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AN APPLICATION OF CRISIS THEORY:
THE SUICIDE PREVENTION CENTER

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I. INTRODUCTION

The author imposes upon the reader a biased assumption that all suicides are undesirable. The right to life is one of the fundamental values on which Western society has been built. Plato, in his work of Phaedo in 440 B.C. said,

Man is a prisoner who has no right to open the door of his prison and run away...Man should wait, and not take his own life until God summons him.

Underlying this study is the Christian attitude. The author believes that suicide is now the leading cause of unnecessary and stigmatizing deaths in this country. Considering the magnitude and seriousness of suicide as a public health problem and the great need for more understanding and education to further prevention of suicide, the author chose suicide as her area of concern.

The most recent available governmental statistics indicate that over 25,000 completed suicides are recorded each year. This is approximately one suicide every twenty minutes. But in view of the fact that many cases are still disguised as fatal accidents or are recorded under other causes of death, this is a minimal number. Suicide is the tenth leading cause of death in adults and sixth in some states. Among college students suicide is the third leading cause of death; only accidents and cancer take more lives. More than half again as many college students commit suicide

than other young people (non-collegians) in the same age group. There are in addition to completed suicides eight to ten as many unsuccessful attempts (over 250,000) per year in this country.^{1,2}

The lack of information concerning suicide and/or its clues, causes, and prevention is alleviated somewhat by the formation in 1966 of a National Center for Studies of Suicide Prevention within the National Institute of Mental Health. By emphasizing suicide research and training and by encouraging the growth of suicide prevention activities it aims, hopefully, to reduce the number of suicides in the United States. The first National Conference on Suicidology was held in May, 1968.

In 1882 Dr. James O'dea in his book, Suicide, said,

There is a growing and even urgent need to punish attempts at suicide. Contemporary society, however, is so apathetic to the evils of suicide that whatever legislations may attempt punishment in the future, other means for suicide prevention must be looked for.

The main need of those tempted to commit suicide is not legal punishment but help. The "crime" lies in the lack of help available. Even though suicide is an important psychiatric, psychologic, sociologic, cultural, and medical phenomenon, there is very little investigation and analysis

¹Louis I. Dublin, "Suicide: An Overview of a Health and Social Problem," Bulletin of Suicidology, (December, 1967), 25.

²Edwin S. Shneidman, "Some Current Developments in Suicide Prevention," Bulletin of Suicidology, (December, 1967), 31.

concerning it. Suicide is more frequent than murder and is more easily predicted or prevented. There has never been a wide campaign against it as there has been against other less easily preventable forms of death.

One aspect of suicide prevention, therefore, might be to arrange for appropriate rescuing responses to more or less disguised and ambivalent communications about suicide. The problem being considered is how to effectively respond to suicidal communications. The solution proposed is an application of crisis theory and therapeutic intervention for suicide prevention.

A crisis as defined by Gerald Caplan, is a disorganization of homeostasis as characterized by acute or prolonged inner tension, unpleasant affect, and disorganization of behavior when faced by a problem which cannot be solved quickly by the individual's normal range of problem-solving mechanisms.³

Crisis intervention is defined as the initiation and timing of therapeutic efforts during the crisis that can influence the situation toward a good outcome. Suicidal communications are verbal and nonverbal indications of suicidal thoughts.

The author is limited in the writing of this paper because of the lack of scientific data on the subject. Although several men of various fields have related their

³N. L. Farberow and S. M. Heilig, "Procedures and Techniques in Evaluation and Management of Suicidal Persons," Los Angeles, 1965, p. 1. (Mimeographed.)

interpretations of the crisis theory, only one organization has utilized data toward proving its effectiveness in suicide prevention. This is the Benjamin Rush Division of the Suicide Prevention Center of Los Angeles.

There are three levels of suicide prevention. The goal of primary prevention is to make it unnecessary for the suicidal crisis ever to occur. Through practices and education of good mental health and provisions for outlets of tensions and frustrations, this is practiced by many facets of society. Secondary prevention is the effective treatment of an existing suicidal crisis. Tertiary prevention is the reduction in the amount of disability in the survivor as caused by the irreversible suicidal event.

The author bypasses primary and tertiary prevention in the scope of this study and concerns herself with secondary suicide prevention only. Secondary prevention includes professional assistance by psychiatrists, psychologists, social workers, nurses, doctors, plus family members, clergy, and friends who assist the individual in crisis to overcome his feelings of hopelessness and helplessness. It also includes the use of antidepressant drugs and other chemical substances. Among those methods being researched for suicide prevention are the relationships of sleep to suicidal activity, peculiarities of reasoning of an individual, and possible biochemical reasons for suicidal inclinations.

Of major importance among the changes proposed in the mental health field are the treatment of the individual

in the community without hospitalization, shortening the length of hospital stay when it is required, and a stress on preventive measures requiring rapid assessment and immediate treatment.⁴

Preventive measures which can be utilized and some of the alternatives to hospitalization to alleviate crises include diagnosis and evaluation services, emergency psychiatric units, outpatient services, inpatient services, day and night care, foster home care, rehabilitation, consultative services to other community agencies, and mental health information and education. This paper will concern itself primarily with one of these services, that of crisis-oriented immediate-access outpatient treatment.

Following is a brief history of crisis treatment as needed for an understanding of the development and current concepts of the crisis theory.

II. HISTORY OF CRISIS TREATMENT

Considered briefly will be the history of crisis theory. The theory developed to a large extent out of the work of Dr. Eric Lindemann in his 1943 study of bereavement reactions among the survivors of those killed in the Coconut Grove night club fire.⁵ He described both grief and abnormally prolonged reactions occurring in different individuals as a result of the loss of a significant person in their lives. He also discussed the "grief work", a process through which a person resolved the distress brought about by his loss, and also outlined the phases through which a person passes. In 1946, Lindemann, along with Dr. Gerald Caplan, established a community-wide program of mental health in the Harvard area, called the Wellesley Project. They postulated that, in the face of an emotional hazard, there are adaptive and maladaptive methods of attempting to cope with the problems which have major influence upon later adjustment and ability of the individual to cope.

Many "emergency clinics" serve primarily as assessment and referral agencies. Among these are Dr. Leopold

⁵Eric Lindemann, "Symptomatology and Management of Acute Grief," American Journal of Psychiatry, CI (September, 1944), 1303-1308.

Bellak's Trouble Shooting Clinic⁶ initiated in 1958 at the City Hospital at Elmhurst, New York City; Doctors M. Donald Coleman and Israel Zwerlig's Emergency Psychotherapy approach begun in 1959 at the Bronx Municipal Hospital⁷; the Precipitating Stress focus psychotherapy approach of Doctors N. Robert Harris and Betty L. Kalis⁸ at the Langley Porter Clinic; the emergency outpatient clinic sponsored by the Los Angeles Society of Clinical Psychologists begun in 1963; and the Benjamin Rush Center Division of the Los Angeles Psychiatric Services founded by Dr. Gerald Jacobsen in 1962.

Motivated by their compassion a majority of non-professional people began operating the first suicide prevention services early in this century. In 1958 the first full-scale, scientifically-oriented suicide prevention operation began in Los Angeles. It had a staff of psychiatrists, psychologists, and social workers, plus a number of carefully selected and trained lay volunteers who helped man the telephones. During the first month more than 600 persons contacted the 24-hour service for help.

In 1965 there were fifteen suicide prevention

⁶Leopold Ballak, "A General Hospital as a Focus of Community Psychiatry," Journal of the American Medical Association, CLXXIV (December 31, 1960), 2214.

⁷M. Donald Coleman and Israel Zwerlig, "The Psychiatric Emergency Clinic: A Flexible Way of Meeting Community Mental Health Needs," American Journal of Psychiatry, CXV (May, 1959), 365.

⁸M. R. Harris and B. L. Kalis, "Precipitating Stress; An Approach to Brief Therapy," American Journal of Psychotherapy, XVII (July, 1963), 465-471.

services in the United States. In April, 1968 there were sixty-three centers, and by August, 1968 there were a reported ninety centers in twenty-six states.⁹

In England is what Louis I. Dublin calls the largest and most successful suicide prevention effort in the world. There are fifty-five centers directed by non-medical people and by volunteers who call themselves the Samaritans.¹⁰

⁹"The Way of Suicide," Newsweek, LXXI (April 12, 1968), 97.

¹⁰Bryce Nelson, "Suicide Prevention: NIMH Wants More Attention for 'Taboo' Subject," Science, CLXI (August 23, 1968), 766.

III. CRISIS THEORY

The following discussion of crisis theory is based for the most part on the work of Eric Lindemann and Gerald Caplan.^{11,12,13}

An initial distinction is made between an emotionally hazardous situation, a crisis, and an emotional predicament. An emotionally hazardous situation is one wherein any sudden alteration in the field of social forces causes the individual's expectations of himself and of his relations with others to undergo change; such alterations could involve loss of or threatened loss of a significant relationship, introduction of one or more significant new individuals into the social orbit, or transition in social status and role relationships as a consequence of such factors as maturation, achievement of a new social role, or horizontal or vertical social mobility.

Crisis is a term reserved for the acute and often

¹¹Donald C. Klein and Eric Lindemann, "Preventive Intervention in Individual and Family Crisis Situations," in Prevention of Mental Disorders in Children, ed. by Gerald Caplan (New York: Basic Books, Inc., 1961), 283-307.

¹²Gerald Caplan, Principles of Preventive Psychiatry (New York: Basic Books, Inc., 1964), 24-39.

¹³G. Caplan, An Approach to Community Mental Health (New York: Grune & Stratton, Inc., 1961), 67-82.

prolonged disturbance that may occur to an individual or a social orbit as the result of emotional hazard. An emotional predicament is a generic term to encompass the distressed individuals, the crisis situation, and the emotional hazard, all of which must be appraised and assessed.

Conceptual Framework of Crisis

The general framework of crises is as follows. As a general rule, the individual is in a state of relative equilibrium, stability, or homeostatic balance. This state of balance of emotional functioning is maintained by means of particular behavioral patterns, involving complicated interchanges between the individual and the meaningful persons in his environment. This equilibrium occurs for every individual at a point on a continuum of mental health, one pole being optimal mental health and the other being the various types of mental ill health. As a general rule, as a person faces problems in his daily life he may become temporarily emotionally upset but soon returns to a state of equilibrium and his place on the continuum of mental health does not change. These temporary upsets are typically solved by means of previously learned coping techniques, tension-tolerance, experience with and therefore expectation of a successful outcome, and various mechanisms of tension discharge. However, when the problem is greater, when it corresponds in a significant manner to problem areas within the individual, or when the previous problem-solving

mechanisms are unsuitable, then the individual moves from an emotionally hazardous into a crisis situation. This period of crisis, the more or less protracted period of emotional upset, is followed by a new state of equilibrium, this one at a different point on the mental health scale.

The disturbance associated with crisis may not, in itself, be an illness. Instead, it is a condition that arises because the individual faces an integrative task for which his coping resources are inadequate.¹⁴

Characteristics of Crisis

What then are the characteristics of crisis? It should be noted initially that crisis as here defined refers only to the emotional state of the individual, his reaction to a hazardous situation, and not to the hazardous situation itself.

Caplan divides the crisis period into four phases.¹⁵ The first is the rise of tension, unpleasant affect, and disorganization of behavior stemming from the impact of the stimulus and calling forth the habitual problem solving techniques in attempt to return to the state of previous equilibrium. Second, a lack of success along with the continuation of stimulus impact exacerbates the state of tension. The third stage is characterized by the tension

¹⁴ Martin Strickler, "Applying Crisis Theory in a Community Clinic," Social Casework, XLVI (March, 1965), 306-307.

¹⁵ Caplan, Principles of Preventive Psychiatry, pp. 307-321.

reaching a point where it mobilizes additional internal and external resources. This may result in the following:

(a) the problem abating in intensity, (b) the use of emergency problem solving mechanisms, (c) defining of the problem in a new way, (d) the giving up of certain goals as unattainable, or (e) exploring by trial and error. In the fourth phase, if the problem continues and can neither be solved by need-satisfaction nor avoided through giving up goals or perceptual distortion, the tension mounts beyond a further threshold or its burden increases over time to a breaking point. Major disorganization of the individual with drastic results then occurs.

Key Implications Arising out of Theory

There are a number of key implications arising out of crisis theory. One, a person in crisis is ripe for great change in a relatively short time because of his disequilibrium and the extreme tension he is experiencing. Caplan has suggested, for example, that "during the upset of a crisis, a person is more susceptible to being influenced by others than at times of relative psychological well-being."¹⁶ Referring to this increased susceptibility, Caplan also suggests,

From a preventive psychiatric point of view, this is a matter of supreme importance; because by deploying helping services to deal with individuals in crisis, a small amount of effort leads to a maximum amount of lasting response.¹⁷

¹⁶Caplan, An Approach to Community Mental Health, 13.

¹⁷Caplan, Principles of Preventive Psychiatry, 82.

A minimal force, therefore, exerted by a family member, therapist, or care-taking agent can govern the outcome of the crisis to a significant degree.

The second implication of the crisis theory is that a crisis repeats important features of a person's emotional struggles, but the outcome is not totally determined by this. Current psychological forces play a large role.

Third, equilibrium following a crisis may be re-established at a lower or a higher point on the mental health continuum. Enduring positive changes can be achieved following a crisis, and crisis may have widespread results in the adjustment and coping capacity of the individual in future crises and in his overall adjustment and life. This can occur through the loss of a psychological defense or support for such a defense, because the person is forced into a position of assuming more and more mature responsibilities, or through the enforced reality-testing resulting in more accurate self-perception.

Factors Influencing Outcome of Crisis

Several factors influence the outcome of crisis, and determine whether it results in increased individual fulfillment or in lasting disruption of behavior. As previously noted, previous experience, personality dynamics, and the person's armamentarium of coping techniques influence but do not directly determine the outcome. Every crisis is by its very nature a novel and unique case, and

its outcome may be affected by a variety of factors. Among these are physical health, the choices made on significant variables, chance, the availability of helping resources. Also of influence are intrapsychic factors such as the extent to which the crisis situation is dynamically linked to parallel problems of the past. Unresolved previous conflicts cause distortions in perception of pertinent elements in the present situation and restrict the individual's capacity for modifying behavior to cope with the difficulty.

IV. SUICIDAL SITUATION AS A CRISIS

Prominent Aspects

The suicidal person is usually in the midst of a crisis. This includes not only the emotional hazard but the potentially hazardous situation itself. In a suicidal crisis there is a radical change in the person's view of himself and of his relationships with others. In thinking about his problems, a suicidal person is often severely constricted; it is difficult for him to generate new ideas, feelings, or plans without help from others. His limited perception causes him to forget the past and makes the future unimaginable. His view of the present is rigidly confined to a small number of alternative behaviors of which suicide is one.¹⁸

Ambivalence

One of the most prominent features characterizing the suicidal person is ambivalence, expressed through feelings of wanting to die and wanting to live, both occurring at the same time. An example of ambivalence is the person who ingests a lethal dose of barbituates and then calls someone for rescue before he loses consciousness. The relationship and strength of the two opposing impulses to live and to die will vary for different persons, and also

¹⁸D. Klugman, R. Litman, and C. Wold, "Suicide: Answering the Cry for Help," Social Work, (October, 1965), 44.

within the same person under different conditions. Most people have a stronger wish to live than to die. It is this fact of ambivalence which makes suicide prevention possible. Suicide prevention depends directly upon an effective response to suicidal communications.¹⁹

Communication

Suicidal activity is frequently a last method of expression when persons feel hopeless about the direction of their lives and helpless to do anything about it. The communication can be verbal or behavioral (nonverbal). Verbal communications may be threats, ideation, or fantasies. Suicidal notes and other written communications would be included here. Nonverbal communications range from actual attempts to destroy the self to less immediate, less direct self-injurious behavior.

Degree of directness.--The communication may also be either direct or indirect and to a specific person or to the world in general. The main significance of the audience to whom the communication is directed is what their anticipated reaction to the communication will be. In general, the audience can be divided into two main groups: those who are likely to react with lifesaving responses to the communication, and those who are likely to react with

¹⁹Norman L. Farberow and Edwin S. Shneidman, ed., The Cry for Help (New York: McGraw-Hill Book Company, 1965), 65-67.

indifferent or even hostile responses.

If the communication is directed toward the first group, the self-destructive potentiality is considered to be much less than if it is directed toward the second group.²⁰

Purpose.--Sometimes the purpose of the communication is subtle; sometimes it is very explicit. The most encouraging purposes are to enter a plea for consideration and cry for help.

Environment

The development of impulses, tendencies, and ideations toward self-destructive activity do not occur only as a result of factors within the individual. A person usually lives in close, intimate relationship with a small group within a social milieu. Stemming from the quality of the interrelated significant others within the environment is the development of motivations and needs of the individual. Emile Durkheim, a pioneer in developing the social theory of suicide said:

Although suicide is a highly personal act, it is explicable only by the state of the society to which the individual belonged....Serious faults in the social structure lead to an increase in suicide rates. The more strongly the individual is integrated with social groups, the smaller is the likelihood of suicide.²¹

²⁰Norman D. Tabachnick and Norman L. Farberow, "The Assessment of Self-destructive Personality," in the Cry for Help, ed by Norman L. Farberow and Edwin Shneidman (New York: McGraw-Hill Book Company, 1965), 70.

²¹Emile Durkheim, Suicide: A Study in Sociology, (Glencoe, Illinois: The Free Press, 1951), p. 300 quoted in Erwin Stengel, Suicide and Attempted Suicide (Barton Manor, England: Macgobbin and Kee, 1964), 43.

Predicaments often arise when, as the result of new demands upon one or more members of a group, previous patterns are no longer satisfactory. Serious individual and group tensions arise as old patterns persist and become increasingly maladaptive. The very strivings of the individual or reactions resulting from their frustration may be pathologic for the individual in question and a pathogenic force for the group. The individual may need help in securing outlets for strivings that cannot be satisfied within his present social orbit.²²

²²Caplan, Prevention of Mental Disorders, pp. 289-292.

V. CRISIS INTERVENTION TO PREVENT SUICIDE

Organized Efforts: Suicide Prevention Centers

The very stresses creating a crisis can also create the necessary impetus and dynamic readiness for change. As it is stated in the old English proverb, "Despair doubles our strength." A potential helping agency for change is the suicide prevention center.

According to the Second Directory of Suicide Prevention Facilities (winter, 1968) a suicide prevention facility is any emergency program providing a 24-hour, 365 day a year telephone answering service. Of the sixty facilities operating at that time, the directors of these programs included fifteen physicians, eight social workers, fifteen unknown, five psychologists, two nurses, and seventeen clergy. Again considering the sixty facilities reporting to the National Institute of Mental Health Suicide Prevention Study Center, the sixty programs function under the following auspices: twenty-two independent and autonomous, ten with local mental health associations, eight with county department of mental health, eight with hospital (psychiatric and general), eleven with mental health clinics or community mental health centers, two with universities, and one with a social agency.

The cost of operation for these services varies greatly. It partly depends on the location of the telephone and needed space; presence of a salaried full or part-time coordinator; and use of volunteers (both professional and non-professional mental health workers) to serve on advisory and training committees, man the twenty-four hour telephone answering lines, provide manpower for research projects, and/or to obtain support and cooperation.²³ Professionals may double up on their present job to cover the telephone when off duty and rotating nights. Also students in social work, nursing, psychology, and medicine can be utilized as well as dedicated citizens and non-working professionals.²⁴

For the suicide prevention worker in a telephone service the primary goal is to stop the caller from killing himself, not to solve all the problems a deeply troubled person faces. Suicide prevention need have only limited mental health goals. Similarly, an active suicide prevention service has a limited goal. It provides a ready contact between the community's highly disturbed citizens and the established helping agencies which are available for them.

²³Anson Haughton, "Suicide Prevention Programs in the United States--An Overview," Bulletin of Suicidology (July, 1968), pp. 3-7.

²⁴Robert Litman, M.D.; Norman Farberow; Edwin Shneidman; Sam Heilig; and Jan Kramer, "Suicide Prevention Telephone Service," Journal of the American Medical Association, CXCVII (April 5, 1965), p. 21.

The role of the suicide prevention worker can be divided into three phases. First, he obtains necessary information, then he forms an evaluative judgment of the situation, and finally he recommends appropriate action. He may, for example, recommend immediate hospitalization for a case; or he may interpret the suicidal communication as having low lethal potentiality and recommend outpatient treatment. Frequently he makes arrangements for additional evaluative interviews with the aim of developing a more definitive treatment plan.

As a method of assembling information, the telephone interview under emergency pressures has definite shortcomings. There is a tendency for the most dramatic and emotionally disturbing aspects of the picture to obscure other equally relevant elements. Several important questions may remain unanswered. The consultant may recommend a course of action based on incomplete data when actually more complete information was potentially available.²⁵

Ideally a suicide prevention center would provide therapists for personal contact interviews in an outpatient facility. Many of the existing centers provide this service. By eliminating the waiting list and focusing on the crisis the evaluation process as such does not loom so separate or so important as it does in a traditional clinic. The goal toward which the consultant is working is explicit-- to aid the consultee to return to at least his pre-crisis level of

²⁵Robert E. Litman and Norman L. Farberow, "Emergency Evaluation of Self-Destructive Potentiality," in the Cry for Help, ed. by Norman L. Farberow and Edwin Shneidman (New York: McGraw-Hill Book Company, 1965), p. 48.

What then is the specific methodology as used by a suicide prevention center (including outpatient facility) for crisis intervention?^{26,27,28} The steps outlined below are somewhat overlapping, and of necessity are flexible so they may meet needs of each individual case.

The first step to be taken is that of the assessment of the problem. Initially, it is necessary to evaluate the consultee for possible need of hospitalization or emergency treatment. Of critical importance here is the immediate potential danger of the caller to himself or others.

Having ruled out the necessity of hospitalization, the assessment phase can proceed. This involves establishing that a crisis does indeed exist, arriving at a working diagnostic impression, reviewing historically the interpersonal relationships involved, considering the personalities of others involved, assessing the dynamics of the social orbit, and identifying the emotional hazards present in the individual's life space over the preceding several years.

The second step is then to plan the nature of the therapeutic intervention. This involves assessing the

²⁶ Klugman, "Answering the Cry for Help," pp. 45-46.

²⁷ N. L. Farberow and S. M. Heilig, "Procedures and Techniques in Evaluation and Management of Suicidal Persons," (September, 1965), Mimeographed.

²⁸ N. Farberow and J. Kramer, "Emergency Ploy Sheet," Los Angeles: Suicide Prevention Center Clinical Associates Program, August, 1965, (Mimeographed.)

degree to which the individual is reacting to the hazard, the degree of reaction of other members of the social orbit, and the duration of the present disequilibrium. Also of importance here is the assessment of the strengths of the individual and others involved which can be utilized for development of more adaptive behavior. Considered also is why the mechanisms which the consultee has used to cope with comparable situations in the past are not proving effective in dealing with the current stress.

The third step is the intervention itself. There are several techniques which are utilized here. One is to describe to the consultee the problem as the consultant sees it, integrating the present crisis into the perspective of his life pattern, still without losing the here-and-now orientation of the treatment. Another is to help him to gain a cognitive grasp of the issues at hand, at the same time bringing into the open his present feelings to which he may not have access. A third technique is to bring into play previously learned behavior patterns not being employed at present. A fourth is to explore with him the alternative mechanisms of coping with the problem, and different ways in which the problem may be seen and defined. A fifth is to consider re-peopleing his social world and re-distributing the role relationships within the group. A sixth is to clarify and re-emphasize the individual's responsibility for his own behavior, decisions, and way of life.

The list is not exhaustive, but offers possible avenues of intervention.

The fourth and final step is the resolution of the crisis and anticipatory planning. As time passes, and the hoped-for reduction in anxiety and increased ability to cope occur, a summary is made of the changes which have occurred, thereby reinforcing the adaptive behaviors which are developing. Help is given to the consultee in making realistic plans for the future. Although the necessity may not arise, plans for referral for long term treatment may be made if need and motivation for it are present. Also explored with him are specific ways of warding off future crises with the new coping tools which he has gained during the consultation.

Judging Effectiveness

There are two kinds of criteria for judging the effectiveness of suicide prevention programs. First, is the reduction of suicidal deaths. Second are the following criteria relevant to the entire area of suicide prevention: decrease in lethality of an individual; increase in mental health or psychological well-being; decrease in taboo or stigma of suicide; increase in the amount of coordination among mental health agencies in the community; improved methods for gathering data; and increased dissemination of information relating to suicide prevention.

VI. CONCLUSIONS

Gerald Caplan's theory of crisis apparently does support the dilemma of a suicidal individual. It is in the nature of crisis that it cannot be tolerated indefinitely. There, the initiation and timing of therapeutic efforts during the crisis can influence the situation toward a good outcome.

Many investigators have pointed out the presence of communication elements in suicidal behavior, so it appears that in many cases the opportunity exists for elements in the community to respond to the plea for assistance. One aspect of secondary suicide prevention is to provide appropriate rescuing responses to suicidal communications. In general the number of responses remains low.

The accessibility and availability of the suicide prevention center services provides a unique opportunity for therapeutic intervention. In Los Angeles this method has been shown to be effective, and the trend to establish such facilities is just beginning in this country. There will be a variety of organizational and funding models for suicide prevention, each growing out of the needs and peculiarities of the local community.

There is a fundamental relationship between clinical practice and research; clinical practice is improved largely through the findings of research efforts. A total program on suicide must therefore not only save lives today but investigate why persons take their lives, so that suicidal behavior can be prevented in the future by increased knowledge concerning its causes.

At present, suicide is not uniformly reported. What constitutes suicide in one county, city, or state is often not the same for the coroner in the neighboring area. Some coroners report as suicides only those deaths which are accompanied by suicide notes. In all cases, coroners and physicians are under pressure in their communities to certify suicides as accidental or natural deaths.

As suicide prevention takes hold across the country, more accurate and standard methods of reporting suicides will become the practice. Reported suicide totals will rise for a while.

Some general benefits of a crisis-oriented suicide prevention center could include the following:

1. Some presuicidal persons receive lifesaving treatment and/or referral who might not otherwise get treatment.
2. Much needed data, especially longitudinal studies of the lives of presuicidal persons are collected and analyzed.
3. The functioning of a number of different agencies

and community resources, where they are concerned with suicide, is facilitated, leading to smoother handling of presuicidal persons.

4. Educational information for police, physicians, judges, and others in a position to recognize presuicidal persons is provided.

5. Proper publicity to help overcome the popular prejudice against psychiatric hospitalization is disseminated.

6. An opportunity for experimental activities is provided.

These benefits fulfill to some extent the criteria for judging the effectiveness of this type of suicide prevention program. (Refer to page 24). The author's general impression is that these suicide prevention agencies serve extremely useful, indeed vital, functions and that they hold promise of providing at least partial answers to questions about self-destruction, concerning which adequate documentation is at present lacking. She hopes that suicide prevention centers will be established in many more communities throughout the world and that support will be found for these programs.

Just as there are fire stations throughout our country, there ought to be suicide-prevention centers in every part of the land. Communities throughout the country should be encouraged to establish some kind of suicide-prevention activity.²⁹

²⁹ Edwin S. Shneidman, "The NIMH Center for Studies of Suicide Prevention," Bulletin of Suicidology, (July, 1967), 3.

Insufficient data is available at this time to justify an evaluation of antisuicide efforts in relationship to the complex issue of how they affect the overall suicide rate. Suicide and suicide prevention will continue to present new problems.

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