Ensuring Safety and Providing Support

During problem definition, the phone worker must be very specific in determining the client's lethality level. If the worker detects the potential for physical injury, then closed-ended questions that obtain information specific to the safety of the client should be asked, not only without hesitation but also with empathic understanding that clearly depicts the worker's overriding concern for and valuing of the client. These questions typically start with *do*, *have*, and *are*, and in phone dialogues they should be put directly and assertively to the client. (For example, one might ask, "Do you have the pills there with you now?" Or "Are you alone, or is someone there who might help you before you do it?") The phone counselor should check what support systems are available to ensure the client's safety. For many phone clients, there will be no support system—the phone counselor is the immediate and sole support system.

CW: I can really hear the hurt and fright in your voice. It's scary being all alone, seeming to have nobody to lean on. I'm concerned about your saying this was your "last chance." Do you mean by that you're thinking of suicide?

TC: (*somewhat emphatically*) I had, but I just couldn't bear to see that bastard and his new girlfriend get custody of Jimmy.

CW: OK. That's good! I needed to check that out. Now you said you were staying with an old college friend, and she asked you to call. Is that where you are now?

TC: Yes, but I hate putting her out like this. But I don't have any other place to go. (*Starts sobbing heavily again.*)

CW: But she's OK with you staying there?

TC: Yesssss. But I hate being a burden on her.

CW: But that's what friends are for. Would you do the same for her if things were reversed?

TC: Well, sure, no question.

CW: So for the time being you've got a roof over your head, something to eat, and are safe?

TC: Yes, I guess so, but I don't know how long this can go on.

CW: What we're going to do is see if we can get some stuff done that will allow you to get back on your own. OK? Are you willing to do that? (*Cicily acknowledges she'll try.*) Good! Although I can't get your husband back, and I know that really left you feeling hopeless and all alone, I can find out about the job problem and perhaps see if we can't do something about that. So let's start with that if it's OK with you. We've got a number of referral sources here that might be able to match your skills, education, and abilities with a job. Would you be willing to tell me a little bit about yourself in that area—education, employment background, desired kind of work? I could pass that on to some of our referral sources and see what we could do. (*Chris listens while Cicily goes through her background, education, and other pieces of pertinent information, reinforcing her for staying on task, mobilizing her thoughts, and keeping her terrifying emotions in control.*)

Looking at Alternatives and Making Plans

Creating alternatives and formulating a plan are integral to one another in any crisis situation but are even more closely tied together in phone counseling. To alleviate the immediate situational threat, the phone counselor needs to jointly explore alternatives that are simple and clear-cut. Without the benefit of an eyewitness view or an in-depth background of the client, the worker needs to be cautious about proposing alternatives that may be difficult to carry out because of logistical or tactical problems of which the worker is unaware. Alternatives need to be explored in a slow, stepwise manner with checks by the worker that the client can do the physical and psychological work necessary to complete the task. Role play, verbal rehearsal, and having the client recapitulate objectives are vital ingredients of a functional plan. No plan should be accepted until the client can reassure the worker that he or she thoroughly understands the plan and has the means and ability to put it into action.

CW: OK! I've got that information. I'll pass it along to the day shift, and they'll pass it along to the JOBS Council and a couple of employment agencies that work with us. I want you to call back to our number tomorrow about 1 P.M. and we'll have some information for you. Can you do that?

TC: Well yes, I can do that. (*Cicily has calmed down and is only occasionally sniffling and lamenting her outcast state. Her triage scale score has moved down to about 15. Chris now approaches other areas of her crisis.*)

CW: I wonder what you did when you got into predicaments beforehand? Maybe there was nothing

quite like this, but I'm guessing there were other times when you were overwhelmed.

TC: Well, nothing like this, but I did take care of my mother before she died, kept a job with a printing company, and worked on my degree. Sometimes that was pretty overwhelming.

CW: So what did you do to take care of being overwhelmed?

TC: I'd make a list and set down my goals of what I was going to do and what I had to do. Like Alcoholics Anonymous, one day at a time, you know. It worked pretty well, but I just have got so many things now, I don't know if I can get it all lined out.

CW: But that worked before, and I understand there are lots of things going on like never before, but if it worked then, how's about giving it a try now? (*Chris immediately seizes on her past coping technique and attempts to put it to work. He acknowledges her belief that this is indeed different than before and doesn't discount the fact that it may be tough. He methodically helps her develop a game plan for tomorrow, not the rest of her life.*) So we've got day care for Jimmy taken care of, and you don't really need the car for a while, you can get a bus or streetcar and go anywhere you need to. Even though you've only got 200 bucks cash, you could cash in that $3,000 worth of U.S. savings bonds your mother gave to Jimmy if you had to, until you got back on your feet. You could then repurchase them, so you won't feel like you're robbing your son of his inheritance. So you've written those things down that you can do tomorrow, right? So we're just managing this, like you say, one day at a time, not worrying much beyond that and doing what can be done. Do you feel like we're making progress?

TC: I guess I do. I can do those things.

Obtaining Commitment

Commitment to a plan of action generated over the phone should be simple, specific, and time limited. If at all possible, the worker should try to obtain the client's phone number and call the client back at a preset time to check on the plan or, if the agency accepts walk-in clients, the worker should try to have the person schedule an appointment as soon as possible. If the worker is linking with other agencies, then a phone call should be made to the referral agent to check whether the client has completed the task. Although it is preferable to have the client take the initiative in contacting other agencies so that dependence on the worker is not created, conditions may block the client from doing so. In that case, the worker should have no hesitation in offering to make the call.

CW: So there are three things you're going to do tomorrow. First you're going to call the day care number I gave you and get Jimmy in there. Second, you're going to go to the bank and open an account and cash in the bonds. Third, you're going to call back here at 1 P.M. and ask for the information on the job hunt. Those places I told you about will probably want you to come down, so you'll call them and make an appointment. Will you call back tomorrow night and ask for me? I come on at 11 P.M. I know this has been a pretty upsetting deal, so could you kinda repeat that to me and write down that stuff?

TC: Yes. I've got it. (*Cicily repeats to Chris the steps he has outlined.*) And I'll call back. Thanks a lot. You're a real lifesaver.

CW: You're welcome. Now get a good night's sleep. It's a fresh day tomorrow, and you'll get through it fine with that attitude. (*Chris judges Cicily now to be at a total triage rating of about 8. Affectively she is in control of her emotions. She is thinking clearly enough to help establish a plan in a collaborative manner with the crisis worker and has committed to act on it the next day. Chris judges her to be mobilized enough that he can let her go off the line and reinforces her for getting back into equlibrium.*)

The call has taken more than an hour and a half, but in that time a woman who is in a severe developmental and situational crisis has been able to grieve away some of the lost relationship with her husband, work through her terror of being all alone and jobless in a strange city, and start to make specific plans on how she'll get out of the dilemma. She still has many issues and a long road ahead of her, but she has returned to being a functional human again. By any criterion of therapy, the crisis worker has done a good night's work!

Errors and Fallacies

LO3

For most of our students who volunteer for crisis line duty, to say that they are scared pea green on their first shift is putting it mildly! Lamb (1973, 2002) has listed a number of irrational ideas

that beginners indoctrinate themselves with as they start their careers as phone counselors. We list them here as a way to depropagandize and calm those of you who are about to start on this grand adventure.

First, you are not omnipotent! You are not there to be the instant expert. Your thoughts of "if only I were a psychiatrist, licensed social worker, counseling supercomputer, I could help this person" are doomed to failure. Nobody is an expert on everything that comes into a crisis line. There is no specific piece of information, if found, that will magically transform the caller into a paragon of good mental health.

Second, talking about "it," whatever "it" is, from suicide to getting a hair replacement, will not make "it" happen, and you will not be the instigator of causing "it" to happen. Callers are resilient and need somebody to talk honestly and openly about "it." Particularly in regard to suicide, tiptoeing around the topic generally indicates to the client that "it" is indeed scaring the daylights out of you too! If you can get an inkling of what "it" is, bring it out into the light of day, specify "it," and talk about "it."

Third, if you feel at times you are being manipulated, you probably are, and that is okay too—within limits. Understand that the caller's need to manipulate you is serving a purpose. As long as that purpose results in restoring the caller to psychological equilibrium without harming anyone, you are doing what you need to do. On the other hand, you are not a doormat to be walked over.

Fourth, all callers are not loving human beings, and you do not have to be Mother Teresa, loving and caring and sharing to all. Many people call exactly because they are *not* loving human beings! They are often overbearing, boring, nasty, insulting, hateful, and a pain in the neck! Having made that assessment, you now know why the caller is facing rejection from others and can directly speak to how his or her actions affect you and reflect on how those actions must be problematic when dealing with others.

By the same token, some callers like to gripe about the incompetence of other agencies, therapists, and significant others who have failed miserably to help them and have made their lives worse. They may be right. Agencies, therapists, and significant others are composed of human beings who get tired of being manipulated and taken advantage of. Questioning your credentials is really more of a question of "Can I really trust you? Can you understand what I am feeling?" Defending yourself and your credentials is pointless. Dr. James, licensed psychologist, licensed professional counselor, National Certified School Counselor, licensed English teacher, licensed school administrator, licensed real estate agent (retired), licensed fisherman, and world-renowned author of crisis textbooks can't! So why should you think you can? Don't get caught up in defending yourself, but rather turn the question back on the caller: "I don't think that is really what you are concerned about, but maybe you are wondering whether you can trust me. Why not run it by me, and let's see?"

Finally, there is the delusion of fixed alternatives. The beginner believes either "If I can't think of it, there must be no answer" or "If that's all I can think of, it must be the only answer." Or, alternatively, "I'll call a consultant. Surely he or she will know." None of these is correct. When you fall under this delusion, crisis intervention is stopped dead in its tracks. Crisis intervention is one part inspiration and nine parts perspiration. You muddle through this together. Solutions are created, not found. Further, you need to understand that you can't palm this caller off on another agency just because the problem is a tough one and you are at a loss as to what to do. Calling the police department Crisis Intervention Team may be appropriate, or it may not. You need to know what other agencies can or cannot do. If you don't know, find out before you embarrass yourself.

What in the world can you do then? You can be yourself. You got into this because you thought you have some pretty good human qualities. You undoubtedly do, so use them. You are there to listen. Few beginners ever believe this, but sometimes, a lot of times in fact, listening is more than enough. You can help the caller come up with alternatives and solutions, or suggest some resources to pursue. You won't know *all* the resources available, but as time goes on you will learn more. You will also learn your own limits and can be honest in owning when you are tired, confused, lacking in knowledge, or downright irritated with the hateful way the caller is acting. You are a pretty good human being doing your best under some trying circumstances. That's it! End of omnipotence!

Regular, Severely Disturbed, and Abusive Callers

LO4

The foregoing dialogue is a textbook example of how things ought to go in telephone crisis line work. The problem is that the real world seldom

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CW: I can really hear the hurt and fright in your voice. It's scary being all alone, seeming to have nobody to lean on. I'm concerned about your saying this was your "last chance." Do you mean by that you're thinking of suicide?

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TC: Yes, but I hate putting her out like this. But I don't have any other place to go. (*Starts sobbing heavily again.*)

CW: But she's OK with you staying there?

TC: Yesssss. But I hate being a burden on her.

CW: But that's what friends are for. Would you do the same for her if things were reversed?

TC: Well, sure, no question.

CW: So for the time being you've got a roof over your head, something to eat, and are safe?

TC: Yes, I guess so, but I don't know how long this can go on.

CW: What we're going to do is see if we can get some stuff done that will allow you to get back on your own. OK? Are you willing to do that? (*Cicily acknowledges she'll try.*) Good! Although I can't get your husband back, and I know that really left you feeling hopeless and all alone, I can find out about the job problem and perhaps see if we can't do something about that. So let's start with that if it's OK with you. We've got a number of referral sources here that might be able to match your skills, education, and abilities with a job. Would you be willing to tell me a little bit about yourself in that area—education, employment background, desired kind of work? I could pass that on to some of our referral sources and see what we could do. (*Chris listens while Cicily goes through her background, education, and other pieces of pertinent information, reinforcing her for staying on task, mobilizing her thoughts, and keeping her terrifying emotions in control.*)

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Creating alternatives and formulating a plan are integral to one another in any crisis situation but are even more closely tied together in phone counseling. To alleviate the immediate situational threat, the phone counselor needs to jointly explore alternatives that are simple and clear-cut. Without the benefit of an eyewitness view or an in-depth background of the client, the worker needs to be cautious about proposing alternatives that may be difficult to carry out because of logistical or tactical problems of which the worker is unaware. Alternatives need to be explored in a slow, stepwise manner with checks by the worker that the client can do the physical and psychological work necessary to complete the task. Role play, verbal rehearsal, and having the client recapitulate objectives are vital ingredients of a functional plan. No plan should be accepted until the client can reassure the worker that he or she thoroughly understands the plan and has the means and ability to put it into action.

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TC: Well yes, I can do that. (*Cicily has calmed down and is only occasionally sniffling and lamenting her outcast state. Her triage scale score has moved down to about 15. Chris now approaches other areas of her crisis.*)

CW: I wonder what you did when you got into predicaments beforehand? Maybe there was nothing

follow through on what they promised to do—which makes them extremely exasperating (Waters & Finn, 1995, p. 269). Regular callers may tend to be placed in a stereotypical catchall category because they represent an aggravation to the crisis line. However, the reasons these people call are diverse. Identifying specific types is at least as important as identifying the specific caller (Peterson & Schoeller, 1991). To this end, McCaskie, Ward, and Rasor (1990) have constructed brief descriptions of some of the more typical personality disorders of regular callers, their outward behavior, inner dynamics, and strategies for counseling them.

Paranoid. People with paranoia are guarded, secretive, and can be pathologically jealous. They live in logic-tight compartments, and it is difficult if not impossible to shake their persecutory beliefs. They see themselves as victims and expect deceit and trickery from everyone. The counseling focus is to stress their safety needs.

Schizoid. Those with schizophrenia have extremely restricted emotional expression and experience. They have few social relationships and feel anxious, shy, and self-conscious in social settings. They are guarded, tactless, and often alienate others. The counseling focus is to build a good sense of self-esteem through acceptance, optimism, and support.

Schizotypal. People with schizotypal behavior have feelings of inadequacy and insecurity. They have strange ideas, behaviors, and appearances. The focus of counseling is to give them reality checks and to promote self-awareness and more socially acceptable behavior in a slow-paced, supportive manner.

Narcissistic. Narcissists are grandiose, extremely self-centered, and believe they have unique problems that others cannot possibly comprehend. They see themselves as victimized by others and always need to be right. The focus of counseling is to get them to see how their behavior is seen and felt by others, while not engaging in a "no-win" debate or argument with them.

Histrionic. People with histrionic personality disorder move from crisis to crisis. They have shallow depth of character and are extremely ego-involved. They crave excitement and become quickly bored with routine and mundane tasks and events. They may behave in self-destructive ways and can be demanding and manipulative. The focus of counseling is to stress their ability to survive using resources that have been helpful to them in the past.

Obsessive-Compulsive. Those with obsessive-compulsive disorder are preoccupied by and fixate on tasks. They expend and waste vast amounts of time and energy on these endeavors. They often do not hear counselors because of futile attempts to obtain self-control over their obsessions. The focus of counseling is to establish the ability to trust others and the use of thought stopping and behavior modification to diminish obsessive thinking and compulsive behavior.

Bipolar (Manic Depressive). The extreme mood swings of these callers range from "superman/superwoman" ideation when in a manic phase to "born loser" ideation in a depressive stage. If they feel thwarted in their grand plans, they may become very aggressive to those who would stop them. At the other end of the continuum, their depressive "doom, despair, and agony on me" outlook puts them at risk for suicidal behavior. Slowing down and pacing these callers in the manic phase is difficult but needs to be done to put a psychological governor on their runaway behavior. Confrontation about their grandiose plans only alienates them. In the depressive stage, suicide intervention is a primary priority.

Dependent. People with dependent personality disorder have trouble making decisions and seek to have others do so—often inappropriately. Feelings of worthlessness, insecurity, and fear of abandonment predominate. They are particularly prone to become involved and stay in self-destructive relationships. The focus of counseling is to reinforce strengths and act as a support for their concerns without becoming critical of them or accepting responsibility for their lives.

Self-Defeating. Those with self-defeating behavior choose people and situations that lead to disappointment, failure, and mistreatment by others. They reject attempts to help them and make sure that such attempts will not succeed. The focus of counseling is stressing talents and the behavioral consequences of sabotaging themselves.

Avoidant. People with avoidant personality disorder are loners who have little ability to establish or

maintain social relationships. Their fear of rejection paralyzes their attempts to risk involvement in social relationships. The focus of counseling is encouragement of successive approximations to meaningful relationships through social skills and assertion training.

Passive-Aggressive. Those with passive-aggressive behavior cannot risk rejection by displaying anger in an overt manner. Rather, they engage in covert attempts to manipulate others and believe that control is more important than self-improvement. The focus of counseling is to promote more open, assertive behavior.

Borderline. Borderline personality disorder is so named because such people are chameleon-like and at any given time may resemble any of the foregoing mental disorders. Also, they are always on the "borderline" of being functional and dysfunctional. One of the most problematic of callers, they are dealt with at length in Chapter 5.

Handling the Severely Disturbed Caller

"The behavior of the severely disturbed is primitive, disorganized, disoriented, and disabling. These people are likely to elicit discomfort, anxiety, and outright fear in the observer. These are strange people. These are different people. These are people we lock away in mental institutions, pumping them full of strong drugs that turn the mania into docileness" (Greenwald, 1985b). This stereotypical public view of the mentally disturbed, quoted in the University of Illinois at Chicago's Counseling Center hotline training manual, introduces hotline workers to the mentally disturbed. These are many of the people who call crisis hotlines. On the neophyte phone counselor's first meeting with the disorganized and disjunctive thought processes of the mentally disturbed, all the training the crisis worker has ever received is likely to fall by the wayside.

LO5

These callers represent a cornucopia of mental illnesses. They may be delusional and hallucinatory; be unable to remotely test what they are doing, believing, or thinking against reality; be emotionally volcanic or conversely demonstrate the emotionality of a stone; lack insight or judgment about their problems and be unable to relate any linear or logical history of these problems; be so suspicious in their paranoid ideation that they believe even the phone worker is out to get them; be manipulative, resistant, and openly hostile and noncompliant to the simplest requests; not have the slightest idea of appropriate interpersonal boundaries with significant others or the crisis worker; demonstrate obsessive behavior and compulsive thoughts that they continually harp on to the exclusion of any effective functioning; have no meaningful interpersonal relationships with the possible exception of crisis line workers; impulsively place themselves in problematic and dangerous situations over and over; and present themselves in childlike or even infantile ways (Grunsted, Cisneros, & Belen, 1991). Whether these behaviors are biochemically or psychologically based makes little difference. These people are so distanced from our own reality and so threatening that the beginning phone counselor's immediate reaction is to get off the line! However, if the worker pictures the disturbed client as a person whose developmental processes have gone terribly awry, then the call may take on structure and sense and become less intimidating. No matter how bizarre the call may be, these primary axioms apply to the caller's behavior (Greenwald, 1985a, p. 1):

1. Behavior is always purposeful and serves motives that may be either conscious or unconscious.
2. Behavior is comprehensible and has meaning even though the language used may not.
3. Behavior is characteristic and consistent with personality even though it is exaggerated.
4. Behavior is used to keep a person safe and free of anxiety.

The following rules for dealing with disturbed callers are abstracted from a number of crisis hotlines (Epstein & Carter, 1991; Greenwald, 1985a, 1985b; Knudson, 1991; Lester & Brockopp, 1973; Tuttle, 1991).

Slow Emotions Down. Although disturbed callers have many feelings that have been submerged from awareness, it is not the best strategy to attempt to uncover these feelings. The caller is being besieged by too many feelings and needs to find a way to get them in control. Focusing on here-and-now issues that are concrete and reality oriented is the preferred mode of operation. Do not elicit more feelings with open-ended questions such as "Can you tell me more about that?" Instead, use calming interventions that force the person to order thinking in small, realistic bits of detail.

CW: I understand how scary those thoughts are that keep creeping into your mind and the "things" you think are in the room. What I want you to do right now is look around the room and tell me

what is there. Then tell me what happened to start this thinking.

The idea is to slow emotions down. Although the worker may acknowledge the feelings, they are not the focus of attention. By breaking up freewheeling ideation into discrete, manageable pieces, the telephone worker gives the caller a sense of regaining control. The worker may also bring the caller back to reality from a flashback by asking the client what he or she is doing.

CW: You say you're in that alley and he's assaulting you. Were you smoking a cigarette then? I know you just lit a cigarette a minute ago. I want you to slowly inhale, smell that smoke, and tell me where you are. Now blow the smoke out and see where it goes around the room.

Refuse to Share Hallucinations and Delusions. If a caller is hallucinating or delusional, the telephone worker should never side with the psychotic ideation.

Caller: Do you see, hear, smell, feel those things?

CW: No! I'm sorry, I don't. I understand right now you do, and that's terrifying, but what I want to do is get you some help. So stay with me. What is your address so we can get some support for you?

Little if any good ever comes of participating in such thinking, and as the delusion increases, it becomes difficult to extricate oneself from it. Yet grandiose thinking, no matter how bizarre, should not be denied.

CW: (*inappropriate and sarcastic*) Come on, now. The CIA isn't really listening to an auto mechanic by electronic eavesdropping. Certainly they've got better things to do than that. Why do you believe that?

CW: (*appropriate and empathic*) It's pretty clear that you really believe the CIA is listening to you. When did this start?

The worker affirms the paranoid delusion is real without agreeing to its veracity. By asking a *when* question, the worker can start eliciting information that will allow assessment of the scope and extent of the paranoia. A *why* question is never appropriate because of the defensive reaction it may elicit in any caller, especially a paranoid.

Determine Medication Usage. If at all possible, the worker should elicit information as to use of any medication, amount and time of dosage, and particularly, stopping medication without consulting the attending physician. Changing, forgetting, or disregarding medication is one of the most common reasons that people become actively psychotic (Ammar & Burdin, 1991). Furthermore, having this information will give the worker a better idea of the type of mental disturbance the caller is being treated for. Regardless of the reasons or excuses clients give for not taking medicine, the worker should endeavor to get them to their prescribing physician so medication can be adjusted or reinstituted.

CW: Lemuel, I want you to call up your doctor as soon as we get off the phone. I understand that the medicine gives you a bad taste in your mouth and makes you feel queasy. However, your doctor needs to know that, and you need to let her know you're not on your meds.

Becoming familiar with the major tranquilizers, antidepressants, and antipsychotic drugs is important for this work (Pope, 1991). However, given all the different kinds of drugs and their numerous generic and trade names, keeping track of them all is extremely difficult. The *Physician's Desk Reference (PDR)* provides information on what these drugs do, how much is generally given, and what the side effects are. No crisis line office should be without a current edition.

Keep Expectations Realistic. The telephone worker should keep expectations realistic. The caller did not become disturbed overnight. No crisis worker is going to change chronic psychotic behavior during one phone call. The crisis worker is buying time for the caller in a period of high anxiety and attempting to restore a minimum amount of control and contact with reality. If the caller is trying to "milk" the worker through an interminable conversation, confronting the problem in a direct manner will generally determine whether the caller is lonely or is in need of immediate assistance.

CW: It seems as if this can't be solved, and you say you can't wait until tomorrow to go to the clinic. I'm concerned enough that I think we ought to make arrangements to transport you to the hospital right now.

Maintain Professional Distance. Calls from severely disturbed individuals may evoke all kinds of

threatening feelings in phone workers, leaving them feeling inadequate, confused, and in crisis themselves! Maintaining professional distance when exceedingly painful and tragic stories are related is difficult for even the most experienced phone worker. When these feelings begin to emerge, it is of utmost importance for workers to make owning statements about their own feelings and get supervision immediately. Passing the line to another worker in no way indicates inadequacy.

CW: Frankly, I'm a bit confused as to what to do. I've done everything I know, and I'm tapped out. I'd like to connect you with Irma, who may have some other ideas, while I talk to our director.

As confused and disoriented as disturbed callers may be, they seem to have a sixth sense about sensitive areas in others. **Countertransference** (the attributing to clients of the therapist's own problems) is not uncommon, and disturbed callers can sometimes unearth the worker's own hidden agendas and insecurities. A worker's strong reactions, either positive or negative, to these callers should alert the hotline worker that processing and feedback with a coworker or supervisor are needed.

Caller: (*paranoid*) I know who you are, when you work on the hotline, and where you live.

CW: (*inappropriately responding to the threat in a shaky voice*) What have I ever done to you? I'm trying to help you, and you get bent out of shape. I've got a good mind to hang this phone up right now or even call the police. We can trace these calls, you know!

CW: (*appropriately responding to the implication in a clear, firm, but empathic voice*) Jacques, those things are not important to what's going on with you right now. What is important is making you feel safe enough to go back to your apartment tonight and go to the doctor in the morning. I understand why you might get upset over my suggesting you see the doctor, but I also want you to clearly understand it's your safety I'm concerned about. So what's making you angry with me?

By deflecting the caller's paranoia and refocusing the dialogue back on the client's issues, the telephone worker directively forces the caller, in an empathic manner, to respond to his own emotional state.

Avoid Placating. Placating and sympathizing do little to bolster the caller's confidence or to help move the client toward action.

Caller: (*depressed*) I'm just not any good to anybody, much less myself.

CW: (*inappropriately sympathetic*) From all you've told me, you've had a really rocky road. Nobody should have to suffer what you have, but things can only look up.

Rather, by empathically responding and exploring past feelings and coping skills when life was better, the telephone worker not only acknowledges the dilemma but also focuses on the client's strengths.

CW: You do sound pretty hopeless right now, but I wonder how you were feeling when things weren't this way, and what you were doing then that you aren't doing now.

Assess Lethality. Many clients who call crisis lines have active suicidal or homicidal ideation. It may seem puzzling that such people would call a crisis line when they seem so bent on harming themselves or others. Regular callers in particular should be assessed for suicidal or homicidal ideation because they are very prone to underscore the critical nature of their problems and "prove" their need for help by threatening lethal behavior (Brockopp, 2002a). What all suicidal callers are doing is trying to put distance between their thoughts and the actions that might result from those lethal thoughts. As much as the callers may avow intentions of lethality, they are still in enough control of themselves to attempt to place a buffer (the telephone worker) between thinking and acting (McCaskie, Ward, & Rasor, 1990).

Caller: If I can't have him, she sure as hell won't. I'll kill them both, and you, the police, or nobody else can stop me.

CW: Yet you called here, for which I'm glad. Something is holding you back, and I'd like to know what that something is.

Caller: Well, I'm a Christian, but their sins go beyond redemption.

CW: So as a Christian, you probably think the commandment "Thou shalt not kill" is pretty important. What you're saying is you're about to commit sin, just as they did. How will that help you, and how will it look in the eyes of God?

Although it may be construed that the telephone worker is manipulating the spiritual philosophy of the caller to achieve an end, the major goal of the crisis worker is to disrupt the irrational chain of thinking that is propelling the client toward violence. In that

regard, when dealing with the disturbed caller, the overriding thesis is "Save the body before the mind" (Grunsted, Cisneros, & Belen, 1991). Crisis intervention over the telephone with those who are severely disturbed is clearly not meant to be curative. It is a stopgap measure designed to be palliative enough to keep action in abeyance until help arrives.

Although no crisis line staff members that we know of would ever instruct their workers to give out their full names or home phone numbers, at times callers can be very seductive in their attempts to extract personal information from crisis line workers. Rookies on the crisis line may be very taken with the heartbreaking stories they hear or feel very gratified by the strokes that dependent callers can give them. Under no circumstances should a crisis line worker ever give out his or her full name or other personal information, nor should the worker ever agree to meet the caller for social or professional reasons. The crisis line's credibility is built on anonymity, and that works both ways. In addition, serious ethical problems may arise when that anonymity is breached. Finally, crisis line workers who do not observe the foregoing run the risk of putting themselves in physical harm's way.

Given all that we have said about severely disturbed callers, our admonition is still to treat these clients not as types, but as individuals with their own idiosyncratic problems. However, those who are severely disturbed are not the only regular or problem callers.

Other Problem Callers

Telephone crisis workers must sometimes deal with covert callers, pranksters, silent callers, manipulators, sexually explicit callers, or even callers presenting legitimate sexual problems. It must be remembered and accepted that every call is an attempt by the caller to fulfill some need or purpose. Following are several types of problem callers and suggestions that should help workers understand and cope with such callers.

Rappers. Some callers may just wish to "rap," or talk. The question becomes whether time should be spent listening to someone who only wants to talk, with no seemingly pressing issues. However, if "lonely" is tacked onto the description of the person, this may change the telephone worker's perception of the problem. It may also be that the caller is having trouble bringing issues into the open and is testing the waters to get enough courage to jump in. By allowing some leeway in approaching issues, but at the same time gently confronting the caller's loneliness, the worker sets reasonable limits on the conversation and still provides a supportive forum (McCaskie, Ward, & Rasor, 1990).

Covert Callers. Callers who ask for help for another individual may actually be asking for help for themselves. As a result, always assume that the call is about the caller, but never attempt to prove the call is about someone else (Brockopp, 1973a, p. 164; Brockopp, 2002a, pp. 171–175). Other callers may act surprised, "Oh, I thought this was a recording." The response is to affirm that it is not. "No it isn't. I am Joe, and this is the crisis line. How can I help you this evening?" Yet others may make humorous jests as a test. "You must be really crazy to work there. I'll bet there are some real nuts who call up." The response to these calls is to avoid the "test" and respond empathically by saying, "I wonder if you're concerned that calls are handled seriously here?" These are most likely ways that timid and embarrassed callers have of checking out the crisis line to see what the opening response is and whether it is safe to talk. Intellectual types, on the other hand, tend to be know-it-alls who probably do have more expertise than volunteers. On their own intellectual ground they always "win." In actuality, these callers are often very insecure and unsure of themselves under their self-assured exterior. The key to dealing with intellectualizers is to immediately let them defeat you. "You're right. I am a volunteer here, and I don't know as much as you do about bipolar disorder. What I do know is you sound pretty concerned about it and seem to be looking for some help." Other callers may call and be silent or say they have the wrong number. Particularly at a suicide center, there are no wrong numbers. "May I help you?" or "What number were you calling?" are default responses to "wrong numbers."

Pranksters or Nuisance Callers. Teenagers who are bored at an overnight party may call the line just to bedevil the workers. If the prank call is treated seriously, they will probably hang up and not call back. If they are hung up on, they will continue to call (Brockopp, 1973b; Waters & Finn, 1995, p. 270). Many calls may appear to be of a nuisance nature. However, any person making a nuisance call should be considered to have a problem. Therefore, it is important that calls not be arbitrarily seen as pranks. The crisis line must answer all calls in a straightforward, no-nonsense

manner. The crisis line must clearly convey that they are not playing games with people but that callers will be listened to honestly and responded to directly no matter what the purpose (Brockopp, 1973b, pp. 206–210). By so doing, the crisis line builds the perception in the community that the line is serious about what they do (Brockopp, 2002a, pp. 187–190). The teenager who is a prankster one night may be the suicidal teenager another night.

CW: Is it a prank or a dare you're playing or maybe something else that you really do need to talk about?

CW: I do wonder if there is something you might like to talk about. If you do, feel free to call back.

Silent Callers. One of the most frustrating of callers is the person who is silent. Silent callers are ambivalent. Either through embarrassment or hurt they are reticent, or from previous negative experiences they fear rejection and are just plain unable to muster the courage to talk. The worker must overcome his or her initial reaction to hang up, demonstrate acceptance, and attempt to remove any impediment that may keep the person from communicating (Brockopp, 2002b). For the silent caller, an appropriate response would be, "I'll be here when you feel you can talk."

CW: Sometimes it is really difficult to say what you need. Maybe it hurts so much you can't find words. Maybe you are not sure you can trust me. Whatever the reason you feel unable to talk, I am going to wait a little bit before I take another call. Even if you can't talk now, understand that this line is open for you when you need to talk.

If there is still no response, after a minute or so you could say, "I guess it is difficult to talk about this right now. I'll stay on the line for another minute, and then I'll have to go to another call. Call back when you feel ready to talk."

Manipulators. A variety of callers achieve their unmet needs by playing games with telephone workers. Typical manipulative games include questioning the worker's ability, role reversal in which the worker is tricked into sharing details of his or her personal life, and harassment. Redirecting the manipulative ploy and focusing on the unmet needs of manipulators force them to look at the reasons for their manipulative behavior (Brockopp, 2002a, p. 174; Waters & Finn, 1995, p. 269).

CW: You certainly know a great deal more about that subject than I do. How does it feel to be in control like that?

CW: When you question my integrity or try to get me to share intimate details, I wonder if you realize that is trying to meet some of your own needs for control. I wonder if you have considered what those needs to control and manipulate others are getting you.

Sexually Explicit Callers. "Call 1-900-LUST. Cindy's lonely and wants to talk to you!" The proliferation of these ads on late-night television, the Internet, and in porn magazines is a sad testimony to the existence of tens of thousands of men whose sexual insecurities, aberrance, and deviance make "sex talk" a multibillion-dollar business. An even sadder testimony is given by those individuals who use crisis lines for the same purpose. It should not be too amazing that Wark's (1984) interviews with a number of sexually explicit callers found them to be characterized by low self-esteem, feelings of isolation, lack of trust, a sense of being sexually unfulfilled, and little insight into their behavior. The primary purpose of the sexually explicit caller is to masturbate while talking to a female.

The sexually explicit caller is a particular millstone hung on the crisis line because many female volunteers become angry, embarrassed, and afraid and resign out of frustration with frequent sex calls (Baird, Bossett, & Smith, 1994; Brockopp & Lester, 2002, pp. 133–135; Fenelon, 1990). Brockopp and Lester (2002, p. 136) propose staying on the line and tolerating the behavior while attempting to build a more trusting relationship without condoning the behavior itself. That is a very idealistic way of treating the problem, and in the opinion of your authors is a great way to lose a lot of volunteers in a hurry! We will take a stand here and state that the crisis line is just not the place for that behavior to occur. Switching the caller to a same-sex worker and reframing the call in a context suggesting that the caller needs help put a severe damper on such calls.

Callers With Legitimate Sexual Problems. However, many people who have serious sexual or sexually related problems call crisis lines because of the anonymity allowed to frankly discuss their most private issues. These calls may embarrass workers who are not psychologically prepared for such intimate

details, feel shocked at what they hear because of the criminal or exploitative nature, or do not have the technical expertise to handle them. Telephone workers must have education in dealing with sexual concerns and training in legal and ethical knowledge about what to do if the caller is a danger to a third party (Horton, 1995, p. 292). The very nature of calls dealing with sexual matters places crisis workers in a potentially value-laden, belief-centered moral and religious arena in which the worker's own opinions come into play. Although in most instances the major role of the worker is to *not* let his or her opinions hold sway and influence clients, avoiding these hot areas may also mean denying the caller much-needed information (Horton, 1995, p. 307). Providing options and information about "responsible" sex is a viable approach, although it should be understood that a very fine line runs between the worker's own biases and providing balanced information and must be monitored carefully.

Even though the preceding types of callers are striving to fulfill their needs, they often pose problems for telephone workers. Following are some techniques to help prepare crisis workers to deal with this sometimes difficult clientele.

Handling the Problem Callers

Pose Open-Ended Questions. Appropriate use of open-ended questions can help defuse the problems generated by frustrated callers (Epstein & Carter, 1991).

TC: You people don't know anything. Everything you've told me is a bunch of crap.

CW: What did you expect to gain from this call, then?

TC: Just to tell you what I think of your lousy service.

CW: If you were me, what would you be doing or saying right now?

These questions refocus the problem back to the caller and force movement toward problem solving rather than keeping the worker subjected to condemnatory statements.

Set Time Limits. When it is apparent that attempts to refocus the problem to the caller are futile, then a time limit should be set (Knudson, 1991).

TC: You ought to be congratulating me on getting my act together, no thanks to you.

CW: I'm glad you've done something positive since you last called. Now we can talk about your current situation for 5 minutes. Then I'll have to take another call.

Terminate Abuse. When the caller's behavior escalates to what the worker perceives as abusiveness, the call should be terminated in a clear and firm manner (McCaskie, Ward, & Rasor, 1990).

TC: You bitch! Don't you dare hang up this goddamned phone!

CW: (*assertively*) I'm sorry, but that is language we do not tolerate, so I'm going to another caller now. When you can talk appropriately, feel free to call back.

Switch Workers. Particularly with a sexually explicit caller, switching the call to another worker, preferably a male, takes the stimulus thrill out of the situation and makes it very difficult for the caller to bring masturbation to orgasm, which is usually the end goal of such a call (Knudson, 1991).

TC: I'd love to cover you with honey and lick you all over.

CW (female): (*calmly and coolly*) Given your specific problem, I'm going to switch you to Ralph. *(Signals to Ralph.)*

CW (Ralph): (*assertively*) I understand you have a problem. How can I help you?

If a male is not available, the call should be shifted to a supervisor and terminated. The caller should be told that the worker will hang up and that action should be taken immediately (McCaskie, Ward, & Rasor, 1990).

CW (supervisor): (*authoritatively and firmly*) We are *not* here to answer demeaning remarks while you masturbate. You need to know that our calls are taped, and obscene calls and using this service to masturbate are illegal. I am going to hang up. You may call back when you are ready to discuss this problem.

To bait a telephone worker and hold her on the line, sexually explicit callers often externalize their fantasies by reporting some hypothetical significant other's problem in florid detail. When the first hint of this ploy occurs, the worker should interpret the behavior as the caller's own and make the switch (Knudson, 1991).

TC: I'm really worried about my uncle and his 10-year-old daughter. She's a little doll, and he's

always giving her these massages in her bedroom and I . . .

CW: (*Interrupts.*) That's out of my area of expertise; please hold the line and let me switch you to our child abuse expert, Ralph.

Use Covert Modeling. Covert modeling or conditioning (Cautela, 1976; Kazdin, 1975) has been used by Baird, Bossett, and Smith (1994) to extinguish repeated calls, particularly by sexually explicit clients. In covert modeling, the client is asked to use mental imagery to picture either reinforcing or extinguishing a particular behavior. The following worker response is abridged from their technique.

CW: As you're talking, I'm wondering if you recognize your real problem and want help with it. I know this would be pretty difficult to give up. But sometime soon, I'm not sure exactly when, as you reach for the phone you'll think to call a therapist instead. And this notion that you'll call a therapist and get help will get stronger every day as you think of it. You'll also start to feel better as you realize the crisis line isn't fulfilling your needs as therapy will. I'm going to hang up now and let you think about getting help with your real problem.

By suggesting that the need to call the therapist will grow, the worker plants the seed for anxiety about the caller's present behavior to grow along with the need to change. Both negative and positive reinforcers are used in the image: the need to seek help and the good feeling that will come from doing so. The worker also speaks of seeking help for the "real problem." This unspecified problem allows the worker to respond emphatically without accusing the caller of terrible, deviant behavior but still clearly states that the caller needs help. The worker does not continue in a dialogue with the client but instead hangs up to let the seed start to grow.

Formulate Administrative Rules. Administratively, crisis lines need to set specific rules to extinguish abusive behavior by doing the following (Knudson, 1991; McCaskie, Ward, & Rasor, 1990; Middleton, Gunn, Bassilios, & Pirkis, 2014): LO6

1. Limiting the number and duration of calls from any single caller
2. Limiting the topics that will be discussed
3. Requiring that only specific workers versed in handling abusive callers take such calls
4. Using speaker phones for on-the-spot consultation
5. Requiring the caller to establish a face-to-face relationship with an outside worker and allow communication between the therapist and crisis line personnel
6. Allowing the staff to prohibit calls for a day, a week, or more, if physical threats are made
7. Service initiating contact with the caller instead of waiting for caller contact and coordinating short-term treatment programs for anxiety and depression by telephone
8. Creating a specific management plan for each caller

The Headquarters Crisis Center of Lawrence, Kansas, uses a tracking log for regular callers that lists their name, phone number, address, style of interaction, major and tangential issues, effective and ineffective response modes, their physician/therapist, medications, support groups, and lethality levels. The log is kept current and available to staff, saving them a great deal of time and energy. This center also has an internal messages notebook labeled "Client Concerns." It contains information about regular callers that workers can quickly read to become updated on the caller's circumstances. It is an effective method to keep staff current and can be used to offer feedback and suggestions to clients (Epstein & Carter, 1991). Staff should be brought together on a regular basis to discuss these callers, plan strategy for them, make suggestions, and voice personal concerns (McCaskie, Ward, & Rasor, 1990). Finally, supervisors need to be acutely aware of the impact that such callers can have on personnel. Crisis center administrators should be ready, willing, and able to process debilitating emotions that such calls often evoke in workers in a caring, empathic, and supportive manner through regularly planned supervision and emergency debriefing sessions when necessary. Crisis intervention over the telephone is tough, grueling work, particularly when clients such as the foregoing emerge. Crisis calls are frequently onetime events with very little opportunity for positive feedback. Particularly because crisis lines are run chiefly by volunteers, they need to be aware that not everyone can be helped (Waters & Finn, 1995, p. 271).

Hotlines

As noted in Chapter 1, the first telephone crisis hotline was established in 1906 by the National Save-a-Life League to prevent suicide (Bloom, 1984). Indeed, the growing suicide prevention movement in LO7

the 1950s adopted the telephone as the primary mode of treatment because of its immediacy (Lester & Brockopp, 1973, p. 5), and over the course of time has been the most often used method of suicide intervention (Lester, 2001; Mishara et al., 2005; National Suicide Prevention Lifeline, 2011; SAMSHA, 2014; Seely, 1997a, 1997b; Slaikeu & Leff-Simon, 1990) with dedicated suicide hotlines in many countries, states, provinces, and cities.

Indeed, in the United States, because of the increase in veterans' suicides a suicide hotline 1-800-TALK was established in 2007 to meet the unique needs of veterans (King et al., 2014; Tull, 2013). Most veterans' calls can be generally categorized as mental health issues, suicidal ideation, and substance abuse issues. Research indicates that all age ranges of veterans avail themselves of the hotline, but for very different reasons. The middle age and older veterans called with issues that were based in loneliness while younger veterans focused on mental health issues (King et al., 2014). Britton and his associates (2013) examined incoming calls for 1 week (October 1–7, 2010, N = 665 calls) found that the veterans hotline was highly effective in 84% of the calls received with 25% being resolved on the phone and 59% referrals to a local health care provider. Probably more impressive was the finding that callers identified as high risk for suicide had greater odds of ending in referral than not. Even more importantly those favorable odds were found on the weekends when essentially few if any other mental health resources were readily available.

It is with good reason there are telephones with direct hotlines to crisis intervention call centers placed on bridges and one of the most notorious jump sites, the San Francisco Golden Gate Bridge (Jacobs, 2010). Since its start in 2005, the National Suicide Prevention life line has fielded over 6 million calls (SAMSHA, 2014).

However, suicidal individuals are not the only callers. The tremendous growth of "hotlines" and "warmlines" in number, types of assistance, kinds of problems handled, and geographical coverage attests to the fact that people in crisis avail themselves of telephones to solve a wide variety of personal problems. These services may range from generic crisis hotlines to a variety of specialized services such as local "warmlines" for latchkey children to the National Centers for Disease Control AIDS Hotline. Generic crisis phone lines are typically open 24 hours a day, 365 days a year, whereas more specialized services may operate during regular business hours. People who are lonely, have panic attacks, gamble and drink to excess, abuse relationships, grieve, are depressed, suffer psychotic breaks, or experience a whole smorgasbord of crises that could qualify for Ripley's "Believe It or Not" call crisis lines. There is indeed a specific helpline for current and former NFL players, coaches, team league staff, and their family members who may be in crisis (NFL lifeline, 2012).

Time-Limited Hotlines. A time-limited hotline is one that is put into operation for a specified period of time; it is typically used to deal with a specific problem or to engage a special client population, such as immediately before a potential disaster or after a disaster. It may provide brief supportive therapy or serve as an information or referral source.

A particular use of such a hotline was in the wake of 9/11. The New York City Missing Persons Hotline was created to develop a database of missing persons and provide crisis counseling and information services. Counselors were given updated daily resource lists to provide information on everything from practical issues about returning to apartments to air toxicity levels. Lists of hospital admissions were compiled to cross-check against missing persons lists, enabling workers to call back to relatives inquiring about missing persons. However, the primary purpose of the hotline was to help grieving, scared, anxious people work through the trauma. To that end, workers used what would generally be the first four tasks of the model presented in Chapter 3 to provide psychological first aid to the callers.

Continuous National Hotlines. Specialized, toll-free, national hotlines deal with specific topics, such as troubled youth. Although brief supportive therapy may occur on such hotlines, generally the major purpose is to provide information about the geographic location nearest the caller where help can be obtained. These lines are heavily used and cut across all geographic areas, cultural groups, and socioeconomic classes. The national runaway hotline (1-800-RUNAWAY) not only spends time talking to runaways about their problems, but also encourages them to get off the streets and into the nearest runaway shelter (National Runaway Safeline, 2015). The national domestic violence hotline (1-800-SAFE) is available to any victim of domestic abuse in the United States (National Domestic Violence Hotline, 2015). These are a few of the national call centers that specialize in every kind of imaginable human dilemma.

Local Crisis Hotlines. Local crisis hotlines typically handle all kinds of calls, ranging from suicidal ideation to lost cats (some calls are not as life threatening as others). They are staffed by volunteers from the local community, are listed in the yellow pages, and provide telephone crisis intervention services for a specific geographic locale or a specific population, such as a university student body.

The Internet's Growing Role in Crisis Intervention

LO8

Suppose you are a cost-conscious student and found a cheap first edition of this book from 1988, you now would be finished reading this chapter because what follows didn't exist then. Hard to imagine for all of you 20-somethings because the Internet has always been a part of who you are and what you do to communicate with others. Winston Churchill said, "Take change by the hand, because if you don't it will take you by the throat!" Since the advent of the Internet and websites, there has never been any doubt that there would be counseling services on the "net." However, the computer is not only a communication device; it can also function as a simulation device (Wolf, 2003). Both of these applications have great potential for psychotherapy and crisis intervention. So far, however, most professional therapists do not use computer-assisted counseling or provide online therapy. Various reasons are given, including ethical concerns, commitment to humanistic values that conflict with technology, cost, and the absence of training (Hertlein, Blumer, & Mihaloliakos, 2015; Lawlor-Savage & Prentice, 2014). Yet, if one reads current writing on the use of technology in counseling (Adlington, 2009; Anthony & Nagel, 2010; Cicila, Georgia, & Doss, 2014; Jones & Stokes, 2009; Rose 2014; Parikh & Huniewicz, 2015), it should be patently clear that the Internet and various forms of electronic communication have become and will become more important in the delivery of psychotherapy and particularly crisis intervention.

Although therapists have been slow to adopt this mode of intervention, most consumers have not been—particularly young consumers who are not at all intimidated by the Internet (Calam et al., 2000) and see it as an integral part of their lives. Why is this so? Haim Weinberg (2014) has written a very interesting book called *The Paradox of Internet Groups: Alone in the Presence of Virtual Others*. This book explores the multiple paradoxes of being involved in In groups. Weinberg states that on the one hand p in their bedrooms are far removed and detache untouched by what is going on in the group, b the other they are involved, invested, and pe even enmeshed in the group. So does one really about people thousands of miles away or is it n curiosity? While these paradoxes exist, they allo ers a great deal of freedom to say when they want involved and feel an integral and contributing m ber to the World Wide Web, but still decide how they wish to self-disclose, keep self-boundaries preserve their own individuality. Thus, while to-face encounters with others are usually either nature, online connections with others can be "b and that is what makes the social medium o Internet group so attractive according to Weinbe

Palfrey and Gasser (2009) identify anyone after 1980 as a "digital native." Digital natives access to digital technology networks, use them, have never known any other way of life—as opp to "digital settlers," who use digital technology still rely heavily on analog forms of communica (which would characterize the authors of this bo So about how many natives and settlers are out th and are they restless? In 2010, 8 out of 10 Ameri used the Internet to find out health informa about themselves and 9 out of those 10 worrie much about it they kept digging down until found out what was TRULY wrong with them have helped coin a new phobia called **cyberchond** (Moyer, 2012).

So people are worried about their health and by appearance of how many hits and chat rooms th are that are devoted to mental health they num in the many millions (Number of "cyberchondria 2005). Right now on June 1, 2015, at 5:15 P.M. CST Healthful Chat's website there are 241 people ch ting about anxiety, bipolar, body dysmorphic, pression, eating, gender identity, OCD and PT disorders (Healthful Chat, 2015). People log into c rooms for support groups by the millions to disc mental health issues, and chat rooms are only part of what has come to be known as "behavio telehealth."

Behavioral Telehealth

Behavioral telehealth is the use of telecommu cation and information technology to provide cess to behavioral health assessment, interventi