GUIDELINES FOR ROLE-PLAYING

I. Helper-helpee interaction.

A. Limit to five minutes.

B. Group members participate by active listening to both parties.

C. Helper should try to develop the following behaviors:

1. Clarifying and expanding the nature of the helpee's problems. Ask yourself if you are sure you understand what the problem is, what variables are involved in making it a problem.

2. Eliciting and clarifying helpee's response to the problem, including his feelings about it and about himself. How is this person "taking it," trying to cope with it, and how does having this problem make him feel about himself?

3. Assessing severity of problem with an eye to sources of help which may be useful to the helpee in resolving the problem or his feelings about it.

(Remember: You don't have to solve the problem yourself. Your function can be one of facilitator, to help the person with the problem to become engaged with the system of "helping" agencies or professions to which he apparently has not had previous access. It is also often important merely to provide support and encouragement for the person to face someone with whom he is having a problem, as that is where it is best solved.)

II. Discussion period.

A. Helper presents to the group a BRIEF (one minute) summary of what he now knows about the helpee and his problem, including:

1. What kinds of stresses are involved in the problems he faces.

2. The individual's current method of responding to or coping with that stress:

   a. Somatic—that is, aches, pains, upset stomach, cramps, headache, or any other physical complaint.

   b. Cognitive—confusion, rumination about the problem or self to the exclusion of any other thoughts, inability to concentrate, etc.

   c. Affective—depression, anxiety, fearfulness,
reltion, lack of feelings, apathetic, pessimistic, feelings of worthlessness, etc.

3. Whether problem is serious enough to require referral.

B. Helpee presents to the group a BRIEF (one minute) summary of his response to the helper, including:

1. Did the helper seem to understand the nature and significance of the problem to you? How did you know that? What did he do to convey that understanding?

2. Did the helper offer anything of value or of help to you? What seemed helpful? What was unhelpful or upsetting?

C. Group discussion follows, and should focus on:

1. Quality of the helper-helpee interaction:
   a. How much understanding was shown? How was it communicated?
   b. How well did the helper clarify the problem? Was it clear to you? What would you have explored further?
   c. Was there a reduction of anxiety and an increase in rationality on the part of the helpee? What did the helper do which seemed to facilitate that?
   d. Effect of helper's interventions on helpee's attempts to express himself—what did the helper do which assisted him, what did he do which hindered or blocked him? Comments on helper's tone of voice, nature of his intervention may be useful here.
   e. Was helpee responsive, hostile, passive, or what? What problems did he present to helper re: ease of communication, acceptance or rejection of communications, etc.?

2. Direction of interaction:
   a. Did they progress toward a solution, or get bogged down in a circular discussion that wasn't going anywhere?
   b. What else would the helper need to know in order to better assess the situation or help the helpee, or make adequate recommendations re: a referral?
      1. More information about the problem?
      11. Clearer picture of helpee's response—e.g., how depressed, anxious, etc. is he?
3. What resources, alternatives does the helpee currently perceive as available? Are they sufficient to allow him to choose a solution, or might it be helpful to explore further alternatives?

During the course of the eight scheduled sessions, you shall receive feedback regarding your growth and performance. The feedback sessions are designed to help you become aware of your strengths as well as of areas which need additional emphasis. These sessions may also help you decide whether the kinds of helping relationships in which we engage are congruent with your own style and desires.

Evaluation

A caller's life may depend upon your actions. We are, therefore, extremely concerned about each volunteer's ability to engage in a helping relationship. At the end of the training program, the training staff will make one of the four following recommendations for each of you:

1. An invitation for you to work on the telephones at the Crisis Intervention Center.

2. An invitation for you to work in some capacity other than as a telephone volunteer at the Crisis Intervention Center.

3. An invitation for you to work at the Center on a probationary basis. This would indicate that the volunteer has shown growth over the course of the training program, but needs more experience. Accordingly, individuals on probation will be required to attend a specific number of weekly on-going training sessions.

4. Temporary exclusion from being scheduled to work at the Center. This usually would indicate that we feel that the individual needs more personal assistance in his current capacity to be a helpful person at the Center than we are able to offer at this time. These individuals, if there are any at all, will be considered for volunteer work at the Center after having completed a subsequent training program where they show evidence of change.
Empathic Understanding in Human Relations

Robert R. Carkhuff

**Level 1**

The helper either pays no attention to or he subtracts very much from the other's expressions. The helper shows no attention to even the most obvious feelings of the other person. The helper may be bored or disinterested or he may be expressing ideas that he had already made up in his own mind which totally shut out what the other person is saying.

The helper does everything except show that he is listening, understanding or being sensitive to the other person.

**Level 2**

While the helper responds to the feelings expressed by the other person, the helper responds in such a way that he subtracts noticeably from the other's feelings.

The helper may show some awareness of obvious surface feelings of the other but what he says drains off some of the feelings and mixes up the meaning. The helper may express his own ideas about what is going on but these do not fit with the expressions of the other person.

**Level 3**

The helper's expression is interchangeable with the expression of the other person. The helper expresses essentially the same feelings and meanings that the second person expressed. The helpee could have said just what the helper said, without changing any of his feelings and meaning.

The helper shows accurate understanding of the surface feelings of the other person but the helper may not respond to or he may misunderstand the deeper feelings.

The helper's response neither subtracts from nor adds to the other person's expression, but the helper does not respond accurately to how that person feels beneath the surface. Level three is the least that a helper needs to offer in order to really help another.

**Level 4**

The helper adds noticeably to the other's expressions. The helper expresses feelings a level deeper than the other person expressed himself, thus enabling the other person to express feelings which he was unable to express before.

**Level 5**

The helper adds very much to the other's expressions. He is "together" with the other or "tuned in" on his wavelength, picking up the other's most deep feelings.

The measurement of accurate empathy

Accurate empathy involves more than just the ability of an S (therapist, teacher, parent, student, trainee, etc.), to sense the other's (client, child, supervisor, pupil, etc.) "private world" as if it were his own. It also involves more than just his ability to know what the other means. Accurate empathy involves both the S's sensitivity to current feelings and his verbal facility to communicate understanding in a language attuned to the other's current feelings.

It is not necessary for the S to share the other's feelings in any sense that would require him to feel the same emotions. It is instead an appreciation and a sensitive awareness of those feelings. At deeper levels of empathy, it also involves enough understanding of patterns of human feelings and experience to sense feelings that the other only partially reveals. With such experience and knowledge, the S can communicate what the other clearly knows as well as meanings in the other's experience of which he is scarcely aware.

At a high level of accurate empathy the message "I am with you" is unmistakably clear—the S's remarks fit perfectly with the other's mood and content. His responses not only indicate his sensitive understanding of the obvious feelings, but also serve to clarify and expand the other's awareness of his own feelings or experiences. Such empathy is communicated by both the language used and all the voice qualities, which unerringly reflect the S's seriousness and depth of feeling. The S's intent concentration upon the other keeps him continuously aware of the other's shifting emotional content so that he can shift his own responses to correct for language or content errors when he temporarily loses touch and is not "with" the other.

At a low level of accurate empathy the S may go off on a tangent of his own or may misinterpret what the other is feeling. At a very low level he may be so preoccupied and interested in his own intellectual interpretations that he is scarcely aware of the other's "being." The S at this low level of accurate empathy may even be uninterested in the other, or may be concentrating on the intellectual content of what the other says rather than what he "is" at the moment, and so may ignore or misunderstand the other's current feelings and experiences. At this low level of empathy the S is doing something other than "listening," "understanding," or
"being sensitive"; he may be evaluating the other, giving advice or sermonizing.

Levels of Accurate Empathy

Level 1:

The S seems completely unaware of even the most conspicuous of the other's feelings; his responses are not appropriate to the mood and content of the other's statements. There is no determinable quality of empathy, and hence no accuracy whatsoever. The S may be bored and disinterested or offering advice without communicating an awareness of the other's current feelings.

Level 2:

The S shows an almost negligible degree of accuracy in his responses, and that only toward the other's most obvious feelings. Any emotions which are not clearly defined he tends to ignore altogether. He may be correctly sensitive to obvious feelings and yet misunderstand much of what the other is really trying to say. By his response he may block off or may misdirect the patient. Level 2 is distinguishable from Level 3 in what the S ignores feelings rather than displaying an inability to understand them.

Level 3:

The S often responds accurately to the other's more exposed feelings. He also displays concern for the deeper, more hidden feelings, which he seems to sense must be present, though he does not understand their nature or sense their meaning to the other.

Level 4:

The S usually responds accurately to the other's more obvious feelings and occasionally recognizes some that are less apparent. In the process of this tentative probing, however, he may misinterpret some present feelings and anticipate some which are not current. Sensitivity and awareness do exist in the S, but he is not entirely "with" the other in the current situation or experience. The desire and effort to understand are both present, but his accuracy is low. This level is distinguishable from level 3 in that the S does occasionally recognize less apparent feelings. He may also seem to know how or why the other feels a particular way, but he is definitely not "with" the other.

Level 5:

The S accurately responds to all of the S's more readily
discernible feelings. He also shows awareness of many less
evident feelings and experiences, but he tends to be some-
what inaccurate in his understanding of these. However, when
he does not understand completely, this lack of complete un-
derstanding is communicated without an anticipatory or jarring
note. His misunderstandings are not disruptive by their ten-
tative nature. Sometimes in Level 5 the S simply communicates
his awareness of the problem of understanding another person's
inner world. This level is the midpoint of the continuum of
accurate empathy.

Level 6:

The S recognizes most of the other's present feelings,
including those which are not readily apparent. Although he
understands their content, he sometimes tends to misjudge the
intensity of these veiled feelings, so that his responses are
not always accurately suited to the exact mood of the other.
The S does deal directly with feelings the other is currently
experiencing although he may misjudge the intensity of those
less apparent. Although sensing the feelings, he often is
unable to communicate meaning to them. In contrast to Level
7, the S's statements contain an almost static quality in the
sense that he handles those feelings that the other offers
but does not bring new elements to life. He is "with" the
other but doesn't encourage exploration. His manner of com-
municating his understanding is such that he makes of it a
finished thing.

Level 7:

The S responds accurately to most of the other's present
feelings and shows awareness of the precise intensity of most
of the underlying emotions. However, his responses move only
slightly beyond the other's own awareness, so that feelings
may be present which neither the other nor the S recognizes.
The S initiates moves toward more emotionally laden material,
and may communicate simply that he and the other are moving
towards more emotionally significant material. Level 7 is
distinguishable from Level 6 in that often the S's response
is a kind of precise pointing of the finger toward emotionally
significant material.

Level 8:

The S accurately interprets all the other's present, ac-
nowledged feelings. He also uncovers the most deeply
shrouded of the other's feelings, voicing meanings in the
other's experience of which the other is scarcely aware.
Since the S must necessarily utilize a method of trial and
error in the new uncharted area, there are minor flaws in
the accuracy of his understanding but these inaccuracies are
held tentatively. With sensitivity and accuracy he moves
into feelings and experiences that the other has only hinted at. The S offers specific explanations or additions to the other's understanding so that underlying emotions are both pointed out and specifically talked about. The content that comes to life may be new but it is not alien.

Although the S in Level 8 makes mistakes, these mistakes are not jarring, because they are covered by the tentative character of the response. Also, this S is sensitive to his mistakes and quickly changes his response in midstream, indicating that he has recognized what is being talked about and what the other is seeking in his own explorations. The S reflects a togetherness with the other in tentative trial and error exploration. His voice tone reflects the seriousness and depth of his empathic grasp.

Level 2:

The S in this stage unerringly responds to the other's full range of feelings in their exact intensity. Without hesitation, he recognizes each emotional nuance and communicates and understanding of every deepest feeling. He is completely attuned to the other's shifting emotional content; he senses each of the other's feelings and reflects them in his words and *voice*. With sensitive accuracy, he expands the other's hints in a full scale (though tentative) elaboration of feeling or experience. He shows precision both in understanding and in communication of this understanding, and expresses and experiences them without hesitancy.

The measurement of nonpossessive warmth

The dimension of *nonpossessive warmth* or unconditional positive regard, ranges from a high level where the S warmly accepts the other's experience as part of that person without imposing conditions; to a low level where the S evaluates the other or his feelings, expresses dislike or disapproval, or expresses warmth in a selective and evaluative way.

Thus, a warm positive feeling toward the other may still rate quite low in this scale if it is given conditionally. Nonpossessive warmth for the other means accepting him as a person with human potentialities. It involves a nonpossessive caring for him as a separate person and, thus, a willingness to share equally his joys and aspirations or his depressions and failures. It involves valuing the other as a person, separate from any evaluation of his behavior or thoughts. Thus, an S can evaluate the other's behavior or his thoughts but still rate high on warmth if it is quite clear that his valuing of the individual as a person is uncontaminated and unconditional. At its highest level this unconditional
warmth involves a nonpossessive caring for the other as a separate person who is allowed to have his own feelings and experiences; a prizing of the other for himself regardless of his behavior. Nonpossessive warmth is present when the S appreciates such feelings or behaviors and their meaning to the other, but shows a nonpossessive caring for the person and not for his behavior. The S's response to the other's thoughts or behaviors is a search for their meaning or value within the other rather than disapproval or approval.

Levels of nonpossessive warmth

Level 1:

The S is actively offering advice or giving clear negative regard. He may be telling the patient what would be "best for him" or in other ways actively approving or disapproving of his behavior. The S's actions make himself the locus of evaluation; he sees himself as responsible for the other.

Level 2:

The S responds mechanically to the other, indicating little positive regard and hence little nonpossessive warmth. He may ignore the other or his feelings or display a lack of concern or interest. The S ignores the other at times when a nonpossessively warm response would be expected; he shows a complete passivity that communicates almost unconditional lack of regard.

Level 3:

The S indicates a positive caring for the other, but it is a semi-possessive caring in the sense that he communicates to the other that his behavior matters to him. That is, the S communicates such things as "It is not all right if you act immorally," "I want you to get along at work," or "It's important to me that you get along with the ward staff." The S sees himself as responsible for the other.

Level 4:

The S clearly communicates a very deep interest and concern for the welfare of the other, showing a nonevaluative and unconditional warmth in almost all areas of his functioning. Although there remains some conditionality in the more personal and private areas, the other is given freedom to be himself and to be liked as himself. There is little evaluation of thoughts and behaviors. In deeply personal areas, however, the S may be conditional and communicate the idea that the other may act in any way he wishes—except that it
is important to the S that he be more mature or not regress in therapy or accept and like the S. In all other areas, however, nonpossessive warmth is communicated. The S sees himself as responsible to the other.

Level 5:

At Level 5, the S communicates warmth without restriction. There is a deep respect for the other's worth as a person and his rights as a free individual. At this level the other is free to be himself even if this means that he is regressing, being defensive, or even disliking or rejecting the S himself. At this level the S cares deeply for the other as a person, but it does not matter to him how the other chooses to behave. He genuinely cares for and deeply proves the other for his human potentials, apart from evaluations of his behavior or his thoughts. He is willing to share equally the other's joys and aspirations or depressions and failures. The only channeling by the S may be the request that the patient communicate personally relevant material.

The measurement of S's genuineness of self-congruence

This scale is an attempt to define five degrees of S genuineness, beginning at a very low level where the S presents a facade or defends and denies feelings; and continuing to a high level of self-congruence where the S is freely and deeply himself. A high level of self-congruence where the S is freely and deeply himself. A high level of self-congruence does not mean that the S must overtly express his feelings but only that he does not deny them. Thus, the S may be actively reflecting, interpreting, or analyzing, but this functioning must be self-congruent, so that he is being himself in the moment rather than playing a role. Thus the S's response must be sincere rather than phony; it must express his real feelings or being rather than defensiveness.

"Being himself" simply means that at the moment the S is really whatever his response denotes. It does not mean that the S must disclose his total self but only that whatever he does show is a real aspect of himself, not a response growing out of defensiveness or a merely "role" response that has been learned and repeated.

Levels of therapist genuineness

Level 1:

The S is clearly defensive in the interaction, and there is explicit evidence of a very considerable discrepancy between what he says and what he experiences. There may be striking contradictions in the S's statements, the content of
his verbalization may contradict the voice qualities or non-verbal cues (i.e., the upset S stating in a strained voice that he is "not bothered at all" by the other's anger.)

**Level 2:**

The S responds appropriately but in an impersonal rather than a personal manner, giving the impression that his responses are said because they sound good from a distance but do not express what he really feels or means. There is a somewhat contrived or rehearsed quality or air of "role playing" present.

**Level 3:**

The S is implicitly either defensive or impersonal, although there is no explicit evidence.

**Level 4:**

There is neither implicit nor explicit evidence of defensiveness or the presence of a facade. The S shows no self-incongruence.

**Level 5:**

The S is freely and deeply himself in the relationship. He is open to experience and feelings of all types—both pleasant and hurtful—without traces of defensiveness or retreat into impersonalism. Although there may be contradictory feelings, these are accepted or recognized. The S is clearly being himself in all of his responses, whether they are personally meaningful or trite. At Level 5 the S need not express personal feelings, but whether he is giving advice, reflecting, interpreting or sharing experiences, it is clear that he is being very much himself, so that his verbalizations match his inner experiences.
SUICIDIOLOGY

Dr. Dobbs

The lecture consisted of a training record in suicide prevention made for the Los Angeles suicide prevention. It is the first record of its kind that was ever made.

The record gives some sort of notion about what happens when a call is made. It is interesting for you to be aware of the kind of responses the volunteer worker is making to the caller.

Call #1

Widower who feels she has no reason to live anymore. She almost took a handful of pills the night before.

Dr. Schneidman remarks (this is on record) that it is not easy to state what an average suicide call is. Most every suicidal "dialogue with death" reveals a characteristic ambivalence between living and dying that identifies almost every suicidal individual's dialogue with death. The contact with a suicidal prevention agency is definitely a cry for help. A suicide prevention worker must assess the lethality of each call to assess how quickly and how deeply he must move. The worker acts to accomplish two things: (1) to determine the lethality of the call, and (2) to work simultaneously to reduce the lethality of the call.

Briefly stated, overall lethality is rated in terms of the caller's suicidal plan, the resources felt by the caller to be available to him, the nature of the crisis experienced by the caller, his recent medical, psychological, and suicidal history and the stability of his character and personality in general.

Call #2

Twenty-seven year old skid row inhabitant. Was a public relations man and in the last 3 years has gone through a wife and eight jobs. Has gone from city to city. He reveals the traumatic, emotional separation from his mother at an early age and also reveals an impulsiveness, a tendency to be self-defeating.

The worker suggests that, since psychotherapy is so popular today, the caller consider it. "Blasting loose from bad pattern of living." This worker widens range of caller from skid row or death to a wider range of alternatives. Worker points out that he has many resources. The caller comes to center the next day and receives short term therapy.

The lethality rating is less at the end of the session
than at the beginning because the promise for life is higher. The worker did not engage in philosophical discussions with the caller, but he answered some of his questions by avoiding answering them at all and he developed the caller's background, his strength, that he empathized with him, that he remained professionally and offered a program for action and for help.

Call #2--Questions and Answers

Q. Is it ordinary for the suicide caller to be so vocal as caller #2 was?
A. (Dr. Dobbs): It varies with the individual. The worker picked up the guy's capacity to verbalize and used this as a resource.

Q. Is there any reason for making the references that the worker did concerning suicide and destructive tendencies or the worker's tendency to agree with the caller when he indicated he had a lack of good qualities?
A. I saw that as being realistic and the worker's attempt to not paint sort of a rosey picture.

Q. Was it wise to suggest to him, in certain spots, references to suicide?
A. I think what the worker was trying to do was determine how serious a threat this was. How realistic is the possibility this guy might commit suicide?

Q. Is that a wise thing to do over the phone, i.e., confront the caller with the possibility of suicide?
A. You have to make the judgment. If you refuse to discuss with him the suicide he will probably begin to think you don't care or you don't understand, thus backing away from you. Honesty is important.
CALL NO. 1

Well, I don't know if anybody can do anything. (Hmm. Tell me about the situation.) Well, I lost my husband five months ago and I can't get over it. I just want to follow him. (How, how'd he die?) Heart, Heart attack. And we had made a pact that if one of us went first the other would go in twenty-four hours. It's sad. I'm just split right down the middle and I don't want to live that way. I have no reason for living now that he's gone. No reason in the world. I'm just, it's just useless, it's...And I almost several times last night, I was the closest to taking a handful of sleeping pills, and just as I could just have put them in, I had them up to my mouth, and someday I'll get to where I'll swallow them.

CALL NO. 2

Worker - 1: Hello.

Caller - 2: Can you offer anything to someone on skid row or should he just die?

W-2: How old are you?

W-3: All right, I'm the Director of the Suicide Prevention Center here. Can you tell me what the nature is of the problem?

C-3: Well, I'm 27 years old and in good health. I was, up to three years ago, a public relations man.

W-4: Uhumm.

C-4: For the past three years I have gone through a wife, about eight jobs.

W-5: For a young man it usually takes alcohol to go down that fast. Is that what it's been with you?

C-5: Alcohol, women, gambling, you name it, I've had it. I've tried alcoholism. I've tried religion. I've tried the works. I've tried missions—they don't work. I've tried the AA, it doesn't work. You tell me, if you can think of one good, sane reason...

W-6: Have you tried psychiatry?

C-6: Well, let's face it. I...I'm a man that's just barely able to make his own living. It's rather difficult to go to a psychiatrist unless you go to a...well, I spent a couple of weeks in a mental hospital, and that doesn't impress me very much. That was for drinking and a number of...
W-7: Suicide attempts?
C-7: No.
W-8: No? Have you ever done anything to yourself, self-destructive actions?
C-8: Well, once I had a fight with my wife, but it wasn't...It was...not a suicide attempt...it was just a...I don't know what the heck it was.
W-9: What did you do?
C-9: I went across my wrist with a rather sharp knife, but devil, I should have known where my own radial artery was.
W-10: You probably were ambivalent about the thing still in relationship with your wife and all...Do you have any children?
C-10: One. But that was, as I say, a few years ago and...
W-11: Where is that child now?

---------

W-31: Well, you know, some pretty...I wouldn't say that. Therapy is...actually, it's geared to the capacity and the need of the person who is having the therapy. For many types of people, therapy is a chance to clear their mind and a chance to get some distance from their own problem and analyze it with an attitude free of some of the complications that you have. You do have quite a bit of guilt and quite a bit of self-criticism and I imagine that does complicate trying to analyze your problem.
C-31: Well, I...
W-32: An indefinable thing should be more clearly definable.
C-32: I have tried to apply all the intelligence that I have to finding out just exactly what was wrong with me and correcting it. I have had every break in the world, and here I am flat on my tail. In other words, oh, I still am well dressed. I manage to get a few days' work in, but for all practical purposes, broke and without any place to go and save, with the choice between going back to skidrow or taking my own life. I think if...if you have the choice...if you had the choice, what would you choose?
W-33: Well, ah, it seems to be more than that. I'd say there is a lot more to your life than just those two choices. As long as you assume that you're stuck in your pattern then I suppose that's the only two choices you have, but to me, viewing it as an outsider, I think it's just ridiculous that a guy should be stuck in his pattern. I have seen so many people blast themselves loose from their pattern so many times that it is a matter often of understanding your pattern, taking and getting some distance from your anxiety, so you can see where you put the proper effort to change it--change the pattern.

C-33: How? I can't see...

W-34: Well, I would say something like this. Here we get four, five, six calls a day from people like yourself, all sorts of people in trouble. In your case, you're the kind of a situation here with enormous resources. We really run into people who are at the end of their rope, older people, sick people, unhealthy people. You're...what you are is a healthy neurotic, just like all the rest of us, only your pattern is one that society doesn't reward at all, and so your self-destructive pattern. Some people with a neurosis, like maybe your brother overwork and they get ulcers later in life but they have money. I'd say that you need out-patient therapy for your neurosis and I'd suggest that you come on in and talk with me to start it out.

C-34: How does a skidrow bum get psychotherapy.

W-35: Let's discuss that and take one step at a time.

CALL NO. 3

Worker-1: Suicide Prevention, may I help you? Is there anything I could help you with?

Caller-1: No. I don't think anybody could help me. Do you ever look at blood?

W-2: At blood?

C-2: Uh, huh.

W-3: Yes, I've looked at a lot of blood.

C-3: How? I mean, you are a nurse?

W-4: No, I've never been a nurse. I worked in dental offices and you see a lot of blood there.
C-4: (Laughter)
W-5: ...a good bit of blood. Why? Can you see some blood, or...
C-5: Yeah.
W-6: Where do you see it?
C-6: Everywhere. I was just wondering, you know.
W-7: Have you cut yourself?
C-7: I want to cut out, you know. But I don't have the right to cut out, even though I want to. I want to, you know, like cut out so bad.
W-8: Why?
C-8: I don't have any choice, you know. I have to stay here and I don't want to stay here.
W-9: Stay where?
C-9: Here.
W-10: Well, where are you?
C-10: You know, I mean like in life, you know.
W-11: Well, I mean, if you are in life, you're somewhere. Where are you?
C-11: Oh, I'm here. Hanging loose.
W-12: What do you do for a living?
C-12: I work as a waitress. Trying to go to college. Trying to raise the kids and making a sad mess of it. Very sad mess of it.
W-13: Where's their daddy?
C-13: It's my problem, not theirs.
W-14: Children have to have a father. Most of them do. I don't know of any...
C-14: No, I've been divorced for years.
W-15: Where are they tonight? They asleep?
C-15: Yeah, They're asleep. So I can't leave.
W-16: No, there's nobody else to take care of them, is there?
C-16: But I want to leave so bad.
W-17: I want to return to that blood. You haven't cut yourself tonight, have you?
C-17: Superficially.
W-18: Where did you cut yourself?
C-18: When I was sitting there I drew patterns on my legs.
W-19: Uh huh. Did you cut a vein?
C-19: No. That was years ago.
W-20: You have tried this before then, uh?
C-20: Oh, yeah. I wish I had the guts to do it all the way.
W-21: Where do you think that'll get you?
C-21: Uhm... it would get me out of it.
W-22: Would it? I never can decide whether it would really get me out of it, or make something worse.
C-22: I think it would get me out of it. I keep thinking that, you know, children, they can't accept their parents going away and leaving them.
W-23: You're right. They can't.
C-23: But there's one thing they can accept. Children can accept death.
W-24: Oh, I don't know.
C-24: My parents, they couldn't help it. My mother couldn't help it.
W-25: Oh, I don't know.
(Both talking at once)
C-25: If their mother died, you know, they could accept that. But if their mother goes away on this, you know, goes away, they can't accept that.
W-26: Suppose your children knew how you died? Wouldn't that make a difference?
C-26: Oh, no.
W-27: Could they accept that?
C-27: I wish my mother had killed herself.
W-28: Your mother? Do you live with your mother?
C-28: No, God, no. I can't stand my mother. She didn't raise me, though.
W-29: Let me ask you something about that blood. That's bothering me. Do you think we ought to get hold of a doctor, or something?
C-29: Oh, no. I'm not to that point yet.
W-30: How do you know?
C-30: I've been through it before.
W-31: Well, you know, if you are bleeding all over the place, don't you think we better get you taken care of? Cleaned up?

(Caller hangs up)

CALL NO. 4

Worker-1: You know, if you take a lethal does of some barbiturate or whatever it is, we're not able to leave here, we have to stay...

Caller-1: So you called the police, huh?

W-2: Who are we going to to call? That's what they're for. They're to save your life!

C-2: Are they?

W-3: Yes.

C-3: Oh, no. This is too much.

W-4: No, no, dear. Look. We are here that if you call us and tell us that you have taken what is listed as a lethal dose of some kind of drug, then you hang up, we are responsible for you and if you don't call back and the doctor doesn't call back, or something...
Now, just a moment. I'll tell you right now. I intend to do something tonight, and lordy, I'm not going to call you people, 'cause you just give me further problems.

When you call and say you have taken a lethal dose of something lethal... We are here to...

Thanks a lot. Thanks. I enjoyed talking to you.

Get help. Get a counsellor.

I'm trying to. Now as far as I'm concerned, this is a bunch of bologney, I... I've given you a bad enough time.

Well, it needs to be understood... that's why I suggested you have professional counselling on a long term basis. We can't help you like a fairy godmother or father.

I already talked to somebody... (Both talking). Would you listen to me?

Yes.

I have already talked to somebody. All right, then I talked to somebody else and they said they'd call. I said, is there anybody else I can talk to medically. I have not heard a word.

As I say, we want to help you and we want to help you help yourself. We cannot be there holding your hand. You have to...

I don't intend for you to hold my hand, but when I asked for medical help I said I cannot reach my doctor. I cannot get through to him.

You can reach General Hospital. That's what they are there for. They're open 24 hours a day.

You are joking, I'm...

I'm not joking.

I do not intend to go to a charity hospital. Now you're making me so irritated...

There's a hospital. It's private.

You shouldn't be on that phone, kiddo. You haven't got the gumption or the guts to talk to me. Let's forget it, huh?
W-13: Okay, but you get group counselling.
C-13: Oh, shit.
W-14: You should see a psychiatrist. (Laughter)
(Caller hangs up)

CALL NO. 5

Caller: (Garbled)...
Worker-1: All right. You've got the right place. And the right person.
C-1: I feel so horrible...everything. I just don't know what to do any more.
W-2: Can you tell me a little bit about yourself? How old you are?
C-2: I'm 30.
W-3: Are you married, single, or...?
C-3: I was married. I have two children, I am divorced now...living by myself...So lonely, I can't stand it.
W-4: You're feeling upset or you are feeling very low, depressed, perhaps?
C-4: I just haven't, I haven't cried for so long, I can't remember and all of a sudden I can't stop, I just...I just want to get out of it all. I just don't know what to do, you know. I feel like what the hell's the use. I mean I can sit here and cry all day or...And for a simple, simple little thing, it is a simple little thing in a person's life to be rejected and be alone, I guess, but I just can't seem to cope with it any more. I've been alone too long now. I don't have any purpose any more. I guess I've had it.
W-5: You say you are thinking of getting out. By that you mean what? Do you have some ideas about suicide?
C-5: If I didn't, I would not now have called you.
W-6: Yeah, I know.
C-6: I don't like that...I don't like that idea. I don't like it at all, but I just don't care.
W-7: What sort of thoughts do you have about suicide?

C-7: I just want to put a bullet in my head and forget about it, you know.

W-8: Do you have a gun?

C-8: Yes, I do.

W-9: You do? Have you ever tried anything in the past? Have you ever made any suicide attempts in the past?

C-9: I beat my head against the wall a few times. Played a little Russian roulette, I guess. I won. Unfortunately.

W-10: Uhha. Well, that's a terribly serious game.
I am not hard on drugs, I think I have empathy. I have used drugs, and so have you, in a variety of shapes and sizes, and I do not particularly like the phrase "drug abuse," or something which connotes that the individual is abusing the drug. My approach, based on my experiences, my contacts with drug abusers, and what learning I have been able to acquire in the area leaves me soft on drugs, with one exception, of course, that is criminology.

In our society, criminal law does two things:
1) Decides what behavior is a crime;
2) Sets forth a punishment.

Whether you like it or not possession of drugs is a crime. It is the popular belief that the punishment for first offenders is becoming less.

The sale of drugs, the transfer of drugs, the giving away of drugs is a crime. Generally, in our society, for the first offender it is 2 to 10 years prison sentence. It varies from state to state. My point is, that while we have some culture in our society about drug users, possession is an offense. The punishments are harsh. The thing I wish to emphasize is that being put in prison in our society does not do anything for you. It's like being poor; that does not do anything for you either.

One of my problems in talking about drugs is to know how to divide the topic up into something that is understandable or even logical. To talk about drugs as we do; to bring everything together into one category, is very confusing. You can divide into terms of two major topics. You can talk about drugs that are the result of a botanical process, or you can talk about drugs that are manufactured in pharmaceutical houses (synthetics). Generally, that is not too successful. So what I try to do is to out the pie of drugs and talk about certain categories of drugs, and I'm not selling anything, I find it useful.

We could divide all the drugs you are likely to run into, into 4 major headings:

1) Hallucinogenic drugs: The drugs that produce hallucinations.
2) Stimulants: Commonly called uppers.
3) Depressants: Commonly called downers.
4) Opiums: A true depressant and a botanical; a plant that grows.

A fifth classification could be Marijuana. If you like six categories, you can add Alcohol. Most people don't think of alcohol as a drug, but it is a depressant, a true depressant.
Sgt. Jack Fisher--Muncie Police Dept., Narcotics Division

The police are here to help people. Narcotics is one of the hardest things in the world to investigate. The Muncie Police Dept. has only had a narcotics division since March of this year. Two officers are assigned to this division as agents.

These agents are available 24 hours a day. They are not there just to make arrests. They know who the pushers are and this is the one individual they are concerned about more than anybody else. Once they cut him off he's going to cut the other supply off until they have a new contact--then they start all over again.

All the officers on the department know basically the operation you people will be doing. They know what to do when they get your call and what's needed, and if they're not they're going to stay out of your business. This information is strictly confidential.

You'll have my phone number, and I want you to call it. It won't be the first time I've gotten out of bed and gone on emergency and it won't be the last.

We don't know everything about drugs; we've got a lot to learn.

Q. What about informers? Do you think that's fair?
A. If I didn't have informants, I couldn't have a narcotics case.

Q. Forcing the informants to do it such as say you bust a user and say "Either you do what we want, or you're going to have a two year sentence and I guarantee it".
A. I don't hold a mine over anybody. If they want to tell me, fine; if they don't, that is their business. I'm not going to deal with anybody on a narcotics case, because if I haven't got a good enough case to start with, I'm not going to make it.

Q. When you said you would come to the emergency room you are not talking about arrest, are you?
A. No.

Q. If you are called for help, and you go to a person and you find him with possession then you will arrest him. Right?
A. This all depends on the circumstances. Just because someone has some pills or something, I'm not going to bust him. Especially if they're overdosed, because I feel like they've got a problem so you see what I mean. We're gonna
help them. On possession on an overdose with nothing on the body, the prosecutor will not press charges no that as to date. He could from the medical tests and reports and make a case, but the man's already overdosed and I can see his point. Why do this when he's got enough problems as it is. Evidently he's seeking some help from somebody so maybe he can start with us. Normally they won't even talk to us on an overdose case because they're afraid they're going to jail, we still have to investigate it but that's no sign that we are going to arrest.

Q. What would be a case where you arrest?
A. I am going to arrest the individual that I have been hearing about day after day, selling pills to kids in junior high school. The seller, the pusher. This is the individual I am more concerned about than the individual user because you don't know who's experimenting and who isn't and I find that a lot of people are just experimenting.

Q. Are you saying that if you got a call from the hospital about a person was very incoherent and you went out there and found grass on him that you wouldn't bust him?
A. No, I wouldn't bust him.

GLOSSARY OF DRUG TERMS

I. Expressions of Drug Terms

<table>
<thead>
<tr>
<th>Formal Terms</th>
<th>Hip Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amphetamines</td>
<td>1. Ups - Speed - Pep pills</td>
</tr>
<tr>
<td>A. Methamphetamine</td>
<td>A. Speed - Meth - Crystal</td>
</tr>
<tr>
<td>B. Benzedrine</td>
<td>E. Bennies</td>
</tr>
<tr>
<td>C. Dexedrine</td>
<td>C. Dexties</td>
</tr>
<tr>
<td>2. Barbiturates</td>
<td>2. Barbs - Downers</td>
</tr>
<tr>
<td>A. Nebutal</td>
<td>A. Yellow Jackets</td>
</tr>
<tr>
<td>B. Seconal</td>
<td>B. Red Devils, Reds</td>
</tr>
<tr>
<td>C. Tunial (Amo Barb) (Seco Barb)</td>
<td>C. Toolies, Christmas Trees</td>
</tr>
<tr>
<td>D. Pheno Barbital</td>
<td>D. Purple Hearts</td>
</tr>
<tr>
<td>E. Librium</td>
<td>E. Floaters</td>
</tr>
<tr>
<td>3. Hallucinogens</td>
<td>3. Psychedelics</td>
</tr>
<tr>
<td>A. LSD</td>
<td>A. Acid - LSD 25</td>
</tr>
<tr>
<td>B. Psilocybin</td>
<td>B. &quot;Sis,&quot; Peyote</td>
</tr>
<tr>
<td>C. Mescaline</td>
<td>C. Meso</td>
</tr>
<tr>
<td>D. STP-DMT</td>
<td>D. STP-DMT</td>
</tr>
</tbody>
</table>
4. Opiates
   A. Morphine
   B. Heroin
   C. Opium
   D. Cocaine

4. Hard Dope
   A. Dope, Stuff
   B. Dope, Smack, Junk, Jive, Hard Stuff, Doosee-Fix
   C. Sugar - Opium
   D. Cole, Baller

5. Marijuana
   A. Marijuana Cigarette
   B. Hash Hish

5. Grass, Pot, Tea, Dope,
A. Joint, Numbers
B. Hash, Lebanese Red, African Black

SUMMARY OF EFFECTS

1. Amphetamines - will lift spirits, excite, increase the body's metabolism, e.g. heartbeat, i.e. activity will produce hypertension, nervous actions, hyperactivity.
2. Barbiturates - will depress, relieve pain - bring on a feeling of euphoria - drowsiness - slurring of speech - clumsiness.
3. Hallucinogens - sensory alterations, non-rational speech and thought - hallucinations - euphoria - wide mental alterations.
4. Opiates - depressed - close to barbs - can be addictive.
5. Marijuana - may act as a stimulant or a depressant - usually causes a feeling of euphoria followed by a feeling of drowsiness - will induce sleep.

THE MAJOR MIND-AFFECTING DRUGS

Hallucinogens

LSD

Slang Name
Acid, Sugar, Big D, Cubes, Trips

Chemical or Trade Name
d-lysergic acid, diethylamide

Pharmacologic Classification
Hallucinogen

Medical Use
Experimental study of mental functional alcoholism
How Taken
In tablet, capsule, ampoule (hypodermic) form or in saturated sugar cubes.

Usual Dose
100 Micrograms

Duration of effect
10 hours

Initial Symptoms
Exhilaration, excitement, rambling speech

Primary Effect
All produce hallucinations, exhilaration, or depression, and can lead to serious mental changes, psychotic manifestations, suicidal or homicidal tendencies.

Physical/Mental Dependence Potential
No/?

How to Spot Abuser
Abusers may undergo complete personality changes, "see" smells, "hear" colors. They may try to fly or brush imaginary insects from their bodies, etc. Behavior is irrational. Marked depersonalization.

Dangers
Very small quantities of LSD may cause hallucinations lasting for days or repetitive psychotoxic episodes, which may recur months after injection. Permanence of mental derangement is still a moot question. Damage to chromosomes, and hence potentially to offspring, has been demonstrated.

DNT
Slang Name
Businessman's High

Chemical or Trade Name
Dimethyltryptamine

Pharmacologic Classification
Hallucinogen

Medical Use
None

How Taken
Injected

Usual Dose
1 Milligram
Duration of Effect
4 - 6 hours

Initial Symptoms
Exhilaration, excitement

Primary Effect
All produce hallucinations, exhilaration, or depression, and can lead to serious mental changes, psychotic manifestations, suicidal or homicidal tendencies.

Physical/Mental Dependence Potential
No/?

How to Spot Abuser
Abusers may undergo complete personality changes, "see" smells, "hear" colors. They may try to fly or brush imaginary insects from their bodies, etc. Behavior is irrational. Marked depersonalization.

Dangers
See LSD

Mescaline

Slang Name
Cactus Peyote

Chemical or Trade Name
trimethoxy-phenethylamine

Pharmacologic Classification
Hallucinogen

Medical Use
None

How Taken
Swallowed

Usual Dose
350 Micrograms

Duration of Effect
12 hours

Initial Symptoms
Exhilaration, anxiety, gastric distress

Primary effect
All produce hallucinations, exhilaration, or depression, and can lead to serious mental changes, psychotic manifestations, suicidal or homicidal tendencies.
Physical/Mental Dependence Potential
No/?

How to Spot Abuser
Abusers may undergo complete personality changes, "see" smells, "hear" colors. They may try to fly or brush imaginary insects from their bodies, etc. Behavior is irrational. Marked depersonalization.

Dangers
See LSD

Psilocybin

Slang Name
Mushrooms

Chemical or Trade Name
dimethylamino, ethylinodol-dihydrogen phosph.

Pharmacologic Classification
Hallucinogen

Medical Use
None

How Taken
Swallowed

Usual Dose
25 Milligrams

Duration of Effect
6 - 8 hours

Initial Symptoms
Nausea, vomiting, headaches

Primary Effect
All produce hallucinations, exhilaration, or depression, and can lead to serious mental changes, psychotic manifestations, suicidal or homicidal tendencies.

Physical/Mental Dependence Potential
No/?

How to Spot Abuser
Abusers may undergo complete personality changes, "see" smells, "hear" colors. They may try to fly or brush imaginary insects from their bodies, etc. Behavior is irrational. Marked depersonalization.

Dangers
See LSD
Heroin

Slang Name
Snow, Stuff, H, Junk, Horse, Scoat, Harry, Joy Powder

Chemical or Trade Name
Diacetylmorphine

Pharmacologic Classification
Depressant

Medical Use
Pain Relief

How Taken:
May be taken by any route, usually by intravenous injection

Usual Dose
Varies

Duration of Effect
4 hours

Initial Symptoms
Euphoria, Drowsiness

Primary Effect
Like morphine in all respects, faster and shorter acting

Physical/Mental Dependence Potential
Yes/Yes

How to Spot Abuser
Morphine-like.

Dangers
Like morphine; dependence usually develops more rapidly. Dependence liability is high.

Marijuana (Cannabis)

Slang Name
Joints, Sticks, Reefers, Weed, Grass, Pot, Muggles, Mooters, Indian hay, Locoweed, Mu, Giggle-smoke, Griffo, Mohasky, Mary Jane, Hashish, Tea, Gage

Chemical or Trade Name
Cannabis Sativa

Pharmacologic Classification
Stimulant, Depressant or Hallucinogen

Medical Use
None in U.S.
How Taken
Marijuana smoked in pipes or cigarettes. Hashish is infrequently made into sandy, sniffed in powder form, mixed with honey for drinking or with butter to spread on bread.

Usual Dose
1 - 2 cig.

Duration of Effect
4 hours

Initial Symptoms
Relaxation, euphoria, alteration of perception of judgment

Primary Effect
A feeling of great perceptiveness and pleasure can accompany even small doses. Erratic behavior, loss of memory, distortion of time and spatial perceptions, and hilarity without apparent cause occur. Marked unpredictability of effect.

Physical/Mental Dependence Potential
No/

How to Spot Abuser
Abusers may feel exhilarated or relaxed, stare off into space; be hilarious without apparent cause; have exaggerated sense of ability.

Dangers
Because of the vivid visions and exhilaration which result from use of marijuana, abusers may lose all restraint and act in a manner dangerous to themselves and/or others. Accident prone because of time and space sense disturbance. Dependence (psychological but not physical) leads to antisocial behavior and could be forerunner of use of other drugs.

Amphetamine (Methamphetamine)

Slang Name
Bennies, Co-pilots, Footballs, Hearts, Pep pills, Dexies, Wake-Ups, Lid Proppers, Speed, Crystal

Chemical or Trade Name
Benzedrine, Preludin, Dexedrine, Dexoxyn, Methedrine

Pharmacologic Classification
Stimulant

Medical Use
Relieve mild depression, control appetite and narcolepsy
How Taken
Orally as a tablet or capsule. Abusers may resort to intravenous injection.

Usual Dose
2.5 - 5 Milligrams

Duration of Effect
4 hours

Initial Symptoms
Alertness, activeness

Primary Effect
Normal doses produce wakefulness, increased alertness and a feeling of increased initiative. Intravenous doses produce cocaine-like psychotoxic effects.

Physical/Mental Dependence Potential
No/Yes ?

How to Spot Abuser
An almost abnormal cheerfulness and unusual increase in activity, jumpiness and irritability; hallucinations and paranoid tendencies after intravenous use.

Dangers
Amphetamines can cause high blood pressure, abnormal heart rhythms and even heart attacks. Teen-agers often take them to increase their "nerve." As a result, they may behave dangerously. Excess or prolonged usage can cause hallucinations, loss of weight, wakefulness, jumpiness and dangerous aggressiveness. Tolerance to large doses is acquired by abusers; psychic dependence develops but physical dependence does not, and there is no characteristic withdrawal syndrome.

Barbiturates

Slang Name
Red Birds, Yellow Jackets, Blue Heavens, Goof Balls, Barbs, Blue Devils, Candy, Phennies, Peanuts

Chemical or Trade Name
Phenobarbitol, Nembutal, Seconal, Amytol

Pharmacologic Classification
Depressant

Medical Use
Sedation, relieve high blood pressure, epilepsy, Hyper-throidism
How Taken
Orally as a tablet or capsule. Sometimes intravenously by drug abusers.

Usual Dose
50 - 100 Milligrams

Duration of Effect
4 hours

Initial Symptoms
Drowsiness, muscle relaxation

Primary Effect
Small amounts make the user relaxed, sociable, good-humored. Heavy doses make him sluggish, gloomy, sometimes quarrelsome. His speech is thick and he staggers. Sedation and incoordination progressive with dose, and at least additive with alcohol and/or other sedatives and tranquilizers.

Physical/Mental Dependence Potential
Yes

How to Spot Abuser
The appearance of drunkenness with no odor of alcohol characterizes heavy dose. Sedation with variable staxia.

Dangers
Sedation, coma and death from respiratory failure. Inattentiveness may cause unintentional repetitious administration to a toxic level. Many deaths each year from intentional and unintentional overdose. Potentiation with alcohol particularly hazardous. The drug is addictive, causing physical as well as psychic dependency, and withdrawal phenomena are characteristically different from withdrawal of opiates.

Cocaine

Slang Name
The Leaf, Snow, Speedballs (when mixed with heroin) Gold Dust, Coke, Bernice, Corine, Flake, Star Dust

Chemical or Trade Name
Methyl ester of benzoylgonnine

Pharmacologic Classification
Stimulant

Medical Use
Local Anesthesia
How Taken
A surface active anesthetic; by abusers, taken orally or, most commonly, intravenously alone, combined with or alternating with heroin. The coca leaves are chewed with lime, producing the effects of the contained cocaine.

Usual Dose
Varies

Duration of Effect
Varies

Initial Symptoms
Excitation, talkativeness, tremors

Primary Effect
Oral use is said to relieve hunger and fatigue, and produce some degree of exhilaration. Intravenous use produces marked psychotoxic effects, hallucinations with paranoid tendencies. Repetitive doses lead to manic al excitation, muscular twitching, convulsive movements.

Physical/Mental Dependence Potential
No/Yes

How to Spot Abuser
Dilated pupils, hyperactive, exhilarated paranoid.

Dangers
Convulsions and death may occur from overdose. Paranoic activity. Very strong psychic but no physical dependence and no tolerance.

Codeine

Slang Name
Schoolboy

Chemical or Trade Name
Methyldopamine

Pharmacologic Classification
Depressant

Medical Use
Ease pain and coughing

How Taken
Usually taken orally, in tablets, for pain; or in a liquid preparation, of variable alcohol content, for cough. Can be injected.
Usual Dose
30 Milligrams

Duration of Effect
4 hours

Initial Symptoms
Drowsiness

Primary Effect
Analgesic and cough suppressant with very little sedation or exhilarant (euphoric) action. Dependence can be produced or partially supported, but large doses are required and risk is minor.

Physical/Mental Dependence Potential
Yes/Yes

How to Spot Abuser
Unless taken intravenously, very little evidence of general effect. Large doses are morphine-like.

Dangers
Occasionally taken (liquid preparations) for kicks, but large amount required. Contribution of the alcohol content to the effect may be significant. Degree and risk of abuse very minor. Occasionally resorted to by opiate-dependent persons to tide them over with inadequate result.

Morphine

Slang Name
W. Dreamer, White Stuff, Miss Emma

Chemical or Trade Name
Morphine sulphate

Pharmacologic Classification
Depressant

Medical Use
Pain relief

How Taken
May be taken by any route; its abusive use is mostly by intravenous injection.

Usual Dose
15 Milligrams

Duration of Effect
6 hours
Initial Symptoms
Euphoria, Drowsiness

Primary Effect
Generally sedative and analgesic (rarely excitatory). The initial reaction is unpleasant to most people, but calming supersedes and, depending on dose, may progress to coma and death from respiratory failure.

Physical/Mental Dependence Potential
Yes/Yes

How to Spot Abuser
Constricted pupils. Calm, inattentive, "on the nod," with slow pulse and respiration.

Dangers
Man is very sensitive to the respiratory depressant effect until tolerance develops. Psychic and physical dependence and tolerance develop readily, with a characteristic withdrawal syndrome.
DEPRESSION AND LONELINESS

Dr. Ken Nunnelly - Depression and Loneliness

Some calls may be from persons who are depressed. Here are some of the things they will say to you:

I feel tired all the time and I do not want to do anything. I'm unhappy and I don't know why - I can't keep crying all the time. There's nothing interesting for me to do. This is a lonely world and nobody cares. Nothing good ever happens to me.

Sometimes a depressed person will say very little. He may greet you with a statement such as: Nobody cares I think I am going to die. And they won't say anything else, but wait for you to say something that gets them off the hook.

In order to cope with depression there are a number of things which you must know about it. Ask yourself: What is this person depressed about?

Look at depression as a sort of cover, covering up another feeling. Can get a feeling of a heaviness or fog about the person - apathy type feeling. What is the feeling, situation underlying this depression. Maybe a variety of answers and responses to this question. Some of the more common are:

1. Depressed individual may be that way because he is frustrated in achieving a goal that is important to him. i.e. Fired from job, flunked out of school, draft, illness.

   Depression is result of something happening to him situationally which he feels is beyond his control.

   Once you begin to talk about situation which brought on depression—the depression will begin to clear up a little. One way to help is to ask if person has some plans in mind for coping with the situation. Many times they have not even thought about it. And have not thought about what they could do as an alternative (i.e. if they flunked out of school, etc.)

2. Depression from some kind of loss or separation from family.

   Many times person needs to get the feelings out in the open - to cry.
3. Feeling of anger turned inward - Individual may have become unhappy with someone very close to him, but toward whom he cannot express his dissatisfaction. (Employee mad at Boss, son at father, mother at baby). Often feeling of anger is there but person tells himself it's wrong to be angry, or if I'm angry, it will destroy our relationship. Feeling of anger just kind of goes back inside. Getting mad at the University - no where for us to go. An angry depression.

Individual starts blaming himself for what has happened when these feelings of anger are turned inward. Blames himself for everything that goes on and begins to think badly of himself. He may attempt a suicide.

His angry depression can lead to suicidal thoughts with the revenge thought in mind.

"If I kill myself it'll drive my mother crazy!"

The response to this might be "isn't there a more constructive way to express your anger? Alternatives? There are many people who have killed themselves in anger.

When talking to someone with this sort of depression you might say: "You sound like you might be irritated by something?" Perhaps you're angry with someone?"

4. Depression which is expressed by the person who is lonely:

Many people are depressed because of loneliness. When an individual feels there is nothing he can do about his loneliness. Especially when a person feels there is something wrong with loneliness.

Can say and talk about feeling. Referral, and/or working out referral.

Sometimes just talking with this individual will be enough because it helps them get in contact with another human being. You can say something like: "I know being alone is not a good feeling sometimes."

Others may need to be referred in order to learn how to cope with the depression.

5. Depression which has to do with a physiological reaction to some kind of medication.

Ask if person is on medication, if so tell them to talk to physician about their depressed reaction to the drug.
6. Depression from being tired, sleeplessness, or sickness.

7. Serious depression caused by emotional illness - (pathological depression). Person may not be able to talk at all, or may be saying some weird kinds of things to you.

Some persons may be neurotically depressed or lonely. A way to tell is that they will always be the same in the sense that they won't change. Many times he will play a game thus gaining all kinds of secondary satisfaction. Don't expect them to make dramatic changes. If possible should encourage them to get some treatment.

Responding to people who are depressed will be easier if you take it easy. How you respond is very important. If you yourself feel you have not accomplished much in one conversation talk to your fellow workers about it - get it off your chest.

Q. Constructive way an angry depressed person can handle anger better.

A. First thing is to get to the feeling. What caused depression? Are you depressed? You seem depressed? Getting to what the depression is all about. He might say he got fired - you say how do you feel about it. If anyone says I don't know what to do about it - what do you think? Turn it back to them. Say what do you think about doing about it. Can you help depressed person get back on own two emotional feet.

Q. How would you deal with physiological related problems?

A. If he's on medication refer him back to his doctor. Tell your doctor you're sleepy, tired, and depressed all the time; and you think it's due to medication.

Q. What agencies would visit the lonely?

A. Concern, the group attached to Gethsemane Church.

Many times depression is just a substitute for the real feelings - one may feel he can't cry or shouldn't feel a particular emotion so he will substitute depression.

Q. What other things contribute to depression?

A. Anger, guilt, grief, loneliness.
You probably will not have many calls concerning problems in sex life. But even though this is not an emergency problem you can refer these people to the E. Washington Street Family Counseling Service, who will provide information to people who are experiencing marital distress.

Dr. Voss does a lot of birth control counseling for people who are married—unmarried. Diaphragm, Intra-Uterine device, etc.

Planned parenthood group meets in building behind Ball Hospital.

People who are unmarried and woman is pregnant. Dr. Voss considers this to be an occurrence that should never happen in these days with the many different forms of contraception that we have. Bringing a child into the world is such a responsibility and entails so much that contraception should be planned rather than be an accident.

However, if the woman goes to a doctor within 72 hours after intercourse, it is possible for the doctor to subscribe a dose of 25 milligrams of a drug.

Abortion: more than 10 states have legalized abortion, especially New York.

Adoption: may be another course of action besides abortion for an unwanted child.

Q. Are there any legal problems in giving a New York telephone number to a person requesting information on a legal abortion?
A. I personally think so. There are bound to be some legal problems, but not, I don't think with just referring; perhaps a local attorney should be contacted to see if we will have any problems by doing so?

Q. Does a girl who is under age need consent of her parents to get an abortion in New York?
A. Yes. Must be 21 without parent's consent.

Q. What agencies are there to help finance an unwed mother?
A. Salvation Army—Red Shield Home. A lot of denominations have these kinds of facilities. Can contact Homer Todd at Hazelwood Christian Church for aid. Welfare Department may also aid.
Q. What is the procedure if a girl is hemorrhaging from a self-induced abortion?
A. If she bleeds more than menstrual period she should go to emergency at Ball Hospital. Otherwise, she should go see her doctor. Her parents' consent would be needed if she required a D and C.

Q. How many illegal abortionists are in the Muncie area?
A. I don't know. But they are very rare in this area.

Q. What about prenatal counseling?
A. Prenatal Clinic—Tuesday morning between 8 and 11 at Gilbert Street, counseling is done and also prenatal care.

Q. Does Health Center on campus prescribe birth control pills?
A. No, because of the possible enormous flood of work on the center this might cause. Also because of the complicated emotionality and unpredictable nature as far as the parents are concerned.
APPENDIX III
FORM USED BY THE CIC
TO RECORD CALLS

86
<table>
<thead>
<tr>
<th>REQUEST:</th>
<th>Category Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>d m y</td>
</tr>
<tr>
<td>Call No.</td>
<td></td>
</tr>
<tr>
<td>Shift</td>
<td>A B C D E F</td>
</tr>
<tr>
<td>Time</td>
<td></td>
</tr>
<tr>
<td>:</td>
<td></td>
</tr>
<tr>
<td>Length</td>
<td>Hr. Min.</td>
</tr>
<tr>
<td>Contact</td>
<td>Tel. W-I</td>
</tr>
<tr>
<td>Caller's Name</td>
<td></td>
</tr>
<tr>
<td>Age/race/sex</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Problem</td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td></td>
</tr>
</tbody>
</table>

| ACTION TAKEN: | |

<table>
<thead>
<tr>
<th>Call Back No.</th>
<th>Call Back No.</th>
<th>Call Back No.</th>
<th>Evaluation</th>
</tr>
</thead>
</table>
APPENDIX IV
CRISIS INTERVENTION CENTER
DO'S AND DON'TS

DO'S

DO read all the memos on bulletin boards and walls when you arrive at CIC.

DO read over information book to review in your mind the agencies and persons available for reference.

DO some housekeeping duties during your shift; if you leave it until the end of your shift you may not have time.

DO be as considerate of others on your shift as you are of those who call in.

DO make it a point to fill out a summary sheet on each call you receive.

DO record calls on weekly log sheet.

DO call CIC if you cannot make your shift. If possible make arrangements with another volunteer to fill in. If you cannot make arrangements with another volunteer, notify the CIC.

DON'Ts

DON'T discuss specific calls and cases with persons not connected with CIC (unless you need to call an agency which may have had contact with the caller.

DON'T try to be a counselor or psychologist; if you are making no referrals you may be trying to find solutions that should be handled by a professional.

DON'T give out phone numbers of any one except bonafide agencies; you make the contact call and either have the caller call you back or have your referral call him.

DON'T allow people not on your shift to enter the phone room and tie up the phones or make it inconvenient for the workers.