Crisis Intervention, 1970, Volume 2, Issue 3

EDITORIALS

Toward a New Image for Suicide and Crisis Services: Richard K. McGee 62
Proposals for the American Association of Suicidology: David Lester 63

PROGRAMS

Training the Volunteer Telephone Therapist: Gene W. Brockopp & Allen Yasser 65

THERAPY AND RESEARCH

The Telephone Call – Conversation or Therapy: Gene W. Brockopp 73
A Comparison of Patients Who Show for Appointments and Those Who Do Not Show: David Lester 75

CASES

The Silent Caller: Gene W. Brockopp 77
The Caller Who Remains Silent: Report of an Unusual Call: David Lester 79

INFORMATION FOR CONTRIBUTORS

CRISIS INTERVENTION is intended to facilitate communication on

1. programs of suicide prevention centers
2. clinical aspects of crisis intervention and suicide prevention; and
3. current issues and research in suicidology and crisis intervention.

CRISIS INTERVENTION is published four times per year (with occasional supplements). It is free of charge to Suicide Prevention Centers and to members of the American Association of Suicidology.

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.

EDITORIALS

Toward a New Image for Suicide and Crisis Services

Richard K. McGee, Ph.D.
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Since about 1965 we have seen in this country a great proliferation of suicide prevention and crisis intervention services. The "movement," as Louis Dublin liked to call it, is now five years old. It can be stated with certainty that we are at a transition point in this process. We have been through the "era of emergence" – that exciting period when new centers came into being every month. With the current roster of 150-plus programs, we will see the tapering off of new programs, for the rate of development must at least reach a plateau, if not begin a noticeable decline. On the other hand, it can be as safely predicted that things will not assume a static character throughout the field of crisis intervention programming. We are entering the "era of change", and it is now that the great challenge to excellence confronts every service.

There are two factors prompting this period of change. The first is the natural phenomena which must surely set in if an agency is to prove viable and effective. Once established, no program can maintain a *status quo* attitude toward development. Its personnel will become complacent, its role will become perfunctory, and when this occurs it will soon (hopefully) cease to exist.

Secondly, for the past nine months, a relative handful of suicidologists have been contemplating the new roles and directions which may – or better, should – be developing during the next decade. Very soon the Center for Studies Prevention at NIMH will publish its Task Force Report, "Suicide Prevention in the Seventies." We have every reason to believe that this report will have a significant impact and influence upon the suicide prevention field. The Task Force was well conceived, carefully managed, and the report has been thoughtfully edited by sincere and dedicated suicidologists. We face the prospect that a dynamic force for social change is about to be unleashed for the benefit of the scientific and service oriented community of crisis intervention specialists. At that time, the full range of personnel – lay and professional, scientist and practitioner – and all of the 150-plus service agencies must accept the challenge and address themselves to some very difficult questions of self identity, and of self-satisfaction. We may anticipate that the result will be a period of controlled and planned change in most of the existing service programs.

It is one thing to predict that change is inevitable, and quite another to presume to speculate about the direction that the change might take. Perhaps only a fool would dare to say what direction it should assume. Since I am not unfamiliar with that role, let me provoke you to consider the following.

As it is true with emergence comes change, so is it true that with change can come maturity. Similarly, with maturity comes independence, along with which must come responsibility. Crisis intervention services have begun to show a rising maturity in recent months. They will surely continue this trend. Suicide and crisis services now rest upon a theoretical and empirical base unlike that of traditional clinical mental health services. They employ a technology unlike that of psychotherapy. They have developed experience and skill at relating to law enforcement, educational, welfare, religious, and legal systems as well as to health and mental health systems. They are equally inter-dependent with (and

upon) all of these systems. In reality, crisis services have no special relationship to the health or mental health enterprise, yet they were developed initially, and tend to continue to behave, as if this were so.

I am firmly persuaded, and I predict that in the next decade I will be less and less alone in this persuasion, that it is time for suicide and crisis services to assume their own special role in the network of community helping systems. Every community needs a police department, a public school system, a mental health clinic, a welfare agency, a fire department, practicing psychotherapists, employment services, attorneys, ministers, a hospital, and a suicide and crisis intervention service. None of these systems needs to be, nor should be, subsumed under the management of any other system. The suicide and crisis intervention services are now ready, and they should begin to take a separate, independent role, side-by-side with other helping resources in the community.

Naturally this notion will evoke some resistance in various quarters. But every existing suicide and crisis service has, by its very survival, demonstrated its ability to overcome resistance from certain elements. Lest there be some intentional misunderstanding as a manifestation of this resistance, perhaps it should be explicitly emphasized that *independence* does not mean *autonomy.* Every mature crisis center knows it cannot function autonomously in a community. But every mature crisis service can, and increasingly many will, begin to operate most efficiently and effectively as an independent – not necessarily health-related – agency.

Proposals For The American Association Of Suicidology

David Lester, Erie County SPCS

In a recent editorial, I criticized the American Association of Suicidology for alleged undemocratic procedures. In this editorial I would like to comment upon two proposed activities of the Association and to suggest more appropriate avenues for its efforts.

According to a recent announcement of the Association, it was unanimously voted at the meeting in San Francisco in 1970 to institute a Louis Dublin Award. (Were you at any meeting where this proposal was unanimously voted?) Inquires to the Association's officers have revealed that the Louis Dublin Award is intended for "senior" suicidologists who are well known and respected. One wonders if the roster of potential awardees will include the same individuals who have been "elected" president of the AAS and/or of the International Association for Suicide Prevention. Is it possible that the officers of the AAS are using the Association to award themselves a succession of honors?

It was also "unanimously" voted to establish a Journal of Life Threatening Behaviors. This journal, if it appears, will be the seventh journal/newsletter published which is concerned with death and suicide. Is another journal really necessary? Wouldn't it be more appropriate for the AAS to work with one of the existing journals (for example, with Omega, an established journal concerned with death, suicide, and bereavement) using it as its official publication?

I would suggest the following more fruitful activities for the AAS to engage in.

(1) The AAS could award a prize each year to the best doctoral dissertation on suicide or self-destructive behavior. This might encourage students to work on the topic of suicide and increase our knowledge of the field through high quality research.

(2) The AAS could award a prize each year to any promising research worker in suicidology. This would again encourage research into suicide.
(3) The American Psychological Association is experimenting with a new article circulation mechanism and is setting up groups to circulate current research on particular topics. The AAS could explore contracting with American Psychological Association to set up a system for suicide research and arrange for the distribution of current research articles for its members.
(4) Rather than establishing a new journal, the AAS should consider initiating a newsletter for its members, informing them of recent developments in suicidology, meetings, research awards, jobs, and even the proposed agenda for the annual business meeting.
(5) The AAS could work with Omega in developing special supplements to publish articles presented at the annual AAS meeting or monographs of special interest to the members of AAS.
(6) The AAS could develop standards for suicide prevention centers to insure the quality of the service extended to the public by these agencies.

I urge other members of the AAS to write to the officers of the association and inform them of how you feel about the direction the association is presently taking.

PROGRAMS

Training the Volunteer Telephone Therapist

Gene W. Brockopp & Allen Yasser, Erie County SPCS

Of the many characteristics of suicide prevention and crisis services, the most outstanding one is its use of volunteer (usually nonprofessional) individuals for the difficult task of giving concerned assistance to individuals who are in a state of crisis or contemplating a suicidal act.

In the more than 150 centers throughout the country, the training program designed to assist the volunteer to work with individuals on all types of difficulties varies quite widely. In most cases what happens in the training program is a direct reflection of the way the agency sees itself, its function, and the suicidal or crisis situation.

The Erie County SPCS is based on the concept that an emergency telephone service should provide more than a listening ear (although that by itself is a remarkable achievement). We feel that the telephone service is best conceptualized as telephone therapy – where the two persons engage in an interaction which has the goal of ameliorating, changing, modifying and, hopefully, improving the psychosocial condition of the caller. We further feel that the assistance should utilize the personal and environmental strengths of the calle and we do not utilize any community agencies unless absolutely necessary. Finally, we feel that this therapy can be effectively accomplished by any mature person who has interpersonal sensitivity (the ability to listen with your "gut") and sufficient intelligence to act judiciously.

We have trained more than 300 volunteer counselors over the past 18 months for the 24-hour telephone oriented counseling services. Over this period of time the training program has evolved into a fairly structured program which is conducted within the context of a small task-oriented experiential group. Typically, the group is composed of approximately 10 to 12 trainees and two leaders selected from the staff. The training program consists of eight, 2½ and 3 hr. didactic and experiential sessions and two three-hour telephone room observation periods. Upon completion of the initial training program, the telephone counselors attend a series of advanced seminars and supervisory sessions.

Selection of Volunteers

One of the most important steps in training a new group of volunteers is the attitude or set that the prospective volunteer has of the agency, its purpose and its function in the community. These attitudes are explored through a questionnaire that they complete when they apply for the position of volunteer. Through using a questionnaire which requests information on the person's attitudes toward difficult or problem areas of life, we are not only indicating to individuals the range of problems with which they will be confronted on the telephone service but also hopefully will cause them to think about their feelings and concepts regarding these areas. Upon completion and return of the questionnaire, the person is called on the telephone by a staff member and given an appointment to be seen at the center for a personal interview. During the telephone call the staff members assess the prospective volunteer by listening to the quality of his voice over the phone, what kind of mental image he presents, whether he can project warmth and concern and if there are any disturbing elements in his voice. The person is then personally interviewed by a staff member and a decision made regarding his suitability for telephone service.

Training Program

The focus of the training program is to increase the person's interpersonal sensitivity and ability to use himself as a therapeutic tool. We emphasize the trainee's natural abilities and normal desires to help people and assist them to integrate these into a therapeutic style which is comfortable for him. One of the more difficult tasks is to help the person learn to listen so that he will avoid developing a premature conclusion about the nature of the caller's problem. We emphasize the need of the telephone therapist to fully survey the forces contributing to the caller's problem so that his understanding of the nature of the person's problem can be as complete as possible before developing with the caller a method for ameliorating his problems.

Over the past two years the structure of the training program has varied quite widely in the way it is presented to the trainee. We have used all-day sessions, twice a week programs, once a week programs, and a number of combinations of the above. At the present time, we feel that a program which operates on a twice a week basis for approximately three hours each session is most profitable in terms of trainee learning, building concepts regarding telephone therapy, and maintaining interest in the service. Over the period of four weeks that the training program operates, we use a variety of center personnel to teach sections of the program with one person being responsible for integrating each of the individual segments together into a total idea.

The following is a summary of the program of training with a brief development of the themes for each of the sessions:

Session 1: The first session is divided into three units. The first focuses on the Center. The trainees are given a tour of the facilities of the Center, a talk on its background, development, and the concepts on which it operates. They are also given an idea what their job will be like, what the responsibilities and privileges are, and the types of calls in which they will be involved.

The second part of the session is devoted is devoted to the volunteer. Using a variety of group approaches, we explore his expectations, fears and concerns about working at the Center and about using himself as a helping being relating to people in crisis. We help them confront themselves with their own feelings about the work and the reasons why they want to be involved in this type of program. Through this process we try to help the new volunteer clarify some of his ideas and expectations and increase his motivation for either working at the Center or leaving the program. During the latter part of this unit, the trainees are asked to pair-off and to get to know one another. Through this dyadic relationship the volunteer begins the process of interviewing and through the process discovers a number of common bonds between himself and other individuals in the group. In the discussion period that follows, two themes are usually brought out: (1) a general fear of giving the wrong advice to people in crisis situations and (2) an expectation of personal growth and development on the part of the new volunteer. The overall result of the initial interview and discussion is to pull the group together and facilitate a free exchange among the group members.

The last unit of the first session builds on the communication process begun in the interviews through a brief lecture on communication. The lecture emphasizes two points: communication is a multi-level phenomena and one cannot not communicate. Examples of the use of silence, phrasing, tone, and

other aspects of verbal and nonverbal communication are discussed and applied to the work on the telephone.

The first unit ends with the volunteer signing up for his first three-hour observation period at the Center.

Session 2: The focus of the second session is the telephone as a therapeutic instrument. The basic advantages and disadvantages of the telephone in crisis counseling are developed for the trainees (for example, the lower defensiveness on the part of the caller, the anonymity and immediacy of the telephone communication). Usually a tape of examples from the Center or from other published materials is used to explore the telephone therapy process.

The remainder of the session consist of a series of role-play situations in which one trainee assumes the role of caller and the other the role of the telephone counselor. The "callers" are given a variety of roles to play in placing the call: (1) portray different types of callers at a Suicide Prevention Center, (2) bring out the possible processes for working on the telephone, (3) confront individuals in the group with types of calls they may have to deal which may relate to some of their personal concerns and questions (for example, calls having sexual content, obscene language, legal problems, etc.). The trainees are placed in a back-to-back configuration during the role-play, so that the only available communication is through verbal contact. After each role-play the group analyzes the communication in terms of how well the people were communicating, the clues about how they felt and the differences between the verbal and non-verbal clues in the communication. Each of the trainees is asked to evaluate how he felt in the "telephone call" and how he felt he was responding to the other individual. During each of the analyses of the "call," the trainees are asked to formulate strategies for dealing with different types of calls or various ways of handling a specific type of caller.

During this session emphasis is also given to the first few minutes of a call with the focus being on how the telephone therapist begins to develop a "set" for the caller and how the relationship is defined within the first minute of the telephone conversation.

Session 3: During the third session, a model for conducting a therapeutic interview over the telephone is presented to the volunteers. The model that we use stresses these four points: (1) How much time do I have? The initial question each telephone therapist should ask himself upon picking up a phone is: "How much time do I have before I must make a decision regarding the disposition of the caller?" We feel that after an individual can come to grips with the concept of time and realizes that he has time to work with the person who is calling, he can reduce his anxiety and deal effectively with the other areas of the call. (2) Formulating the caller's problem. We emphasize the need of the telephone therapist to explore quite widely the caller's difficulty, being open to the whole range of possible problems an individual may have before focusing on the specific problems the individuals are bringing to the telephone therapist. (3) Assessing the caller's resources and the forces which have moved him into a crisis situation. We feel that this aspect of the interview should focus both on the positive and the negative aspects of the individual's life, so that the telephone therapist can attend to both his needs and his fears in order to develop a therapeutic plan which will maximally use his personal and interpersonal resources with minimal reliance on the community at large. (4) Developing a treatment plan. This is pulling together the above other three points, focusing the individual in the direction which we feel is most appropriate for him in terms of the problem he has presented and the resources available to him. During

this session we discuss techniques for obtaining information about the caller and ways in which calls can be ended.

We again focus heavily on role-playing situations and may add to the role-playing process ego auxiliaries to help the volunteers listen more carefully to what is going on in the caller and in the telephone therapist.

Session 4: The fourth session emphasizes the concept of crisis intervention with a discussion of the theoretical and practical aspect of the process. An understanding of "crisis," its effect on an individual's life and on the person's psychological state is emphasized, along with the process by which intervention may occur and what it is intended to accomplish for the person. The PIE model of proximity, immediacy and expectancy is emphasized. Role-playing is again developed around various crisis situations. It is usually during these role-plays that the volunteers are introduced to the intake form which the agency uses to record the callers. Each time a role-play situation is used, the group not directly involved in the dyadic relationship, is expected to complete an intake sheet on the caller as if they were taking the call. By continually engaging in this process, we emphasize the need for information gathering and reduce this process to a more mechanical and automatic procedure.

Session 5: The fifth session of the training process focuses on suicide and the suicidal process. The information on suicide, its epidemiological and statistical aspects are given to the trainees, and questions are answered about the individual who may make a suicide attempt or commit suicide. The trainees' individual concerns about suicide are also explored along with how they may feel about talking to an individual about life or death situations. A discussion of lethality along with various methods of evaluating the lethality of a suicidal situation is given to the trainees.

The last half of the session is devoted to role-playing involving suicidal situations with each role-playing being designed to teach certain aspects of the suicidal process or to develop certain ways of working with suicidal individuals.

Session 6: The sixth session focuses on drugs, their use and abuse. Chemicals ranging from Coca-Cola to heroin are discussed and the drug experience is examined as a process involving an interaction between the user's personality, attitudes, environment and the type of chemical that he has consumed. Ways of responding to bad trips and helping a caller through bad trips are discussed along with the "flash-back" process and techniques that can be used for turning a bad trip into a good one.

During the last half of this session, role-plays around drug problems are developed along with some increasingly complex, emotionally charged situations, in which the therapist is called on to use a number of the techniques which have been previously developed and explained in the previous training sessions.

Session 7: The focus of this session is an examination of community resources and referral techniques. The use of various resource books and an understanding of the agencies in the region are explored with the trainee. He is also assisted in recognizing situations that require immediate emergency medical attention or other outside intervention. The process of tracing a call, using the police, or making a referral to social or clinical agencies is also developed. Emphasis is given to the making of an appropriate referral to the short-term, intensive psychotherapy unit which is part of the Center's service. Information

on the operation of the Center, the use of forms, the confidentiality of information, etc., along with expectations of the Center for the person regarding scheduling and maintaining accuracy of records is emphasized.

Session 8: This session explores the special problems of the repeat, crank, depressed, or very young callers. During this session the trainee also evaluates the training experience and discusses his readiness to assume counseling duties. This latter experience is usually handled in a didactic relationship. At this time the trainee is also given the option to leave the program and not work on the telephone. We emphasize that the trainee must freely choose to work at the Center and that the Center must also choose him as a person that it will want to represent it to the person in need of help and to the community.

The newly trained telephone counselor is required to sign up for a minimum of one six-hour duty every two weeks with a maximum of two, six hour units in any one week. He is also required to tape record all the calls which he takes during this period of time. After he has served for two six-hour periods he is required to meet with his supervisor, at which time his calls will be analyzed and reviewed. If it is felt by both the supervisor and the volunteer that he is doing an adequate job on the telephone, he is placed on the volunteer schedule. His work at the Center, however, is continually monitored. For every two, six hour units he works at the Center he will meet one hour with his supervisor and go over a sample of his calls, discuss his difficult calls and the intake sheets he has completed, and thereby increase his counseling abilities. In addition each telephone therapist is required to attend regular seminars which deal with specific treatment plans for high frequency callers or to discuss different types of treatment programs or types of problem callers.

Appendix: SPCS Telephone Forms

Show_____ Date_____ Client's Name_____

No Show_____ Date of Scheduled Appointment_____ Case #_____

Therapist_____ Problem Area_____

CRITERIA FOR REFERRAL TO AN SPCS COUNSELING INTERVIEW AT THE CENTER
Although many of our caller's problems are well handled by telephone contact, a small percentage of our clients may best be helped through a series of interviews at the Center. The following guidelines are designed to help you decide whether a referral to the agency would be beneficial for the caller.

1._____Isolation: The caller has a sense of aloneness.
Examples:
a. The caller is preoccupied with loneliness.
b. The caller is actually isolated or feels that way: there is very limited person-to-person contact.
c. The caller experiences difficulty in communicating with others.

11.____Danger: There is some threat to the caller's well being.
Examples:
a. The caller is suicidal or homicidal, and telephone contact does not lower his anxieties.
b. There is some other pressing, threatening situation such as health or financial problems.

111.___Diffusion: The caller has difficulty in saying what the problem is.
Examples:
a. There seems to be an underlying problem but the caller has difficulty in identifying it.
b. The caller seems confused.

1V.____Relationship Problems: The caller's problem involved a second person.
Examples:
a. Person calls because of a marital issue, and you feel that the caller's family should be treated as a unit.
b. Friendship problems, boyfriend-girlfriend, etc. In each case you feel treatment as a unit is best.

V._____Referral to another agency inappropriate, but a referral is necessary:
Examples:
a. There is no other agency which handles this particular problem.
b. Caller has been to other agencies and not found them helpful.
c. Caller feels he cannot tolerate a long wait for therapy.

V1.____Factors not directly related to a specific problem:
Examples:
a. Caller requests an interview.
b. Telephone worker has a strong and yet hard to define feeling that the caller should come in for an interview.
c. A professional in the community has referred the caller for an interview.

INITIAL CONTACT SHEET (Fill out EVERY item) Try to get some identifying information on callers, especially those referred to agencies)

Line: SPCS TPS PL JV
Case number: _____ COUNSELOR:_____
Call began: _____am pm
Date: _____Day: _____ Call ended: _____am pm
Taped: yes no
Caller: _____Age: _____Sex: _____ Marital Status: _____
Address: _____Telephone: _____
(If patient will not give address
get street, block, area, etc.) _____
Calling for: self other If other, Who?_____

PROBLEM
check one primary problem and
as many secondary as appropriate

	prim.	sec.
alcoholism:_____		
anxiety:_____		
depression:_____		
drugs:_____		
employment:_____		
family:_____		
financial:_____		
homicidal:_____		
info:_____		
legal:_____		
lonely:_____		
mental dis.: _____		
physical dis.:_____		
pregnancy:_____		
school:_____		
sexual:_____		
suicidal:_____		
other:_____		

Check all appropriate items

CRISIS: acute: _____(change in past 2 days)
chronic _____(duration exceeds 6 mo.)
neither _____

SEVERITY OF CRISIS: (counselor evaluation)
0 1 2 3 4 5
none moderate severe

SUICIDAL HISTORY:
unknown: _____
none: _____
ideation: _____
threats: _____
attempts: _____

CURRENT SUICIDAL BEHAVIOR:
none: _____
ideation: _____
threats: _____
attempts: _____

SUICIDAL RISK: (counselor evaluation)
0 1 2 3 4 5
none moderate high

CHECK THE FOLLOWING WHERE APPROPRIATE:

traced: _____police: _____rescue squad:_____
cab: _____ambulance: _____consultation: _____

COMPLETE INFORMATION ON THE OTHER SIDE

Background to problem:

Disposition (be specific. Which agencies did you refer caller to, if any? Did you suggest particular time?)

Suggestion for future contacts: _____

How did you feel about the call: _____

THERAPY AND RESEARCH

The Telephone Call: Conversation or Therapy

Gene W. Brockopp, Erie County SPCS

It is very important when working on the telephone at a crisis center which is designed to be more than an information or referral unit to sharply differentiate between the conversational telephone call and the therapeutic one. Although the training program may emphasize the need for a therapeutic engagement between the caller and the telephone therapist, individuals very easily move back into the former habit pattern of using the telephone as a means to obtain a conversational relationship based on the interaction of the two personalities. As a result the therapeutic process is minimized, distorted, or possibly even eliminated entirely. This is especially true when working on a chronic call or a call from an individual with whom the telephone therapist has talked previously. In a center which has the implied assumption (on the part of the patient) of being a therapeutic unit, such as a suicide and crisis service, a conversational telephone call with a patient is worse than none at all for it sets up certain expectations on the part of the patient regarding the relationship.

1. It virtually eliminates the possibility that the telephone therapist can be objective and therapeutic in his function, for he is cast in his role of a friend, rather than in the role of a counselor.

2. Any confrontation that may take place, tales place in terms of the personalities of the individuals and their ideas and opinions (which is basically non-therapeutic). In contradistinction, a therapeutic confrontation takes place between the individual patient and his own thought processes or behaviors.

3. By talking conversationally with the person, the telephone therapist may reduce the anxiety of the individual to the point where he does not feel a need to come in for therapy.

4. Since the caller is calling a place which is designated as being a therapeutic unit, i.e., suicide prevention and crisis service, he develops the expectation that this is a process of therapy. If then he later moves into a therapeutic situation, he will have the same expectation, thereby making it very difficult for a therapist to engage with him on a therapeutic level.

From listening to a variety of calls, it appears to me that the therapeutic aspect of a telephone therapy decreases dramatically as the caller increases the number of his calls to the center. It also appears that one sure mark that the interaction on the telephone has degenerated to a conversational level is when the patient requests to talk to one individual and only one individual, especially when the patient places his calls at such a time when he knows a certain telephone therapist will be present on the telephone. The reasons I feel that this is so, are: (1) The reason the patient usually gives why he wishes to talk to a particular person is because he has given this individual background information on himself and therefore will not need to reiterate it to another person. Very seldom is it mentioned that this person was particularly helpful to him, or this person has given him directions for change. (2) Often the “caller to one therapist” problem degenerates into a communication between the two by letter or other means, and almost always these communications are of a very personal nature, having almost no therapeutic quality to them. (3) The telephone calls between the two individuals tend to result in much more commiseration and acceptance than confrontation and change. (4) The telephone therapist in this situation is almost always operating without a therapeutic plan in terms of the direction of treatment and the goal toward which he is striving. Therefore the conversation tends to float along in terms of feelings of the moment, rather than being directed toward a goal or termination point.

The relationship between the telephone therapist and the patient should be neither social nor anti-social but asocial in orientation and in content. This allows for the telephone therapist to be objective looking at the behavior of the individual, his social relationship, and the problems that the individual has. The therapist then has the right to engage the patient in some directive behavior which is intended to assist him to improve his situation or modify the problem that he has. If the relationship between the two remains on a social level, any type of interaction or confrontation will take place between the two personalities. If the relationship is asocial in nature, the telephone therapist will be able to relate to the individual emotionally while at the same time assisting the person to confront his own behavior and thereby make any changes which the patient feels are necessary. The relationship then does not become a situation of dominance and submission, but rather one in which the primary function of the telephone therapist is to understand the person, the problems with which he is confronted and for which he has the responsibility to assist the individual in amelioration through self-confrontation or suggestions for changes in his life pattern. This requires a great deal of finesse and skill on the part of the telephone therapist, for he must listen very carefully to what is going on in the conversation, not just in terms of his personal relationship to the patient, but in terms of the way in which the patient is "playing out himself" and his normal way of interacting with people through that relationship, the changes in the direction of the conversation, the emphasis on aspects of the conversation given by the patient, and changes in mood or omissions. All of these will be used as a basis for understanding the patient. The therapist's objective yet emotional involvement with the person will enable him to see past the content and into the pattern of behavior through which the patient has gotten himself in a difficulty which he has not been able to work out of by himself.

It is important to re-emphasize the point that a suicide prevention and crisis telephone service is not a social telephone line, nor is its primary purpose that of providing social interaction for individuals. We cannot go under the assumption that, if the therapist is doing no harm by being conversational, we can continue on that level because he may be doing some good. An adequate therapeutic relationship seldom takes place in a social setting and, when it does, it is accomplished only because of the skill of the therapist in being able to separate the social element from the therapeutic one. It is unlikely that the average telephone therapist has either the insight or the skill to accomplish this. Therefore, it is necessary that we clearly differentiate between the therapeutic relationship and the social relationship and train individuals who work on the telephone to be involved in the former and not in the latter.

There is no question that a service which provides a social interaction for lonely people may be advantageous and useful. However, when a service is classified as being therapeutic and then provides only conversational, social relationships it is both distorting its purpose and setting up a certain assumption in the patient's eyes which often preclude his obtaining therapeutic help. It may be necessary for us to differentiate our telephone services by using the Problems of Living line for conversational types of problems and relationships and the Suicide and Crisis lines for therapeutic-oriented services.

A Comparison of Patients Who Show for Appointments and Those Who Do Not Show

David Lester, Erie County SPCS

One of the referrals that a counselor can make for callers to the three problem services of the Suicide Prevention and Crisis Service in Buffalo is to the SPCS itself. Patients can be seen anytime between the hours of 9:00 a.m. and 9:00 p.m. for individual face-to-face therapy.

The proportion of patients given appointment at the SPCS for therapy who actually showed ranged in successive months from 29% to 56% (Lester, 1970). Since the proportion of no-shows was high, it was decided to see whether any clues as to why patients were not showing could be obtained from the records of the telephone calls.

Method

In order to find reasons why some patients were showing for interviews and why others were not showing, the initial contact sheets of a sample of patients who showed were compared with the initial contact sheets of a sample who did not show.

In November, 1969, the proportion of patients referred by night-watchers to the center who showed was 27%. During the month of November there were two types night-watchers working: the regular night-watch staff and the new teenage counselors.

For all the patients referred by night-watch staff and teenage counselors, there was no significant difference between the shows and the no-shows in whether they were calling for the first time or a subsequent time. It was decided to study in more detail only those patients calling for the first time.

For the patients calling for the first time in the month of November, the teenage counselors did better that the regular night-watch staff in referring patients who showed, but the difference was not quite significant (Fisher exact $p = 0.09$).

In November there were 30 patients who were calling for the first time who did not show and 12 who did show. In order to increase the sample size an additional 6 patients who did show were obtained for the study by including the last 15 days of October and the first 15 days of December. Thus, the results described below derive from a comparison of the 30 no-shows with the 18 shows.

Results

The two groups did not differ in whether they were calling on a weeknight or on a weekend, whether they were anonymous or not, sex, marital status, presence of children, whether calling for self or other, suicidal history, suicidal risk as rated by the counselor, or hour of the call.

The shows were significantly more often aged 20-34 years while the no-shows were more often aged 0-19 and 35-54 years (Fisher exact $p = 0.025$). The no-shows were significantly more often calling on the Teenage Problem Service as compared to the Problems in Living Service and the Suicide Prevention and Crisis Service (Fisher exact $p = 0.025$).

The mean length of call of the shows was 34.2 minutes whereas the mean length of call of the no-shows was 23.2

The intact sheets of the two groups were compared for the amount of information written down. On 14 of the 19 coded items examined, there was more information for the no-shows (binomial $p = 0.032$).

Discussion

In general, there were few differences between the shows and no-shows. More information was known about the no-shows than the shows but this may reflect the fact that there were more young people (aged 0-19 years) among the no-shows and for these it is easier to determine whether they are married, and so on. However, in view of the shorter length of calls from no-shows as compared to shows, it may

reflect a greater concern of the counselor with getting information from the patient rather than establishing a satisfactory therapeutic relationship.

However, the shows and no-shows appear to be very similar in characteristics and it seems that an examination of the content of the initial calls will be necessary to arrive at a satisfactory explanation of why patients fail to show.

Summary

Patients who show for an appointment at the SPCS for therapy after being referred in via a telephone contact are:

more often aged 20-34
more likely to have called on the suicide prevention service or the problems of living service
likely to have less information recorded on the contact sheet describing their telephone call
likely to have had a longer telephone call with the counselor who referred them in for therapy.

Reference

Lester, D., Steps toward the evaluation of a suicide prevention center: Part One. Crisis intervention, 1970, 2, suppl. to #2, 42-45.

CASES

The Silent Caller

Gene W. Brockopp, Erie County SPCS

One of the most frustrating people to work with in either a face-to-face therapeutic interview or over the telephone is the person who does not engage in a verbal interaction with a therapist. In a face-to-face contact, other means of communication can be elicited and utilized by the therapist to engage the client. When the telephone is used as the medium for communication, the therapist is at a disadvantage as most of those other avenues of communication are not available.

In the silent caller we have an excellent example of ambivalence. At the same time as this person calls a center designed to assist people who have personal problems he, for any number of reasons, chooses not to engage in verbal communication. This behavior which appears inconsistent, usually has a basis in his psychological makeup or previous experiences with helping agencies. Many callers to a suicide prevention center have been rejected by other agencies and organizations or by their families and friends and are unsure whether or not they will be accepted at the suicide prevention center. As a result, they may call in a reluctant manner to reduce the psychological effect of the potential rejection.[1]

One of the advantages of a telephone is that the caller is psychologically next to the person he is talking to regardless of the physical distance. To the silent caller this psychological advantage may be a disadvantage. With his concern about being accepted by the telephone therapist, the immediacy of this intimate relationship with another individual may become too frightening for him so while he utilizes the telephone in order to gain psychological mobility without a change in his physical environment, the rapidity of the change and the impact of the closeness may frighten him away from beginning a conversation unless the person on the other end of the telephone is aware of this concern and does something to facilitate his talking with a statement that says, “You can trust me,” “I want to help,” or “I’m here to listen.”[2]

But what does one do when the caller makes no verbal response, yet remains on the line, making his presence known? Faced with this type of caller, the telephone therapist must first overcome his initial tendency (which maybe appropriate in other non-therapeutic situations) to hang up the phone assuming that it is a so called “prank” or “nuisance” call. He must remember that his first task as a telephone therapist is to meet the caller at his level of acceptance and to try and remove any impediment which may keep the person from communicating his problem or difficulty.

At the center we have developed the following procedure for working with this type of caller. If upon answering the telephone with a “Suicide and Crisis Service may I help you?” the therapist receives no response from the caller he is to respond to any nonverbal cues which he feels may be appropriate at that time. If there are any sighs or heavy breathing he may say, “Sometimes it’s very hard to begin talking about things that trouble you” or if he feels that the person may be in pain or unable to verbalize he may say “Have you hurt yourself, is there anyway in which I can help you?”

If there’s no response and he is convinced, based on the minimal cues he has, that the person is not in any desperate situation, the telephone therapist will repeat “SPCS may I help you” and continue to

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[1] In fact, in every type of therapeutic situation the patient presents a test to the therapist whereby he, the patient, ascertains whether or not the person he is talking to is one who will understand him or one who is worthy of the trust which he, the patient, has to give.

[2] This type of caller is also one who may use the ply after the telephone is answered of saying, “Oh I’m sorry, I must have the wrong number.” It is for this reason that the telephone therapist must not accept at face value a “wrong number.” Instead of saying “Ok,” or “I’m sorry,” the therapist must respond with a helpful comment such as “What number were you calling?” or “May I be of assistance to you?” Even though this usually will not engage the person in a conversation at that time, it does indicate to him that the people at the center are real, human, and interested in helping him if he needs help. It will be easier for him to place his call and to complete it next time.

sound reassuring, interested, and willing to wait until the caller is ready to talk. He may, after a few moments of silence, say "I'll be here and willing to talk with you as soon as you're ready." Again after a silent period he may respond with "I like to talk with you and maybe together we can work out the problem that's bothering you." After a few moments he may say, "It's very hard for me to know what's happening to you and what kinds of things are taking place that make you feel you can't talk to me about your problems. If you like, maybe we can talk about something else for a few minutes." If there still is no response he may, after a period of silence say, "I'll be here to listen and talk with you as soon as you're ready." If a minute or so has gone by without any response on the part of the caller (and assuming that the telephone therapist feels that the individual is in no physical danger) the telephone therapist may say, "I'd like to talk to you but I guess you find it very difficult to talk right now. I'll stay on the line for about another minute if you want to talk I'll be here to listen to you." Again following a period of silence he may say, "I like to talk with you but I'll have to hang up the phone in about another half-a-minute unless we can begin a conversation. I want you to know that we're interested in talking with you about any problems you may have and we're here 24 hours a day." After a few moments of silence the telephone therapist will terminate the call with a statement like, "I'm sorry you found it so difficult to talk at the time. Sometimes it's very hard to talk about problems that one feels very deeply. There is someone here at 854-1966 24 hours a day. If you feel we can be of any help to you, please call us. If you would rather talk to someone in person you can come to the center at 560 Main St. anytime between 9 and 5 o'clock. I have to hang up the hone now. Thank you for calling. Good-bye." He then hangs up the phone, terminating the call.

We find that a very small number of callers must go through a process of being rejected by the center before they are willing to engage in a verbal relationship with the telephone therapist. These callers will virtually force one to go through the above routine then immediately call back and begin talking to the telephone therapist. We find that these individuals will, after a period of time, give out a cue during their first call of the evening that indicates who they are so that the center can "reject" them by hanging up the telephone. They then immediately call the center again and begin to talk.

We also have noted that some individuals are unable or unwilling to talk over the telephone about things that disturb them or problems that they have. In some cases we have engaged in a therapeutic relationship with these individuals by asking them to write to us at the center (which is an effective way of removing oneself one more step from the intimacy of the telephone relationship). Other individuals want a closer relationship one in which they can see the therapist and will accept the invitation to come into the center and be seen on a face-to-face basis. (That a person has accepted the invitation is, of course, only known after a patient has been seen at the center and who in the course of therapy may identify himself as a person who did not just "walk-in" to the center, but one to whom it was suggested to come into the center and talk because he was unwilling to converse over the telephone.)

The silent caller presents the center with a problem and a challenge. By refusing to engage with us on a verbal level, he hits the telephone therapy service at its most vulnerable spot. Expecting anger, rejection, or hurt as a response to this "low blow" he waits for the telephone therapist and hangs up on him. By accepting his feelings and concerns and exploring with him a basis for a relationship which is acceptable to him, the center reinforces its role as a therapeutic service.

The following case illustrates how a telephone therapist can engage in a conversation in which information and concerned assistance can be given to a caller without any verbal exchange.

The Caller Who Remains Silent: Report of an Unusual Case

David Lester, Erie County SPCS

Occasionally suicide-prevention centers and crisis service receive calls in which the caller remains silent. The aim to this paper is to describe an unusual case of this problem.

It is important to note that counselors frequently classify these kinds of calls as nuisance calls or pranks. To do this runs the danger that people in crisis will not be aided by the service. Brockopp (1970) has discussed the so-called nuisance call. The telephone counselor cannot reliably judge a call to be a prank call. As Brockopp noted, to classify a call as a prank call is to set up an arbitrary standard as to the type of problem or situation with which the counselor will work.

If the counselor stays with the person, speaks sympathetically to them, and encourages them they may eventually overcome their fear or embarrassment. If the caller hangs-up without talking, this may reflect upon the counselor's competence rather than the seriousness of the caller.

If the caller initially remains silent it may prove to be difficult for him to begin talking to the counselor, to break the silence. In that case, the counselor has several alternatives. He can stay with the caller and continue to encourage him to talk. He can suggest that the caller hang-up and call back at another time. He can suggest that the caller write to the center rather than call. The following case report describes a fourth possibility. In this the counselor suggested to the caller that she answer yes or no in a code. A sigh represented yes and silence represented no. In this way he was able to elicit a great deal of information from the caller.[3]

In order to best illustrate how this call proceeded, some extracts from the call are reproduced below.

> …OK. So here's what I know that you're 15.
> I know that you're a girl. And I know that Tuesday you broke up with your boyfriend. And you've been thinking about it and felt really bad and depressed and you cried a lot since then. And you haven't talked with anybody about it and you cut yourself. You cut your wrists tonight. And they bled a little. Did you call us before you cut your wrists or after?
> Did you call after? sigh
> Did you call before? –
> You called after. OK. So I know that about you. That's when I stopped being able to find out things about you.
> I know that you haven't talked to your parents about it. I know you haven't talked to your girlfriends about it or anybody else. And I know you say you want to talk to me and I know you can talk. But you won't. And I don't know why.
> Do you know why? –
> You don't know why.
>
> …Do you want to use words to talk with me? sigh
> You do.
> Have you started to talk to me but never been able to begin? Sigh
>
> …Do you feel…I don't know how you feel when you can't talk with me. I know you feel bad and depressed. You feel like it's the end of the world and you can't live without your boyfriend. I know you feel all that but I don't know what it is that won't let you talk.

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[3] To those readers who feel that the patient here was playing games, I would again point out that it is not really essential for the counselor to decide whether the patient is playing a game. A patient may equally well play games during a verbal conversation with the counselor. To prejudge and accuse a caller of playing games may serve to reject the caller and render therapeutic intervention impossible.

…I'm interested in what you do when we're silent. When I don't say anything and you never say anything. When I don't say anything and you don't sigh and everything's just kinda pretty quiet.
Are you thinking? sigh
Are you thinking about talking with me? sigh
A little bit. Are you thinking about your boyfriend? sigh
Are you thinking about yourself? sigh
A lot? sigh
Are you going to hurt yourself tonight? Sigh

…I should believe that you can begin?
No. I should believe that you do want to talk to me? sigh
Yes. I should believe that you can't begin? –
Do you think that you can begin? –
You think you can't begin? sigh

…Have you told me the truth tonight? sigh
Yes? sigh
All of it? –
Was all of it the truth? –
Did you lie to me tonight? sigh[4]

It was clear that the counselor here was able to learn a lot about the patient. Although having to ask questions that could be answered "yes or no" restricted him, he was able to discuss feelings, events, and assess the lethality of the caller. He was also able to present himself as a sympathetic and understanding person. In doing so he increased the likelihood that this patient would call back and make use of the SPCS. It is possible that on subsequent calls, her reluctance to talk will be less and that this first contact served to reduce her inhabitations about talking to a counselor.

REFERENCE

Brockopp, G. W., The Nuisance Call: A Point of View. Crisis Intervention, 1970, 2, 52-54.

[4] Further questioning revealed that she had lied about the area of the city in which she lived.