhole” various influential people in the Pueblo community. With such statistics as: Colorado ranking fifth in the nation in suicides; Pueblo having twice the national rate of suicides per 100,000 people; young adult suicides increasing; and the lack of any emergency-scaffolding crisis center in the area, he found a number of people willing to back his proposal that Pueblo establish such a Center.

Along with the influential people, Dr. Osberg gave lectures (as well as presenting the film, Cry For Help) to civic groups, church groups, school personnel and students. A suicide Commission was formed early in1968. In March of 1968 William Griglak, clinical psychologist, was named as Director. In April, Dr. Michael Peck and Mr. Sam Heilig of the Los Angeles Suicide Prevention Center arrived to conduct a weekend workshop for the first class of volunteers. Through a month-long, intense screening and training process, the ninety original applicants resulted in thirty five, trained volunteers.

The original starting date of May 1, 1968, was delayed due to a telephone strike! Finally, at midnight of May 14, 1968, the Center officially began. Switchboard facilities were provided by the Pueblo Fire Department—with the Suicide Center having its own phone number (544-1133) trunked off of their main line. This type of arrangement was used – with varying degrees of success – until April of 1969 when the Center contracted with an answering service, which directly shunts the call to the volunteer on duty.

Service – The Pueblo Center provides a 24 hour telephone answering service, with four six-hour shifts per day. The volunteers take the calls in their own homes. They fill out worksheets, make necessary back-up professional arrangements (if these are called for) and some of them engage in follow-up work (1, 3, 6, 12 month checks) should they desire to do so. The volunteers have regular meetings at which on-going education and training are featured. Such meetings are also an opportunity for them to consult with each other and the training staff about procedures, cases, methods, etc.

Publicity – Prior to the opening of the Center, cards and notices giving the telephone number of the Center, were sent to all the bars, hotels, motels, restaurants, trailer parks, offices, and churches throughout the city. Occasionally the local newspaper features articles about the Center. At the present time we are conducting a rather unsuccessful attempt to have the newspaper provide us daily advertising space. Perhaps, with a bit more prodding this service can be implemented. Talks to civic and school groups still continue. The local radio and television stations have provided spot announcements for our Center any time we wished.

Resources – Each volunteer is provided with a workbook in which is contained theory and resource people within the community who can be called upon to provide additional emergency service to the client in stress or crisis. The resource people include our own training staff (psychiatrist, two psychologists, psychiatric nurse, the co-director) as well as well as some doctors, lawyers, clergymen, agencies. The people who agree to provide the necessary professional back-up services for us have agreed to see clients of ours on a first-time no-fee basis. This concept has been a great boon to our Center, both for the volunteers as well as the clients. Additional or on-going services are arranged between the professional and the clients. The delicate balance between use and abuse of these professional resources has been handled well by our volunteers. To date, no professional has felt overburdened or harassed by our Center. In addition, through advance publicity and public relation work, the agencies have been "clued" in on our needs and have responded, for the most part, very well.

Calls – The first annual report of the Pueblo Suicide Prevention Center showed that we had received calls from746 different individuals. All repeaters and repeat calls are tabulated separately so that the complete number of calls numbered well over 900. In addition, the Southern Colorado State College began a college crisis center called Help Anonymous which has proven to be a tremendous asset to the community, as well as diminishing the number of callers to our Center. The college group, who train their members with ours, received over 400 calls during its first year of operation providing a six hour service each evening. Most or our calls were from people who were in crisis but non-suicidal (185 calls were of a suicidal nature while the remainder were classified as non-suicidal). The average number of calls received at our Center was 2.04 per day with the peak times coning on Wednesday and Thursday of each week. Calls by females totaled 413 and calls by men totaled 333. The median age of women calling was 36.6 years and the median age of men was 41.7 years. Anonymous calls numbered only 41 out of 746 calls – which, we believe, is a rather small proportion. Third person calls numbered 73. There were 34 attempted suicides using our service after some form of suicidal gesture (mostly ingestion of pills). The major portion of calls contained some ingredients of marital

difficulties and the high incidence of calls from the Belmont area was interesting to observe. (Belmont is a suburban area of Pueblo wherein "keeping up with the Joneses" seems uppermost. It is a middle-class, relatively prosperous, struggling-for-more area.)

Funding – The Center operates, at the present time, on the basis of $4,000 per annum. The City-County government provides $2,500 and the State of Colorado, through the local mental health agency, provides $1,500. The Director receives $100 monthly for consultant services. The rest of the monies are used to provide books for the suicidology library of the Center; to provide speakers for the volunteer meeting; conventions; training sessions; telephone service; as well as a Client Aid fund in emergencies. This revolving fund provides minimal, emergency finances for clients in distress. The client, if possible, is asked to pay the money back when he is able. So far, the fund has proven a successful venture.

In addition to direct services, Colorado State Hospital has agreed to provide printing and mailing services for the Center, and the City-County Health Department provides free office space and secretarial service. The Mountain States Telephone Company lends the training phones, and the State Hospital lends training films, projector and projectionist for the Center. The locale of training will move, as of next Spring, to the State Hospital where the use of closed circuit television and video tape will be available in the training of our volunteers.

Future projects – At the present time the Pueblo Suicide Prevention Center has submitted a grant proposal with the Department of Transportation to study lone occupant car crashes. It is felt that our five county, 100 fatal crashes a year study, encompassing city, country, super-highways and two lane highways, army bases and colleges, etc., will provide and authentic base for the a belief that more people than we suspect do commit suicide by automobile. Automotive, physical, and psychological teams would hope to participate in this grant study. We are presently waiting word of acceptance (or refusal) of this grant study.

A more refined tabulation and cardex system is being developed so that more accurate and full information can be recorded. In addition, the Center has begun efforts to mobilize the community into developing more effective and comprehensive mental health services. As each month goes by, the work load of the Center increases. The Director, for example, is engaged in counseling some eighty people per month on a part-time basis.

We are preparing materials for future publication on the subject of meeting the crisis person "up the road." It is our feeling that Suicide Prevention Centers really do not prevent suicides as much as they may provide a healthy outlet for the crisis person who is traveling pell-mell down the road toward a suicidal impasse. In other words, we have the distinct impression that our center is providing a service (a "now" service) for people who may become suicidal – and would be serious candidates within months or years if the Center were not around to intervene and stop the trend.

The Telephone Therapy Problem: Problems and Prospects

Marcia Schlenker, MSW
Erie County Suicide Prevention and Crisis Service

As in most suicide prevention centers in the United States, the 24-hour telephone emergency service of the Buffalo center in manned by individuals from the community who volunteer for this important and often life-saving function.

In each center this program, which often is the only one the center offers to the community, is a reflection of the community and the philosophy under which it began. Critical in the pragmatic development is the way the center views the interaction that takes place over the telephone. In the Buffalo center we view the interaction as a therapeutic activity and define the primary function of the nightwatcher[2] or clinical associate[3] to be a telephone therapist.

We do not see them as merely referral agents, information givers, or "just someone to lend an ear." They function primarily as therapists in their service to people with both long-term chronic problems and especially crisis problems. Therefore, they are expected to build a relationship with the caller which enables him to verbalize his problems and needs, express and accept feelings, draw conclusions and formulate goals, and possibly make some movement toward amelioration of his situation. In this role the telephone therapist very often will work toward helping the caller to mobilize his resources such as family, friends, clergyman, employer, or neighbor. He may also find it necessary to refer the caller for specialized or professional help, at such places as Legal Aid Society, Department of Social Services, and a number of counseling agencies including the Suicide Prevention and Crisis Service. However, the number of referrals is relatively small, and 60% of all callers are handled only through telephone contact. We believe that valid and important therapy can and is being done by trained non-professionals via telephone. This is a vital point upon which our service pivots.

The therapists who man the telephones are drawn from a wide variety of people in the community. A good number of them are graduate students in the professional areas, especially psychology, social work and nursing, and a few professional people. In addition, there are undergraduate students with interests in the area of social science, as well as businessmen, salesmen, housewives, and secretaries.[4]

During this first year of operation, we have not found it necessary to carry on a formal recruitment process. Most of our personnel have come to us through the center's community contacts, such as speeches to service organizations and professional clubs, classes and symposia given at the university, and seminars presented in various agencies in Buffalo. A smaller number

---

[2] Nightwatcher is a term we use to designate individuals who have completed a training program at the center and who volunteer their time and services at the center through answering the telephone. They are paid $1.00 per hour expenses.

[3] Clinical Associate is a term we use to designate individuals selected from the nightwatch group who have proven telephone skills. They are part-time paid staff members who work one night a week.

[4] See Appendix for additional information.

of people come to us through informal contacts with the center staff and through advertising of the center through mass media.

Each person is asked to complete a detailed application containing questions about background as well as psychological and personality data. Upon completion of the application, they are interviewed by a member of the staff. In this interview the staff member attempts to ascertain whether the applicant has resolved his own problems to the point that he is capable of counseling others. The applicant may be put under stress in order to ascertain how he will perform in a crisis situation. He is also carefully evaluated as to his ability to be giving, accepting, and non-judgmental, and to grasp and use theoretical concepts in working with people. After this, he enters a training program during which he is continually evaluated by the staff members.

Training sessions are run every two or three months and usually with groups of 8 to 10 trainees. Each training session is 20-30 hours in duration depending on the background of the trainee. In addition, each trainee is expected to put in 6-10 hours in observation at the center.

The training groups are run like seminars, with about a quarter of the time being devoted to lecture on theoretical material, and the remainder spent in discussion and practice. Some major areas of discussion are communication theory, interviewing theory and skills, the dynamics of crisis and crisis intervention, the suicidal process and behavior, and the use of the telephone as a therapeutic modality. Also discussed are such areas as the function and purpose of a suicide prevention and crisis service, the role of the non-professional volunteer, and the mobilization of community resources. Throughout the sessions each trainee is involved in role-plays in which he plays both the caller and the telephone therapist. Each role-play is observed and discussed by the group. Emphasis in the discussions is given to such things as what is the problem of the caller, what sort of relationship is developed, what skills has the trainee developed and in which areas is he weak. Aids such as films and training tapes are used widely in these sessions.

Since the telephone therapist is the vital link of the center to the community (about 65% of all calls come in during the night[5]), and since he is very often dealing with life and death situations, the center has very high expectations of his performance. He is expected to act as a therapeutic agent in all situations. When he feels he is faced with a situation which he does not have the knowledge or skill to handle adequately, he is encouraged to contact the professional consultant who is on call for support and back-up. Bi-monthly follow-up training seminars are held to discuss specific cases, procedures and policies, and general feelings the person or staff have about the work of the center.

The telephone therapist also has certain expectations of the agency and of his role as a therapist. Most importantly, he expects good and comprehensive training before he begins work. Likewise, he expects to have follow-up training, both in group sessions and individual sessions when necessary, to continue to develop his skills and work out whatever problems he encounters in his work. He should have contact and open channels of communication with the day staff at

[5] All calls are taken directly at the center. In no case is an answering service used or the call taken in a private home.

the center so that he may feel and function as part of the total agency. He should be able to give and receive feedback on this own work, have knowledge of and participate in decision and policy making, and work together with the total staff on patient care. This open-flow of communication is very important to the functioning of the center and, as we shall discuss later, equally difficult to achieve.

We have already noted that a large majority of callers contact the center at night and, therefore, the short-term, face-to face program and the telephone therapy program relate very directly. Very often individuals call both during the day and at night or patients being seen in therapy at the center will call at night for support or assistance. In addition, patients being seen at the center for therapy are in almost all cases referred by telephone counselors.

This program also relates very closely to the educative function of the agency. The telephone therapists are either from the university or colleges in the area, mental health or social service agencies, or lay persons from the community. In their training sessions and through their work at the agency, they learn about suicide and crises, what agencies are available to deal with such problems in the community, and how difficult it is to find help for those in need. They become educated not only in the problems people face, but also in what services are available in Erie County. By providing data about the calls to the agency, they participate in the research function of the agency.

During the past 15 months of operation, this program has been revised and changed to fit the needs of the agency and the community it serves. In the first year the program was run as a volunteer operation, with the personnel being given only expense money (approximately $1 an hour). They worked 11-hour, all night shifts, from 9 P. M. to 8 A. M. at the center. Most of the nightwatchers were students between the ages of 20-25 and made excellent and sensitive telephone therapists. However, during the year many problems were associated with the operation. Some of the most important of these were:

1. Lack of coverage – We found emergencies in terms of coverage were arising much too often for the operation to function smoothly. Most difficult were the times of holidays, exams, and vacations, owing to the fact that most workers were students. Also, it was not always possible to get volunteers to make firm and regular commitments to work.

2. High attrition rate – A large number of volunteers were trained, worked for a month or two, and then left the agency. This, of course, made it necessary to constantly train new volunteers who were lost as soon as their skills began to develop. The reasons for this high attrition rate were probably many, but some of the important ones were: (a) once that the nightwatcher develops basic skills and gets to know the agency, he does not feel it is necessary to continue at the agency, (b) there is little compensation in terms of money, seminars, etc., which encouraged him to stay at the agency, and (c) perhaps he may want to move on to a new volunteer experience at another agency.

3. Poor follow-up training – We found that there was very little follow-up training in telephone skills. People were basically maintaining the same level of competence which they had when the initial training period was ended, and there was little growth

> in phone work, aside from that which was a result of experience alone. One of the reasons for this was, of course, the high attrition rate. Another was that volunteers did not have a commitment to attend follow-up training sessions. Also, the staff was so heavily occupied with training new volunteers or taking care of coverage problems that they did not have sufficient time to devote to follow-up training.

In the summer and early fall of 1969 a study of the program was made and alternatives discussed. The best alternative seemed to be to combine the good points of a volunteer program with a part-time paid staff.

The new program for night-time telephone therapy began in November, 1969. The basic innovative aspect of this program was that it centered around a core of paid, part-time staff members called clinical associates. These part-time staff members became the backbone of the night-time telephone therapy program and, although volunteers are still used, the program is not entirely dependent on them. We feel that these part-time staff members give a stability to the program which was previously lacking. Each of them is committed to one night a week, so the problem of adequate coverage is minimal. They meet at least bi-weekly for on-going training and seminars, so that follow-up training is a reality with this group. The clinical associate is compensated at the rate of $25 per 12-hour shift of telephone work. Through these part-time staff members, the program has stability, continuity, and the potential for developing highly skilled workers.

The volunteers who now work from 9 P.M. to 3 A.M. have shorter, less demanding shifts. They are not required to attend training sessions other than the initial training sessions, are continuously supervised by the clinical associates and can move freely in and out of the agency or the program, and the program is no longer dependent on them. They continue to be enthusiastic and eager workers who add fresh ideas and valued criticisms to the existing programs. They also continue to serve the function of transmitting this center's ideas and philosophy of dealing with people in crisis to their community groups, classrooms, and agencies. In addition, they are a group from which new clinical associates can be selected.

The clinical associates are chosen largely for (a) their ability to respond to callers in a way which is therapeutic, (b) their ability to grasp theoretical concepts such as dynamics of personality, suicidal behavior, crisis intervention, etc. and to relate these concepts to their own work, (c) their potential as persons who could contribute to and learn from others in a small, task-oriented group, and (d) their capacity for expanding and growing in self-awareness and the understanding of behavior.

The part-time clinical associate staff consists of individuals from diverse backgrounds and vocations. Two are graduate students in the helping professions, two are undergraduate students majoring in the social sciences, three are non-professional members of therapy teams in Community Mental Health agencies, one works in an industry in the community, and the remaining two are professional, a social worker and a nurse. (See Appendix for additional data.)

This program has been in effect for three months. Although there has not been enough time for formal evaluation, through observation it appears that the stabilizing effect it has had on the telephone service has been significant. Energies of professional staff members have been released and diverted into areas other than maintaining and stabilizing this program. Within the next few months, an evaluation will be made to determine the assets and limitations of the program and to guide future developments.

Appendix

Characteristics of the Telephone Therapists at the SPCS (11/1/68-10/31/69)

		Volunteer	Clinical associate			Volunteer	Clinical associate
Sex:				Education			
	Male	19	4		grammar	1	0
	Female	59	6		high school	1	1
Age:					some college	29	4
	20	4	2		BA	38	5
	21-30	54	7		MA	7	0
	31-40	7	0		PhD	2	0
	41-50	12	1	Employment:			
	51+	1	0		unemployed	5	0
Marital status:					student	43	4
	Single	58	5		non-professional	11	4
	Married	18	3		professional	19	2

The Amount of Volunteering

	No longer current	Current
# times:		
range	0-40	1-33
mean	7.6	10.4
SD	8.0	9.1
# months at least once		
mean	2.9	4.0

RESEARCH

Suicidal tendencies: Innate or acquired?[6]

David Lester, Ph. D. Erie County SPCS

It is probable that both inherited and experiential factors play a role in the determination of suicidal behavior. There is good evidence for the role of experiential factors (McConaghy, et al., 1966) but little evidence for the role of inheritance (Lester, 1968).

Thus, it is of interest to explore a suggestion of Uematsu (1961) for demonstrating the role of inheritance. If inherited factors determine the occurrence of suicide, of a group of people born in a given year, a number determined by these inherited factors should complete suicide. If this group has a high suicide rate at one time its existence, then it should have a low rate at other times since the number of potential suicides is limited.

Uematsu tested the suggestion by correlating the suicide rate of subgroups of the Japanese population at different times in their lives and found that, in general, there was a negative correlation. For example, if a subgroup had a low suicide rate when aged 20-25 then it was likely to have a high suicide rate when aged 40-45 and vice versa. The present paper tested these ideas using the population of the United States.

Several limitations were placed on the data. To minimize the effects of migration the whole country was used. (The effects of emigration and immigration could not be controlled.) Since statistics prior to 1935 are not based on the complete population but only on the "registration states", data prior to 1935 were not used. Since the period 1935-1965 includes the Second World War which removed males from the population and allowed them to be killed in war rather than realizing their suicidal potential (or allowed them to suicide without the action being so classified), the hypothesis is best tested on females. Finally, since the non-white suicide rate is low (and so variable and unreliable) the hypothesis is best tested on white females.

The suicide rates for all four race-by-sex groups for the years 1935, 1940, 1945, 1950, 1955, 1960, and 1965 were obtained from the United States Bureau of the Census.

The suicide rates for, say, white females in 1935, 1940, 1945, 1950, 1955, and 1960 aged 20-24 were compared with the suicide rates for these same groups in 1940, 1945, 1950, 1955, 1960, and 1965, when they were aged 25-29. This was done for all possible groups. When the age gap between the two comparisons was 5 years, the number of pairs in the correlation computation was 6, when the age gap was 10 years the number was 5, when the gap was 15 years the number was 4, when the gap was 20 years the number was 3, and when the gap was 25 years the number was 2.

Product-moment correlations were used since the data constitute an interval scale.

---

[6] [1]Kitty Priebe assisted in collecting these data.

For each possible age-gap, several correlations were computed. For example, for a 5 year age gap the population aged 20-24 was looked at when it was aged 24-29, the population aged 25-29 was looked at when aged 30-34, and so on. Since the correlations are not independent, they cannot be averaged. Accordingly, the median coefficient for each age gap was computed. The median coefficients are shown in Table 1.

It is evident that data from white females fit the hypothesis well. For a small age gap there is a positive correlation but as the gap increased the correlation becomes negative. That is, groups that have a low suicide rate at one point in their existence have a high rate at other times. Thus, Uematsu's hypothesis was supported.

For the sake of comparison, the median coefficients for the other three sex-by-race groups are shown. It can be seen that the data from non-white females and nonwhite males show a tendency in the direction of the hypothesis. Reasons for this were discussed above. However, it may be that Uematsu's hypothesis might be false and the data from white females a non-replicable chance occurrence. It is necessary, therefore, to replicate those results on other populations.

The results of this study show that there may be effects from inherited factors in the determination of suicide. If inherited factors are assumed to play the major role in the determination of suicidal behavior, then any population has a given number of individuals who are potential suicides. This number is determined by inherited factors. If a large number of these potential suicides commit suicide early in their life, then the population will be found to have a low suicide rate subsequently. If this view is considered in the extreme, the only role allowed for experiential factors is in whether potentially suicidal individuals will be stressed sufficiently so as to releases their suicidal tendencies.

Obviously, such an extreme position is unlikely to be valid. However, the methodology suggested here does represent a new way to evaluate possible effects from inherited factors in the determination of suicide.

REFERENCES

Lester, D. Note on the inheritance of suicide. Psychol. Rep., 1968, 22, 320.

McConaghy, N., Linane, J., & Buckle, R. C. Parental deprivation and attempted suicide. Med. J. Austral., 1966, 1, 886-892.

Uematsu, M. A statistical approach to the host factor of suicide in adolescence. Acta Med. et Biol., 1961, 8, 279-286.

Table 1. Median correlation coefficients between the suicide rate of a group of people at one time in their lives and the suicide rate of the same group at a different time.

	Time interval between comparisons			
	5 years	10 years	15 years	20 years
white females	0.57	-0.19	-0.65	-0.90
white males	0.50	0.20	0.46	0.69
non-white females	0.06	-0.30	-0.24	-0.36
non-white males	0.21	-0.06	-0.46	-0.24

Reactions to Crises by Suicidal Individuals[7]

David Lester, Ph. D. Erie County SPCS

Neuringer (1964) presented fictional information to suicidal individuals about fictional friends and noted how the evaluation of these fictional friends changed as a result of the information. He found that suicidal patients and nonsuicidal psychosomatic patients reacted more extremely than did medical patients. In another study (1961) he found that suicidal individuals and nonsuicidal psychosomatic patients tended to think more dichotomously than nonsuicidal medical patients.

The present study looked at the responses to the RES Test (Kelly, 1955) of college students with a history of suicidal behavior and those without such a history to see if there was any evidence of extreme and dichotomous reactions.

The RES Test protocol consists of a grid with 22 crises along one axis and 22 individuals known to the subject along the other axis, one of the 22 individuals being the subject himself. The subject checks for each crisis the individuals to whom he could have turned for help had they been available. (For detailed instructions for the administration of the RES Test see Kelly [1955]).

Five measures are possible: (a) the number of checks given to the subject himself (out of 22 possible), (b) the number of checks given to the other 21 individuals on the grid for all 22 crises (out or 462), (c) the number of individuals (out of 21) turned to for at least one crisis, often called the dispersion of the grid, (d) the standard deviation for each subject of the number of individuals available for turning to for the 22 crises, and (e) the standard deviation of the number of crises for which the 21 individuals were checked as being resources. (These two latter measures are not significantly correlated (Lester, 1969)).

The present study looked for extreme responding on these five measures.

METHOD

The subjects were six students who reported having attempted suicide, eight who had threatened suicide, and 30 who had never considered suicide. The nonsuicidal students were

[7] Dr. Gene Lester helped to devise the hypotheses tested in this study.

divided into a group with high neuroticism scores on the Maudsley Personality Inventory (Jensen, 1958) and a group with low scores. The suicidal students did not differ significantly from the nonsuicidal students with high neuroticism scores (Non-high) on the neuroticism scale but both of these groups differed significantly from the nonsuicidal students with low neuroticism scores (Non-low).

Each student completed the RES Test and the Devries suicidal potential scale (Devries, 1966) which appears to measure suicidal potential independently of degree of emotional disturbance (Lester, 1968).

The suicidal group did not differ from the two nonsuicidal groups in the number of checks given to themselves ($F=1.21$, $df=2/41$) on a one-way analysis of variance, the dispersion ($F=1.32$, $df=2/41$), or in the total number of checks given to the resources ($F=0.34$, $df=2/41$.

For the measures of extreme responding, the groups did not differ in the standard deviation of the number of people chosen for the 22 crises ($F=0.05$, $df=2/41$) or in the standard deviation of the number of crises checked for each individual resource ($F=0.54$, $df=2/41$). Tests on the differences in the variances of the scores revealed no differences for the measures of dispersion (the largest $F=1.94$, $df=14/15$) and total number of checks given to the resources (the largest ($F=1.56$, $df=14/15$). However, the suicidal students had significantly higher variances than the Non-lows for the number of checks given to the self ($F=2.98$, $df=14/15$, $p < 0.05$).

As an additional test of the hypothesis, a group of students with high scores on the suicide potential scale were matched for their scores on the Maudsley Personality Inventory with a group having low scores. It was possible to select 10 matched pairs. These two groups did not differ in the number of checks given to the self ($t=0.55$, $df=9$) or in the dispersion ($t=0.06$, $df=9$) but those with high scores on the Devries scale did have more total checks on the grid ($t=2.41$, $df=9$, two-tailed $p < 0.05$). The groups did not differ in the variances for these three measures (the largest $t=1.52$, $df=8$). The groups did not differ in the standard deviation of the number of crises checked for each individual ($t=0.21$, $df=9$) but those with high scores on the Devries scale did have higher standard deviations for the number of people chosen for each crisis ($t=2.00$,$df=9$, one-tailed $p < 0.05$), in accordance with the prediction.

Of 10 tests of the hypothesis, only one supported the prediction.

DISCUSSION

The results of this study indicate little support for the hypothesis that suicidal people react more extremely and undifferentiatedly to crises. Students with a history of suicidal preoccupation did not differ from non-suicidal students on any of five measures used to test the hypothesis. When scores on a suicide potential scale were used only one of the five measures supported the hypothesis.

The reason for this failure may lie in the fact that extreme reaction to crisis is not a long-term characteristic of suicidal individuals but is manifest only during crises. The students in the

present study were not necessarily in current suicidal crises. The failure of the suicide potential scale, used as the criterion of suicidal preoccupation, to produce data in support of the hypothesis may merely reflect the inadequacy of this particular scale to differentiate suicidal from nonsuicidal individuals or the fact that the scores on the scale obtained by the subjects here were not very high (out of a possible score of 13, the high scores in this study were 4-8).

Whatever the reason, this study raises questions about the generality of Neuringer's results.

SUMMARY

Suicidal students were compared to nonsuicidal students for tendencies to respond extremely during crises, using the RES Test. No evidence for this tendency was found.

REFERENCES

Devries, A. G. A potential suicide personality inventory. Psychol. Rep., 1966, 18, 731-738.
Jensen, A. R. The Maudsley Personlity Inventory. Acta Psychol. 1958, 14, 314-325.
Kelly, G. A. The Psychology of Personal Constructs. New York: Norton, 1955.
Lester, D. Suicide as an aggressive act: A replication with a control for neuroticism. J. Gen. Psychol., 1968, 79, 83-86
Lester, D. The relationship between measures possible from the RES Test. Unpublished manuscript, Suicide Prevention and Crisis Service, Buffalo, New York, 1969.
Neuringer, C. Dichotomous evaluations in suicidal individuals. J. Consult. Psychol., 1961, 25, 445-449.
Neuringer, C. Reactions to interpersonal crises in suicidal individuals. J. Gen. Psychol., 1964, 71, 47-55.

CASES

The Chronic Caller to a Suicide Prevention Center: Report of a Case

Diane Blum and David Lester, Ph. D., Erie County SPCS

Lester and Brockopp (1970) have discussed the individual who makes a large number of calls to a suicide prevention center. In their paper they described the characteristics of these chronic callers, presented some case illustrations, and discussed possible approaches that a counselor might take with the chronic caller.

The present paper examines one chronic caller in greater detail, explores some of the approaches that the counselors have taken with the caller, what their reactions are to the caller, and how they affect the counseling process.

Mrs. A. is a 40-year old divorced woman who called the SPCS at least once a day (and often as many as three or four times a day) for over six months. She usually discussed her feelings of loneliness, depression, and rejection and expressed hostility toward all the people who have been unwilling to establish relationships with her. She could not understand why her neighbors did not like her. Much of her concern centered on why her 15-year old daughter chose

to live in a foster home rather than with her. Mrs. A. was often hostile and angry but occasionally she was happy and able to laugh and talk to the counselor about cheerful topics.

The problem facing a suicide prevention center in trying to help such a patient is increased by the fact that a caller who calls frequently may speak to any of about two or three dozen counselors. Therefore, it is not only difficult to formulate a therapeutic plan that might prove useful in helping the caller but it is also difficult to be consistent in such a plan. Consequently the caller is often handled in a variety of ways. Discussion of Mrs. A. with the counselors at the SPCS revealed a number of different approaches that they had taken with her.

1) Many of the telephone counselors have demonstrated their acceptance of Mrs. A. and conveyed their warmth and support. This approach was often taken after she had been released from the State Hospital and felt very insecure living alone. Counselors employed it to encourage Mrs. A. to find a job and to support her efforts to succeed at it. The counselors using this approach assured Mrs. A. that they realized how difficult it was for her and recognized her loneliness.

This approach was helpful since Mrs. A. had few interpersonal contacts and received very little support from any person in her life. The continued support she received may have helped her find a job and maintain it. The disadvantage of continually rendering acceptance to Mrs. A. lies in the reactions of the counselor. When the counselors told Mrs. A. that they know how difficult it is for her, she often replied, “How do you know how hard it is? You’ve never been alone like I am.” The counselors felt frustrated when Mrs. A. reacted in this way to them.

2) The counselors also focused on particular problems Mrs. A. presented and offered interpretations to her as to why she was feeling a certain way.

Concentrating on a particular problem helped to focus Mrs. A.’s often disorganized conversation. However, interpretations such as “Are you feeling bad today because your daughter did not call?” and discussing Mrs. A.’s feelings about her daughter often resulted in her generalizing her emotional reaction to her daughter to everyone else. Her conversation again became a statement of her overwhelming loneliness and unhappiness.

3) The counselors also reacted with hostility to Mrs. A. and told her that they were tired of listening to her problems. This approach was used when the particular counselor had had several long conversations with Mrs. A. when she has been especially angry.

The counselors all said that at times their only reaction to Mrs. A. has been one of hostility. However, usually they controlled their anger and they felt that Mrs. A. had not sensed their hostile feelings. Anger is an understandable feeling here but may result in guilt on the part of the counselor as it is at odds with the idea of communicating acceptance over the telephone. It is also very unlikely that Mrs. A. did not recognize, at some level, the hostility in the counselor and react to it. Expression of anger by the counselor to a patient is not necessarily unwise or damaging. However, for a counselor to use such a response to a patient usefully, the counselor

should, in general, be aware of her feelings and in control of them (as opposed to being controlled by them).

4) The counselors limited Mrs. A's time to 10 or 15 minutes and permitted her to control the conversation during this time.

This response to Mrs. A. often occurred inadvertently as the counselor had to terminate the call to take another call. A time-limited conversation did not seem to upset Mrs. A. since she maintained the conviction that the counselors at SPCS must talk to her and will when she called at another time. This belief on her part differentiated the therapy she received here from the traditional kind of therapy in which the patient must submit to certain conventions.

5) The counselors confronted her with the fact that she was not accepting any suggestions and demonstrated to her that this was a pattern of behavior for her. The counselors indicated that if she treated her friends and relatives the way she treated the counselors, then it was not surprising that people rebuffed her attempts at friendship.

Confronting Mrs. A. with her patterns of behavior would be a valid treatment method if it was utilized consistently. However, the counselors' lack of patience weakened the usefulness of this approach. Several of the counselors expressed the feeling that when they confronted Mrs. A. she merely turned their statement back to them and said they had no idea of what she was going through. This made the counselors frustrated and angry.

6) The counselors concentrated on specific suggestions such as going to Recovery, bingo, or church. It seems as if Mrs. A. usually initiated the subject of one of the activities and then questioned various counselors about their opinion of her going to them.

The last treatment method of concentrating on specific suggestions was utilized frequently. However, there was no combined effort on the part of the counselors to develop particular plans of activity for Mrs. A. and no one was able to determine who initiated a certain suggestion. One counselor suggested that it was Mrs. A. who mentioned an activity initially and then each counselor reacted to it personally. The danger in this stems from the fact that Mrs. A. could have received conflicting opinions from the various counselors with whom she spoke. However, she received consistent advice and support for the idea of going to Recovery and bingo, and she expressed satisfaction from participating in these activities. Several of the counselors focused on the importance of her medication as Mrs. A. continued to say that she refused to take her medicine.

It is the general impression of the counselors that Mrs. A. improved during the time she called the center. Initially she appeared to be unable to leave her house alone whereas later she appeared to have sought and found employment. To what extent her contact with the center was responsible for this change is difficult to estimate. It is impossible, therefore, to try to evaluate the usefulness of the different approaches utilized by counselors.

Two points are worth emphasizing here. First, the reactions of counselors to particular types of callers may on occasions interfere with the effective handling of the therapeutic relationship that the counselor must establish with the caller. Secondly, since a suicide prevention center uses a large number of counselors, attempts must be made to formulate and implement a reasoned and consistent policy for particular patients. Both of these problems can be dealt with by means of case conferences centered around particular patients. In such a meeting, the feelings of the counselors can be expressed and dealt with and a therapeutic intervention policy can be formulated.

REFERENCE

Lester, D. and Brockopp, G. W. Chronic callers to a suicide prevention center. Community Mental Health Journal, 1970, in press.

The Chronic Caller to a Suicide Prevention Center: Therapeutic Management

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

With the chronic caller it is very difficult to know which treatment method is most therapeutic and to isolate the single, most effective approach especially since one has little influence over the range of the person's experience. In the case of person reported in this paper, she also contacted other agencies in the area and received support from them. It is also possible that changes in her behavior were related to her taking or not taking the medication which was prescribed for her by a physician. Since she continually called regardless of the nature of her most recent contact, it appears that she was receiving some positive help from the counselors (and it is their subjective impression that she has improved since she has been calling the Center). Initially this improvement was evidenced by her being able to leave the house to seek and find employment. Perhaps it was not the specific type of help that the counselor gave which was critical in her case, but the warm, spontaneous, human interaction which each counselor offered which was most critical. An analysis of the calls reinforced this impression. Her conversations with the counselors were most meaningful to her when she had a warm, human relationship.

From an analysis of this caller, and other chronic callers, we can deduce certain principles that seem to be appropriate when dealing with this type of caller.

1) Since the Center uses a large number of counselors, an attempt must be made to formulate and implement a reasoned, consistent therapy program for chronic patients, and every effort must be made to keep this constant so that the differences between the therapists will not be taken by the chronic caller as weakness or unsureness. Consistency in approach also allows for the person-to-person interaction to come through, by minimizing the hostility and frustration that the counselor may feel when working with a difficult patient.

2) With a chronic caller, it is always necessary to be aware that the individual may be seeing other therapists, calling other services in the community, and possibly dealing with one or more medical personnel. When this is known, it is necessary to work with the other agencies and professional people in order to maintain a consistent approach with the individual.

3) Chronic callers, especially if they have had suicidal ideation in the past, or have evidenced suicidal behavior, are extremely prone to make suicide attempts and may eventually kill themselves. Although the chronic callers is a low risk at any particular time, since this kind of person tends to live in a continual upset state, he is a high risk over time and may end his life through suicide. Care must therefore be taken not to underestimate the seriousness of any life-threatening behavior.

4) The chronic caller is usually one who is at a very basic level of relationship with other individuals. The focus of telephone therapy should be on the level of trust, support, and confidence, and not at the level of insight or confrontation. If confrontation with the individual is necessary, the confrontation should be made on the content of the material rather than on the person-to-person level. Even then it is very difficult for the chronic patient not to use confrontation as implied rejection of self by the counselor. Confrontations, when they are used, are best stated in terms of open-ended statements which allow the individual calling to accept the confrontation at the level of his psychological state at that moment.

5) While allowing the chronic caller to maintain some dependency on the Center and on persons at the Center, the emphasis of the contact should be on the person's own support systems and on those in the neighborhood, rather than on the Center. The emphasis should be on assisting the individual to make better use of himself and of his own environment, rather than the Center and the telephone contact.

It is interesting to note that with some chronic callers, the telephone therapist gives clues which imply the desire to maintain contact with the caller and to continue the dependency relationship, instead of moving the caller to a more independent status.

6) It is necessary to help the patient to focus on a specific problem. From our experience in working with the chronic caller, focusing on the problem or assisting them with this process reduces the length of the call and maximized

their ability to work with the anxiety and concern that they have when facing a problem. It is a type of teaching approach to the chronic patient, whereby a method of problem solving is taught to them by the telephone therapist which they can then use on their own.

Chronic callers tend to be the most frustrating caller of a suicide or crisis service. In an attempt to work with them more effectively, we have formulated a number of new directions which we may use to maximize our service to callers and to minimize the negative effect that they may have on the Center and its personnel:

1) To arrange a liaison between the chronic caller and other lonely people in the community who may desire a relationship or who may wish a human contact but be unable to obtain it. Perhaps through a careful analysis of the phone calls received at the Center, a number of people can be found who could profit from listening to the hurts and problems of another person and be able to respond to them on a person-to-person level.

   Another possibility is to use people who live at night, or who for one reason or another tend to be up at night, for example, the wives of men who work a swing shift, and enlist their help and support to take telephone calls from these people at night.

2) To enlist the aid of former telephone therapists at the Center who have dropped out of scheduled work at the center and who might be willing to have their name and their number given out to a number of chronic callers. The chronic callers could then call them for support of friendship, rather than calling the Center.

3) Since chronic callers tend to be older individuals, or individuals who demand a great deal of support and succorance, Golden Age Club members could talk with these individuals via the telephone.

4) Group therapy approaches could be attempted with these individuals through bringing together a group of individuals who are chronic callers, for a period of time each week, and allowing them to interact with other people having problems similar to theirs. This minimizes the phone contact with the center and increases the interpersonal contact they may have with individuals who have similar problems.

5) It sometimes may help to have the individual write to a center, rather than call, and to respond to them in writing, rather than through a telephone call. This allows both parties to give a more thoughtful type of response to each other and allows the service to deal with the problem through a less time-consuming method.

6) It appears that sometimes one can help the chronic caller best through showing them interest and concern through calling them, rather than waiting for them to call the Center. This way, the telephone therapist also has more control over the conversation, and is able to direct it, without the caller feeling hurt. It also assures the caller of the interest and concern of the agency, and makes it less necessary for them to call, to be reassured that the agency is still there and available to them.

NEWS AND NOTES

The Prediction of Suicidal Risk

Dr. Lester has an article in press in Psychological Bulletin which reviews attempts to use psychological tests to predict suicidal risk. Pre-prints are available and can be requested from Dr. Lester, Suicide Prevention Center and Crisis Service, 560 Main Street, Suite 405, Buffalo, New York, 14202

The American Association of Suicidology Meeting

This year's meeting of the American Association of Suicidology is meeting in the Fairmont Hotel, San Francisco on March 22-23, 1970. Information about the meeting can be obtained from:

Roger Cornut
San Francisco Suicide Prevention Service
307 12th Avenue
San Francisco, California 94118

Request for Information

1. We would very much appreciate receiving a copy of the intake sheet that each suicide prevention center uses to note down the information on each caller to the service. Please send them to Dr. Lester and the Suicide Prevention and Crisis Service in Buffalo.

2. If any center has papers, tapes, etc. available that they feel are useful for training and planning, we would be happy to list them so that other centers can write for them.

NOTICE

Address corrections are requested if we have your address incorrect.

Mental Health Centers are requested to indicate to us if they wish to receive CRISIS INTEVENTION unless they have already done so.

We would very much appreciate receiving copies of the Annual Reports for 1969 of centers who produce these reports. Please address them to Dr. David Lester.