Crisis Intervention, 1970

Supplement to Volume 2, Number 4

CONTENTS

PROGRAMS:

RESEARCH & THEORY:

CRISIS INTERVENTION is published four times a year. Each issue is sent free of charge to Suicide Prevention Centers in the United States. Occasional supplements are produced with articles of more local interest and are sent to those who might find them of interest. The editors welcome comments and contributions from readers.

560 Main Street
Buffalo, N. Y. 14202

Hotlines For Help[1]

Telephone number 617-969-5906 rings and a frightened girl asks what a pregnancy test is and where it can be done. A calm, patient voice familiar with such problems replies. The voices belongs to a 17-year old volunteer at the Newton Hotline in Newton, Mass. Here volunteers aged 15 to 19 sit at a switchboard with three lines from 8 p.m. to 11 p.m. week nights and 8 p.m. to 12:30 a.m. on weekends. They handle calls concerning family problems, drugs, venereal disease, and birth control. They provide information on legal, medical, and psychiatric assistance. But mostly they listen perceptively to frustrated, alienated people their own age who can't find anyone to communicate with.

The Newton Hotline, one of many springing up all over the country, is run by teens for teens under the direction of Frederick Whitmeyer, a young research associate at Harvard Business School. Set up a little over a year ago, its objective is to help young people help themselves. Teens taking calls never impose their own values on those of the caller and they don't give advice. What they try to do is point out the consequences of a particular problem, discuss it, and guide the troubled caller into solving it in his own way.

If the person answering the phone is in doubt as to how to cope with the situation or feels another point of view is vital, more than one person may be "patched" in to listen and help. Although a psychiatric social worker meets with the volunteers every other week to discuss things, she does not answer the phones. Mr. Whitmeyer stresses that youth seems to understand youth best, being a part of the same culture and lifestyle. Older people generally turn off and tend to be too judgmental. Should a referral be necessary, physicians, clergy, medical clinics, and drug-oriented therapy groups are detailed on a master list. To understand what really goes on at referral places, volunteers visit them and speak with them on the phone.

How are volunteers chosen for the hotlines? First they are interviewed by a committee consisting of two or three experienced volunteers who must feel they're sincere, interested in helping others, and willing to learn. Then they come to work meetings held weekly at Frederick Whitmeyer's home. Next they sign up to observe the hotline in action and talk about what they've seen and heard. They continue to attend meetings where they join in role playing with five- or ten-minute simulated conversations.

One member acts as a caller presenting his hang-up; the novice volunteer pretends he's taking the call. Others then comment on how the situation has been handled. This goes on for three or four months. Finally the new volunteer must say in front of the entire group, "I'm ready to answer phones. Are there any objections?" If there aren't any, he starts immediately. This general approval makes the hotline cohesive and responsive.

Young people in their late teens and early twenties also man the phones at Teenage Problem Line, a service of a large crisis and suicide prevention center in Buffalo, New York. Director Allen Yasser, a 26-year old clinical psychology Ph. D., like Frederick Whitmeyer, feels "teens are reluctant to talk about their problems in a face-to-face way and want and need a

---

[1] Reprinted with permission from *Co-ed* (August 1970, 15 (10), 18, 23, 60), copyright 1970 by Scholastic Magazines, Inc.

private manner which the phone provides. There are real cultural differences between adolescents and older people. What a young person says must be accepted. Suggestions must be made to him in his own reality.

The lines at Buffalo are open 24 hours a day and the average shift worked is six hours. At least four listeners are always on duty. Although some callers give their names and ages, this information is never requested. The need for anonymity is respected.

Almost anyone who's interested in becoming a volunteer has a good chance of being chosen, following an application and interview with Dr. Yasser and an associate. Warmth, respect for others, and awareness of young, contemporary values are some of the criteria used in volunteer selection. Although the service provides training for social work, psychology, nursing and medical students from local universities, the broad cross section of people who call is reflected in those who listen. Dr. Yasser points out that a mixture of all races, religions, and economic backgrounds makes the hotline more receptive.

Where can a runaway stay at night when home is out of the question? Project PLACE in Boston, Mass., can probably provide the answer. The Rev. Robert Shire, one of its young directors, says that it was started three years ago by a group of seniors at the Harvard Divinity School and the Andover-Newton Theological Seminary. They wanted young people to have a place to be heard and listened to. Project PLACE has a special runaway counseling service that receives calls from both parents and young people all over the country, a Bad-Trip number for drug-induced emergencies, and a drop-in center. In addition to speaking with disturbed teens on the phone, Project PLACE workers go into the schools to talk with teachers, students, and parents about drugs, communication, and the availability of help.

In Milwaukee, Wis., Underground Switchboard Volunteers have their own speakers bureau which also makes efforts to open community and family communication channels at schools, churches, and meetings. This hotline was organized by a 22-year-old college student who wanted to start a drop-in clinic for drug abusers. But because of red tape and lack of money, a 24-hour crisis line was set up. Now with money raised through rock concerts, benefit dances, and private donations, a free clinic with its own laboratory has been founded in the basement of St. Mary's Hospital. This, plus the hotline, answers a definite need for Milwaukee young people who can't or won't be aided by standard "establishment" agencies.

Although Help Line Center in New York City is located at an "establishment" institution, Marble Collegiate Church, it has averaged 6,000 calls a month since it opened early this year. Unwed mothers and fathers as well as college drop-outs considering what to do about the draft have used the line without concern for its location. "People in the metropolis need help. They're confronted with massive directories, competing services, and indifference," says the Rev. H. Leslie Christie, executive director of Help Line.

And the 150 volunteer listeners, 40 of whom are young people, try to combat this indifference with trust, understanding, and acceptance.

Where to call for help? Here's a partial listing of hotlines:

EAST

Help Line Telephone Center, New York City 212-686-3061
Newton Hotline, Newton, Mass., 617-969-5906
Project PLACE, Boston, Mass., 617-267-5280
Teenage Problem Line, Buffalo, N.Y., 716-856-1313

SOUTH

Hotline, El Paso, Tex., 915-543-4222
Mid-Town Alliance, Atlanta, Ga., 404-892-1358
Switchboard, Chapel Hill, N.C., 919-929-7178
Teenage Hotline, Daytona Beach, Fla., 904-255-1931

MIDWEST

Hotline, Tulsa, Okla., 918-939-2002
Teen Trouble Line, Waterloo, Iowa, 319-235-3506
Underground Switchboard, Milwaukee, Wis., 414-271-3123
Youth Aid and Rap Service, Lombard, Ill., 312-495-1681
Youth Emergency Service, St Louis, Mo., 314-727-6294
Youth Emergency Service, Minneapolis, Minn., 612-338-7588

WEST

Hotline Telephone Service, Los Angeles, Calif., 213-666-1015
Open Line, Tucson, Ariz., 602-327-6681
Listening Post, Salt Lake City, Utah, 801-278-4716
Youth Emergency Service, Seattle, Wash., 206-365-0890

CANADA

Community Switchboard, Montreal, Quebec, 514-861-4502
Mental Health Metro, Toronto, Ontario, 416-487-3651

An Evaluation Of A Summer Internship Program

David Lester and Frank Endres, Erie County SPCS

The SPCS brought 8 students to the center for a ten week period of training in crisis intervention (June 22 - August 28, 1970). The students were chosen from a variety of disciplines and included: graduate students in nursing (1), social welfare (1), and medicine (1 half time), a student about to enter graduate school in social welfare (1), a conscientious objector, and a seminarian (1), Each was paid $1,000 for full-time attendance.

The first week of the program was devoted to orientation and training in telephone counseling at a suicide prevention and crisis service. For the remaining nine weeks, the interns were responsible for daytime coverage of the SPCS telephone service (7:30 am to 5 pm plus 1/3 of the coverage from 5 pm - 9 pm.). During these nine weeks several weekly seminars were organized: one on suicidology, one on telephone training, a case conference, an interpersonal process group, and a seminar in which a new topic was discussed each week, a field visit made, or visitors from other agencies interviewed. In addition, each intern was expected to engage in a project (research or clinical) and see several clients at the center in individual face-to-face therapy. Each intern was assigned a staff member as supervisor for telephone therapy and another as supervisor for face-to-face therapy.

At the end of the program, each intern was asked to complete an evaluation questionnaire by one of us (F.E.) and the other (D.L.) has summarized the anonymous data below:

1. What are your feelings about the summer intern program? Six were very satisfied, one was somewhat satisfied, one was somewhat disappointed, and none were very disappointed.

2. Which phase of the training did you profit from most? One from the topical seminar, one from the training group and three from the telephone training and conference. Two wrote in “association with other interns” and one wrote in “supervision about patients”.

3. Which phase of the training did you profit from least? Four from the suicidology seminar and four from the case conference.

4. How many hours did you work per week considering all program; research, night people, etc.? The part-time intern put in 25 hours each week, the others 30 hours to 55 hours. (median 37 hours).

5. Did you consider the stipend adequate? Six said yes, one wanted $1,250 and one wanted $2,000.

6. What is your response in regard to staff direction? Two felt that the staff were very helpful, four that they were somewhat helpful, two that they were indifferent, and none that they were unhelpful.

7. How did you feel about your fellow interns? They felt positive toward them. The composition was seen as very good by six, good by two, and bad or very bad by none. Two commented on the absence of minority groups.

8. How much do you feel you learned from your fellow interns professionally? Three felt a lot, five a little, and none not much or nothing.

9. Would you like to work for the SPCS after the internship is over? Seven said yes and one was not sure. The reasons stressed the potential for growth, the stimulating and instructive atmosphere, and pleasant staff.

10. Can you make some suggestions as to how the SPCS can be improved as an agency?
    (a) With regard to its internal functioning: The informality of the SPCS was liked (3), the need for better communication and more trust between staff noted (3), and more concern with service issues rather than self-group issues urged (1).
    (b) With regard to its services? More community work (4), and home visits (3), especially in the poorer areas of the county (1), give the teen hotline to another organization to run (2), have groups as well as face-to-face therapy (1), and improve the intake procedure (1).

11. What, if any, suggestions would you make regarding next year's intern program? Better introduction of interns to staff members (3), better availability of supervisors (1), and a split between better organization and planning (3) and less organization/more laissez-fare (2).

12. Any other comments you have to make? Three noted that it was a great experience, one commented on the "amateurism" of the program with everyone doing his own thing, and four had no additional comments.

Discussion

In general, the summer internship program seems to have been a success. There were aspects of the program disliked by individual interns but the variety of activities possible at the SPCS seems to have given nearly everyone some profitable experiences.

The selection of the interns resulted in a bright, compatible group of people. They were motivated and able to profit from style of the program which was intended to provide some structure but was such that, the more the intern put into his work, the more he got out of it.

The criticisms of the program and the SPCS in general touch upon some real problems and issues but in the context of the positive experience of most of the interns may be no more trenchant than those applicable to any organization.

A Matter Of Life[2]

SUICIDE IS TABOO. Nice people don't even talk about it. The subject makes palms sweat and faces flush. So, if you don't like to read about it and what you can do to prevent it - stop here.

Some facts and figures. Suicide is not common, but it is costly. First there is a cost in human life. Some 25,000 Americans will kill themselves this year. That is, about that number of suicides will be reported. Others that will not be reported or will be called something else have been estimated to number another 50,000.

Beginning with the ambulance call and including public assistance to survivors, an immediate cost of about $50,000 can be laid to each suicide. Losses to the public do not end there though. One expert estimates that lost taxes, lost profits to the employer, and loss of the creative potential of each suicide can cost the public up to $1 million. The highest costs of all may be psychological, paid by the surviving spouse and children. About one person in every ten in the U.S. has been touched by a suicide.

Suicide in industry

Dr. Gene Brockopp of the Erie County, N.Y. Suicide Prevention and Crisis Intervention Center says that he has never heard of a confirmed suicide in a factory by an employee during working hours. So you probably are not going to have the problem presented to you in this form. But presuicidal behavior at work is not uncommon. Attempts at suicide are estimated at from eight to twenty times the number completed. Attempts and completions can cause a significant amount of time lost from jobs by employees because of themselves or members of their families.

A good comparison can be made between the problems of alcoholism and suicide as they affect industrial costs. Similarly, suicide prevention and crisis intervention programs in industry can be compared to industrial support of Alcoholics Anonymous and drug abuse prevention programs.

You get two chances

Crisis intervention programs within industry operate in more areas than just suicide prevention, but that seems to be the best area to begin with because the advantages are readily visible. In dealing with suicidal behavior, you usually get two chances to step in and do something positive. The first time is often missed by the company people closest to the problem, the doctor or nurse.

Dr. Brockopp refers to the first visible signs of suicidal behavior as "the broad, unfocused plea for help which we all too often do not hear." Usually, this is some seemingly simple statement such as. "You won't see me again," or, "I'm unable to go on." Sudden behavioral

[2] Reprinted from *Industry Week* (Nov. 30 1970) with the permission of the publishers.

changes in the broad cultural context often accompany these first signs, like sudden drunkenness or fits of depression.

The second chance occurs when you hear such things as “If my wife doesn’t treat me better, I’ll kill myself.” This is a more focused warning. The nature of the problem and its possible solution in the mind of the person in trouble have been verbalized. Not too many people can or will recognize this as a real warning. Among many other myths and fallacies surrounding the topic of suicide is the one that bringing up the subject at this time may tip a person over the brink and literally lead to suicide.

“It is more likely that talking to someone in trouble at this point may give him the idea that someone really cares about his problem and the effect may be good,” says Dr. Brockopp. At this time people are often referred to the plant physician. The plant nurse may also see them because of minor injuries. These “accident prones” may be sending out cues about their feelings that should not be ignored.

Likely situations

There is a greater risk of suicide in some groups at specific times because of a thing called “negative contagion.” A suicide in a closed group tends to make another one more likely. Others in the group think over their relations with the deceased member and sometimes brood on them.

People who have been isolated from other people and who have developed feelings of worthlessness (“I’m just a machine not a human and nobody cares”) are in a particularly trouble-prone situation. These feelings often seem to develop near retirement age.

What is intervention?

Communicate and focus - these are the two major aspects of positive intervention. Dr. Brockopp and his colleague, Dr. David Lester, cite one instance where a person in trouble phoned a suicide center and talked for 4 hours - a dramatic example of keeping the communications lines open. The focus part comes in directing the conversation at the person in trouble. This “caring” often turns the tide.

Both Dr. Lester and Dr. Brockopp emphasize that you need not, in fact should not, try to be a psychiatrist when you talk to someone in suicidal trouble. It’s the talking itself with the person as the subject of the conversation that really matters, part of the removal of the taboo on suicide.

Nearly everyone has felt depressed at one time or another and has got over it. When faced with someone else in that condition, it may bring back some unpleasant memories and we may try to change the subject. That is not the way to help someone in trouble.

Industrial programs

Crisis intervention of any kind is largely a matter for experts, but there are things we can all do. Dr. Brockopp suggests that we take advantage of services that already exist. There are about 170 suicide and crisis intervention agencies in the U.S. Dr. Brockopp's Buffalo (Erie County) agency is by far the largest. It is unusual in that it is tax-supported. The Dept. of Health, Education & Welfare's National Institute of Health, Washington, has a center for the study of suicide prevention and a publication called "The Bulletin of Suicidology." These agencies, some private, others publicly supported, should receive wide publicity. It's a good idea to get their literature and make it available in your plant. The more people know about the existence of an agency, the more likely they are to use it.

Company publications can emphasize the fact that centers exist. They can also carry articles aimed at the families of individuals who should be seeking help. Dr. Brockopp says that he has seen teen-agers who seem to have got in trouble for the sole purpose of focusing attention on some family problem like suicidal behavior.

Most suicide prevention centers make use of specially trained people who are not mental health professionals. They are volunteers trained in telephone therapy to the extent that they can forestall the immediate crises they deal with and get the caller to professional help. A part-time volunteer from any industry could form the nucleus of an in-plant service.

The trouble with executives

Middle managers in industry belong to an age and background group that makes them trouble prone. Foremen who work directly with large numbers of workers are in a specific situation where they can intervene in trouble prone situations. These two facts make managers - whether they like it or not - directly involved with crisis intervention in industry, among themselves and with the people they supervise.

When a job is central to the life of an individual, as it often is in the executive ranks, the things that surround it take on added importance. It is also clear to most managers in their forties just how far up the executive ladder they are going. The combination of having to be satisfied with the attainable level plus some chance major disappointment can cause a crisis.

Wives are frequently an important factor in executive problem times. They fit the description of the "significant other," the person (present or absent) who is always involved along with the person in trouble.

The executive wife should consider taking crisis intervention training. In a small plant which cannot establish a full-fledged program, she can learn not only to help avoid problems in her own family, but to be of real help in her husband's employee group. Dr. Brockopp and Dr. Lester refer to this kind of activity as "seeding" a group with a qualified source of help.

Suicide prevention agencies complain that they don't see the executive. He won't come in. They attribute this to the aura of "welfare" or "free service" that executives place around these agencies. They feel (wrongly) that that kind of service is not suitable for them. Such an attitude can cost a life.

Mental health trends

Just as the principles of behaviors science have been added to management development courses in recent years, so will the principles of mental health be included in a few years. Beginning with the foremen and continuing on to the chief executive, emphasis will be placed on thinking that avoids narrowing down the solution of personal problems in suicide. Techniques of keeping the mental processes open and vital will be taught. Management will learn how to meet problems without losing sight of the broader picture of mental health. Management seminars will include lessons on how to recognize and positively intervene in in-plant mental health crisis.

Crisis Intervention Concepts for Emergency Telephone Service[3]

Donald E. Berg ACSW, The Olympic Center, Washington

At lunch, our group discussion leaders asked me to begin the afternoon session with a talk . . . a talk about: (1) what are the characteristics of a crisis; and (2) what helps the caller in crisis.

So, with only 15 minutes preparation, I shall attempt to build a rickety bridge between crisis theory, crisis intervention theory, and how to use these two theories in our telephone work.

There are five spans in this bridge: (1) the characteristics of a crisis; (2) the feelings of the caller in crisis; (3) the behavior of the caller in crisis; (4) what constitutes effective telephone crisis intervention; and, finally, (5) your feelings as a crisis intervener.

First, what are some of the characteristics of a crisis:

Much has been made of the meaning of the word crisis. Some writers translate from the Chinese ideogram, according to which crisis means both danger and opportunity. Fair enough, since every crisis poses a threat to the individual which places his equilibrium and sense of self in jeopardy. Yet, each crisis also possesses the potential for opportunity in the sense of either a favorable outcome, or a positive, though perhaps painful, growth experience.

Why writers turn to the Chinese for etymological enlightenment is puzzling since “crisis” comes directly to us from the Greek, and the Greek meaning of crisis is judgment and decision. A time of crisis is a time of reckoning. The response to crisis is revealing, and often evokes subsequent self-judgment, if not judgment by others about the person’s performance. The second meaning, decision, also fits our knowledge of crisis. The resolution of any crisis is reached by a decision towards some action. Without some decision, including the decision not to decide, the crisis will not be resolved.

So much for etymology. How is crisis experienced?

Every individual has a coping threshold, a level below which they are able to “successfully” deal with challenges. This coping threshold changes continually, through the interplay of (1) the individual’s basic personality, (2) supportive resources within the environment (e.g., relationships, money) (3) interpersonal skills, (4) and new challenges. As long as external events or internal pressures do not exceed the coping threshold, the individual is able to manage. But when external or internal events are too great, that is, they exceed the coping threshold, then the person experiences crisis, or to use Gerald Caplan’s phrase, “finds himself in a hazardous position.”

When this occurs, and especially if the hazardous position becomes more hazardous, there follows a progression in several phases to full crisis.

Initially, the individual perceives that he is up against something with which he cannot cope using the normal resources at hand. At this point, there is the beginning of uncomfortable feelings and the person turns to “primary resources.”

[3] From a talk given at a workshop on Emergency Telephone Service at Olympia Wash.. in October, 1969.

Primary resources are familiar, helping persons or previously helpful behavior patterns, such as a fishing trip, alcohol, a long drive, keeping busy, or talking. If the primary resources work, that is, others respond helpfully or the activities have a calming effect, then the crisis passes.

However, if these familiar resources fail, the second stage of crisis begins. The first feelings of discomfort and anxiety are increased. The person in crisis then turns to "secondary resources."

Secondary resources are generally other persons less well known, but who are seen as potentially helpful. These can be an acquaintance, bartender, cabby, minister, or social agency. If the secondary resources also fail, feelings of helplessness, personal failure, and a lowered self-esteem develop. At this point, the individual in crisis turns to "tertiary resources."

Tertiary resources are unfamiliar individuals and institutions. Tertiary resources are "last chance, end of the line" type resources, such as hospital emergency rooms, the police, or the fire department. Emergency telephone services are a tertiary resource for individuals in full crisis.

From this there emerges a general principle about crisis. The more advanced the state of the individual's crisis, the further he is from familiar sources of support, and the more dependent he is upon strange and unfamiliar sources of help.

There are several other characteristics of the crisis state. For one, they are time-limited. By definition, one cannot remain in crisis indefinitely. Caplan suggests a maximum duration of six weeks. Most of us have the experience, however, of crisis lasting for less, two or three days perhaps, if the intervention is effective. (I am not talking about what precipitated the crisis, but the crisis state itself as being time-limited.)

Also, for the person in crisis, change, often rapid and dramatic, has occurred, is occurring, and will continue to occur even after the crisis has been resolved. This is what is meant by "being upset in a steady state." The steady state is one's normal way of functioning, the upset occurs when the impact of events exceeds that coping ability.

So a crisis is judgment and decision, danger and opportunity, time-limited, dynamic, not static, and it produces a constellation of feelings.

How does the person in crisis feel?

Anxiety is the most common and universal feeling experienced by individuals in crisis. Any substantial threat produces anxiety. Anxiety assists in mobilizing against the threat. It is appropriate and helpful. However, great anxiety produces confusion, distortion, poor judgment, questionable decisions, and self-defeating behavior. In full crisis, there is great anxiety, and this is usually the first emotion the volunteer must learn to deal with in others.

Another feeling is helplessness. Individuals work hard to manage successfully and develop coping skills. Then to have the rug pulled out from underneath, either by an external event or a welter of unfamiliar emotions produces a feeling of helplessness.

An attendant feeling is often shame. Taught to be competent, independent and self-reliant, the person in crisis feels incompetent, and has to depend upon others. This can produce feelings of shame.

I also think that there is always a component of anger present, directed at another person, an irrational event, or the self. However, the anger is often hidden behind other more blatant expressions of feeling.

The person in crisis, furthermore, feels ambivalent, caused by struggling with: independence versus dependence; self-reliance versus relying on others; controlling emotions versus losing control; increasing self-confidence through managing by himself versus risking reaching out to another human being for help.

All of these feelings produce a decrease in self-esteem and leave the person in crisis extremely vulnerable. It is this decreased self-esteem and great vulnerability that matches the description of crisis as being both danger and opportunity.

The person in crisis finds the orderly, carefully constructed world shaky and uncertain. His normal coping ability is challenged and whether or not he develops newer and, perhaps, better coping abilities depends upon the response of the person to whom he turns.

How, then, does the person in crisis, whose feelings are confusing and upsetting, <u>behave</u> when he reaches out?

The caller behaves according to the way he feels. Behavior is based upon the interplay between feelings and how one thinks one ought to behave in order to accomplish something. This is why some callers act angry, demanding, and manipulative. These are tactics to defend against feeling anxious, helpless, ashamed, and incompetent. They are at the same time attempts to regain control. This behavior generally fails. It fails to obtain the necessary help, and fails to restore control.

However, the caller has expectations of the answerer. One expectation is that you will solve his problem, that somehow you will rescue him. Generally this expectation is erroneous. In most instances, you cannot solve another person's problem.

A second expectation, however, is real, appropriate, and one to which you can respond given skill, training, and a basic desire to help. It is that you will be a person who behaves on the phone as though you care, will try to be helpful, and possesses helpful knowledge.

A word about technique. Don't allow the caller's behavior based on the first expectation to get in the way of your responding to the second. It is sometimes necessary to maintain a stance of concern and caring despite what may be upsetting behavior inappropriately directed at you. Understanding the confused and frightening feelings within the caller will help you to work with behaviors that, in another context, might cause you to hang up or retaliate.

To do effective crisis intervention demands you knowing that the person in crisis is often at the mercy of feelings which may be confusing, frightening, or even unknown and that, while behavior is based upon feelings, the behavior may be different from or even opposite to what you would expect if you knew the feeling. So your task is to explore the caller's feelings, not just react to the behavior.

What, then, are some of the elements of effective crisis intervention?

The goal of effective crisis intervention is to develop a relationship through which the caller can sort out his thoughts and feelings and eventually come to a decision or action.

How is this accomplished? First of all, you are available at the time of crisis, and meet an essential need - an answer to the cry for help. Also, you are concerned, empathic, and want to help. Effective crisis intervention starts by encouraging the caller to tell you his thoughts and feelings in a confidential context.

Your voice, and how you use it to convey interest is crucial. If you compare yourself with a switchboard operator in a busy institution, whose job is a obtain information quickly for relaying the call on, you can see the importance of your voice, words, pace, and the way you communicate your interest. Furthermore, you have time. Time to pay attention, time to listen, time to think, and time to let the relationship develop.

You also can give something of yourself. Some volunteers give their name. Others talk about themselves in a way little different from trying to establish any kind of relationship.

You can let the caller know how you hear him, by letting him know that he sounds upset or angry or depressed or frightened. Another word about technique: comment on what the feelings sounds like, don't label the person with the feeling. For example, "You sound angry" encourages the caller to affirm or deny, then clarity the feeling behind the angry sounds. Conversely, "You are angry" generally leads to an argument or, at least, a one-word reply.

I think of the role of the effective crisis intervener as that of an evocateur - one who evokes facts and feelings without censure or deprecation. But emotions are still strange and mysterious to many people. The person in crisis may be experiencing some emotions for the first time ever. This in itself is frightening. Comments such as "I never knew I could feel this way," "I'm afraid of what I might do," "I can't understand what's happening to me" are clear clues that the caller is experiencing emotions either new to him or of greater in intensity than ever before.

When this occurs, the caller can be told that having new and intense feelings is alarming in itself, and adds to the upset.

The emotional state of the individual in crisis is related to a recent event. A good question to ask yourself is, "Why is the caller upset now?" Explore the connection which always exists - the connection between the current feelings and something which has happened recently.

Effective crisis intervention focuses upon the feelings of the present and the events of the very recent past. It is concerned with feelings now, relationships now, other resources now, and the relationship of all these to the event which triggered the crisis. In this way, crisis intervention is different from of froms of helping relationships in which there is extensive exploration of childhood relationships or early origins of the present problem. Admittedly, feelings originate from early childhood relationships, yet it still is possible to accept and work with current feelings without understanding their earliest origins. Understanding the current feelings and their relation to recent events helps the caller reach a decision.

If the caller has been helped to sort out and understand the feelings and has calmed down in the process, then the first stage of crisis intervention has been reached - the restoration of

emotional control. No longer do the run-away feelings dominate the caller's judgment and reasoning ability.

The second phase of crisis intervention consists of exploring what the "real" problem is, now that the "problem" is no longer excessive emotionality. At this stage of the call the development of the trust relationship has begun. The caller and the answerer can now focus upon the event which precipitated the crisis.

By event, I really mean a point in time when something happened. Very often a loss has occurred. The loss may be that of a person or thing, or even the loss of a familiar and comfortable way of life. An illustration of this latter loss could be depression experienced following a job promotion. While it may seem on the surface to be a gain, what might have been lost are work relationships, security, and familiar surroundings.

Once the problem has been defined, possible solutions are considered. For some problems no other solution is called for. Having talked is sufficient. At the other end of the continuum there are problems for which no solution is possible. However, for most problems there are alternative paths of action, not to solve the crisis, but resources for obtaining help with the problem. Which solutions are practical depend upon the kind of problem it is, the financial position of the callers, resources available in your community, and other factors which you must know about in order to explore alternatives.

The last stage of effective crisis intervention consists of the caller deciding what to do. Remember that the decision to do something always remains with the caller. You can suggest, cajole, brow-beat, argue and threaten, but the caller must decide what to do and when. There is good reason for this. If you usurp the decision-making process, you determine the caller's self-esteem. The caller's self-esteem is already low from being unable to make decision, while feeling that he should, if not must. He has to live with his decision, you don't, and so he has to make it.

Although not an integral part of crisis intervention theory, there are two other areas that I would like to touch on briefly. First, making a referral. Let's call these eight basic principles.

1. Do not confuse the caller by referring him to three or four places at the same time. Establish a priority need and make one referral for that problem. The caller may always call back should the initial referral not work.

2. Be sure the caller clearly has the information. Repeat it or ask the caller to write it down.

3. Even when referring to private practitioners, don't give three referrals. That's a waste of time and an artificial sensitivity to being accused of loading up and favoring one private practitioner over another. Put yourself in the caller's shoes. You called for help and somebody gave you three names and didn't clearly indicate to you which of the three he preferred - how would you feel?

4. Except in cases where it seems to you obvious that the caller will not be able to call on this own behalf, encourage the caller to contact the referring agency himself.

5. Never discuss another agency's fee policy except in the most general terms. Encourage the caller, if he asks questions about cost, to raise these with the agency to which you referred him.

6. Don't be afraid to take time out from the call to think about a referral. Not every call has to end with a referral. You can end a call before making a referral by telling the caller that you need time to think about it or to discuss it with somebody else and that you'll call them right back.

7. Before making any referral, find out if the caller is in an active treatment relationship and then refer the caller back to the current helping person. Remember that very often callers will insist that the current helping relationship is worthless when, in fact, they are commenting upon their own fear of impending change and decision. If you refer this caller to somebody else you are, in effect, helping them to avoid change.

8. If possible develop and carry out a follow-up call procedure for crisis calls. Inform the caller that you will call back or someone else will call back. This provides continuity, it expresses your concern, and it will also give you valuable information regarding how effective your referral has been and, in urban areas, what's happening at agencies you often refer people to.

Next, a few remarks in response to questions about specialized techniques.

First, of all, specialized techniques generally do not work until the volunteer has gained considerable experience with a wide variety of calls. Certain techniques require, at the least, the development of a good listening ear and a repertoire of evocative questioning skills.

Our experience is that the best "specialized techniques" arise from the volunteer's effort to cope with difficult calls. These techniques are discovered during discussions among volunteers, all who have been troubled by dealing with certain types of calls. It is almost as though the impact of the caller upon the volunteer has exceeded the volunteer's coping threshold, and the mild anxiety this produces creates the need for discussion out of which can arise ideas for solving this particular problem.

The search for specialized techniques that work seems to be summed up by the ever - present question, "What do you do when . . .?" As unsatisfactory and non-specific as it may seem, often the best answer to this question is "be yourself." This answer is given, I believe, because the value of lay volunteers in an emergency telephone service is that they are somewhat technique-less, and the volunteer's creative attempt to develop a trust relationship is, perhaps, the most useful technique of all.

Another reason why a specialized technique often fails has to do with the individual personality of the volunteer. The volunteer has certain needs and certain personality assets, and very often the best relationship is developed when the kind of person the caller is matches the kind of person the volunteer is. By "match" I do not mean that the personalities need to be the same, but rather that the volunteer has a self-perception of being able to help certain individuals while feeling somewhat inadequate in dealing with other callers. Because of my own upbringing and life experience, I find it extremely difficult to work with alcoholics. Techniques are of little help to me. It is better for me to realize my shortcomings in this area and, perhaps, have someone

else deal with this kind of a caller than it would be for me to attempt to learn specialized techniques which do not fit the way I generally relate to people.

So, in a sense, the search for specialized techniques may be a way of allaying our feelings of ineptitude and incompetence and a desire to master the anxiety certain callers produce in us. Rather than a search for specialized techniques to deal with certain types of calls, open discussion about our own feelings and reactions towards certain callers and an assessment of our ability to work with them is generally more profitable than the attempt to develop special techniques.

Now what about the volunteer's feelings, the last span in this bridge?

It is important to realize what your role is both in regard to the basic philosophy of the service in which you are working as well as in relationship to the caller.

First of all, understand the limits of your responsibility. These limits are partially defined by the policies of the service in which you work. Some simple illustrations may help. Generally, you work on the phone rather than having the person come in and talk to you directly. Generally, you work from a certain location, either a central building or in your home. You most probably do not go out and work with the caller in their own home. We encourage our volunteers not to develop private relationships with callers except in rare, and then closely supervised, instances.

All emergency telephone services occupy a unique position in terms of responsibility, in that they never assume complete responsibility for the caller. Compare this with, for example, a policeman at the scene of a crime, a physician in an emergency room, a teacher in a classroom, or an attorney representing a client. We do not enforce the law, treat physically, educate, or represent in court those persons with whom we work. The basic relationship is primarily determined by the caller and not by us. We have no leverage, or power with which to coerce or strongly influence callers. This means that the caller must come to his own decision after discussing various alternative solutions to the particular problem. Almost always, the primary responsibility for the caller in dealing with ongoing problem will be assumed by some other agent, whether it be a physician, the police, a therapist, or attorney.

This has staffing implications because good volunteers are those who wish to listen, to defend, to encourage, and to respect the autonomy and the competence of the caller. Persons who wish to manipulate, preach to, and coerce other people into a style of life or set of beliefs do not make good volunteers in emergency telephone services.

But even knowing fairly well what your role is you will experience many feelings which may be strange or greater in intensity than you had experienced before. What to do about these feelings? Use them as basic tools for helping others because your feelings are clues to the caller's problem. Generally, you can assume that, when a caller makes you feel a certain way, it is because the caller is communicating something to you about his situation, not that you have a problem with your own feelings. If you doubt your own feelings in regard to a particular call, talk it over with somebody and discuss your feelings so that you can get them clear in order for you to be able to use them. If during a call you become angry, most probably the caller has caused you to become angry. The same is true for depression, elation, and other feelings states.

Once you identify what your own feelings are, comment on them. This serves three purposes: (1) you serve as a model for talking about feelings, thereby making it clear that a crisis intervention call needs to focus on feelings, not just facts; (2) If you do comment on your own feelings, it very often changes the relationship and frees you up to attend more to the caller than to you own feelings; and (3) It can help the caller identify for himself the feelings he has or open the door to expressing how his telephone behavior may be based on his own feelings.

To clarify what I mean by commenting on the feelings, let me illustrate. Generally, it is better not to state how you feel, but rather comment to the caller your perception of his feelings based on your own. For example:

> A 28 yr. old mother of two children whose husband is away from home for days at a time because of business calls "just to talk." As she describes the situation, you find yourself getting angry at the husband. Now, the thing to say is *not*, "Your husband is a terrible man for leaving you," but rather, "I wonder if it makes you angry that you have to be alone so much of the time?" or "It must be difficult trying to run the house by yourself," or "It's no fun trying to be both mother and father."

The principle here is that behind the anger which you perceive is probably the anger the caller feels, and that behind the caller's anger is a feeling of being left alone. The caller needs to understand that this is a basic feeling before you can even begin to explore what might be done about the basic feeling of loneliness.

> A 37 year old married father of two teenage boys calls with a barrage of recent troubles at home. One son is failing in school, the other is experimenting with marijuana, the marriage is extremely difficult, he's having trouble at work, and he's home sick with the flu. As he talks, you begin to get confused. Rather than saying, "I'm confused," or "I'm so mixed up I don't know where to begin," you might say, "So many things are happening to you that it must be hard to know what's important or what to begin with," or "You have so many things happening that it must be hard to know where to start." Despite what I said earlier about special techniques, there is a technique that very often is successful in dealing with a call like this, and it is simply to say, "Let's start with you, how are you feeling right now?" Then focus on his current feeling, which include feeling terrible because he has the flu, how it's affecting him, has he seen a doctor, how long will he be out of work, etc. It may well be that all of the other problems this caller has unloaded on you have not been crisis producing until the caller became sick himself, and it's helpful to point out that the flu itself may be "the straw that broke this particular camel's back" and until he begins to feel better physically, it won't make much sense to come to decisions about some of the other problems at this point.

Those two simple illustrations I hope will clarify how volunteers use their own feelings, stimulated by the caller, to help the caller understand how he is feeling.

What about feelings that are overwhelming to you? Generally, most of the feelings you have when answering crisis calls can be helpful to you in helping the client, but there are times when your feelings will be overwhelming. Some volunteers become very upset with obscene phone calls, almost all are upset following the successful suicide of a caller with whom they have worked. Certainly callers, who threaten or manipulate, create feelings in volunteers that are very difficult to think of as being useful.

What helps volunteers is the same thing that helps callers - talking with someone else whom you trust about your own feelings. However, there is a major and very important difference.

Since the work is confidential, do not discuss your telephone work with anyone outside of the service. This means very specifically don't talk about cases with family and friends. *Do* talk about cases with colleagues, with professional staff you have available to you. If there is no established time to discuss these things, established the time. If you're constantly going to be working with people on a feeling level, you need to be able to work on a feeling level with colleagues also. The hardest lesson to learn is that it's precisely the feelings you find difficult to talk about that most often need to be talked about. But don't burden family and friends with these feelings. Rather than help you understand your feelings, they may instead encourage you to quit.

Among your colleagues, be open about your feelings. We are all afraid that we won't do a good job, that we'll miss a very important clue on the phone and that someone might be injured as a result of this. New volunteers in particular should express these feelings with more experienced volunteers and with staff.

Be open about failure. The desire to do the right thing often overpowers our common sense understanding that we need to talk about our failures. It serves no purpose to keep a lid on when we fail. We learn from our failures more than we do from our successes because generally they mean more to us. Nobody worries and ruminates over successes, but we all think a long time about our failures. Open discussion of "failures" helps us to understand that very often there is no answer, that many others have tried, and that there is no magic box of answers in this work.

If we remain open, honest about ourselves, and continue to grow we will succeed in remaining amateurs. And the definition of an amateur very simply is "one who loves."

Steps Toward The Evaluation Of Suicide Prevention Centers: Part Four

David Lester, Erie County SPCS

Counseling Effectiveness[4]

Truax and Carkhuff (1967) have developed a standardized system for evaluating counseling effectiveness for the dimensions of empathy, respect, genuineness, concreteness, and self-disclosure on the part of the counselor. Segments of telephone therapy can be rated by trained raters for the degree of these variables shown by the counselor. To illustrate the application of these rating scales, three samples of telephone calls taken by counselors at the Erie County SPCS were rated:

(1) a brief (ten minute) call taken by each of the 9 clinical associates who cover the weekends and nights on 12 hour shifts,
(2) a second brief call taken by the same clinical associates, and
(3) a ten minute segment of a call taken by each of 13 new volunteers on their first 6-hour shift as a volunteer telephone counselor.

The median ratings were:

Clinical Associates	E	R	G	C	S-D
first sample	2.50	3.00	3.00	3.00	2.25
second sample	2.50	2.50	3.00	2.75	2.00
Volunteers	1.75	1.75	2.00	2.25	2.00

To assist in the interpretation of these median ratings, the scale values are given below:

Empathy (E)

Level 1 - Counselor shows no awareness of feelings of client
2 - Counselor shows some awareness
3 - Counselor shows responds in accurate manner as to feelings of client
4 - Counselor adds to feelings of clients in meaningful way
5 - Counselor totally tuned in to all that client feels

Respect (R)

Level 1. - Counselor shows lack of respect to client
2. - Counselor shows little respect in passive ways
3. - Counselor shows active feeling of respect for client
4. - Counselor shows he values the client for his person
5. - Counselor shows he cares deeply for client

Genuineness (G)

Level 1. - Counselor's words are unrelated to his real feelings.

[4] I should like to thank Lewis Leitner for rating the calls.

2. - Counselor is slightly congruent with self but comes across mechanically
3. - Counselor is congruent but not totally involved
4. - Counselor's expressions are congruent and appropriate
5. - Counselor's is completely spontaneous and open in a congruent manner

Concreteness (C)

Level 1. Counselor is vague and general
2. Counselor intellectualized in abstraction
3. Counselor is frequently concrete and specific
4. Counselor is concrete and specific in almost all circumstances
5. Counselor always completely specific and concrete

Self-Disclosure (SD)

Level 1. - Counselor is personally detached
2. - Counselor does not volunteer personal information
3. - Counselor volunteers some personal information
4. - Counselor freely discusses himself
5. - Counselor is intimate as to personal information

There are several issues worth noting in connection with the use of these rating scales:

(1) Since the stimulus of each call of each counselor is different (a different patient), it may be necessary to rate a number of calls for each counselor in order to get at a meaningful estimate of the level of his functioning. For the clinical associates rated above, the distribution of their scores on each sample of calls was too small to enable the reliability of their performance to be measured over two calls. Thus, it is not clear how many calls are necessary to get at a reliable estimate of performance. One way of overcoming this problem is to present telephone counselors with a standardized caller (a role play) so that the stimulus remains constant (or at least very similar) for all counselors to be rated.

(2) Are the Truax and Carkhuff dimensions of counseling behavior relevant to being a good crisis counselor? They may be relevant to being a good psychotherapist, but a good psychotherapist may not be a good crisis counselor.

The Cost of the Service

One way of evaluating a suicide-prevention service is to translate the activity of the service into dollars. This is possible in several ways.

(1) One way is to divide the annual budget of the center by the number of call, or cases handled in one year. Comparison of different centers is made difficult because different centers classify calls differently. Few centers include "nuisance" calls in their published total volume of calls for the year, but centers differ in how they classify information calls. However, some representative amounts are for center that have telephone counseling as their sole service are"

cost per call:

$ 2.90
$47.57
$ 1.85
$ 6.84
$ 6.67

The discrepancies arise through many factors: the relative use of volunteers versus paid workers, the amount of time spent by the center in education and consulting in the community, and so on. However, the comparison is of interest.

(2) Rather than reporting the total number of calls handled, some centers report the total number of patients handled via the telephone. The number of cases will be less than the number of calls since many patients make multiple calls to a center. Some data relevant to this measure from different centers are:

cost per case:

$ 2.06
$ 7.79
$ 5.04

(3) Some centers see patients in face-to-face therapy and operate reach-out teams as well as maintaining telephone counseling services. These centers occasionally report the total number of patient contacts. Some comparative data here are:

cost per contact:

$ 4.95
$15.08

(4) Another way of evaluating a service in financial terms is to estimate the amount of services and equipment donated voluntarily to the center. However, the only center known which does estimate the total amount of donated service and equipment does not mention its total funding for the equivalent period and so it impossible to compute a proportion.

It might be thought that the cheaper a service, the better it is. It should, therefore, be made clear that the cost of a service may not be related to the adequacy of its service or the quality of the help provided by the service. All that is intended here is to note that the cost of a service can be computed and compared with the costs of comparable services in other areas.