OVERVIEW

This chapter deals with the most prominent forms of mental health emergencies and emotional crises that occur in society today. Within the last decade most knowledgeable professionals have come to realize that difficulties in the mental health realm cannot be separated from social problems, which are of great concern among various cultural and subcultural groups. Social problems have a reciprocal influence upon emotional and mental health. Because crisis intervention procedures are closely related to social and economic problems, they have recently gained more recognition and emphasis nationally, both in the news media and in various levels of government. Poverty and health problems, especially among children, marital discord, frictions leading to child abuse, economic stress, difficulty in upward mobility, racial disturbances, housing problems, and inadequate preparation, emotionally and educationally, to take one's place in society are all interwoven into the mental health fabric of daily living.

In this chapter a special emphasis is placed upon the practical components of crisis intervention, including the role that volunteer work can play. The importance of training is underscored for professionals, paraprofessionals, and volunteer workers. The areas taken into account here include disaster relief, suicide prevention, rape, marital difficulties, and child abuse. Focus is upon psychological first aid for use in emergency mental health situations.

It is hoped that the information presented and the activities suggested will help readers function more effectively in the inevitable crisis situations of modern life.

INQUIRY

1. What are the available facilities for managing mental health emergencies in your community?
2. Are there any mechanisms in your community for handling crises associated with a major disaster?
3. What would you do if a member of your family attempted or committed suicide or was arrested for rape or drug addiction?
4. What effect will economic conditions and changing times have upon services in the future?
5. Will mental health service delivery procedures follow the same treatment disciplines 20 years from now as those that are employed today?
6. Will future health services be focused upon the individual or oriented toward larger groups of the population?

INTRODUCTION

Mental health crises appear daily throughout the world. Peak periods and special incidents are often publicized in the news media because large numbers of persons are affected or because of the sheer drama of a

particular situation. Present-day crisis procedures have stemmed primarily from three sources: war experiences, catastrophic and natural disasters, and suicide prevention. All represent dramatic situations constituting emergencies that require immediate attention. Despite the fact that mental health crises have existed for centuries, it has been only during the past two decades that a sizable body of knowledge has appeared for teaching purposes in graduate and professional schools. A demonstration project in crisis intervention and suicide prevention in Los Angeles in the late 1950s contributed materially to the growth of this field. In 1974 the Federal Disaster Relief Act added a new dimension of interest to crisis work nationwide by providing mental health services in time of disaster.

Historically the first organized crisis intervention or suicide prevention effort in the United States is believed to have originated with the National Save-a-Life League, founded in 1906 in New York City. National standards are currently being established through the efforts of the American Association of Suicidology, which covers management, service, and training activities for professionals and nonprofessionals in the various facets of crisis intervention and suicide prevention work. Although most of these centers operate independently from community mental health centers, the programs of the latter include emergency service sections that have crisis intervention capabilities. Many crisis intervention programs are affiliated with health departments, hospitals, and clinics, although they often function as separately identifiable units. By the mid-1970s there were approximately 180 professionally operated suicide prevention centers in the United States, but if "hot lines," high school and college crisis lines, as well as personal contact projects were included, it is probable that the number would be well over a thousand. Moreover, there are approximately 600 government-funded community mental health centers.

The term *crisis* indicates a crucial or critical period. For mental health purposes, a crisis means the existence of any situation that so affects the emotional or mental equilibrium of the individual that intervention should be provided so as to avoid possible damaging psychological or physical consequences to the person or persons involved. Crises can be of differing intensities and for varying lengths of time—from a few minutes to several months. A mental or emotional crisis may wax or wane; it may also evolve into an emergency, necessitating more immediate and dramatic attention. Essentially the word *crisis* refers to a time span or interval, a state in a given sequence of events, whereas *emergency* implies a compelling need for action, which may be related to a particular crisis.

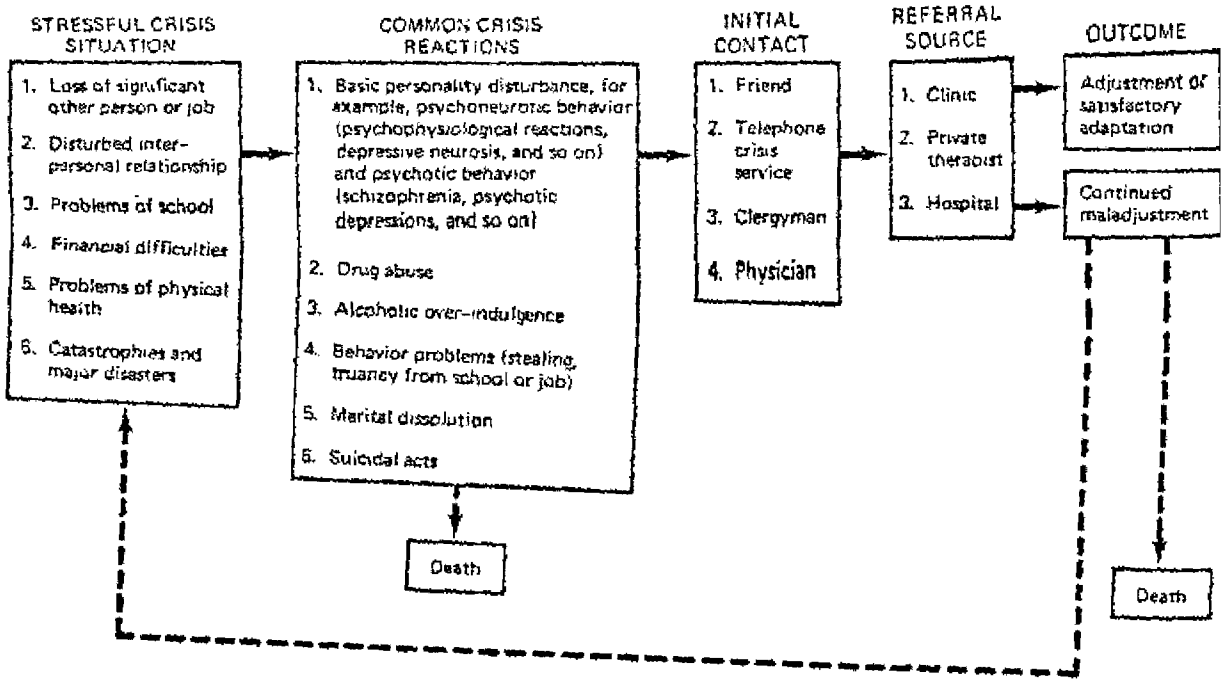
Mental health emergency denotes a sudden, urgent, pressing need, just as any emergency situation does. The quick change inherent in the problem suggests a marked intensification of symptoms. *Mental health emergency* means existence of an emotional or mental disturbance that requires prompt attention in order to preclude the possible loss of life

or injurious psychological and/or physical effects. "Emergency" is often defined arbitrarily as covering a time span of less than 12 hours.

Crisis counseling refers to any short-term method in which appropriate techniques are used to reduce emotional and mental stresses and problems related to the crisis. It is designed to assist victims of any situation causing psychological trauma or marked emotional disequilibrium. The source of such a disturbance may be a personal loss, a natural or man-made disaster, financial difficulty, a problem with school, or physical health. Any crisis procedure is intended to aid in the management of these disturbances at the time of occurrence so as to establish emotional and mental equilibrium and thereby restore the affected person to the useful pursuits of daily living. Crisis counseling may be appropriate at different points in time during or following a psychological trauma. The primary emphasis is upon short-term treatment. Other forms of mental treatment, such as long-term psychotherapy, may follow crisis counseling.

Figure 11-1
Schematic illustration of common crisis situations, courses of responses, and outcomes

Various stressful situations in crisis, followed by common crisis reactions, may be seen in Figure 11-1. Such reactions evoke an initial



contact, which is followed by one of the common referral sources, namely, a clinic, private therapist, or hospital. After experience with one of these referral sources, the outcome leads either to a good personal adjustment or some other satisfactory adaptation to the problem or else to a continued maladjustment, depending upon the extent to which the individual has been able to utilize the services and the general effectiveness of the program offered. As you will note, crisis

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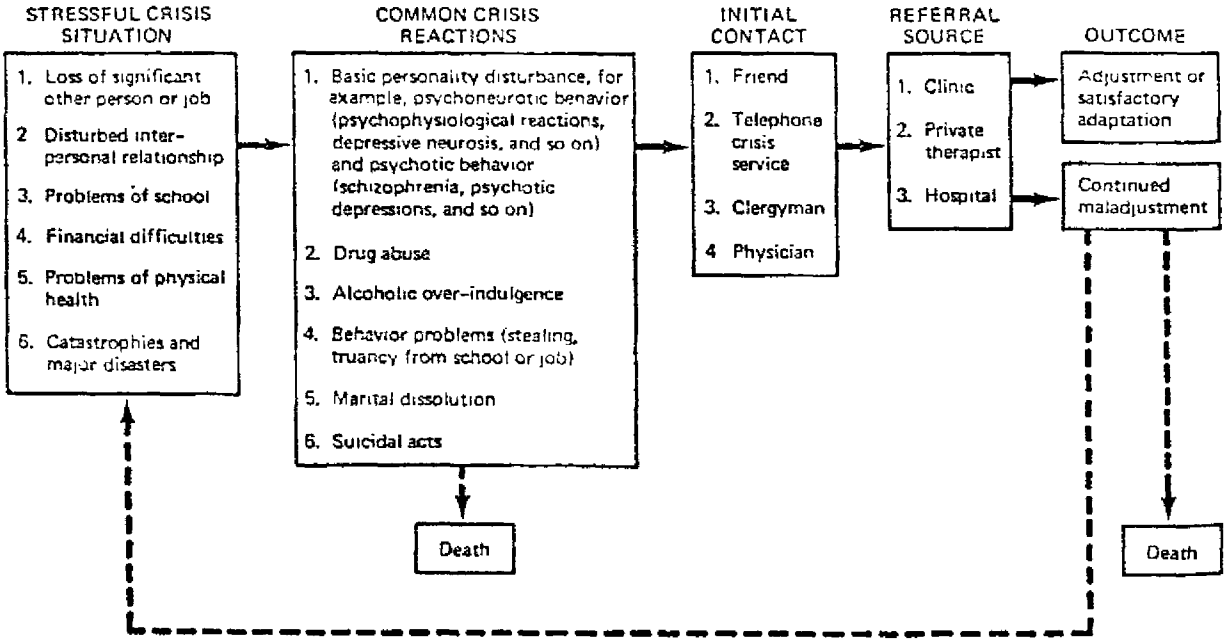

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situations can lead to continued maladjustment, or even death. The most common areas where these phenomena are likely to occur have been connected by dotted lines in Figure 11-1.

THEORIES OF ABERRANT CRISIS BEHAVIOR

A number of theories have been proposed to explain aberrant (abnormal or strange) reactions to crisis. One of the most time-honored explanations for a variety of abnormal behaviors, ranging from suicide to drug addiction, has been the concept of "anomie." In essence this theory states that when an individual has become adapted to a particular set of societal regulations and norms and that way of life becomes abruptly disturbed for any reason, the strain connected with the need for adjustment can become intolerable. Moreover, if there is a blocking of both legitimate and illegitimate avenues to successful behavior, such blocking acts as an additional causal factor in producing aberrant behavior. Sudden shifting in the life situation of the individual, whether it be in an upward or downward direction in terms of socioeconomic mobility, may produce essentially the same result. The chief difficulty with this concept is that it fails to explain why many individuals who experience these changes do not resort to such aberrant forms of behavior.

The mental illness theory holds that when individuals engage in behavior that is different from what we expect, such behavior is rooted in psychopathology and should be regarded as some form of emotional or mental illness or moral weakness. One of the reasons for this view is the threat that unusual behavior poses to our own egos. The unconscious thought that "there but for the grace of God go I" becomes overwhelming, and we wish to put as much psychological distance between ourselves and such an individual as we can as a protective reaction. Some behaviors make people so uncomfortable that we declare them crimes, as in the case of drug addiction and suicide attempts. However, this theory does not stand the test of objective research. People who engage in most forms of crisis behavior have not been found to be mentally ill, even those who commit or attempt suicide or become alcoholic.

Inheritance or genetic theories have always been tempting means to account for that which is unknown. It is easy to ascribe phrases like "organ diatheses" and "weak nervous systems" to those individuals who display aberrant behavior. Still, solid evidence to support a genetic explanation of unusual behavior during crisis is even more tenuous than the mental illness theory. Despite any known inheritable weaknesses, including those where mental retardation existed, it is still virtually impossible to assign specific behavior to inheritance.

Learning theory and conditioning seem to provide the most plausible explanation for particular behaviors. Under stress our behavior is likely to be affected by what we have previously experienced. Other things being equal, past behavior is always the best indicator of future behavior. This holds for crisis behavior as well. Even though there may

be other influences in crisis behavior, it is difficult to imagine any explanation of behavior without a strong learning component. The following model represents the learning sequence found in crisis: stress⟶tension⟶aberrant act⟶relief⟶shame and guilt⟶tension ⟶aberrant act. The cycle then repeats itself. This model explains how the use of various drugs, such as energizers on the one hand or tranquilizing agents on the other, serve to establish or condition behavior rather than eliminate it. Both bring relief from tension and thereby effect a strengthening of the behavior as a rewarded act. To illustrate, drugs may be taken to relieve tensions. Once relief has occurred, the individual will be likely to repeat the same act that brought relief before. The more intense the emotional aspects are that have accompanied past events the more likely the resultant behavior will be to recur.

GENERAL PROCEDURES IN EMERGENCY MENTAL HEALTH

Psychological first aid can be of vital importance, just as physical first aid has been in the past. In the future it is hoped that psychological first-aid training will routinely go along with training in physical first aid. It can be a crucial component in the delivery of effective service in any crisis or emergency situation. Some of the general procedures for use by crisis workers are listed here:

1. *Be calm.* The crisis worker's own personal demeanor and bearing are crucial. The patient or victim in crisis may interpret from the worker what his own situation is likely to be. If he is seriously injured, disclosure of a negative or disquieting reaction can create often unjustified anxiety and panic on the patient's part.

2. *Provide honest reassurance.* Give supportive information that is truthful. To illustrate, if a person appears to be seriously injured upon cursory examination, and asks about his condition, the worker might respond by saying, "I don't know," or "I am not sure, but you have an injury, and we are going to see that it's taken care of." In this way the victim's trust and hope will be nurtured. Heightening the victim's anxiety should always be avoided.

3. *Attempt to engage the person in conversation if he is able to talk.* Conversation allows for a verbal catharsis, which can be tension-reducing and help to delineate some of the person's emotional difficulties. Such information may be extremely valuable for a professional therapist who may be working with the individual later. Moreover, it may help relieve the victim's mind or focus his attention away from some physical injury.

4. *Take a definite plan of action.* An action plan is important even though it has not always been made firm. As an example, one might say, "We are trying to arrange for you to be taken to a clinic or to Dr. "X," or some other comment that appears probable and appropriate. This gives the feeling that something tangible is being done to help. Nothing can be more anxiety-provoking than feeling that little or nothing is being done to assist the person under stress.

5. *Attempt to contact relatives or friends.* Input from other persons of significance can be valuable. Not only may friends and relatives exert a positive influence, but they may serve as adjunctive treatment resources. In the event that negative feelings toward such persons appear on the part of the victim, it is especially important to have this knowledge in order to plan appropriate follow-up procedures. For example, if an individual has attempted suicide in an effort to hurt a significant person in his life, that very fact may constitute the nucleus of an effective treatment approach.

6. *Mobilize the individual's own resources.* Although there are cases where dependency feelings can be accepted and nurtured temporarily, it is helpful to highlight the inner personal strengths of the individual as early as possible. Children and others may be depending upon him or her, and it may be very useful to build upon such relationships as an aid in restoring the person's psychological equilibrium.

7. *Provide reassurance.* The use of reassurances supplies immediate support of a very direct and critical nature to persons in crisis. It offers a vital first step in helping to mobilize the person's psychic reorganizational processes.

8. *Give appropriate advice and guidance.* Persons in crisis need direction. In formal psychotherapy advice is not regarded as particularly helpful, inasmuch as the individual is simply following the suggestions of another person rather than solving his own problems. However, during periods of psychological frustration and impotency, thoughtful advice can be a valuable tool in getting an individual to take tangible steps toward solutions to his problems. Thus both advice and guidance are supplied where needed.

9. *Scotch rumors.* It is important to discourage rumors, since the information from which they come may be inaccurate or may generate harmful emotional reactions that can become contagious and create group chaos. The person in crisis should not be flooded with information he is not prepared to handle. It is best to answer only what is necessary in order to alleviate uncertainty. In crisis definitive statements may be made in order to manage rumors effectively. A lack of direct response or parrying of a question can simply add to uncertainty.

10. *Promote activity.* Motor responses are extremely beneficial in alleviating anxiety, reducing panic, and motivating an individual to move away from depressed feelings. Simply using the muscles to accomplish a task may be extremely valuable. This can be done by encouraging the person to help someone else accomplish a task. Assuming that he or she is physically capable, an individual under stress might be encouraged to attend a community meeting, while giving another in need of a car a ride to the same meeting. If the experience turns out to be a positive one, personal confidence has been enhanced. If it should not prove especially rewarding, another activity can be suggested.

A San Francisco street, split open after the earthquake of 1906

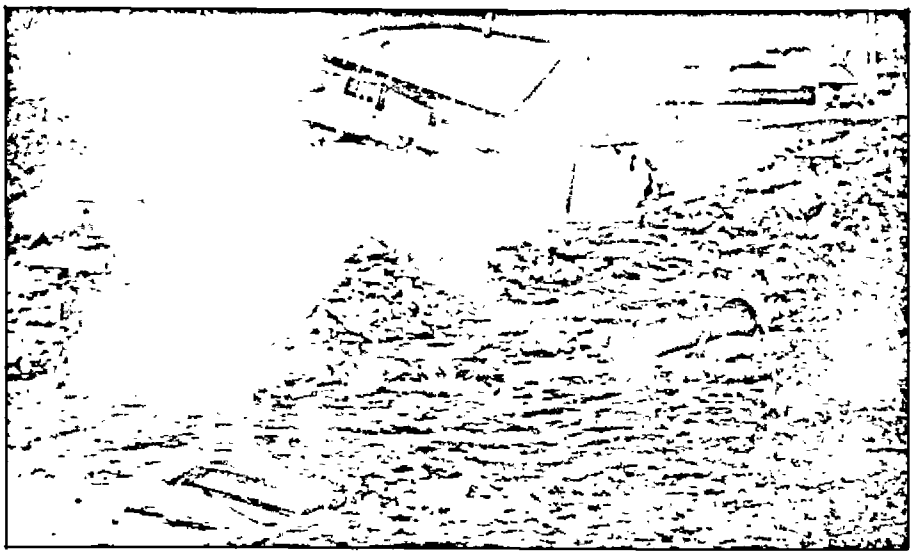
Culver Pictures

THE CRISIS OF MAJOR DISASTERS

In the 1971 earthquake in San Fernando, California, 74 people were killed and thousands suffered emotional disturbances. A large percentage of the children in the immediate area became psychological casualties. In June 1972 persistent rains caused rivers and streams to overflow in Rapid City, South Dakota, resulting in a loss of 237 lives, with hundreds left homeless and in need of psychological intervention. In February 1972 a torrent of rain in West Virginia caused a dam to break at Buffalo Creek. Over 100 people were killed, 1000 were injured, and 4000 were homeless. The psychological impact of that disaster has continued to manifest itself for years. And so it goes: tornadoes, hurricanes, fires. Most recently in 1976, Guatemalan earthquakes killed over 15,000, injured countless others, and destroyed entire neighborhoods. Dramatic as these examples are in numbers, they do not reflect the psychological consequences involved in surviving such incidents.

Until recently the personal loss and special stresses accompanying disasters have been overlooked as significant factors in the mental health sphere. A number of misconceptions still exist concerning personal responses during and after these events. Serious emotional and psychological problems follow, but not of the type customarily imagined. Rarely do persons become overtly panicky or run amok. On the other hand, disasters do not always unite or unify people. Such situations frequently bring about psychological disintegration along with physical injury and property damage. Although some people may assist their neighbors and other community members in times of disaster, many others do not respond in such a cooperative and helpful way. Surprisingly, some victims will often harbor feelings of resentment toward those who have been spared serious loss. Contrary to what one might expect, standard psychotherapy techniques are inappropriate during the acute phase of disasters. In terms of readily assessable damage, many of the physical results are often grotesquely apparent. Psychological damage, particularly of a long-term nature, is more subtle and often requires professional expertise to assess.

One of the reasons people are likely to believe that cohesiveness occurs after disasters stems from past national efforts during wartime.



A Big Thompson River flood destroying houses and cars in Drake Colorado

Wide World Photos

However, unlike during war, people affected by disaster frequently do not mobilize community resources and become a cohesive unit, working in concert toward a common cause. Some of the differences that appear are the following:

1. War is a continuous, ongoing process, which disasters are not. Jobs are made available specifically targeted toward the war effort, accompanied by various activities centering around both work and play, all focused upon effective production and winning the war. Disasters occur quickly and are over, leaving people with a feeling of frustration and impotency.

2. There is a gearing-up period in war efforts that does not occur in disasters. The nation's resources, both in the private and government sector, all assist in this period of preparation and mobilization of effort. Disasters, being of a shorter time frame, permit no such gearing up. There are no pep talks by leaders and no literature and entertainment geared toward the ongoing functions of persons involved in the alleviation of the trouble.

3. During war a nation's spirit has been insulted or challenged, which does not obtain in disaster situations. There is no "rallying around the flag" movement during disasters. There is only a temporary call for cooperation, which does not persist in people's minds since they know that the disaster has already occurred and that the focus is chiefly upon mopping-up operations. Rebuilding is cast in an individual light rather than as a group responsibility.

4. There is a firm personal and societal resolve during a war to right a wrong, which does not obtain in time of disaster. In war another nation has stepped on our toes, so to speak, and created a great misdeed or injustice that must be undone. Disasters are seen as fateful events over which we have little control.

5. As a rule, wars do not occur quickly and precipitously, whereas disasters do. There is no time for preparation or fighting back. In effect, disasters occur on a hit-and-run basis. Generally if an opponent strikes us and remains on the scene, we can often muster the courage to fight back; when there is nothing present to fight, our self-concepts are of little use in the process of reorganization or reconstruction.

An important variable in the psychological reaction to disaster appears to be the time factor. Disasters that occur over a period of several days, such as hurricanes and floods, appear to take a greater toll psychologically than those occurring rapidly since in the latter case recovery measures can begin immediately. Some of the most specific reactions commonly seen in disasters are noted in the following discussion.

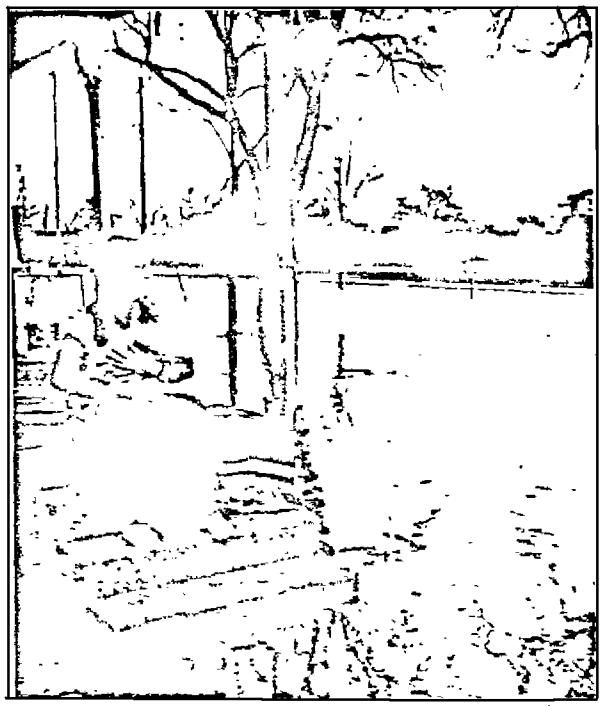
Problems Affecting Children

A variety of emotional and mental health problems in children have been reported following disasters in the past few years. The most prominent of these seem to be phobias (irrational fears) concerning the elements and future disasters, sleep disturbances, and lack of responsibility. To illustrate, the tornado that struck Xenia, Ohio, the earthquake in San Fernando, California, and the Buffalo Creek flood disaster in West Virginia all left these problems in their wake. An unexpected result is the fact that these disturbances have been observed consistently in children even a year or two later. Moreover, such problems have been reported in a large segment of the children in the affected community. For example, in Xenia, Ohio, the area Inter-Faith Council reported that following the tornado 86 percent were less happy, 70 percent showed a loss of interest in school, and 70 percent experienced nightmares and severe problems. After the earthquake in San Fernando, California, the local Child Guidance Clinic noted that scores of children literally clung to their mothers, hid under beds, and refused to go to school for protracted periods of time.

Problems Affecting Adults

Frequent symptoms among adults are those of initial anxiety, followed by anger, resentment, and hostility. This in turn leads to depression and loss of ambition. The commonly expected reactions of panic, followed by community cohesiveness, love, understanding, and mutual assistance, do not always manifest themselves. Hostilities often develop that are directed toward others nearby. For example, anger is transferred from disastrous events themselves to neighbors, family members, children, helping personnel, and others in the individual's life space. This is followed by feelings of self-blame, often resulting in depression and hopelessness. In some instances suicidal or even homicidal acts occur.

It is frequently helpful to avoid references to mental health assistance in standard terms. The notion that anyone would need psychological or psychiatric help may constitute a threat in itself. The view has been perpetuated in many parts of the country that it is a sign of



Wide World Photos

Mother cradling her baby in Lansing, Michigan, as the Grand River creeps up to her doorstep

disgrace and moral weakness to need psychological counseling. The idea of being able to stand on one's own two feet, straighten up, and get a hold on oneself are all ingredients of the rugged individualist so admired by North Americans. Although such a feeling of independence has merit for some occasions, it is totally inappropriate in many forms of emotional and mental disturbance. It prevents the receipt of needed services. Self-treatment for serious emotional disturbance is likely to be ineffective and self-defeating.

The traditional physical model for evaluating disasters does not suffice in the mental health realm. This model arbitrarily categorizes disasters into the following phases: warning, threat, impact, inventory, rescue, remedy, and recovery. A more suitable mental health model would simply list a generic sequence: (1) *the event*, (2) *the perception of the event*, (3) *attempt at adaptation*, (4) *residual aftereffects*, and (5) *reorganization*. An event is established initially by definition. This is followed by a particular perception of it, which may bring about fear and a number of other reactions varying with the individual and severity of the disaster. Attempts to adapt may include flight or freezing behavior in a primitive manner, such as many lower animals do. Immobilization is a traditional response. Anxiety is an immediate reaction, whereas other responses and feelings such as depression, anger, hostility, persecutory thoughts, psychophysiological symptoms, and sleep disturbances often follow. Some of these may occur rather quickly, but in general they are not part of the immediate disaster reaction.

What to Do during a Disaster Disasters, characteristically, are relatively short-lived, depending upon the type. Earthquakes may last only a matter of seconds, whereas flood and hurricane activity may last for much longer periods. In such a situation:

1. Think and act in a deliberate manner. This will also affect other persons.
2. Watch for falling objects and broken wires.
3. Stay away from chimneys and mirrors.
4. Get under a strong desk or table, or stand in a doorway.
5. Do not run outdoors, since the danger of falling objects is enhanced.
6. Stay away from elevators and stairwells because they may be broken or jammed with people. Elevators may fail and be hazardous.
7. Move slowly to a suitable exit after surveying the situation.

What to Do after a Disaster Following a disaster there are a number of sensible steps you should take. The following list is typical.

1. Make sure that you are not injured; then you may proceed to assist others.
2. Check for fire hazards and fires.
3. Check all utility lines and appliances, such as observing gas leaks and electrical connections.
4. Make sure that you wear a good pair of shoes to protect your feet from sharp objects and broken glass.
5. Do not eat or drink anything from open containers that have been near shattered glass. Liquids may be strained through a clean handkerchief or cloth if danger of glass contamination is thought to be present. Check refrigerators and electric outlets to make sure that electricity is working properly. Outdoor charcoal broilers can be used for emergency cooking.
6. Do not use your telephone, except in an emergency. Turn on the radio.
7. Do not spread rumors. They can create great harm.
8. Do not explore the surrounding area. You may create more problems than you solve.
9. Apply both psychological and physical first aid where appropriate. In brief, helpful first aid measures are: reassure and relax the injured person; obtain information through direct questioning; determine the patient's level of consciousness orientation, alertness, and emotional state; and check breathing and circulation. If the individual is unconscious, you can simply observe whether or not the chest is moving and place fingertips on the carotid artery just under the jaw at the side of the neck for a pulse check. It should be somewhere in the neighborhood of 70 beats per minute. Check to make sure there is no blockage of the airway and breathing apparatus.

10. Take note of the victim's complaint, since he may pinpoint his own problem.
11. Visually scan the person's entire body from head to foot.
12. Look for injuries to any part of the body, and observe unusual bleeding, odors, or temperature. Watch for convulsions and pain sensitivity. Check arms and legs in terms of skin color, temperature, texture, position, sensation, and tenderness to touch and movement. Report all your findings to the medical technician or another individual capable of handling the problem later. *Do not move or manipulate the victim! Observe only!*

TAKING ACTION

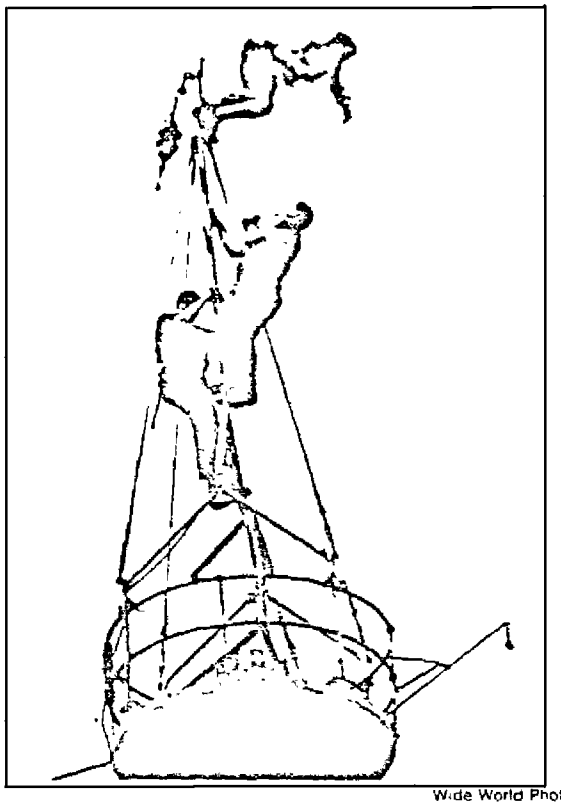
Preparedness training of persons to manage difficulties ahead of time is of vital importance if people are to respond sensibly. How would you manage in a crisis? Some definite steps in the action process are listed below. Follow through with as many as you can during a period of one week.

1. *Set up emergency situations in class. Role-play the handling of them. Evaluate.*
2. *Obtain and distribute printed matter, cassettes, or films for discussion so as to acquaint your community with problems of disaster.*
3. *Find out if there are local safe building codes with efficient inspection and firm enforcement. Modern engineering can provide structures that will resist many kinds of disasters, especially earthquakes. If there are no codes or regulations in your community, explore ways to enact such procedures with community officials.*
4. *Teachers and parents should instruct schoolchildren in what to do in terms of disaster. Contact local principals and PTA groups to determine how your community is prepared. Fire drills have long been a standard procedure in schools. Other kinds of disaster and first-aid procedures, including psychological first aid, ought to be established as an integral part of such a program.*
5. *Check your own home, whether you own it or are a tenant. Water mains, gas mains, fire extinguishers, and so on should all be made available and should be secured and fastened.*
6. *Rehearse with those with whom you live action to be taken in event of various disasters. Each family member can be assigned tasks to be done at regular intervals, such as checking for gas, electricity, and so on. First-aid kits can be examined. Water can be made available in bottles. Flashlights can be checked to make sure the batteries are working. Radios of a transistor or portable type can be checked to make certain that they are in working order*
7. *Discuss emergency actions to be taken in different locations, at work, while driving, in a theater, and at home.*

THE CRISIS OF SUICIDE

The incidence of suicide has increased steadily in recent years. For practical purposes, *suicide may be defined as any willful act designed to bring an end to one's own life.* Any person who ingests a handful of aspirin with the belief that such an act will end his or her life possesses

A man jumping to his death from the mast of a ship docked in New York.



Wide World Photos

the necessary frame of mind to justify the classification of suicidal behavior. On the other hand, if a housewife ingests a dose of lethal medication a few minutes prior to the time she expects her husband home from work, the act may not be so clearly suicidal but may be in part an attention-getting device to make her husband save and feel sorry for her. All suicidal acts, even those that do not have an apparent cause, should be taken seriously because many suicidal threats turn out to produce tragic results. Generally it is a mistake to dismiss any kind of suicidal behavior as a mere gesture or attempt to obtain attention. There is everything to lose by taking the threat lightly, and everything to gain by taking it seriously.

Let us examine some brief case illustrations.

1. Josephine is a 16-year-old girl who has had a number of quarrels with her mother and has received little support from a rather weak and ineffectual father. Her mother is quite self-centered and makes strong demands upon her daughter, which the latter feels are unreasonable. The girl turns to a boyfriend for psychological and financial support, which he is unable to supply. At that point she believes that her boyfriend is rejecting her. Is she a suicidal possibility?

2. John is a 20-year-old college student who has done reasonably well in his studies, is quite bright, and is capable of doing even better. His father, who was rather well-to-do, died from a heart attack when

John was in his early teens. The father, an attorney, was absorbed with the pursuit of his career and the achievement of financial success. During the period of his secondary education, the boy was sent to a private boarding school. Although John was given most of the material things he requested, he has always believed that the mother in particular and the father to a lesser extent favored a younger brother. Is John a likely suicidal risk?

3. Joanne is the wife of a successful, middle-class businessman. She has two attractive and well-liked teenage daughters and appears to have experienced a happy marriage. She is approaching her forty-seventh birthday but has recently suffered pangs of anxiety, coupled with feelings of depression and loss of motivation. A favorite aunt, with whom she lived as a child, took her life while in a mental hospital when Joanne was 13 years of age. Her physician has prescribed an antidepressant medication and decided to hospitalize her for a few weeks to permit her to get away from the stresses of daily living. Is Joanne apt to take her life?

Josephine will probably not commit suicide, but she may attempt it. John and Joanne are high-risk cases, with a marked probability of suicide, if skillful intervention does not occur. Teenage girls, as a rule, are attempters rather than committers, although there has recently been some increase in suicides among younger females. Young males who have never had a satisfactory relationship with their fathers, who tend to become isolated and lacking in focus, with feelings of rejection, are serious cases for concern. Among persons at highest risk one finds the middle-aged female who experiences menopausal problems and feelings of depression. For both John and Joanne, there have been losses of important figures in their lives, a fact that correlates highly as a prognostic indicator of suicidal behavior. Suicide is the third leading cause of death among persons of both sexes in the age group from 15 to 25 years, and it is the fourth leading cause of death among persons of both sexes between the ages of 25 and 45. Interestingly, the other significant causes of death among the younger age group are (in order): accidents, homicide, malignant neoplasms, and diseases of the heart.

Psychological Equivalents of Suicide

Crisis workers often cast deaths into this grouping according to intent: intentional, unintentional, and subintentional. The definition of an intentional death is reasonably clear. It means that an individual is seriously intent upon taking his or her life. An unintentional death is one in which it is obvious that the individual had no idea that he was going to die, as in an unavoidable accident. A subintentional death is the psychological equivalent of suicide. Examples of this type may be seen in the way an individual maltreats himself when drinking to excess or overeating. This category probably accounts for the largest number of suicidal deaths, even though they are not reported as self-induced. All kinds of deaths wherein the degree of intent is uncertain are taken into account, like various accidental deaths or neglecting one's personal health in the face of a known infirmity.

Self-induced deaths may be clarified when placed on the continuum in Figure 11-2. Self-assaultive behavior is characterized by personal

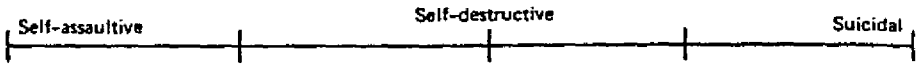


Figure 11-2
Scale of behavior showing psychic intent to end one's own life

abuse of oneself without total awareness of its life-threatening components. Self-destructive behavior suggests more awareness. An example could be an individual who possesses a known physical problem and yet neglects taking proper steps to care for himself. Specific illustrations would be smoking after developing emphysema or improper eating and the neglect of medication in the presence of severe diabetes mellitus. Suicidal behavior per se involves any overt act with a relatively clear plan and intent. Behavior that is self-assaultive and self-destructive can become suicidal, even though it would not be characterized as such initially.

Many psychological equivalents of suicide occur every day without being recognized. In addition to the neglect of the medical problems just noted, reckless driving constitutes an equivalent form of suicidal behavior, particularly of the individual who drives regularly under the influence of alcohol.

Causes of Suicide

Self-destruction is a complex phenomenon; several variables contribute to the actual act.

1. *Feelings of loneliness.* Invariably individuals who have made suicidal attempts, as well as those who have written about it in suicide notes, have commented upon feelings of persistent and pervasive loneliness. This feeling is one that tends to be rooted in rejection, perceived or actual, feeling of lack of confidence, loss of self-esteem, feelings of unworthiness and shame, and loss of love. Frequently a significant individual in the victim's life has been lost or has turned away.

2. *A quality of haplessness.* The cards seem to have been stacked against individuals who take their lives. A series of events has often taken place in which bad breaks seem to have been inevitable. These events may have been self-induced, in large measure, but they give the appearance of a hapless quality to the individual's demeanor. The person may have experienced continuing difficulty with an automobile, enduring numerous accidents, or he may have suffered some physical injury or medical difficulty, lost money, failed examinations in school, lost a job, and experienced a variety of other difficulties that suggest a series of bad breaks.

3. *Feelings of helplessness.* When an individual is feeling lonely and has experienced personal difficulty, he tends to feel helpless. The idea of being unable to manage one's own life becomes a pervasive and deleterious concept. The thought that an individual is unable to do anything to help himself tends to undermine feelings of self-worth,

self-esteem, and confidence necessary to function effectively. The ability to ask for help from another person, in time of need, can have a salutary effect, but many people feel as if they ought to be able to manage their lives without seeking help from others. Helplessness is debilitating in itself and is a likely accompaniment to depression.

4. *Feelings of hopelessness.* The loss of hope is likely to be the straw that breaks the camel's back. When an individual has experienced a hapless series of events, becomes consumed with helplessness, and then sees little hope, it is as if the entire world has collapsed before his very eyes. The loss of hope brings down the final curtain on the person's perception of his life situation and carries with it a finality, which can be seen as irreversible. Although many people experience one or two of these feelings occasionally, most of us do not feel or experience all of them simultaneously.

When individuals feel hapless, helpless, and hopeless, it suggests an imminent suicidal act. This can be called the "syndrome of the three Hs," namely, *haplessness, helplessness,* and *hopelessness,* as indicative of self-destructive behavior.

Identification of Suicidal Behavior

Self-destructive acts contain the "three Ps" as courses of action for the crisis worker who is to intervene, whether professional or nonprofessional. The three Ps will serve to remind the worker that suicide is *perceptible, predictable,* and *preventable.*

Perceptibility If we can learn to observe the way an individual behaves, we can increase our sensitivity to suicidal acts. Through talking with those who know the individual, crisis workers will realize that certain signs were recognizable all along. Clues to suicidal behavior are both overt and covert and appear as verbal and behavioral indicators. Frequently the youngsters in lower socioeconomic groups are products of an unwanted pregnancy, become problems even as preschoolers, are one of many other youngsters, have been given an inadequate amount of responsibility, and have had unattainable goals and expectations pushed upon them. If a personal loss is part of the picture, the probability of suicide is always increased.

Verbal indicators are those whereby an individual states openly or covertly that he or she has entertained the notion of suicide. This may be done by saying flatly that he intends to take his life or that he is fed up with living. More subtle forms include inquiring about insurance policies, discussing the hereafter, or asking about procedures for leaving one's body to a medical school after death.

Behavioral indicators that may assist in identifying suicidal behavior include such actions as the purchase of lethal instruments, such as a gun, ropes, pills, or knives. More hidden and less obvious behavioral clues involve those of depression. These are characteristically loss of appetite, loss of weight, loss of libido, loss of sleep, loss of energy,

Attempted suicide victim being comforted by a police rescue squad

Steve Eagle-Nancy Palmer Photo

fatigue, mood changes, isolation, withdrawal, and heightened irritability. Sudden changes of behavior on one's job or in school, in the home, or throughout the neighborhood, may signal an incipient suicidal act. In recent times heavy ingestion of drugs, as well as alcohol, have been contributing factors.

Depressive symptoms may not always be clearly apparent, especially among young people Some depressive signs may appear in youngsters, but all of the classical symptoms noted above are not usually apparent. It is an error to believe that an individual will not take his life unless he is depressed. Many persons kill themselves who are not depressed, while some who are depressed do not make suicidal attempts. Nevertheless, it is always cause for concern when depression persists and goes untreated.

The following behavioral patterns or circumstances are typically evident in self-destructive youth.

1. There is poor communication with relatives. Part of the difficulty stems from the fact that there is often a communication gap between young people and older ones, like parents, who might help them. A potentially suicidal individual is more likely to communicate with another interested individual or peer than with his own parents. If it seems that a young person cannot talk to his parents, the listener should be alert to any subtleties that may signal a serious problem.

2. The victim often gives away items of personal value. A personally treasured possession may be given away with the comment that it is no longer needed. This act may signal a feeling of finality and hopelessness in the person's life.

3. Isolation may become apparent. The tendency to withdraw and isolate oneself from others is an ominous sign. Even if the person is