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CRISIS INTERVENTION is intended to facilitate communication on

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

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If you have any thoughts, ideas, antagonism, 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 Gene Brockopp, Suicide Prevention and Crisis Service, 560 Main Street Buffalo, New York, 14202.

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EDITORIAL NOTE

David Lester, Ph. D., Erie County SPCS

This is the last issue of Crisis Intervention that I shall help produce. This summer I am moving down to Pomona in New Jersey, where I'll be Associate Professor and Coordinator of the Psychology Program at Richard Stockton State College. (This is a new college in the New Jersey State system which opens this fall.)

Producing Crisis Intervention has been very rewarding. It is gratifying to carry out research and write articles for professional journals, but there is too often an immense gap between the information contained in professional journals and the information required by the person working with patients. I feel that in Crisis Intervention, we manage to distribute information in a form that is immediately useful to the crisis worker. This is evidenced in part by the requests we have received from centers to reprint our articles for use in training.

In order to increase the availability of Crisis Intervention, we have endeavored to keep it free of charge. Whether this will be possible in the future depends upon the good will of our funding source. Because of limitations in funds, the supplements were mailed only to suicide prevention centers. (The regular issues were mailed also to members of the AAS.)

It is with regret, therefore, but with wishes for success that I hand over production of Crisis Intervention to the new Director of Research here.

Social Work and Suicide

Robert C. Austin III[1], Central Arizona College

Once every minute, or even more often, someone in the United States either kills himself or tries to kill himself with conscious intent. Sixty or seventy times every day these attempts succeed. In many instances, they could have been prevented by some of the rest of us.[2] Suicide prevention is not a new concept to social work, yet not too many social workers are entering this field of specialization. Social work research and literature related to suicide is very limited. This might be due partly to the social worker's orientation, and suicide showing a definite liaison to the medical profession. Social workers are accustomed to working with crisis-orientated situations, such as stress, familial, and community. However, the clinical aspects of suicide are very unfamiliar areas, hardly touched by the social work profession. Shneidman says that the first reason is that people who kill themselves are in a crisis in their lives, involving shame, guilt,

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[2] E. S. Shneidman and N. L. Faberow, eds. Clues to Suicide, New York: McGraw Hill Book Co. 1957, p. Vll.

remorse – even honor.[3] There are not nearly enough social workers involved with the individual at the height of his crisis.

What is the role of the social worker with suicide prevention? Those who maintain some connection with clinics or hospitals, or those who are employed, working directly with the potential suicide, have their roles and functions outlined for them. However, there are not nearly enough clinically-oriented social workers. Heilig and Klugman state that the social worker accepts an unusually heavy responsibility in working with suicide crises in that he carries primary responsibility for his cases. He must be able independently to make important clinical judgments, to assess suicidal potential, and to recommend proper action. It is not unusual for him to recommend hospitalization or family separation, and he must be secure enough to trust his judgment and be able to act quickly in a crisis.[4]

If social workers are to become more involved in suicide prevention, there needs to be greater emphasis placed on social work education. The theoretical concepts and practical field experience need to incorporate some aspects of suicide prevention in social work training. Social work schools need also to make known to graduating students the availability of post-graduate stipends and fellowships in suicide prevention. Many foundations and medical centers offer monies for social workers to complete a clinical program that would offer them preparation in the field of suicide prevention The Los Angeles S.P.C. has a post-graduate plan where social workers can undergo the additional training they need in working with suicide. A formal training program has been established for university students in psychiatry, psychology, psychiatric social work, and public health psychiatric nursing. Professional graduates and practitioners may receive post-doctoral appointments for periods of one year or less and obtain clinical training and supervision from the suicide prevention center staff.[5]

Social work education needs also to add to its curriculum more literature and teaching on suicide prevention. Social work schools must prepare more graduates to work in this field. There also needs to be additional emphasis placed on research and involvement of social workers in the investigation and study of suicide. Social work lags behind in the area of research.

Social workers need to be affiliated with professional organizations directly concerned with suicide prevention. There are probably organizations in their communities that they can join. On a broader level, the International Association of Suicide Prevention and the American Association of Suicidology should provide an adequate foundation to gain increased knowledge on suicide.

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[3] E. S. Shneidman, "Some Reflections on Death Suicide," Special Lecture Presented at the 62 Annual Meeting of the Japanese society of Psychiatry and Neurology, Hiroshima, Japan, April 22, 1965.
[4] S.M. Heilig and David Klugman, "The Social Worker in a Suicide Prevention Center, "Social Work Practice, New York, 1963, P. 105 and 106.
[5] Ibid, p. 104.

Current trends and developments in suicide prevention point to a movement toward several new issues. One is the utilization of non-professional workers in crisis situations. Since there are not nearly enough professionally trained social workers, research has indicated focusing on the non-professional. The trained worker might, in these situations be of more assistance as a consultant.

Secondly, what roles and functions will social workers have in the new comprehensive community mental health centers? Programs in the new centers tend to seek new approaches to treatment of the mentally ill. This approach will also be related to crisis situations. Social workers will need to discard traditional methods of functioning in crisis situations. Treatment methodology is continually changing, and special workers need to become part of the change.

In summary, social workers need to heed the individual's "cry for help." The professional social worker can find satisfaction in working with crisis situations. Crises present an opportunity for preventive action, and it is important to use this opportunity to offer professional assistance and help prevent continued suffering and loss of life.

Social work education must keep pace with other disciplines in developing and preparing social workers to work in suicide prevention. There is also a need for social work involvement in new theory and research. Social work has to decide what its role in crisis intervention will be with the new comprehensive community mental health centers. The goals and objectives need to be defined. It is suggested that we begin at the grass roots level in obtaining continued training. Also greater emphasis and attention should be paid to suicide prevention in development of programs.

ALTERNATIVE FAMILY STRUCTURES AS A REHABILITATIVE MODEL

William Prensky, Director, Infra-Personal
Communications Center, Los Angeles, California

Within the development of what has been called the counterculture, there has been noted the growth of a "street culture" which is in some ways quite distinct from those street cultures which have been studied previously. The emphasis on study and rehabilitation/treatment of street cultures has focused largely upon ghettos and minority groups disenfranchised because of their poverty and because of prejudicial conditions within society. The emergence of the "street culture"—young Americans with long hair and attitudes that can be broadly construed as antisocial with an intense involvement in drugs, often supported through prostitution—presents a different pattern than ordinarily presented by the traditional ghetto. There is a subjective feeling of being surrounded by what they often, rightfully so, consider to be a hostile social environment. This perception can exist regardless of the socio-economic background or "status" of their parental families.

The population of which we are speaking is comprised of young people, ranging in age from 16 up to 24 or 25. Generally called "street people," they are characteristically high school graduates or dropouts who have few or no marketable vocational skills and profess no stable means of earning a livelihood. They manifest no clear goal-directed behavior towards a career and lack any aspirations towards one. They are transients or vagrants exhibiting a pathology that stems from malnutrition and/or toxicosis and have been or are currently engaged in illicit trafficking of drugs and/or prostitution. They are, in general, estranged from their families and receive no immediate support from them. Inclusion into a growing petty organized criminal class or death or disability from some form of toxicosis is not an unlikely final outcome.

This is a pathogenic society, a community of young people whose talents are not being actualized and who possess little or no vocational or interpersonal skills. There has been a strong clinically-oriented response on the part of communities which harbor these street cultures. This response has manifested itself in the form of free clinics and drop-in centers, hotlines, suicide centers, detoxification programs, venereal disease control programs, and a smattering of live-in rehabilitation centers geared to specific populations, primarily with specific drug addiction problems. These programs represent a response on the part of members of the community itself and are identified as being a part of that general mileau of which the street culture consists.

It is dysfunctional to consider all individuals within this culture to be pathological. It is more a problem of pathogenesis. The pattern of drug usage and sexual behavior and the lack of material productivity are considered to be disorders by established society. It must be recognized, however, that the emergence of a stable acculturative pattern will require an extensive reorganization of the basis for nosological thinking. To avert a reasonable prognosis of desolation so that these young people do not end up a drain on society (in that their personal lives incorporate criminal behavior to a major extent, or that society must support them in prisons, detention homes, or through welfare), the continuing development of the community's own resources in the direction of rehabilitative live-in centers presenting a strong socialization program must be developed. It behooves the parent society, who perhaps unwillingly birthed this counterculture, to aid in enabling that activity to proceed.

It is empirically obvious that, for many young people, the ordinary family upbringing which they received was not sufficient. The causes are not of consequence at the moment. People who are individualistically at odds with the parent culture may well develop individualistic pathologies because of their isolation from society. Regarding of the changing cultural mores, if the psychological health of the individual components can be improved, the likelihood of gross social dysfunction is decreased.

We propose the development of a residential, rehabilitative program for these street people that will help to eliminate their self-destructive and criminal behavior. The program will take place in a family home setting. It will provide a positive socialization model patterned after an extended family unit consisting of six to ten members of a residential staff. Participation in the program must be voluntary. Clients for the residential program will be referred from numerous sources in the Los Angeles County area. The program capacity is designed to be forty young people, thirty residential regular members and ten emergency "crashers." The young person entering the program becomes a member of the residential family for a period of approximately six months. He will undergo a screening procedure containing medical, psychiatric and psychological examination. If, in the opinion of the examiners, the applicant is not suited for the program, he will be referred to some other center. When admitted to the program, the individual will become a member of the ongoing family setting. It will be his free choice to participate in family life and to engage in those activities, both for the maintenance of the family and for his own enrichment and growth. The day-to-day governing of the home will be within the purview of a governing council plenary which will consist of all regular member of the program and all members of the residential staff. This council will be responsible to a residential director who will be one of three paid staff members on the premises. A suggested set of basic guidelines includes regulations prohibiting the use or possession of drugs or weapons on the premises, a specific prohibition against destructive behavior or interpersonal violence, and a prohibition against stealing and illegal or destructive behavior which jeopardizes the entire group and the program. (It is the value that the individual places on the group and the program over his desire to immediately gratify some destructive or dangerous wish that will define the ethic for not placing the program in jeopardy.) Activities engaged in by participants in the program will include participation in the council plenary's functions, both legislative and judiciary, household maintenance, and specific interactive and growth activities including movements, encounter groups, individual counseling and classes in specific vocational and avocational skills leading to the development of some vocational training. The program will closely interact with vocational training centers and with free schools such as the Free Clinic Free School in Los Angeles.

The social psychological literature indicates that the peer group possesses potent rewarding and punishing sanctions, the bulk of which are covert. Among the influence groups with whom he interacts, the adolescent is most responsive to his peers. Peers groups provide both positive and negative reinforcement. The adolescent is certainly conscious of the sanctions the group imposes upon him. He does not see these reactions as a means of deliberately shaping behavior towards conformity, but rather as a spontaneous reaction towards him by the group—as a display of their feelings. It is our proposal that the development of a residential rehabilitative program be designed in such a way as to maximize the positive effects of peer group pressure, even insofar as construing the residential staff as a member of a we/they peer group as far as counterculture is concerned. This group will comprise its own peer society, and the compliance to the pressures of this peer group toward non-self-destructive and more productive behavior will hopefully lead to a change in attitude and socialization. It is this compliance which leads to attitude formation or change which comes into consistency with behavior.

The attitudes which are promoted are aimed at becoming a part of a much larger category and life style, for example, a naturalistic health-oriented philosophy, which is in opposition to a predominately self-destructive pattern of drug usage. The informational value of various components of attitude formation should become internalized as part of a complex self-definition and set of aspirations. If behavior is then changed within the context of new information being assimilated which supports it, this information can act as an internal reinforcement for such behavior even in the face of contrary group pressure at a later time. The individual will tend to select associates who agree with his conceptualizations. If this program presents itself as the embodiment of ideas and life styles which the target population can identify or which it admires and aspires towards, and if the client can see his present behavior as being at variance with this model, then a decision to alter the behavior which is perceived as free choice will lead to a stable change in attitude and socialization pattern. It is with this ability to present itself as an assimilative model that gives hope that the attitude change will remain stable in the face of outside pressure at a later time.

A phenomenon widely observed in penal and rehabilitative institutions is the individual perceiving a peer group acting as his ally in residence and encouraging rebellious and antisocial behavior. Inmates often form a strong peer society which punishes cooperation with the institution and its staff and reinforces resistance to and alienation from the aims, values and behavior desired by the institution and the authority that it represents. It is largely because the entire program represents a positive aspiration model with which the individual can identify that this eventuality should not be realized. In the long run, it is hoped that the graduate of this program will be enabled to find a stable and function life style for himself and to maintain income-producing and interpersonal activity in reference to it. Without some assessment of its effects, no experimental or innovative program can be judged.

A research program developed around the program has three major purposes. The first is to give information on whether or not the program is indeed successful. The second is whether or not it provides some keys, hints or insights about why this program is or is not successful. The third is that the research program will provide some information that will be valuable quite apart from whether or not this experience is a constructive one for runaways and street people. Extensive demographic information will be taken during the initial interview and examination. These young people will be compared against young people from other parts of the country who are not as disenfranchised and alienated from society. Specific therapeutic and non-therapeutic interactions within the family setting will be studied and examined, and finally those successful graduates of the program will be followed for a period of two years and their progress charted and evaluated.

We see two separate clusters of measures to define success of the program. The first can be viewed as mediational links, behaviors that indicate some form prior street life existence. These might be viewed as indices of intermediate success. A second set of success criteria focuses on behavior after the termination of the experience. Here there are two concerns. First, has there been a return to previous drug use pattern. Second, has the post-resident returned to his previous street life or is he now at least in some marginal sense economically self-sufficient and involved in some other kinds of social activities.

We suspect that the people on whom most of the data will be collected will be generally resistant to psychological testing, particularly in the form of paper-and-pencil measures. Given this awareness, most, if not all of the measures of process variables will be observational, indirect or based upon staff

assessment. Where possible, those features of the total situation which legitimately, from the eye of the potential participant, lend themselves to psychological assessment will be utilized. There is no question that we are not in a position culturally to be able to sacrifice a considerable portion of our potentially productive and talented young people. These young people, members of the counterculture, who have evolved into a seemingly ghettoistic society, must be encouraged and aided to break out of those restrictions and to develop their individual human potentialities. It is towards this end that we intend the program to exist, and it is incidental that a fertile field for social psychological research shall be developed. If this program can be seen or construed as a model and a basis for further development of such programs, the insights which can be gained by the marriage of a competent research program with an ongoing rehabilitative function will be invaluable.

NOTE: The Intra-Personal Communications Center of West Los Angeles, California, is a consulting group dealing primarily with drug and counter-cultural problems. Founded in November of 1970, by a group of psychologists, attorneys and medical doctors, it has concentrated its attention upon the development of crisis intervention centers, residential rehabilitation programs and the development of community resources through community councils. Further information can be obtained by writing to William Prensky, Director, IPCC, 1019 Gayley Avenue, Suite 102, Los Angeles, California 90024.

IF YOU'VE MISSED THE AGE YOU'VE MISSED A LOT

Harriette Buckner Kolker and Sedelle Katz

Suicide Prevention Inc., St. Louis, Missouri

Suicide Prevention, Inc of St. Louis recently completed a statistical study aimed at evaluating all facets of our service. A special corps of volunteers, recruited for the purpose, coded records filed from January through June of 1970 on seventy-six different items taken from the record forms.

Along with other information was coded the name of the clinical associate (volunteer) who took each call. It was then possible to run a print-out on each clinical associate in order to examine with him his habitual methods of handling callers and, hopefully, to improve them. Furthermore, we thus had a record of who took the calls on every phase of the study.

It was on a print-out labeled AGE UNKNOWN that we discovered a very simple means of determining how thorough a volunteer is. It became apparent that when a volunteer fails to find out a subject's age, the whole level of information is low.

A subject's age is perhaps the easiest information to elicit. Therefore, it came as a shock to find out that out of 1089 calls presenting crisis situations (that is, eliminating hoaxes, administrative calls, etc.) no age was recorded in 134 instances. This constituted 13% of the total.

Some of this lack of information can be explained by the fact that attempts were higher in the AGE KNOWN group than in the 955 calls where age was recorded (16% versus 11.5%). At the time of an attempt the immediate need for medical attention takes precedence over everything else. The St. Louis Suicide Prevention, Inc. volunteers are trained in a priority of information-gathering. When someone has

taken a bottle of pills, it is much more important to find out what he has taken, how long ago, in what quantity, etc., than how old he is. It is also more important to find out his name and address than why he felt so unhappy. What hospital is nearby? Who can take him there? Those practical considerations make the report of an attempt somewhat different from a non-attempt crisis call. However, we can give our AGE KNOWN calls only a 5.3% attempters' handicap. Number of attempts was not the one, big issue making a difference in the amount of information reported.

Another factor perhaps contributing to a lesser amount of information was the high number of persons calling about someone other than themselves. Eight-one of the 134 AGE KNOWN calls came from persons other than the subject. This 3rd-person type call is more apt to present the problem than a description of the subject. The caller is more apt to ask for direct advice than to give details. However, the clinical associates have been trained to contact the subject himself whenever possible. For example, should a wife call about her husband, it is considered good practice to ask, "Would it be all right with you if I called Mr. ----?" More often than not, permission is obtained, and the volunteer talks directly to the subject after the initial call. The report is written up as ONE call, and there is usually a good deal of information in such a case.

Even when the clinical associate cannot talk to the subject himself, he is told to ask the caller as much as possible about the situation. Family members inevitably know age, marital status, occupation, etc., and even neighbors or agencies can approximate a description.

The clinical associates handling these 81 calls from persons other than the subject, on all of which the age was unknown, talked to only 15 of the subjects. That was half as many subject contacts as we generally average from that many calls. These clinical associates evidently did not broach the idea of talking to the subject as often as they might have, nor did they ask the party calling all they might have asked about the subject. There was obviously less persistence in pursuing these 3rd-party calls than there should have been.

The AGE KNOWN calls were, for the most part, short calls, averaging just over half the length of all crisis calls. When age was not obtained, the average call lasted only twenty-six minutes. When age was obtained, the average call lasted forty-four minutes.

If age was not given, very little else was known about the person. Marital status, for instance, is another fairly easy bit of information to elicit. Among the 134 cases where age was unknown, marital status was also unknown in 53 of them. Out of the 955 cases where age was recorded, marital status was known in only 25 cases. Employment status was unknown in 92 of the 134 ageless cases, occupation in 123. So it went through all the census-type statistical items.

Symptoms and problems were recorded among AGE UNKNOWN cases only about half as often as they were among the records that gave the subject's age.

Although the clinical associates indicated that suicidal intention, among the AGE UNKNOWN cases, was relatively high, (or at least not ruled out), they rated current risk, long-term risk and emotional disturbance as largely unknown or indeterminate. In other words, they refrained from judgment as to the seriousness of the situation.

AGE UNKNOWN	Number	Percent	AGE KNOWN	Number	Percent
None	20	14.9	None	260	27.3
Thinking about it	13	9.7	Thinking about it	206	21.5
Threats	13	9.7	Threats	131	13.7
Serious Possibility	26	19.4	Serious Possibility	145	15.2
Attempt last 8 hrs	18	13.4	Attempt last 8 hours	81	8.7
Attempt last 24 hrs	3	2.2	Attempt last 24 hours 1	12	1.2
Attempt last few days	2	1.4	Attempt last few days	21	2.1
Unknown	39	29.1	Unknown	99	9.8
	134	100.0		955	100.2

ESTIMATED CURRENT RISK		Percent	ESTIMATED CURRENT RISK		Percent
High	15	11.1	High	175	18.3
Medium	11	8.2	Medium	170	17.8
Low	11	8.2	Low	230	24.1
None	13	9.7	None	114	11.9
Indeterminate	23	17.1	Indeterminate	98	10.3
Increasing	0	0.0	Increasing	4	.3
Decreasing	1	0.7	Decreasing	20	2.0
Same	0	0.0	Same	14	1.4
Unknown	60	44.7	Unknown	130	13.6
	134	99.7		955	99.7

ESTIMATED LONG TERM RISK			ESTIMATED LONG TERM RISK		
High	8	5.9	High	213	22.3
Medium	7	5.2	Medium	149	15.6
Low	9	6.7	Low	159	16.4
None	5	3.7	None	62	6.5
Indeterminate	33	24.6	Indeterminate	137	14.3
Increasing	0	0.0	Increasing	0	0.0
Decreasing	0	0.0	Decreasing	1	0.0
Same	0	0.0	Same	0	0.0
Unknown	72	53.7	Unknown	236	24.7
	134	99.8		955	99.8

ESTIMATED LONG TERM RISK			ESTIMATED LONG TERM RISK		
High	17	12.6	High	285	29.8
Medium	13	9.7	Medium	267	27.9
Low	10	7.4	Low	106	11.1
None	3	2.2	None	24	2.5
Indeterminate	26	19.4	Indeterminate	83	8.7
Increasing	0	0.0	Increasing	0	0.0
Decreasing	0	0.0	Decreasing	2	0.1
Same	0	0.0	Same	0	0.0
Unknown	65	48.5	Unknown	188	19.7
	134	99.8		955	99.8

Because attempts were slightly more prevalent among the AGE UNKNOWN cases (16.8% compared to 11.5% among cases where age was known), emergency referrals were also slightly higher. However, no referral was given in 51 of the 134 AGE UNKNOWN cases, or, in other words, 38% of those callers were not sent on to further help. Only 193 or 20.2% of the callers whose ages were known were not referred for further evaluation. Furthermore, a higher percentage of the AGE UNKNOWN cases were sent to counseling services rather than to psychiatric agencies. Few were recognized as already under treatment, probably because the question was not asked. It was unknown, for example, whether 111 of the 134 had ever been in a psychiatric hospital - 83% of the group.

Suicide Prevention, Inc. of St. Louis has always been quite successful in securing identification of its callers. Strangely enough, full identification of subject was obtained in 81 cases (69%) and identification of the caller (other than subject) in another 15 when age was not known. This compares to a 75% full identity and an additional 27 callers' name (other than subject) among the cases where age was reported. Since name is considered one of the most difficult pieces of information to elicit, perhaps we have put undue importance upon it.

In analyzing the records of the individual volunteers, we found that the more experienced clinical associates, those who gave more time to the service, were apt to record age in almost every instance. A few, newer, less experienced volunteers accounted for a disproportionate number of "unknowns." One, for example, failed to record age in twelve out of twenty-two cases. There were four or five with records almost as bad.

Conclusion

The separate computation of suicide prevention records showing no age for the subject tends to show that when age, the simplest information to elicit, is not obtained, the call tends to be handled loosely. The one item which holds up is identification. Perhaps we are emphasizing too much in our training the need to find out WHO the caller is instead of WHAT he is and HOW he is and what we can do for him. A very quick test of a volunteer's thoroughness seems to be whether he bothers to find out how old a caller is.

NOTES FROM THE LITERATURE

David Lester, Erie County SPCS

Telephone Helping Behavior

Simon (1971) asked male and female students to phone randomly determined houses between 6 P.M. and 10 P.M. and asked whether they had reached Paul's Service Station. On being informed that they had not, the caller told the answerer that his car had broken down and he had just used his last dime and would the answerer please call Paul's Service Station for him.

Simon investigated the effects of having make or female callers and male and female answerer. The percentages of answerers who helped in each condition were as follow:

Male calling male	63%
Male calling female	71%
Total	79%

Although this situation is very different to that encountered in a telephone crisis service, the effects of sex of client and counselor may be important variables in the adequacy of counseling behavior and the likelihood that a client will accept a referral.

TRACOM

Nathan, et al. (1968) have described a technique for face therapy that has many similarities to counseling by telephone. TRACOM is "televised reciprocal analysis of conjugate communication." What happens is that therapist and client are placed in separated rooms and each can view the other over closed-circuit television. In order to maintain sound and vision on the television screen, the therapist and the client have a button to press. Pressing the button at about 120 pushes per minute maintains maximum brightness and sound.

What this means is that either the therapist or the counselor can eliminate communications from the other by reducing the frequency of button pushing. This makes the face-top-face situation more similar to telephone therapy in that the patient can "hang-up" or tune out the therapist. This gives the patient more control over the therapy situation. The patient described in Nathan's paper commented upon how the situation reduced the dominance of the therapist. There was no therapist's chair placed in a commanding way behind the therapist's desk in the room where the patient was.

For a description of how Nathan uses the TRACOM situation to study the process of therapy, see Nathan's article.

Tracing Calls

General Telephone and Electronics in an ad in TIME (11 May, 1970) claimed that they can trace a call even if the caller hangs up. So long as the party called doesn't hang up, the line can be kept open and the call traced. They also state they are working on voice-printing. Their ad was aimed at deterring the obscene caller, but they refused me permission to reprint their ad in full in these pages.

The Obscene Caller

In a recent paper (Lester, 1970) I summarized some research findings on the obscene caller. Since then, I have found another source of information. Gebhard, et al. (1965) studied 1,356 white males convinced of sexual offenses and, of these, 6 were convicted for making obscene telephone calls to females.

The females chosen were almost all total strangers, usually selected randomly from a telephone directory. The males masturbated while telephoning quite often. While most sex offenders came from broken homes, the obscene caller did not. They got on with their parents quite well and had siblings. There was nothing unusual about their relationships with peers. They had adequate (or abundant) heterosexual coital activity in terms of quantity. Homosexual experiences were part of these men's history, but it did not loom large in terms of frequency.

The men were above average in number of orgasms (all methods). Three of the six averaged more than one a day, two averaged over 5 a week, and one averaged 2-3 a week. Thus, these men seem to have a greater need for sexual outlets than the average man and perhaps are unable to delay gratification as

well. Telephoning, therefore, provides a readily available and relatively safe means for gratification. The hypothesis of a strong drive was buttressed by their continuing to telephone after having been arrested on one or more prior occasions, and by the fact alcohol and drugs were rarely used (to overcome inhibitions and scruples).

Three of the men had no previous convictions for other offenses; one was an unstable youth disfigured facially, one was mentally dull, and one had problems exacerbated by drinking. The other three were very different. All had convictions for exhibitionism, 2 for burglary and theft, etc.

Gebhard, et al. concluded that obscene telephone communication was not a discrete behavioral and psychological entity, as are some sexual offenses, but merely one instance of a pathological development of an interest common to most males – a symptom of some sexual and emotional difficulty. The difficulty may be related to exhibitionism, and Gebhard, et al. saw obscene calls as a sort of verbal exhibitionism. Both the true exhibitionist and the obscene caller want to cause a strong emotional reaction in his feminine audience and arouse the females sexually. Furthermore, self-masturbation frequently accompanies both behaviors.

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TELEPHONE THERAPY: THE FACELESS THERAPIST

Tim Williams, Erie County SPCS

Telephone contact is a meeting of voices, a contact purely in sound. Communication between participants is limited to what they explicitly can glean from the tone, rhythm and color of each other's voices. No clues of sight, touch and smell are possible.

The relative anonymity that this affords a client calling a helping agency, and the advantages of this anonymity for the client, have often been noted. Most notably, the client has the power to end the communication at any moment, simply by hanging up the phone. This power can serve to reduce his anxiety and make it possible for him to call for help while he may be unable to visit a clinical for a face-to-face interview.

In this paper, however, I shall examine the therapeutic advantages involved in the parallel fact that the therapist also remains anonymous. The therapist remains faceless, and this too can have important consequences for the progress of the therapy.

A client may call a telephone counseling service because he is simply unable to go for help on a face-to-face basis. The inability may stem from practical problems – distance, transport difficulties,

physical disability – but it is often the case that the client has not the psychic strength at the particular point in time to expose himself in person to a stranger.

It has been the experience of the Erie County Suicide Prevention and Crisis Center that clients who have no hesitation in calling the center's telephone service perhaps several times a day cannot be prevailed upon to come to the clinic in person under any circumstances. It seems that such people can take contact with a disembodied helper (quite literally disembodied), but cannot stand even the idea of the helper's physical presence. I suggest that this may be due in large part not only to the power to terminate the communication which the caller has, but also to his power to make of the helper a great deal of what he wants or needs.

In his state of psychic weakness he can support contact only with a helper who will intrude upon him to an absolute minimum, who will offer only a minimal threat to his precarious identity, who will accept him fully as he is at that time, and who will supply those strengths which he desperately is seeking. It is no slight to therapists to suggest that those who can be such a helper are rare in the extreme. Indeed, many therapists today deliberately resist revealing themselves under a bland professional exterior.

What such a client needs at such a point is a fantasy therapist, a helper devoid of any personality except that which the client specifically needs in another. It may be, and my illustration below will support this, that what the client needs is simply an extension of himself, be it either a reflection of traits of his own, or an addition in terms of strengths he currently lacks.

In person, complete with his body and what it says about him, his face and its expression, his smell, his cloths etc., the therapist must be very much more, or less, than the client's ideal. But reduced to a voice on the telephone, no matter how expressive, he is much closer to that ideal. The very limited clues he gives the client leave a lot of empty spaces in the client's picture of him which the client can fill as he pleases. I am not suggesting that this process is conscious, that the caller has any conscious idea of what he wants his therapist to be, simply that it is there, defined by what he can or cannot cope with.

Much of the current psychotherapy, with its emphasis on dealing with the reality of here and now, which includes the reality of the therapist as a feeling person, rejects strongly the notion of the therapist playing into any manipulation by the client to make the therapist be or do what the client wants. It rejects, too, the traditional psychoanalytic view of the therapist as a faceless, shadowy figure both in terms of the amount of himself the therapist injects into the interaction with clients and in terms of physical presence. The traditional model has the client lie on a couch, unable to see the therapist without special effort, precisely to disembody the therapist as much as possible, so that the client may project onto the therapist what he needs to project onto him.

Ernest Jones talks of the importance of "the necessity for the analyst to be in a position to give free rein to his thoughts without the patient detecting them from the play on his features, which would impair the purity of the transference phenomena" (Jones, 1955).

This model has been widely rejected, and quite appropriately I would contend, and yet it may be that there are certain clients, the psychically damaged or weakened, who can only deal with a therapist under such distancing conditions. And these may be the clients who can make such extensive and relatively uninhibited use of a telephone service while resisting anything face-to-face.

To illustrate my contention, I shall describe two cases observed at the Erie County SPCS which appear to support the idea of the telephone as usefully permitting a client to deal with a partially-fantastic therapist. Both are teenage girls, but I do not think that is a significant factor for my purposes.

Mary called frequently to talk mainly about her problem in breaking a habit of very frequent soft drug use, and spoke regularly, although not exclusively, with a particular counselor, She seemed to be making progress and attributed most of this to the “firm line” the counselor was taking with her. She even described her physical picture of him – well-built, tall, muscular, a veritable Tarzan. The counselor was a long way from that physical type, and had done very little in the way of taking a firm line on the drug issue, concentrating more on other areas. It seems that the girl projected onto him the strong, forceful, masculine qualities she was seeking in someone to control her behavior. Her image of the voice of the therapist gave her the space to do this.

The second illustration deals with a case in which the caller was finally persuaded to come to the clinic after some months of very frequent calling. Kathy was very aware of the fantasy nature of her telephone contacts, of how the counselors were what she wanted them to be. She told the therapist when she finally came in: “This place was too good to be true. I kept wondering if it was all in my head, if I was just talking in my head.”

After she came in, Kathy’s relationship with the Center became much more ambivalent. She began expressing anger at the therapists, threatening to cease all contact. Of course, there were doubtless many factors at work here, but I would suggest that this was in part due to the process of erosion of her fantasies which coming in brought about.

This case illustrates perfectly both the advantage and disadvantage of the fantasy in therapy that the telephone affords. It is sufficiently non-threatening and permissive of “therapist-embroidery” for the fragile individual to use and draw much of what he needs from. However, there must come a point at which the client begins to deal with real people, threatening and non-ideal as they are, and this will inevitably cause distress until sufficient strength has been built. The telephone therapist must keep this in mind and begin to present the client with these realities as soon as he feels sufficient strength there to sustain them.

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THE VISIBILITY OF EMERGENCY SERVICES IN TELEPHONE DIRECTORIES

Gene Brockopp and David Lester, Erie County SPCS

The telephone number of an emergency telephone service must have a high degree of visibility if the service is to be accessible to those individuals who need it. One way to accomplish this is to have the service listed in the telephone directory in such a way that will assist an individual who is upset, anxious, concerned and over-wrought with anxiety to immediately locate the number of the appropriate service and to make the call with dispatch. To facilitate this process, many localities have the telephone number of emergency services listed together on the inside cover of the telephone directory. A recent survey of the telephone directories of 129 American cities revealed that a total of 17 different kinds of emergency services were listed on the inside cover. The frequency with which each of them was listed is shown in Table 1.

It is interesting to note that not all of the cities list the police or fire department among the emergency numbers. Almost as many cities as include the police number include the number of the FBI although it is questionable whether this is really an emergency number. Most of the telephone books from the Southern states listed the Secret Service under this category while other areas included specialized numbers, like one for forest fires, tornadoes, or civil defense. As indicated in the chart, 25 of the 129 listed a suicide prevention service under emergency numbers or 19% of the total number of directories surveyed.

TABLE 1

The service listed in 129 telephone directories

Service	N	Service	N	Service	N
Police/Crime (all kinds)	118	Suicide Prev. Serv.	23+2[6]		
Fire	119	FBI	106	Tornado	1
Coast Guard	36	Ambulance	19	Civil Defense	4
Gas	5	Secret Service	49	Child Protection Service	1
Poison Control Information	35	U.S. Marshal or Border			
Medical Emergency	9	Patrol	3	Water & Sewer Emergencies	1
Forest Fire	4	Hospitals	4	Electricity	1

In order to see what proportion of cities with suicide prevention centers have their number listed on the cover of the telephone directory, a sample of 34 telephone directories were searched.

		number of directories where the spc is listed in the white pages under the "word" suicide	
		listed	not listed
number of directories where the spc is listed on the front cover	listed	5	2[7]
	not listed	13	14

Thus 28% of suicide prevention centers in this sample have their number listed along with other emergency services on the front cover of the telephone directory.[8]

[6] One of these was a psychiatric emergency service and the second was a mental health information service.
[7] The Boston service is listed in the white pages as Rescue, Inc. The Rochester service is listed in the white pages as a Crisis Service.

It is obvious from the above that telephone companies differ in whether they will permit the listing of a local crisis intervention service number on the inside cover of the telephone book. In some cases it is possible that the local crisis service has decided not to list its number for fear that the additional publicity may result in more nuisance calls.[9] It is more likely, however, that the telephone company has decided that the inclusion of this number under emergency listed is not justified or that it would constitute advertising of a specific mental health service which if they accepted, would open the door to any other mental health service that may at times be involved in life-saving activities. In Buffalo the Center was initially turned down by the telephone company when it requested that the number be included among emergency services in the front page of the phone book. However, upon presentation of evidence that this was an emergency number involved in life and death situations and that similar numbers were listed in a number of telephone books throughout the country, the telephone company agreed to include the crisis number under emergency services.

It is possible that some centers have not requested the listing.

Conclusion

The visibility of emergency services in the community varies widely from city to city. It is still unusual for the suicide prevention center to be listed on the inside cover of the local telephone directory. It would appear that the inclusion of the number of the service in that part of the directory would facilitate location of the service by a person in need. The information in this paper may assist crisis services in obtaining inclusion of their number under the emergency services listed in the inside cover of the telephone book.

THE MYERS-BRIGGS TYPE INDICATOR AS A PREDICTOR OF COUNSELOR EFFECTIVENESS

David Lester, Erie County SPCS

There is currently a great demand for manpower in the mental health field and increasingly nonprofessionals are being trained to assist in counseling (Grosser, Henry, and Kelly, 1969). In crisis intervention, the nonprofessional is often preferred over the professional (McGee, 1972). The need is, therefore, apparent today for assistance in selecting which professionals might be suitable for training as counselors. (The majority of nonprofessionals are selected presently on the basis of interviews with

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[8] One incidental finding was that the names given to suicide prevention centers varies from region to region. For example:

Anchorage	Suicide Prevention
Washington DC	Suicide Prevention – Mental Problems
St. Petersburg	Emergency Mental Health (Suicide Prevention)
Atlanta	Emergency Mental Health Service
Honolulu	Suicide and Crisis Center
Boston	Rescue Inc. (Devoted to the prevention of suicide
Detroit	Suicide Prevention Center
Lincoln, NE	Personal Crisis Service
Buffalo	Suicide & Crisis Counseling

[9] It is possible that some center have not requested the listing.

professionals and the resulting clinical judgments.) A likely test for use in selecting counselors is the Myer-Briggs Type Indicator (Myer, 1962).

The Myer-Briggs Type Indicator has four subscales: (1) El – Extraversion or introversion – whether to direct perception and judgment upon environment or world of ideas, (2) SN – Sensing or intuition – which of these two kinds of perception to rely on, (3) TF – Thinking or feeling – which of the two kinds of judgment to rely on, and (4) JP – Judgment or perception – whether to use judging or perceptive attitude for dealing with environment.

The present study examined the relationship between the scores obtained by people on these four subscales of the Myer-Briggs Type Indicator and measures of their counselor effectiveness obtained before training. Counselor effectiveness was measured by assessing the empathy of the responses of the people in a simulated counseling situation.

Subjects

The Ss were 28 nonprofessionals who were part of a program to train them as counselors. The majority of the Ss were aides in two local psychiatric hospitals. Each S was tested in a counseling situation prior to commencement of training. The responses of the S were recorded (on a tape recorder) to five client statements (also on tape). These statements came from the Counseling Simulation Inventory (Carkhuff, 1969). A tape played the client statements while a second tape recorder recorded both the client statements and the S's response.

Two trained raters then rated the Ss responses for the dimension of empathy. The inter-rater reliability for each of the five responses ranged from 0.76 to 0.94 for the complete sample of ratings (of which the present study utilized only a portion). Thus, the two raters showed good agreement in their ratings of empathy.[10]

Each S was also administered the Myers-Briggs Type Indicator (Myers, 1962) on a separate occasion.

Results

The correlations between the scores on the four sub-scales of the Myers-Briggs Type Indicator and the empathy scores of the Ss are shown in Table 1. It can be seen that only the subscale of "judgmental/perception" correlated significantly with the Ss' empathy score (using product-moment correlations.

[10] The ratings of counselor effectiveness used in this study came from research conducted by Kolk (1970) for a doctoral dissertation on nonprofessionals being trained by the Manpower Development training programs financed by Research For Health in Erie County, and directed under the auspices of the Suicide Prevention and Crisis Service of Erie County, New York, by Gene W. Brockopp and Robert Hartl. Kolk (1970) tested a total of 43 Ss prior to training and after training. The present study utilizes pre-training data from two of Kolk's three groups. I would like to thank Dr. Charles van der Kolk making his data available.

TABLE I

Product-moment correlations between scores on the Myers-Briggs Type Indicator and Empathy scores of 28 Ss.

Number of items missed on test	-0.09
Extraversion/introversion	+0.30
Sensing/intuition	+0.17
Thinking/feeling	-0.13
Judgmental/perception	-0.41*

*two-tailed $p<0.05$

Discussion

The dimension that correlated significantly with the empathy of the subjects' responses was that of judgment/perception. Counselors with higher empathy scores tended significantly to be more judgmental than perceptive, that is relied on a judging process (T or F) rather than a perceptive process (S or N) in their dealings with the outer world. To better understand this dimension, we may quote from Myers (1962, p 58):

> In the judging attitude, in order to come to a conclusion, perception must be shut off for the time being. The evidence is all in. Anything more is incompetent, irrelevant and immaterial. One now arrives at a verdict and gets things settled. Conversely, in the perceptive attitude one shuts off judgment for the time being. The evidence is not all in. There is much more to it. New developments will occur. It is much too soon to do anything irrevocable...The judging people run their lives and the perceptive people just live them....

It might be hypothesized, therefore, that empathic responding requires commitment on the part of the counselor. He must have judged, judging not right or wrong, nor good or bad, but rather giving the patient some immediate evaluative feedback. This feedback, clearly, for empathic responding, is supportive. The perceptive approach, in which judgment is delayed, perhaps does not provide enough feedback to the patient for empathy to be high.

The subjects of the present study were nonprofessionals functioning at quite low levels of empathy (range 1 to 1.7, maximum range possible 1 to 5). It would be of interest to examine the predictability of the Myers-Briggs Type Indicator for trained subjects, whose empathy would be expected to be higher than that of the present subjects.

Summary

Empathy scores of nonprofessionals in a simulated counseling situation were correlated with four personality measures obtained from the Myers-Briggs Type Indicator. Those persons with higher empathy scores were significantly more likely to be judgmental rather than perceptive, that is to rely on a judging process rather than a perceptive process in dealing with the world.

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