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Remembered Pain: The Relationships Between Loss, Hopelessness, and Suicidal Intent for Men in Early Adulthood

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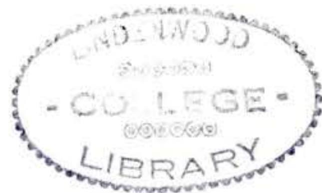
REMEMBERED PAIN:

THE RELATIONSHIPS BETWEEN LOSS, HOPELESSNESS,

AND SUICIDAL INTENT FOR MEN IN EARLY ADULTHOOD

ROY COADY MARKS, B.A., M.A.



An Abstract Presented to the Faculty of the Graduate School
of Lindenwood College in Partial Fullfillment of the
Requirements for the Degree of
Master of Arts

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ABSTRACT

Men between the ages of 20 and 35 calling a suicide prevention hotline and assessed as suicidal to some degree were the subjects of a study to explore the relationship between levels of hopelessness and recent loss and the overall risk for a probable suicide attempt. Suicide lethality assessments completed by telephone crisis workers at the time of the call were examined for 124 subjects. Significant relationships were found between the level of hopelessness and the overall risk of a probable suicide attempt and between the level of recent loss and the overall risk of a probable suicide attempt.

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ROY COADY MARKS, B.A., M.A.

A Culminating Project Presented to the Faculty of the Graduate School
of Lindenwood College in Partial Fulfillment of the
Requirements for the Degree of
Master of Arts

1989

COMMITTEE IN CHARGE OF CANDIDACY:

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DEDICATION

This work is dedicated to Sheila Kennedy who encouraged and supported the difficult process of my career change from beginning to end and who understood more than I did myself that...

> "Man by suffering shall learn
> So the heart of him, again
> Aching with remembered pain,
> Bleeds and sleepeth not, until
> Wisdom come again against his will."
>
> Aeschylus

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CHAPTER I

INTRODUCTION

Suicide is a major mental health problem in our country, as it is in most of the civilized nations of the world. In 1988, twelve people per every 100,000 in the United States carried out these irrevocable and awful decisions to cease to live (National Center for Health Statistics, 1989). Suicide, the human act of self-inflicted, self-intentioned death, is an affliction that robs us of some of the most productive members of our community. It is a form of mental illness in which the anguish and terror of the victims lead them to prefer death to their suffering.

Since at least 1950, men in the United States have consistently been found to commit suicide 2.5 to 4 times as often as women (National Center for Health Statistics, 1967). For the years 1984, 1985, and 1986, suicides among men were 19.7, 19.9, and 20.6 respectively per 100,000 men compared to rates of 5.4, 5.1, and 5.4 respectively per 100,000 women and 12.4, 12.5, and 12.8 respectively for both sexes combined. Earlier studies attributed the higher rate of completed suicides to men's choice of methods--guns, hanging, etc.--which are more immediately fatal than women's, who preferred drugs and wrist slashing. However, hypotheses about suicidal behavior in men are changing.

A recent study (Rich, Ricketts, Fowler, & Young, 1988) asked why men commit suicide more than women and examined 61 women and 143 men who committed suicide in San Diego County between November, 1981 and June, 1983. Methods of suicide, psychiatric diagnoses, and psychosocial stressors (such as work, relationships, and illness which create measurable stress in living) for each sex were examined, but could not be identified as causal to a significant degree.

The researchers concluded: "Our data favor the conclusion that the major reason more men than women in the United States commit suicide is that more men intend to do it" (p. 721). Though method of suicide, types of mental illness (including substance abuse and depression), and psychosocial stressors--all popular notions of causation--were ruled out in favor of intentionality, little is known about suicidal intent in men specifically.

Suicidal behavior is studied more thoroughly in some age groups of men than others. Males in their teen years, middle age, and senior years get considerable attention from researchers. Little is known about the early adulthood of men (ages 20-35). Some things are known, however. Early adulthood is defined by Daniel Levinson, (1978) as a critical developmental period in a man's life. The young man must accomplish the three major tasks of (a) leaving home, (b) making his first decisions as an adult which usually include

marriage, family, and career, and (c) evaluating, retaining, or changing his first decisions as an adult. Suicide for men in the early adulthood group in the United States in 1986 was 15.7 per 100,000 men as compared to 12.8 per 100,000 for the population as a whole (National Center for Health Statistics, 1987).

The lack of attention by social scientists paid to men in early adulthood is perplexing. Suicide is the eighth leading cause of death in the United States. It is also the third leading cause of death for all age groups in 15 to 24 year old population (Hegg, 1989), a population which overlaps early adulthood. In 1985, rates for men climbed steadily from age 35 to a high of 55.4 per 100,000 for the age group 85 years and over (Bureau of the Census, 1988). Still little is known about suicidal behavior in early adulthood, an age group which links adolescence and middle age, two periods which are high risk for suicide in males.

Early adulthood is a time of unusual challenge for a man and may be a time of unusual despair. He plants his feet firmly in the adult world. Success in work and love looms large. However, it is also a time of intense psychosocial stressors and first failures as an adult. The personality variables which shape a man in early adulthood into a normal functioning, mentally disturbed, or suicidally disturbed

being deserve more attention by practitioners in the field of psychotherapy and suicide prevention.

Since the beginning of this century community-formed suicide prevention centers and practitioners in the field of psychotherapy have both made efforts to identify the variables which contribute to suicidal intent in the general population, which includes men in early adulthood. Many variables contributing to suicidal behavior have been examined by suicide prevention centers and psychotherapists working individually and in cross-disciplinary efforts. No variables were found to be exclusively causal, rather a complex of variables seemed to operated in the suicidally disturbed person in a manner unique to each individual. Two variables found to be worthy of further study were hopelessness and loss. Hopelessness is the feeling that one cannot with consistency and certainty provide gratification for oneself when interacting with (a) others and/or (b) one's own internal psychic world. Feelings of hopelessness are part of normal psychological functioning. However, when feelings of hopelessness become a patterned response to life, hopelessness can become a core element in suicidal intent.

Loss, the second variable, is the damage, trouble, disadvantage, or deprivation caused by losing someone or something that is important. Loss stimulates patterns of hopelessness which may lead to suicide in two ways. First,

the passing of time, the attention of others, and self-care may not adequately compensate for the real or perceived loss of the important person or an important person's love in a child's or adolescent's life. In such a case feelings of anger, fear, guilt, and shame may accumulate in such a way that the person dwells unconsciously on his losses rather than on his success in overcoming loss. Unconsciously, the person despairs of dealing with new loss well-based on his experience with previous loss. A pattern of loss forms when the unconscious retains the feelings of loss. Patterns of loss thus influence patterns of hopelessness. Secondly, recent loss (real or perceived) of someone or something may trigger patterns of loss in the unconscious which influence patterns of hopelessness.

To summarize, early losses are not adequately compensated for and thus patterns of loss and hopelessness form in the unconscious. New loss to the person stimulates these unconscious patterns of loss and hopelessness, which, in turn, stimulate suicidal intent. Increasing suicidal intent, unless assessed and diminished, leads to suicide.

Thus, the relationship between hopelessness, recent loss, and suicidal intent using data from suicide prevention centers is a viable field of study. For hopelessness, recent loss, and suicidal intent are untested psychological constructs of personality theory from the mental health

discipline of psychotherapy. These constructs need empirical scrutiny using data from a variety of sources. From the beginning of this century to the present, suicide prevention centers continue to be a valuable source for testing hypotheses and collecting data related to the personality variables of suicidally disturbed people.

Statement of Purpose

This study used descriptive and empirical methods to investigate the relationships of two specific risk factors to the risk for probable suicide attempt. Hopelessness and recent loss were studied to examine the strength of the influence of these variables on the risk for probable suicide attempt of male callers, ages 20 to 35, to a suicide prevention center. The study, using the variables of hopelessness and recent loss, attempted to determine whether these two variables are reliable predictors of suicidal risk for men in early adulthood.

Chapter II

Literature Review

Suicidal Behavior in Men

In 1976, Herb Goldberg, clinical psychologist, asked in his book, The Hazards of Being Male: "By what perverse logic can the male continue to imagine himself top dog?" (p. 181). He continues:

> Emotionally repressed, out of touch with his body, alienated and isolated from other men, terrorized by the fear of failure, afraid to ask for help, thrown out at a moment's notice on the occupational junkpile when all he ever knew was how to work, it is perhaps surprising that the suicide statistics [for men] are only what they are. (p. 181)

Suicidal behavior in men has a long history and suggests that some men are far from feeling in a winning position in the battle of the sexes or any of life's struggles, for that matter. Thus, early adulthood may be a particularly suicidally-vulnerable time for men.

The period from 20 to 35 years of age is called early adulthood by Levinson (1978). It is a period high in psychosocial stressors as the young man attempts a number of crucial developmental tasks. The degree of success and failure in coping with psychosocial stressors influences and is influenced by patterns of loss, hopelessness, and suicidal behavior.

Levinson divides early adulthood into three subphases. Early adult transition (ages 17-22) finds the young man separating from his family of origin psychically, socially, and perhaps physically. He also prepares for adulthood. He explores college, job, career, marriage, and family intrapsychically and in talks with parents, counselors, teachers, friends, and employers.

In the second subphase, entering the adult world (ages 22-28), he makes his first choices in adult life. He goes to work full-time or to college, and begins what he thinks is his lifelong career. He also dates on increasingly more serious levels, usually marries, and often begins a family. Rounding out his adult life, he becomes active in the community and church on his own terms and chooses his adult friends, which may include but are not restricted to his adolescent chums.

In the final subphase, the age 30 transition (ages 28-33), Levinson likenes the man's experience to a mini and earlier mid-life crisis. The age 30 transition is the period between a young man's first cluster of decisions in adult life (work, mate, etc.) and his second cluster of decisions in adult life.

Levinson (1978) studied 40 men through in-depth historical interviews, personal follow-ups, and comparisons with the lives of famous people in biographies and

autobiographies. He concluded that the male life cycle consists of alternating 5 to 7 year periods of transition and stability. Transitional periods demand more of the man. In these he must retool himself for the next period of stability. Change ignites anxiety. Anxiety demands gratification and self-soothing to tame it. The combination of two transitional periods in the short span of early adulthood in which the boy must become the adult man, and the psychosocial failures in first colleges, jobs, careers, marriages, etc. create an early adult developmental period which tests mightily his fragile need-gratifying, self-soothing, hope-maintaining, and regression-defeating mechanisms. Under these conditions, he is high risk for more psychosocial failure, mental illness, and suicidal behavior.

Too many stressors on the earlier developmental periods of the boy influence the course of early adulthood toward mental health, mental illness, or suicidal disturbance. In their attempts to understand pathological personality development, psychoanalytic theorists focused on two critical periods in the child's life. The preoedipal period concentrated on the child's development from birth to three years of age. In this period, two interacting processes were considered of critical importance: In the organically healthy child, the mother-child relationship and the

developmental progress (and arrests) of the child toward psychological separation from his mother.

Following, overlapping, and interacting with the preoedipal period is the Oedipal period, roughly from ages 3 or 4 to 6. In this period, a third party, the father, is added to the critical preoedipal relationship of child and mother. Then, three interacting processes were of critical importance: the mother, father, and child relationships, the developmental progress (and arrests) of the child toward further psychological separation from his parents, and the acquisition (or interrupted acquisition) by the child of self-orienting (sexual identification) and self-guidance (conscience) mechanisms necessary for continued healthy growth.

In the early years of psychoanalytic personality theory construction, especially S. Freud (roughly 1887 to 1920), emphases were given to the Oedipal period. From 1920 to the present psychoanalytic personality theories concerning the preoedipal period have been added to those concerning the Oedipal period. Some theorists attach importance for child development to one period more than another. Most theorists now recognize the mutual importance of both periods and their interaction with each other as equally necessary and contributory to child development in the first six years of life.

The development during the six years encompassing the preoedipal and Oedipal periods sets the pattern for all later development. Here, healthy, pathological, and suicidally-disturbed patterns of feeling, thought, and actions for men are blue-printed. A conviction of some psychoanalytic theorists about personality development is the earlier and more severe the insult to natural child development, the more severe the resulting pathology (Klein, 1964; Fairbairn, 1952; Winnicott, 1958, 1965). Put another way, the earlier and more severe the failure of reliability, attentiveness, responsiveness, memory, and durability in the care of the normally endowed male child, the greater the likelihood and severity of emotionally disturbed and suicidally disturbed behavior will be in the adult man. In early and severe failure in parental care lay patterns for the ultimate failure of self-care in men--suicide. However, despite almost 80 years of personality theory construction by the psychoanalytic community about suicide, regressive and progressive qualities in the personality are not fully understood. Regressive qualities are those which keep a man more focused on his psychological deficits from his early development. Progressive qualities are those which keep a man moving beyond his deficits to healthier living and an overcoming or better coping with his psychological deficits (Brenner, 1973).

Both regressive and progressive qualities reside in each person. Assessment of the health, pathology, or suicidology of the male personality is an assessment of the mix of (1) the earliness and severity of the psychic injury (or its absence), and (2) the regressive or progressive qualities used to adapt to the psychic injury in childhood, adolescence, and adulthood.

Generally, since its inception with the publication of S. Freud's Studies in Hysteria (1896), personality theorists have used psychoanalytic theory to attempt to understand these regressive and progressive qualities in terms of variables in the human which shape a man into a normal functioning, mentally disturbed, or suicidally disturbed being. Specifically, in 1910, the psychoanalytic community formally turned its attention to the question of suicide. That year, the International Association of Psychoanalysis devoted its annual conference in Vienna to the subject of suicide (Shneidman, 1969). This association, based in Vienna, "was founded by S. Freud in 1902 as a weekly discussion group for those interested to learn his conceptions of 'psychoanalysis,' the term he applied to his approach" (Watson, 1978, p. 502) to treating mentally disturbed patients.

At the conference, Wilhelm Stekel (cited in Shneidman, 1969, p. 2) identified suicidal behavior as a pattern

influenced by the person's wish to kill someone else expressed as the wish (and sometimes the act) to kill oneself. Stekel focused attention on suicide as the result of hateful rage for another misdirected at one's self due to a confused blending of the other person and the self in the mind of the suicide victim. The formal diagnosis, per Stekel (cited in Shneidman, 1969), was suicide is "hostility directed toward the introjected love object" (p. 8).

S. Freud's own thinking about suicide (cited in Litman, 1967) was more complex than Stekel's formulation. Besides aggression (hateful rage turned into action), Stekel's contribution, S. Freud factored into suicidal behavior the additional affects (feelings) of shame, guilt, dependence, hopelessness, and helplessness.

Leenaars (1988) summarized S. Freud's views on suicidal behavior in ten propositions (cited in Lester, 1988, p. 13):

1. Though the person has conscious desires to kill himself, the act appears also to be motivated by unconscious desires.
2. The suicidal person is preoccupied with a person who he has lost or who has rejected him.
3. He feels ambivalent about the lost or rejecting person, that is, both affectionate and hostile.
4. He is in some direct or indirect fashion identifying himself with the rejecting or lost person.

5. He appears to be treating himself as if he were reacting to another person.
6. The person has feelings of vengefulness and aggression toward himself as well as anger toward others.
7. The person is turning back upon himself murderous impulses felt toward some other person.
8. The person sees suicide as a way of punishing himself.
9. The person feels guilt and is self-critical.
10. The person feels that his personal organization of his experiences is impaired, and he can no longer synthesize his experiences properly.

The importance of S. Freud's thoughts on suicide was that it provided inspiration and direction for later theory-building on suicide. Freud's contribution can be summarized as follows:

1. He stressed the importance of many suicidal wishes, feelings, and fantasies as unconscious in nature and, therefore, out of the person's conscious awareness.
2. He emphasized the key role loss of a loved object (person) played in suicidal ideation.
3. He identified the connection in the suicidal person's mind between loss of a loved object and self blame (guilt), self punishment, and self doubt (he feels he cannot organize and synthesize his present experiences with loss).

4. He pointed towards the evolution of hopelessness in the suicidal person, the movement from feeling that he cannot organize and synthesize his present experiences with loss of feeling that he will not be able to organize and synthesize future experiences of loss.

Many psychoanalytically-oriented personality theorists (Menninger, 1938; Rado, 1951; Futterman, 1961; Hendin, 1965; Litman, 1967; Tabachnick and Klugman, 1967; Draper, 1976; Farberow, 1980; and Lester, 1988) influenced by the Vienna conference on suicide in 1910 and S. Freud's seminal thinking continued to identify and understand the variables contributing to suicidal intent.

Shein and Stone (1969) tied suicidal behavior, past patterns of hopelessness and loss, and recent experiences with loss to suicide in men. They described the suicidal man in these terms:

> ...[He] no longer expects gratifying contact with new objects nor does he gain sufficient sustenance from his old internalized objects, i.e., his ego ideal and object representations (a product of his early loss), to ward off his conclusion of helplessness. (p. 64)

Concurring with Shein and Stone, Morse (1973) linked suicidal behavior and patterns of hopelessness in men this way:

> ...A basic component of suicide is that the person has lost hope, i.e., he no longer expects to be able to be gratified

> in this world under present conditions
> which he is helpless to change. (p. 230)

To summarize, suicidal behavior becomes actual suicide when a man ceases to struggle with the suffering incurred from old, unconscious patterns of loss, which include, intersect with, and are included in patterns of hopelessness.

Psychoanalytic personality theorists (Freud, 1926; Winnicott, 1965; Klein, 1964; Mahler, Pine & Bergman, 1975) have identified three patterns of loss with origins in the preoedipal and Oedipal development of the child. These three patterns of loss are:

1. the loss of an effective mother
2. failure to master anxiety
3. the loss of healthy self concepts and healthy concepts of others.

Whereas historically theorists have tried to understand the impact of losses on the healthy and pathological formation of the human personality, the construct of hopelessness is a relative newcomer as a variable studied for its relationship to mental and suicidal disturbance. Loss is a much broader construct than hopelessness, and the psychological literature on loss is vast compared to that of hopelessness.

Loss and hopelessness as variables of mental illness occur about the same time in the literature of psychotherapy

and share some of the same theorists. Both constructs also share the condition that they exist as patterns of response accumulated and stored partially in the unconscious.

As with loss, S. Freud (1924) was the first major theorist to address the subject of hopelessness. Interestingly, he did so two years (1926) before he outlined the danger situations involving loss and defined four types of loss (to be addressed later).

Patterns of Loss

Patterns of loss reflect the anomalies of growth itself. An irony of growth is that it also involves change. Change involves gaining, going on to new things, but change also involves losing, giving up old things. Losses and the threat of losses give rise to emotions of all types in the child. In the preoedipal period, the mother is the primary mediator of change for the child. She must function in such a way that natural losses for the child do not become psychological losses so severe that they overshadow the overall developmental gains (physical, psychological, etc.) perhaps for a life time. Mental disturbances may surface in early adulthood which reflect unresolved losses incurred in the Oedipal (ages 3-6) through adolescent (ages 12-18) periods. Early, severe, repeated, uncorrected, and repressed experiences of losses yield patterns of loss. Patterns of

loss can be defined as the unconscious (and so out of the man's awareness), severe, and repeated dwelling on earlier experiences of loss. When losses to the preoedipal child are early, severe, repeated, uncorrected, and repressed enough, the patterns of loss produced may yield a suicidal intent in the adult male strong enough to yield the completed act of suicide. Loss patterns resulting from and contributing to the failure of mothering, the failure to master anxiety, and the failure to form healthy concepts of oneself and others interact with each other in the preoedipal child and have lethal implications for the male in early adulthood.

The Loss of Good-enough Mothering

One loss pattern affecting suicidal behavior may be "good-enough mothering." Winnicott (1965) used the term "good-enough" mothering, as opposed to perfect mothering (an impossibility), to describe normal mothering which, despite mistakes, helps the child along the path of normal development. Winnicott explained, "Good-enough mothering provides a certain type of environment" (1948, p. 168) which holds the baby psychologically in the "reliability, attentiveness, responsiveness, memory, and durability" (cited in Greenberg & Mitchell, 1983, p. 201) of the mother as securely as she would physically hold the baby in her arms. To continue the analogy, the psychologically healthy child at 3 years of age

has lived a life so far relatively free of the insecurity of being psychologically dropped.

Not good enough mothering of the child, i.e., child neglect, when early and severe, leaves psychological scars which may result in the ultimate not good enough mothering of the early adult male--suicide.

While Winnicott gave the process of good mothering a name and inferred what good-enough mothering was and was not from his experiences with adult patients, Mahler et al. (1975) charted the development of good-enough or not good enough mothering in a laboratory setting.

Mahler et al. (1975) in her pioneering longitudinal study of mother-child pairs at the Masters Children's Center in New York focused on the development of the psychological functions of the child in the first 3 years of life. The purpose of her study was to verify the occurrence of the separation-individuation process. Mahler postulated that the separation-individuation process was the process in which the child separates from the psychological union with his mother, called symbiosis, and becomes a separate psychological person This becoming a separate psychological person Mahler called individuation. Separation and individuation are critical to adult mental health and the psychic forces which counter suicidal intent.

Another purpose of her study was to delineate both the

patterns of mother-child interaction and the developmental patterns of the child occurring at specific times in the period of the child's life from 5 months to 3 years of age. She drew particular attention to the later period of the child's separation-individuation process.

During the period which spans the ages of roughly 14 months to 3 years, two broad, complex, and interrelated developmental tasks are to reach a good enough degree of completedness for psychological health. The two tasks of the child are the consolidation of individuality (hereafter identity) and the beginnings of emotional object constancy. The achievement of identity and object constancy by the normally endowed child rest on the reliability, attentiveness, responsiveness, memory, and durability of the mother. Identity is the image of oneself as a unique, competent, and self-determining individual (Bootzin, 1984, p. 43). Identity forms gradually over a life time and affects the early adult male's predisposition to suicide. However, the child's preoedipal task is to reach the age of three with a fairly firm set of thoughts, feelings, and behaviors which indicate the good beginnings of a concept (image) of himself as unique, competent, and self-determining. Emotional object constancy is a condition of the mind in which a mental image of the mother is now available to the child for his own sustenance, comfort, and love just as the actual mother was

previously available (Horner, 1984, p. 34). The child has gradually internalized the equilibrium-maintaining maternal functions that lead to a separate, self-regulating person (Tolpin, 1971). Burgner and Edgcumbe (1972) described object constancy as:

> the capacity for constant relationships... the capacity to recognize and tolerate loving and hostile feelings toward the same object (person), the capacity to keep feelings centered on a specific object, and the capacity to value an object for attributes other than its function of satisfying needs. (p. 328)

Not good enough mothering, then, may leave the child uncertain of himself (a failure of identity constancy), confused, and thus more dependent on the mother than he should be. At the same time, approaching age 3, the child is not as sure of the mother as a reliable caretaker (a failure of emotional object constancy) as he should be. The child of three whose mothering has failed him is at an impasse. He can neither rely on himself nor his mother to the degree necessary as he continues development from the preoedipal into the Oedipal period. Projected into adult life, the male in early adulthood facing the psychosocial stressors of this period may find himself unconsciously trusting neither himself nor others. If stressors prove too great, and there is no one to trust, all exits to relief may seem blocked. Suicide may seem the only exit viable.

S. Freud's (1926) ideas about loss approach the loss of good-enough mothering in a different way. He outlined four danger situations which involve loss in the sequence of a child's life which have profound implications for the suicidally disturbed man. The first loss was the separation from a person who is important to the child as a source of gratification. This is often referred to as loss of the object or loved object. Usually, the infant's mother is the first loved object. Her loss threatens every vital need the infant has and its very survival.

The second loss is the loss of the love of a person in the child's environment on whom it must depend for gratification. Even though the person remains present, for example, the mother, the child may fear the loss of the mother's love. This is referred to as loss of the object's love.

The third loss is different for the two sexes. For little boys, it is the danger of the loss of the penis, which is referred to as castration. For little girls, the danger is some analogous genital injury.

The final loss posited by S. Freud is called guilt or the loss of approval of the child or person's own superego (the conscience). In other words, the person's own conscience punishes him (Brenner, 1973). These losses and danger situations involving loss, if not adequately compensated for, haunt the adult in various ways and account

in large part for the two broad categories of mental illness, psychoses and neuroses, and the many types of mental illness between the two, often called character disorders. S. Freud asserted that these losses and danger situations involving loss persisted at least to some degree throughout life unconsciously (Brenner, 1973). The relative importance of each loss and danger varies from person to person. Loss and danger situations involving loss are related to the affect (feeling) of anxiety. The suicidally-disturbed man may never have mastered his anxiety. Anxiety, when unmastered, accumulates in the individual. Too much anxiety produces pain, a physical and psychological suffering. Accumulated pain requires relief, but anxiety also blocks thinking and problem-solving which can relieve pain. In such situations, the suicidally-disturbed man may seek suicide as relief.

Loss of Anxiety Control Mechanisms

The mastery of anxiety is a crucial developmental task for the preoedipal child, but the loss of good-enough mothering may put mastery of anxiety at risk.

The mother in the first 3 years of life is the primary mediator of the child's increasing ability to master anxiety. From birth to roughly 14 months, she is the exclusive protector of the child from overwhelming experiences of anxiety. From 15 months to 36 months, she gradually, in bit by bit fashion, supervises the increasing mastery of anxiety

by the child himself using the model of the mother's psychological holding of his anxiety in the first 14 months.

S. Freud (1926) gave a central place in all mental illness to anxiety. Loss and danger situations (as he defined them) trigger anxiety. Anxiety, in turn, triggers other affects such as anger, fear, helplessness, guilt, shame, and hopelessness (Schmale, 1964). The ability to master anxiety and other affects determines people's effectiveness in controlling their responses to loss and danger situations of loss (as defined by S. Freud).

Anxiety, according to Schmale, is the child's earliest psychic awareness of biological disequilibrium. The child's first anxiety attack, according to S. Freud (1926), is caused by his birth. Anxiety was the first affect to differentiate from the undifferentiated mass of affects which is the infant's psychobiological inheritence at birth. Anxiety became the child's earliest psychic awareness of biological disequilibrium (Freud, 1915; Schmale, 1964).

This earliest biological disequilibrium is the body's sense that something is stimulating it and will not let it remain undisturbed. Biological disequilibrium becomes psychic awareness, according to S. Freud (1915), because the stimulation of the body sets afoot a stimulation of the mind. S. Freud (1905, 1915) called this "demand made upon the mind for work" (p. 120) by the body a drive. He furthermore

conceived drives as lying "on the frontier between the psychic and somatic" (cited in Greenberg & Mitchell, 1983, p. 21), this is, between the mind and the body.

Anxiety is the earliest affect the infant experiences in response to the body's demand on the forerunner of his undeveloped mind. S. Freud (1926) suggested anxiety began with the trauma of birth for the infant. Thus, birth and anxiety go hand in hand.

Anxiety was inherited in all people and was the universal affect from which all others ultimately differentiated (S. Freud, 1916-1917). Schmale (1964) stated that anxiety remains with man throughout life and "is the first and immediate reaction to the perception of psychic tension in any situation" (p. 289).

Anxiety serves and saves the infant, but an overriding crucial developmental task of the preoedipal child is to gain increasing mastery over anxiety lest it master him. Mahler et al. (1975) concluded that mental health, as well as pathology, was determined in the first 3 years of life of the male infant by the child's hereditary endowment, the early mother-child interaction and relationship, and crucial events in the child's growing up. Each condition just described could disturb the child's efforts to master anxiety. Crucial events might include premature or prolonged separation from the mother due to mother or child hospitalization, divorce,

unemployment, death of a parent, physical or mental illness of a parent, etc.

So anxiety is with men all their lives and demands mastery. Yet factors which include the child's hereditary endowment, the early mother-child interaction and relationship, and an enormous number of external events can wreck havoc on the child's attempt to master anxiety. Anxiety is always there, a bedfellow to the normally functioning adult. So, too, is the control of anxiety. Not so with the suicidally-disturbed man. Whereas, anxiety is his constant companion, anxiety control is not. Anxiety serves and saves the infant, but anxiety is a seed which can germinate to destroy the suicidally-disturbed man who has never mastered it because he never internalized his mother's ability to control his anxiety. His mother may not have served as a good model. She may not have relieved his anxiety because she may have never mastered her own.

The Loss of Healthy Concepts of Self and Others

The loss of good-enough mothering precipitates and permeates all other patterns of loss. Loss of anxiety mastery at the hands of failed mothering negatively influences the forming of concepts of self and others. Especially destructive for the suicidally disturbed man is the loss as a child of a world of internal representation in which he unconsciously stores healthy impressions (hereafter

representations) of himself and others in the forms of thoughts, feelings, and fantasies by the end of the separation-individuation process, roughly at age 3.

Jacobson (1954) described the culmination of the separation-individuation process as postulated, studied, and verified by Mahler as the beginnings of the formulation of the child's "weltbild, his fundamental position in relation to the world" (Jacobson, 1954, p. 126). The child's "fundamental position in relation to the world" is determined by the quality of a complex grouping of internal representations of himself, called self representations and an equally complex grouping of internal representations of other people and things, called object representations. Both self and object representations, also known as the child's representational world, are unconscious. Their healthy formation is crucial to normal adult functioning, for they are an important part of the psychological glasses through which adults see themselves, others, and their world.

If the child's representational world was pathological, Jacobson contended, the child would "experience the world as a constant source of harm, disappointment and failure, and himself, accordingly, as a poor devil forever apt to be deprived and hurt. Consequently, the level of his mood would be preponderently low" (p. 125-126).

Thus, the implications of early and severely distorted internal and unconscious self and other representations is dire for the suicidally-disturbed man in early adulthood. Without knowing it consciously, he may mistrust and see as bad (unworthy of reliability, attention, responsiveness, memory, and durability) himself and others. Therefore, when suicidal ideation presses him, he may refuse to turn to his own inner resources or the help of others to intervene to stop suicidal ideation from becoming a completed suicide. He finds himself unworthy of life and better off dead. He believes others see him this way and will not offer help, or feels that their help will be insincere or ineffective.

At this time the child faces the considerable trauma of disidentifying with mother, his first love object and identifying with father. The change was additionally traumatic for the child who up to this time may have perceived the father as a strange, shadowy, and distant figure.

The loss of good-enough mothering, the anxiety-mastery, and healthy concepts of self and others produce an overall pattern, dominated by pathology rather than health, from the preoedipal period. Several personality theorists have explored the total effect of these loss patterns as the child bridges from the preoedipal to the Oedipal period.

Unlike the theorists previously cited whose theories and empirical studies contributed to personality constructs fitted to both sexes, Rubin (1983) speculated in a dramatic way directly on the boy's unconscious experience in the separation-individuation process and the Oedipal period.

She described in some detail the emotional experience of the boy's separation from his mother which has its earliest beginnings when the boy is scarcely 6 months old in this way:

> When a boy who has been raised by a woman confronts the need to establish his gender identity, it means a profound upheaval in his internal world...if mother has been the main care-giver, the attachment and the identification with her remain the primary ones...he must renounce this connection with the first person outside self to be internalized into his inner psychic world--the one who has been so deeply embedded in his psychic life as to seem a part of himself--and seek instead attachment and identification with father,...a secondary character in his internal life and sometimes troublesome shadow on the consciousness of the developing child (p. 55-56). This 'demand (that he separate from mother and identify with father) that feels so unreasonable' is a complicated and painful process that takes its toll on a boy. (p. 58)
>
> [His] identifications and attachment are so closely linked that the child can't give up one without an assault to the other. With the repression of the identification with mother, therefore, attachment to her becomes ambivalent. He still needs her, but he can't be certain anymore that she will be there, that she can be trusted. (p. 56)

The boy's response to this early loss (his attachment to his mother must be given up along with his identification

with her) is a sense of deep and painful and lasting betrayal (Rubin, 1983).

> His inner experience is not that he did something but that something was done to him--that his mother who had, until then, been the loved adult, the love of his life on whom he could count, with whom he could identify, abandoned him to the shadowy and alien world of men. (p. 56)

The boy also responds by developing rigid, impermeable ego boundaries that separate himself from others "and from connection to his inner emotional life as well" (p. 56).

The separation from mother in the real or distorted experience is invasive, abrupt, swift, deep, painful, lasting, unprepared for, unreasonable, and unexplained as outlined by Rubin (1983) except possibly by expressions like "there's a big boy," "big boys don't cry," "mommy's little helper (or man)," and "he's daddy's boy." Every developmental gain--walking, climbing, exploring, throwing his first ball, talking--has the seeds of loss. One of his legacies along with pain and loss is aggression. Rubin (1983) concluded:

> ...it seems to me that we are witness also to a case of aggression turned outward in an attempt to compensate for the original aggression that was turned in when, as a small child, he had to sunder his inner life so ruthlessly. (p. 57)

Intense aggression is hateful rage turned inward for the suicidally-disturbed man, but the origin suggested by Rubin

may be the same. Like the healthy boy who must separate from the mother, the suicidally-disturbed boy's life has been ruthlessly sundered in this normal developmental process. But, unlike the healthy boy, the suicidally-disturbed boy lacks the anxiety, rage, guilt, and punishment-relieving functions of a good-enough mother, parents, and self.

Addressing the boy's angst somewhat differently, Greenson (1968) called the process of separation-individuation in the boy "dis-identifying" (p. 370) from the mother. He stated that he used this term to sharpen the focus on "the complex and interrelated processes which occur in the child's struggle to free himself from the early symbiotic fusion with mother" (p. 370). His ability to dis-identify will determine the success or failure of his later identification with his father. The dis-identifying from mother and counter-identifying with father are interdependent and form a complementary series, but one in which the mother and/or father can hinder the process (Mahler & LaPerriere, 1965).

A. Freud (1965) contended that mothers must demonstrate their willingness to allow the boy to identify with the father figure by genuinely enjoying and admiring the boy's boyish features and skills and by looking forward to further male developmental efforts of their sons. Mothers also

encourage identification by the boy with the father through their love and respect for their husbands (A. Freud, 1963).

The result in the psychologically healthy child of 3 was inner sustainment (Parens, 1970 & Saul, 1970), which Horner (1984) described as the ability to sustain "good self-feelings" (p. 35), and gave one "sustenance, comfort, and love" (p. 36). Saul (1970) put it this way, "The child is...internally sustained by the continuance in his mind, in his feelings, his self-image, his relation with others because of the love, confidence, and tolerance of his mother during his early years" (p. 222). The result in the psychologically unhealthy child of 3 was significantly less ability to self sooth, that is, to summon good self-feelings for sustenance, comfort, and love in times of need. The suicidally-disturbed man is without the internal resources to protect himself from his anxiety, guilt, shame, anger, and self-punishing ideation. There are not enough thoughts, feelings, fantasies, and memories of his own calm, goodness, and need satisfying experiences to combat the destructive forces in him calling for the forfeit of his life. Pain in life always outdistances relief, so he may believe relief waits for him in death.

Early Loss and Recent Loss

Early patterns of loss determine present responses to later loss as they filter from the unconscious to contaminate

what might otherwise be a clear and objective assessment and response to new and inevitable losses in life. Richman (1986) noted that suicidal people may be those who experienced early loss which then sensitized them to later loss. Lester and Beck (1976) found empirical support for this notion. The literature on persons surviving a suicide of a friend or family member suggests that these survivors are particularly at risk.

Phillips (1979) felt that loss due to separation or divorce (but not death) might be more common in both completed and attempted suicides. Bunch (1972; Bunch et al., 1971) has reported an excess of recent loss of parents in some completed suicides of males and an excess of recent loss of a spouse. Kearney (1970) found an excess of early loss of parents due to separation and divorce and an excess of recent disruptions in interpersonal relationships in a sample of attempted suicides. Stein, Levy, and Glasberg (1974) reported an excess of both early and later loss in suicide attempters. In contrast, other studies (Lester, 1983) found no excess of childhood loss of parents in suicidal individuals. Also, Lester and Beck (1976) found only female suicide attempters who had experienced early childhood separation from parents were more likely to have a recent loss as a precipitant for their suicide attempt. This condition was not found for males.

Whatever the future connection between early loss and recent loss has in store, at the end of the separation-individuation process, the boy of 3 continues his development in the crucible of the Oedipal struggle. The degree of preoedipal pathology in the boy of 3 affects the outcomes of the Oedipal struggle. The Oedipal struggle between the ages of 3 or 4 and 6 may either exacerbate preoedipal pathology or turn it in a healthier direction if preoedipal pathology is not too severe. A crucial consequence from pathological development at the preoedipal and Oedipal stages is the development of patterns of hopelessness, another important influence on suicidal intent in men.

Preoedipal Origins in Patterns of Hopelessness

Some theorists have conceptualized the onset or seeds of hopelessness in the child much earlier than the Oedipal period. Cooper (1986) asserted that patterns of hopelessness and many other pathological personality traits had an earlier origin in the preoedipal period. Morse (1973) predicted that the seeds of hopelessness reside in the experiences of the first few months of infancy for some people.

Morse also tied the early gestation of hopelessness to suicide in the adult. The lack of hope, he contended, that seems to precede suicide, the feeling that gratification is impossible, and the possibility of severe regression (going back to a level of psychic functioning more primitive than

the present one), all point to disturbances in the earliest stage of development. Schmale (1964) cited Erikson (1950) who pointed out that if there is a lack of proper care in the earliest stage (birth to age 2) then the person shall never develop basic trust that the world will gratify his needs, and he shall be prone to a lack of hope.

Both Schmale (1970) and Giovacchini (1979) suggested a defensive function with origins bridging both the preoedipal and Oedipal periods for people feeling hopeless. Schmale postulated that hopelessness defends against depression. Hopelessness, he thought, was a symptom formed of "the desire to be worthless" (p. 352). Hopelessness, here a type of depression, protects the individual from a conscious awareness of his unresolved castration conflict, his ambivalently held self representation, and his inability to give himself support from his own superego (conscience). In this defensive compromise, to avoid the punishment of the superego or the difficulty of psychic change through therapy, the person prefers, instead, to prove himself worthless. He overvalues in an obsessive way the competence and moral standards of others while thinking himself inadequate, bad, and in need of punishment.

Giovacchini (1979) hypothesized that hopelessness was used by some patients to defend against a worse affect--terror. Cohesion (the wholeness of the ego or self

representation) was achieved and the threatened identity reestablished by feelings of misery and hopelessness. Giovacchini found these conditions in treating patients with primitive mental states. For these people psychic functioning resembles that of the very young child or infant. For them, anxiety acts as a signal to the ego to summon defenses against an attack. Unlike higher functioning adults, the attack is on the identity. Confusion ensues, a sense of emptiness and purposelessness develops, and anxiety signals hopelessness to rescue the person from terror.

In summary, early deprivation (birth to age 3) can be understood as the origin of patterns of hopelessness occurring in the child either as a deficit along with basic mistrust of the mother (and later all other people) or as a defense against depression--the complex of feelings related to feeling worthless to the mother, or terror--the feeling of annihilation due to the mother's neglect. Patterns of hopelessness originating in the preoedipal period may be compounded by the struggles in the Oedipal period in which the boy now may experience additional feelings of hopelessness as he loses his perceived primary position with his mother to a new stranger--his father.

Oedipal Origins of Patterns of Hopelessness

S. Freud (1924) spoke of the affect of hopelessness and its relationship to early loss in "The Dissolution of the

Oedipus Complex." He describes the painful disappointments expressed in giving up the choice of the libidinally desired parental object, that is, the boy for his mother. According to S. Freud, "Even when no special events occur...the absence of the satisfaction hoped for, the...continued denial of the desired baby (the boy himself), must in the end lead the small lover to turn away from his hopeless longing" (p. 175). S. Freud went on to say that the painful disappointments experienced at the phallic stage (when the boy's attention turns to his penis, possession of his mother, and competition with and defeat of his father), which are the result of biological inheritance and overall maturation, had to be overcome or put aside in order to go on to the next level of development.

S. Freud (1924) looked further at the consequences of one pathological adaptation to the "painful disappointments" of the small boy lover who must give up his mother. Those who have had to completely repress the unresolved Oedipal complex (in boys, the striving for mother) will have a confused self-identity. They will also have an exaggerated but tenuous attachment to others, which occurs because of the ambivalent way in which the Oedipal objects (mother and father) are introjected (internalized). Images of mother and father are projected on to others as well, in an attempt to avoid danger. The longing for complete satisfaction of the

self in a relationship with such objects is recognized by the child as a hopeless one, and such longing is thus repressed.

Abraham (1924) referred to hopelessness as an expression of the ego's inability to achieve a complete love and an unyielding hatred as the result of unresolved ambivalence. But Abraham assumed some fixation (getting stuck) at the anal level (ages 2-4) of libidinal development (child turns attention to activities involving the anus) along with regression to the earliest level of oral development (birth to 2 years of age, when child turns attention to activities involving the mouth). S. Freud (1926) called the transformation of anxiety in the young boy during the phallic phase of development castration anxiety. He related the boy's fear of losing his mother as a love object he could exclusively possess (sexually and other ways) during the Oedipal struggle, to the danger of being separated from his genitals. Jones (1927) conceptualized an intrapsychic giving up by the young boy along with the total extinction of the capacity and opportunity for sexual enjoyment. Erikson (1950) saw the young boy in the stage of infantile genital sexual curiosity. Erikson called this time the stage of guilt versus initiative. He concluded that the boy would be required to regress or forget many of his fondest hopes and most energetic wishes and tame his exuberant imagination.

The boy also had to learn the necessities of self-restraint and interest in impersonal things of the external world.

French (1952) also discussed the relationship between hopelessness and frustration a young boy in the Oedipal stuggle must experience. He saw frustration as the realization that a goal one is committed to is unattainable. If the young boy has been pursuing a goal (say continuing uninterrupted into the future his exclusive preoedipal love affair with mother) with confidence and realizes that it is unattainable, hope is destroyed.

Schmale (1964) called this overwhelming defeat or loss of control over the self which may be precipitated by the loss of the other as the feeling of hopelessness. In other words, when two parts of the personality are at odds over the loss of a loved object, the self (which is the total concept one has of oneself) may feel powerless. In such a condition, the person may feel hopeless. Schmale suggested that the more independent and flexible the self representation was the less was the chance that any change or series of change in relationships with people would lead to the threat of loss and feelings of hopelessness.

The origins of hopelessness, Schmale contended, lie in what happens to the boy during the Oedipal struggle. To simplify, with the shattering loss of the mother as his sexualized love object, the boy realizes that he will never

possess his mother as he did in earlier symbiosis. He also realizes that development lies in a direction away from symbiosis. The boy with this sad knowledge experiences deep frustration of deeply held wishes. If his parents fail to mediate (help sooth) the frustration and ensuing anxiety so that these affects are experienced in small increments (optimal frustration), the boy may experience the affect of hopelessness in a pathological way. While conducting research on psychosomatic illness, Schmale found hope and hopelessness in the Oedipal period tied to the boy's emerging awareness of his sexual identification.

In the healthy boy, the Oedipal struggle ends with the achievement of a healthy sexual identity and conscience and the knowledge that though father is primary to mother, there is enough love from both parents and between both parents to guide and protect him. In contrast, if the first six years of development end in pathological ideas about himself, his parents, and all others, there is a different scenario.

Pathological patterns of hopelessness uncorrected by experiences which yield gain and hope, become increasingly rigid as the adolescent approaches early adulthood (Blos, 1962). Patterns of hopelessness then merge or coexist with patterns of depression, a complex of thoughts, feelings, fantasies, wishes, and behaviors often associated with suicide.

Patterns of Hopelessness and Suicidal Intent

Early in his practice of psychoanalysis, S. Freud (cited in Litman, 1967) discovered depressive states in his patients. He began to speculate that depression was some form of unconscious process in which anger is turned against the depressed person himself, sometimes with fatal consequences (cited in Leenaars, 1988).

Beck, Kovacs, and Weissman (1975) understood the process in which a depressed person turned against himself and often to suicide. Beck et al. saw depression, hopelessness, and suicide as cognitive processes, i.e., a series of thoughts, in contrast to S. Freud (1924) and Schmale (1964) who defined hopelessness as an affect, a feeling.

Beck et al. studied depression for many years and conceived of it as a distorted belief system, which in the extreme, precipitated suicide. Like many others, he felt depression was the key variable influencing suicidal intent. People with mental disorders involving a major component of depression (Major Depresson, Bipolar Disorders) historically have been more prone to suicide attempts and completions than people with other psychiatric disorders. But along with many other theorists and practitioners, Beck et al. found depression a complex phenomenon with variables of its own. Isolating depression did not predict suicide.

In 1974, Beck, Weissman, and Lester developed an instrument, the Hopelessness Scale, to measure hopelessness. Hopelessness was isolated from other variables of depression. Hopelessness was found to be "a core characteristic of depression [which] serves as the link between depression and suicide. ...Hopelessness associated with other psychiatric disorders also predisposes the patient to suicidal behavior" (cited in Beck Steer, Kovacs, & Garrison, 1985, p. 559).

The Hopelessness Scale encouraged a series of studies of the relationship among hopelessness, depression, and suicidal behavior. Minkoff, Bergman and Beck (1973) found that the intensity of suicidal intent was more highly correlated with hopelessness than depression. Beck et al. (1975) studied 384 hospitalized suicide attempters and found in 76% of this population that hopelessness accounted for the association between depression and suicidal intent. Hopelessness was found highly correlated with depression and suicidal intent among attempters in 4 studies (Wetzel, 1976; Goldney, 1979; Petrie & Chamberlain, 1983; Dyer & Kreitman, 1984). Hopelessness was found to correlate more strongly than depression with suicidal intent among drug abusing suicide attempters (Weissman, Beck & Kovacs, 1979) and to be a key determinant of suicidal intent in alcoholic suicide attempters (Beck, Weissman & Kovacs, 1976). In two other studies (Bedrosian & Beck, 1979; Wetzel, Margulies & Davis,

1980), patients who were hospitalized for depression or suicide risk, rather than for a recent suicide attempt, revealed hopelessness, rather than depression per se, was a determinant of suicidal intent.

Statland (1969) defined hopelessness as "negative expectancies toward oneself and toward the future." The Hopelessness Scale (1974) includes affective, motivational, cognitive components which have confirmed these negative expectancies.

Beck et al. (1985) studied 207 patients hospitalized for ideation, but not for recent attempts at the time of admission. During a follow-up period of 5 to 10 years, 14 patients committed suicide. Of all data collected at the time of hospitalization only the Hopelessness Scale (1974) and one other instrument, Beck Depression Inventory (a self inventory) predicted the eventual suicide. It was found that a score of 10 or more on the Hopelessness Scale correctly predicted 91% of the eventual suicides. The authors concluded that their findings supported by others indicate the importance of degree of hopelessness as an indicator of long-term suicidal risk in hospitalized depressed patients. The studies just cited suggested that patterns of hopelessness fueled suicidal intent in a variety of in-patient and out-patient populations. These studies also found connections between patterns of early loss, hopelessness, recent loss, and suicidal intent.

Patterns of Early Loss, Hopelessness, Recent Loss, and Suicidal Intent

Morse (1973) and others pointed to the connection that can exist between the variables of early loss, hopelessness, recent loss (current or near current loss in relationships, work, health, etc.), and suicidal intent. The degree to which these variables form a lethal pattern depended on some conditions which were not known at the time of his studies. Some conditions were known to precipitate the fatal connection of these four variables.

Morse (1973) considered that lack of proper maternal care in the earliest stage of child development (birth to two years of age) would be one predictor of suicide precipitated by the chain of early loss, hopelessness, and recent loss experiences stored in the unconscious. The earlier the maternal neglect the greater the basic mistrust of oneself and others would be and, thus, the potential damage to self and object representations. In other words, there are no permanent bad feelings of self without commensurate permanent bad feelings about others. So the earlier a child was neglected, the more the child suffered the two deficits which can build up in him--bad self and bad object representation which say to him, "not only can you not trust yourself to get the gratification you need, but also you cannot trust others to give gratification either."

Early neglect, then, bred feelings that gratification is impossible from any source ("I cannot help myself and no one can help me"). Morse (1973) stated it this way, "A basic component of suicide is that the person has lost hope, i.e. he no longer expects to be able to be gratified in this world under present conditions which he is helpless to change" p. 230). Shein and Stone (1969) showed the connection between early loss, hopelessness, and recent loss in this statement:

> ...[He] no longer expects gratifying contact with new objects (he fears disappointment from new people and predisposes himself to to fail with them) nor does he gain sufficient sustenance (self soothing) from his old internalized objects, i.e. his ego ideal and object representations [these two are his internal representations of an object, usually maternal care and the idealized way the subject wants to be (his role model) which is based on the mother who failed him] to ward off his conclusion of helplessness (in this case hopelessness, too). (p. 64)

As new life goes on, Morse (1973) described, later experiences of loss, frustration, and deprivation will be felt as repetitions of earlier losses and thus will be experienced as unusually severe. The suicide is a person, Morse felt, who is terribly "entitled" because he feels deprived, and he is a person who is most likely to feel unusually hopeless in the face of anxiety.

Various personality theorists, then, have linked patterns of early loss and hopelessness and recent loss to suicidal intent, but sufficient empirical data is lacking to verify these ideas. Therefore, it was the intention of the present study to statistically explore the influence of hopelessness and recent loss on a suicidally disturbed man's ideation about suicide attempt and completion.

Life Crisis Services crisis worker suicide lethality assessments for suicidally disturbed men callers were examined for this purpose. Through the measurement of the degree of risk assessed for hopelessness, recent loss, and probable suicide attempt, the study explored the correlation between the degree of risk in two separate correlations: (1) degree of hopelessness and degree of overall risk for suicide attempt and (2) degree of recent loss and degree of overall risk for suicide attempt.

Since the literature of psychoanalysis and other psychologies suggest relationships between early loss, hopelessness, and suicidal intent on the one hand and between early loss and recent loss on the other, the following hypotheses seem worthy of exploration:

Statement of Hypotheses

The hypotheses of the study were as follows:

1. For a sample of men, ages 20-35, calling a suicide prevention hotline and assessed to have a high risk for probable suicide attempt, more than 50% will have high ratings.
2. A sample of men, ages 20-35, calling a suicide prevention hotline and assessed to have a medium risk for probable suicide attempt will have more high ratings on a hopelessness scale and a recent loss scale than men callers, ages 20-35, assessed to have a low risk for attempting suicide.
3. For a sample of men, ages 20-35, calling a suicide prevention hotline, the ratings assessing risk for probable suicide attempt will be significantly correlated with ratings on a hopelessness scale and ratings on a recent loss scale.

CHAPTER 3

METHOD

Subjects

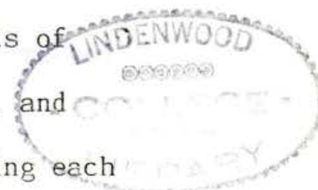
The 124 subjects of this study were male callers to Life Crisis Services, Incorporated (hereafter LCS), a suicide prevention hotline in St. Louis, Missouri, founded in 1966 and offering 24 hour intervention for suicidal persons. Male callers were between the ages of 20 and 35 and were identified as suicidal and living in the St. Louis Metropolitan area. Subjects were selected for the study based on four criteria. The callers were (a) men, (b) between the ages of 20 and 35, (c) assessed by the crisis worker using the suicide lethality assessmemt section of the Life Crisis Services Call Report Assessment as being suicidal to some degree, and (d) calling the hotline from June through December, 1988. All subjects meeting these criteria were used.

Instrument

The Life Crisis Services Call Report Assessment (see Appendix A), constructed by the staff of LCS (1988), is the standard instrument used by LCS to collect information on all callers of both sexes to their telephone hotline. The call report form is completed for every call, except prank calls, chronic callers (a separate form is used for these), callers who hang up immediately, or callers referred to the business

offices of LCS. The instrument has thirteen sections for collecting and assessing data to determine the nature and extent of the caller's crisis or referral needs and the appropriate intervention. The sections cover initial suicide assessment, crisis worker identification, demographic data about the caller, written description of the problem, action plan, a second assessment of suicidal risk, follow-up plan, a checklist of problem areas, referrals given, and collateral calls made to obtain help from other people who might help relieve the caller's crisis. For suicidal callers in immediate danger collateral calls may be made to trace anonymous calls and to contact police, poison control, psychiatric assessment teams, therapists, or family members.

The Suicide Lethality Assessment (SLA) is the thirteenth and largest section of the Life Crisis Services Report Assessment. It consists of 16 risk factors that are used during the call by the crisis worker to perform a complete and final assessment of the caller's risk for a probable suicide attempt. The risk factors assessed are time and place of attempt, method to be used, availability of harmful means, means taken to prevent intervention, drug/alcohol use, recent loss, survivor of suicide, previous suicide attempts, present or past psychiatric care received, and levels of disorientation, helplessness, hopelessness, anxiety, and depression. Crisis workers complete the SLA by rating each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caller initially identified as suicidal on each risk factor using a 3-point scale which includes low, medium, and high ratings.

Two other parts of the SLA are the details section and the signs of depression section. The details section provides space for details about the caller which support each risk rating. The signs of depression section assesses the caller for depression which may precipitate suicide. Signs of depression assessed are appetite, sleep, confusion, weight loss or gain, loss of interest in usual activities, physical health, memory problems, and social isolation.

The 16th and final risk factor is the Overall Risk Assessment, which is completed after all other risk factors have been assessed and the details and signs of depression sections completed. The Overall Risk Assessment is the most important assessment of the SLA and rates the callers on a 5-point scale which includes no risk, low risk, medium risk, high risk, and immediate high risk. The Overall Risk Assessment determines what level (if any) of emergency procedure will be put into operation by the crisis worker. Emergency procedures are located in Appendix B under the title, General Guidelines and Suggested Intervention Strategies for Callers at Risk.

The focus of this study is the risk factors of recent loss and hopelessness and the Overall Risk Assessment

of the SLA. The risk factor of recent loss is used to assess how recently the caller has experienced a loss which is serious to him or her. The loss may be due to death, divorce, or the breakup of a relationship. The lost object may be a person, a job, or one's health. The type of object lost and the method of loss are left open-ended. Serious loss is a subjective experience. For a child it may be the loss of a pet. For a Japanese businessman, it is the loss of honor, face, self-esteem, or public esteem. A high rating for the risk factor of recent loss is described in the SLA as "just realized loss." A medium rating is for loss within the last three months. A low rating is for no loss or a loss experienced more than three months ago.

The risk factor of hopelessness is used to assess the degree of hopeless feelings expressed or implied by the caller. More specifically, the crisis worker here attempts to assess to what degree the caller has given up expectations of his own ability to provide himself with gratification either through contact with others or when turning to his own inner resources. The hopeless person to some degree has lost motivation, vivacity, courage, vigor, enthusiasm, and a will for life. The SLA describes a high rating for the risk of hopelessness as "marked feelings of hopelessness." A medium rating is described as "some feelings of hopelessness." A low rating is described as "no feelings of hopelessness."

Crisis Workers

Crisis workers are male and female volunteers from the community. They are trained by the LCS clinical staff, advanced volunteers, and health professionals from the community. Training workshops are 60 hours in length and consist of 13 sessions in a three week period. Sessions emphasize didactic presentations, group interaction, role plays by staff and trainees, and exercises. Training includes active listening, crisis management, suicide assessement and intervention, values clarification, triage (multiple call handling and decision making) and caller management. Trainees are observed by the clinical staff or advanced volunteers prior to taking calls alone. Crisis worker performance is evaluated every 90 days by the clinical staff. Crisis workers are required to attend in-service workshops three times a year. Each trainee receives an LCS Training Syllabus containing background material and exercises. The training syllabus is used during training and when volunteers are active on the telephone lines.

Procedure

The LCS Call Report Assessments used in the study were selected from the total assessments completed for males by crisis workers from June through December, 1988. Assessments were sorted by hand, using three criteria: (a) the callers were men, (b) the callers were between the ages of 20 and

35, and (c) the callers were assessed by the crisis worker as low, medium, high, or immediate high in the overall risk assessment category of the Suicide Lethality Assessment section.

CHAPTER 4

RESULTS

Using the LCS Suicide Lethality Assessments (hereafter LCS-SLA) completed by crisis workers, data were obtained for each of the 124 subjects. Eighteen males were assessed as high risk, 34 as medium risk, and 71 as low risk for attempting suicide. No subjects were assessed immediate high risk during the period. The crisis worker circled the terms "high," "medium," and "low" on the scale for overall risk for attempting suicide (Section VIII of LCS-SLA) after completing the first seven sections.

Percentages were used to examine the relationships between high ratings on the risk factors of hopelessness and recent loss for three groups of men rated low, medium, and high risk for probable suicide attempt. The Pearson Product-moment Correlation Coefficient (hereafter Pearson r), a statistical test, was used to examine two relationships. The first was the relationship between crisis worker ratings for male callers on the risk factor scale for recent loss (Section II of LCS-SLA) and crisis workers ratings of male callers on the scale for overall risk for probable suicide attempt (Section VIII of LCS-SLA). The second was the relationship between crisis workers ratings of male callers on the risk factor scale for hopelessness (Section VII of LCS-SLA) and crisis workers ratings of male callers on the

scale for overall risk for probable suicide attempt (Section VIII of LCS-SLA).

In each test of relationship, 52 subjects were eliminated because of missing data, leaving a total of 72 subjects in the sample. Though each test used samples totaling 72 subjects, the subjects in the samples were not the same. Of the 52 subjects eliminated due to missing data, 39 subjects were the same for each sample and 13 subjects were different in each. The two samples, then, have heavily overlapping populations.

Seventy-two subjects is a sufficient sample size for $\underline{r}$ to be statistically significant at a .05 level of significance. $\underline{r}$ is defined as the measurement of the magnitude or strength of a relationship in a sample of data. The .001 level of significance was used for both tests.

<u>Hopelessness and Suicidal Risk</u>

Table 1 presents the percentages of men in each of three risk groups receiving the highest rating for hopelessness. Sixty-seven percent of the men rated high risk for probable suicide attempt were also rated high for hopelessness. In addition, 35% of the men in the medium risk group were rated high for hopelessness compared to 18% with the low risk group.

When the Pearson r was applied to the data for 72 subjects from all risk groups to index the relationship

strength of ratings of hopelessness to risk ratings for probable suicide attempt, ratings on the hopelessness scale correlated significantly and positively with the ratings for probable suicide attempt ($\underline{r}$ (70) = +.42, $\underline{p} < .001$). This correlation indicates that low, medium, and high ratings for hopelessness appear to moderately influence low, medium, and high ratings for overall risk for probable suicide attempt for the sample of 72 suicidally disturbed men callers. No tables or figures represent this statistical test in this study.

Recent Loss and Suicide Risk

Table 2 presents the percentages of men in each of three risk groups receiving the highest rating for recent loss. Fifty-five percent of the men rated high for probable suicide attempt were also rated high for recent loss. In addition, 23% of the men in the medium risk group were rated high for recent loss compared to 12% in the low risk group.

When Pearson r was applied to the data for 72 subjects from all risk groups to index the relationship strength of ratings of recent loss to risk ratings for probable suicide attempt, ratings on the recent loss scale correlated significantly and positively with ratings for probable suicide attempt ($\underline{r}$ (70) = +.40, $\underline{p} < .001$). This correlation indicates that low, medium, and high ratings for recent loss appear to moderately influence low, medium, and high ratings

for overall risk for suicide attempts for our sample of 72 suicidally disturbed men callers. No tables or figures represent this statistical test in this study.

Table 1

Percentage of Each Risk Group With Highest Hopelessness Rating

	Risk Group		
	Low _n_ = 71	Medium _n_ = 34	High _n_ = 18
Highest hopelessness rating	18%	35%	67%

Note: _N_ = 124

Table 2

Percentage of Each Risk Group With Highest Recent Loss Rating

	Risk Group		
	Low _n_ = 71	Medium _n_ = 34	High _n_ = 18
Highest recent loss rating	12%	23%	55%

Note: _N_ = 124

CHAPTER 5

DISCUSSION

This study explored the relationship between levels of hopelessness and recent loss and the risk for probable suicide attempt in a sample of men, ages 20-35, early adulthood calling a suicide prevention hot line. The SLA section of the Life Crisis Services Call Report Assessment was used by telephone crisis workers to assess levels of hopelessness, recent loss, and risk for probable suicide attempt. The study results supported the hypothesis that more than 50% of the men callers assessed to have a high risk for probable suicide attempt would also have high ratings on a hopelessness scale and a recent loss scale. Men callers assessed by crisis workers as having a high risk of probable suicide attempt were also assessed to be experiencing a high degree of hopelessness in their lives and to have just experienced an important loss.

The study also sought to determine if men assessed as medium risk for probable suicide attempt would have more high ratings on the hopelessness and recent loss scales than men assessed as low risk for probable suicide intent. The study also supports this hypothesis. Men rated as medium risk for probable suicide attempt by the telephone crisis workers were also rated as having more marked feelings of hopelessness (the high hopelessness rating) than men rated as low risk for

probable suicide attempt. Also, men rated as medium risk for probable suicide attempt were found to have had a loss that was more recent, i.e., closer to the time of the telephone call, than men rated as low risk for probable suicide attempt. The term used for most recent loss on the SLA for a high rating on recent loss is "just realized loss."

Finally, when the Pearson r correlation coefficient was used to examine the relationship between the risk of probable suicide attempt and hopelessness and the risk for probable suicide attempt and recent loss for all risk groups, hopelessness and recent loss were both found to be determiners of and equally influence the risk assessment for probable suicide attempt. To summarize, the results of the study support the hypotheses that feelings of hopelessness and experiences of recent loss are related to and influence the intent to commit suicide in men, ages 20-35, calling a suicide prevention hotline. The findings of this study are also consistent with empirical studies and psychoanalytic theoretical formulations found in the literature concerning the role of hopelessness and recent loss play in the mind of the person who thinks about, attempts, or completes the act of suicide.

Limitations of the Study

There are some inherent difficulties in using the result of this study to support or refute assertions in the literature about the influence of hopelessness and loss on

suicidal intent or the reliablility of these two variables as predictors of suicide lethality. The link between loss early in life and suicidal behavior later in life has been suggested for over 70 years in psychoanalytic literature. This study, however, could not measure the impact of early loss on the suicidal intent of the subjects because the SLA from which the data were taken does not query the caller on the nature and extent of his early losses. The nature and extent of recent loss is assessed, but the link made in the training of crisis workers between the trauma of early loss and the trauma of recent loss is not clear.

In contrast, hopelessness as a risk factor does appear in the SLA. Historically, however, it has been difficult to determine what hopelessness is because of the vagueness of the term. In psychoanalytic and psychological literature, hopelessness and helplessness are often used interchangeably. Helplessness is also assessed in the SLA but neither hopelessness nor helplessness is defined specifically in the literature used to train crisis workers.

An additional confusion which contributes to lack of precision in defining hopelessness is found in the literature of psychology. Beck et al. (1974, 1975, 1976, 1979) who have identified hopelessness as an important predictor of suicidal intent call hopelessness a cognition, a thought. Schmale (1964), who traced the origin of hopelessness back to ages

3 to 6 in a child's life, calls hopelessness an affect, a feeling.

Recommendations for Future Study

Gilligan (1982) has pointed out that "among the most pressing items on the agenda for research on adult development is the need to delineate in women's own terms the experience of the adult life" (p. 173). Levinson et al. (1978) and Goldberg (1976) assert the same needs for men. We do not know as well as we could in the male's own terms his experience of loss, hopelessness, and suicidal behavior. Such experiences are a fundamental part of adult life. Understanding of the pathology in men's lives derived from the collision of inadequately coped with early loss, pervasive feelings of hopelessness, and, hence, overwhelming recent loss is necessary if intervention is to address the suicide completion rate among men. Men in general and men in early adulthood warrant additional study in agencies offering suicide prevention telephone services. Such studies could also target race, other age groups of men, other dimensions of lethality, and cohort groups of men and women in order to expand the agency's understanding and service to the male caller with suicidal intent. One outcome of such studies might be assessment instruments more sensitive to the lives, crises, and suicidality of men. Instruments of this type might be standardized and/or shared among suicide prevention hotlines for the purpose of intervention and research.

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APPENDIX A:

LIFE CRISIS SERVICES CALL REPORT ASSESSMENT

LIFE CRISIS SERVICES
CALL REPORT ASSESSMENT

EACH CALL WITH "LIFE CRISIS, MY NAME IS _______________". I'LL BE HAPPY TO TALK WITH YOU BUT FIRST I NEED TO KNOW IF YOU AR
G ANY THOUGHTS ABOUT SUICIDE, AND YOUR NAME, ADDRESS AND PHONE NUMBER. NOW TO THE FIRST QUESTION....

OU THINKING ABOUT SUICIDE?"
R: YES___ NO___ MAYBE____ UNKNOWN___ THIRD PARTY: YES___ NO___ MAYBE___ UNKNOWN___
"NOW I NEED TO KNOW YOUR NAME, ADDRESS AND PHONE NUMBER"

me________________________Alias________________________Call Report NO.__________ TIME OF CALL________am/pm
of Call____________Length of call____________ (H)HELP_____(9)911_____(8)800_____(F)FCFH_____(K)KUTO_____

R INFORMATION:

____

SS:________________________ZIP__________
(H):____________PHONE(W)________________RACE______

______

TAT(DIV,SEP,W,S,LT,M):___ GENDER: MALE__ FEMALE__
G ARRANGEMENTS:
ONE ___WITH FAMILY ___SIG.OTHER ___ROOMMATE
P.HOME ___HOMELESS ___OTHER
FICANT OTHER:

____
____
OF EMPLOYMENT________________________
ADDRESS________________________PHONE__________

THIRD PARTY INFORMATION:

NAME:________________________________

ADDRESS:________________________ZIP_________
PHONE(H):_____________PHONE(W)______________RACE__________
AGE:__________
MAR STAT(DIV,SEP,W,S,LT,M):___ GENDER: MALE___ FEMALE__
LIVING ARRANGEMENTS:
___ALONE ___WITH FAMILY ___SIG.OTHER ___ROOMMATE
___GRP.HOME ___HOMELESS ___OTHER
TALKED TO 3RD PARTY:YES__NO__ RELATIONSHIP TO CALLER________
NAME:________________________________
ADDRESS/PHONE:________________________________
PLACE OF EMPLOYMENT (third party)__________________________

LY DESCRIBE THE PROBLEM AND GIVE YOUR FEELINGS ABOUT THE CALL. (APPLIES TO THIRD PARTY___(Y/N))

N PLAN

SSESSMENT AT END OF CALL: ___NO ___LOW ____MEDIUM ____HIGH ____IMMEDIATE HIGH (FOR SUICIDE, HOMICIDE, OR ABUSE)

W UP
HEN: DATE_________________SHIFT________________

M AREAS/(PROBLEM CODES): PLEASE CHECK ALL THAT APPLY

S(001) ___DEPRESSION(008) ___FOOD(015) ___LONELY(022) ___RAPE(029)
RTION(002) ___EATING DISORDERS(009) ___GAY/LESBIAN(016) ___MARITAL/RELATIONSHIP(023) ___RUNAWAY(030)
SE-ADULT(003) ___EMERGENCY SHELTER(010) ___GRIEF/BEREAVEMENT(017) ___MASTURBATOR(024) ___SCHOOL PROBLEMS(03
SE-CHILD(004) ___EMERGENCY NEEDS(011) ___HOMICIDE(018) ___MEDICAL/HEALTH(025) ___SEXUAL ISSUES(032)
OHOL/DRUG ABUSE(005) ___EMOTIONAL NEEDS(012) ___INCEST(019) ___PEER PRESSURE(026) ___SUICIDAL/3RD PARTY(
TH CONTROL(006) ___EMPLOYMENT/VOCATIONAL(013) ___INFORMATION/REFERRAL(020) ___PHOBIAS(027) ___SUICIDE SURVIVOR(0
ARRE/PSYCHOTIC(007) ___FAMILY(014) ___LEGAL(021) ___PRANK(028) ___OTHER(035)________

ALS GIVEN:

____
____

CRISIS WORKER'S COLLATERAL CALLS: ___YELLOW CAB
___LCS PAGER ___4-CNTY PAGER ___POISON CONTROL ___PSYCHIATRIC ASSESSMENT
___TRACE ___POLICE ___OTHER TEAM
___THERAPIST (NAME)________________________PHONE:______________
FAMILY MEMBER (NAME)

CIDE LETHALITY ASSESSMENT

INTENSITY OF RISK

SUICIDAL PLAN	LOW	MEDIUM	HIGH	DETAILS
Time/when	___in the future	___>24 hrs	*___0-24 hrs	___FIREARMS
Method	___unclear	___some plans	*___well thought out	___DRUGS(type_______________) ___ALCOHOL
Availability	___have to get	___close access	*___have with/used in past	___CARBON MONOXIDE ___HANGING
Location/where	___unplanned	___maybe at location specified	*___at location specified	___JUMPING ___SLITTING WRIST(S) ___OTHER______________________
Intervention	___designed with probability of interruption	___no attention given to interruption of plan	___conscious effort made to prevent interruption of plan	______________________________ ___LOCATION____________________ ______________________________ ______________________________
DRUG/ALCOHOL USE	___none	___average use	___excessive use ___history of abuse	DETAILS ______________________________ ______________________________
RECENT LOSS	___none, or greater than 3 months ago	___within 3 months	___just realized loss	DETAILS ___JOB ___HEALTH ___DIVORCE ___OTHER__________ ___RELATIONSHIP ________________ ___DEATH ________________ ___WHO_________________________
SURVIVOR OF SUICIDE	___no	___yes	___yes(recent)	DETAILS ___HUSBAND ___WIFE ___PARENT ___CHILD ___FRIEND ___EXTENDED FAMILY ___OTHER_______________________ ______________________________
PREVIOUS SUICIDE ATTEMPTS	___none	___one	___two ___three ___more	DETAILS WHEN:__________________________ METHOD:________________________ ______________________________
PSYCHIATRIC CARE	___none	___past WHEN:__________ ___present	___hospital ___therapist	DETAILS NAME__________________________ ______________________________ ADDRESS_______________________ ______________________________ PHONE_________________________
DAILY FUNCTIONING	___not disoriented disorganized	___somewhat disoriented disorganized	___markedly disoriented disorganized	DETAILS ______________________________ ______________________________ ______________________________ ______________________________
MOOD				DETAILS SIGNS OF DEPRESSION
Isolation	___no feelings of helplessness	___some feelings of helplessness	*___marked feelings of helplessness	___APPETITE ___PHYSICAL HEALTH
Spirit	___no feelings of hopelessness	___some feelings of hopelessness	*___marked feelings of hopelessness	___SLEEP ___MEMORY PROBLEMS ___CONFUSION ___SOCIAL ISOLATION
Anxiety	___mild	___moderate	___high panic ___calm, decision made	___WT LOSS/GAIN ___LBS IN ___WKS ___LOSS OF INTEREST IN USUAL ACTIVITIES
Depression	___mild	___moderate	___severe	

OVERALL RISK ASSESSMENT (AFTER COMPLETING THE ABOVE LETHALITY ASSESSMENT)

APPENDIX B:

GENERAL GUIDELINES

AND SUGGESTED INTERVENTION STRATEGIES

FOR CALLERS AT RISK

GENERAL GUIDELINES AND SUGGESTED INTERVENTION STRATEGIES FOR CALLERS AT RISK

A. Low-Risk Suicide (no/vague plans; time frame unspecified)
1. find out plan
2. dispose of means
3. contact family member if minor
4. contact therapist if in therapy
5. offer referrals for counseling if not in therapy
6. verbal contract
7. follow-up within 14 days

B. Medium-Risk Suicide (some plans; time frame greater than 24 hours)
1. find out plan
2. dispose of means
3. contact family members or enlist help of friends
4. contact therapist if in therapy
5. offer referrals for counseling if not in therapy
6. verbal contract
7. follow-up within at least 7 days to assess risk and to determine if caller is in therapy

C. High-Risk Suicide (detailed plan, means available, time frame greater than 24 hours)
1. assess homicidal ideations
2. find out plan
3. dispose of means
4. trace if caller refuses to give identifying information
5. verbal contract to call LCS back within a specified period of time
6. follow-up within the time-frame specified in verbal contract; if no contact is made:
    a) send police
    b) contact therapist if in therapy
    c) contact family members
    d) contact a neighbor or friend through Hanes if family is unavailable
7. do not leave caller "alone"; terminate only when help has arrived and/or caller has agreed to contract
8. follow-up within 24 hours to assess risk and to determine if caller is in therapy

D. Immediate High-Risk Suicide (detailed plan, means available, attempt imminent)

1. find out plan
2. dispose of means
3. trace if caller refuses to give identifying information
4. verbal contract to call LCS back hourly until risk has diminished or caller is calm enough to go to sleep
5. follow-up hourly; HAND TO NEXT SHIFT. If no contact is made:
   a) send police
   b) contact therapist if in therapy
   c) contact family members
   d) contact neighbors/friends through Hanes if family is unavailable
6. do not leave caller "alone"; terminate only when help has arrived and/or caller has agreed to contract
7. follow-up within 2-4 hours to determine caller's whereabouts; if no contact is made, call the police or the hospital to find out what happened

E. Third-Party Suicide

1. inform caller of LCS' policy regarding third-party suicides
2. get name, address, and phone of caller and person at risk
3. emphasize the importance of LCS contacting the person at risk directly
4. if caller refuses to give identifying information on the person at risk, contract with caller to call LCS back within a specified time-frame for an update on the situation

F. Suicide in Progress

1. find out plan (what was taken, how much, when, where the weapon is)
2. contact Poison Control if uncertain about the toxicity of the drugs ingested
3. trace if caller refuses to give identifying information (police will be dispatched by the phone company if the trace is successful)
4. do not leave caller "alone"; terminate only when help has arrived
5. notify caller's family (and therapist if in therapy)
6. follow-up within 2-4 hours to determine caller's whereabouts; if no contact is made, call the police or the hospital to find out what happened

G. Medium- and High-Risk Homicide

1. find out plan and who is threatened
2. notify police and potential victim(s) or victim's family
3. trace if caller refuses to give identifying information
4. contact family members
5. contact therapist if in therapy
6. verbal contract to call LCS back within a specified period of time
7. follow-up within the time-frame specified in verbal contract; for high-risk, if no contact is made:
    a) notify police
    b) contact therapist if in therapy
    c) notify potential victim(s) or victim's family
    d) contact caller's family
8. follow-up within 2-4 hours with high-risk calls to determine caller's whereabouts and victim(s)' safety; if no contact is made, call the police or the hospital to find out what happened

H. Medium- and High-Risk Abuse

1. trace if caller refuses to give identifying information and danger is immediate or caller is injured
2. if the victim is a minor, contact the Child Abuse Hotline; if the victim is a senior adult, contact the Elderly Abuse Hotline
3. send police for victims of rape and family violence
4. send cabs for transport to emergency shelters only if caller is uninjured (police will provide transport for injured callers)
5. follow-up within 2-4 hours with high-risk calls to determine the caller's whereabouts and safety; if no contact is made, contact the Abuse Hotline, the police, or the hospital to find out what happened