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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.

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If you have any thoughts, ideas, antagonisms, etc., in response to the articles published here, please send them to the editors.

If you have anything you would like to contribute to the bulletin, send them to David Lester or Gene Brockopp, Suicide Prevention and Crisis Service, 560 Main Street, Buffalo, New York 142023

EDITORIALS

Taking Accountability Seriously

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Measuring from the Phoenix Conference on "Suicide Prevention in the Seventies" we are entering the second decade of the "Suicide Prevention movement in this country. During the past ten years there has been a steadily rising tide of publications about suicide, some of which purport to present research findings. There is something about these "research" documents which strikes a more traditional researcher with a serious sense of malaise. There is a curious tentativeness about the commitment to research, the air that it is done with the back of the hand, while attention is on more serious problems. The alleged findings were more often used to shape the attitudes of the general public or foundations and government agencies than to guide suicide preventers to more effective methods. It is understandable that, with massive public and official ignorance and apathy to be overcome, some kind of propaganda was necessary at the beginning. But it is mystifying that there has been so little commitment of personnel and funds to improving our systematic understanding of suicidal individuals and the social and institutional contexts in which they act. There is little, if any, room in the Suicide Prevention movement for full-time researchers. Mostly research is done on a part-time basis by individuals who, by training and contract, are devoted principally to offering service. For suicide prevention this policy has led to the same difficulties it produced for clinical psychology in general: research done is what is feasible rather than what is needed; insufficient time is devoted to the development of fruitful ides; procedures are limited to familiar routines instead of being innovative; and inadequate amounts of data are subjected to inadequate analysis. It is fair to say that this state of affairs, pervasive and persistent though it is, is not the fault of any one individual or group. The fault lies with "the system" and the way we think about it. When it comes to the equally necessary, equally desirable, equally time consuming and difficult specialties of research and service we keep trying to use the old fashioned turn-of-the-century model of "clinical research" in which the physician or other "helping professional" compiled as much data as he had time to record on a "series" of cases, and when he could find the time he "wrote them up" by summarizing their outstanding features. This is a way to systematize experience, and such systematized experience is often a useful and sometimes necessary precondition of more profound *knowledge*. But it should require no great erudition to recognize the distinction between experience and knowledge. The little that we actually know about suicide is sufficient to suggest that the complexity of its causation and control far transcends the ability of any single individual, method, or discipline to comprehend.

There have always been two outstanding questions in the field of suicide prevention to which we still lack positive answers. The first of these is the problem of reliably identifying individuals who are going to commit suicide. Most research on this problem has concentrated on attempts to invent or discover a single easily understood and quickly used test, rating scale, or checklist which will identify with nearly infallible precision people who will kill themselves unless somebody stops them. The persistence which suicide preventers and their allies yearn for such an instrument is surprising. Why should one continue to search or wish for an instrument which is more infallible than any psychological measuring device has ever been, especially when our most powerful prediction methods are not used in the search? Psychological measurement has been used with great economic and social benefit in educational, military, and industrial settings despite the fact that in none of those instances has any test or

selection or detection device ever operated without error. Furthermore, if prediction errors are too large there are techniques which are likely to reduce them to some more tolerable level. But in practically no instance of suicide prediction research have such error reducing techniques ever been used.

The other persistent problem is that of demonstrating whether suicide prevention efforts work at all. And this entails the additional question about which prevention methods are more effective than other. These two questions lead back to the problem of creativity: have we discovered, thought of, or invented all of the reasonable services or treatment methods which might conceivably apply to the preventing of suicide? The lack of data in this area is almost total. A suicide preventer may have the very strong feeling that his efforts have prevented suicides, but there is no way in which he can demonstrate it to a critical observer. There does not seem to be any reason, in principle, why this should be so.

Probably we will never be able to answer the questions of predicting suicides and the effectiveness of suicide prevention efforts without putting more money and manpower into the effort than we have already done. Such data as already exist strongly indicate that there are vast differences in suicidal behavior from one community to another and that these differences are of sufficient magnitude and importance to warrant the establishment of separate research programs in every community where suicide prevention activities are going on. We cannot any longer uncritically accent the assumption that facts about suicide relating to community A are automatically transferable to community B and thence generalizable to all other communities. Scant though it is, our evidence is already sufficient to brand that assumption as false.

Unless we make a determined effort to introduce more effective research procedures into this field then there are few obvious reasons why limited community resources should continue to be spent on suicide prevention efforts as they are now practiced. On the other hand, there appear no good reasons why suicide preventers should not render themselves more fully accountable to the communities they want to serve.

The Patient Nobody Wants

David Lester, Erie County SPCS

The patient nobody wants? Each of us can think of many kinds of patients that bother us and whom we wish would go elsewhere. Two articles have recently appeared on these patients. Goldfarb's (1970) patients that nobody wants are skid row alcoholics while Grant's are the chronic multiproblem patients often found in psychiatric wards. Lipsitt (1970) has described "crocks," patients who make multiple visits to medical clinics and psychiatric clinics have their share of such patients.

Crisis clinics and suicide prevention centers come into contact with many patients that nobody wants. Most often, we can offer these people no more than other agencies and services have done in the past. A good illustration is Joe.

Joe is a young Mohawk Indian in his early twenties. He is an alcoholic and takes drugs too. He is medium build and has a scar on one side of his face. He cuts his wrists from time to time. Rumor has it that he was discharged from the Buffalo State Hospital alcoholism unit as incurable. None of the halfway houses will take him any more because he breaks their rules by bringing alcohol on the premises. On July 3rd this year he was picked up by the police for drunken and disorderly behavior and put in a cell overnight. He cut his wrists in the cell and so the police took him to the Emergency Room at Mayer Memorial Hospital where his cuts were bandaged. Then he was released. He arrived at the SPCS the next morning, drunk. It was July 4th, a holiday. The downtown alcoholism clinic was closed. They have sent

people over to pick him up and kept him for a while in the past. But it was a holiday. I guess you have to fend for yourself on July 4th. One of our social workers talked to him but had no idea what to do with him. Eventually, he took him down to the street, hailed a taxi cab, and paid the driver to take him to Sister's of Charity Hospital. I'm sure they put him back on the street.

What do you do with people like Joe? Each agency finds him a problem and tries to get rid of him as fast as possible. He is assumed to be incurable. He is treated as a nuisance.

In fact, people like Joe are a good test of the adequacy of our community mental health services. As long as Joe is shuttled around from agency to agency, we know there is a lack of resources in the community and that the mental health professionals are focusing on the easy patients rather than the problem patients. Most likely, it's going to be unsatisfying to work with Joe and to set up resources to help him. Too much work with too little prospect of salvation. But he remains as one of our failures.

Although crisis clinics are not the kinds of agencies that are best suited to helping Joe and people like him, we are the kind of agency he is going to contact eventually. Perhaps because crisis clinics have shown ingenuity and flexibility in the past, it will be our responsibility to work in the community to encourage the establishment of more varied kinds of resources so that eventually there won't be patients that nobody wants.

1. Goldfarb, C. Patients nobody wants – Slid Row alcoholics. Dis. Nerv. Sys., 1970, 31, 274-280.
2. Grant, W. B. The patient nobody wants. Ment. Hyg.,
3. Lipsitt, D. R. Medical and psychological characteristics of "crocks." Psychiatry in Medicine, 1970, 1, 15-25.

PROGRAMS

A Telephone Service for the Elderly[1]

David Lester, Erie County SPCS

The use of the telephone for crisis intervention has moved in a commercial direction with the introduction of calling services for the ill and the elderly. In this paper, I shall describe the operation of one such agency: Care-Ring in New York City.

Care-Ring began operation early in 1969. For a fee of $17.50 a month, a subscriber receives two telephone calls each day at any times he wishes. Most subscribers choose a morning and an evening hour. Each subscriber completes an application form giving the name and phone number of his doctor, his building superintendent, a neighbor, his nearest relative, and his closest friend. A registered nurse on Care-Ring's staff obtains a medical history for the subscriber from his doctor.

If a subscriber will not be at home to receive either of his daily calls, he is required to notify Care-Ring. He may receive his calls at another number if he wishes. The calls from the Care-Ring staff are brief—they are limited to 90 seconds. The Care-Ring staff member greets the subscriber cheerfully, may tell him what the weather is like, or briefly discuss the news. The staff is not allowed to give out their

[1] The information about Care-Ring was obtained from an article in The New Yorker, 1969, 45(17), 30-31.

names or any personal information and they are pledged to confidentiality about what they hear from the subscriber. A card is kept on each subscriber and personal data are added from time to time on such things as his favorite topics for discussion and his disposition.

Although some people use Care-Ring as a cheap waking-up service, most of the subscribers are ill or elderly people living alone. If Care-Ring calls a subscriber and there is no answer, a second call is placed 30 minutes later. If there is still no answer, the subscriber's doctor is notified by phone and a nurse is sent to the subscriber's apartment. The neighbor and the building superintendent are then alerted to arrange for the nurse to be let in. In this way, many ill people have been able to receive fast medical treatment and their lonely existence has been relieved by two brief telephone calls each day. There is also an emergency number for subscribers to call if they sudden help.

The offices of Care-Ring are in use 24 hours a day, seven days a week. The Census Bureau in New York City estimated that about 750,000 people live alone in the city. Care-Ring estimated that it needed 1,000 subscribers in order to break even.

I had some difficulty obtaining further information from the Director of Care-Ring, Mrs. Marion H. Parker owing to her uncooperativeness. If any readers know of similar or related services in their communities, I would appreciate receiving information about them. it would be of interest to know what kinds of emergency calls they get, what problems such services have encountered (for example, do they get nuisance callers as do many suicide prevention centers), how do they train their "telephone companions," what kinds of back-up consultants do they have and so on.

Such services, though limited (and perhaps because they are limited), can serve a vital need in the community. The telephone is an excellent medium for serving health and mental health needs as we all know. We must be on the alert to find new imaginative uses for telephone contact in the provision of services to the community.

THE PHILADELPHIA SUICIDE PREVENTION CENTER

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How the Center Evolved

Actually, the process started in 1955 when the City of Philadelphia replaced its coroner with a medical examiner. Shortly after the medical examiner was appointed he sought the services of Mental Health Division of the Department of Public Health to see whether any meaningful information could be developed on the problem of suicide from records in his office. From an initial study of the characteristics of suicide over a five-year period, an ongoing research program developed, which has continued since that time. Following the early studies we made a recommendation for the establishment of a suicide control unit within the Health Department, but apparently the Managing Director felt that this type of facility was not as attractive as other proposals. We then solicited the help of the Mental Health Association of Southeastern Pennsylvania which set up an ad hoc committee which over a three or four year period studied the problem, stimulated groups to become interested and involved, found funds to send out at two different times a psychiatrist to participate in a training program offered by the Los Angeles Suicide Prevention Center, visited or wrote to other communities with suicide prevention

facilities and developed a proposal for a center in Philadelphia. The activities described above, along with the impetus of the establishment of the Center for Studies of Suicide Prevention in NIMH and of suicide prevention facilities in other parts of the country, contributed to the development of the Philadelphia Center which was established in September, 1967 and became operational in February, 1968. The Center is a component unit of the Division of Special Services of the Office of Mental Health and Mental Retardation of the Department of Public Health. Its services are not limited to Philadelphia; rather it serves the Greater Delaware Valley with a population of about five million which includes the four contiguous counties in Pennsylvania and several counties in New Jersey.

Organizational Matters

Since the Center is under the auspices of a public rather than a private agency, the organizational problems are more complicated. For example, staff can be hired only under existing Civil Service procedures. If job titles do not exist for the positions that are necessary to carry out the functions of the Center, as much as six to eight months may be needed to develop job specifications, get approval for the establishment of the positions from Personnel, haggle about salaries, announce examinations, recruit prospective applicants and finally hire qualified persons. Another example related to the roadblocks in such matters as office space or telephone service which comes out of the budgets of other City departments rather than from that of the Health Department.

Staff

Currently the day professional staff consists of three suicide prevention counselors, a psychiatric social worker, a psychiatrist, and a psychologist who also serves as director. All are full-time personnel. We also have an unfilled position for a research psychologist. The night staff consists of a highly sophisticated group of psychologists, psychiatric social workers and a psychiatric nurse. At the beginning we had several second and third year psychiatric residents on the night staff but we discontinued their involvement after about six months because we felt that they were not as fully committed to our program as we would have liked because of their concern, and understandably so, with plans for their own future. Currently, all members of the night staff have full-time jobs with the Office of Mental Health and Mental Retardation.

The training of our night staff required three full days. Two local psychiatrists with an interest in suicide, the medical examiner, and a representative from the Center of Studies in Suicide Prevention were involved in the training. There is a monthly training session for the night staff. The day staff was put through a week of training before they took over their functions and training continues through weekly clinical meetings and regular staff meetings.

In some centers the assumption is made implicitly or explicitly that professionally trained personnel are necessary to effectively carryout the work, but they may still depend on non-professional volunteers because of limitations of budget. In other centers the assumption is made that non-professional volunteers are better than professionals. Still others suggest that the utilization of trained professionals is not necessary until the suicidal person actually appears for help, i.e., professional training is not necessarily an asset in bringing these persons to sources of aid. We ourselves use no volunteers in our program for two reasons: (1) We feel that suicidal behavior is very difficult to deal with and that this can be done adequately only by well trained professionals; (2) The time, money and energy costs for

recruiting, training and supervising a group of volunteers are quite great. However, it is fair to say that at this stage of development of suicide prevention centers we simply do not know what type of personnel to employ and how best to utilize them. Each community will have to make its own decisions based on its own needs and resources.

Forms

Our basic form, which consists of about 50 items, is used as the record of our contact with the patient and serves three purposes. The first is to help the interviewer assess suicide risk. We rely on two types of items. The first deals with factors developed from clinical observation and experience in the Los Angeles Suicide Prevention Center; the second is based on our own research in Philadelphia and geared to differentiating high and low risk groups among persons who have made a suicide attempt. The second purpose is to obtain information on the personal and social characteristics of patients using the services of the Center. The third is used for administrative purposes, e. g., what are the peak periods during the day, during the week or during the year for emergency calls so that personnel can be used to best advantage. Many of the items have been precoded so as to facilitate transfer of the data to IBM cards. Information of this kind is used in evaluating the effectiveness of certain aspects of the center's services.

Functions of the Center

In the field of suicide prevention, which is new, and where there is no systematic body of information to serve as guidelines, the content of the program should be broad and flexible. Services offered by suicide prevention facilities vary widely and are conditioned by the needs and resources of the community, and by philosophy of operation. All have at least one element of program in common and that is a telephone consultation service available around the clock, every day in the year, so that people faced with a crisis can get immediate assistance. Our own program includes the following aspects:

1) A telephone consultation service, around the clock, manned by mental health professionals.
2) A walk-in service during regular working hours.
3) Assessment and clinical evaluation of the suicidal person. For some situations this type of assessment and evaluation can be done over the phone but generally a face-to-face contact in the office is necessary to evaluate the problem more adequately and to arrive at a decision regarding next steps in dealing with the patient and his problems. In the office the varied skills of the psychiatrist, clinical psychologist, psychiatric social worker, and psychiatric nurse can be brought to bear in making such a determination.
4) Referral to appropriate health and welfare agencies for further care or referral directly to private psychiatric care.
5) Consultation to families, physicians, ministers and social agencies seeking advice in dealing with suicidal persons.
6) Follow-up services to determine whether the individual has carried through in the referrals that have been made, the kinds of services made available to him, the extent to which he has utilized these services and the disposition.
7) Counseling and psychotherapy on a very limited basis. The prolonged treatment of suicidal patients is not a primary function of the Center. However, to develop a better understanding of the suicidal patient his problems and management, and also to carry out the other functions of the Center in the areas of training and research, it is necessary that a small caseload be carried on an

intensive basis. We are planning a group psychotherapy project with adolescent girls who have made a suicide attempt, and with their parents.

8) Follow-up of attempted suicides coming to the attention of the Philadelphia Police Department, the Poison Information Center and the Accident Control Unit of the Health Department, with special emphasis on children.
9) Services to surviving relatives of suicides. Since the emotional impact of suicide on members of the family is great, much can be done to give support to the family by helping its members work through their guilt feelings, dispelling some of the misconceptions about suicide, and referring them to appropriate community resources where indicated.
10) Training of professional groups such as physicians, ministers, social workers, and nurses to help them recognize the clinical manifestations of suicide and depression and how to approach it most expeditiously.
11) Public information which includes the preparation and dissemination of leaflets and brochures, and supplying speakers and films for community education programs.
12) Research oriented toward the best treatment approaches and the identification of individuals with a high suicide potential.

The services mentioned above are not given equal attention; rather, the emphasis differs, based on community need and its readiness to move in certain directions.

Rescue Services

As a center, we do not offer emergency rescue services, i. e., sending a staff member to the scene of a possible suicide whether it be a bridge, a high building, a hotel room or the person's own home. Obviously, the issue involves not only certain philosophic considerations but also important implications for budget, delivery of services, and utilization of community resources. I conducted survey by mail of 97 facilities about two years ago with respect to this question. We received a 70% return. Two important findings emerged from the survey. The first is that only one in four suicide prevention centers provide rescue services at the scene of a possible suicide. Even this is an overestimation since one-third of these facilities do not send staffs to the scene except in conjunction with the police and an additional one-fifth do not provide such services around the clock. The reluctance to provide this type of service is due primarily to three factors not necessarily unrelated: (1) the centers do not have sufficient resources to man an emergency telephone and at the same time to send staff into the field; (2) the staff is untrained for this kind of work, or other resources, primarily the police, are better trained and better equipped; and (3) the conviction that provision of such services is contrary to agency function and policy.

A second finding relates to the inadequate provision for training and protection of the staff, paid or volunteer, in facilities offering emergency rescue services. Only about one-half train their staff for this type of work, less than one-half carry insurance to cover their employees in the event they are injured in the course of rescue operations, and only one in four carries insurance to protect its employees from any potential lawsuits arising from the rendering of such services. Failure to provide training is obviously not only a disservice to the staff but also to the clientele requiring emergency services; failure to provide insurance protection is not only unfair to the staff but also to the center since its obligation is in no way lessened.

Confidentiality of Records

We have been scrupulous in maintaining confidentiality of our contacts. We do not clear any of our cases with the Social Service Exchange which is a clearing house for all health and welfare agencies, because we feel that registration with the Exchange would violate confidentiality. We contact no one – relative, friend, employer, family doctor, etc. – without the patient's permission. The only time confidentiality is violated is when we are faced with a genuine medical emergency.

Clientele

Despite efforts to publicize the existence of the Center through radio, television, news releases from time to time, brochures, listing of the Center under emergency numbers in the phone book, etc. it is clear that large segments of the population are still unaware of the existence of the Center. At the present time, we are considering the use of car cards in subways, buses and streetcars. The Center's services are used more by higher socioeconomic groups. This is not surprising since they have a better understanding of community resources and how to use them than lower status groups. Moreover they have telephones whereas a substantial number of the poorer groups do not. They are also more comfortable using the phone than the less verbal, lower status groups. On the basis of our first year's intake, two-thirds of the calls to the Center were from women. 30% of the calls were from persons under age 25, 45% from those between the ages of 25 and 44, and 25% from those 45 years and older. Only 3% of the calls were from persons over 65. I think it is fair to say that the clientele of suicide prevention centers tend to be individuals of lower risk, i. e., women and younger people. We have attempted to get more deeply involved with a higher risk population in several ways. First, we attempt to follow up all cases of attempted suicide reported to us, a group that is at very high risk. At the present time, the number of attempted suicide reported to us by the Police Department, the Poison Information Center, the Accident Control Unit, and general hospitals is about 45 a month, of which approximately 20% are children and adolescents under age 18. Second, we have had a series of meetings with agencies whose caseload includes a large percentage of older people (e.g., Centers for Older people, Department of Public Assistance, Department of Public Welfare, Housing Authority) to alert them to the problem of suicide among the old and to urge them to refer persons who are suicidal or to use us as consultants in dealing with these individuals. Much remains to be done in this direction.

THERAPY

The Obscene Caller

David Lester, Erie County SPCS

In a recent article, Brockopp and Lester (1969) discussed the problems associated with the caller to a 24-hour telephone service whose purpose in calling is to masturbate while being stimulated by a female voice. Brockopp and Lester discussed the emotional reactions of counselors handling this kind of caller and possible approaches that they can take in dealing therapeutically with him. There is nothing written in the psychiatric literature about such men, but there is some documentation of other kinds of obscene callers.

Here I want to present some data on the prevalence of obscene calls received by the general public and on the psychodynamics of the obscene caller.

The Prevalence of Obscene Calls

Murray (1967) questioned 396 female undergraduates enrolled in Introductory Psychology courses and of these 183 (47%) indicated that they had received an obscene phone call: 69 had received one, 35 had received 2, and 79 had received 3 or more. Among the calls received, 70% involved sexual suggestion and lewd language from the caller, while the remaining calls were humorous or threatening. Relatively few of the calls were reported to the police or the telephone company (only 32%). There was a tendency for more nuisance calls to be received in the warm months than in the cold months, which suggests that a large proportion of calls may be made to people known to and recently seen by the caller (assuming that people go out more in public in the summer than in the winter).

Murray interviewed 34 of the girls and classified the calls they had received into five kinds:

1) The prank, nuisance call which is made by teenagers of either sex to either friends or people selected randomly from the phone directory. An example is “Is your refrigerator running? Then you’d better catch it before catch it before it gets away”.

2) One kind of obscene call has implicit sexual propositions. There is no lewd or foul language in these calls, but they have reference to sexual behavior. The caller often seems to know the daily routine of the callee. An example is “How about going with me to some place dark and quiet and we’ll really make love?”

3) Another kind of obscene call has explicit sexual propositions and employs lewd and foul language. The caller may know the callee. For example, often the calls are received immediately after the callee arrives home from a social engagement. Many obscene callers, however, do select names at random from the phone directory or from the news media.

4) The vicious or threatening call may consist merely of silence and breathing but be received frequently. One callee received about 18 a day over a six month period. An example of a spoken vicious call is “Is this…? I am going to kill you because your father cheated me”.

5) Other nuisance calls use particular ruses such as surveys, quizzes, “a friend recommended you ….”, and so on.

Murray and Beran (1968) surveyed more students in Introductory Psychology courses and found that in this survey 90% of the females and 73% of the males had received nuisance calls. Thirty-nine percent of the males and 75% of the females had received obscene calls. It appears, therefore, that males also received obscene calls.

Nadler (1968) noted that, in a 9-month period in New York City in 1966, the telephone business office received 65,500 complaints of which 5% concerned threats, 19% obscene calls, 66% harassment and 10% mechanical difficulties in the telephone service.

The Psychodynamics of the Obscene Caller

What kind of person makes obscene calls? If we could describe these individuals, then we might be better able to devise particular kinds of therapeutic approaches for dealing with them.

Nadler (1968) noted that, in the past, the obscene call has been categorized as a scoptophilic act (deriving pleasure from the contemplation or looking) and as an exhibitionistic act (deriving pleasure from the reactions of another person by exposing them to sexual stimuli). Nadler presented three case reports of men who had made obscene calls.

1) A 16 year-old white male started making obscene calls to his friends and moved to calling at random. His calls became more threatening with time. His need to call ebbed at times – when he had a job, when he was in camp, and when he was hospitalized. His frequency of calling increased when he was tense or fearful about his adequacy or performance in almost any area. He would become increasingly tense until eventually he telephoned. After the call, the tension went away without any genital activity. While telephoning, he was fearful and felt as though he had no control over what he might say. He was not close to his parents or his sister and did not fraternize much with boys of his own age.

2) A white graduate student in his mid-twenties came into therapy for impotence. Whenever he felt particularly unworthy because of school work or after an argument with his mother he would try to demean a woman in a sexual way. For example, he would pick up a black prostitute while dressed impeccably himself and would insult her with lewd expressions. Occasionally he would engage in sexual activity with her also. He then began masturbating (while not exposed) in subways, seeking to contrast the crudity of his action with his appearance. Finally, he began making obscene calls. He had always been a lonely youngster unable to get close to anyone and seemed to be defending against a sense of inferiority.

3) A 25 year-old white male was referred by a court for exhibitionism. He began making obscene calls to telephone operators after his release from military service when other sexual activity became less easy to obtain.

Nadler noted the low self-esteem and the dependence upon others for reassurance in these men. In each case there was evidence of anger toward women which perhaps stemmed from their relationships with the mother. Their mothers were described as bossy, overprotective, and dominating. The fathers tended to be meek with regard to the mother and uninterested in the sons. From a psychopathological point of view, Nadler noted schizoid and depressive tendencies. Nadler noted that the use of the telephone

for exhibitionism eliminated the anxiety felt in face-to-face confrontation. He feels safer from retribution and he is less likely to be laughed at. It prevents him from getting too involved with the person and protects him from the danger of physically acting out his rage and murderous fantasies.

The use of telephone calls in order to gain through the reactions of others a sense of mastery and power was seen as similar by Nadler to the behavior of the exhibitionist. It is likely however, that the obscene caller is more timid and scared than the exhibitionist since he lacks the courage to physically confront another but would prefer to interpose the telephone.

Kisker (1964) also saw the obscene caller as similar psychodynamically to the exhibitionist but a case report of a 16 year-old boy describes a boy with gross sexual confusion and lack of awareness of appropriateness. This boy was apprehended for patting coeds on the rear in a park and he had formerly made sexual advances to his teacher and on older friend's wife. Kisker diagnosed the boy as having strong, but latent, homosexual inclinations. Although Kisker does not report on the boy's social relationships, it appears that they were poor and minimal. Again, we have a relatively lonely and isolated individual, perhaps with feelings of inferiority, trying to find a sexual outlet and master his feelings of inadequacy.

Therapy for the Obscene Caller

We have seen how the obscene caller is frequently seen as similar to the exhibitionist. Ideas for the therapeutic handling of the obscene caller may be obtained, therefore, from experiences with the therapy of exhibitionists. Mathis and Collins (1970) have reported upon their experiences with group therapy with exhibitionists and their conclusions have some relevance for the obscene caller.

Their group work was with exhibitionists forced into a therapy situation by legal authorities. All had been arrested at least once. Of the 45 men treated, 15 were able to escape the legal pressure and all but 2 of these quit treatment. It appears, therefore, that legal pressure is essential initially to keep the men in treatment.

In the course of the group therapy, Mathis and Collins noted six distinct phases.

1) Initially, the men used denial extensively. They usually felt remorse, shame, and guilt after the first few exhibiting episodes but these uncomfortable feelings were quickly denied access to awareness. The men remain convinced that treatment was unnecessary since the problem no longer existed. Occasionally, the abnormality of the act is denied. This use of denial permeated the whole life style of the exhibitionist. They had low tolerance for anxiety and little awareness of emotional aspects of life, which in turn led to a poverty of relationships. They frequently denied the need for the group. Mathis and Collins felt that it takes up to six months for this pattern of behavior to break down and for the exhibitionist to face reality and to continue treatment voluntarily. The presence of confrontations from exhibitionists who have passed through this phase is necessary to break through the denial. Interpretations and explanations by the group leaders have little effect here.

2) There follows a period of acceptance that he is emotionally immature and the exhibitionist begins to talk and recognize emotions. The group is now over-idealized by him.

3) Anger is most frightening to the exhibitionist, probably because he fears being overwhelmed by his infantile-like rage if he allows it expression (rather than fearing retaliation). Eventually, anger begins to be expressed in the group and in other situations.

4) There follows a phase of disappointment resulting from the over-idealization in the second phase and fright encountered during the phase of anger. He becomes disappointed at his lack of progress and improvement.

5) After about a year of group participation, the patients, who are usually underachievers, begin to make changes that promote upward mobility and promote feelings of mastery. For example, one of the patients in Mathis and Collins' group returned to college while maintaining his job as a laborer and managing to stay independent from his parents.

6) Finally, the phase of separation must be faced.

Mathis and Collins noted that these phases may not be unique to the exhibitionist and may be characteristic of groups. Furthermore, the phases are rarely as distinct as implied by a formal presentation and description. However, their findings have many implications for the treatment of the obscene caller.

If the obscene caller is motivated by psychodynamics similar to those of the exhibitionist, then there are several clear implications. First, the obscene caller is very likely to use denial as a defense mechanism. He may deny that he has a problem or that he needs treatment. He may resist ordinary counseling because of his avoidance of talk and consideration of emotions. It is notable that no obscene caller to the Erie County SPCS has ever been successfully referred in for therapy. This may mean that, if we want to treat the obscene caller meaningfully, then we must identify him and have him forced into therapy by legal pressure. To generalize from the experience with exhibitionists, this pressure must be maintained for a long period of time—up to six months or more—or he will terminate treatment. This entails tracing the obscene caller and instituting legal procedures to commit him to treatment. Clearly, this may conflict with the values and policies of many counselors. However, not to do so may mean that successful therapy with the obscene caller is impossible.

The necessity for legal pressure in the case of the obscene caller is perhaps even greater due to the fact that he is possibly even more timid and anxious than the exhibitionist who at least can face open confrontation with his "viewer."

It may not be feasible, in terms of whether a center feels that it is ethical for such callers to be traced and threatened with legal action, for such calls to be traced and for the callers to be referred in for therapy by a court. However, if there is no reason to suppose that telephone counseling can assist the obscene caller therapeutically, then perhaps centers should give up trying to be therapeutic toward these callers. Trying to be therapeutic may merely result in the telephone counselors providing sexual stimulation for such callers with no therapeutic movement and, thus, they may be merely reinforcing the behavior of these men. It may be more appropriate to discourage such callers from using the telephone service for sexual stimulation. To discourage callers is against the policy of many crisis centers, and many counselors might feel that to do so is inappropriate for a telephone crisis service where the aim is to help people with any kind of problem. Occasionally, however, when a crisis service realizes that it is ineffective in dealing with particular types of callers, it may be legitimate to discourage such callers from using the service.

Secondly, Mathis and Collins argue for the use of group therapy for such men. They note that other men who are in a later stage of therapy are more useful in building up the ability of the patient to face reality and admit his problems than is the therapist. However, since exhibitionists are more common

than obscene callers, it may prove difficult to form a group of obscene callers for therapy. One possibility is to integrate the obscene caller into a group of exhibitionists.

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A Note on the Telephone Handling of the Obscene Caller

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As was emphasized previously, the caller who uses any verbal aspect of sexuality in his relationship with the telephone therapist usually puts the helping person at a distinct disadvantage because of his “uptightness” in this area. The tendency to blame, moralize or punish the caller is immediate and the super-ego-pat-on-the-back that we receive when we do these things helps to assuage any feelings of guilt which we may have.

The information contained in a previous article by Lester can be very useful in dealing with this type of difficult call. To place this information in perspective, I feel two points need to be emphasized. (1) There is very little basis for assuming that the obscene caller and the exhibitionist are similar enough that a treatment programs which works with one will work with the other and (2) It is much easier to obtain legal sanctions and treatment for the exhibitionist than for the obscene caller. I also feel that it is important to emphasize that a call to a telephone therapy service differs from a call to the general public. It follows that a center should also differ from the public both in the way they respond to these individuals and in the kind of help that they try to obtain for them. If, for example, a center attempts to trace every obscene caller to obtain legal sanctions against them, it is questionable whether they will continue to receive calls from individuals with other types of difficulties for the word will quickly spread throughout the area that a call to the telephone service that is not made in a way which is appropriate to the accepted standards of behavior in the community will result in an individual’s incarceration. If necessary, even at the price of not getting a person into therapy, the integrity of the telephone service as a place where individuals can call with any type of problem and receive interested, concerned and therapeutically appropriate response must be maintained.

With this basic idea in mind, I would propose the following differentiation in handling the obscene caller.

The Part-Time Obscene Caller: The individual who calls up on the telephone and uses obscene language or other overt sexual material should be dealt with in a similar way to the masturbator (Brockopp & Lester, 1969). That is, we respond to both the overt or covert messages in the telephone call and give the individual a chance to use the telephone service in the hope that the accepting attitude of the telephone therapist will assist him in developing a trust relationship with the center in which he will move past the overt sexual aspects of his call into the areas or concerns that he is covering up through this aggressive approach. It is hope that he will be assisted to receive help for these either through a continuous contact with the center on the telephone or by taking a referral to an appropriate mental health agency.

For this type of call, no trace or threat of police or legal action should be used. For to do so is to play into his "game" of being rejected or wishing to be rejected (and confirming his feelings about himself). This caller is ambivalent about dealing directly with his problem and therefore uses a method which is generally assured of bringing rejection in order to assure him that no one really cares about helping him. Only by getting past this test of rejection can the telephone therapist or any other individual give him the help which he is asking for in his ambivalent way.

The Chronic Obscene Caller: The chronic obscene caller by flaunting his problem at the telephone service may be asking for direct help with this particular problem, even though he would be the first to deny that either it is a problem or that he is asking for help. Yet, it is through his continual calling (of an obscene nature) to a service which advertising itself as being a helping agency of the community that he is covertly asking for assistance. If he were not, he could be making these types of calls to any other person or agency in the community. This type of call requires a different type of handling. First, a conference should be called between the individuals who have worked with the obscene caller on the telephone and a consultant who has worked with the people having this type of problem. In the conference, a case history including a summarization of the patient's contacts with the center should be presented. A tape recording of his calls might be very appropriately used at this point to clarify whether the obscene calls are being made in response to some of the latent non-verbal messages of the staff or a result of pathology which the individual has manifested. The staff should then explore what type of help he is requesting through his continued obscene calls to the center and make recommendations regarding what type of treatment program would be most appropriate for him. A decision <u>may</u> be made at this point to trace the call so as to obtain the person's name and address so a legal sanction can be obtained against the individual. Before this is done, the center should clearly look into the probably legal results of this action. If the individual is apprehended for placing obscene calls, will he be given an opportunity for treatment or will he be turned away because of lack of evidence or because the telephone company, police agencies or the legal community does not wish to deal with this type of problem situation? It is also important to check whether or not appropriate therapy is available in the community where this person can obtain help. As emphasized in the previous article, at least one year of intensive therapy is necessary in order to effectively treat this type of problem. If the center is going to attempt to get help for an individual through using the legal sanctions of the community, it must be willing to completely and thoroughly follow this so that the individual who is placing the obscene calls will be able to receive the type of help which will assist him in his overcoming the problem which he has. If this does not occur, tracing the call may simply result in his going to jail, being given a fine, and reaffirming that the community does not care to assist him with the problem that he has.

It should be emphasized that, for most obscene callers, tracing of their call and the use of legal sanctions will be the exception rather than the rule of a telephone crisis service. In any encounter, this type of a caller is one of the most difficult type to relate to for he stimulates our fantasies while, at the same time, affronting our sense of modesty and our moral standards. The telephone therapist who can work with this type of call with equanimity, calmness, and good judgment is an exceptional person.

RESEARCH

Time Perspective in Suicidal and Nonsuicidal Individuals[2]

Gene W. Brockopp & David Lester, Erie County SPCS

The experience of time is an intrinsically personal one. It is state of mind peculiar to the individual. The uniqueness and value of a moment of time lies in the subjective framework with which each individual uses time. It is a basic framework one uses for establishing his own private world of thought and action. The way in which he uses time is a reflection of his attitude towards life and his concept of himself as a being in time.

An investigation into a person's concept of time should give us clues on his view of life and of his behavior. This concept should be particularly relevant to understanding of behavior of the suicidal person if we accept the idea that his action is a reflection of his view towards life which is, of course, intrinsically related to his concept of time. Accordingly, the present study was designed to explore the time orientation of the suicidal individual. It is an investigation which attempts to ascertain the relationship between a suicidal person and his subjective concept of time. A variety of techniques for estimating time perception and time orientation were used to see which might differentiate the suicidal individual from the non-suicidal individual.

Method

Subjects

The Ss were 15 psychiatric patients who had attempted suicide and 14 unmatched psychiatric patients who had not attempted suicide. The attempted suicides consisted of 8 males and 7 females, the controls 8 males and 6 females. The two groups did not differ significantly in age (range 18-54 and 18-63, medians 27 and 37 respectively). Diagnosis and medication status were not noted.

Procedure

Each S was interviewed individually and administered the following tests:[3]

1) Each S was presented with a blank piece of paper and a pencil and instructed to draw through circles which represented his concept of the past, present and future. The following instructions were given: think of the past, present and future as being in the shape of circles. Now draw three circles of any size you wish arranging them in any way you want to show how you see the relationship of the past, present, and future.

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[2] This paper was presented at the American Association of Suicidology meeting in San Francisco, 1970.
[3] The Ss in this study were run by Gene Brockopp and Paul Villardi.

2) Each S was asked to estimate in succession the following periods of time: five seconds, one minute, twenty-five seconds, forty-five seconds, and one-and-one-half minutes.

3) Each S was given two stories stems to complete from which the extent of the story into the past and the future was measured.[4]

4) Each S was asked to name the most important recent event that had taken place in his life and then to go to the most important one that occurred before that and then the one before that so that the three most important recent events in his life were listed. They were then asked in the same manner to list the three most important events they anticipated happening in the future.

5) After fifteen minutes of the interview had elapsed, the person was asked to estimate the amount of time that had elapsed according to their own concept of time.

6) Each S completed the22 items of the time orientation scale of the personal orientation inventory (Shostrom, 1963).

Results

In only one of the six tests on the concept of time was there significant statistical difference between the control and the experimental groups. This was in the time orientation scale of the POI with the attempted suicide scoring significantly higher than the non-suicidal controls ($t=3.15$, $df=27$, two-tailed $t<0.01$, means 13.9 and 10.0 respectively).[5] Two groups did not differ significantly on any other measure (the largest $t=1.14$, $df=27$).

Looking at the data clinically, the following patterns of responses were seen.

1) The future rather than being less dominant for suicidal persons appeared to be more defined, more definite, and more time related.

2) More distortion was seen among the suicidal group's concept of past, present, and future. One is less likely to see a developmental orientation, yet the pattern was as atomistic as the normal person's view of time.

3) A suicidal person's concept of time changes with the inclusion of an affective element in the stem. This appears to restrict the range of the present for them. They also show a strong tendency toward the completion or the conclusion of an idea within the near future.

4) Along with this is the statistical conclusion that the suicidal person was more active in time, more present-oriented, and more self-actualized in time. Therefore, it appears clinically that a suicide attempt would be more likely to occur.

5) There is no indication, clinically or statistically, that a different "time clock" exists in the suicidal person as compared to the average individual.

Discussion

The only measure that statistically differentiated the two groups was that of time orientation as measured by the POI. The attempted suicides were significantly more time competent (lives in the present rather than in the past or the future) than the nonsuicidal controls and thus resemble the self-actualized

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[4] The story stems were: "It was 1 o'clock in the afternoon when Jack and his friend left home" and "It was 11 o'clock in the morning and Betty and her friend were having a wonderful time"

[5] None of the controls scored more than 14 out of 23 on the scale. The attempted suicides scored up to 20 out of 23 on the scale. The self-actualized score, according to Shostrom is 21-23 out of 23.

person more than the nonsuicidal controls. This result, however, may have been a chance occurrence among the many comparisons made and needs replication with a new sample.

A clinical review of the data indicates we need to look more at the relationship between the concepts of time, death and dying in the suicidal person and to compare the suicidal person and other control groups, for example, with accident or normal groups. Future investigations should include a more thorough look into the effect of the affective experience on the time-concepts of the suicidal person and should include a test-retest in time estimation to reduce intra-subject and intra-trial variability.

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