CRISIS INTERVENTION - I

COU442

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CRISIS INTERVENTION

COU442
Syllabus

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LESSON 1

"Understanding Crisis"

One general rule that applies to crisis: most people in crisis are normal.

1) Most people in crisis are even capable of helping themselves.
2) If they're given a little help, most people in crisis are capable of turning the crisis situation into an opportunity for growth.
3) People in crisis are people like you--not severely mentally disturbed people.

The Breaking Point

Every person has a breaking point.

The Delicate Balance

Most of the time, people live in a steady state--a balance between emotions and thoughts. When a person's own balancing system fails and his equilibrium is disrupted, crisis can occur. The potential for crisis depends on how completely the state of equilibrium--the delicate balance--has been upset. When the equilibrium shifts rapidly, the person experiences a problem. If the problem is not resolved quickly, she enters a state of stress. Stress usually causes enough tension that she works to resolve her problem, but if that doesn't happen within a reasonable amount of time, crisis occurs.

What Is Crisis?

Crisis is a serious interruption in equilibrium. It is a state of emotional turmoil, in which emotions overcome thoughts. It is a state in which the delicate balance breaks down under stress, a state in which emotional pressure simply becomes too great for the individual to cope with.

A crisis state is relatively infrequent for most people because of "coping mechanisms"--self-regulating mechanisms we use to avoid, reduce, or control pain.

Reasons Coping Mechanisms Don't Work

1) The problem is too great. Sometimes we encounter a problem that is simply too great to deal with--the death of a spouse, the breakup of a marriage, financial collapse.
2) The problem has special significance that makes it overwhelming. Example: Woman finds husband has cancer which reminds her of the agony her father went through with cancer.

3) The problem occurs at a time of special vulnerability. A series of problems may occur within a short period of time, or the problem may occur when a person's normal coping mechanisms are blocked for one reason or another.
4) The problem is a new one, so appropriate coping mechanisms haven't been developed.
    1) A woman whose family has always enjoyed financial security may not be able to deal with the situation she encounters in her early marriage.
    2) A man who has never had to deal with the death of a loved one may have problems coping with death of child.
    3) Man or woman who has never been exposed to the pain of divorce may have particular problems coping with the breakup of their own marriage.
5) The usual network of social support fails. A person who suddenly finds herself alone--abandoned by friends or family members in a time of stress--may find it extremely difficult to cope.

Characteristics of Crisis

1) The crisis is sudden. It is unforeseen and unexpected.
2) Normal coping methods have failed.
3) The crisis is short in duration.
    1) A true crisis rarely lasts longer than six weeks; most resolved within 36 hours.
    2) People can't remain in a crisis state for very long--it is unbearable.
4) Crisis may result in dangerous, unacceptable, or self-destructive behavior. If feelings of panic and defeat are not resolved, a person may become homicidal or suicidal.

Two General Classifications of Crisis

1) ***Predictable Crises***. Adolescence.
2) ***Unpredictable Crises***. Rape, robbery, tornado, accidents.

Stages of Crisis

1) **Impact**.
    1) The occurrence of the stressful event--the final blow that destroys equilibrium.
    2) During impact stage, victim feels dazed and shocked; may become disoriented or distracted.
    3) All of the victim's energies are concentrated on the present and on the upsetting event.
2) **Crisis**.
    1) The victim's reaction to the stressful or hazardous event.
    2) The range of emotions during the crisis can go all the way from rage and hostility to uncertainty and detachment.
3) **Resolution**.
    1) As the crisis period wanes, the period of resolution--adjustment--begins.

2) Victim regains control of self; begins to think clearly; explore alternatives, make plans, set goals, and carry out what has been planned.
3) Looks forward to the future with hope and energy. A crisis can motivate people to make changes in their lives.

4) **Reconstruction**.
1) Once resolution is complete--a stage that requires several weeks to several months, depending on the person--the victim resumes his normal activities or style of living.
2) While a few scars may linger, most of the signs and effects of the crisis are over and forgotten.

Recognizing a Person in Crisis

1) The person might have lost some or all contact with reality.
2) The person probably isn't acting the way he usually does. May have to rely on reports from friends and family members if you don't know the person yourself.
3) When you talk to the person, you may feel as though you're talking to a brick wall.
1) The person is preoccupied--doesn't have ability to listen to you and concentrate on what you're saying.
2) May be completely unresponsive.
4) The person is unable to work at her maximum or usual level. Productivity may go down, or may be completely unable to perform usual tasks.
5) Person may seem withdrawn.
6) Persons shows signs of trying to avoid a sensory overload.
7) The person may exhibit an extraordinary amount of unwarranted fear.
8) The person may also exhibit an extraordinary amount of anger, usually at an inappropriate source.
9) Experience extreme amount of anxiety.
10) Person may seem confused.
11) Person may be unusually depressed.
12) Person may become impulsive or take foolish risks.
13) People in cris may become overly dependent on others.
14) Many people in crisis reject offers of help.

Six Stages of Emotional Reaction to Crisis

1) **Emotional shock**.
1) Either hysterical or stunned; may even be combative.
2) May be nauseated or may vomit.
3) Crying, screaming loudly, wringing hands, speaking rapidly and at high pitch.
4) Agitated and out of control
5) May wander around aimlessly, staring into space.

6) May lapse into complete inactivity.

2) **Denial**.
   1) Person is attempting to protect himself.
   2) Can't let too happen too quickly--so denies that the crisis is happening.
3) Anger.
   1) Once victim passes through denial stage and admits the crisis has occurred, it is a normal and understandable emotion to be angry.
   2) May be common for people in this stage of crisis to direct their anger at people who are trying to help.
      i) Never take anger personally.
      ii) Let person hurl all the verbal abuse at you, but don't let him strike you.
4) **Remorse**.
   1) In this stage, person is overwhelmed by guilt and sorrow.
   2) During this stage, the victim may twist events out of proportion and may create scenarios that are clearly irrational or impossible.
5) **Grief**.
   1) Once the victim begins to grieve, he enters the first real stage of healing.
   2) The grieving process must be completed before the person can go on to overcome the crisis.
6) **Reconciliation**.
   1) Passes through crisis and emerges at least at the level of functioning before the crisis.
   2) May emerge stronger and better able to cope with life's frustrations.

LESSON 2

"Effecting Change"

Goals of Crisis Intervention

Crisis intervention is earmarked by narrow goals of short duration. Aimed at helping a person regain equilibrium--return to normal functioning--by providing emotional support during a time of emotional vulnerability. The emphasis is on what's happening now not on what has happened in the past.

1) Goal: Protect the victim from additional stress.
2) Goal: Give the victim a sense of hope.
3) Goal: Help the victim mobilize his resources.
    1) External: friends, family members, coworkers.
    2) Internal: Help him remember that he is strong, intelligent, resourceful, and creative. He has what it takes!
4) Goal: Leave the person at least as well as he was before the crisis occurred.

Effecting Change in Crisis

1) Act quickly.
    1) May become self-destructive if don't receive help immediately.
    2) Most crises are short-lived. Your quick help can make the crisis less severe and can help protect the person from hurting himself.
    3) Help the person understand the crisis.
    4) Once the person is expressing himself well, help him explore the alternatives for dealing with the crisis.
        i) Help him remember what he has done in the past in similar situations.
        ii) Lead victim to support system.
2) Control the environment.
    1) Move person to quiet area, away from noise and onlookers.
    2) If person doesn't know you, identify yourself immediately.
    3) Identify the problem and let the person know that you are there to help.
    4) Talk to him wherever you find him.
3) Assess the person.
    1) It is the person's perception that triggers crisis.
    2) Assess the person's general alertness and ability to communicate by asking him questions that force him to respond.
    3) Try to identify the cause of the crisis by asking open-ended questions that call for answers from the person.

i) What's happened to make you so upset?
ii) Why are you away from home?
iii) Have you recently lost someone?
iv) Is there a reason you need help right now?

4) Watch person's posture, body movements, eye glances, and mannerisms. Note whether persons is intoxicated, distracted, forgetful, abnormally depressed or euphoric, or worried.

4) Set a limited goal.
   1) Part of resolving a crisis lies in the fact that the person can once again achieve some balance in his life. As a first step, help the persona achieve a limited goal; make it something that will challenge but not overwhelm him.
   2) A person who is suffering a crisis after the death of a spouse may achieve a goal of collecting keepsakes and storing them in a safe place for his children to cherish in the future.
5) Foster hope and expectations.
   1) Clearly express expectations of the victim.
   2) Plan with the person; help him set goals
6) Assess the person's support system.
   1) Find out what kinds of external resources the person has.
   2) The person must be able to think relatively clearly, have control of some of his emotions, recognize that there are significant people who can help him.
7) Plan for the future.
   1) Help person to move forward.
   2) Place limits on the achievement of each goal.
8) Promote a good self-image.
   1) To promote a better self-image, treat the person with courtesy and respect.
   2) Show interest in the areas of the person's life that are not involved with the problem.
9) Encourage self-reliance.
   1) Make revert back to dependency, where the demands are less.
   2) Find things the person can successfully accomplish, and urge him to do everything possible.
10) Listen actively.
   1) Use three ears: Two to hear the verbal message; one to sense the underlying feelings.
   2) As you listen, don't try to solve the person's problems for him.

Crisis Intervention Skills

The most important crisis intervention tools are verbal and nonverbal communication skills. Careful use of these skills will help the individual reduce emotional overreaction.

Guideline 1: Provide a Reality Basis

Clearly identify yourself and your position. Identifying yourself and your role will help the individual, family, and friends know not only who you are, but what they can expect from you.

Be sure to use the individual's name as you talk to him.

1) Anticipate the concerns of the individual, family, and friends.
    1) Give supportive but truthful information.
    2) Inform those present about reasons for questions, investigation, or treatment being conducted and the outcomes.
    3) Explain any emotional or physical reactions the person might have as a result of stress or intervention.
    4) Explain the presence of legal authorities such as police.
2) Be calm and self-assured.
    1) Your behavior should indicate that you have confidence in the person's ability to maintain control.
    2) If you are nervous, the individual will be more so. The calmer you are, the better able you will be to intervene actively in those areas where the person is unable to manage for himself.
    3) Use gentle strength in your verbal statements.
    4) Honest and sincere reassurance is communicated by such phrases as "I am sure that," "I know," "I'm convinced," and "I understand."
3) Be nonjudgmental.
    1) Accept an individuals' right to have his own feelings, and do not blame or criticize him for feeling as he does.
    2) One common reaction among health professionals is a feeling of irritation at a person who does not appear to be particular upset or ill.
    3) Being nonjudgmental also means that you do not take sides in a conflict within a group. Maintain objectivity.

Guideline 2: Provide Appropriate Verbal and Nonverbal Support

1) Maintain a relaxed body posture. Sit down near the individual.
2) Touch the person if it seems appropriate.
3) Stay with the individual at all times, especially if suicidal risk is present. Once you have responded to the emergency, the individual's well-being becomes your responsibility.
4) Encourage communication with gestures or noncommittal words, such as a nod of the head or a phrase like "Go on" or "I see."

Guideline 3: Listen and Respond

1) One of the most effective ways of showing understanding is to reflect back to him the feelings you heard him talk about or the feelings you guess he is experiencing because of what he says and does.
2) There are real skills involved in listening and responding effectively in facilitating crisis resolution.
    1) Attending. Eye contact, body posture, accurate verbal following.

2) Paraphrasing. A statement that mirrors an individual's statement in exact or similar wording.
3) Reflection of feeling. The essence of an individual's feelings, either stated or implied, as expressed by the helper.
4) Summarizing. A brief review of the main points discussed to insure continuity in a focused direction.
5) Probing. A response that directs an individual's attention inward to help both parties examine the individual's situation in greater depth.
6) Helper self-disclosure. Helper's sharing of his personal feelings, attitudes, opinions, and experiences for the benefit of the individual.
7) Interpreting. Presenting the individual with alternative ways of looking at his situation.
8) Confrontation. A statement or question intended to point out contradictions in an individual's behavior and statements or to induce the individual to face an issue that the helper feels the individual is avoiding.

Guideline 4: Ask Clear, Simple Questions

1) After obtaining basic, identifying information about an individual, an interview should be open-ended. Let him tell his own story in his own way.
2) Specific questions should be as nondirective as possible. Avoid questions that can be answered with a yes or no. "How" or "what" questions are preferred.
3) Ask clear, simple questions.
4) Ask questions one at a time. Wait for a reply.
5) When open-ended questions are met with uncomprehending silence, adapt your techniques to the situation and take a more directive approach.
6) Taking a definite plan of action gives the individual the feeling that something is being done to help, which in turn relieves anxiety.
7) Do not confront an individual with decisions (such as "Do you want to go to the hospital?") but rather state what you think is the best course of action.

Other Hints to Improve Communication

1) Tolerate repetition.
2) Communicate to the individual--not through others.
3) Take time. Individuals in crisis require patient, concerned attention.
4) Don't be afraid of silences.
    1) It is especially important to be silent when an individual must stop speaking because of being overwhelmed by emotion.
    2) Avoid the temptation to forestall expressions of emotion, such as crying, by saying something.
    3) Your silence allows the person to get control of himself in his own way.
5) Reinforce progress.

1) Keep the individual informed of the positive steps he has made, even if they are very small steps.
2) However, don't be patronizing.

LESSON 3

"Psychiatric Emergencies"

The Principles of Psychiatric Emergency Care

1) Emotional injury is every bit as real (and as serious) as physical injury.
2) Any person who is involved in a disaster or who is injured will experience some emotional disturbance.
3) Every person has a breaking point.
4) Every person's feelings are valid to him. No matter how irrational, silly, unrealistic, or melodramatic a person's feelings seem to you, to him they are real and valid.
5) No one chooses to be disturbed.
6) Every person has more psychological strength than he appears to have. People are amazingly resilient.
7) Your job is to keep the person from hurting more and to help him return to normal as quickly as possible.

Emotional Responses to Physical Illness and Injury

1) Realistic fear.
2) General anxiety.
3) Depression.
4) Regression.
5) Denial.
6) Displacement of anger.
7) Confusion.

The Signs and Symptoms of Psychiatric Emergencies

1) The victim will do things that are dangerous to himself or others.
2) The victim may begin behaving in ways that are radically different from the way he usually acts.
3) The victim may be extremely frightened, even to a point of panic.
4) The victim may experience memory loss.
5) The victim may seem extremely preoccupied.
6) The victim may complain of body ailments or diseases that are clearly not possible.
7) The victim may believe people are plotting against them.
8) The victim may be confused.
9) The person talks to himself loudly and persistently in front of other people.

10) The person may exhibit intense, brief, and inappropriate anger, almost like an explosion.
11) The person may lose touch with reality.
12) The victim may have delusions of grandeur.
13) The victim may seem extremely anxious.
14) The victim may be depressed.
15) The victim may seem withdrawn.
16) The victim may become manic; the becomes almost hysterically happy, overly optimistic, almost giddy.

Common Psychiatric Emergencies

1) Acute anxiety or panic state.
    1) Usually experience extreme fear.
    2) The victim of senility will probably become even more confused if he is approached by strangers.
2) Schizophrenia.
    1) Usually tense, overactive, and unpredictable; most lose touch with reality.
    2) Usually alone in his world and is usually detached, confused, and very paranoid.
    3) May explode suddenly.
    4) Becomes extremely suspicious of others.
    5) When schizophrenia advances to a catatonic state, the victim is slowed down to almost total detachment. He rarely speaks, may not move, and might assume some odd posture or curl up in a corner and refuse to move or communicate.
3) Mania.
    1) Cannot slow down long enough to eat, drink, or sleep.
    2) Hyperactive; speaks gibberish, exercises poor judgment, and moves quickly.
    3) Most maniacs are extremely strong and prone to attack or run away from those trying to help.
4) Psychoneurosis.
    1) Presents a complex picture of extreme anxiety, including crying, intense nervousness, and overactivity.
    2) Often become overdramatic or overdemonstrative; most become hysterical.
    3) Look like they have no control over their actions.
    4) In good contact with others but may become dangerous.
5) Old age and chronic illness.
    1) Memory problems.
    2) Because they are confused and cannot remember much, they become irrational and may wander away and get lost.
    3) Some may become violent; most are unpredictable and are generally uncommunicative.
6) Phobia.
    1) Extremely frightened.
    2) All of his anxieties are focused on one situation or object.

3) The intense fear may be one of heights, animals, or leaving the house.

7) Paranoia.
   1) Believes everyone is out to get him.
   2) Becomes secluded, distrustful, and jealous.
   3) Many are hostile; most are uncooperative and difficult to handle.
8) Impaired consciousness.
   1) Most are suffering from an organic disorder, usually of cerebral or systemic origin.
   2) At one moment may seem well oriented; at the next he may be disoriented or unconscious.
   3) May be related to physical ailment.

The Phenomenon of Conversion

Conversion symptoms: the phenomenon in which an idea or desire is expressed in bodily rather than verbal terms and is experienced as a physical, not mental, symptom. Mental thoughts are literally "converted to" bodily sensations or feelings.

Conversion generally occurs in response to serious frustration, deprivation, need, or difficulty in responding to others. Internal conflict or the presence of a perceived life-threatening situation can also bring on conversion symptoms.

Conversion symptoms accomplishes four things for the victim:

1) It allows him to express "forbidden" feelings (great anguish, fear, anger, frustration, hatred, and so on) in a way that is acceptable to society and in a way that he does not even recognize himself.
2) It gives him a chance to punish himself for having such feelings (even though he is not aware of the feelings or the need for "punishment").
3) It allows the person to escape from the extreme psychiatric stress or the life-threatening situation.
4) Because the person becomes "sick," he can assume a new role and a new way of relating in the situation that has caused him so much stress.

Common conversion symptoms include severe headaches, backache, nausea, vomiting, gastrointestinal problems, skin lesions, dermatitis, hives, chest pain, shortness of breath, heart palpitations, nervousness, fatigue, weakness, severe anxiety, memory loss, and extreme fear.

Conversion symptoms would be suspected in the following situations:

1) The symptom can't be explained by normal physiological processes.
2) The victim is obviously under some psychiatric stress.
   1) Watch for the tendency to use the body for expression--to become extremely dramatic in

both voice and gestures when describing something.

2) Watch for the tendency of the victim to be fearful, forgetful, depressed, and extremely dependent.

3) The victim is in a situation where he saw someone else suffer the same symptoms. In some cases, the victim experiences a symptom that he wishes someone else had suffered.

4) The victim is bothered by but attached to the symptom. Watch out for the person who seems to be suffering and experiencing great upset over the symptom on the one hand, but who is obviously enjoying it or receiving some kind of gain or compensation from it on the other hand.

LESSON 4

"Managing Psychiatric Emergencies"

Assessing the Victim

1) Thought process.
    1) Are the victim's thoughts coherent?
    2) Is he thinking at a normal pace, or does his thinking seem to be slow?
    3) Are his thoughts fragmented or repetitious?
    4) Listen to what the victim reveals about his thoughts.
        i) May describe hallucinations.
        ii) May take great pains to tell you about his importance, his status, his possessions, or his special abilities.
2) General intelligence.
    1) Pay attention to abstractions, indications of judgment, and level of vocabulary.
    2) If the victim shows indications of being intelligent but cannot relate her name, tell you what day of the week it is, or remember her problem, she is probably suffering from an emotional crisis.
3) General appearance.
    1) Watch out for a person who is wearing clothes that are extremely soiled, in need of mending, or are inappropriate for the season.
    2) Also note general grooming, body build, and the presence of any physical defects.
4) Motor skills.
    1) Watch the way the victim moves. Motor movements should be smooth, coordinated, and frequent.
    2) Emotional problems may manifest themselves in motor movements that are jerky, uncoordinated, awkward, infrequent, or twitching.
    3) Take note of the way the victim sits, the way she walks in and out of the room, and the way she shakes your hand.
5) Expressions and gestures.
    1) Normal speech is easy, spontaneous, well paced, and not too loud or soft.
    2) Listen to determine whether the victim uses profanity, repeats information, or seems disoriented and confused.
    3) Facial expression can provide some clues; it should be congruent with the situation.
6) Orientation.
    1) The victim should know who he is, where he is, what day of the week it is, what month it is, and approximately what time it is.
    2) Determine whether he is able to concentrate on the conversation and whether he is paying attention to what you are saying.
7) Mood.
    1) Try to determine the victim's mood.

2) After assessing physical appearance, watching expression and gestures, and talking briefly, you should have some good clues as to whether victim is generally happy, depressed, anxious, fearful, angry, or withdrawn.

A person who seems seriously disturbed or who poses a danger to himself or others should be seen by a physician as soon as possible.

What to Do in a Psychiatric Emergency

1) Begin by clearly identifying yourself.
2) Expect the best.
3) Immediately calm the person down.
4) Be prepared to invest time with the victim.
5) Express confience in the victim's ability to get control of the situation.
6) Don't rush the victim to the hospital unless he is posing immediate danger to himself or others or he has sustained life-threatening injuries.
7) Work with the victim on a one-to-one basis; ask friends and relatives to move into another room so that you can have privacy.
8) As you work with the victim sit down. Put yourself on his level; never tower over him.
9) Encourage the victim to speak freely, ventilating his feelings and telling his story in his own words.
10) Do not deny the victim's feelings or experiences.
11) Avoid arguments.

A cardinal rule in working with troubled people: if you are afraid of the person's reaction, say nothing.

1) Don't be judgmental.
2) Don't require the victim to make decisions
3) If the person is having a difficult time talking, do things that encourage him to relax.
4) Don't be afraid of silences.
5) If the victim doesn't start speaking again after a reasonable length of time, make a statement that will start things going again.
    1) "You seem worried."
    2) "You seem very angry. What are you feeling now?"
6) Guard against your own reactions.
    1) Don't show negative reactions.
    2) Don't let the victim make you angry.
7) Provide ordinary comforts for the victim.
8) Once you have started working with the victim, don't leave her alone.
9) Once the person has told her entire story, go back over it for details.
10) Never assume that it is impossible to communicate with someone until you have tried.

11) When you ask questions, make them open-ended.
12) Don't give the victim false hope or build false expectations.
13) Don't make promises you can't keep.
14) As soon as you can, talk to others who are involved with the person (such as family members, friends, or coworkers).
15) As soon as you figure out what the problem is, explain it clearly to the victim.
16) Encourage the victim to go to sleep; sleep often helps restore psychological equilibrium.
17) Make detailed notes about what you've learned about the victim.

Helping Someone Who Doesn't Want Help

1) Don't be surprised by resistance.
2) Try to get the person to talk.
3) State clearly the way in which you see the problem if the person is unwilling to admit to it.
4) Avoid the temptation to give simple advice.
5) Don't be judgmental, and don't fix blame for the problem.
6) If the victim is clearly in trouble and is still resisting help, be brutally honest in your forecast of the situation.

"I know that you think you can work through this thing alone, but I don't think you realize the seriousness of the situation. Anyone in your shoes would need some help in getting back on their feet. I'm afraid that if you don't accept help, you will end up hurting yourself or someone else."

1) If the victim becomes combative and resists efforts at help, you may have to restrain him and transport him to a hospital.
    1) You can restrain and force only if you are clearly convinced that the victim is posing a serious danger to himself or someone else.
    2) If this is the case, proceed with caution.
    3) Count on at least four adults to overpower another adult.
2) If the victim is armed or barricaded, surround him at a distance, try to get him talking, and wait for police to arrive.
3) When you transport a person against his will, make sure that he cannot escape fromt he vehicle or injure the driver.

Paranoia

The paranoid victim is hostile, distrustful, suspicious, and excitable. To protect yourself and the victim follow these guidelines:

1) Maintain a certain distance from the victim, and act in a business like manner.
    1) May become violent if he fears that you are getting too close or are invading his personal

space.
    2) Don't try to befriend him. He is distrustful and suspicious and will mistake your efforts for an attempt to overcome him.
2) Clearly explain who you are and what you are going to do.
3) Before you start talking to a paranoid person, try to make sure that he is unarmed.
4) If you need to talk to family members or friends, do so openly and in the rpesence of the victim.
5) If you are unable to work with the victim and need to overpower him to protect him or others (including yourself), realize that he may react with incredible force and violence if he senses that he is about to be attacked.
    1) Need to act swiftly and with great force.
    2) The struggle must be brief and painless.
6) If the victim is armed and barricaded, let the police handle the situation.

Depression

Depress deserves a special mention because it carries with it a special risk: suicide. Because of the distinct possibility of suicide, there are two specific guidelines in dealing with a depressed victim:

1) Ask the victim directly if she has had suicidal thoughts (Have you ever thought about killing yourself? Do you ever wish you were dead?). If she says she has thought about it, ask her how she would plan on doing it. If she immediately relates a well-thought-out plan, her risk is extreme. She should be transported to the hospital immediately.
2) Do not leave the depressed person alone. If you do not transport him to the hosptial, make sure that a family member or friend will stay with him until other help can be obtained.

LESSON 5

"Suicide"

Out of all the hurt and confusion that suicide can bring, is it possible to make some sense? Is it possible to predict who might try to take his own life? Do the self-destructive leave clues that others can recognize? Can suicide be prevented, at least some of the time?

The answer to all of these is yes. It takes an understanding of what suicide is, a look at who its victims are, an analysis of what causes suicide, and a clear explanation of what clues its victims leave behind.

The Myths and the Realities

1) People who commit suicide always leave notes.
2) People who commit suicide are psychotic or mentally ill. Many suicidal people are just severely depressed and can't figure out any other solution to their problems.
3) People who talk about suicide are just trying to get attention; people who really commit suicide don't talk about it first.
    1) Eight out of ten people who commit suicide give definite warnings of their intentions; the other two usually give some kind of verbal clues.
    2) Almost no one commits suicide without first letting someone else know how he feels.
4) Suicide happens without warning. Most suicidal people leave a host of clues and warnings of their intentions.
5) If someone has decided to commit suicide, there is nothing you can do to stop him.
    1) The majority of suicides can be stopped.
    2) The most depressed person is torn between wanting to live and wanting to die--and you can push him toward the "living" side of it.

For suicide to happen, three things must happen:

- The person must want to die.
- The person must have the means to carry out his wish.
- The person must have energy enough to complete the act.

6) A person who is once suicidal is suicidal forever.
7) A person attempts suicide but survives, he probably won't attempt it again.
    1) Four out of five people who succeed in committing suicide had made at least one previous attempt.
    2) About half of these who try will try again.
8) The secret lies in getting someone over the "hump;" if you can just pull someone out of a

depression, he won't try to kill himself.
    1) Most suicides occur within about three months of an apparent "improvement" in a severely depressed condition.
    2) Once he starts to "improve," he gets the energy to follow through.
9) Terminally ill people are the ones most likely to commit suicide.
    1) Terminally ill people are not as likely to commit suicide as are chronically ill people--people who are tired of suffering and who see no cure or end to that suffering other than self-destruction. The tendency increases among those over the age of sixty.
10) Suicide is hereditary.
    1) Suicide does tend to "run in families," which has given the mistaken idea that it is genetically inherited.it is not a genetic trait. However, since family members tend to share the same emotional climate, and since coping can be a learned skill, suicide can be more common in some families than in others.
    2) A person who is suffering from a deep depression sees that her mother ended her suffering through suicide, and she does the same.
11) The most common method of suicide is drug overdose.
    1) Leading cause is gunshot wounds.
    2) Those who take drugs are less successful.
12) Most suicides happen late at night.
    1) Most suicidal people don't really want to die. The attempt of suicide is a call for help. As a result, many suicidal attempts happen in late afternoon or in early evening, when friends and family members are most likely to discover the victim and "save" him.
    2) Only those who are truly intent on dying attempt suicide late at night when sleeping friends and family members aren't around to intervene.
13) You should never talk about suicide to someone who is depressed, because you'll give him ideas.
    1) If a person has not seriously considered suicide, your talking about it won't plant those ideas in his head.
    2) The act of talking about it helps a person work through them.
    3) Someone who is dropping clues, however subtle, will be relieved to talk about it.

Types of Suicide

1) **Referred suicide.**
    1) Person perceives himself to be a failure because he becomes overwhelmed by what he imagines others are thinking of him.
    2) Has feeling of little value to himself or to others.
    3) Can't live up to others' expectations.
2) **Surcease suicide.**
    1) Victim wants to be released from emotional or physical pain.
    2) In almost all cases, there are alternatives to suicide, but the suicidal victim doesn't understand that. He truly believes he has no other options.

3) **Cultural suicide.**
    1) Kamikaze pilot in World War II.
    2) Jim Jones cult in Guyanna.
4) **Psychotic suicide.**
    1) The suicide usually occurs without an intention to die, but instead as a desire to get rid of the psychosis or to "punish" himself for some reason.
    2) Because of being irrational, the victim cannot distinguish the fact that his attempts will indeed result in death.
5) **Subintentional suicide.**
    1) Often not recognized as a suicide. The person plays a partial, covert, or subliminal (and often unconscious) role in his own destruction.
    2) Because of circumstances surrounding the death, it can't really be classified as "natural" or "accidental."
    3) Taking unnecessary risks.
    4) Can occur when a person loses the "will to live" making it easy for death to occur by putting up little resistance to it.

Most Common Methods

1) Firearms and explosives.
2) Jumping from a high place.
3) Cutting vital organs.
4) Hanging.
5) Drowning (if person doesn't know how to swim).
6) Poison
7) Cutting of nonvital organs.
8) Drowning (if the person does know how to swim).
9) Poisoning (with gas, such as carbon monoxide)
10) Analgesic substances (pain medications).

Lethality

1) Firearms and explosives.
2) Carbon monoxide.
3) Hanging.
4) Drowning.
5) Plastic bag (suffocation).
6) Jumping from a high place.
7) Fire
8) Poison.
9) Drugs.

10) Gas.
11) Cutting.

Surviving Suicide

1) According to studies, those who survive a suicide attempt with a highly lethal method are less likely to attempt suicide again than those who survive with a less lethal method.
2) Those who tried to commit suicide by suffocating on a plastic bag, inhaling carbon monoxide, or drowning are most likely to try again.
3) Those who survived attempts with wrist-slashing, drug taking, hanging, or burning are least likely to try again.

Choice of Method

1) Availability.
2) Experience and familiarity.
    1) Policeman might use handgun.
    2) Pharmacist might resort to drugs.
3) Consideration of impact on survivors.
4) Symbolism or imagery.
    1) Woman may choose to overdose on tranquilizers because that's the way her mother committed suicide.
    2) A man may choose to drown because he envisions it as a fluid way of becoming one again with the universe.
    3) Another may mimic the method chosen by a movie star or a rock idol.

LESSON 6

"Suicide - Continued"

Why People Choose Suicide

1) Suicide as a reaction to loss of a loved one.
    1) Life becomes meaningless; not worth living without the loved one.
    2) As time goes on, the feelings of loneliness and sadness intensify.
2) Suicide as a way to escape suffering.
3) Suicide as an impulsive reaction.
    1) Impulsive act committed in reaction to a major disappointment or frustration.
    2) Person suffers a sudden and extensive blow to his pride, confidence, or self-esteem.
4) Suicide as a way of controlling others.
    1) Person doesn't really want to die--wants to change the way others treat him.
    2) May be communicating that he needs more attention, affection, and caring.
    3) May attempt suicide to pay someone back for the pain they've given them.
    4) To make survivors feel guilty.
    5) Can also be used to express rage, anger, and hostility.
5) Suicide as a reaction to depression.
    1) Life unbearable.
    2) Because depression clouds the ability to reason, the person sees no other alternative.
    3) Those most prone to suicide are those who have been moderately to severely depressed for a long period of time--they see no other way to escape their depression.
    4) Severely depressed people often become convinced that they need to be "punished" for some wrongdoing or for their own worthlessness.

Clues to Suicidal Behavior

Experts believe that approximately 90 percent of all who commit suicide give clues about it first; unfortunately, people don't recognize the clues. They fail to respond.

1) Person may become unconcerned about personal welfare.
2) Verbal clues.
    1) "I think I'll just kill myself!"
    2) Often, more subtle and more difficult to pinpoint.
        i) "You'll be sorry you treated me like that when I'm not around anymore."
        ii) "You'd be better off if I were dead."
        iii) "Soon I won't have to worry about that anymore."
        iv) "Don't worry, I won't be making a mess of the family finances much longer."
        v) "I don't think we'll need to see a counselor. Things won't be like this for long."

3) Person may seem unusually accident-prone.
    1) May be suicide attempts that failed, or may be minor attempts at self-destruction with which the person is "practicing" in order to build up courage for the real thing.
    2) May also be unconscious attempts at self-destruction.
4) The person may undergo a sudden change in his habits, attitudes, or personality.
    1) Once confident and aggressive, may become passive and withdrawn.
    2) Once talkative and happy may become sullen and quiet.
    3) Once a meticulous housekeeper may begin neglecting the house.
5) May become depressed.
6) A sudden or noticeable decline on the job or in school.
7) Be alert for signs of confusion, such as difficulty in concentrating or in thinking clearly.
8) Watch for signs that the person is "putting his affairs in order."
9) The person may lose interest in people or activities that used to interest him.
10) The person may joke about suicide; but suicide is no laughing matter. May be trying to clothe it in humor while he "tries it on" and assesses other people's reactions to it.
11) Many suicidal victims become physically ill.
12) The person may begin having difficulty in communicating with other people.
13) The person may seem to develop an unusually intense interest in his own problems. May seem preoccupied with what is happening to him with little interest in what is happening to others or how others are feeling.
14) Certain physical complaints are common in suicidal people.
    1) Signs of sleep disturbances.
    2) Anorexia.
    3) Profound and rapid weight loss.
    4) Fatigue.
    5) Loss of energy.
15) A suicidal person may weep easily, with seemingly little provocation.
16) The person may become preoccupied with something that happened in the past, usually some wrongdoing or that she committed.
17) Person may become preoccupied with a poor self image.
18) May suddenly go on a spending spree, make donations to charities he previously ignored, gamble excessively, or take vacations he has been putting off.
19) May be reacting to intense stress or a life crisis.
20) May become preoccupied with thoughts of death.

Assessing Risk: How Serious Is the Threat?

Once you've determined that someone may be suicidal, you need to ask him, directly and in a straightforward way, if he is considering killing himself or if he has thought about suicide. That may seem extremely difficult to do, but it is critical.

Determining Those Who Are at High Risk

1) The person is at extremely high risk if he has attempted suicide in the past, especially if the method he chose then was not a particularly lethal one.
2) Ask the person if he plans on trying to commit suicide again. Ask him if he plans on using the same method, or if he has chosen a new one. If a different one, ask him in detail about it.
3) If the person attempted suicide before, find out how he feels about his failure to complete the act.
    1) How he was rescued; whether he intended to be rescued. A person who felt relieved about being rescued is at lower risk than a person who felt hostile and angry.
    2) A person who intended on being rescued is at lower risk than a person who was accidentally discovered and rescued.
    3) A high risk would be suffered by a person who took a bottle of sleeping pills while her husband was out of state and son was at camp.
4) Ask the person how she feels about the significant people in her life.
    1) Those who are at higher risk will feel isolated, cut off, withdrawn, or unimportant to significant people in their lives.
    2) Those who have healthy, vigorous relationships at the time are at a lower risk.
5) Ask the person about recent losses or troubling experiences.
    1) Those at highest risk will have suffered stressful incidents (divorce, failure in school, termination on the job, loss of loved one).
    2) Those at lower risk will probably still be feeling stress but may not be going through intense life crises.
6) Ask the person if he is using alcohol or drugs.
    1) Those at highest risk are using one or both.
7) Ask the person if he is physically ill or if he has been to visit a doctor within the last three months.
    1) Those at highest risk are suffering from chronic or severely painful illnesses; also at high risk are people who have a number of less serious illnesses that affect different body systems simultaneously.
    2) High risk is also suffered by people who imagine themselves to have various illnesses and who visit the doctor frequently in an attempt to get help.
8) A person who lives alone (whether single, divorce, separated, or widowed) is at high risk; a person who lives with others, especially if she is a member of a large, active family, is at less risk.
9) A person with hostile feelings is at a much higher risk than a person who is passive or has only a few hostile thoughts and feelings.
    1) The degree of hostility can usually be directly correlated with the success of a suicide attempt.
    2) Those who are angry and hostile usually choose a dramatic, shocking way of committing suicide so as to have the greatest possible impact on survivors.
    3) A hostile person will probably outline details of that plan for you.
10) ask the person how long he has had suicidal thoughts.
    1) If he's had them for a few days or a few weeks, he is at lower risk.

2) If he has had them for a few months or for years, he is at higher risk.
3) Generally, the longer the person has thought about committing suicide, the more dangerous his situation.

11) Ask the person if she is taking medication.
1) Generally, a person is at high risk if she is taking medication and does not feel as though the medication is "working" or having the desired effect (regardless of what the medication is for).

12) Find out if the person has recently been discharged from the hospital.
1) The period just following hospitalization for depression can be a critical time; doctors think that recovery has begun when, in reality, the person is just now getting enough strength to follow through with a suicidal thought.

13) Determine whether the person seems cogent and in control of his thought processes.
1) A person who is disorganized, disoriented, or confused runs a much greater risk of following through with suicide.

14) Are you talking to a man or a woman, and how old is the person?
1) Generally, an older male is at the highest risk, while a younger female is at the lowest risk.

15) Find out whether the person knows anyone else who has committed suicide. If so, his risk is automatically higher. The risk is highest if a member of the family (especially a parent or spouse) committed suicide.

16) Ask the person if he would consider getting help, or if he has tried to get help in the past.
1) The highest risk is faced by those who do not believe they can be helped and by those who have had unsuccessfulor dissatisfying experiences with therapist s or therapy programs in the past.
2) Consider the person an extremely high risk if he tells you that no help is available and that no one wants to be of help.

Suicide Notes

Suicide among Children

Suicide among Adolescents

Suicide among the Elderly

Responding to Suicide

1) Never leave the person alone.
2) Treat life-threatening injuries.
3) Don't try to talk the person out of his feelings.

    1) Your attempt to talk him out of either one will increase his sense of isolation and loneliness.
    2) Instead, acknowledge his desire to die, and encourage his desire to live.
4) React with honesty to the victim.
5) Be prepared for resistance.
6) Collect the evidence.
7) Enlist the help of friends and neighbors.
8) As soon as you can, make the environment safe.
9) Avoid the temptation to moralize or analyze.
10) Never promise anything you can't deliver.
11) Remember that there are “survivors” who may need help.
12) Move slowly and take your time.
13) Take care of yourself.
14) Above all, remember this: the victim's life is his responsibility. Some people will succeed in their attempts to end their own lives, and you are not to blame.

LESSON 7

"Death and Dying"

Signs of Death

1) Changes in the appearance of the eye.
    1) The cornea becomes wrinkled and turns milky or cloudy, losing its transparency.
2) A drop in body temperature.
3) Rigor mortis.
    1) Stiffening of the muscles, usually appears within two to eight hours after death, and it lasts for sixteen to twenty-four hours.
    2) Marked by rigidity of body tissues, usually starts in the face and extends gradually to the legs; disappears in the same order.
4) Postmortem lividity.
    1) Gradual discoloration of the skin due to the settling of blood.
    2) Occurs in the skin upon which the body rests--the back, shoulders, and buttocks in most cases; lividity spots look like bruises.
5) Absolute proof of death is putrefaction.
    1) Rotting decomposition.
    2) Occurs after rigor mortis has disappeared.

Elizabeth Kubler-Ross' Stages of Death and Dying

1) Denial.
    1) The dying person denies the fact that he's dying.
    2) News is too overwhelming to accept all at once.
    3) Valuable defense mechanism that gives him the chance to adjust to the death.
    4) Many forms of denial.
        i) Ignore what they have been told.
        ii) Seek second opinions.
        iii) Ask for verification of medical reports.
        iv) Seek news of miracle cures.
    5) Deny so they can go on about business of living from day to day.
2) Anger.
    1) The dying person may lash out at those who are trying to help him.
    2) Reacting with anger that his life is being cut short.
3) Bargaining.
    1) After anger subsides, the dying person enters an almost frantic stage of bargaining, usually to try for an extension of life or a higher quality of life.
    2) Most "bargains" are secret, made with God, and are rarely kept.

4) Depression.
    1) The dying person accepts the fact that she is dying, realizes that death is imminent, and prepares to say goodbye to everyone and everything she has ever known.
    2) Difficult stage of being torn from everything she ever loved.
5) Acceptance.
    1) Person quietly accepts the imminent death, knowing that he has done everything he can to prepare to die.
    2) During this stage, the person seems to be calm; most important wish is not to die alone.

Some progress smoothly through all five stages. Others regress to a stage they've already been through. Still others get "stuck" in a particular stage (such as anger and depression). Yet others move from to another rapidly.

Sudden Death

Survivors of sudden death characteristically experience some combination of the following reactions:

1) Hostility.
    1) Expression of outrage that the death occurred.
    2) Usually directed at doctors, nurses, emergency medical personnel, or others who attempted to help the victim.
2) Guilt and self-blame.
    1) Ponder what could have been done differently--not only in period immediately preceding the death, but throughout life with the dead person.
3) Preoccupation with the dead person.
    1) Filling days with thoughts about her or about their life together.
    2) For a period, survivor unable to function normally because of this preoccupation.
4) Disbelief.
    1) May cause disbelief for the survivor.
    2) Difficult to accept the fact that someone who left the house an hour earlier in the peak of health and vitality now lies crumpled on a roadside, devoid of life.
5) Physical distress.
    1) Survivor may develop any number of physical complaints in reaction to the news of the death, including gastrointestinal problems, headache, dizziness, trembling, and weakness.

One study that involved those who lost a spouse to sudden death indicated that the survivors have certain needs that can help ease the shock of sudden death:
1) The need to see the person after he is admitted to the emergency department.
    1) Be with him during his "hour of greatest need."
    2) Make sure he is really dead.
    3) A chance to say goodbye for a final time.

2) The need to make sure that prompt physical attention is given.
    1) If such attention isn't given, survivors may feel that something could have been done to change the outcome.
3) The need to immediately be told of the severity of the situation.
    1) Need to be told immediately how serious the situation is.
    2) Gives chance to see the victim, say goodbye, or do other things necessary to their peace of mind.
4) The need to express anxieties about the impending death.
    1) Survivor needs the chance to express anxiety and concern over the victim's condition and the chance to express anxieties over the impending death.
    2) Need to be available to listen and talk to the survivors about their feelings.
5) The need for comfort and support from family members.
6) The need for concern and support of health professionals.
    1) Should show concern about loss.
    2) Should remain with survivor and talk about the death.

Terminal Illness

1) Terminally ill patients go through same stages as dying.
2) Helping a patient cope with a terminal illness takes understanding, compassion, and empathy.
3) Caretaker should have responsibility to be honest with the patient.
    1) Keeping the fact of death away from a person who wants to know his condition removes some of his options and makes him a passive recipient of a medical program that someone else has designed.
    2) Essential to allow and encourage terminally ill people to maintain their sense of self-worth, to exercise choice about their treatment, to stay actively involved with their families, and to set goals and strive to reach them.

Coping with Death and Dying

Helping a Dying Person

1) Even if the victim seems dazed or incoherent, make a real effort to orient him.
    1) Explain where he is, who you are, what you are doing, and what is happening.
    2) As you tell him what is happening to his body, be honest but tactful; be careful not to shock him.
2) Remember: Even an unconscious person can hear and understand.
    1) Don't make negative comments about the victim's condition even if you think he is in a coma
    2) If asks if he's dying, offer some hope. "I don't know. You and I are going to fight this out

together! I'm not going to give up on you, so don't give up on yourself!"

3) Make every effort to find the victim's family before he dies.
    1) Communicate the urgency of the situation to them.
    2) If you can't find the family, reassure the victim that you will find them as quickly as you can and explain what has happened to him.
4) If the victim tries to resist treatment or refuses to be transported to the hospital, do what is necessary to convince him of the seriousness of his situation.
5) If other family members have been involved in the same accident or disaster, be cautious about giving news of their condition to an unstable person who is dying.
6) Continue resuscitation efforts until you have restored spontaneous circulation and respiration, until you have transferred responsibility to another person, until you have transferred responsibility to the medical facility.

Helping Survivors Cope

In helping survivors to cope, follow these general guidelines:

1) If you can, let the family member stay with the dying person during emergency care.
    1) If family member arrives before the victim dies, always let them see the victim.
    2) They want to communicate their love one last time and may even have the need to ask forgiveness for some wrongdoing or take care of some unfinished business.
2) No matter what the situation, show the utmost respect for the patient who is dying.
3) Speak to an unconscious person as though he were fully conscious; carefully explain what you are doing before you do it.
4) Encourage family members to talk to a comatose person.
    1) Explain that he still may be able to hear and understand, even though he cannot respond.
    2) Family members can gain great emotional relief from trying to communicate one last time.
5) Encourage family members to express their emotions freely.
6) Be prepared for an attack.

LESSON 8

"Sudden Infant Death Syndrome"

Sudden Infant Death Syndrome (SIDS) is the death of an apparently healthy infant that occurs suddenly and unexpectedly during the child's first year of life. Knowing that an apparently healthy baby can be robbed in its sleep without warning is tremendously frightening for most parents. Approximately 7,500 babies die in the United States from SIDS each year; it is the major cause of death for babies between the ages of one month and one year.

Basic Facts about SIDS

Parents who are confronted with the death of their baby face extreme emotional upset and guilt. Did they cause the death? Could they have prevented the death? Did the baby suffer? Is the condition hereditary or contagious--will other children in the family die from it?

Some facts:

1) SIDS is not hereditary, and it is not contagious.
2) SIDS is not caused by external suffocation, by vomiting, or by choking. The baby did not suffocate on a blanket, as many parents fear.
3) SIDS cannot be predicted. Through extensive research we have been able to isolate some risk factors, but that is our only clue; no test can determine ahead of time which babies will succumb to SIDS.
4) SIDS cannot, in most cases, be prevented.
5) SIDS occurs rapidly and silently, usually during periods of sleep; there are usually no signs of struggle.
6) SIDS babies do not suffer.
7) SIDS can strike any family: it does not respect race, religion, economic status, nationalities, or geographies.
8) SIDS is not predictable nor completely preventable, even by a physician; most important, SIDS is not anyone's fault.

Almost always, SIDS strikes babies between the ages of two weeks and one year; rarely, it has been known to strike babies as young as one week and toddlers as old as two years. The peak age range for SIDS seems to be two to four months of age. It strikes year-round but seems to be more prevalent during the winter months; it usually occurs during the night but can occur any time the baby is sleeping. It is more common in nonwhite babies and more common among boys than girls.

SIDS Risk Factors

Through extensive research, doctors have isolated some risk factors that seem to place a baby at higher risk for dying from SIDS.

1) Premature birth.
2) Low APGAR score.
3) Multiple-birth pregnancy.
4) Second or third in birth order.
5) Low birth weight.
6) Required oxygen or ventilatory assistance at birth.
7) Had a mild infection (usually respiratory) at time of death.
8) Has a history of feeding difficulties.
9) Is a boy.

A number of factors involving the mother also may increase the risk of SIDS:

1) Are narcotics abusers.
2) Have short spacing between pregnancies.
3) Are younger than twenty years of age.
4) Have inadequate prenatal care.
5) Smoke cigarettes during pregnancy.
6) Have had previous spontaneous abortions (miscarriages).
7) Come from a low socioeconomic group.
8) Have another child who died from SIDS.
9) Are Black or American Indian (lower SIDS rates occur among whites and Orientals).

Many victims of SIDS appear to have suffered from long-term underventilation of the lungs, possibly due to poor control of breathing during sleep and possibly caused by abnormalities within the brainstem.

A Parent's Grief

Parents of a SIDS baby commonly suffer the following:

1) Difficulty in concentrating.
2) Sleep disruptions.
3) Extreme fatigue or exhaustion (even when sleep is not interrupted.
4) Loss of appetite.
5) Gastrointestinal distress.
6) A variety of physical symptoms, including a feeling of being tied up in knots inside; mothers often report that their “arms ache to hold the baby.”
7) Irresistible urge to escape.

8) Dread of being alone.
9) Unreasonable fears of danger.
10) Fear of the responsibility of caring for other children.
11) Extreme irritation and impatience with other children.

While mothers tend to talk about their feelings and share their grief, fathers tend to grieve in silence. Both husbands and wives who work outside the home may be diverted from their grief by the demands of their work, while those who stay at home are surrounded by constant reminders of the loss.

A Child's Grief

Children who lose a brother or sister to SIDS are always affected by the death. Very young children often have frightening thoughts that they can't express verbally; instead, they cling to their parents or misbehave intentionally to attract and hold their parents' attention. Some may manifest their grief through increased insecurity, nightmares, bedwetting, difficulty in school, and other disturbances.

Older children will likely understand the death and will have certain grief reactions. Some will feel extremely guilty about the baby's death, worrying that because they wished the baby would die they caused the death.

Grief and Mourning

Survivors who do not go through those normal phases of grief may develop long-term psychiatric problems associated with the death.

Normal Grief Reactions

1) **Denial.**
    1) Denial that persists more than a few days is a signal that something is wrong.
    2) The period of denial is often a blessing to survivors, who rely on the feelings of numbness to get them through the difficult period of making funeral arrangements and burying their loved one.
2) **Awareness.**
    1) Survivor emotionally acknowledges the death.
    2) Begins to feel the anguish and emptiness of the loss; most severe at night.
    3) Physical symptoms present during this stage.
    4) It is important that grieving individuals feel free to fully express their feelings during this stage.
3) **Restitution.**

    1) The survivor is helped to clearly see and accept the reality of the death.
    2) The practice of religion is an important part of the restitution stage and an important part of coming to terms with the death.
4) **Resolution.**
    1) Person begins to "pick up the pieces" and determine how he is going to go on with life.
    2) Person moves from feelings of anguish and emptiness when he remembers the dead person to feelings of love, pleasure, and interest.
5) **Idealization.**
    1) Survivor may experience brief periods of anguish and a sense of loss, but the terrible anguish that characterized earlier stages of grief has disappeared.
    2) During this period, the survivor represses all negative and hostile feelings toward the dead person and creates a positive, well-balanced image of the person that helps to soften the sense of loss.

The normal period of grief usually requires a year or longer. Those who are able to realistically remember both the pleasant and unpleasant aspects of their relationship with the dead person are able to heal more completely and quickly than those who cannot realistically do so.

Abnormal or Unresolved Grief

Reasons for failure to progress through the normal grief process:

1) The death reawakens the memory of a previous loss with which the survivor never completely dealt.
2) The cause of death is an embarrassment to the survivor, so the survivor cannot face the death and does not receive support and encouragement from others.
3) The survivor is acutely afraid of losing control, so he will not allow himself to confront he strong feelings associated with the death.
4) The survivor is afraid to show signs of weakness.
    1) Will not allow himself to display such behaviors as crying, sobbing.
    2) Some stifle such feelings because they feel a responsibility to be stoic.
5) The survivor has lost more than one loved one at the same time and is overwhelmed by the multiple loss.
6) The survivor may have been too dependent on the dead person. To grieve means admission that the person is gone forever and will no longer be able to support him.
7) The survivor may have ambivalent feelings toward the dead person.
8) The survivor may be geographically isolated from the death.
    1) Not able to see the body, attend funeral, see coffin lowered into the ground.
    2) Isolated by distance from family members, the usual network of support.

Signs of Abnormal Grief

1) Significant change in personality.
2) Adoption of the dead person's habits and personality traits.
3) A breakdown in interpersonal relationships.
4) An inability to talk about the dead person even after a prolonged period.
5) A continued search for the dead person.
6) An overreaction to someone else's tragedy.
7) A development of the dead person's symptoms after a reasonable amount of time.
8) An exhibition of self-destructive behavior, such as excessive risk-taking, reckless driving, excessive drinking. Subconsciously may be trying to punish or hurt himself.
9) Withdrawal from the dead person.
10) The development of chronic grief reactions (over a period of several years or more.)
11) Recurring symptoms of normal grief, such as the overwhelming feelings of anguish or the feelings of anger and denial long after the death has occurred.
12) An obsession with loss.
13) The onset of disease; especially emotionally induced diseases and illnesses, such as migraine headaches, asthma, rheumatism, or ulcerative colitis.

LESSON 9

"Rape and Sexual Assault"

Categories of Rape

1) **Forcible rape.**
    1) Intercourse forced against woman's will.
    2) Two factors critical to defining rape:
        i) The rape must be forceful.
        ii) Must be committed against the woman's will.
2) **Date rape.**
    1) Limited consent prior to the rape.
    2) The woman wants to terminate the sexual act or the relationship, but the man forces her (usually through physical force or verbal threats) into sexual intercourse.
3) **Statutory rape.**
    1) A man takes advantage of a woman or child who is not able to use proper judgment.
    2) Woman may be under legal age, may be mentally retarded, may be inebriated, or may be on drugs.
    3) Even though the man does not have to use force; even though the woman may seem to consent--still legally classified as rape.

Kinds of Rape.

The Random Blitz Rape

This is the type that conforms with most stereotypes. The rapist and victim have had no previous contact. She is for him an anonymous target. While some random blitz rapes occur in buildings, most occur outdoors (usually in parks or in streets). The rapist has carefully calculated his moves, but the victim happens to be in the wrong place at the wrong time.

The Specific Blitz Rape

Here, the rapist has selected a specific victim. He probably does not know the victim, but he has observed her for some time. Possibly he's watched her walking her dog.

The Confidence Rape

The rapist obtains sex under false pretenses from someone with whom he has had prior contact.

He may be a casual friend or acquaintance. He may be a friend or relative or school teacher or date. Instead of using force, he uses the prior relationship to justify his presence--and then he betrays the woman's confidence by not honoring the bounds of the relationship.

The acquaintance rape (or confidence rape) accounts for about 60 percent of all reported rapes. Unfortunately, a great number of them are not reported because their victims are so reluctant to press charges. The "date rape" usually occurs on the rapist's turf. They often last for hours, and few involve threats with lethal weapons--instead the rapist uses verbal threats or sheer physical force to overpower his victim. Most occur on weekends between the hours of 10 p.m. and 2 a.m.

Women who are raped by strangers often develop a fear of the unfamiliar; women who are raped by men they know or have tusted develop a triple-barreled crisis: they no longer know whom to trust, they doubt their own judgment, and they develop overwhelming guilt (because they initially wanted to be with the rapist). Victims say that their rapists seem to have a split personality--at one moment they are tender, loving, and charming, and the next moment they are hostile and aggressive. A surprising number of people almost condone the practice: men have come to believe that they "deserve" sex at the end of a date, even if the woman doesn't want it.

Sometimes the rapist is the victim's husband. Only recently has this kind of rape been recognized. Many believed that a wife was "property" and that sex was a husband's "right," no matter what the wife wanted.

White Collar Rape

White collar rape occurs when a professional or semi-professional uses his position and influence to gain the confidence of a colleague or client, whom he then victimizes.

Contractual Rape

Usually, the victim is a prostitute; she contracts with the rapist, whom she views as "simply another client," a price is agreed on, and the sexual act begins. The rapist forces the prostitute to do something that is definitely against her will, but he overpowers her, ties her up, or uses physical violence to subdue her. Often the rapist does not pay the agreed-upon price. Few of these rapes are reported, and the ones that are reported are rarely successfully prosecuted.

Family Rape

The rapist generally uses his role in the family to catch the victim off-guard in a situation in which she is isolated from other people. Family rape is the most unreported type of rape, probably because the victim is afraid of her relatives' reaction.

Friendship Rape

Rape may occur between two people who are friends, who have had a good relationship and who have not had any kind of sexual relationship. It can also occur between friends who have had prior sexual experiences. Victims of this kind of rape frequently do not report it because of their previous relationship with the rapist; they become guilty and assume that they somehow "asked for it" after months of a good, stable relationship.

Myths about Rape

1) It's not possible to rape someone: if a woman doesn't really want it, you can't force her. Many women who are raped submit only when the rapist threatens their lives.
2) Women ask for it by the way they dress or the way they act; they are so provocative that the rapist simply can't resist.
    1) Rape is not a crime of sexual passion; it is a crime of violence.
    2) The main thing a rapist considers is whether he can overpower the woman, not how she looks.
3) Nice women don't get raped; the woman who is raped is "Cheap," unchaste, or "used goods." Rape affects women from all socioeconomic classes and in all age and racial groups.
4) Men can't be held responsible for rape, because they can't control their sexual desires.
    1) Rape is not a sexual crime; it is a crime of violence.
    2) Sex is used simply because it is a way of exercising control and power over a woman.
5) Rapists are pathological perverts and criminals.
6) Blacks usually attack whites.
    1) Only one in ten rapists attacks someone of another race.
    2) Ninety percent of all rapes occur between members of the same race.
7) Rape is a just punishment for being out alone at night.
    1) Many rapes occur in a woman's own bed because the rapist gained entrance into her home.
    2) Many other rapes occur between a man and a woman who were on a date, engaged in a business relationship, or married.
8) If the woman resists, the rapist will flee. Her act of resistance can further anger the rapist.
9) Rape only occurs to teenage girls.
10) Women are only raped by strangers.

LESSON 10

"The Victims of Rape"

Why Men Rape

1) Many men rape to satisfy the desire for power.
    1) Many come from homes that were dominated by women or they have been controlled by women.
    2) The power rapist usually suffers from low self-esteem and feelings of worthlessness, inadequacy, and vulnerability.
    3) He feels especially inadequate in his sexual abilities.
    4) The power rapist is more likely to choose a stranger as a victim.
2) Over one half of all rapists commit their crime out of anger; those rapes are characterized by force, intimidation, and physical brutality.
    1) Angry rapes are characterized by actions that are true expressions of rage, anger, hatred, and contempt.
    2) The rapist will do whatever he can to degrade the victim.
    3) The angry rapist often feels put down by women.
3) Only a few men rape out of a desire to be sadistic--to torture, abuse, and punish the victim.
    1) Most sadistic rapists carefully plan their rapes to avoid discovery; the rapes are premeditated, and they are repetitive, with each rape increasing in the level of violence.
    2) Most sadistic rapists are married, but most have problems in their marriages
    3) Sadistic rapes are the least common, they are the most sensationalized by the press and attract the most curiosity.
4) In some cases, men rape because they are trying to defend against homosexual impulses.
5) Others rape to gain status among their peers (as in notorious gang rapes).

Characteristics of the Rapist

1) A man who rapes may have suffered repeated sexual rejection.
    1) He is raping now to prove his sexual prowess, but it is not a sexual desire--it is a motive of power.
    2) He wants to be powerful enough to attract and hold women.
2) Rapists are generally unable to control their impulses.
3) Most rapists have a low tolerance for frustration. They want things now and cannot cope normally if their goals or desires are frustrated.
    1) Most have low self-esteem and feelings of worthlessness.
    2) They usually hate people in general and women in particular.
4) Many rapists are demanding and self-centered; when obstacles appear, they react with sudden force and violence to remove the obstacles.

5) The typical rapist is between fifteen and twenty-four years of age.
6) Some rapes occur in the course of another violent crime--such as armed robbery.
7) Adolescents who have suffered sexual rejection and who are anxious over their ability to prove themselves sexually may use rape to prove themselves.
8) In child rape, the rapist is usually someone in the child's own family
    1) Seventy-five percent of all child rapes, the rapist was a member of the household, a relative that was not a member of the immediate household, or a friend with whom the child had frequent contact.
    2) Because the rapist has extreme feelings of inadequacy and a low self-esteem, he is fearful that he will not be able to subdue or overcome an adult.

Characteristics of the Victim

1) The rape victim is easily frightened when she is threatened.
2) She is handicapped; she is not likely to be able to fight back, nor is she likely to be able to move quickly enough to alert police after the rape.
3) She is alone. She may be divorced, widowed, never married, separate, or simply by herself at the time of the attack. Widowed women and single mothers are most often victimized.
4) She is young--less likely to fight back, easier to take advantage of.
5) She is quick to respond to a friendly smile or a request for help.
6) Basically, the rapist is looking for a woman he believes he can overpower, intimidate, and threaten with success.
    1) He is looking for someone who will not scream or attract attention.
    2) He is looking for someone who will not move quickly to alert police once the rape is over.

Adolescents

The most common victims involved in rape are adolescents. Most are raped on the weekends, after dark, and away from home, usually at a social event. Gang rapes are common for this age group, and rapes usually last longer than an hour. Most of the time, the rapist is someone the girl knows (even though she may have known him only briefly, such as a few hours). Not as much brutality is involved as in adult rapes.

A special category of adolescent rape is incest: rape by a father, grandfather, or brother. Most are not reported. Adult victims are usually raped at night, indoors, by total strangers; the rape is usually brief but generally involves brutal violence.

Children

Up to 80 percent of those who have been sexually assaulted go unreported. Usually, rape (or sexual abuse) of a child is not an isolated, one-time occurrence; it usually builds in frequency and

intensity until it is stopped. The rapist usually doesn't stop on his own. Because children are trusting and usually defenseless, they are perfect targets. Because they are easily frightened and threatened, they can easily be silenced afterward. Children often fantasize and pretend about many things, but they rarely lie about being victims of sexual assault.

Unfortunately, children are often too confused or frightened to tell anyone about the rape. Watch for physical or behavioral clues. Look for irritation, infection, or injury to the genital areas; watch for torn, stained, or bloody underwear. The child might be having trouble sleeping. A child who has been raped might also develop behavioral problems, such as withdrawal, refusal to go to school, fear of being alone, increased anxiety, or sudden immature behavior.

Elderly Women

Elderly women are vulnerable, not likely to resist force, not likely to defend themselves, more likely to be alone, and not likely to summon help quickly enough to endanger the rapist.

Fear plays a great part in the elderly victim's reaction. She fears that she will no longer be able to protect herself; that she will be victimized again, and that she cannot survive.

An elderly victim may also suddenly become dependent on others. She is too afraid to live alone; she is paralyzed by the thought that another rapist will come back.

The Disabled or Handicapped Woman

Disabled people often think they are immune to rape because they are unattractive or perceived as being "asexual." The contrary is true: because their disabilities often make them vulnerable, they are easy marks for rapists.

Unfortunately, the disabled person has probably fought for her sense of independence, her ability to live alone, and her capacity to function well on her own. The rape may change all that. She may react much like the elderly victim, fearful of venturing out alone, afraid to live alone. Family may become overprotective instead of encouraging the victim to return to her life-style as quickly as possible. The disabled victim has a special challenge in trying to overcome feelings of helplessness, powerlessness, and fear.

Regardless of the victim's age or circumstances, she is likely to pass through a five-stage reaction to rape known as rape trauma syndrome. The following reactions are characteristic of the syndrome:

The Rape Trauma Syndrome

1) **The Rape**.
    1) During the rape, the victim will feel terrified and may lapse into acute emotional shock;

her consciousness may disintegrate.
   2) She may appear to be drugged.
   3) During the rape itself, she may have a number of physical reactions, including seizures, urination, paralysis, pain, hyperventilation, nausea, and vomiting.
2) **The Acute Reaction Phase**
   1) Immediately following the rape, the victim may experience shock, disbelief, and incoherence.
   2) As the reality of the situation occurs to her, she becomes visibly upset, shaken, agitated, angry, and restless.
   3) Her general fears and feelings of anxiety may interfere with the reporting of the rape.
      i) May not know who to tell.
      ii) May fear that she will not be believed.
      iii) May fear the physical examination by a male physician.
      iv) May fear that the rapist will retaliate against her if she reports him
3) The Outward Adjustment Phase
   1) For a period that may last for several months after the rape, the woman attempts to adjust to what has happened.
   2) She recovers from any physical injury but may suffer a number of physical problems, including nightmares, headaches, insomnia, a loss of appetite, nausea, vaginal infections, and burning during urination.
   3) The outward adjustment phase is one of fear.
      i) The victim is often jumpy and nervous.
      ii) She feels anxious and insecure.
      iii) She may be afraid of crowds, of physical violence, of death, of being approached from behind, of the unexpected, and of intercourse.
      iv) May be fearful of possibility of venereal disease or pregnancy and over legal procedures that await her.
      v) Her normal life-style remains disrupted.
4) **The Depression Phase**
   1) Previously successful defenses, such as denial, break down over the days and months following the rape.
   2) She loses her self-esteem and begins having both waking and sleeping nightmares about the rape.
   3) She is afraid that her life will never be normal again, tries to resolve her feelings, and needs help in removing guilt feelings about the rape.
5) **The Integration and Resolution Phase**
   1) During the months and years that follow the rape, the victim takes the steps necessary to return her life to as normal as possible.
   2) May feel anxious and afraid when confronted with situations that remind her in small ways of the rape.
   3) While she feels some sexual apprehension, it is during this stage that she is able to return to normal sexual function.
   4) In some cases, the victim does not return to a normal life-style, despite the passage of

time.

i) In these cases, the victim suffers permanent psychic damage, a reaction more common among those who had a history of physical, social, or psychiatric difficulties.
ii) Common reactions include lesbianism, depression, suicidal behavior, alcoholism, drug abuse, psychotic behavior, and sexual acting out.

5) Some discomfort, fear, anxiety, panic, or frigidity may persist for weeks, months, or sometimes years following a rape, and it requires the compassion and understanding of the victim's partner to help her overcome those feelings.
6) Some husbands or lovers may have a difficult time with the rape for several reasons.
   i) He may be indignant, eager to seek out revenge with the rapist.
   ii) Many men feel guilty because they were not able to stop or prevent the rape. Some may become concerned about their own rape fantasies.
   iii) Others may not be able to understand the victim's special needs.
7) Occasionally, a victim will not adjust to the rape properly.
   i) Instead of releasing and venting her emotions over a period of time, she becomes a "rock," dealing with her attack in silent suffering.
   ii) May have persistent violent dreams or nightmares, long periods of silence, minor stuttering, chronic loss of self-confidence or self-esteem, paranoia, physical distress of undetermined origin, increasing anxiety, sudden onset of phobias, marked changes in sexual behavior, and avoidance of relationships with men.

LESSON 11

"Protecting Yourself Against Rape"

False Rape Accusations

Most often, reasons for false rape accusations fall into these categories:

1) The woman accuses the man of rape as a way to get revenge or as a method of blackmail.
2) The woman feels a need to protect her reputation; instead of admitting that she willingly participated in sexual activities, she accuses her partner of forcing her.
3) Rape is often used to explain a pregnancy in an unmarried girl, a divorced woman, or a married woman whose husband is sterile or away at the time of conception.
4) Parents who discover that their young girl is engaging in sexual activity may accuse the boy of rape to convince themselves and others in the community that the girl wasn't willing--it wasn't "her fault."
5) A schoolgirl crush may turn into an ugly rape accusation if the hysterical girl wants others to believe that her teacher "wants her."
6) A child who wants to get rid of an unwelcome stepfather may accuse him of raping her, knowing that he will probably be forced from the home. (Usually the case with older children, not younger).
7) A woman who wants an abortion in a state where abortions are difficult to obtain except in cases of rape or incest may claim rape to get the abortion.
8) A woman who agrees to sexual intercourse after prolonged courtship may become distraught when her boyfriend drops her; she feels resentment and claims she was raped.
9) A woman may be embarrassed that their own husband assaulted her, so she may explain her injuries by claiming she was raped.
10) A woman may claim she was raped if she picks up venereal disease during a covert extramarital affair.
11) False claims of rape may be made due to fear of losing welfare payments for illegitimacy or due to a desire to protect the woman's reputation during a child custody battle.
12) A woman may claim she has been raped to elicit the sympathy of a lost husband or lover, whom she hopes will rush to her defense.
13) A woman may want to attract publicity or attention.
14) A woman who is anxious over her sexual relations may claim that she has been raped so that she can be examined for pregnancy or venereal disease; parents who are anxious over a daughter's sexual activities may also claim rape so that they can submit her to examinations to detect pregnancy or venereal disease without admitting that she has been promiscuous.
15) When sexual activity is interrupted by the police or by parents, a girl may claim that she was being forced against her will in order to avoid being punished.

Protecting Yourself Against Rape

1) Don't advertise that you live alone.
    1) Keep window shades drawn at night.
    2) Use only initials on your mailbox and in the phone book.
2) If you are alone and the doorbell rings, call out, "I'll get it, John."
3) If someone comes to your door and asks to use your phone, refuse, even if the person claims it is an "emergency."
4) Make sure that your home always looks occupied.
    1) Use a timer for your lights and a timer for your radio.
    2) Don't pin notes on door.
    3) Unplug your telephone when away.
    4) Keep a bathroom light on at night.
5) Keep your doors and windows locked, even when you're in the house.
    1) If renting, have locks changed.
    2) If lose key, have locks changed.
    3) Don't put name on keying.
6) Have phone near bed. Good to have cellular phone.
    1) Have friend call same time everyday to check on you.
    2) Have secret code to indicate something is wrong.
    3) If receive obscene phone call, blow a shrill whistle into the phone receiver or tap the mouthpiece sharply and say, "Operator, this is the call I wanted you to trace."
7) If you wake up and suspect that an intruder has entered your house, stay in your bedroom and pretend to be asleep.
    1) Most injuries result from burglar being cornered or was startled.
    2) If the intruder confronts you, remain calm.
8) Always have your keys in hand before you reach your door or the entrance to a building.
9) If alone, avoid going into deserted areas of a building, such as the stairway, laundry room, trash room, and storage area.
10) Avoid getting into an elevator with a strange man.
11) If you think that you are being watched as you leave your apartment, call back to a mythical companion, "Remember to take the cake out in ten minutes, John."
12) If you are assaulted in a building, yell "fire" instead of "rape," and make as much noise as you can.
13) When you are outside, never walk alone; always walk with a companion or in a group.
    1) Don't take shortcuts through parking lots, vacant lots, or alleys.
    2) Walk on the sidewalk next to the curb; avoid walking near doorways or shrubbery, where an assailant could be lurking.
14) Avoid talking to strangers on the street. Never walk through a group of men; walk around them or, if they look threatening, cross the street.
15) If you can, avoid carrying a purse.
    1) If someone does try to grab your purse, throw it into the street into heavy traffic or turn it upside down, dumping out the contents.

2) If someone might try to take your purse, drop it in the nearest mailbox.

16) If you travel a regular route, know where you can get help.
17) When you travel, try to go with a companion.
18) When waiting on a bus, stand in a confident, erect position, balanced with your feet slightly apart.
19) When you are driving an automobile, keep car keys on a separate key ring from your house keys. Never put your name and address on your keying always have at least one-quarter of a tank of gasoline in your car, and drive with the doors locked and with windows at least three-quarters rolled up.
20) Never pick up hitchhikers.
21) If your car becomes disabled, raise the hood, tie a white cloth to the radio antenna or door handle, get inside, and lock the doors. If someone comes along to help, stay in the cr and ask the motorist to call the police for you.
22) At night, always park in a well-lighted, busy area and ask a friend to escort you to your car. Keep your car locked, and always check the back seat and floor before you get in the car.
23) Never leave personal papers or credentials in your car.
24) If you see a motorist in distress, don't stop to offer help. Note the location of the car and stop as soon as you can to call the police and alert them to the motorist's troubles.