Crisis Intervention, 1971, Volume 3, Issue 1

EDITORIALS



ARTICLES



INFORMATION FOR CONTRIBUTORS

CRISIS INTERVENTION is intended to facilitate communication on

(i) programs of suicide prevention centers
(ii) clinical aspects of crisis intervention and suicide prevention; and
(iii) current issues and research in suicidology and crisis intervention.

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

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 14202.

# EDITORIALS

## After Los Angeles – What?

**Gene W. Brockopp, Erie County SPCS**

The Suicide Prevention movement in the United States has barely moved into its adolescent stage. Beginning as a lusty infant in the late 1950's it has developed rapidly throughout the country and is now to be found in over 200 locations at the present time. Each of these 200 locations, however, is tied, both theoretically and practically to the Los Angeles Suicide Prevention Center for it was there that the basic concepts of suicide prevention were developed, clarified and perfected to the present state of the art. From the Los Angeles center has come a continuous flow of ideas regarding the condition of suicide and methods for working with suicidal individuals. Through their careful and meticulous efforts, longitudinal case files have been developed which may provide some keys to answering the questions about the suicidal condition, its treatment or amelioration. Each of the 200 centers in the United States has a stake in the continuation of the Los Angeles Center. In the same way, the country as a whole has much to gain or lose depending on whether the center is continued or is allowed to die.

I feel it is important that the Center for the Study of Suicide Prevention continue to support the program in Los Angeles. No amount of money spent for research projects anywhere else in the country could give the same return as monies spent to continue the program of education, research and clinical service at the Los Angeles Center. The experience, knowledge and information that they have gained about suicide over the past decade is invaluable. The demise of the Los Angeles Suicide Prevention Center would be a loss not only to Los Angeles, but also to the more than 200 Centers throughout the country.

I strongly urge that Suicide Prevention Centers throughout the United States acknowledge their debt to the Los Angeles Center, and urge the continuation of federal support for their programs. If suicide prevention is to move past its adolescent stage into a mature, adult concept, it will be because centers such as the Los Angeles Suicide Prevention Center have been supported both financially and psychologically in their effort to study, understand and treat this condition.

# Suicide Communication?

**Michael J. Donovan, Suicide Prevention Service, Columbus, Ohio**

On the occasion of the advent of the Fourth Annual Conference of the American Association of Suicidology (AAS) and in anticipation of the publication of the first issue of the AAS journal, Life Threatening Behavior (LTB), some observations may be pertinent.

If it be assumed that the AAS is a scholarly and professional association, then it may be assumed that its two mechanisms of communication, the Conference and LTB, are intended as well-refereed arenas in which knowledgeable scholars and professionals are to present solid research findings and informed opinions for critical review and dissemination. What might be some relevant data available for examination to help evaluate these assumptions?

Shortly after the Third Annual Conference of AAS a request for a copy was sent to the first author of each of the 33 papers presented. About two months later a second request was sent to those from whom copies had not been received. Copies were received from 18 or 55% of the respondents. Replies were received from 5 or 15% of the authors, of whom 4 stated that copies would be forthcoming at a later time: none were ever received. Of the 33 authors, 10 or 30% made no reply of any kind to the requests.

Since LTB is the journal of AAS with the stated purpose of serving as publication medium for papers presented at the conference it might be anticipated that its consulting editors might be unusually productive, responsible and actively involved members of AAS and would thus display exemplary conduct in this regard.

Of the 33 papers read at the Conference only 6 or 18% were presented by consulting editors of LTB. Conversely, of the 40 consulting editors only 6 or 15% presented papers at the conference. Of the 6 only 2 responded; 4 or 67% made no reply, a failure rate more than twice that for all conference participants combined.

Perhaps AAS communication might be improved. The LTD editor in the selection of consulting editors might attempt to give more consideration to current productivity in AAS. The program chairman might require prior submission and insure subsequent availability of papers presented at the conference. In keeping with the practice of other organizations, *both* conference and journal presentations should be recognized as media for archival publication.

# PROGRAMS

## A University Affiliated Suicide Prevention Center

**James K. Mikawa**

The Suicide Prevention and Crisis Call Center in Reno, Nevada, was originally organized as a result of citizen concern regarding the suicide rate in Nevada, which at 26.8 per 100.000, is the highest in the nation (Vital Health Statistics Office, 1967). Subsequently, it became affiliated with the University of Nevada, Reno, which added another dimension to the functions of the Center beyond its community service aspects. Following the model established by the Los Angeles Suicide Prevention Service (Farberow et al., 1966), the Reno Center offers a 24-hour crisis counseling and referral telephone service which functions primarily with non-professional volunteers. As the Center developed, its functions as a crisis intervention service and an educational and research program for the University of Nevada became dominant features. At the present time, requests from the community emphasize the need to enlarge the referral and coordinative aspects of the services offered. The broadening of functions suggested also includes dealing with everyday program of living and not just those characterized as emergencies. In addition, increased participation of students in all phases of the Center's program is anticipated.

### Crisis Intervention

The primary focus of the Center is crisis intervention, with suicide seen as a particular event within the general area of crises (Farberow, 1967). A "crisis" is broadly defined as a working definition for the Center, and includes a variety of stressful events such as a lack of lodging for the night, interpersonal breaks, and drug panic. Most of the stressful events are time-limited in nature, following a generally accepted criteria for what constitutes a crisis (Caplan, 1961). A notable exception is the psychotic individual who may seek the ongoing support of the volunteers on the crisis line for chronic dysfunction. In many of these cases, the Center serves a maintenance function for a period of time, since services are required by the individual which are not available in the community beyond initial hospitalization and psychiatric treatment. Mobilization of family resources, renewal of contacts with the individual's therapist, and involvement of the professional backups are suggested alternatives emphasized in the training of volunteers in dealing with these types of cases. In general, however the volunteers are trained to serve an intermediary function between those who need services and the resource agencies. It is recognized, however, that the task of providing alternatives for coping, and motivating individuals to seek them is not a simple one. Often it is time consuming, requiring multiple contacts and continuing involvement of the volunteer.

Each volunteer receives 20 to 30 hours of training prior to taking calls on the line and also attends monthly inservice training sessions. The training emphasizes crisis intervention procedures such as crisis identification, coping with the emotions of callers' evaluation of the crisis situation, development of coping alternatives, mobilization of resources, initiation of motivation to change, and follow-up. In addition, the volunteer receives information about crisis, suicide, counseling, ethics, referral techniques, community resources, and administrative procedures. Self-awareness is seen as an important aspect of what is learned in the training program. The volunteer's values, beliefs, attitudes, and behavior toward various problems such as suicide, alcoholism, and drug addiction are discussed with respect to his role on

the line. The most critical part of the training program is a series of practicum-oriented mock calls where the volunteer can have actual experience in taking crisis calls under supervisory conditions. The amount of this sort of supervised experience varies, depending upon individual needs.

**Non-Professional Volunteers**

The use of non-professionals to provide an important mental health function such as crisis intervention is a recent trend which is particularly characteristic of suicide centers across the country (Heilig et al., 1968). Our experience indicates that non-professionals can provide a useful service function if properly trained and supervised. In addition, the availability of professional backups to the non-professionals allows a blending of expertise and knowledge. The recognition of one's limitations with respect to dealing with events and people in crisis situations is emphasized during the training period.

*Students.* Even though a substantial number of non-professionals are people working in the community, almost 50% are students at the University of Nevada. Most of the students are graduate students enrolled in the clinical psychology program, which includes participation in crisis intervention activities as an integral part of the program's emphasis on community psychology. A significant result of the Center being associated with a university has been the continuing involvement of students as part of their regular educational experience. In addition to gaining experience in dealing with crisis events, graduate students have participated in the training of community volunteers, research activities, public presentations about suicide and crisis, the development of a directory of community services, representing the Center on Boards of Directors of community agencies, and the development of mental health services in the community. The educational role of the Center in seen as one of its most important functions.

In addition to graduate students, a number of undergraduate students have participated in the Center program. For some, the experience is an integral part of their major program in the Department of Social Services and Corrections. Course credit is available for almost all undergraduate students either through this program or others On the other hand, some of the undergraduate students who have participated in the past did not receive any course credit, but sought the experience as one which was not available in their present educational programs. Most of the undergraduate students serve during daytime hours and are available for almost constant supervision.

*Community Volunteers.* As the years pass, the number of non-professional people in the community who have been trained in crisis intervention work at the Center has slowly increased. These people, after about a year of service on the average, provide the community with a corps of people who have valuable experience in assisting others through crisis intervention. Their occupational backgrounds are varied, including telephone switchboard operators, secretaries, salesmen, school teachers, rehabilitation counselors, and housewives. Fifty community volunteers have been trained during the past four years.

There are no age or educational requirements explicitly defined for people wishing to become volunteers for the Center. The age of volunteers has ranged from 19 to 55. Educational background has ranged from those lacking a high school degree to those with college degrees. Earlier, a formal screening process, including a battery of psychological tests, was used in the selection of volunteers, but this procedure has been discarded in favor of ongoing evaluation during the training period. As much as possible, the training program is oriented toward clarifying and coping with problems each may have as

he serves in the role of a volunteer. If the trainee is unable to cope with some significant problem after ample training and discussion, he may be asked to serve in a capacity other than crisis intervention. For example, a volunteer who is unable to cope with feelings of rejection and hostility toward an alcoholic caller may be asked to serve in a different capacity, since a significant number of callers are drunk when calling or are alcoholic. Sometimes, increasing awareness of his own problem or lack of motivation will lead the volunteer to drop out of the training program at an early stage.

**Professional Volunteers**

A corps of professional volunteers support the non-professionals and are available for consultation on a 24-hour basis. These professionals, who have experience in mental health consultation, volunteer to serve as resource persons for the non-professionals. In cases where the non-professional is unable to assess the situation, uncertain of coping alternatives, disturbed by a difficult case, needs reassurance, support or direction regarding a decision, needs clarification of policies and procedures, requires the assumption of professional responsibility, or is in general need of assistance, the professional is available. The specific role of the professional with respect to the non-professional is quite flexible and is determined by individual judgment and discretion. The professional, however, is encouraged to allow the non-professional to develop his skills through minimum intervention by the professional. The professional rarely "takes over" a case unless asked to do so, or conditions are such that this sort of action would be advisable. At the present time, the professional corps consists of psychologists, social workers, and psychiatrists.

**Present Status**

The Center, which began in April, 1966, with four persons, now has 34 non-professional volunteers and nine professional consultants. In addition to these volunteers, the Center has a coordinator working on a full-time basis. The coordinator has responsibility for maintaining day-to-day operations on a 24-hour basis; scheduling and coordinating the working hours of the volunteers; assisting in the training and supervision of the non-professionals; maintaining appropriate records and data on cases; assisting on the development of policy and procedures; up-dating the Center's knowledge of services and resources in the community; promoting communication and coordination with other agencies in the community; and supporting the morale and general cohesiveness of the volunteers.

The Center serves a population of approximately 125,000 in Washoe County, although calls also are received from neighboring counties as well as occasional calls from different areas of the United States. The economy in the area is largely supported by tourism and the gambling industry. It is recognized that the area attracts transient and geographically mobile people. As a result, the suicide rate may be somewhat inflated.

During a 12-month period from November, 1969 through October, 1970, the Center processed 1,901 cases. Of these cases, 57% were crisis calls, 20% were suicide-related calls, and 23% were information or miscellaneous calls. The average length of time spent per case was 3 hours and 24 minutes.

Crisis calls are broadly defined, as indicted earlier, to include a variety of stressful events of time-limited nature. They represent the bulk of the calls received and are considered the primary emphasis of the Center. Although suicide is seen as a particular event in the general area of crisis, suicide related calls are categorized separately because of their particular significance to the Center. Suicide related calls are seen as crisis calls with a definite suicide threat present. Information calls are of miscellaneous variety such as requests regarding the availability or particular community resource of service.

At the present time, office space is donated by the Economic Opportunity Board of Washoe County. Equipment and part of the administrative services are provided by the University of Nevada. General financial support is provided by grant monies and funds from the University of Nevada. Partial support also will be provided by the United Fund of Washoe County. It is estimated that the current expense of the program would be tripled if conventional forms of service agency operation were utilized.

**New Directions**

As many suicide centers across the country have done, the Suicide Prevention and Crisis Call Center has tended to change its functions from a restricted suicide prevention service to broader community involvement. The nature of crisis intervention service leads to multiple contacts with numerous community agencies and people because of the variety of problems which are dealt with in some way. As a result, many people in the community view the Center as providing an integrative and coordinative function among community services. At several workshops during the past few years, the suggestion has been that the Center serves as a central clearing house for referrals, information on resources, and people seeking services. The involvement of the Center in planning of a comprehensive mental health and mental retardation center in Washoe County has added impetus to the request. Consequently, the Center has recently initiated a pilot project reflecting the central clearing house concept. The pilot project will attempt to indicate the feasibility of coordinating the activities of several service agencies by providing a central place where information such as number of referrals, availability of services, kinds of services, and extent of waiting lists, can be collected, collated, and disseminated to the participating agencies. The pilot project will be used to provide guidelines and direction for the administrative structure of the planned comprehensive center.

A current emphasis, which will be expanded in the future, is the involvement of the Center in providing meaningful educational experiences for students. One of the serious weaknesses of conventional classroom presentations for undergraduates majoring in social science professions is the minimal opportunity to have actual experience in working with people. Consequently, the difficulty of relating abstract concepts to what they find exciting and motivating leads many to view the class material as part of a boring academic exercise with grades as the only payoff. When meaningful experiences such as working with people are part of the learning sequence, the students are often highly motivated to seek knowledge about persons and effectively utilize the avenues available in a university community. Motivation is seen as a critical factor.

A continuing and expanding effort will be to involve both the University of Nevada and the Reno-Sparks community in the activities of the Center. It is expected that both will benefit by this coordination of efforts. The University of Nevada could benefit from the unique educational and research

opportunities provided by community involvement. The Reno-Sparks community could benefit, in turn from the resources available at a university such as a knowledge and students commitment.

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## RESEARCH

### Residential Segregation and Complete Suicide[1]

**David Lester, Erie County SPCS**

It has been a common notion, since the idea was first introduced by Durkheim (1951), that the more socially integrated an individual is the less likely he is to complete suicide. If we consider the black population of a city, we might predict that the more defined and definite the boundaries between the area of the city in which the white population live, the more socially integrated and socially regulated the population will be. As the dwelling areas of the two populations come to overlap more and more the two populations should become less socially integrated and socially regulated because of the clash of the two cultures. Alternatively, we could point to the probable increase in tensions and frustrations as the two groups come into closer contact through their residence and this increase in tension and frustration might well increase the incidence of suicidal behavior in the populations.

This prediction was tested by examining the rates of completed suicide in a number of cities in the United States and correlating these rates with the extent of residential segregation in those cities. The relationship of the completed suicide rates of cities to the size of their population and to the proportion of non-whites was also examined.

### Method

The data for completed suicide were obtained from the Department of Health, Education, and Welfare. All that was available were the completed suicide rates for whites and non-whites for selected

[1] I should like to thank Mrs. Mabel Smith of the National Center for Health Statistics for providing the data on suicide rates.

cities in the United States in 1960. The rates of completed suicide in the black population of the cities were not available.

The data for the index of residential segregation were obtained from Taeuber and Taeuber (1965).

Spearman rank correlation coefficients were computed between the suicide rate and the extent of residential segregation. It was decided to investigate the correlation separately for cities in each of the major regions of the United States so as to have some control over the large variation in the characteristics of the population in different regions of the United States.

Data on the population of urban places and the proportion of non-whites in these urban places were obtained from the 1960 U.S. Census.

**Results**

The correlations obtained are sown in Table 1. The prediction was confirmed in only one of the nine sets of cities – for the eight major cities in the East South Central States. The nine correlation coefficients were averaged (Guilford, 1965), and it was found that the correlation between the suicide rate and residential segregation for non-whites was almost significant in the predicted direction (Spearman rho= -.18, $t=1.55$, $df=70$, $p<0.10$) while the correlation for whites was almost significant in the opposite direction (Spearman rho=.16, $t=1.36$, $df=70$, $p<0.10$). The two correlation coefficients differed significantly ($t=2.31$, $df=69$, $p<0.025$).

Stronger correlations were obtained between the suicide rate and the size of the cities. The correlations for both whites and non-whites were positive, indicating that the larger the city the higher the suicide rate.

The correlation between the proportion of non-whites in a city and the suicide rate for whites was positive, indicating that the more non-whites in a city the higher the suicide rate of whites. For non-whites, however, their suicide rate was not significantly related to the proportion of non-whites in the city.

**Summary**

It was predicted that the suicide rate of non-whites should be greater where residential segregation is least. Data from 96 cities in the United States did not support this prediction. The suicide rate of both whites and non-whites was found to be greater in the larger cities and the suicide rate of whites was greater in cities where there was a large proportion of non-whites.

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Table 1. Correlations between the completed suicide rate for whites (W) and for non-whites (NW) and indices of residential segregation, population size, and population composition by race for cities in the United States.

| Regions# | Number of cities in region | Residential segregation | | Population of cities | | Proportion of non-whites | |
|---|---|---|---|---|---|---|---|
| | | W | NW | W | NW | W | NW |
| New England | 7 | -.07 | -.56 | .11 | .29 | .07 | -.49 |
| Middle Atlantic | 16 | .24 | .06 | .41 | .52* | .70** | .57* |
| E.N. Central | 18 | .30 | .05 | .36 | .25 | .47* | .06 |
| W. N. Central | 8 | .24 | -.19 | .09 | .21 | .79* | .33 |
| Pacific | 12 | -.20 | .02 | .29 | .24 | .76** | .30 |
| S. Atlantic | 11 | .10 | -.45 | .19 | .10 | .05 | -.23 |
| E. S. Central | 8 | .69* | -.86** | .21 | -.26 | .50 | -.41 |
| W. S. Central | 13 | -.09 | -.05 | -.10 | -.15 | .09 | .02 |
| Mountain | 3 | -.50 | .50 | .50 | 1.00 | .50 | 1.00 |
| Mean correlation | 96 (weighted mean has an effective n=72) | .16 | -.18 | .24* | .20* | .54** | .11 |

# The division into regions followed that used by the United States Census.
* one-tailed $p < 0.05$.
** one-tailed $p < 0.01$.

# Suicide: Aggression or Hostility?

**David Lester, Erie County SPCS**

The person who kills himself has often been viewed as an unaggressive person. He is the sort who doesn't attack others either physically or verbally, but instead inhibits his aggression and turns it inward upon himself in some self-destructive way.

This idea was first suggested by Freud. Although he never considered the psychodynamics of suicide in detail, Freud had considerable experience with suicidal patients and he, himself, threatened to kill himself if he ever were to lose his fiancé. (Luckily he never did lose her.) So the idea of suicide was not alien to Freud.

Robert Litman collected Freud's scattered comments on suicide and noted that Freud had outlined two stages in the development of suicidal behavior. First of all, emotional investment is withdrawn from a lost object of love and relocated in the ego where the loved one is recreated as a permanent feature of the self, as a kind of ideal self. This is called identification of the ego with the abandoned object and Litman called the process ego-splitting. Secondly, the ego can kill itself if it can direct aggression that it feels toward some object in the external world toward itself. So, after identifying with the lost love-object, the ego can direct its aggressive impulses felt for that object toward the part of the ego that has identified with the object and, thence, kill itself.

Psychologists and sociologists have emphasized only the part of this formulation dealing with aggression turned inwards upon the self, and they have neglected the essential role of ego-splitting after loss of a love-object. Suicide has been seen as an act of inward-directed aggression to be contrasted with acts of outward-directed aggression such as homicide. For example, the sociologists Andrew Henry and James Short argued that homicide and suicide were opposed behaviors. They suggested that people who killed others and those who killed themselves had very different kinds of childhood experiences of punishment. Experience of love-oriented techniques of punishment should favor the development of a strong super-ego for, when a child is punished by his mother threatening to withdraw her love, he must learn to inhibit his aggressive impulses for if he attacks her he may lose her love. Thus, the child who experiences love-oriented techniques of punishment is likely to develop tendencies to inhibit aggression as an adult whereas the child punished physically is unlikely to do so.

One conspicuous thing about these ideas is that there is very little empirical support for them. The ideas make sense but often what makes sense is not correct. Let me look at some recent research on this issue.

## Suicide as Inward-Directed Aggression

What evidence do we have that suicidal people inhibit aggression? In one of my studies, I inquired about the aggressive behavior of students who had differing histories of suicidal preoccupation. Some had attempted and threatened suicide and others had never considered suicide. The students did not differ in the extent to which they attacked others when frustrated, destroyed objects, verbally abused others, or inhibited aggression. These students with differing degrees of suicidal preoccupation reported similar aggressive habits.

One psychological test that attempts to measure the response of people to frustration is the Rosenzweig Picture-Frustration Test. This test presents people with a series of cartoons depicting two characters, one of whom is frustrating the other. The subject is asked to write a verbal reply for the victim. The responses to the test can be categorized as extrapunitive (aggression is directed toward the frustrator), intropunitive (aggression is directed by the victim toward himself), and impunitive (nonaggressive response).

Psychologists have given this test mainly to people after they have attempted suicide unsuccessfully and have found no evidence that they respond differently from nonsuicidal people who have a similar degree of emotional disturbance. For example, Seymour Fisher and Edith Hinds compared a group of hospitalized attempted suicides with a group of nonsuicidal paranoid schizophrenics and a group of applicants for jobs at the hospital and found no differences.

There is also a great deal of clinical data that support the notion that the suicidal person is an outwardly aggressive person. Norman Farberow and his colleagues looked at the case records of a group of psychiatric patients who killed themselves and found that they had been very violent when on the wards of the hospital. They had needed physical restraints more often than the nonsuicidal patients and had gotten into more first-fights.

**Suicide and Murder**

Donald West studied murderers in England and found that about one-third of them killed themselves after killing their victims. A large proportion of murderers must also make attempts to kill themselves, though I can find no documentation of this. The suicidal murderer differs from the nonsuicidal murderer in many ways. For example, the suicidal murderer is more likely to be killing a spouse or a child and is much less likely to use brutal methods. Infanticides, death pacts, and mercy killings are common, and West felt that some suicidal murderers were motivated more by despair than by aggression. However, in other cases there appeared long-standing histories of violent behavior, and West saw the suicidal murderers as individuals with a high level of aggression which may be turned against others or themselves depending upon the circumstances. The following case is typical of those reported by West.

The offender was an excitable, talkative, boastful man of low intelligence. He was constantly unemployed on account of symptoms of backache, which were considered by hospital doctors to be largely hysterical. He was referred to a psychiatrist and put on a tranquillizer. He was in severe conflict with his wife, and various authorities had been approached to intervene on account of his violence toward her and his children. He was described by a family doctor as “a pale little man, full of resentments against the world and immensely aggressive.” He so resented interference that when his baby had pneumonia he turned out of the house the doctor who called to examine the child. He was reported to have been so irritated by his baby crying during a fatal illness that he picked it up and threw it across the room. His wife had been seen by social workers badly bruised and with a tooth knocked out following arguments with her husband, and on other occasion he had attacked his wife in a very frightening way in the presence of a social worker who had called about the children.

Six weeks before the murder, the offender's wife finally left the home, and two children remained behind. He made numerous threats that unless she returned he would kill the children and himself. Finally, he did so, leaving behind a note blaming his wife.

There is also some data from primitive nonliterate societies collected by Stuart Palmer. He found that societies with a high incidence of homicide also had a high incidence of suicide and those societies with a low incidence of homicide also had a low incidence of suicide. There appeared to be aggressive societies and nonaggressive societies.

It seems clear, therefore, that suicide and homicide are not opposed behaviors. It is common for them to be found in the same individuals and in the same societies.

**Aggression or Hostility?**

It is clear so far that the suicidal person is not an unaggressive person. He does not tend to inhibit aggression or turn it inward. There are many studies that support this conclusion and few that contradict it. We have destroyed one theory. Can we replace it with another?

So far I have used the word *aggression.* For example, Webster's defines aggression as "a first or unprovoked attack or act of *hostility*". However, we can distinguish between these two concepts if we consider them carefully.

George Kelly noted that we usually look at hostile behavior from the viewpoint of the victim. You hurt me, and so I judge you to be hostile or aggressive. Kelly suggested that we would do better to look at hostility from the point of view of the hostile person.

Kelly first distinguished between aggression and hostility. Aggression is most appropriately viewed as energetic behavior or as assertive behavior and, to help tie down the meaning of the concept, its opposite is passivity. Aggression is very similar to adventuresomeness.

Kelly saw hostility as very different from this. Hostility for him was epitomized by the person who holds a particular view of the world and who cannot accept evidence that is incongruent with this view. When such a man meets some incongruent data, he could accept it and attempt to erect from the ruins of his old view a new view of the world, a view that would be congruent with the new data. But the hostile man does not do this. He attempts to distort the evidence to fit his old view and he sets out to extract evidence from the world that is congruent with his beliefs.

Hostility, for Kelly, is a refusal to accept new information and its polar opposite is realistic acceptance. Kelly suggested that Procrustes was perhaps a fine example of a hostile man. Procrustes had a bed and his world view included the belief that everyone fitted his bed. When he was presented with disconfirming evidence in the guise of a visitor who was too short or too tall, then Procrustes distorted with the evidence. He stretched those who were too short and amputated parts of those who were too tall. After these manipulations, everyone fitted his bed.

If the concept of aggression does not appear to be too useful in helping us to understand the suicidal person, what about the concept of hostility?

If we conceptualize the suicidal personas a hostile person, there are two questions to answer. First, why can he not accept evidence that is incongruent with his view of the world? Why must he distort the evidence? There is good evidence from research carried out by Charles Neuringer that the suicidal person is more rigid in his thinking than others and that he tends to overreact. It is clear that such a person will find it difficult to change his view of the world and find it easier, perhaps, to distort evidence and extract congruent evidence.

The second question we must attend to concerns the ends to which the suicidal individual extracts and distorts evidence. Here it is impossible to give a simple answer. Each person has his own idiosyncratic motivations for killing himself. But let me try to suggest some reasons.

It is a common notion that the suicidal individual is seeking love and attention by means of his suicidal behavior. Norman Farberow and Edwin Shneidman called their book on attempted suicide *The Cry for Help* to emphasize this aspect of suicidal motivations. If a person has a view of the world in which he is central and loved and if this view is not being confirmed, an attempt at suicide may serve to extract confirming evidence from his friends. They may rush to him after his suicidal action and tell him they care for him.

I have met individuals who saw the world as an unfriendly place with unfriendly people. Such individuals often attempt suicide in a situation where help will not be forthcoming and so they are rejected and left to die, confirming their view of the world as an unfriendly place. Their feelings of worthlessness may similarly be confirmed in this way. I wasn't even worth saving.

We would expect those seeking attention and those seeking rejection to arrange their suicidal acts differently. The person who seeks attention will arrange for his friends to find him and rush to his aid. The one seeking rejection will wait till he has alienated his friends and only enemies are near before he tries to kill himself.

At the moment there are no studies to confirm or disconfirm these hypotheses. But when the data come in, we may find that we have moved from seeing the suicidal individual as an unaggressive person to seeing him as a hostile person.

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**INDEX FOR CRISIS INTERVENTION**
(S stands for Supplement)

1969



1970

## Suicides and the Press[2]

**David Lester, Erie County SPCS**

Some of those who kill themselves each year have their death reported in the newspaper. A typical report from the Buffalo Evening News is the following report.

> Policeman, Shot, Dies
> Joe Doe, 40 of 100 Main Street, a Buffalo policeman, died Monday evening in Buffalo General Hospital where he was admitted with a bullet wound of the chest in the afternoon. He was found in his bedroom by a sister, Jane, and his service revolver was lying nearby, police said. The medical examiner's office is investigating the incident.

Occasionally, a more extensive report is given, as when the individual is very famous.

The present paper was designed to investigate which completed suicides do get their death reported in the newspaper and which do not.

Buffalo has two newspapers: The Courier Express and the Buffalo Evening News. Only the latter maintains a library service that lists suicides and so the present data are based on the practices of the Buffalo Evening News.

### How Many Suicides are Reported?

It was expected that the advent of a suicide-prevention center would increase the newspaper coverage of suicides in the area. The data showed the opposite tendency. In the years 1959-1961 there were 245 completed suicides in Erie County (of which 118 were in the city of Buffalo) and 152 reports of cases in the Buffalo Evening News. In 1969, the first year that Erie County had a stable suicide prevention center in operation for the whole year, there were 78 completed suicides (of which 44 took place in the city of Buffalo) and the Buffalo Evening News had 29 reports of cases. Thus, the percentage dropped from 62% to 37%.

### Are Newspaper Reports of Possible Suicides about Deaths Classified as Suicide?

The 29 reports of deaths in the Buffalo Evening News in 1969 that the library service classified as suicide were checked and only 23 actually received a death certificate classifying the death as suicide. The remaining 6 were classified as undetermined.

It might be noted that, of these 6, 5 were classified as undetermined by the same medical examiner, attesting to the reluctance of the Erie County medical examiners to classify deaths as suicidal. Mildred Spencer of the Buffalo Evening News wrote of the inefficiencies of the Erie County medical examiner system in the newspaper in 1970.

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[2] In the following analyses, 4 persons who died by suicide while out of Erie County are excluded.

**Who Gets Reported?**

Of the actual suicides whose death was recorded in the Buffalo Evening News, 18 lived in the city of Buffalo and 4 lived in the surrounding county. Of the total sample of completed suicides in 1969, 44 lived in the city and 30 in the surrounding suburbs. A chi-square test of these data showed that living in the city of Buffalo significantly increased the chances that a suicidal death would be reported ($X^2$=5.24, df=1, $p < 0.05$).

The 18 suicides in the city of Buffalo who were reported were compared with the 26 who were not reported and the results of the analyses are shown in Table 1.

The only significant factor was the method of suicide (those using active methods such as firearms, hanging, cutting and jumping were more likely to get reported than those using passive methods such as gas and poisons.

There were no differences in age (though those reported tended to be slightly younger), sex (males were more likely to be reported), race (nonwhites tended to be reported more), marital status (the widowed divorced, and separated tended to be reported less), day of week (suicides on Thursday and Friday tended to be reported more), month of year, whether an autopsy was performed or not (those reported were less likely to have an autopsy), and whether the police were involved or not (the majority of cases reported by the newspaper had involved the police).

The Buffalo Evening News did tend to report cases in which the police had been involved (83% of their reported cases had police involvement). The statistical test failed to show this difference to be significant because a large number of cases in which the police were involved were not reported by the newspaper. In spite of this, it seems safe to conclude that the newspaper primarily reported suicides involving the police.

The effects of occupation are difficult to analyze statistically because of the small samples. The data in Table 2 show, however, that craftsmen, foreman, and kindred tended to be reported more often while laborers and private household workers (including housewives) tended to be less often.

**Discussion**

The primary causes of a suicide being reported in the newspaper appear to be that the death is from an active method of suicide such as jumping and shooting and involved the police in the investigation of the death. Those using passive methods of suicide (such as gas and poisons) and who are housewives are less often reported. There were no significant effects from age, sex, or race on whether the suicide is reported or not in the newspaper.

It is suspected that death from suicide is more often hidden by those in the upper classes and the mode of death recorded as accidental or natural. The present data on occupational status indicate that, if the death is recorded as suicidal, then all classes are likely to have the death reported. The failure of race to affect whether or not a suicidal death also supports the conclusion that social class does not appear to affect whether or not a suicidal death is reported. The newspapers appear to be free of bias in this respect.

TABLE 1

Differences between completed suicides reported in the newspaper and those not reported.

| **variable** | **statistical test** | **results of test** |
|---|---|---|
| living in city vs suburb | chi-square | $X^2$=5.24, df=1, $p < 0.05$ |
| method of suicide (active vs passive) | chi-square | $X^2$=6.65, df-1, $p < 0.01$ |
| sex | chi-square | $X^2$=0.65, df-1, not sign |
| age | t-test | t=1.01, df=42, not sign |
| race | Fisher exact | p=0.33 not sign |
| month | Kolmogorov-Smirnov | $X^2$=0.49, df=2, not sign |
| day of week | Kolmogorov-Smirnov | $X^2$=1.72, df=2, not sign |
| marital status | Fisher exact | p=0.13, not sign |
| autopsy performed | Fisher exact | p=0.18, not sign |
| police involved[3] | chi-square | $X^2$=2.91, df=1, not sign |

TABLE 2

The occupational status of those suicides reported in the newspaper and those not reported.

| | number reported in newspaper | number not reported |
|---|---|---|
| professional, technical, & kindred | 1 | 2 |
| managers, officials, & proprietors | 3 | 2 |
| clerical & kindred | 1 | 4 |
| sales workers | 0 | 2 |
| craftsmen, foreman, & kindred | 7 | 3 |
| operatives & kindred | 2 | 1 |
| private household workers (incl. housewife) | 1 | 6 |
| service workers (excl. private households) | 3 | 1 |
| laborers | 0 | 3 |
| students | 0 | 1 |
| farmers & miners | 0 | 0 |
| unemployed | 0 | 0 |
| unknown | 0 | 1 |

[3] whether case in files of the Buffalo Homicide Bureau. [Precinct files were not examine]

**BOOK REVIEW: Suicide and Greek Tragedy, By M. D. Faber**

**Sphinx Press, 212 W. 22nd.St. New York, 10011. 208 pages $6.95**

**David Lester, Erie County SPCS**

Dr. Faber is Professor of English literature at the University of Victoria, British Columbia, Canada. He received his Ph. D. from UCLA for a study of suicide in Shakespeare. He is the author of a number of articles on suicidal behavior in literature and has edited a book on psychoanalytic approaches to Shakespeare called "The Design Within" (Science House 1970).

In "Suicide and Greek Tragedy", Faber looks at the insights that can be gained about suicidal behavior from an examination of the plays of Sophocles and Euripides. He is not interested in the Greek playwrights or the plays in themselves, but rather he is interested in using the plays as a source of case studies with which to test, illustrate and develop modern views about suicide.

Suicide for Sophocles was an ambivalent act in which the individual does not seek death *per se*, but rather a solution to an emotional conflict. There is, secondly, the view that suicide is an act by which the individual seeks to maintain or restore a self-image that he has tarnished through his misdeeds. (To use Shneidman and Farberow's concepts, he is focusing upon his self as experienced by others.) Through his death, the individual hopes to change people's attitudes toward him. The suicidal actions of Sophocles' victims are also tinged with disguised or overt aggression toward the significant other who has betrayed and abandoned the hero and toward the hero's own self which has failed to match his ideal self. There is guilt and a need for expiation.

In contrast, the heroes of Euripides are trying by their suicides to prevent occurrences which they do not want. His heroes are anxious over future developments. More importantly, the majority of Euripides' suicides are altruistic suicides. For example, Agamemnon has been told by the prophet Calchas that, to win against Troy, he must sacrifice his own daughter, Iphigenia.

In case studies of suicidal people, there is often a paucity of data. Even after a psychological autopsy, the dead individual remains a stranger. We do not know that he was like, how he behaved, or what he thought. We have the impressions of others and technical jargon. It is striking to realize how precise and detailed the characters in Greek tragedy, created by Sophocles and Euripides, are. Through the use of the chorus, messengers, friends, and the hero himself, the playwrights manage to convey the conscious and unconscious conflicts and motivations of the heroes. This is conveyed to us simply through the actions and words of the characters, and we are allowed to make our own interpretations. One puts down Faber's book with a feeling of how brilliant and insightful both Sophocles and Euripides were that they could capture the nuance of people, but of course this judgment of brilliance is made possible only by Faber's careful analysis of the heroes.

One might question whether much can be learn about suicide that could not be gleaned from other sources. Should you think that you have only to turn to Faber's analysis of altruistic suicide to find an analysis that surpasses previous discussions? Faber describes the optional and the obligatory components of altruistic suicides and the way in which the victim can modify psychologically the contribution of each component.

Faber's book stimulates many ideas (as any good book should). For example, if these plays can be used as "mirrors held to nature," cannot the audience response to the plays be used as an index to the suicidal motivations? For example, when I was a student in England the plays of Sophocles were performed much more often than those of Euripides. Might this not indicate the prevailing motivations in a society? If we traced the relative popularity of these two playwrights (and others), might we not be able to speak to the self-destructive tendencies of these different epochs? To take another example, I was struck by the predominance of female suicides in both playwrights: 4 of the 6 deaths in Sophocles and 6 of the 7 in Euripides. What import does this have for an understanding of the Greeks, of Sophocles and Euripides, or for us who respond to these plays with judgments of their greatness?

Faber, although primarily interested in the psychoanalytic interpretation of literature, in no way restricts himself to psychoanalytic inferences. He draws fully upon all contributions to the study of suicide. Among these resources are the conception of suicide as a magical act (discussed by Wahl) and the confusion of the self as experienced by the self with the self as experienced by others (discussed by Shneidman and Farberow). Here I would like to take issue with the prejudice of these two concepts. Some suicidal individuals are considered to be partially motivated in their self-sacrifice by a belief that they can change the attitudes of others toward them. The concepts used stress that this is magical or confused because the self as experienced by our self will not be around to know. In reality, it is neither. We <u>are</u> capable by our deaths of doing this. The manner and timing of our deaths can have a profound influence on how others think of us. And we can anticipate with a degree of assurance that our image will change. The confusion may lie only in the mind of the psychologist. The man about to kill himself need not confuse the two "selves." It is clear that for some men, at the point of their death, the self as experienced by others has become more important than hitherto. But the suicidal individual need be no more confused or resorting to magic than Faber, Wahl, or Shneidman and Farberow, who each , most likely, are arranging for their "life-after-death" to be adorned by their children, their chattels and their scholarly contributions. If we are all confused and susceptible to magical thought, then the concept has lost its explanatory power.

In conclusion, Faber's book "Suicide and Greek Tragedy" is a superb book. It is enjoyable to read, stimulating to think about, and makes a notable contribution to our knowledge about suicide.

## I'll Be Here Tuesday, If You Need Me

**Gene W. Brockopp, Erie County SPCS**

Every telephone emergency service (like any service system which deals with a large number of people and has a large diverse staff) eventually must deal with the problem of the client who wishes to relate with only one person on the staff. Unlike large service agencies, for example Welfare or Medicare, which divide clients among various full-time case workers who maintain contact with the client and responsibility for helping them obtain the service that they need., suicide prevention centers are usually staffed by volunteers who have limited training and only part-time contact with the agency. The kind of client who wants to relate to only one person usually has insistent needs for "distant intimacy" (such as a telephone might permit) a history of rejections by various social and mental health agencies and some feeling of concern that now he is calling a suicide or crisis service. The statement the client makes why he wants to talk to the same person as he spoke to before may be one of the following:

(1) Joe or Sally has helped me before. Most clients will automatically return to those individuals who have helped them previously or those with whom they have developed a sense of trust. Their advice, assistance or thoughtful listening has proven useful in reducing the anxiety of the individual or assisting him to work through the problem which he has had. However, the line between getting assistance and developing a dependency relationship is very close. Although we are not opposed to the development of a dependency relationship when it is appropriate or needed by the individual for maintaining himself or his life, we do feel that the person who calls back a telephone service usually is not in this type of condition but rather is a chronic caller who is unlikely to be self-destructive. If the person were seriously self-destructive, it is certainly hoped that there would be professional intervention on a face-to-face basis rather than depending on the phone service exclusively.

(2) Joe understands me. Again, although this characteristic of a therapeutic relationship is desirable and necessary if any help is to be given to the individual, the implicit assumption is that no one else can understand him or give him the help he needs. This often closes off many other areas of help for the individual and makes a referral to an agency improbable and unlikely to be taken by the person.

(3) I won't have to repeat myself or begin at the beginning once again. Although some callers delight in telling their story of grief and trouble to various individuals, most individuals would prefer not to go through the details to the problem with another individual unless this is absolutely necessary or unless they are trying to rationalize their feelings to themselves or if the re-telling of their history of problems reinforces the correctness of their actions.

(4) I like talking to this person. Requests or demands for the same therapist which fall into this category of reasons usually very strongly imply that the relationship between the counselor and the client is one of conversation and friendship rather than one of therapy. In this kind of relationship, there is little chance of confrontation of the individual with his problem or movement toward a solution of these problems.

(5) I can't or won't talk to anyone else. In this situation, the counselee is setting demands on the service or on the individual which, if granted, overtly and covertly place him in a controlling position—one in which the relationship is much more important than the solving of a problem or the working through of the difficulty. The person who sets up this type of condition generally is not hurting very much and usually has more of a friendship relationship than a therapeutic one with the counselor.

These five reasons or variations of them are commonly used by the caller to request talking to the same individual with whom he has spoken before. I feel that the only ones that are justified are the first and the third. The other three indicate that the client has reduced the therapeutic relationship to one of a conversation, thereby making emergency telephone service into an old-fashioned party-line type of operation.

In addition to the above reasons why the client may want to talk to a particular counselor, I feel there are decided disadvantages to allowing this type of relationship to develop from the point of view of the service itself:

(1) The counselor may not be there or able to take the call from the client at a particular time. If there is a stated or implied agreement that the counselor is going to take calls from this particular individual the counselor must be available to the individual at all times or deal with the feelings of rejection that the individual may feel as a result of his lack of availability to the counselee. In addition, since the person working on the telephone must be available to any individual regardless of his previous relationship with

a specific client, to develop a relationship with one client which makes this difficult to achieve, distorts the purpose of the telephone service.

(2) Calls of this type tend to be conversational rather than therapeutic partly because of the type of training the telephone therapist has had. In most cases the volunteer telephone therapist is able to deal with crisis calls quite well and to work through crisis situations. However, dealing with individuals on a long-term basis is quite different and requires a different type of competency. This skill is usually not available to the telephone therapist, and so the telephone call generally deteriorates into a conversational one. Although talking may give some support to the individual who is calling the center, the function of the telephone therapist is often then limited to merely listening. In a sense, he prostitutes his therapeutic function to becoming a conversationalist. This service may be very useful, but it does not appear to me to be a desirable one for a phone operation.

(3) Pressure by the client on the counselor may result in covert rejection. Extending the idea developed above, since the counselor is usually not able to handle this type of call over a long period of time in an appropriate therapeutic way, what often develops is an initial sense of importance on being requested by the client to work with him with his problems. As the telephone call deteriorates into a conversational relationship, a sense of inadequacy often develops on the part of the counselor. In a short time, a sense of frustration and covert wishing to get rid of the problem caller develop because nothing seems to work with him. In either case, whether the person is covertly rejected or maintained at a conversational level because of the inadequacy of the telephone therapist, change is unlikely to occur in the caller and eventually neither the caller nor the counselor find the relationship satisfactory.

(4) Calls of this type move toward an "owning" of callers by specific counselors. The feeling of importance and value that each of us has about ourselves and wishes to maintain and enhance is tapped by the single-person caller. What results is that, rather than functioning as cooperative workers in the center, a competition develops between phone workers regarding specific callers and each person, in essence, sets up a private practice within the phone service operation.

(5) The one-person caller may develop more out of the need of the counselor than the needs of the client. Extending point #4 above, we find that some individuals who work in a telephone answering service do so to fulfill deep needs in themselves for developing close personal relationships with other individuals. They use the one-person caller to achieve these ends. Consequently, a symbiotic type of relationship develops in which each person is fulfilling his own pathological needs and the problem that the client has is unattended to.

(6) Manipulation by the caller is much easier. With a type of dependency relationship developing between the counselor and the client, which taps some of the needs of the counselor for consistency, importance and value, the one-person caller (who is usually a past-master at using his environment to maintain a level of functioning which is neither healthy nor sick) usually is able to keep his psychological "hook" into the counselor, controlling and manipulate him to his own ends.

At the same time as there are disadvantages, I feel that there are important advantages that need to be considered in determining how a telephone service will handle the one-person caller.

(1) Consistency in therapeutic approach. Clearly, consistency in working with an individual is enhanced when only one individual maintains the counseling relationship. Each person develops some sense of the style of the other individual and is able to function within that style. Although as pointed out above, the handling of the call may not be appropriate, it is, however, consistent, and this is an important value to consider with certain types of callers.

(2) Calls from the chronic caller can be limited, focused and evaluated. The chronic caller poses a number of severe problems for the telephone emergency service. Since their life style is usually self-destructive from a long-range perspective, it is critical that an evaluation be made of each call to find out where the individual is at that particular time so that an appropriate response without manipulation can be made. If one person handles the calls from a chronic caller, this can be achieved.

(3) The one-person caller gives the counselor a sense of continuity. Probably one of the most difficult aspects of working at a telephone emergency service is the sense of discontinuity in working with people. Each time the phone rings, a crisis is occurring in someone's life, and the individual who answers the phone must be able to respond to that crisis without, in many cases, knowing the disposition of the previous one he has worked. We have found that the professional staff members in a suicide and crisis service need a few long-term patients to maintain a balance for themselves, to see outcomes and maintain a perspective on the work they are doing with crisis clients. The same may be true of the person who works on the telephone service, unless he is able to find this continuity in other aspects of his life.

(4) The patient does not need to repeat himself. I emphasized this point previously and would merely like to add here that the need for an adequate record system is evident if the calls are to be handled properly.

(5) The patient has an increased sense of belonging and value. Through the one-person contact, the patient takes on an identity as a person rather than losing his identity and becoming a number or a file folder in the center. Since the individuals who call a telephone service are often on the peripheral edges of society, the sense of belongingness may be most important to them and may give them a base from which they can move into more involved areas of social life.

(6) With the one-person caller, both the level and the extent of the communication may be enhanced if the telephone therapist is adequately trained to respond to this type of caller. For example, the insecure individual who may trust only one person or be able to relate to only one individual, may, through this relationship, develop sufficient trust to move out into the community, Also the problem which the individual has (which may be embarrassing to him because of its severity or because of the areas of concern) may be more easily brought out as the depth of relationship with one person increases and the positive transferences continues.

Reviewing the advantages and disadvantages of this problem within the context of an emergency telephone service, I feel that the following guidelines are appropriate in working with this type of caller.

(1) The one-person caller should not be encouraged. The emphasis should be placed upon calling the agency for assistance rather than calling an individual person. I feel that an analogous situation would be for an individual who is being robbed to call the police station and request to talk to a specific policeman or requesting that a certain fireman come to put out his fire. If a telephone service is to maintain its integrity as an emergency service, it must be responsive as a unit to individuals in crisis. At the same time, we recognize the importance and value of the conversational-friend relationship that each individual appears to need. This, however, is not the area of responsibility of a crisis phone service. Rather than providing this service to an individual, the service should help him develop it within his circle of friends or community. By focusing the individual on his home environment for conversation and friend relationship, we are decreasing the possibility of a dependency relationship developing and with it a distortion of the emergency telephone service.

(2) If a person calls requesting a particular counselor, everything should be done by the counselor who takes the call to develop a relationship with this individual rather than giving in to his wish to talk to a specific person.

(3) During each telephone call, the counselor should make references to the agency and to calling the agency for assistance rather than calling a specific person at the agency. In addition, at the end of the telephone call, a statement should be made to the caller regarding the fact that if he wishes, he can again call the agency, not the person, for assistance and that there are a number of individuals at the service who are able to take his call and to work with him in any crisis problem he may have. In addition, the telephone therapist should not fall into the trap of giving out personal information about himself to the caller, for this will enhance the conversational aspect of the call. To do so gives the caller *de facto* permission to develop a friend relationship with the therapist.

(4) The process of selecting counselors to work at a telephone service should include looking at the insistent needs of the counselors who are applying for this position. An attempt should be made to obtain individuals who are secure themselves and who do not need dependent relationships with other individuals to maintain their integrity, value or importance.

(5) During the call the client must be continually focused on the problem that he is having and assisted in working toward the solution or amelioration of the condition. The telephone therapist must be alert to the test that the caller will give him to determine whether or not he (the caller) can move the telephone relationship into a conversational area. If the telephone therapist is alert, and is secure in himself, he will move toward terminating the call when the individual moves past the problem and into a conversation relationship.

(6) Each counselor must be constantly on guard so that personal information such as the names, addresses or phone numbers of individual counselor working at the center are not given out to people who call. In addition, in no case should the time when any specific counselor is working at the center be given out to a caller, either by the counselor himself or by other counselors who work at the center.

(7) Finally, I feel that before a counselor is allowed to develop a one-therapist relationship with a client, the decision as to its value and need should be made at a consultant or clinical director level. It appears to me that this should only be done when the caller *requires* the consistency in working with a specific person or when the tenuousness of the relationship *requires* contact with one individual. When it is decided that this approach is to be used, a careful study should first be made of the individual who is calling, his specific needs and the type of person who should be most appropriate for handling this type of caller. Then a clinical plan for obtaining the appropriate therapeutic relationship should be developed with the selected counselor to insure that it will be carried out. The rest of the telephone counselors should then be apprised of the treatment plan. It should be emphasized that this procedure should be the exception. Only a few callers require this type of approach.

In summary, it does not appear to me to be appropriate that a crisis phone service should allow its emergency responding ability to degenerate to a mere conversational supportive relationship. By permitting this type of relationship to develop, the phone service is reducing the effectiveness of its function and in many cases enhancing the pathology of the individual who is calling or feeding the psychological needs of the counselor working on the telephone.