THE CHARACTERISTICS OF CHRONIC CALLERS

TO TELEPHONE CRISIS CENTRES

by

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Abstract

The characteristics that identify chronic callers to telephone crisis centres were investigated. The telephone workers from four crisis lines identified and recruited subjects. Eight chronic callers were interviewed by telephone. Subjects participated in a structured interview, responding to questions on their experiences with crisis lines, contacts with other community services, their support network of friends and family, their mental health and substance use, and major events in their family history. Subjects telephoned from three to five times a month to four times a day. They had been telephoning crisis lines from 6 months to over 13 years. They usually telephoned two or three different crisis lines regularly. Qualitative analysis of the interview data consisted of three concurrent activities: data reduction, data display, and drawing/verifying conclusions. Analysis identified 17 chronic caller characteristics common to most subjects: 5 personal characteristics, 5 involving relationships and their support network, 3 relating to their family background, and 4 concerning their experience with counselling, therapy or other treatment. Support, contact, esteem-building, friendliness and the telephone volunteers emerged as positive characteristics from the subjects' experiences with crisis lines. Poor "business" practice, call management and "labelled" callers emerged as negative characteristics from the subjects' experiences of crisis lines. Callers also displayed eight characteristics distinguishing lower

frequency from higher frequency chronic callers based on the frequency of telephoning. Three characteristics involved the callers' relationship to the crisis lines; one regarded their therapeutic history; and four concerned family history or special others. Four global themes - victimization, esteem, isolation, and connection - emerged across all callers for the information they shared. The results point to the subjects' personal, family and therapeutic histories feeding into a dynamic of ongoing contact with crisis lines. The callers' increased use of crisis lines accentuates the mismatch between chronic caller characteristics and the crisis lines' goal of crisis intervention. Telephone crisis centres are left to consider different methods of managing chronic callers and how to better work with those higher frequency chronic callers turning to the crisis lines as a therapeutic resource.

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Acknowledgements

I am very grateful to those regular callers that took the time to share their lives and answer my questions. They are clearly survivors and thrivers with much valuable life experience to enrich others' lives should people take the time to listen.

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Introduction

In Canada and the United States there exists over 500 telephone suicide prevention and crisis intervention centres. Many of these services are staffed 24 hours a day providing intervention and support to individuals in crisis within their communities (Slaikeu, 1990). Some calls to these centres are from people in crisis or suicidal. Many calls come from individuals who are lonely, depressed, or in a relationship conflict (Lester & Brockopp, 1970; Lester & Brockopp, 1973).

Frequently these telephone services encounter individuals who call quite regularly. Farberow et al. (1966) and Lester and Brockopp (1970) long ago identified these "chronic" callers. They present unique challenges to telephone workers and crisis intervention centres alike. Rarely thought as high risk in terms of immediate need of crisis intervention, chronic callers make numerous calls that interfere with service availability to those in more urgent crisis or distress (Lester, 1971; Lester & Brockopp, 1970). They remain difficult to manage because of their personal characteristics and history and the interaction patterns they initiate between themselves and the telephone workers (Rudestam, 1978). For all their challenge and contact, chronic callers are little understood and vaguely identified. Though no consistent nor complete definition of a chronic caller exists, some common characteristics have been identified.

Chronic Callers

Over 75% of chronic callers have received prior psychiatric

treatment for a mental illness or some other psychological concern (Farberow et al., 1966; Lester & Brockopp, 1970; Sawyer & Jameton, 1979). Over half have attempted suicide and nearly half suffer from substance abuse (Faberow et al., 1966; Sawyer & Jameton, 1979). Possibly because of these personal challenges, chronic callers often are in contact with other community agencies and resources in addition to the telephone crisis intervention services (Faberow et al., 1966; Lester & Brockopp, 1973; Sawyer & Jameton, 1979). Easily 75% of chronic callers have had previous experience with counselling, therapy or psychiatric treatment (Greer, 1976; Murphy, Wetzel, Swallow & McClure, 1969).

While equivalent numbers of chronic and other callers appear to be married, significantly more chronic callers are reported as unmarried: single, divorced, separated or widowed (Greer, 1976; Sawyer & Jameton, 1979). Also, chronic callers appear to have a limited support network of friends and family (Haywood, 1981; Imdoden, 1981; Leuthe & O'Connor, 1981; Sawyer & Jameton, 1979).

Chronic callers maintain frequent and ongoing contact with crisis centres. They represent large portions of the total numbers of calls to a crisis line (Johnson & Barry, 1978; Lester, 1971; Lester & Brockopp, 1970; Murphy et al., 1969; Speer, 1971). However, when a chronic caller can be defined in terms of a specific frequency or duration of ongoing telephone contact remains vague (Johnson & Barry, 1978; Sawyer & Jameton, 1979).

Their frequent and ongoing contact with the crisis centres

continually wears at the telephone workers' ability to understand and effectively deal with them (Leuthe & O'Connor, 1981). Chronic callers seem to initiate interactional dynamics with telephone workers that seriously impair the ability of suicide prevention and crisis intervention workers to deliver adequate and needed services to them (Rudestam, 1978). With increasing caller contact, the quality of interaction and the effectiveness of the telephone worker decreases (Greer, 1976; Leuthe & O'Connor, 1981).

Though research has outlined some characteristics of chronic callers, more information is needed to understand better and to manage effectively these challenging callers. Also, how these characteristics are associated with one another has not been researched and rarely speculated on. A gap in the research on chronic callers exists here.

The principal investigator studied the characteristics that identify chronic callers to suicide prevention and crisis intervention centres. Chronic caller characteristics were studied to expand and develop the chronic caller profile. Also, the research attempted to discover some possible associations that exist between these characteristics. The discovered characteristics and the associations between them will lead to greater and more consistent identification of chronic callers and the development of more effective and comprehensive management strategies for these callers.

Declaration of Biases

I bring both my experience and viewpoints of working in telephone crisis intervention for eight years. Though no longer with crisis lines, I remain interested in the challenge of client chronicity, particularly that of chronic callers. Trained in short-term, immediate crisis intervention, I view chronic callers as having some life "stuckness" and long-term difficulties which crisis intervention models cannot address. These "characteristics" of chronic callers make it very problematic for them to initiate substantial and quick change in their lives. I have experienced the frustration of working with these individuals directly and indirectly as a telephone worker and supervisor of a crisis line. I have strived to apply or initiate other forms of telephone intervention to these individuals with limited success. I believe now these callers need to be better understood to provide more appropriate and effective assistance to them. If possible, I hope this assistance can be provided within the telephone crisis centres' programs and service objectives, moving away from strict adherence to a crisis intervention model.

I have experienced in my years with crisis lines chronic callers treated as individuals with unique needs requiring specific attention and treatment. Also, I have heard these callers being disparagingly called "chronic callers," frustrating to the workers and centres, burdening the phone lines with their constant problems. The individual callers disappear behind their

chronicity, and they seem to be deemed as less worthy of telephone crisis intervention services.

I now view the name "chronic caller" as an often pejorative label. (I use the term chronic caller only to capture the ongoing nature of these callers' telephone contact and to conform with general usage in the research literature.) While looking for uniform characteristics across all these callers, I hope to give a better understanding of chronic callers so that crisis lines can better identify and meet the needs of this challenging and unique group of individuals. I believe it is important and necessary to move beyond these callers' chronicity to understand the different characteristics that are part of these individuals.

Besides the existing research literature and speculation, my views have influenced the focus and direction of the research questions. Similarly, the collective experience of both Langley Crisis Line's and Richmond Crisis Centre's administrative staff have influenced the importance to which they attached to particular research questions and how they would approach chronic callers through their telephone lines.

Significance

This study is designed to expand on the understanding and information available on chronic callers to telephone crisis intervention centres. The derived profile of chronic caller characteristics will aid in the easier identification of these callers, allowing for the more ready engagement of management strategies to these challenging individuals. This profile also

would allow for faster identification of potential chronic callers before they establish frequent and long term telephone contact.

Greater understanding of the associations between the identifying characteristics and the callers' chronicity would allow for more effective and comprehensive management and intervention with these individuals. Also, the characteristics and their associations to caller chronicity would provide a starting point for applying services and resources to reduce the callers' need for frequent and ongoing contact. These actions would increase telephone counsellor effectiveness, depleted by ongoing chronic caller contact.

The identified characteristics would assist in the development of general management strategies for chronic callers. Historically, management plans for chronic callers have been difficult to carry out because of the large number of telephone counsellors that a crisis centre employs (Lester, 1971; Lester & Brockopp, 1973). Management plans developed were generally unique to a specific chronic caller, often involving one-to-one ongoing contact with a designated telephone counsellor (Barmann, 1980; Tapp & Murray, 1973). These unique management plans frequently were applied inconsistently because the telephone counsellors at the crisis centre often had varying degrees of familiarity with the management plan. With general identifying characteristics of chronic callers, a crisis centre could develop a standard set of management strategies to apply when talking

with any chronic caller.

Other public service agencies, such as transition houses and mental health services, also receive calls from individuals on a consistent, repeat basis (K. Johnson, personal communication, January 26, 1994[1]; D. Marshall, personal communication, October 14, 1991[2]). This research also would benefit these service agencies, giving them starting points for effective and consistent handling of their repeat callers.

Literature Review

Characteristics of Chronic Callers

Frequency of Calls

Research has provided data on the frequency of calls made by repeat callers. Lester and Brockopp (1970) reported that the 24 identified chronic callers to the Erie County Suicide Prevention and Crisis Service made 649 (16.6%) of the total calls in eight months. Later, Speer (1971) reported that individuals who had telephoned previously made 42% of calls to the same centre. Murphy, Wetzel, Swallow, and McClure (1969) reported 34% of the calls to St. Louis Suicide Prevention, Inc. were from 21 repeat callers. Lastly, Johnson and Barry (1978) reported in their study that 23% of the sample made multiple calls beyond one week representing 20.6% of the incoming calls to the centre. Clearly repeat callers to suicide prevention and crisis intervention centres represent a substantial proportion of the calls. However, it remains unclear what portion of these callers are "chronic callers" as opposed to callers in "real" crisis requiring ongoing support and intervention.

Other research has attempted a definition of chronic callers based on the number of calls to the crisis service. Lester and Brockopp (1970) defined chronic callers to the Erie County Suicide Prevention and Crisis Service as those callers making 10 or more calls over an 8-month period. Lester (1971) later defined chronic callers as those individuals who call regularly to the centre, sometimes as often as five times a day. Still

other studies have defined chronic callers in terms of "repeaters" (Farberow et al., 1966) or callers administratively viewed as chronic callers (Sawyer & Jameton, 1979). Johnson and Barry (1978) have rightly reported that chronic callers typically have been defined in terms of an arbitrary number of calls from the caller over a given period. Further, they point out that using Lester and Brockopp's (1970) definition of 10 or more calls in eight months, only one of their callers was chronic - a woman whose husband was suicidal. From their research, the number of calls alone to the crisis intervention centre cannot be the criterion to decide whether or not a caller is chronic.

Identified chronic callers also use crisis services over long periods of time. Sawyer and Jameton (1979) have indicated that of the 67 identified chronic callers to the Cleveland Suicide Prevention Center nine had been calling less than six months, 58 longer than six months, and 29 longer than three years. A few had been calling over the nine years since agency started in 1967. Consequently, it can be stated that not only do chronic callers telephone frequently and in great numbers, they also call over long periods.

Mental Health and Substance Misuse

Several studies have investigated chronic callers' psychiatric background and substance misuse. Farberow et al. (1966) in their caller survey for the Suicide Prevention Center of Los Angeles examined 55 repeat callers and reported these people "were more tenuously structured in their personalities,

and were frequently borderline, if not outrightly psychotic" (p. 556). More than 85% of the callers had been in prior psychiatric treatment. Often they were chronically suicidal. Lester and Brockopp (1970) indicated 18 out of the 24 chronic callers to the centre had a psychiatric background: three had been seeking psychiatric treatment, six were seeing a psychiatrist, and nine had been former patients. Sawyer and Jameton (1979) indicated of the 67 chronic callers to the suicide prevention centre, 34 (51%) were diagnosed as drug or alcohol dependent, 14 (21%) had a definite affective disorder, and six (9%) were diagnosed as schizophrenic. Some callers were given a secondary diagnosis of substance abuse. Many had transient depressive symptoms.

As in the Sawyer and Jameton (1979) study, substance misuse has characterized chronic callers. Greer (1976) reported 63.6% of the frequent callers versus 35.3% of the infrequent callers to the San Jose Suicide and Crisis Center had used alcohol or other drugs at the time of the call or had revealed a substance use problem. Farberow, et al. (1966) pointed out the most frequent reasons for calling for repeaters was marital problems or alcoholism.

Psychiatric treatment does not necessarily indicate the repeat or chronic caller has a mental illness. Callers could be involved in psychiatric treatment for other difficulties, such as sexual abuse, without a concurrent psychiatric illness. Also, the accuracy of the psychiatric diagnoses may be argued in the above studies, especially if suicide indicates a further

psychiatric impairment. Additionally, contacting a crisis line after using alcohol or other drugs is not a definite indicator of a substance misuse problem or addiction. Substance use may give the callers the "courage" to telephone, or make the callers' concerns more burdensome, leading to the telephone call. No substance misuse problem or dependency may exist.

Between 75% and 85% of chronic or repeat callers have received prior psychiatric treatment for a diagnosed mental illness or some other psychological concern. Also, a primary diagnosis of substance abuse was given to upwards 50% of these callers. Both a psychiatric background and a history of substance abuse appear to distinguish chronic callers.

Suicide

Whether suicide is a distinguishing characteristic of a chronic caller is unclear. Sawyer and Jameton (1979) reported 4 out of 67 chronic callers had committed suicide over the 9-year period of the study, and 37 (55%) had attempted suicide. But they had no comparison group of infrequent or other callers. Using a comparison group, Greer (1976) reported 83.3% of frequent callers disclosed a previous history of suicide attempts versus only 36.4% of the infrequent callers.

Other studies comparing infrequent callers and repeat callers reported no differences between the two groups. Lester and Brockopp (1970) noted no differences in suicidal history and related suicide risk on the first call between repeat callers and one-time callers to a suicide line. Murphy et al. (1969)

reported 9 (52.9%) of the interviewed repeat self-callers had a history of previous suicide attempts. They reported also that over half of all self callers had made previous suicide attempts.

Research shows over half of chronic callers have made previous suicide attempts. However, whether this is unique to chronic callers is uncertain.

Past or Present Experience with Counselling, Therapy or Treatment

High percentages of all callers (repeat or one time callers) seem to have been involved in some type of counselling, therapy or mental health treatment. Murphy et al. (1969) reported that of the 17 repeat self callers interviewed, 13 (76.5%) had a previous or current psychiatric history involving some degree of treatment. And of the total self callers, repeaters included, four fifths had previous psychiatric attention. Greer (1976) indicated 95.8% of frequent callers versus 92.3% of infrequent callers had past or present experience with counselling, therapy or hospitalization. Previous or current experience with therapy, counselling or treatment is not unique to chronic callers.

Contact with Other Community Services

Having experienced a past or current psychiatric challenge, chronic callers often have had frequent contact with other community services. Farberow et al. (1966) stated "with more than 85% in prior treatment, they [chronic callers] are known to the community and its agencies, having made the rounds and often exhausted the facilities..." (p. 556). Lester and Brockopp (1973) reviewed the chronic callers to the Suicide Prevention and

Crisis Service of Erie County. They stated that "in most
instances, the chronic caller is being heard not only by the
[crisis] center but by many other agencies and organizations in
the community" (p. 182). Sawyer and Jameton (1979) said that of
the 67 chronic callers to the suicide prevention centre, at
follow-up, 31 (47%) were referred for ongoing treatment at other
community mental health resources.

Relationship Status

Considering the unmarried (single, divorced, separated and
widowed), significant differences between chronic and other
callers appear. Greer (1976) reported 77.4% of frequent callers
as unmarried versus 56.0% of infrequent callers. Sawyer and
Jameton (1979) reported 67% of the chronic callers were unmarried
or separated compared with 47.2% of the total population of
callers.

However, considering only married callers, the differences
between chronic and usual callers disappear. Sawyer and Jameton
(1979) reported similar percentages of married callers for
chronic callers (31%) and the total population of callers
(32.8%). Approximately 20% of the total population of their
study had and unknown marital status, possibly partnered, common-
law, etc. Unfortunately, Greer (1976) did not report any
percentages for married callers for frequent or infrequent
callers, providing no additional information to the marital
status of chronic callers other than cited above.

Chronic callers seem to be more likely unmarried - divorced,

separated, single or widowed - than other callers. However, chronic callers also appear undistinguishable by marriage from other callers. Because the marital status of some callers remained unknown in the above studies, firm statements for differences or similarities between chronic and other callers cannot be made.

Support Network

Studies noting the chronic callers' support network report a limited support network of family and friends. Haywood (1981) stated chronic callers are isolated individuals, having few social supports, telephoning crisis lines to chat. Imboden (1981) reported chronic callers as lacking support systems and social networks. He stated these callers inappropriately fill their need for social contact and support through the crisis lines. Also, Leuthe and O'Connor (1981) acknowledged repeat callers as lacking support systems and resources.

These studies relied on the researchers' experiences with chronic callers and anecdotal information on these callers from other telephone workers. Only one study was quantitative in nature. Sawyer and Jameton (1979) reported 51 (76%) of the 67 chronic callers investigated had no contact with peers during the past year. This finding remains consistent with above studies.

This research only addresses the size or amount of contact with the callers' support network. None addresses the chronic callers' ability to engage and utilize their support network of family or friends. Further, no research compares chronic callers

with other crisis line callers on this dimension. However, considering size and amount of contact, a limited support network appears to characterize chronic callers.

The Caller-Worker Relationship

Some research has also investigated the impact of chronic callers on the telephone workers and the worker-caller relationship. Leuthe and O'Connor (1981) have said continued lack of movement and change by chronic callers lead to less effectiveness, tolerance, and sensitivity to caller needs. This then produces poor therapeutic relationships, caregiver self-doubt, and burnout. They state the mismatch between caller and worker needs makes negative contact for each most likely. Further, they point to chronic callers being a major factor in the premature termination of volunteering for telephone workers. Also, Greer (1976) has stated the quality of volunteer interactions decreases as the frequency of callers' contact with the service increase, as is true with chronic callers.

Rudestam (1978) has conceptualized chronic caller characteristics in terms of the interactional dynamics set up between the caller and the telephone worker. He speculates that persistent callers are often profoundly depressed and suicidal. Telephone workers try to provide for the chronic callers' needs and become increasingly frustrated and hostile as the callers fail to improve. Chronic callers cannot understand this change in the relationship. In spite of their confusion and uncertainty, they are unwilling to give up one of the few

remaining relationships they have. Telephone workers cannot distinguish between the chronic callers' confusion over the change in the relationship and their previous behaviour. However, they will continue to deny and reject the callers' demanding behaviours out of guilt and responsibility to the depressed and suicidal chronic caller. An interactional stalemate results.

Rudestam (1978) is only speculating on the dynamics that exist between the telephone worker and the chronic caller. Previous research suggests that though many chronic callers to crisis services are suffering from depressive symptoms, not all persistent callers to the centres are depressed or suicidal. Though many telephone workers may get caught up in a deadlock with the chronic caller, some readily address their feelings of frustration and annoyance with caller behaviours. Further research and information is required to expand and support Rudestam's view.

Research Methods

Log Sheets

Most research with chronic callers to crisis centres has involved review of crisis centre telephone log sheets (Farberow et al., 1966; Greer, 1976; Johnson & Barry, 1978; Lester & Brockopp, 1971; Sawyer & Jameton, 1979; Speer, 1976). The inadequate and inconsistent records kept by most crisis lines often has limited this research (Rosenbaum & Calhoun, 1977). Many crisis lines maintain the callers' anonymity by operating on

a first name only basis, making the task of keeping individual files very difficult. Even at those centres that keep individual files on callers, usually chronic callers, the files often are not maintained (Rosenbaum & Calhoun, 1977).

Most crisis centres keep only general statistical data consisting of age, gender, problem, disposition, time of call, et cetera (Greer, 1976; Rosenbaum & Calhoun, 1977). Often on the log sheets there exists a divergence between what is heard over the telephone lines and what is recorded on paper (M. Chand, personal communication, February 4, 1994[3]; J. Rawlyns, personal communication, February 5, 1994[4]). Specifically related to chronic callers, Greer (1976) reported that out of a total of ten informational spots on the "Follow-Up Sheet," the frequent caller group showed a median of 4.8 vacancies (μ = 4.6) versus a median of 2.4 (μ = 3.1) for the infrequent caller group. He notes that half the time there is only 50% of the log sheet filled out for the frequent caller.

Greer (1976) and Leuthe and O'Connor (1981) reported a decrease in the quality of telephone worker interactions as the frequency of callers' contact with the service increases. A reasonable assumption could be made here that frustrated and less effective telephone workers may not report as much or as accurately the content and context of the call. Also, with increasing contact, the telephone worker could perceive both the call and caller as "routine," expecting no new information and requiring little log sheet write-up. Therefore, both the routine

nature of the contact and the decreased quality of caller-worker interactions could influence the completeness and accuracy of log sheet data for chronic callers.

Telephone Follow-up

    Little crisis line research has employed direct telephone follow-up with callers. That which has involved brief surveys investigating the effectiveness of telephone crisis intervention (Auerbach & Kilman, 1977; Hornblow, 1986a; Stein & Lambert, 1984). In the research, direct telephone follow-up has been used successfully, although rigorous follow-up was assumed difficult given the desire of many callers to remain anonymous (Hornblow, 1986b; Slaikeu & Leff-Simon, 1990).

    Gingerich, Gurney and Wirtz (1988) designed their research to evaluate the effectiveness of a crisis line to include telephone follow-up. They reported that approximately 25 to 30% of the callers declined to participate when approached. At the time of the telephone follow-up, a further 10 to 15% of those callers who had agreed to participate could not be contacted or declined to participate. Overall approximately 60 to 65% of approached callers participated in the study and completed the telephone follow-up.

    Slaikeu, Tulkin and Speer (1975) demonstrated that self-report follow-up data could be obtained on most callers to a crisis line. They reported 95% of the shows for a face-to-face appointment booked during a crisis call responded to the follow-up questionnaire. Also, 70% of the no-shows and 93% of

the cancels who could be reached by telephone returned the questionnaire. The researchers effectively used a telephone follow-up to obtain outcome data.

Slaikeu and Leff-Simon (1990) reported that telephone workers could elicit from the caller at least a name and telephone number to allow for a subsequent call back. The most important considerations for the workers are to (a) explain to the callers the reasons for the follow-up, and (b) ensure the confidentiality of those telephone contacts. They suggest that the callers are presented with the option to give a name and telephone number for follow-up or to call back the centre on their own, both within a specified period. Callers choose whether or not to maintain their anonymity.

Telephone follow-up can be used effectively to obtain outcome data from a large percentage of callers to a telephone crisis line. Procedures can be employed to ensure caller confidentiality, such as the telephone follow-up scheduled so that the caller will be alone to receive the call. Also, the callers always are given the choice whether or not to maintain their anonymity. Therefore, telephone follow-up can be both an effective and appropriate method for research with callers.

Research Interviews with Crisis Line Callers

Only one study (Murphy et al., 1969) was located that completed in-depth interviews with callers to a telephone crisis intervention service. The researchers asked the callers about the circumstances around their call, the effectiveness of the

suicide prevention service, suicidal and psychiatric history, and a life history seeking information on education, job, military, marital and family background and economic status. However, this study did not specifically use chronic or repeat callers as subjects, but attempted to sample all self-callers to the suicide prevention service between January 1 and March 31, 1967.

Of the 73 self-callers to Suicide Prevention, Inc. (S.P.I.) of St. Louis, 55 (75%) were interviewed. Contact of these callers was made possible because the telephone number of S.P.I. was a telephone answering service. At the time of the call, the service would request the name and telephone number of the caller and pass this on to the person on call for S.P.I. then. (Few, if any, suicide and distress lines would operate in this manner today. The obligation to a caller's confidentiality and anonymity would make this procedure unacceptable.) People identified as self-callers were contacted by letter requesting an interview appointment. The researchers did not specify how they obtained the mailing address of subjects for the study.

There were eight refusals. One caller listed as a refusal was an alcoholic man who threatened to shoot himself and the interviewer when the interviewer arrived for the agreed upon appointment - a clear danger of face-to-face interviews. Ten self-callers were not located.

Forty-six of the 55 interviews were face-to-face. Thirty-six took place in the callers' home, a potential safety risk for both caller and interviewer, as shown by the above

suicide/homicide threat. Five interviews occurred in the researchers office, potentially both frightening and inconvenient for a person whose usual means of contact is a telephone. Four took place in hospitals where the callers were then patients, and one in an interviewer's automobile. The appropriateness of both these settings can be argued.

Nine interviews were conducted over the telephone because this was the only other option to the caller's outright refusal to be interviewed face-to-face. No written consent is possible here, though informed consent can still be obtained through appropriate verbal protocols.

Murphy et al. (1969) shows the potential personal danger for callers and interviewers of face-to-face interviews with suicide and distress line users. Sixteen percent (9 of the 55 interviewed callers) outrightly refused to be interviewed face-to-face. Some remaining interviews were conducted in less than ideal environments, ie., the hospital and the interviewer's vehicle. A telephone interview format would allow the caller and researcher the safety and security of their "home" environment. This method also would ease the hesitancy and reluctance of the caller to be interviewed, providing a medium (a telephone line) already quite natural to the chronic caller.

Telephone Interviews

The telephone interview can bring into question the accuracy of the obtained interview data. However, research comparing in-person with telephone interview methods have shown that the

quality of data obtained by telephone interviews is comparable or
superior to that obtained through face-to-face interviews
(Aneshensel, Frerichs, Clark & Yokopenic, 1982; Colombotos, 1969;
Hochstim, 1967; Pless & Miller, 1979; Reich & Earls, 1990;
Rogers, 1976; Siemiatychi, 1979; Simon, Fleiss, Fisher & Gurland,
1974; Weeks, Kulka, Lessler & Whitmore, 1983; Wells, Burnam,
Leake & Robins, 1988). Aneshensel et al. (1982) reported no
statistically significant differences between telephone
interviews and in-person interviews for the assessment of health
status, illnesses reported for the previous four months, or
reports of hospitalization. They attributed the one
statistically significant difference reported to the interview
item and not the interview methods. Reich and Earls (1990),
using a structured psychiatric interview, interviewed 25 youths
by telephone and 25 youths in-person. They obtained no
significant differences in the reporting of diagnostic categories
for the two groups.

Rogers (1976) asked subjects information on their personal
income, voting patterns, educational background and attitudes
about local services. She interviewed 85 people by telephone and
98 subjects in-person. She concluded that the data obtained by
telephone was as accurate as in-person data. Simon et al. (1974)
compared face-to-face interviews with telephone interviews
investigating the information obtained from informants of
psychiatric patients. A semistructured psychiatric interview was
used with the 85 subjects, 50 interviewed face-to-face and 35

over the telephone. Their results indicated the quality of historical psychiatric data collected from informants did not relate to the interview method used. Weeks et al. (1983) reported that telephone respondents appeared to be somewhat more accurate in reporting visits to medical providers than in-person respondents. The researchers noted some minor differences in responses between the two methods of interviewing, but they attributed these differences to sociodemographic differences between the telephone and in-person interview respondents.

The research on the quantity of data obtained with telephone versus face-to-face interviews is less conclusive. Rogers (1976) and Simon et al. (1974) reported that the information obtained from telephone interviews as complete as that obtained from in-person interviews. However, Reich and Earls (1990) recorded fewer psychiatric symptoms reported by those youth interviewed by telephone as compared with those interviewed in-person. They speculated the lower reporting was due to the lack of privacy for the youth with their parents possibly listening in to the telephone interview. Also, Weeks et al. (1983) reported a greater effort by those subjects interviewed face-to-face in reporting medical conditions than those interviewed by telephone. However, with the greater reporting of respondents personally interviewed, more disagreements between their reports of medical conditions and hospital records were shown. The researchers concluded that though telephone respondents reported less, they tended to be more accurate than in-person respondents.

Lastly, the literature comparing in-person versus telephone interviews has shown there can be more truthfulness in response, ie., less social desirability, with telephone interviews than with face-to-face interviews (Pless & Miller, 1979; Rogers, 1976). However, other researchers have reported that telephone and in-person interviews are equivalent in social desirability for responses, with the advantage going to mailed out questionnaires (Siemiatycki, 1979; Wiseman, 1972). No clear statement can be made on the advantage of telephone interviews over in-person interviews concerning social desirability.

Telephone interviews can obtain a comparable quality of information from subjects as that obtained by in-person interviews using a variety of interview schedules and outlines. However, the completeness of data and accuracy of information with regard to social desirability remain to be established firmly in favour of either telephone or face-to-face interviewing.

<div align="center">Delimitations: Other Chronic Callers</div>

Sex callers were excluded from this study (see Appendix A for the definition and characteristics used for identifying sex callers). Though chronic in nature, these callers use crisis intervention centres for sexual gratification (Lester & Brockopp, 1973; Wark, 1984). The chronicity of their calling results from a sexual addiction (Carnes, 1983; Earle & Crow, 1989).

The telephone crisis centres did not recruit those chronic callers they deemed too psychiatrically challenged to

participate. They were concerned over the vulnerability of these particular callers. The centres were concerned also about the potential for verbal abuse and aggression directed at the telephone workers should the chronic callers respond negatively to the request to participate. Therefore, these callers were excluded from the study.

Those individuals with an extreme psychiatric challenge could be defined as a discrete group of chronic callers - the long term mentally ill. This group of callers has been characterized as: (a) low-functioning, with an ongoing, often acute, psychiatric condition; (b) often isolated individuals with limited social supports; (c) having difficulty establishing rapport with others; (d) often exhibiting anger and hostility under stress; and (e) requiring particular techniques and strategies for their management (Bachrach, 1980; Bassuk & Gerson, 1980; Chrzanowski, 1980; Crisis Clinic, February, 1988; Schwartz & Goldfinger, 1981). Consequently, some telephone crisis intervention centres do treat these individuals as a distinct group of regular (chronic) callers (Crisis Clinic, February, 1988; Langley Family Services Association, 1993; T. Lohnes, personal communication, June 10, 1994[5]).

Assumptions and Limitations

A possible limitation of the study could have been the exclusion of those chronic callers deemed too psychiatrically challenged by the telephone crisis centres to participate in the research. Rather than being a discrete group as outlined above,

this group of chronic callers could be just a segment toward the extreme of the chronic caller continuum. As such, this exclusion could have reduced the number of potential subjects and produced a limited set of identifying chronic caller characteristics. (However, this limitation did benefit the study by excluding those callers who could not give informed consent to participate.)

The researcher assumed the remaining population of chronic callers to be a homogeneous group, excluding sex callers and those callers deemed too psychiatrically impaired to participate. A further assumption was that there exists a set of uniquely identifying characteristics of chronic callers associated with the frequency and duration of their contact with crisis lines. This assumption is identical in concept to the understanding that the frequency of sex caller telephone contact relates uniquely to the identified characteristics of sexual addiction and the need for sexual stimulation (Carnes, 1983; Wark, 1984).

Another research limitation was the incomplete participation of telephone workers for recruiting chronic callers. Not all telephone counsellors asked to assist felt comfortable with the study. Those that did help missed opportunities to request chronic callers' participation because the workers forgot or were on a training shift with another telephone volunteer. Additionally, sometimes the circumstances around recruiting the caller were not appropriate, the caller distressed or abusive at the time of the call. (M. Chand, personal communication, October

4, 1994; D. Knight, personal communication, October 17, 1994[6]; J.
Rawlyns, personal communication, October 18, 1994). However, the
voluntary participation of the telephone workers remained the
most appropriate to reduce worker unease and resistance to the
research.

An additional limitation was the time of year. Crisis line
calls often drop off over the summer months. Further, with the
warm, sunny weather, calls also decline (M. Chand, personal
communication, October 4, 1994; J. Rawlyns, personal
communication, October 18, 1994). With these influences, the
recruitment opportunities for chronic callers also declined.

A limitation also was the small population of chronic
callers that existed within metropolitan Vancouver and the Fraser
Valley region. Previous studies of chronic callers have
consistently experienced small subject pools. Lester and
Brockopp (1970) identified 24 chronic callers to the Suicide
Prevention and Crisis Service of Erie County from October 31,
1968, to June 30, 1969. Greer (1976) identified 37 chronic
callers telephoning two or more years to the San Jose Suicide and
Crisis Service. Sawyer and Jameton (1979) identified 67 chronic
callers to the Cleveland Suicide Prevention Centers over a 9-year
period. For this study, only 38 chronic callers were identified
as potential participants in the research by the four
participating telephone crisis centres. Therefore, this small
number of chronic callers locally could have yielded a limited
set of identified characteristics for chronic callers to

telephone crisis intervention centres. Also, the results of the study may not generalize to other chronic caller populations in regions outside the Lower Mainland and Fraser Valley.

Definitions

The researcher studied those callers identified as chronic callers by the administrations of the distress and crisis intervention services. These centres identify chronic callers through a list of criteria. No single characteristic is sufficient for identification. Rather, the identification of chronic callers requires a combination of factors. Commonly, the criteria used in the identification of chronic callers are: (1) frequency of contact, ranging anywhere from once weekly, to three times daily, to three times per shift; (2) duration of ongoing contact, usually over several months; (3) there is an absence of a crisis or emergency; (4) the event or stressor precipitating the call is unclear; (5) immediate action or decision making by the caller rarely occurs; (6) the person is unreceptive and reluctant to accept interventions, encouragement, or develop action plans; therefore, assistance usually is "yes, but..." and rejected; (7) often the person calls for social support and to meet his or her need for contact; and (8) the caller is very difficult to terminate (Chimo Personal Distress Intervention Services in Richmond, 1993; Langley Family Services Association, 1993).

Questions

The researcher chose a qualitative method to investigate the

characteristics of chronic callers. There are two approaches to qualitative methodology. On one side, the researchers investigate the phenomenon of interest with a more loosely structured, emergent, inductively "grounded" approach to gathering data. The most important research questions and the conceptual framework that relate the various factors or variables of the research area emerge as the investigation proceeds. On the other side, researchers look to confirm and expand on a nearly complete theory or set of hypotheses. They would start the investigation with a structured instrument, like a questionnaire or set interview format, to address the specific research questions arising from the conceptual framework.

For this study the principal investigator took the middle ground between the extremes of qualitative methodology. Chronic callers are not a new phenomenon. Some characteristics are well known and researched. Others are speculative, based on experience and anecdote of crisis line workers and administrators. Unfortunately, most of this information is dated, and that which is current deals with chronic caller management, not characteristics. Therefore, the research was designed to "confirm" those already identified chronic caller characteristics, to build on the existing research, and to discover possible associations between identified chronic caller characteristics.

From the outset a basic conceptual framework and information base on chronic callers was used to draw out research questions.

The research questions were framed to seek specific data to support and expand on the characteristics of chronic callers, and to investigate associations among these characteristics. Further, because the research involved obtaining information from multiple subjects, the principal investigator wanted research questions to collect selective and similar data for comparison across subjects. However, other data was not ignored that went beyond the original research questions, contradicted the original conceptual framework, or challenged existing information.

For the study, the major global questions guiding the research were: (a) What are the identifying characteristics of chronic callers to telephone crisis intervention centres? and (b) What are the possible associations between these identified characteristics and the frequency and duration of contact by chronic callers to telephone crisis intervention centres? More specifically, the following list represents the basic research questions for the specific interview questions used in the study:

1. What is the regularity of contact with crisis lines of chronic callers?

2. What is that contact like for the chronic callers?

3. What is the crisis lines' impact on the chronic callers' lives?

4. What purpose does the crisis line serve for the chronic callers?

5. What is the chronic callers' contact with other community services?

6. What has been the callers' experiences with counselling, therapy or other treatment?

7. What is the chronic callers' support network like, both past and present, involving family and friends?

8. What were some major family changes that influenced the callers' lives?

9. What were the alcohol and other drug history and mental health history of the callers' families?

10. What is the chronic callers' suicide history?

11. What are the callers' current and past experiences with their own mental health?

12. What are the callers' current and past experiences around their own substance use?

Method

This research was a descriptive study that expected to lend support to previously identified characteristics and to identify further chronic caller characteristics. Also, the study was designed to discover some possible associations that exist between the identifying characteristics of chronic callers.

Procedure

A qualitative research approach was chosen to provide descriptive depth and detail that would facilitate the identification of chronic caller characteristics and the possible associations between these characteristics. Also, a qualitative method was used to help move beyond the usual crisis line log sheet review for chronic callers and investigate these callers with a rarely used in-depth interview.

Telephone interviews were conducted. This method was selected to help avoid the hesitancy and reluctance of callers with face-to-face communication (Murphy et al., 1969). Second, the telephone is the usual and "natural" communication medium for the chronic callers. The telephone interview allowed for a more appropriate and comfortable environment for the caller and the interviewer over previous research with in-person interviews (Murphy et al., 1969). Lastly, the telephone interview provided for the security of the caller and the interviewer (Murphy et al., 1969).

Sampling

The first step was to enlist the cooperation of four

telephone crisis centres in the Lower Mainland and Fraser Valley region. The principal investigator obtained their consent after addressing their concerns around participation in the research. The administrative staff at two centres negotiated particular conditions for their participation around the procedures for scheduling subject interviews and the participation of their telephone workers. These conditions are delineated below where appropriate.

The next step was to obtain ethical approval from the University of British Columbia. The administrative staff of the participating crisis lines provided consent letters for the principal investigator to conduct the research through their programs. These consent letters and the "Request for Ethical Review," including proposed protocols for requesting the participation of callers and the interview, were sent to the Behaviourial Sciences Screening Committee for Research Involving Human Subjects at the University of British Columbia Office of Research Services. Once the ethical approval was received, the "Certificate of Approval" was presented to the participating telephone crisis centres. The administrative staff at the crisis lines then began to request the participation of their telephone workers.

The third step was to enlist the cooperation of the telephone workers, who were asked to recruit subjects for the study. The crisis line workers at the participating telephone centres were approached in two ways: (1) by general announcement

to all telephone workers requesting their assistance in recruiting chronic callers to the study, and (2) by specific request to those telephone workers believed confident and skilled enough by the crisis centres' administrations to request the callers' participation. Administrative staff at two centres made a general announcement to their telephone workers for their assistance. The administrative staff at one centre approached its telephone volunteers using both methods. The administrative staff at the other centre requested specific workers to participate in the research. The telephone workers' participation was voluntary at all centres.

The last step was to recruit subjects (chronic callers to the crisis lines). Those callers identified as chronic callers by the crisis lines' administrations' criteria were sampled (see "Definitions" section earlier). The crisis centres excluded from sampling identified sex callers and those chronic callers deemed too psychiatrically impaired to participate in the research.

Participating telephone workers read verbatim from a prepared protocol to introduce the study to the callers (see Appendix B for the protocol to request caller participation). Because anonymity is an important aspect of the service provided by telephone suicide prevention and crisis intervention services, a procedure was provided that allowed follow-up access to the callers without violating the telephone volunteers' and the callers' rights to anonymity. At the conclusion of the call, the telephone worker first asked the caller if he or she had called

the crisis line before. If the caller self-identified as a return caller, the worker explained the purpose of the study - to understand better repeat and frequent callers and their response to the service provided to them. The telephone worker then asked the callers if they were willing to participate in a telephone interview later outside the crisis centre environment.

When callers agreed to participate, they negotiated an available interview time, gave a name for the interview, and arranged who would telephone whom at the time of the interview. When no interview time could be scheduled from those available, the telephone worker gave the callers the principal investigator's telephone number and asked them to arrange an interview directly. If the callers agreed to be contacted for the interview, the crisis line worker took a telephone number where the caller could be reached for the interview. If callers agreed to contact the research interviewer themselves at the interview time, the worker gave them the telephone number for the contact. The telephone worker recorded all this information on the interview schedule sheet.

One crisis line's administration was uncomfortable with scheduling interview times for subjects. Another crisis centre's administration could not communicate the chronic caller interview schedule to all their participating telephone workers and declined booking interview times for the callers. For these crisis lines, the protocol for requesting the callers' participation was altered (see Appendix C for the revised

protocol to request caller participation without the telephone workers scheduling interviews). The protocol excluded the scheduling of interviews and included giving out the principal investigator's telephone number so that the callers could arrange the interview directly.

Caller Participation

The four participating telephone crisis centres identified 38 potentially different chronic callers within the Lower Mainland and Fraser Valley area. Those callers listed by more than one crisis line were counted only once, assuming that the callers used the same name to identify themselves at the various centres. All these individuals were current callers to these crisis lines.

Sixteen (42%) of the 38 callers were not requested to participate in the research. These callers either did not telephone the participating crisis lines during the period of subject recruitment, or they were missed by participating telephone workers for subject recruitment.

Twenty-two (58%) of the 38 callers were requested to participate in the research. Three of these callers declined to participate. Three other callers were uncertain whether they would participate. The remaining sixteen callers (42%) that were requested to participate agreed to be interviewed for the study.

Nine of these 16 callers completed the contact with the principal investigator for an interview. One of these callers was not appropriate. This caller indicated a severe psychiatric

impairment and sufficient sex caller characteristics to be excluded from the study. Eight callers (21%) of the 38 potential callers were interviewed and included in the research data base.

Data Collection

Initially data collection began by negotiating access to four telephone crisis centres. The telephone workers interested in recruiting callers for the study had the purpose of the study explained to them in-person and through information sheets. The telephone counsellors, who agreed to participate, received the protocol for presenting the request for participation of return callers. They then reviewed and practiced the protocol. Once on their telephone shift, the worker read the protocol verbatim to their centre's identified chronic callers, asking the callers for their participation. If callers agreed to participate, the telephone worker scheduled an interview time or gave the callers a telephone number to book an interview time themselves. If the callers did not wish to participate, the worker recorded the caller's desire not to participate so other workers did not ask the caller again.

The principal investigator conducted the interviews. Once contacted, the participating callers again had the purpose of the study explained to them and their desire to participate confirmed (see Appendix D for the protocol to confirm caller participation).

The callers were asked to respond to questions from a standardized interview format. The interview questions were

derived initially from general assessment interview formats, previous chronic caller research, and the administration personnel of the crisis lines. From a dialogue with the crisis lines' administrations and information on qualitative interviewing (Patton, 1990), an initial standardized interview format resulted.

The researcher role-played the protocols and interview format to pretest the items and try to anticipate how actual callers might react to the procedure. Changes were made as a result of the pretest in the interview protocols and standardized interview format. Some questions were reworded for clarity. The interview protocol also was shortened to reduce the possibility of subject fatigue during interviewing.

A one-subject pilot study was then conducted to test further the questions and the interview protocol length with an actual caller. As a result of the test interview, one question was modified for greater ease of understanding by callers and to ask more clearly their reasons for contacting crisis lines. Three other follow-ups or sub-questions were eliminated which yielded no information or seemed too confusing. Lastly, the scheduled interim summaries were dropped from the interview protocol to reduce the interview time.

Questions on the final interview format addressed two areas. First was the callers' experiences with crisis line services: the frequency and nature of their contacts, and their experience and contacts with other community services. Second was their life

experience: mental health and substance use, their support network of family and friends, and a brief history of major family events (see Appendix E for standardized interview format).

A request was made to tape record the interviews with the callers. Notes also were taken with the standardized interview format as guide. Because some callers declined to be taped, these noted were "fleshed out" at the completion of the interview and transcribed for data analysis. If the caller agreed to tape recording, the interview was transcribed for later data analysis.

Validation of Interview Data

The validity and quality of the interview data were checked with the callers. All 8 subjects agreed to a follow-up contact to check the accuracy of the information provided. Six agreed to the researcher telephoning them. The other two subjects scheduled a phone back time when they contacted the researcher.

The researcher only obtained follow-up confirmation of the interview information with 5 subjects. One subject could not be reached; another did not complete the scheduled call back. The remaining subject completed the call back, but was in the midst of dealing with a personal crisis, and chose not to do the follow-up check of the interview data.

The researcher read to the subjects a detailed interview summary at the follow-up. The subjects were asked to add or correct any information from the summary.

All callers were very direct and exacting to clarify and

correct any information that was not precise to their experience. All callers provided additional information to enlarge on some points in their summaries. No more than three points in any one summary needed corrections or clarification. Overall, all subjects said the summaries were accurate and reflected what they had said.

Data Analysis

Because the investigation of chronic caller characteristics started with the previous research findings, the qualitative research method needed had to provide for the confirmation of previous as well as the discovery of new chronic caller characteristics. The qualitative method wanted also had to begin data analysis with the standardized interview questions. Further, the method of data analysis would need to provide a structured, systematic approach to find regularities across multiple subjects from the large amount of interview data. Lastly, the data analysis method used needed to provide a means to compare the emerging regularities with one another to discover possible associations among them, allowing for the display of these relationships. Miles and Huberman's (1984) method of qualitative analysis best fit the needs of data analysis.

Miles and Huberman (1984) begin their research with a general conceptual framework developed from the current knowledge of the research area. From the framework they draft a set of research questions to guide the investigation. Using both the framework and research questions, they then develop a

prestructured format for data collection, such as interview questions. They then use the prestructured format to develop a series of start-up codes for analyzing data as the data collection proceeds.

Miles and Huberman (1984) engage in data analysis through three simultaneous currents of activity: data reduction, data display, and conclusion drawing/verification. For them data reduction begins with the coding of the data to identify emerging themes. The purpose is to bring together the volume of data in an efficient and more manageable way, synthesizing and drawing together the most relevant aspects of the information. While coding, they use marginal comments to record their reactions and thoughts about the data. Later memos are written to start to combine the information bits into larger and more encompassing concepts, patterns and associations.

Data display takes the reduced chunks of information and shows them by code, theme or pattern across all subjects. The data in this stream of analysis is further reduced and rendered into display formats where new patterns, themes or associations between the different variables can be viewed at a glance. The researchers use matrices to order the information bits into grids. They would start with unordered meta-matrix to display all the reduced data and begin a descriptive analysis of the information. They would move through various levels of order and analysis, eventually to a subject-ordered predictor-outcome matrix to begin an inferential level of analysis. At this point

they would discover what factors/variables covary with other factors/variables.

Data display also would include causal networks. Causal networks link together the different variables into a chain of events, activities and processes influencing or initiating one another.

In the remaining data analysis stream of conclusion drawing/verification, Miles and Huberman (1984) generate meaning from the data and test or confirm the findings. They employ several strategies for generating conclusions from the information, moving the analysis from description to explanation, and from the concrete to higher levels conceptualization and abstraction. Noting patterns and themes, seeing plausibility, and clustering helps the researchers discover which information groups with other data. Subsuming particular data chunks into a general category, factoring, noting relations between variables, and finding intervening variables facilitates in generating higher levels of abstraction and the discovery of relationships in the data. Lastly, building a logical chain of evidence helps the researcher assemble a coherent understanding of the data.

The researchers use specific strategies to test and confirm the veracity of the conclusions. Drawing contrasts and comparisons, checking the meaning of exceptions in the data, and using extreme cases tests the conclusion about a pattern or theme by describing what the conclusion is not like. Ruling out spurious relations, checking out rival explanations, and looking

for negative evidence allows the researchers to confirm findings against opposing facts and views from the data. Finally, Miles and Huberman (1984) encourage the cycling back of the findings to the subjects to check the validity of the results.

Data Reduction

The content from the chronic callers' interviews was subjected to an initial coding procedure that sought to identify emerging patterns and themes. These start-up codes were derived directly from the interview questions (see Appendix F for the final initial codes used). Each code was operationally defined. A few start-up codes were changed, such as CALL-PUR (the callers' purpose in phoning the crisis line). This code was changed to CALL-GETS to better reflect the fact the code was used to mark what the callers received from contacting the crisis lines, and not the concerns the callers telephoned the crisis lines over. Other codes were discarded, such as CLR-AP (callers' appreciation of crisis lines), because they were infrequently used or were subsumed into other codes. (CLR-AP was later encompassed by LN-POS: what the callers found helpful or positive about crisis line.) Some codes were added, such as THPY-ABU (callers' experiences of abuse in therapy, counselling or treatment), as the patterns or themes emerged from the interview data. (See Figure 1 for illustrations of initial codes and coding.)

Marginal remarks noted possible themes or patterns as coding proceeded (see Figure 1 for an illustration). For example, the word "isolation" was written beside a subject's statement "...and

Figure 1

Data Reduction: Illustration of Techniques

Initial Codes   Marginal Remarks

Pattern Codes   Memoing

CALL-REAS
lonel
LN-POS
est
eem

isolation

validation from crisis lines

44   physically or financially do an awful lot; so that my regular
45   contact I have with people every day is on crisis lines.
46   So since you can't get out a lot, your contact with people
47   is basically on the crisis lines?
48   Yeah.

49   *Callers Reactions - Likes and Dislikes - about Crisis Lines*
50   **3. Now that we talked about your usual call to the crisis line,**
51   **overall...**
52   **a. What do you like about crisis lines?**
53   I learned it was okay to be myself. When I first started
54   calling them, I was anonymous. And just I had a lot of problems
55   in life because I had been abused all life. And I had always
56   been told if anybody ever knew the real me, they wouldn't like
57   me. But I was in such bad shape when I first started calling,
58   and I think I was taking off everybody's head when I phoned and
59   everything, and they were all just so nice about it. Like nobody
60   took it personally. And once they was that side of me, I just
61   didn't have to hide anymore. I just learned it was okay to be
62   myself. Once I calmed down and wasn't suicidal anymore, it
63   wasn't like I had to pretend I was somebody
64   I wasn't because these were people I was
65   never going to meet.
66   **So that anonymous nature allowed you to**
67   **they accepted you for who you were, and it**
68   **that was lifted.**
69   Yeah.
70   **I guess you mentioned the abuse and**
71   **crisis line treat you, "Hey, I'm not stigm**
72   **myself."**
            Yeah.

Memo (handwritten box):
Esteem-building thru
self-acceptance of
caller thru crisis
line. Person T also
mentions esteem
building thru
validation & self
acceptance thru
crisis lines

I can't physically or financially do an awful lot; so that my regular contact I have with people every day is on crisis lines." Some marginal comments were later used as a guide to interview data that was elaborated further in memos. For example, the researcher later explored interview data with marginal comments like "labelled and discredited: victimization," "powerlessness," and "family outcast and victim" in a larger theme of "Caller victimization."

Memoing (memos) brought together bits of information across callers that alluded to a possible theme or pattern (see Figure 1 for an illustration). For example, "Esteem building thru [sic] self-acceptance of caller thru [sic] crisis line. Person T also mentions esteem building thru [sic] validation & [sic] self-acceptance thru crisis lines."

Some memos were deadends. Other memos were thoroughfares for rich exploration of the interview data. For example, "Callers feeling powerless to move on, feel have no control/influence over their environments and contact crisis lines for direction. When crisis lines empower and encourage, they build callers' esteem so they take personal action." This memo led to the development of the pattern code "Caller empowerment and esteem building." (See Appendix G for pattern codes used. Also, see Figure 1 for an illustration of pattern coding.)

Validation of Data Coding

The principal investigator used two other data coders to

check the validity of data coding. Data coders were chosen with previous crisis line experience. However, both data coders had not volunteered for a telephone crisis centre for over three years.

The principal investigator and data coders compared coded segments of callers' interviews. The principal investigator and data coders began with the first subject's interview data. A dialogue was established between the principal investigator and the data coders to review and clarify the data codes used. Working through to the last subject's interview, a similar understanding of the data codes was created and then maintained.

Initial intercoder reliabilities were determined for the first interviews coded. Final intercoder reliabilities were determined with the last interviews coded.

The principal investigator and the first data coder had an initial intercoder reliability of 68% to 73%. Intercoder reliability eventually ranged from 82% to 86%.

The second data coder and the principal investigator had an initial intercoder reliability of 77% to 80%. Final intercoder reliability ranged from 85% to 87%.

Though within the 80 percent range, the intercoder reliabilities fall short of the 90 percent range recommended by Miles and Huberman (1984).

Data Display: Matrices

Overall data display began with an unordered (massive) meta-matrix displaying reduced data in each cell of a "caller-by-coded

question" grid. Data analysis proceeded from here by sorting all the information bits within a code across all subjects on flip chart paper on a wall. Where appropriate, broader categories, such as "Crisis Line: Positive aspects" were used to subsume smaller, more limited categories, such as "Crisis line recognition of caller: Positive aspects" and "Crisis line non-recognition of caller: Positive aspects." In this manner the interview data was further reduced and displayed.

Once the interview data was displayed, information bits were connected and combined as emerging patterns and themes appeared in the data. "Caller-by-conceptual cluster" matrices now were used. For example, "Mental health: Negative," "Physical health: Negative" and "Therapy: Negative" were combined into a category of "Helping: Negative." "Mental health: Positive," "Physical health: Positive" and "Therapy: Positive" were combined into a category of "Helping: Positive." The categories of "Helping experience" then were brought together in a conceptually clustered matrix of "caller-by-helping profession experience" to juxtapose those data reflecting the callers' experiences with helping professions. (See Figure 2 for an illustration of a caller by conceptual cluster matrix.)

Data display continued using earlier memos from the data reduction stream. These memos were further developed and investigated for possible patterns across all subjects. Information bits were combined into further conceptual clusters, such as "Victimization: Neglect" and "Victimization: Active

Figure 2

Caller by Conceptual Cluster Matrix: An Illustration

Caller	Mental Health Positive	Physical Health Positive	Therapy Positive	Mental Health Negative	Physical Health Negative	Therapy Negative
	Helping - Positive			Helping - Negative		
T	-doctor believed not mentally ill; wouldn't commit to hospital -challenged doctor in manic-depression support group			-uneasy with helping professionals; can't tell them what wants to -committed 3 times by family -doctors say follow my instructions or won't get better -health professional just treat symptoms; don't look at background		
L	-will tell nurses they're doing too much -too much mental health, but helpful -stand ground with doctor to get what wants			-mental health treats caller like child -nurses do too much for caller -yelled at by mental health worker -doctor refuses to address medical needs		
N	-support groups very helpful: can express emotions to people who know what caller going through			-psychiatrist not helpful -support groups limited support; caller not ready to change yet		
Y	-mental health teams not supportive; only pills given			-psychiatrist most supportive; treats caller like a queen		
R	-doing a lot of good work with counsellor on emotions, etc			-counsellor didn't listen: burnt out -counsellor uncomfortable with caller's issues -expensive; limited low cost service available		
S	-reported abusive therapists to referral sources; therapists removed from lists -some therapy empowering; found safety & understanding of abusive family history -validation & reassurance through therapists -treated as equal by therapist			-confidentiality breached by mental health -history of 5 abusive & inappropriate therapists -trusted & worked well with one therapist, who turned on caller with severe abuse -mental health tries to keep caller in their system of care -professionals try to cover up for one another -too much power in the medical & mental health systems		

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Figure 2

Caller by Conceptual Cluster Matrix: An Illustration (continued)

Caller	Mental Health Positive	Physical Health Positive	Therapy Positive	Mental Health Negative	Physical Health Negative	Therapy Negative
	Helping - Positive ·			Helping - Negative		
M	-support group good to talk with others in similar situation			-mental health very busy -lousy counselling from psychiatrist -religious groups limited help		
P	-learned to take on own stuff & pass on others			-some counsellors not approachable; they can't relate or communicate -counsellor says lack of connection responsibility of caller		

Example matrix: "Caller by Helping Profession Experience."
"Helping-positive" and "helping-negative" conceptual clusters.

Abuse." These clusters, or emerging patterns, were applied

across the initial broad categories to combine the discrete bits

of information into larger emerging, global themes, such as

"Victimization." Eventually, four leitmotifs - victimization,

connection, isolation and esteem - emerged from the continued

clustering of the callers' interview data. (The leitmotifs are

outlined in the "Results" section.)

The interview data was further reduced and displayed by

using caller-ordered descriptive matrices. Caller chronicity was

the main variable of interest for data analysis. Callers'

chronicity, as defined by the current frequency of telephone

contact with crisis lines, was the major caller variable used.

"Callers' chronicity by...." matrices then were built. For

example, a "Chronicity and Callers' Family Background" matrix was

constructed using the caller variables of telephoning frequency,

alcohol and other drug use in callers' family of origin, mental

illness in callers' family of origin, callers' experience of

abuse in their families, callers' role(s) in their families, and

callers' birth order in their family of origin. (See Figure 3

for an illustration of a caller-ordered descriptive matrix.)

Some of these comparisons yielded nothing, such as "callers'

chronicity by mental illness in callers' family of origin" - no

patterns were discovered. Other comparisons produced significant

or interesting patterns. For example, "callers' chronicity by

alcohol and other drug use in callers' family of origin" showed

all callers coming from an alcoholic or other drug addicted

Figure 3

Caller-Ordered Descriptive Matrix: An Illustration

Caller	Frequency	Family - A & D	Family - Mental Health
S	4/day	-mother drank too much -caller sent to psychiatrist to get pills for mother	-mother sent caller to psychiatrist as the identified patient
T	2/day	-alcoholic father; personality varied by level of intoxication -scary incidents	-caller was the identified patient; committed by family several times -does say family dysfunctional
P	4-5/week	-father's drinking and blame game in the family -victimized by father's drinking	-identified patient and mother wanted caller committed
R	daily or 1-2/week	-mother never drank, but into tranquilizers for awhile -sibling has drinking problem	-mother may have had nervous breakdown when caller born -grandmother kind of out of it when living with family
N	3-4/week	-father alcoholic & mother caught up in it -caller believes parents never really cared because into alcohol	-nothing mentioned
Y	3/week	-father had drinking problem in past; abusive -sibling also drinking problem in past	-nothing mentioned
L	8-12/month	-told by others that father had a alcohol problem -siblings took a lot of drugs at home	-parents sick mentally; put all children into mental health it seems -dysfunctional family: too many secrets

Figure 3

Caller-Ordered Descriptive Matrix: An Illustration (continued)

Caller	Frequency	Family - A & D	Family - Mental Health
M	3-5/month	-whole family with drinking problems & hid it from one another	-father "psychotic" -mother emotional wreck; very emotionally labile

Example matrix: "Callers' Chronicity by Callers' Family Background." Caller-ordered by "callers' telephoning frequency." "Family-alcohol and other drug history" and "family-mental health history" descriptive variables.

family background. Also, "callers' chronicity by callers' overall experience with therapy or treatment" suggested a tendency for higher frequency callers to have had more negative experiences with the helping professions. All variable comparisons showing emerging patterns or themes were explored as data analysis proceeded.

Not all caller-ordered descriptive matrices were useful. When callers' chronicity was defined by the years of ongoing contact with crisis lines, these caller-ordered descriptive matrices yielded no clarifying or beneficial comparisons between variables. No further understanding of the information was produced.

Other caller-ordered descriptive matrices became central to further data analysis. When callers' chronicity, as defined by the current frequency of telephone contact with crisis lines, was the main variable, many valuable comparisons between variables were produced. The researcher discovered additional patterns and themes in the data. These patterns and themes then were further explored and expanded in the next level of analysis with display matrices.

Data display now moved to caller-ordered predictor-outcome matrices. Asking the prediction question, "What factors seem to be associated with more or less contact with telephone crisis lines?," data analysis proceeded with scaled variables of interest from earlier analysis. For example, the callers' support network was scaled on two dimensions. First, the

researcher scaled the support network from none/small to large by the number of people mentioned by every caller. Second, the callers' ability to engage or use their support network was scaled from none/low to high by counting the frequency and number of contacts with others, and by how much the callers' share of themselves when engaging their support network.

Various caller-ordered predictor-outcome matrices were constructed. (See Tables 4 through 6 in the "Results" for examples using the final caller-ordered predicator-outcome matrices.) For example, using the previously defined callers' chronicity as current telephoning frequency, a "Callers' Chronicity and the Callers' Support Network and Special Relationships" matrix was constructed. Some predictor variables displayed no relationship with callers' chronicity, such as callers' support network. Neither the size of the callers' support network, nor the callers' ability to engage or use their support network, showed any relationship to increasing or decreasing frequency or telephone contact. Other variables did show an association to callers' chronicity. For example, the special others/relationships did appear to increase as the frequency of telephone contact with the crisis lines decreased.

Data Display: Causal Networks

The researcher analyzed individual subjects for important events and activities in their lives. These events and activities were combined visually in a descriptive network, linking together the information bits to form a chronology and

process for the callers' lives. As suggested by the data, possible explanatory variables were pencilled into the networks to connect and better understand the relationship between the discrete events and activities.

The interview data from all subjects was considered next. Matching events and activities, as well as similar chronological and process streams, were rendered across all callers into more general variables producing a single causal meta-network. For example, two callers were disabled, and four callers had a current or chronic illness or injury that had existed over many years. These events were rendered into the general variable of "Prolonged Health Concerns" and entered into the meta-network. As data analysis proceeded, other descriptive and explanatory variables were added to individual causal networks and the single meta-network.

Some earlier hypothesized intervening variables on individual causal networks were confirmed by interview data in other callers' causal networks. These were then incorporated into the meta-network. For example, other interviewed subjects discussed and confirmed the hypothesized intervening variables of "Limited Employment" and "Limited Finances," linking the variable of "Prolonged Health Concerns" to the variable of "Limited Support Network."

Chronic callers became distinguishable based on their telephoning frequency with crisis centres when the researcher used a caller-ordered descriptive matrix as mentioned above.

Where event, activities, and chronological and process streams distinguished higher frequency chronic callers from lower frequency chronic callers, these descriptive variables were added to the emerging causal network for higher and lower frequency callers. For example, higher frequency callers tended to have had more negative experience with previous therapy or treatment. This characteristic was entered into the higher frequency callers' causal network as a descriptive variable. Explanatory variables also were entered into the emerging causal network as data analysis proceeded from the caller-ordered descriptive matrices to the caller-ordered predictor-outcome matrices.

Eventually similar event, activity and process streams, descriptive and explanatory variables from across all subjects were combined for the final chronic caller causal network. The common chronic caller characteristics were used to link the two different causal pathways for lower and higher frequency chronic callers into the larger chronic caller causal network. (Though Miles and Huberman (1984) use the term "causal network," this is somewhat misleading and has been replaced by the term "relational network" throughout the remainder of the study. Explanation for this word change is given in the "Results". Also, see Figure 4 in the "Results" for an illustration of the final chronic caller relational network.)

Conclusion Drawing/Verification

Data reduction through coding and data display through unordered meta-matrices to caller-ordered descriptive matrices

facilitated the discovery of the general characteristics of chronic callers. Moving through caller-ordered descriptive matrices, to caller-ordered predictor-outcome matrices, and finally to causal networks, helped reveal the possible associations between chronic caller characteristics. Concurrent with this data reduction and display, conclusions were made about chronic caller characteristics and the associations between them. They were then tested and confirmed for their veracity.

Conclusion Drawing. Several strategies were used for generating conclusions from the information. The strategies employed moved data analysis from concrete description to explanatory concepts and higher levels of abstraction. Counting, noting patterns/themes, seeing plausibility and clustering helped the researcher discover which information bits grouped with other data. Counting just tallied something that happened a number of times and that happened in a consistent way. With identifying patterns/themes, the finding that all chronic callers come from alcoholic or other drug addicted family backgrounds emerged from noting this recurring pattern in their families of origin. A plausible conclusion reached from the data was that "limited employment" and "limited finances" linked the variable of "personal and physical limitations from health" with the caller variable of "limited ability to use and engage support network." This conclusion was later supported by other subjects' interview data. Lastly, clustering was used to understand better and conceptualize data with similar characteristics, i.e., data on

the callers' chronic illness or disability, current injury or illness, and past injury or illness was conceptually clustered under the caller characteristic of "prolonged health concerns."

Subsuming particular data chunks into a general category, factoring, noting relations between variables and finding intervening variables helped the researcher generate explanation and higher levels of abstraction from the data and discover relationships in the information. Specific data chunks, like the callers' experiences of abuse and neglect in their families and their occasions of powerlessness against physical and mental health treatments, were subsumed into the larger, more general category of "callers' victimization." With factoring conclusions were generated by pulling a common thread from disparate data bits. For example, the crisis line activities of giving callers resources and referrals, problem-solving with them, exploring new perspectives and options with them, and giving the callers validation all have the common thread of empowering the caller. Often relations between variables were noted, a frequent source of generated findings. The last strategy here, finding intervening variables, builds the relationship between two variables that were not expected to be associated, or were expected to go together and do so only weakly. For example, using the crisis line for comfort and support was expected to associate strongly with increased calls to the crisis centre. It did not. When the intervening variable of "using crisis lines as a therapeutic resource" was discovered, the relationship between

the above variables strengthened.

Building a logical chain of evidence helped assemble a coherent understanding of the information. When this occurred, several subjects emphasized the specific factors independently and indicated causal links, directly or indirectly, between the factors. For example, several callers said they use the crisis lines with a very high frequency. Some of these callers stated they used the crisis lines as a fill-in when they have no counselling or therapy available to them. Other callers revealed crisis line personnel had told them that if they were using the crisis lines as therapy, this was not an appropriate use of the service. Additionally, for most callers, in response to their increased telephoning, crisis centre staff had imposed call and time limits. From this information, a chain of events was built: inconsistent counselling or therapy led to the callers using the crisis lines therapeutically, and increased calling results. The crisis lines noted the increase and the change in the nature of the crisis line calls. The telephone workers confronted the callers on their therapeutic use of the phone lines and initiated call management techniques to reduce the amount of contact the callers have with the crisis centre.

Conclusion Verification. The above techniques generated findings from the callers' interviews that required verification. Again several strategies were used to confirm and test the conclusions drawn. Drawing contrasts and comparisons, checking the meaning of exceptions in the data, and using extreme cases

helped test the conclusions about a pattern or theme by
describing what the conclusions were not like. Drawing contrasts
and comparisons for higher and lower frequency chronic callers
were often used to test the conclusions about these groups. For
example, contrasting these two groups tested the finding that
these individuals were treated differently in their families of
origin. Specifically, lower frequency chronic callers tended to
be in family roles like the invisible child or the outcast,
unwanted by their parents, and generally ignored by the family;
higher frequency chronic callers tended to be in family roles
like the scapegoat or identified patient, where the family
generally blamed them for family problems. In checking the
meaning of exceptions to the conclusions, findings were
strengthened, i.e., callers disliked the use of call management
by the crisis lines. When the exceptions to this finding were
considered - those callers not mentioning call limits - they all
disliked crisis line call management as well if they had
experienced it. The exceptions confirmed the conclusion.
Lastly, extreme cases were used, like the lowest frequency
caller, to test the conclusions from the data. For example, the
information from the lowest frequency chronic caller confirmed
the conclusion that lower frequency chronic callers are not using
the crisis lines therapeutically. This caller disclosed non-
therapeutic use of crisis lines and said during follow-up, "I get
my therapy and counselling elsewhere" when asked about
therapeutic use of crisis lines.

Other strategies also were used to confirm the findings against opposing facts and views from the data. Spurious relations were ruled out between variables. For example, greater experience with therapy or counselling was not variable linking the callers' therapeutic use of crisis lines and increased crisis line use. Many callers had a rich experience with therapy and treatment and still did not telephone the crisis centres frequently. Rival explanations, like increased crisis line use being related to a limited support network, were checked out. Some callers with the high frequency crisis line use had both a large support network and engaged it with ease, not supporting the rival explanation. Other evidence in the interview data was also searched for to counter conclusions, i.e., no caller reporting a current substance misuse problem. Present difficulties in family or other relationships and challenges in day to day living were reviewed for the callers with an eye to substance misuse. The researcher encountered no negative evidence to the finding.

Finally, the principal investigator cycled back the findings to the callers agreeable to this further contact.

Validation Procedure for the Results with Callers

The validity of the results was checked with five callers. One subject could not be reached for validation of the interview data or validation of the results. The two subjects that originally scheduled a phone back time, when they contacted the principal investigator to validate the interview data, did not

complete the phone back. Without the original phone back, a further phone back to validate the results could not be scheduled.

Crisis line characteristics emerging from the interview data were validated by confirmation with the callers. The callers also validated the four leitmotifs through their confirmation of the themes.

Chronic caller characteristics and the relational network of those characteristics also were validated with the callers. All five callers provided validation for chronic caller characteristics common to all the subjects. Lower frequency chronic caller characteristics were validated through confirmation with lower frequency chronic callers and disagreement with higher frequency chronic callers. Higher frequency chronic caller characteristics were validated through confirmation with higher frequency chronic callers and disagreement with lower frequency chronic callers.

Results

The callers' confidentiality and anonymity remain primary research concerns. Because crisis line personnel frequently know their chronic callers well, steps have been taken to ensure the callers' identities remain concealed. Detailed descriptive characteristics, such as gender, have been omitted in the results. Also, where possible, results and data tables have been written to minimize caller identification through associating characteristics. Similarly, to ensure the anonymity of the telephone crisis centres, references to specific crisis lines have been omitted.

The findings are presented in six parts: the callers and their crisis line contact, chronic caller characteristics, variations on chronic caller characteristics by telephoning frequency, crisis line characteristics, leitmotifs, and the chronic caller relational network.

The Callers and their Crisis Line Contact

The principal investigator interviewed eight chronic callers. Five callers were female and three male. Callers' ages ranged from 26 to 49, with an average age of 37 years (see Table 1).

Four callers lived in an urban centre - an older, higher density part of a city. Two lived in suburban outlaying areas, away from the city core. Two callers lived in valley suburbs. No callers lived in a rural area.

The callers reported years of contact ranging from 6 months

Table 1

Descriptive Characteristics of Callers and Crisis Line Contact

Subject	Age	Years of Contact	Frequency of Contact	Crisis Lines Contacted
S	43	7	4/day	2-4
T	38	6	2/day	3-5
P	33	10	4-5/week	2-4
R	31	10-11	daily or 1-2/week	1-4
N	33	½	3-4/week	·2-3
Y	43	7-8	3/week	3-5
L	49	13	8-12/ month	1
M	26	5	3-5/ month	1-2

through to 13 years (see Table 1).

The average length of ongoing contact was approximately 7½ years. This average was obtained by adding the years of contact for all subjects and dividing by the total number of subjects. (When a caller stated a range for years of contact, midway in the range of years was taken as the years of contact. For example, 10 to 11 years of contact was taken as 10½ years.)

Callers also reported a wide range of telephoning frequency. The greatest was four calls a day. The lowest frequency was three to five times a month, about once a week (see Table 1).

The average caller phoned about once a day. In obtaining this average, the following procedure was used. First, the frequency of contact for all subjects was changed to the number of calls per week. Next, the number of calls per week for all subjects was added and divided by the total number of subjects to obtain the average number of calls per week for a caller. Lastly, the average number of calls per week was divided by seven to obtain the average number of calls per day for a caller.

The callers reported they telephoned regularly from one to five different crisis lines. One caller mentioned telephoning one crisis line consistently and no others. To the other extreme, two callers stated they telephoned three to five different crisis lines regularly (see Table 1).

On average the callers phoned two or three different crisis lines. In obtaining this average, the low number from the range of crisis lines regularly contacted for all subjects was added

and divided by the total number of subjects. Next, the high number from the range of crisis lines regularly contacted for all subjects was added and divided by the total number of subjects. (For those subjects with a specific number of regularly contacted crisis lines, this number was used for both the low and high number of crisis lines regularly contacted.) These two numbers then gave the range of crisis lines regularly contacted by the callers.

<div align="center">Chronic Caller Characteristics</div>

The chronic caller characteristics are grouped into four categories: personal characteristics; relational; family background; and counselling, therapy or treatment. The results reported reflect those chronic caller characteristics indicated from previous research and those characteristics newly identified (see Table 2).

Personal Characteristics

No Substance Misuse. None of the callers in the study revealed a current substance misuse concern. Of the three callers mentioning an alcohol or other drug problem, all were now in recovery for their substance misuse. The remaining callers put forward: "It's not an issue."

Prolonged Health Concerns. All callers disclosed prolonged health problems, either physical, mental or emotional, sometimes concurrently. Two callers said they were disabled from birth. The other callers reported physical health concerns lasting several years, sometimes as adults, sometimes as children. Four

Table 2

Chronic Caller Characteristics

$\underline{n}$	Chronic Caller Characteristic
	Personal Characteristics
8	no substance misuse
8	prolonged health concerns
6	personal and physical limitations from health
6	limited employment, then limited finances
5	suicide history
3	mental illness
	Relational
6	definitely friends
6	little family contact
6	few with special others
6	challenging relationship history
5	limited ability to engage and use support systems
	Family Background
8	alcohol or other drug addicted families
8	severe abuse or neglect
7	two parent families

Table 2

Chronic Caller Characteristics (Continued)

n	Chronic Caller Characteristic
	Counselling, Therapy or Treatment
8	previous or current counselling, therapy or treatment
8	early life start to counselling, therapy or treatment
8	mental health contact
8	more years with helping services than with crisis lines

callers talked about ongoing physical health problems, two of these callers with concurrent mental illnesses.

Three callers disclosed a psychiatric diagnosis. Another caller shared a severe emotional difficulty around personal identity, stressing to the point of attempted suicide. For all these callers they reported their psychiatric or emotional concerns lasted many years. Additionally, for the three callers that disclosed a diagnosed mental illness, they also mentioned a concurrent physical health concern.

Personal and Physical Limitations from Health. Six of the callers discussed their health concerns as physically hampering them or personally limiting them. Three callers said they had a limited ability to get out in the world because health problems had physically disabled them. The other three mentioned personal and emotional limitations arising from their health challenges. They reported feeling their health problem somehow stigmatized them later. As one caller stated, representative of the experience for all: "I had epilepsy until I was the age of seven. I had a very difficult time learning through school. I was put back in class. I always felt I was being called stupid"(N)[7].

Limited Employment, then Limited Finances. Only two callers mentioned regular employment. One of the two mentioned living from pay cheque to pay cheque. The other caller mentioned being off work currently due to a back injury. Only this caller indicated current financial success.

The remaining six callers shared a history of limited

employment or unemployment. Unable to get a job or having only limited employment, these callers reported reduced financial resources. With limited money, they stated they were restricted in other resources they could engage for themselves, like counselling or recreational services.

Suicide History. Four callers disclosed a previous suicide attempt. For one the "suicide attempt" was described as an effort to gain some control and power back from mental health over enforced institutionalization. For the other three the reported suicide attempts were to end their lives. One other caller mentioned a drug overdose - not a suicide attempt - trying to engage help from mental health services.

Three callers stated they initially contacted crisis lines with suicidal feelings. Currently, only two callers said they might telephone crisis lines with some suicidal feelings. For one, this was rare. For the other, this was a chronic, passive suicidal tendency, eg., suicide by neglecting one's health, such as drinking too much, like the caller did in the past. In all five callers mentioned feeling suicidal or previous suicide attempts.

Mental Illness. Three callers had a psychiatric diagnosis that they disclosed. All were diagnosed manic-depressive. Two mentioned receiving ongoing treatment. The other caller indicated that treatment was no longer needed.

Relational

Definitely Friends. Two callers mentioned they got out

socially with others but called these people only acquaintances. The other six callers reported two or more friends that they engaged with socially at least once or more times a month. Three of these callers reported a social support network of five or more people that they saw at least once every two weeks to daily.

Little Family Contact. Only two callers mentioned regular, significant and meaningful contact with family members. However, they stated this contact was limited only to some of their family members. For both callers, they indicated one parent was not part of their family support network.

The other callers revealed more limited contact and relationships with their family. Four callers said they had regular but distance relationships with their family members. They described their family relationships as satisfactory, all family members generally living their own lives. The remaining two callers mentioned rare or no contact with their family members, particularly parents.

Few with Special Others. The callers tended to be more often unmarried/unpartnered: single, divorced, widowed or separated. Only two callers mentioned a current relationship. Two other callers indicated a relationship had ended within the last year. The remaining callers reported either no previous significant relationships or being out of a special relationship well over a year.

Challenging Relationship History. One caller mentioned no current or previous relationships. Another caller still was

maintaining the first relationship. The remaining six callers mentioned one or more significant relationships. Three of these callers disclosed one previous relationship, one of the three now in a second relationship. Two others mentioned two previous relationships. Another caller discussed three previous significant relationships.

Four callers reported previous relationships that were abusive. For one caller, the abuse revealed was limited to severe emotional and verbal abuse. For the other three, the emotional and verbal abuse disclosed was compounded by physical abuse.

For the other two callers reporting previous relationships, both described their relationships as unsatisfying and said they left the relationships to better deal with their own needs. They stated they felt a sense of incompatibility and wanted to make their lives what they desired instead.

Limited Ability to Engage and Use Support Systems. Only one caller reported significant and meaningful support from both family and friends. This caller mentioned a current special other giving support as well. Two other callers mentioned engaging support from others: one from their family, and the other from their network of friends. The remaining five callers indicated limited or no substantial support from family or friends, and no special others to draw support from.

Three of the five callers that indicated a limited support network and no special others also relayed an inability to share

themselves more deeply and to connect more intimately with others. They shared a hesitancy or inability to move beyond the social surface. One caller represented this for all three callers in the statement: "We talk about each others' problems, but I never really go into detail about things other than like surface. But that's the best I can do. Usually I don't talk about myself"(M). One caller even mentioned a fear to build more intimacy. Also, for two of these callers their reported frequency of contact with others was no indicator of depth of contact. They reported seeing friends or acquaintances daily or even weekly and still mentioned difficulties connecting with others with greater intimacy.

Only two callers mentioned any support from their family network, though this support was restricted in the callers' view. The remaining six callers reported limited or no contact with family members. They indicated if any family contact occurred, it was not supportive for them. Four of these callers even said their parents and other family members were not really interested in them.

While all callers reported a social network of two or more people, only two callers showed an ability to use their social network for more significant support. They reported significant and meaningful support from these friends, like help through personal losses. They also reported their efforts to maintain these friendships, such as working together to work through disagreements. Both indicated the friendships as satisfying.

The three gay/lesbian identified callers tended to report larger, more beneficial, and more meaningful support networks of friends than did those callers heterosexual identified.

Family Background

Alcohol or Other Drug Addicted Families. Without exception all callers reported an alcohol or other drug addicted family background. Five callers mentioned a substance abusing father. Two mentioned a substance abusing mother. One caller reported both parents as substance abusers. Two callers revealed a parent misusing a substance other than alcohol.

Two callers shared the information came to them through second hand news - they never saw the substance abusing parent themselves. The other six callers reported direct experiences with the substance abusing parent. They mentioned family conflicts, physical abuse in the home, and neglectful parenting as part of their experiences. For all, representing the general impact of the substance abuse, one caller stated: "And I think that's why I had a difficult time...because I feel that maybe if my father was into alcohol, they [my parents] really didn't care one way or another what I was going through"(N).

Severe Abuse or Neglect. At a minimum all callers reported experiencing verbal and emotional abuse in their families. Four of the callers said their substance abusing parents contributed to the emotional abuse and neglect endured by them. For the two callers reporting only verbal and emotional abuse, even they mentioned long term challenges, represented in one caller's

statement: "I still have a lot of problems with my esteem, but it's a lot better. I don't know if you get over it, but you, sometimes it just takes a long time"(P).

Five callers reported the family abuse was physical and personally violating. Four of these callers also reported sexual abuse that happened to them. All five callers reported long term impact from the abuse that they still were working through.

Four callers revealed the abuse they reported was the most significant influence from their family of origin. For the other four, even if they reported abuse, the abuse was less influential on them than the neglecting parents or outright ostracism from the entire family.

Five callers mentioned severe neglect from their parents. They said their parents did not notice or show interest in them as children or youth. Four callers indicated their parents were unavailable to them to address their needs and concerns, often because of alcohol or other drug abuse.

Four callers stated they were actively shuffled away from the rest of the family, either institutionalized or forced out of the home. Two of these callers stated they were clearly unwanted by their parents.

One caller revealed a more subtle form of neglect - the parents sheltered the caller as a child because of a disability. This caller said this led to difficulties later in life, such as choosing friends, because the caller did not develop the life skills needed in the sheltered family situation.

Two Parent Families. Six callers indicated they were raised consistently in a two parent family. One caller mentioned growing up in a single parent family for three years until the father remarried. The remaining caller revealed usually living in a single parent family, the family's father sporadically living with the mother and children.

Counselling, Therapy or Treatment

Previous or Current Counselling, Therapy or Treatment. All callers reported involvement with some type of counselling, therapy or treatment. Two of the callers stated they had ended therapy and/or counselling for three or more years. One caller mentioned looking for a new counselling resource. Another talked about starting therapy again. The remaining four callers stated they were in ongoing therapy, treatment or counselling.

Early Life Start to Counselling, Therapy or Treatment. All callers interviewed stated their experiences with counselling, therapy or treatment - medical or mental health - began early in their lives. Five callers said they were involved in some type of medical or mental health treatment before age 10; the other three callers stated by their late teens.

Mental Health Contact. All callers mentioned contact with mental health services at sometime in their lives. Three callers said they had received a psychiatric diagnosis: two still receiving treatment; one out of treatment. Two other callers stated they were involved with psychiatric services as youth without a mental illness, pushed into treatment by their parents.

The remaining three callers reported contact with mental health services, all with non-psychiatric concerns.

More Years with Helping Services than with Crisis Lines. All the callers mentioned contact with other helping services before their initial contact with telephone crisis centres. The caller reporting the greatest amount of contact with other helping services had been in contact with them for over twenty years, probably closer to 30 years, and mentioned only telephoning crisis lines for about thirteen years. The caller mentioning least contact with other helping professions had only been receiving services for about eight months. This caller reported only contacting crisis lines for a few weeks less than other helping services.

Only two callers said they found out about crisis lines from another helping service. Four callers said they found out about crisis lines from the telephone book. The other two callers stated they did not remember where they first found out about crisis lines.

Validation of Chronic Caller Characteristics with Callers

The five callers contacted at follow-up confirmed, and sometimes clarified, the chronic caller characteristics common to all subjects. For example, the common chronic caller characteristic of "at least some friends" was clarified further at follow-up. Though still a characteristic common mostly to all callers, a slight trend for the highest frequency chronic callers identifying acquaintances, not friends, was starting to emerge.

Variations on Chronic Caller Characteristics

by Telephoning Frequency

The four callers telephoning with the greatest frequency were regarded as higher frequency chronic callers. The four callers telephoning with the least frequency were regarded as lower frequency chronic callers. With this distinction, the chronic callers displayed differences depending on whether they were higher or lower frequency callers.

The four higher frequency chronic callers tended to telephone crisis lines with a greater and more consistent frequency than the four lower frequency chronic callers. Two lower frequency chronic callers stated in the past they were a frequent, daily or more user of crisis lines. However, these lower frequency chronic callers indicated they had maintained their current consistent level of contact for several months, even years. Two lower frequency chronic callers mentioned even going a month or more without any crisis line contact.

The discriminating characteristics between the four higher frequency and the four lower frequency chronic callers occur across three broad categories: the callers' relationship with the crisis lines, the callers' therapeutic history, and the callers' family history and special relationships.

Relationship with Crisis Lines

Therapeutic Use versus Practical Use. The four higher frequency chronic callers tended to report more therapeutic use of crisis lines than did the four lower frequency chronic

callers. The higher frequency callers revealed telephoning crisis centres for support, friendship, contact, and for therapeutic reasons, like validation and relationship building skills. The four lower frequency chronic callers mentioned telephoning crisis lines for support, friendship and contact, similar to higher frequency callers. The lower frequency chronic callers also tended to report more practical use of crisis lines, such as for referrals or problem-solving, these services more available from crisis lines than therapy. (See Table 3 for callers' chronicity by the callers use of crisis lines.)

All four higher frequency chronic callers revealed a relationship with the crisis lines that was frequently therapeutic. They tended to report using the crisis lines between counselling appointments for therapeutic support. For three of these callers they stated the crisis line even became the replacement for inconsistent or abusive therapy.

The four higher frequency chronic callers reported finding telephone workers and crisis lines where they could get validation, practice and build relationship skills, and learn to reconnect with others. For all these callers they indicated conflict with the crisis lines did develop when the callers used the phone lines for more than crisis intervention. One caller stated a similar experience for all the callers: "And then it was like they're telling you that you can't call all the time...they say to you: 'We're not therapists. We are not psychologists. We're not psychiatrists. We're not counsellors.' And if you're

Table 3

Callers' Chronicity by Use of Crisis Lines, Callers' Dislikes
about Crisis Lines, and Other Helping Resources

Caller	Frequency	Callers Use of Crisis Lines	Dislikes about Crisis Lines	Other Helping Resources
S	4/day	-regular contact with people, like friends -disclose secrets of abuse so can focus on relationships face-to-face -practice & build relationships -life information -fill in between counselling	-labelled chronic -time & call limits -different treatment because chronic -complaints ignored -problem-solving when want to vent -business-like -rigid to procedures	-one private therapist -recently started again
T	2/day	-validation on what accomplishing -mirroring of esteem to build health -help since refuses therapy ever again -contact to overcome loneliness	-time & call limits -focusing/ directing call -rigid to procedures -rushed off phone when recognized	-none for 4 years
P	4-5/week	-emotional support & venting -maintenance now -get perspectives on concerns -connecting with others, like friends or family	-labelled caller -time & call limits -focusing/ directing call -complaints ignored -worker unease with sexuality -rushed off phone -workers assuming what saying -business-like, cold -responses scripted	-none for about a year

Table 3

Callers' Chronicity by Use of Crisis Lines, Callers' Dislikes about Crisis Lines, and Other Helping Resources (continued)

Caller	Frequency	Callers Use of Crisis Lines	Dislikes about Crisis Lines	Other Helping Resources
Y	3/week	-break loneliness -support -friendliness	-sometimes workers frustrated with calls	-7 years same psychiatrist -doctors -employment services
L	8-12/month	-talk through & input on problems -encourage workers -chat -resources & referrals -life information	-call limits	-doctor -two mental health workers -with mental health services many years
M	3-5/month	-talk about problems can't talk to others about -chat, like friends -resources & referrals -new perspectives & advice	-worker unease with sexuality -forced opinions	-reconnected with counsellor -ongoing support group
R	daily or 1-2/week	-support & contact when alone -get sense of security -problem-solve -fill gaps in between therapy	-worker unease with sexuality -busy signals	-none for 4 months -inconsistent counselling -therapists keepleaving
N	3-4/week	-support through difficulties -emotional release & comfort -to talk with someone -resources & referrals -new perspectives	-time limits -focusing/directing call -"Oh! You've called today. Now what?" -busy signals	-psychiatrist -support group -consistent since first contact

using it for that purpose, then they try to wean you away from
it. Now, procedure and policy wise, I can see that. But if
you're hurting so bad that you can't see it, their approach is
lousy"(P). Further, like the above quotation, all the higher
frequency callers acknowledged their use of crisis lines as a
fill-in for counselling or other therapy. They just were unaware
of it at the moment of the crisis line worker's confrontation.

The four lower frequency chronic callers reported
telephoning crisis lines for many of the same reasons as the
higher frequency chronic callers: support, friendship, contact
and conversation. They differed from the higher frequency
callers in their stated use of crisis centres for more practical
reasons. The lower frequency chronic callers mentioned often
telephoning for information and referrals, new perspectives on
their concerns, and action plans to deal with their problems.
Rather than therapy, these callers reported they received the
problem-solving, information, and referrals the crisis lines
readily had available.

Complaints versus Appreciations

The four higher frequency chronic callers tended to report
more complaints and a greater variety of complaints about crisis
line services. All expressed a recognition of their increased
use of crisis lines and appreciated the fact that they cannot
telephone all the time. However, these callers shared their
dislike and negative responses to the crisis centres' attempts to
manage their calls, especially when the callers were phoning in

pain or distress. They reported their most adverse responses to the crisis centres' efforts to limit and to focus their calls when they felt the telephone workers were not treating them as an individual but only as another "chronic" caller. One caller mentioned: "I guess for me I find that sometimes you're not getting...a personal touch. I guess I feel that there's some of them are just too policy based and too procedure-like, and it really would be nice if they could cut some of that b.s. out of their mandate"(P). Another higher frequency chronic caller stated: "Then your call is over at ten minutes. You could be mid-sentence or something, and they, a lot of times, treat you as if they're just putting up with you. You're a chronic caller and you're not one of the important ones"(S). These statements typify the callers' negative responses. The higher frequency chronic callers uniformly stated their dislike of call restrictions, the efforts to direct and focus their calls, and the chronic caller label. (See Table 3 for callers' chronicity by the callers' dislikes about the crisis lines.)

The four lower frequency chronic callers mentioned fewer, if any, complaints about crisis lines, even when asked about their dislikes of crisis lines by the principal investigator. They more often expressed appreciation of the service they received from crisis lines. For example, "I'm just so very grateful that they're out there....I don't take them for granted....they've helped me out so much"(L). Rather than complaints, the lower frequency chronic callers reported much more easily the positives

and their appreciations of crisis lines.

Crisis Line Dependent versus Many More Helping Resources

The four higher frequency chronic callers often mentioned crisis lines as the only helping resource available to them. Because they were out of counselling or treatment, they reported using crisis lines extensively as a replacement for the missing support and therapy. They also reported difficulty finding consistent, appropriate counselling or other helping resources when looking for therapy or treatment. One caller, indicating the difficulty for all callers, stated: "I've been through fifteen counsellors in the last 12 to 15 years. It's hard to find services I can afford. When I do find one, the counsellor doesn't stay long before finding a better paying job"(R). These callers revealed the telephone crisis centres as the only reliable helping resource available to them.

The four lower frequency chronic callers reported much more involvement and more consistent involvement with helping resources other than crisis lines, often over several years. These callers also reported more positive experiences with the helping resources. Representative of these experiences, one caller said: "The...support group...that has been the best resource I've found out of all it because they have been really supportive. I feel I'm not out there alone - there're other people out there that have gone through similar situations"(N). These callers reported crisis lines as just one helping resource available to them. (See Table 3 for callers' chronicity by the

callers' contact with other helping resources.)

Therapeutic History

Negative Therapeutic History versus Mostly Positive
Therapeutic History. The four higher frequency chronic callers
tended to report more negative and more severely negative
experiences with counselling, therapy or treatment than lower
frequency chronic callers. Often the experiences they shared
involved having the power and control over their lives removed by
a diagnosis of physical or mental illness. Three of the callers
stated they were forced into treatment or therapy. (One caller
even revealed being forced into a psychiatric institution by
family.) Further, two of the callers mentioned years of
therapeutic or psychiatric abuse. Overall, these four callers
shared mostly negative views and experiences of therapy and
counselling.

A few positive experiences were mentioned by the higher
frequency chronic callers, often part of a negative experience,
for example, "I was with her for three years. For the first year
and a half, she [the therapist] was so kind and wonderful, and
she made it safe enough for the first person face-to-face that I
could trust with everything. And she turned on me viciously
overnight. She didn't even answer to why she done it"(S). For
the higher frequency chronic callers they always explained the
negative therapeutic experiences first. The positive, beneficial
experiences, if any, they acknowledged always later in the
interview. (See Table 4 for callers' chronicity by the callers'

therapeutic history.)

     The four lower frequency chronic callers also mentioned some negative therapeutic experiences, though rarely as severe or extensive as higher frequency callers. For example, "It's too much mental health. And yet, why am I complaining? Maybe I'm complaining because I feel that I wasn't strong enough. You know, because, if it wasn't for mental health people, where would I be today?"(L). Typically, like the previous example, the lower frequency callers wove the negative experience into an overall positive context or outcome. However, they shared more positive experiences with therapy and treatment than negative ones. Also, they more readily shared these positive experiences with counselling and therapy.

Family History and Special Others

     <u>Severe Abuse versus Severe Neglect</u>. The four higher frequency chronic callers tended to report more active abuse (physical, sexual, and verbal) and abuse from more sources (family, friends, and therapy) than the four lower frequency chronic callers. The four lower frequency callers also reported active abuse: physical, sexual and verbal abuse; however, the most significant abuse mentioned by these callers was neglect by their parents. The active abuse mentioned by the lower frequency chronic callers always was discussed later in the interview process. For the higher frequency chronic callers they indicated the most influential abuse was the active abuse that they experienced. They mentioned this abuse first and most often.

Table 4

Callers' Chronicity by First Experiences with Therapy/Treatment,
and Experiences with Therapy/Treatment/Counselling

Caller	Frequency	First Experiences with Therapy or Treatment	Experiences with Therapy, Treatment or Counselling
S	4/day	-psychiatrist forced on caller by mother -seen as family problem	-4 therapists abusive or inappropriate -trusted one therapist deeply, then abused & betrayed after few years of good therapy -one counsellor consistently appropriate & helpful -mental health system labelling & overpowering; don't want clients to leave system
T	2/day	-forced medical treatment for health problems by parents; experimental treatments used -institutionalized for mental illness by family	-institutionalized by family 3 times; all power & rights removed -experiences medical & mental health people as controlling
P	4-5/week	-family forced into counselling -mother wanted caller institutionalized	-difficulties connecting with some therapists -some counsellors unapproachable; they put out caller responsible for resistance
R	daily or 1-2/week	-support group through women's centre on own initiative; tended to be positive	-difficulty finding low cost & consistent therapy -some therapists uncomfortable with sexuality -some therapy helpful with issues and emotions
N	3-4/week	-started within last year	-psychiatrist useless -support groups very helpful;others with similar experiences

Table 4

Callers' Chronicity by First Experiences with Therapy/Treatment, and Experiences with Therapy/Treatment/Counselling (continued)

Caller	Frequency	First Experiences with Therapy or Treatment	Experiences with Therapy, Treatment or Counselling
Y	3/week	-not disclosed	-previous institutional treatment -really connected with psychiatrist -current medical problems concerning
L	8-12/month	-started with mental health in youth -institutions & psychiatric treatments	-wouldn't be alive today without mental health -much mental health support -coping well & appreciative -current dislike of workers
M	3-5/month	-started in late teens	-support groups mostly beneficial -one poor psychiatric -mostly appreciated of help; finds it helpful

(See Table 5 for callers' chronicity by the callers' family history and other abuse experiences.)

None or One Special Other to Two or More Special Others. Going from the highest frequency chronic caller to the lowest frequency chronic caller, the number of relationships reported with special others tended to increase. The higher frequency chronic callers tended to mention no or one special other. The lower frequency chronic callers tended to mention two or three special others throughout their lives. (See Table 5 callers' chronicity by the callers' special others.)

One caller said telephoning the crisis lines was influenced by a special other. This caller said without someone to talk to, increased support from the crisis lines was needed. The caller then telephoned more often.

Traumatic Parental Connection versus No Parental Contact. The four higher frequency chronic callers revealed a traumatic connection with a parent that resulted from the other parent's death, abuse or abandonment. They indicated their relationship with the remaining parent also became traumatic. They mentioned this parent later abused or abandoned them physically or emotionally. (See Table 5 for callers' chronicity by the callers' family history.)

The four lower frequency chronic callers reported being neglected or unwanted by their parents and family. They reported they were ignored by their parents and excluded from family activities. These callers indicated their parents rarely were

Table 5

Callers' Chronicity by Family History, Other Abuses, and Special
Others

Caller	Frequency	Family History	Other Abuse	Special Others
S	4/day	-severe emotional & sexual abuse -mother drug addicted -isolated from siblings and others through father's training in social skills; extreme loyalty -forced into therapy -scapegoat & identified patient for family	-mental health -medical -therapy -crisis lines	none
T	2/day	-father alcoholic -severe physical & emotional abuse -severe dependency with mother -forced into treatment -became identified patient for family	-mental health -medical -partner abuse	one
P	4-5/week	-father alcoholic & caller victimized -mother's death, then dependency on father -severe emotional & verbal abuse from parents -almost institutionalized -family blacksheep, scapegoat & identified patient	-therapy -crisis lines	one
R	daily or 1-2/week	-mother drug addicted -physical & emotional abuse -over protected as child -father abandoned family -family rebel	-therapy -partner abuse	two
N	3-4/week	-alcoholic father -ignored by parents because of alcoholism -severe neglect -sexual abuse in home		one

Table 5

Callers' Chronicity by Family History, Other Abuse, and Special
Others (continued)

Caller	Frequency	Family History	Other Abuse	Special Others
Y	3/week	-not wanted by parents -physical abuse in home -outcast & neglected by family -excluded from family events -father drinking problem	-partner abuse	-two
L	8-12/month	-parents never there for caller -father drinking problem -lots of family secrets -physical & sexual abuse as well -parents okay with mentally ill children; they're the patients, not them -parents sick mentally	-partner abuse	-three
M	3-5/month	-unwanted child -parents alcoholic -father psychotic -mother emotional wreck -the family outcast & blacksheep -abandoned & kicked out of family -sexual & physical abuse as well		two

there for them as they grew up. Further, they stated their parents remained unavailable to support them as adults with personal difficulties they may be undergoing.

Blamed for the Families' Ills versus Ignored by the Family. The four higher frequency chronic callers stated the scapegoat, blacksheep, or rebel label often accompanied them in their families. They stated they were blamed for the families' ills, and they often became the families' identified patient. Their family experience is summed up in this callers' statement: "I can remember when I was younger, my family sent me to a psychiatrist when I was about fifteen. I was sent as the scapegoat. It was like everything that was wrong with our family was my fault....I was the identified patient in a sick family"(S). (See Table 5 for callers' chronicity by the callers' family history.)

The four lower frequency chronic callers mentioned they received no attention from the family generally. They stated they were ignored whatever they did. One caller represented all these callers' experiences in the statement: "Nobody ever really felt anything for me, like they didn't appreciate me when I did so much for them all the time"(M). The callers indicated they all were abandoned to their own resources, and they survived on their own.

Validation of Higher and Lower Frequency Chronic Caller Characteristics with Callers

All five callers contacted for the validity follow-up confirmed both the higher frequency and lower frequency chronic

caller characteristics. Only two subjects discussed that for them a characteristic was somewhat incongruent with their lower or higher frequency calling identification. Some lower frequency chronic callers even provided confirmation for higher frequency chronic caller characteristics by identifying with the characteristic from the time they telephoned more frequently. For example, two callers, now telephoning with less frequency, both reported crisis line call management was used on them when they were telephoning with greater frequency.

<div align="center">Crisis Line Characteristics</div>

The results reported here are those characteristics - positive or negative - that the chronic callers revealed as themes in their interactions with the telephone crisis centres (see Table 6). The crisis line characteristics are the callers' view.

Crisis Line Positives

Support and Comfort. All the callers reported the crisis lines as supportive when they were caught up in the emotions and challenges of their lives. More specifically, three callers shared sometimes they just needed to vent, and the crisis line workers supported them through being available to talk and vent their emotions and anxiety. Four callers shared the telephone workers provided them support by comforting them when they were lonely, depressed or vulnerable. Representative of the comfort received, one caller stated: "And, of course, the help I get from it, the benefit I get out of it, because when I phone when I'm

Table 6

Crisis Line Characteristics

n	Crisis Line Characteristic

Crisis Line Positives

8	support and comfort
8	contact and conversation
8	esteem building
8	volunteers create a positive experience
6	like friends

Crisis Line Negatives

6	poor "business" practice
6	call management
5	labelled

depressed, it uplifts me"(M). For two callers, the workers' voices also were very comforting. They stated they found the workers' voices soothing, allowing the emotions and anxiety to be released.

Contact and Conversation. The callers all revealed that they used the crisis lines for contact. Five callers stated some of their contact was no more than an opportunity to socialize or chat. Five callers also mentioned they telephoned to break away from the loneliness or isolation they may feel and to have regular contact with others.

However, all the callers reported that some crisis line workers allowed them to share their day, like with a friend or family member, and just to check in with someone else. Indicative of the contact the callers had developed with the crisis lines, one caller stated: "Usually...[I telephone]...just to try to voice to someone what's happening, but lately it's been more of a maintenance....This is what's happening presently....but it's almost like a family relationship with me and them"(P).

Esteem Building. All callers showed esteem building through the crisis lines. They indicated their esteem had grown through (a) the acknowledgement and encouragement from telephone workers, and (b) the action plans developed between the crisis line workers and the callers to address the callers' concerns.

All the callers reported at least some validation and acknowledgement of them and their life experiences from the

telephone workers. They indicated this came to them through the telephone workers' use of listening skills and empathy to understand what the callers were saying. Also, three callers indicated non-judgemental telephone workers helped the callers feel better about themselves.

The callers reported that they learned it was okay to be themselves. Similar for all callers, one caller directly stated: "I learned it was okay to be myself....And I had always been told if anybody ever knew the real me, they wouldn't like me. But I was in such bad shape when I first started calling...And once they saw that side of me, I just didn't have to hide me anymore. I just learned it was okay to be myself"(S). As well, three callers stated the crisis line workers acknowledged their uniqueness, putting forward that the callers were special people. For example, one caller said: "They told me: 'Well, you're one of a kind. You've got a lot of, you know, qualities in life, and you're a very caring, loving person. It's very great of you"(N).

Callers also revealed the telephone workers encouraged their esteem through helping the callers with their problems and concerns. Five callers stated crisis line workers helped them expand their perspectives on their concerns and develop action plans to alleviate the problems. Further, for three callers, the help they reported receiving from the crisis lines also included life information they never received. They stated this information better helped them with their day-to-day living.

Volunteers Create a Positive Experience. All callers shared

that telephone workers made a positive difference for them with the crisis lines. Representative of all the callers' experiences, one caller said: "I feel like, well, that person really doesn't know me, but cares. And it makes me think the world is a better place after all....It makes me feel good that somebody out there actually cares, and you can talk about things you can't really talk about to anybody"(M). Two callers said the volunteers clearly made the difference for them between crisis lines. They perceived some people at one crisis line as more considerate and better able to deal with their situations. Two callers also expressed their appreciation for those workers that used their discretion and acted independently, when needed, from crisis line policies and procedures. For these callers, they believed these telephone crisis centres were better phone lines because of the volunteers.

Four callers mentioned the telephone workers' life experience as important. These callers stated the volunteers' life experience was a place where the workers could draw more understanding and compassion to connect with them. The callers reported feeling better connected with those volunteers having similar life experiences to their own and that were shared at a professional level with them.

The years of contact between some telephone workers and some callers also appeared to build a positive experience for a few callers. Two callers revealed a special long term contact over the years with some volunteers. As said by one of these callers:

"I've been phoning in many years. And a lot of people are the same people on the line. A few anyway, you know. I'm just so very grateful that they're out there"(L). For these callers they indicated the consistency of knowing another person helped build a positive experience and connection with the crisis lines.

Like Friends. Six callers mentioned friendliness coming from the crisis lines. All said their connection and rapport with some workers was like a friendship. One caller stated: "A lot of them know me so well through the telephone that they feel like a friend, which is a kind of unique rapport as far as I'm concerned"(P). This caller's statement reflected all the callers' experiences. They reported the workers acted much like friends because they asked how the callers were doing. One caller even described the workers as very personable because they joked around with the caller. However, even with the perceived friendliness, four callers said clearly it was not true friendship. They stated they did not know the workers personally, and the relationship only was somewhat like a friendship.

Crisis Line Negatives

Poor "Business" Practice. Six callers made direct comments relating to the crisis lines' handling of calls. Three callers stated their calls were handled too businesslike, without warmth, with the workers too rigid to crisis line procedures. One caller revealed what these callers experienced in stating: "I find sometimes their cliché, trite responses that they give...it's

very robotic. It's very impersonal"(P). Three callers mentioned receiving busy signals, sometimes over an hour. And two callers shared that the telephone workers put them on hold as other calls came in.

Call Management. Six callers shared that crisis centres have restricted and managed their calls. These callers mentioned two call management methods: (a) call and time limits, and (b) focusing and directing the content of their calls. Without exception all callers mentioned disliking these call management methods. Only one caller mentioned anything positive about call management: "I can respect crisis lines that have time limits and stick by them. It shows they have boundaries"(T).

The callers expressed that call and time limits resulted in them being cutoff mid-sentence when the telephone workers rigidly following the restriction. They reported they were often neither given the opportunity nor control to decide that they needed more time this call to talk through their concerns. They shared that they often were rushed, treated like a case, and not respected. One caller explained the experience of call restrictions like: "It makes me feel like I'm just a number they're trying to get rid of....It's like they're doing you a favour by tolerating you for 10 minutes"(S). This statement reflected a similar experience for all callers. Two callers even noted a contradiction in the time limits, one stating: "Sometimes I find that when I am limited to a certain time in my phone calls, this sort of upsets me and makes me feel that nobody cares about how

I'm feeling anymore....But the crisis line has told me that it's better to phone somebody and talk to them about your emotions and your feelings than to hold them inside"(N).

One caller mentioned that some telephone workers gently imposed or negotiated time limits. This caller said that after it had been determined no crisis existed for the caller, and when the crisis line was busy, some telephone volunteers would say: "It's been kind of busy tonight. I would like to keep this call short." The caller said this approach seemed much more appropriate.

Four callers mentioned that they felt the telephone workers were sometimes ignoring their emotions and not allowing them to vent when the workers focused and directed the calls. One caller, indicating the difficulty for all, stated: "I'm going through a very emotional period where I just need their support and to be there to hear me out and to help give me the support I need. And others are very up front and all they want to do is sort of direct me in a direction as to what am I going to do for myself today"(N). These callers shared that the focusing and directing of their calls left them feeling hurt and rejected because the telephone worker did not address their emotions. They reported they were left feeling not fully understood.

Labelled. Five callers mentioned receiving different treatment from crisis lines because they were labelled "chronic" or gay/lesbian identified.

Three callers stated they were labelled "chronic" callers by

crisis lines. They mentioned they experienced a substandard service as chronic callers because they were not crisis callers. Representative of all these callers, one caller stated: "They called me 'chronic caller,' with chronic has a negative connotation to it....they, a lot of times, treat you as if they're putting up with you. You're a chronic caller and you're not one of the important ones"(S). For two callers that complained about the service they received, they said the crisis lines' administrations disregarded their complaints and attributed the complaints to the "chronic" label. They stated a reputation followed them, even if they did change. They indicated the only way the treatment or label disappeared was if they stopped telephoning for a while.

Three callers also reported telephone workers as seeming awkward or not accepting of their gay or lesbian lifestyle. As one caller said, reflecting all three callers' experiences: "Certain fellows make me uneasy. It's only happened two or three times in all the years I've been phoning. They're uncomfortable when I talk about my lifestyle"(R). One caller even stated the telephone workers read things into what the caller said regarding the caller's sexuality and acted on their assumptions.

Validation of Crisis Line Characteristics with Callers

The five callers reached for follow-up confirmed the crisis line characteristics that emerged from the interview data. Callers that originally provided limited evidence for some crisis line characteristics provided additional information that

strengthened the identified characteristics. No counter evidence for the identified crisis line characteristics was provided by the callers at follow-up.

<div align="center">Leitmotifs</div>

Four global themes, or leitmotifs, emerged from the data analysis. The leitmotifs of isolation, connection, victimization and esteem captured greater, more meaningful patterns arising out of what the callers directly said or implied. These global themes cut across all aspects of the callers' lives: their interaction with the crisis lines, their use of other helping services, and their experiences with family, friends and special others. The leitmotifs put the callers into a larger context for their lives.

Isolation

The isolation leitmotif emerged from interview data indicating caller isolation and loneliness. The global theme arose from the callers' information on their physical and psychological health, their families, and their intimate relationships.

Limitations Creating Loneliness. Four callers clearly stated one of their reasons for contacting crisis lines as isolation or loneliness. For these callers, they said the crisis lines became a regular contact for them because they could not connect with others. Further, six callers mentioned limited finances that hampered their ability to connect socially. For three of these callers, they also stated their physical health limited their

ability to get out.

Sexual Orientation. Three callers indicated they were isolated from their families and others because these people did not accept the callers' sexual orientation. These callers mentioned the nonacceptance came across as uneasiness to outright hostility toward them from family, helping professionals and others. One caller disclosed a solid reluctance to talk about sexuality out of fear of being not accepted and judged by others.

Families. All callers mentioned some isolation from family members. Only two callers mentioned a connection with some family members; they said they did not speak with other family members. Four other callers revealed a tenuous connection with their families. The remaining two callers said they never or rarely contacted their families.

Half the callers indicated isolation from their families that arose from neglect by their parents - their parents just were not there for them because of substance abuse or illness. Two of these callers stated their parents and family clearly did not want them. One caller expressed the similar experience for both callers in the statement: "Both my parents wanted a boy, but when they had him, they were happy. But I was completely ignored"(M). For these two callers, they reported later in their lives they even were excluded from family activities, like parties, and being taught how to run a home, such as cooking.

For the other half of the callers, they revealed a parental connection through the trauma of the other parents' death,

parental abuse or abandonment. They indicated their parental connection developed at the exclusion of other family members. Once the parental connection was broken, they mentioned that no one in the family initially remained to provide support. Three callers even stated they were blamed for their exclusion from the family.

Four callers indicated they were the identified patient in the family and forced into therapy for the conflict they created in the home. Four callers mentioned they became the family rebel, outcast or scapegoat, and were cut off from the remainder of the family. All indicated their families disowned them because of their actions.

Better Health Creates Some Loneliness. All the callers mentioned that when they improved their emotional and psychological health, they lost some family and friends. Representing the experience for all callers, one caller said: "I used to see a lot [of friends]. When I was a doormat, I had a lot of friends, a lot of friends. But, you know, I hardly see anybody [now with better esteem]"(L). They shared that they broke off contact to maintain and to build their health, or that the family cast them out because they challenged family loyalties and beliefs when they got better.

Few Special Others. Half the callers mentioned they had no or only one special other in their lives. The other half revealed they had two or three special others in their lives. Only two callers mentioned a current special relationship. Six

callers stated they lived alone.

Connection

Callers disclosed information on their interactions with crisis lines and other helping services, and on their relationships with family and friends. From this interview data emerged the global theme of connection.

Crisis Lines. Callers stated they connected with crisis lines in many ways. Five callers mentioned telephoning crisis lines to have someone listen to them, to talk with, and share their day and feelings. Three callers specifically mentioned how they appreciated they could telephone the crisis lines just to chat. They said the telephone workers also would chat and even ask the callers how things were going. Five callers stated they connected with the crisis lines like family or friends. One caller stated a similar experience for all: "There's one crisis line I'm very in touch with more than the others, and these people, I almost feel like - I don't know if you'll sound shocked by this - but it's almost like a family relationship with me and them. And a lot of them know me so well through the telephone that they feel like a friend"(P).

Four callers mentioned the telephone workers with similar life experiences to them helped build the telephone relationship through the sharing of that experience. They indicated the shared experience between the worker and the caller helped foster and build greater rapport and connection. Also, these callers said they found telephone workers were better able to understand

and help them if the workers had been through a similar life experience to them.

Two callers indicated their contact with crisis lines was therapeutic and allowed better interaction with others. They shared their contact with the crisis lines had fostered life changes that allowed them to connect with others. They stated they learned to take the focus off themselves and focus on the other person. They indicated they were better able to connect with others then.

Other Helping Resources. Callers also revealed their need for connection through their therapeutic relationships. Six callers stated they had poor therapeutic relationships at sometime. They indicated they wanted to connect but they perceived they had counsellors or therapists that could not relate to them or support them. However, five of the eight callers also mentioned a clear connection with their therapeutic resource through having their experiences, feelings and beliefs validated and assured. Representative of the experience for all callers, one caller stated: "The...support group...I feel I'm not alone - there're other people out there that have gone through similar situations"(N).

Families. Six callers revealed contact with their families that was nonexistent or tenuous at best. Only two callers reported they had connected or enhanced their contact with their families or, at least, some family members.

Friends and Special Others. All callers mentioned some

contact with others, excluding family. Seven callers talked about at least one intimate relationship with a special other. Six of the callers mentioned their friends; the other two talked about acquaintances. Still, all eight said they connected socially at least every few weeks.

Victimization

The global theme of victimization emerged across all callers from the information they shared about their families, their interactions with the crisis lines, and their experiences with other helping resources.

Crisis Lines. Five callers reported they received different treatment because they were not the usual callers to the crisis lines. Representative of this different treatment, one caller said: "They actually put your name on a board as warning as a list of people to watch on. And I actually had one of the crisis line supervisors phone, talking to me about that, and saying, 'You know, we'd like to tell you we really need to sort of warn you that you do call often'"(P). Two callers said the label "chronic" caller seemed as they were less worthy of service and open to violations of their anonymity and confidentiality. One caller represented both in the statement: "It's like...it's acceptable to abuse...[chronic] callers....It's just like in an office or something if somebody transfers into the office and they have a bad reputation. They're abused from their first day there, so they can never lose it"(S). For two callers that said they complained about the inappropriate service they received,

they stated the crisis centres' administrations discredited them
because they were "chronic" callers. The callers perceived
crisis lines' administrations as disregarding them because they
were "chronic."

Six callers mentioned that their crisis line calls had been
managed through time restrictions and focusing the content of
their calls. Three callers reported the crisis line workers
maintained the time limits even when the callers needed more than
the 10 or 15 minutes to vent the pain and emotional distress they
were undergoing. Also, three callers said focusing them to one
or two issues in a call ignored what they considered important to
understanding the total situation and them. Showing the
difficulty all these callers experienced with call management,
one caller stated: "When the worker says, 'We only have 15
minutes. Let's focus on this for the next two minutes,' it
sounds like a reprimand to me. It sounds like I'm being
interviewed by a doctor"(T). For these callers, they indicated
call management as hurtful and punitive for them.

Counselling, Therapy and Other Treatment. Three callers
indicated they felt caught up in the health care system to treat
their mental or physical illness. Five callers revealed a sense
of powerlessness against the professionals helping them. They
stated the medical and psychiatric professionals believed they
knew what was best for the callers' treatment and would not
listen to the callers' concerns. Three callers shared that they
were institutionalized and their rights removed. When two

callers said they did speak out against the treatment they had received, they said others used the label of mentally ill to confine them and limit their control over their treatment. They said their current actions were seen as part of the illness.

Five callers mentioned inappropriate helpers in later therapy. Representative of the type of inappropriate helpers experienced by all these callers, one caller stated: "I went back to him a second time...he was sitting behind his desk, looking at a sheet of paper. And he glanced up over the top of it, 'I've been reviewing my notes I made after your last session,' and he said, 'I want you to know I don't treat losers'"(S). Two callers reported they were even blamed for the abusive or inappropriate treatment because of their behaviour. They said they were told by other helpers there must have been good reason for the therapists' actions: the therapists were probably responding to the callers' behaviour.

One caller mentioned being overly sheltered in treatment and feeling like a child. This caller indicated that in situations where opportunities existed to learn and practice life skills, the workers took over for the caller. The caller mentioned feeling scared by the worker's actions and prevented from learning life skills the caller needed.

Family. Three callers clearly stated they were victimized in their families. These callers indicated a pattern of victimization that repeated through out their lives in friendships, work, therapy, treatment, and relationships with

special others. Three other callers said they witnessed and experienced physical abuse in their family and mentioned they went on to have significant relationships with physically abusive partners. Two callers, who mentioned a dependent controlling relationship with a parent, indicated they repeated this pattern with those friends and significant others later in their lives. One caller made a statement representative for both: "I get codependent too quickly. I get emotionally involved and lose myself in the person"(T).

Four callers reported severe neglect, two of them stating they were unwanted by their parents. All these callers indicated their parents were unavailable to them for support even through the callers' most difficult times. As one caller stated: "I got raped...And I had a baby from it. And everybody disassociated with me because I had the baby"(M).

For the other four callers, they reported parental abuse and betrayal. All mentioned a similar history where one parent became unavailable either through death, substance abuse or abandonment. They indicated they then built a connection with the remaining parent, which was later betrayed through this parent's substance misuse, abuse of the caller, or unavailability to protect the caller against other abuse. They all indicated they mistrusted their parent ever since.

Esteem

The esteem leitmotif emerged from interview data indicating esteem building and caller empowerment. The global theme arose

from the callers' shared information on their interactions with
the crisis lines, their therapeutic relationship with other
helping resources, and their changing relationships with family
and friends.

Crisis Lines. The callers indicated a developing esteem as
they talked about how the crisis lines helped them through their
concerns and difficulties. Three callers stated the telephone
workers helped them through brain-storming and problem-solving
activities, moving the callers to action and building the
callers' self-reliance. Indicative of all these callers, one
caller said: "At one time I would be very frustrated that on one
call I couldn't come to a conclusion on a problem. But that was
a long time ago. And now I understand it might take me working
on it a month....And maybe they [the crisis line] wouldn't even
be instrumental in me finding a solution"(L). Four callers
mentioned they developed action plans with the telephone workers
and were given the resources and referrals to carry out the
plans. Five callers reported the crisis line workers also gave
them new perspectives on their concerns that encouraged the
callers to view their problems differently.

Four callers stated they received validation and
acknowledgement of their life experiences and feelings from
telephone workers. They indicated they learned it was okay to be
themselves, and they would be accepted whether they were good or
bad. Two callers also mentioned they were told to look after
themselves because they were unique. All indicated they felt

better about themselves. One caller represented the attitudes of all the callers in the statement: "It took a long time before I could do it [feel good about myself]. Now, I don't know how I live it any other way"(L).

Other Helping Resources. Five callers stated their experiences were validated by their support group, therapist or other helping professional. Further, four callers reported their therapy was beneficial in helping them build their esteem and stand up for themselves. One caller stated: "Where I got the strength from - my first year and a half with that therapist. I felt so empowered....because of the good work I did with her...that gave me the strength to speak up..."(S). This statement typifies all the callers' experiences. With helpful therapy, they indicated they were letting go of personal relationships that were hindering or painful. They also started to speak up about previous treatment they perceived as inappropriate.

Four callers mentioned they took action for themselves to counter the mistreatment they had undergone through abuse or involvement in the health care system. They spoke up against health care treatment they had received, confronting the health care professional in front of others. They indicated they were taking control back to care for themselves and their own interests.

Five callers also stated they left helping relationships when the helper was inappropriate, and two said they took action

against the inappropriate therapy they received. These two callers said they reported the therapists to referral agencies. These agencies then would ensure others would be informed of the poor and inappropriate professional behaviours.

Family. Four callers indicated they had built their esteem and maintained it by establishing boundaries and new relationships with family members. They revealed they no longer got stuck in old family games and patterns and only took on what was their responsibility. This is represented by the statement one caller gave: "I don't worry anymore. I'm not as victimized by his behaviour as I used to be....I used to take it very personally....It's his choice, his problem. Let him own it"(P).

The four other callers indicated they still struggled to move further beyond their awareness of their family dynamics to concrete actions that help them maintain themselves against family patterns. They mentioned freedom from their dysfunctional family loyalties and responsibilities when they were on their own, away from family members. However, they revealed a struggle to maintain their esteem when family members entered their lives.

Friends. Two callers shared they befriended people they could rely on and share themselves equally. They indicated these friendships enhanced their esteem through the mutual understanding, support and caring. The remaining six callers revealed they still struggled to overcome their feelings of self-doubt to reach out and connect with others. Indicative of this struggle for all, one caller said: "I am finding it easier

because of crisis lines who have let me know I'm okay to make the - to not be afraid to reach out to other people"(S). As these callers found better psychological health, they indicated they were slowly building their esteem through better care in choosing their friends.

Validation of Leitmotifs with Callers

All four leitmotifs - isolation, connection, victimization and esteem - were confirmed by all five callers contacted for the validity check. The callers identified the themes as present in their lives, for at least a period of time. For example, one caller could see victimization as once being a part of life. Now, the caller could best identify only with the theme of esteem.

The Chronic Caller Relational Network

The term "causal network" is used by Miles and Huberman (1984) to describe how different variables are linked into a chain of events, activities and processes which influence or initiate one another. However, this term is somewhat misleading for this study and is replaced by the term "relational network." Though many variables appeared to influence or initiate other factors in the network, to state all variables were causally linked would be inaccurate. Some variables were only chronologically linked, one factor preceding the other. Other variables appeared to influence additional variables, though definite support for these variables' influences was not present in the interview data. Therefore, the relational network

attempts best to show the possible relationships between
identified chronic caller characteristics.

The identified chronic caller characteristics were used to
produce the relational network. The characteristics were taken
as representative of all chronic callers, though caller
exceptions for a few identified characteristics existed. Rather
than look at exceptions, the chronic caller relational network
attempts to show the possible connections between identified
chronic caller characteristics. It provides paths between the
different factors that lead to a chronic caller's higher or lower
frequency of crisis line contact.

The chronic caller relational network contains three parts
(see Figure 4). Characteristics 1 through 11, approximately left
and centre of the figure, are those characteristics common both
to higher and lower frequency chronic callers. Characteristics
12 through 21, roughly along the bottom portion of the figure,
are characteristics unique to the lower frequency chronic
callers. Characteristics 22 through 32, contained in the top
portion of the figure, are those characteristics identifying to
the higher frequency chronic callers.

Common Characteristics

All callers reported coming from an alcohol or other drug
addicted family (1). (The number in parentheses refers to the
chronic caller characteristic on Figure 4.) How this caller
characteristic influenced the early life start to counselling,
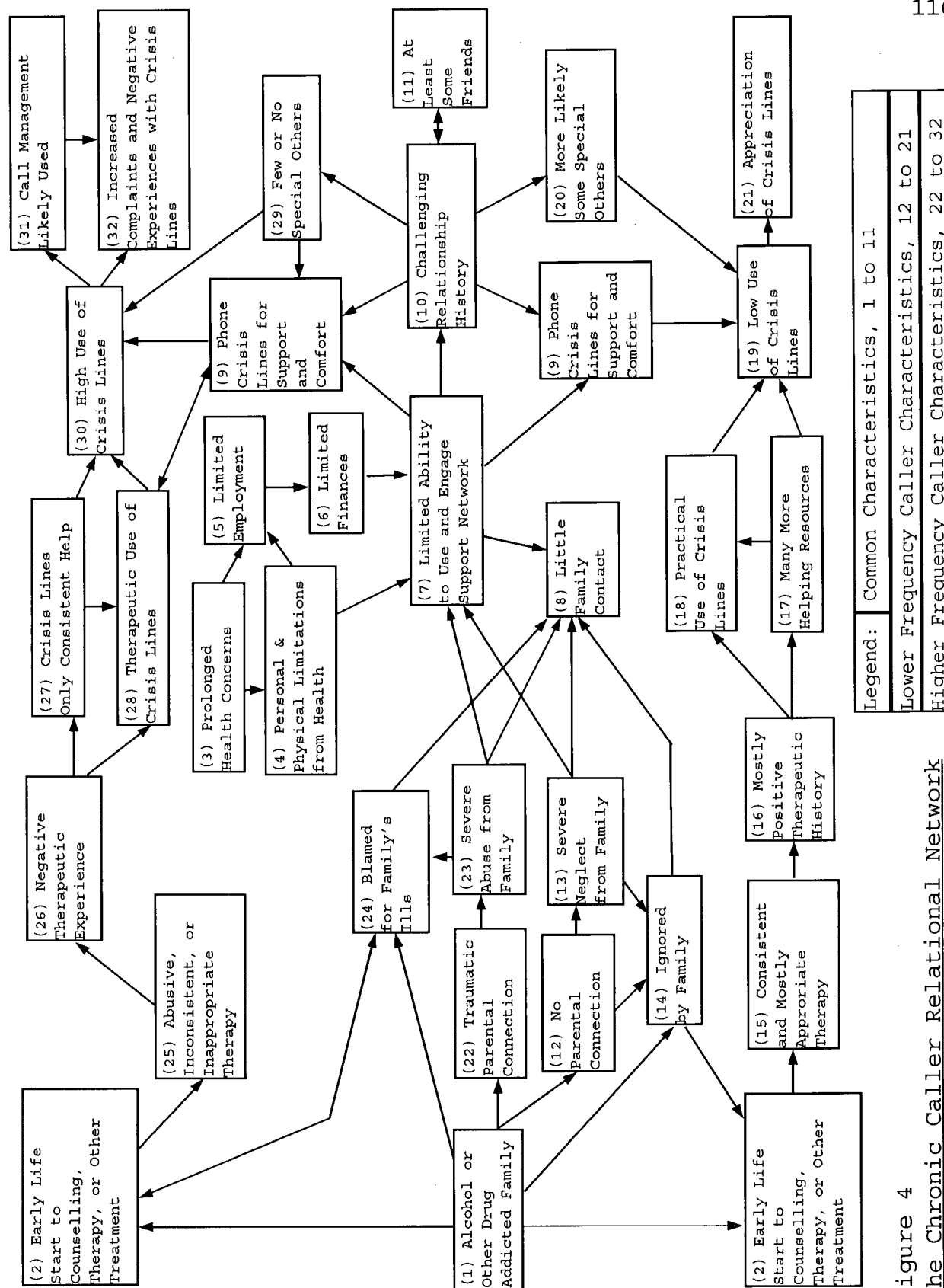
Figure 4
The Chronic Caller Relational Network

Legend: Common Characteristics, 1 to 11
Lower Frequency Caller Characteristics, 12 to 21
Higher Frequency Caller Characteristics, 22 to 32

therapy or other treatment (2) remained unclear. Those callers revealing early childhood involvement in helping services reported the early treatment start to be the result of their physical or mental health, not a parent's alcohol or other drug problem. When the callers' reported involvement in therapy starting in their youth, they stated the family viewed them as the "problem," rather than the substance abusing parent. The callers mentioned they were then forced into counselling or treatment by their parents.

All chronic callers reported prolonged health concerns (3). Callers also mentioned personal or physical limitations from their health concerns (4). Both the prolonged health concerns and the limitations experienced because of them contributed to callers having limited employment opportunities (5), and then limited finances (6).

The callers' personal or physical limitations from their health (4) and the callers' limited finances (6) contributed to the chronic callers limited ability to use and engage their support network (7). Also, severe family neglect (13) for lower frequency chronic callers and severe family abuse (23) for higher frequency chronic callers contributed to the callers limited ability to use and engage their support network. Both the severe neglect and the severe abuse reported by the callers in their families appeared to affect their social and relationship skills.

The callers limited ability to use and engage their support network (7), as well as the callers' family history, encouraged

little family contact (8) for chronic callers. More
specifically, for the lower frequency chronic callers, their
history of severe family neglect (13) and being ignored by the
family (14), contributed to little family contact. For the
higher frequency chronic callers, their history of severe family
abuse (23) and being blamed for the family's ills (24) encouraged
little family contact for them.

The chronic callers limited ability to use and engage their
support network (7) contributed to callers needing crisis lines
and continuing to telephone them for support and contact (9).
The impairment and lack of interpersonal skills, implied in the
callers limited ability to use and engage their support network,
also contributed the callers challenging relationship history
(10). However, callers also reported at least some friends (11)
that they maintain regular contact with. How this characteristic
exactly related to the other chronic caller characteristics
remained unclear. Friends did not seem to add or reduce the
callers' frequency of telephoning. However, a slight tendency
for the highest frequency chronic callers to report
acquaintances, not friends, was beginning to emerge.

Lower Frequency Chronic Caller Characteristics

The reported common characteristic of an alcoholic or other
drug addicted family (1) appeared to contribute somewhat to the
lower frequency chronic callers revealing no parental connection
(12) and being ignored by their families (14). For these
callers, they reported their parents generally unavailable to

them because of the parents' substance abuse. Also, without a parental connection (12), these callers reported they were often severely neglected in the family (13). No parental connection and severe family neglect both contributed to the callers being ignored by the entire family (14).

The alcoholic and other drug addicted family (1) and the callers being ignored in their family (14) were reported as ongoing in these callers' lives before the callers' early entry into counselling, therapy or other treatment (2). Whether these variables influenced early entry into the helping services remained uncertain from the interview data. The lower frequency chronic callers' early entry into counselling, therapy or other treatment (2) was associated with the callers' physical or psychological health, not necessarily the callers' family background.

The lower frequency chronic callers reported more consistent and mostly appropriate therapy and other help (15), contributing to their mostly positive therapeutic experience (16). With a mostly positive therapeutic history, these callers indicated they remained in contact with and benefited from many more helping resources (17). With more helping resources, and a mostly positive therapeutic history, the lower frequency chronic callers said they used crisis lines for practical purposes (18), such as brain-storming and obtaining other resources and referrals.

These callers' low use of crisis lines (19) is influenced by the callers contact with many more helping resources (17), their

practical use of the phone service (18), their need for support and contact (9), and the fact these callers are more likely to have a special other (20) in their lives. Both these callers' many more helping resources (17) and the likelihood having a special other (20) reduced the callers' reliance on the crisis lines for contact and support. The lower frequency chronic callers reported that they had other persons with whom they could share themselves deeply with. Further, with many more helping resources (17), the callers met their therapy and treatment needs outside the crisis lines. These callers then only needed the crisis lines for practical help (18).

Lastly, the lower frequency chronic callers often reported positive experiences with the crisis lines that contributed to their frequent appreciation of the service (21).

Higher Frequency Chronic Caller Characteristics

The reported common characteristic of an alcoholic or other drug addicted family (1) contributed to the traumatic parental connection (22). Already formed out of a parent's death, parental abuse or abandonment, the reported traumatic connection intensified with the familial substance abuse. This intensified parental connection then added to the severity of the family abuse (23) for the higher frequency chronic callers. In combination, the severe family abuse (23) and alcoholic or other drug addicted family background (1) contributed to the higher frequency chronic callers being blamed for the family's ills (24).

Both the alcohol or other drug addicted family background
(1) and the callers being blamed for the family's ills (24)
contributed to the higher frequency chronic callers early start
to counselling, therapy or other treatment (2). These callers
reported being the identified patient in the family. Therefore,
usually forced into therapy or treatment by their parents or
family, these callers indicated their early therapeutic
experience began negatively. The callers also reported their
therapeutic experience usually continued in an abusive,
inconsistent and inappropriate manner (25), contributing to a
general negative therapeutic experience (26).

With a negative and inconsistent therapeutic history, these
callers reported that crisis lines became the only consistent and
appropriate help (27). With no other or inconsistent helping
resources, and a reluctance to engage other help because of a
negative therapeutic history, the higher frequency chronic
callers said they used crisis lines as a therapeutic resource
(28).

Both the callers' dependency on crisis lines as their only
consistent help (27) and the callers' therapeutic use of crisis
lines (28) contributed strongly to the callers high use of crisis
lines (30). Using the crisis lines as a therapeutic resource
(28) moved these chronic callers beyond crisis line contact for
only support and connection (9), and added to the callers'
reasons for telephoning crisis lines. Crisis line contact then
increased (30). Also, with few or no special others (29) in

these callers' lives to share with, the callers' crisis line
contact for support and connection (9) was enhanced. Then, both
these factors provided further influence for higher use of the
crisis lines (30).

With the higher use of the crisis lines (30), these callers
reported more frequent use of call management techniques (31) by
the crisis lines. The higher frequency chronic callers mentioned
they disliked call management, increasing their complaints and
negative experience with crisis lines (32). Further, with
increased use of the crisis lines (30), these callers mentioned
more negative experiences with crisis lines (32), call management
aside.

Validation of the Chronic Caller Relational Network

The five callers reached for follow-up confirmed the chronic
caller relational network. No disagreement with the relational
network was expressed. Rather the callers provided elaboration
of the possible associations between characteristics. For
example, one caller clarified the relationship between the higher
frequency chronic caller characteristics of "few or no special
others" and "high use of crisis lines." This caller did not want
to burden a special other with personal concerns. Therefore, the
caller telephoned crisis lines for support and with greater
frequency.

Discussion

Several characteristics arose from the data in this study. The interview data supported and expanded some results of previous studies. Such characteristics as the chronic callers' limited support network and their experience with other community resources were confirmed and clarified. Also, the data did not support some previous findings, such as the callers' substance misuse. Many new findings did emerge from the chronic caller interviews, most interestingly the differences between the higher and lower frequency callers, and the leitmotifs. The following discussion will examine the characteristics as they relate to one another and the previous research.

Family Background and Victimization

All the callers displayed a pattern of victimization beginning in their families of origin. All indicated living in an alcohol or other drug addicted family, with one or both parents unavailable because of the substance abuse. The callers reported frequently living through either severe abuse or severe neglect by their parents and other family members. Victimization had become very much a life theme for all the callers.

For the lower frequency chronic callers, the parental substance abuse contributed to the neglect they reported from the family. For these callers a pattern of victimization through severe neglect and family abandonment began. Often they reported being unwanted children and left to their own resources growing up. They said nothing they did, positive or negative, got them

any consistent attention from their family members. Usually they were the family outcasts. Later in life, these callers reported intimate relationships that failed, often from abuse or neglect by their partners, and more failed relationships than their higher frequency telephoning counterparts. They clearly repeated a pattern of abandonment started in their families of origin.

The higher frequency chronic callers outlined severe abuse in their families. One of their parents abandoned the family through death, separation or substance abuse. The callers then formed a traumatic connection with the remaining parent. When abuse occurred, the parental connection shattered. The callers reported they experienced intensified abuse and abandonment because the substance addicted parent did not see or stop the abuse. Their negative familial relationships continued. They said they were often blamed for the families' ills. Perhaps distrusting people or fearing further abuse, the higher frequency chronic callers never or rarely connected with others intimately. When they did establish an intimate relationship, it ended with abuse for them. This pattern of abusive relationships appeared established in their families. The victimization then appeared in their work, friendships, intimate relationships, and therapy. Later, some even reported experiencing abusive relationships on the crisis lines.

Isolation

The callers often expressed a sense of loneliness or isolation. The isolation they experienced often arose out of

abusive and dysfunctional family dynamics they reported. From their family background developed personal and familial limitations that hampered their ability to connect with others, leaving family and others often unavailable to them for support. A lack of appropriate social skills and a difficulty with intimacy limited their relationships with friends and special others. Adding to their loneliness, the callers mentioned physical or financial limitations to reaching out to others. Isolation became a strong theme for all callers.

The lower frequency chronic callers showed they never connected with their families. They said they were neglected and ignored by their parents and siblings, two of the callers reporting the ultimate neglect of being unwanted children. These callers often said they were excluded from family activities. Isolation and abandonment started early in their lives.

The higher frequency chronic callers said they suffered abuse from parents and siblings. The callers reported they were blamed and scapegoated for the families problems. They often said that they were forced out, even exiled, from the family later in life because of their apparent inappropriate behaviours. Their earlier connections with their parents and siblings became abusive and untrustworthy. They went from connection to isolation.

Because of the neglect, the lower frequency chronic callers rarely received any skills to connect with others. Because the higher frequency callers had their early connections betrayed,

they became reluctant to connect with others. With their family backgrounds, these callers' limited ability to engage and use their support network of friends and family becomes clear. Their isolation emerges from their inability or reluctance to connect, started in their families.

With limited support networks and challenging personal and familial experiences, all callers reached out to therapy, counselling and other treatment. The callers also found crisis lines as an ongoing consistent helping resource. For all the callers, they said they received at least some support, contact and help from the helping resources. Their sense of isolation was reduced with their connections to helping services.

Unfortunately for the higher frequency callers, they reported their pattern of abusive and negative experiences continued into their helping relationships, even with crisis lines. Because of the abusive and inappropriate helping relationships, these callers often left the helping service. Their isolation repeated. Differently, the lower frequency seemed to find the attention and concern of the helping resources (and the crisis lines) positive. They indicated they continued with most of their helping contacts as long as needed, enjoying the connection.

Limited Support

Consistent with previous experience and findings of a limited support network (Haywood, 1981; Imboden, 1981; Sawyer & Jameton, 1979), only two callers reported significant and

meaningful contact and support from family members. Even for these two callers, not all family members were part of their support network. They said they had limited or no contact with some family members. The remaining six callers showed no support and rare contact with family members, especially their parents.

Limited family contact remains consistent with the callers' family backgrounds. All the callers reported alcohol or other drug addicted families where the callers experienced severe abuse or neglect from their parents and other family members. They were frequently excluded from their families. Some callers reported they are still blamed for the family's problems and their families maintain little contact with them. The other callers made a choice to maintain limited contact with their family to the callers' benefit. Their limited family contact avoided a repeat of the victimization they reported they experienced in their family.

Somewhat differing from the previous anecdote and research (Haywood, 1981; Imboden, 1981; Sawyer & Jameton, 1979), six callers reported a social support network of two or more friends, and three of these callers socialized regularly with five or more people. However, these friends mostly provided social outlets for the callers, and very little support. Only two callers reported significant or meaningful support from their network of friends.

A Challenging Relationship History

The callers' frequent familial experience of severe abuse or

severe neglect seemed to contribute to their later ability to connect with others. Consistent with previous research (Greer, 1976; Sawyer & Jameton, 1979), the callers interviewed largely reported to be unmarried or unpartnered. Six callers stated they had no special other in their lives now. Living alone, these people only had their friends and family as a support network. The other two callers, currently in relationships, showed substantial support from their partners - one past support, and the other past and current support.

Finding and maintaining special relationships proved challenging for all the callers. The lower frequency chronic callers tended to report more intimate relationships than higher frequency chronic callers. Perhaps, not experiencing familial connection, the lower frequency chronic callers had more special others because they did not learn the skills to connect effectively with a special other. For the higher frequency chronic callers, perhaps the abusive and broken connections in their families made them cautious with later relationships. Whatever the reasons, all the callers shared a difficulty establishing and maintaining special relationships, often revealing a difficulty building intimacy with others.

Prolonged Health Concerns, then Limitations

All callers reported prolonged health concerns. For some this began in infancy or childhood, sometimes as a disability. For others they were in their youth. Often their health problems generated personal and physical limitations for them.

With their health limitations and disabilities, the callers revealed limited employment. From their limited employment, the callers said their financial opportunities and resources were reduced. These limitations hampered the callers' ability to get out and connect with others socially and intimately. They were limited from engaging a social and support network.

Limited Ability to Use and Engage Support Network

Often the callers reported difficulties moving beyond social conversation and activities to friendships with more personal engagement and depth. Also, callers remained disengaged and distance from their family members out of personal choice or family intent. The chronic callers' ability to engage and to use their support network of family and friends appeared more at issue than the support network itself.

Only two callers mentioned a supportive, special someone in their lives. The others said they lived alone.

Only one caller reported significant and meaningful contact with both friends and family. Another caller also indicated support from family, though neither of these two callers received support from all their family members. Another caller also showed significant and supportive friendships. For the remaining six callers, they revealed no extensive support network of family nor friends. For most callers, their ability to connect with and use their friends and family for support remained limited.

Connection

Most callers reported limited support from others. All the

callers said loneliness often was a frequent feeling in their lives. However, because of these or in spite of them, the theme of contact or connection recurred through any relationship the callers had.

All callers appeared to want or have at least some connection with others. The callers showed they strived to build relationships and connect with others, like friends and family. They showed they had some connection with others through the friendships, social times and rapport they established. They also showed connection through the rapport they had with their friends, family, special others or helpers.

The callers developed both rapport and intimacy with crisis line workers and helping professionals. The callers said they felt better and connected when they talked with and were heard by helpers. They also said those telephone workers that shared similar life experiences with them helped the callers establish even a better connection to those workers. For five of the callers the telephone workers became a different kind of friend. However, the callers only interpreted friendliness from the intimacy and rapport of the helping relationship. The friendship was not reciprocated.

Therapy, Treatment and the Callers' Personal Background

Previous or Current Counselling, Therapy or Treatment

Prior research by Greer (1976) and Murphy et al. (1969) reported from 75% to 95% of frequent and one time callers have had previous therapy, counselling or treatment. Consistent with

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this research, all the subjects in the current study reported
they had received some type of counselling, therapy or treatment.
Four callers also said they still maintained contact with
additional helping services beside the crisis lines. This
maintained contact with other services is consistent with
previous research reporting chronic callers have or have had
frequent contact with other community services (Farberow et al.,
1966; Lester & Brockopp, 1973; Sawyer & Jameton, 1979). Further,
all the chronic callers reported an involvement in therapy,
treatment, or another helping resource before their first contact
with crisis lines.

Perhaps unique to chronic callers is their early involvement
in therapy or other treatment. All the callers of this study
reported they had been involved in medical or mental health
therapy or treatment by their late teens. Most said treatment
began in their childhood before age 10. Clearly because of the
callers' ages at the time, their parents initiated the therapy or
treatment and had the control over the type and course of it.
For some this early contact with medical and mental health
services was to their benefit and they clearly expressed their
appreciation of the help they received. Their early experience
with therapy or other treatment began a positive therapeutic
history for them.

For the others, especially the higher frequency callers,
this early contact with therapy and treatment was the start of a
generally negative experience with the helping professions. All

reported their parents forced them into therapy or other treatment. Some callers reported their parents even attempted to institutionalize them. For these callers began a negative and often abusive therapeutic experience.

Mental Health Contact

All callers reported contact with mental health or psychiatric services at some point in their lives. Three callers said they had received psychiatric treatment for a diagnosed mental illness. Four other callers reported they had received therapy from a psychiatrist. The remaining caller reported receiving counselling from a community mental health service. All callers mentioned prior psychiatric treatment, though not necessarily for a diagnosed mental illness. This is consistent with the previous research that stated between 75% and 85% of chronic callers reported prior psychiatric treatment (Farberow et al., 1996; Lester & Brockopp, 1970; Sawyer & Jameton, 1979).

Suicide

The chronic callers' contact with therapy or treatment often involved suicide. In total five chronic callers revealed feeling suicidal or previous suicide attempts. This is similar to prior research mentioning over half of all callers, chronic or otherwise, disclosing suicidal ideation or attempts (Greer, 1976; Lester & Brockopp, 1970; Murphy et al., 1969; Sawyer & Jameton, 1979). Only three callers, however, contacted crisis lines while feeling suicidal.

No Substance Misuse

Three callers disclosed they had an alcohol or other drug problem and now were in recovery. The remaining five callers reported no difficulties or concerns with their alcohol or other drug use.

The previous research had suggested approximately fifty percent of those chronic callers to a crisis line have an ongoing substance abuse problem (Farberow et al., 1966; Greer, 1976; Sawyer & Jameton, 1979). The results from the current research do not support this view. A possible explanation for the lack of support for the previous research could be the callers' "denial" around their substance use. The interview was not designed to obtain information on specific indicators of substance abuse or dependency. The interview protocol only contained questions that asked the callers' views and difficulties about their alcohol or other drug use. The callers could have been unaware that they have a substance abuse problem, or they may have been reluctant to disclose any substance use difficulties.

Another possible explanation for the lack of support involves the association between substance use and mental illness in the research. Farberow et al. (1966) and the Sawyer and Jameton (1979) looked at substance abuse or dependency and mental illness in the same caller. Only Greer (1976) looked at substance use independently of mental illness or psychiatric challenge. Perhaps, because of the exclusion of psychiatrically challenged callers from the current study, this research's

chronic callers are different enough from the other studies'
subjects to produce differing results. Ignoring this
consideration, the general assertion can be made that those
chronic callers, excluding the psychiatrically challenged, are
not uniquely identified by a current substance misuse problem.

Positive Therapeutic History versus Negative Therapeutic History

The lower frequency chronic callers reported severe neglect
and that they generally were ignored and unwanted by their
parents and families. Perhaps, starved for attention, when they
entered therapy or other treatment, the interest and attention
they received created a positive experience for them. Additional
attention and interest expressed by helpers continued these
positive experiences. The callers then remained connected to
many helping services and their various needs met. When they
began telephoning crisis lines, their positive experiences
continued. Connected with other helping resources, they reported
they used the crisis lines for practical, day to day assistance,
support and contact. They maintained consistent, appropriate and
positive help from several sources.

The higher frequency chronic callers experienced their
families differently. Severely abused and blamed for their
families ills, they revealed a history of abusive relationships
beginning in their families. Pushed into therapy or treatment by
their parents, they reported they started therapy negatively.
They showed a pattern of abusive and controlling relationships
that developed and continued into later therapy. They frequently

struggled with and left helping services because of the inconsistent and inappropriate help they received. They reported that when they contacted crisis lines, the phone services fulfilled a need for contact, ongoing support, and therapy. No other services existed for them. However, when their calls increased, the crisis lines started to manage their calls. Limited from another helping resource when in need, these callers reported another negative situation reminiscent of their previous therapy, and even their family life.

Contradictions in Helping Experience

Callers often reported a double edged experience with counselling, therapy and helping professionals. While frequently reporting that they were constrained, abused and disempowered, the callers often displayed personal growth, esteem-growth and empowerment through their counselling and other treatment experiences. For example, three callers stated they were committed and restrained by mental health services; yet, it was these very same mental health services that they said empowered them to break away from their institutionalization and mentally ill label to take care of themselves. The callers indicated helping services both repeated their sense of victimization and helped boost their sense of esteem. Therefore, they often appeared caught in a cycle where they reported hurt and abuse to achieve some connection and personal power.

Telephone Crisis Centres

The callers' years of contact remain consistent with

previous findings (Sawyer & Jameton, 1979). Most chronic callers interviewed reported telephoning the crisis lines for several years: seven callers for over 5 years, and three callers for over 10 years. Only one caller had been calling under a year.

Also, the chronic callers' telephoning frequency is consistent with previous research (Lester & Brockopp, 1970; Johnson & Barry, 1978). The callers said they telephoned three to five times a month to four times a day.

Increasing Crisis Line Contact and Mismatched Needs

Disadvantaged or unmet relationship needs do not appear strong factors leading to increased crisis line use. If this were the case, both the higher frequency and lower frequency chronic callers would likely have more equivalent rates of crisis line use because both groups display a limited ability to engage and use their support network.

What does seem the stronger influence is the callers' need for therapeutic contact. The higher frequency chronic callers reported much more severe abuse than their lower frequency counterparts. Also, they stated previous therapy and treatment tended to include more frequent and more severe negative therapeutic experiences than other callers. They also tended to report much more inconsistent therapy and other treatment. All these factors seem to increase these callers' need for consistent and appropriate therapy or counselling. However, these callers' prior negative and inconsistent experiences with therapy would appear to isolate these callers from helping resources from which

they could benefit.

Crisis lines are a readily available helping resource. Though not therapists, the crisis line workers can and do provide a positive and beneficial helping relationship to callers. Because these callers were isolated from other potential help and in need of a therapeutic resource, they said the crisis lines became a helping replacement - a therapeutic stop gap - for them. Therefore, they increased their calls to the only helping resource available to them consistently, at anytime.

A mismatch between the callers' and crisis lines' needs exists. The callers, looking for a therapeutic resource, increase their telephone contact. However, the crisis lines provide crisis intervention - not therapy. The telephone workers expect the callers to improve quickly and stop telephoning, with the crisis resolved. The crisis lines' need to resolve crises and the callers' want of therapy do not agree. As Leuthe and O'Conner (1981) said, this mismatch between needs results in negative experiences for both parties.

Greer (1976) stated the quality of telephone volunteer interactions decreases as the frequency of callers' contact with the service increases. For the higher frequency chronic callers, who reported negative experiences with the crisis lines and their workers, this is definitely the case. The negative crisis line experiences from the mismatched needs would be part of the decreasing quality of telephone interactions.

Building Self-Esteem

Limited family contact helped the callers avoid a repeat of the victimization they reported having experienced in their family. It also helped them rebuild their esteem after the years of abuse and neglect. However, the callers needed a place, or relationship, where they could build their esteem.

The callers revealed many interactions with helpers that enhanced their esteem and empowered them to healthier living. They said that they received validation, acknowledgement, and understanding of their life experiences from telephone workers and helping professionals. However, for all the callers, they said the crisis lines often provided the most consistent accepting and supportive environment where they could enhance their lives. The callers indicated the information, resources and referrals, brain-storming and new perspectives on their concerns received from telephone workers worked toward building their esteem. Through crisis line workers' validation and acknowledgement, the callers displayed a sense of acceptance and support that boosted their esteem.

Over the years of contact with the crisis lines, and to a degree other helping resources, the callers revealed they started to address the previous abuse they had received in their familial, intimate and helping relationships. Resolving their past, the callers' esteem grew as they began better caring for themselves. They established healthier relationships with family and friends. Those callers without new relationships indicated

they continued to maintain and further build their esteem with crisis line workers and other helpers. They still searched for healthier relationships with others.

The callers showed improved esteem through their contact with crisis lines. The emotional support and understanding provided by the crisis lines strengthened the callers. They were allowed to vent their emotional distress and concerns and were shown ways to overcome their challenges. Callers and telephone volunteers worked together to brainstorm solutions and to find new perspectives. The callers increased their esteem and empowerment, receiving emotional release and building action plans that improved their physical, emotional and mental health.

The crisis lines also provided a safe place where the callers could gain self-knowledge through personal exploration. Like a mirror, the telephone workers validated and acknowledged the callers' experiences and feelings. The callers showed they had a relationship with the crisis lines where they learned to better understand and accept themselves. Their esteem grew through the encouragement, acceptance and connection with someone else.

Crisis Lines as a Therapeutic Resource

Those callers with better financial resources showed they were better able to cope with the day-to-day stressors and improve themselves. They could better afford therapy and counselling services. Those callers with reduced or few financial resources reported they were limited to helping

services offered at a sliding scale or free through community and government agencies. When affordable therapy and counselling services were found, these resources frequently were limited in time and inconsistent. The helping professional often moved onto better paying positions. For these callers with limited financially available counselling, the crisis lines can and do become a "therapeutic" helping resource between times.

Positive and Negatives of Therapeutic Use

Because callers reported they tended to use crisis lines therapeutically, crisis lines appear to provide both a therapeutic and positive helping relationship. Chronic callers are meeting counselling needs that they are not fulfilling elsewhere. This seems particularly true for the higher frequency chronic callers who most often rely on the crisis lines as their only therapeutic resource. However, therapeutic use of crisis lines and the higher frequency chronic callers' previous negative therapeutic experiences appear to combine to create more aware and more vocal callers on the negative and inappropriate service they may receive from crisis lines. These callers displayed the greatest awareness of inappropriate crisis line worker behaviours and were very vocal on them. These callers also proved to be the most precise in what they found beneficial and positive about crisis line service.

The Chronic Callers' Negative Responses

The higher frequency chronic callers often reported they had suffered severe abuse in their families of origin. They

indicated their abusive experiences tended to repeat themselves in future relationships: friends, special others, and therapeutic. They revealed a pattern of victimization that was set early and continued throughout their lives.

The higher frequency chronic callers suggested their pattern of victimization continued with crisis lines. When crisis line personnel initiated call management to restrict their calls, the callers responded negatively. The crisis lines' efforts to manage their calls came across like previous negatives experiences with helping services, their families and their intimate relationships. They reported feeling abused and mistreated.

Additionally, the higher frequency chronic callers reported the crisis lines as their only consistent therapeutic contact. The crisis line workers, detecting the change in the telephone relationship toward therapy, moved to reestablish the original crisis intervention relationship. These callers again reported they responded negatively to the crisis lines efforts. This appeared to them as another abuse or betrayal of yet another therapeutic relationship.

Complaints

Clearly for the higher frequency chronic callers, their greater and more diverse reporting of complaints about crisis line service relate to their greater telephoning frequency. With greater contact, the crisis lines are more likely to call manage. However, also contributing to these complaints could be the

reported tendency of the higher frequency chronic callers to have had more frequent and more intense negative experiences with therapy, counselling and other treatment. They could have from this prior experience with the helping professionals a greater awareness of and sensitivity to inappropriate and unprofessional helping behaviours toward them.

Call Management

Contradictions. Callers pointed out the contradictions in crisis line service. When callers first started calling the crisis lines in distress, they stated they were encouraged to vent out their feelings and express their concerns rather than keep them inside. However, when they began to telephone too frequently, they said they were placed on time limits. The telephone workers also started to focus and to direct their calls to move the callers along and keep them from "wandering." Callers mentioned, even if they telephone distressed, they were not given the opportunity to vent completely their feelings and concerns before the call is ended. Therefore, they said they left the call still high with unexpressed emotions and problems. They stated a contradiction existed between crisis line personnel encouraging them to talk and vent and the later call restrictions when they telephoned too often to do just that.

Application. From what the callers have said about the crisis lines' attempts to manage their calls, crisis lines appear to call manage uniformly once the caller has reached a particular telephoning frequency to a specific phone line. The callers

showed they are fully aware of the changes in service to them. They stated the changes often ignore their individual uniqueness and specific needs for a particular call. They remain highly resistant to any changes that do not involve them in the decision process, as displayed by their continued phoning and increased frustration with the crisis lines' service.

Implications and Conclusion

The discovered chronic caller characteristics, and the associations between them, provide new information for the operation of telephone crisis intervention services. Chronic caller management is a dynamic event between the crisis lines and the chronic callers. The findings encourage a reexamination of both chronic callers' and the crisis lines' contribution to the ongoing telephone contact to understand better this process. Therefore, the implications of the results for the identification of chronic callers, the telephone call dynamics, and the management of their calls will be discussed. A possible application of some characteristics to chronic caller identification will be provided. Also, recommendations will be provided to enhance crisis line service with regard to chronic callers.

Chronic Caller Identification

Previous Definition

Most crisis line administrations use a list of criteria to identify chronic callers. Commonly, eight criteria are used in the identification of chronic callers. The identification of a chronic caller usually requires a combination of these factors: (1) frequency of contact; (2) duration of ongoing contact; (3) an absence of crisis or emergency; (4) an unclear precipitating event or stressor for the call; (5) the caller rarely engages in immediate action or decision making; (6) the person is unreceptive and reluctant to accept interventions and develop

action plans; therefore, assistance usually is "yes, but..." and

rejected; (7) the caller often telephones for social support and

contact; and (8) the caller is often difficult to terminate

(Chimo Personal Distress Intervention Services in Richmond, 1993;

Langley Family Services Association, 1993). With regard to the

current study, these criteria are reviewed.

1. Frequency of contact, ranging anywhere from once weekly, to three times daily, to three times per shift. This criterion

is supported by the research. The callers interviewed reported

telephoning from once/week to four calls/day. However, as

previous research has stated, frequency of telephoning alone is a

limited criterion to identify a chronic caller (Johnson & Barry,

1978). Chronic callers may telephone just as frequently as

crisis callers. What becomes essential to the identification of

chronic callers are additional criteria.

2. Duration of ongoing contact, usually over several months. This criterion is supported by the current research. The callers

interviewed reported telephoning crisis lines from 6 months to

over 13 years. However, whether this is chronic or crisis

calling remains unclear.

The research literature on crisis intervention and theory

emphasizes there exist limits to the duration of a crisis

(Auerbach & Kilman, 1977; Rosenbaum & Calhoun, 1977; Slaikeu,

1990). The initial disequilibrium experienced from a crisis

event usually is eliminated and equilibrium restored within four

to six weeks. However, this literature shows that the effects of

a crisis may continue and take up to a year to resolve.

If callers telephone frequently over a four to six-week period, this contact may be the result of crises. Continued telephoning beyond this period still may be an attempt to resolve the crisis event. These callers could be identified as "chronic" callers although they are still working to resolve the effects of the crises. Therefore, especially if frequent telephoning only over several months is considered, duration of ongoing contact is a limited criterion to identify chronic callers. However, if telephoning continues beyond several months into a year or more, the callers' successful resolution of the crisis would grow suspect. After a year or more, the problem(s), even if crisis in origin, definitely would appear chronic in duration.

3. There is an absence of a crisis or emergency.

4. The event or stressor precipitating the call is unclear. These criteria generally are supported by the study. The callers indicated they at times telephoned crisis lines in crisis as the result of some event or stressor. However, they most often reported they telephoned wanting social contact or distressed with an ongoing problem.

Telephone workers, operating from a crisis intervention model, would be expecting a crisis call precipitated by some event. Though the chronic caller may be telephoning distressed by some ongoing concern, the usual indicators of a crisis would be absent (Rosenbaum & Calhoun, 1977; Slaikeu, 1990). The chronic callers' problems possibly could be the residual effects

of past crises (Auerbach & Kilman, 1977; Slaikeu, 1990).
However, a more likely factor would be the past experience of the callers.

All subjects reported exceptionally neglectful and abusive family backgrounds. All also reported prolonged physical, mental and/or emotional health concerns lasting several years. With this personal and family background, all the callers reported previous counselling, therapy, or other treatment for their problems. All the callers clearly stated, and provided additional information to support, the fact that the problems they telephoned the crisis lines with were ongoing and historical. Therefore, telephone workers would find it difficult to identify either a crisis or its precipitating event from a chronic caller's problem.

5. Immediate action or decision making by the caller rarely occurs. This criterion is supported by the study. Because the callers rarely reported telephoning in crisis, the usual motivations of a crisis - personal disequilibrium and tension, and the striving to find new resources to cope - are missing (Rosenbaum & Calhoun, 1977; Slaikeu, 1990). The crisis motivation to immediate action and decision making does not exist for the chronic caller.

Besides social contact, the subjects reported they often telephoned to work on ongoing problems. Again, their reported personal and family history would be a significant factor here. The callers showed they have lived with their concerns for many

years and adapted (or maladapted) to the challenges initiated by their life experiences. Also, seven of the callers indicated a substantial history of therapy or other treatment lasting many years. The callers probably are not expecting or have experienced quick change in their problems. Without the motivation of a crisis, the callers could be assumed unlikely to engage in immediate action or decision making.

6. The person is unreceptive and reluctant to accept interventions, encouragement, or develop action plans; therefore, assistance usually is "yes, but..." and rejected. This criterion is partially supported by the current research. As the chronic callers' telephoning frequency decreases, caller support for this criterion also decreases.

The higher frequency chronic callers provided the information that supported this criterion. They said they most often telephoned crisis lines as a therapeutic resource to obtain ongoing assistance with historical and unresolved life issues. They stated they often received inconsistent and inappropriate therapy in the past and looked to the crisis lines as a therapeutic replacement. The crisis line workers' usual resources, referrals, new perspectives and action plans, effective for others, proved to be less helpful to them because they were looking for therapy, not just interventions, for their problems. Assistance short of the therapeutic help they indicated they wanted was often rejected.

The lower frequency chronic callers reported they currently

were involved in therapy or counselling. They stated they recieved effective and consistent therapeutic assistance from their helping resources. As a result, the lower frequency chronic callers indicated they most often contacted crisis lines wanting practical support and actions to their problems. Looking more for day-to-day assistance and support, they reported receiving and benefitting from the new resources, referrals, perspectives and action plans to their concerns. They clearly showed they were receptive to interventions. Further, the crisis line interventions of venting, empathy, referral information, new perspectives and action plans apparently fulfilled the needs of these callers. Therefore, the interview data provided by lower frequency chronic callers did not support this criterion.

7. <u>Often the person calls for social support and to meet his or her need for contact</u>. The subjects generally provided information that supported this criterion. The frequency of contact for social support and contact clearly varied from caller to caller. At a minimum, all callers reported they did telephone at sometime and to some degree for contact and social support. However, to state all chronic callers telephoned *often* for contact and social support was not supported by the interview data.

8. <u>The caller is very difficult to terminate</u>. No interview data referred to this criterion. The principal investigator did not ask any specific questions on how the callers perceived their calls ended. Six subjects did report how crisis line

personnel terminated their calls with call restrictions. However, whether the crisis line workers found call restrictions necessary because the chronic callers were difficult to terminate, or telephoning too often, or wandering too much in the calls, or some other reason was not discussed by the subjects.

The current study supported and clarified seven of the eight general criteria used to identify chronic callers to telephone crisis centres. However, as previous research and this study demonstrate, individual criteria are insufficient and limited in positively identifying chronic callers. The more characteristics used to determine chronic callers, the more confidently chronic callers can be identified.

The New Criteria and Their Application

The additional chronic caller characteristics discovered can be used to improve the confidence by which crisis line personnel identify chronic callers. During a distress call, telephone workers easily could obtain caller background information helpful in chronic caller identification even from the individual's first call. The information from further calls then could be used to support the chronic caller identification or to reaffirm the individual as a non-chronic caller.

Individuals telephoning for social contact and chit-chat easily can be identified as non-crisis callers. Whether or not these people are chronic callers should not be an issue. Insomuch these individuals are telephoning a crisis line, their calls probably are best ended after a few minutes of social

conversation to open the telephone lines for crisis callers.

When individuals telephone in distress, not crisis, crisis line workers help individuals who do not clearly fit into the crisis intervention model. Whether these callers are potential chronic callers becomes a concern. These callers already do not fit clearly into the crisis intervention model and the potential for ongoing telephone contact and challenging call dynamics may exist.

Some discovered characteristics can be used to identify chronic callers even from a first call. The application of these criteria is discussed below.

The First Telephone Call: Obtaining a Helping History. When speaking with first time callers, taking a therapeutic or helping history would be appropriate, if not essential, to understanding the callers' problems. While investigating the dimensions of the callers' concerns, telephone workers would need to obtain a history of what resources the callers have used in the past, eg., counselling, therapy, mental health, other community services, and what helping resources the callers are currently using. Also, the crisis line workers would best ask what the callers' experiences were like with those helping resources.

1. Previous or current counselling, therapy or other treatment.

2. Mental health contact.

3. More years with helping services than crisis lines.

An affirmative response to previous mental health contact

and/or any previous counselling, therapy or treatment would be a positive indicator of a potential chronic caller. All research subjects reported prior mental health contact and previous involvement in counselling, therapy or treatment. Also, all the interviewed callers reported more time with helping resources other than crisis lines. Therefore, those first time callers with a helping resource history and saying the call is their first ever contact with a crisis line would be showing another chronic caller characteristic.

4. Negative therapeutic history versus mostly positive therapeutic history.

5. Crisis line dependent versus many more helping resources.

The therapeutic history obtained from an individual's first call would be beneficial in identifying the individual's telephoning frequency and potential use of crisis lines. The crisis line callers that mentioned a mostly positive therapeutic history and current contact with other helping services would be showing a potential for lower frequency telephone contact. Also, these callers potentially would be using crisis lines for only practical interventions, like developing action plans and obtaining new resources. Those crisis line callers that shared a negative therapeutic history and no current involvement in other helping resources would be showing a potential for higher frequency telephoning. Also, with crisis lines as their only helping resource, these callers potentially would be using crisis lines as a therapeutic resource rather than for practical

interventions.

The First Telephone Call: Exploring the Caller's Support System. Telephone workers also could appropriately ask about a caller's support system on a first call. The size and strength of the support network the callers can engage and use could be beneficial to the resolution of the callers' problems. In asking about the callers' support network, telephone workers would need to ask about their friends, family and special others that the callers' have available for support.

6. Definitely friends.

7. Little family contact.

8. Few with special others.

9. Limited ability to engage and use support systems.

Callers that reported some friends, no current significant relationships, and little family contact would be showing positive indicators of a potential chronic caller. Also, those callers reporting difficulty in talking intimately about themselves, few people they felt close to, and distance or non-existent relationships with their family would be displaying a limited ability to engage and use their support network. This limited ability for the callers to use their support network also would support the identification of a chronic caller. However, because only six subjects at the most revealed any one characteristic, two or more of these particular characteristics in combination would increase the confidence of chronic caller identification.

Further Telephone Calls. The remaining characteristics
discovered in this study would be difficult to use to identify a
chronic caller from a first time call. Depending on the callers'
concerns, the telephone workers would be in a position of asking
inappropriate questions to gather additional information to
identify chronic callers from the remaining characteristics.
Crisis line personnel would need to rely on further calls to
obtain additional caller information to identify more confidently
chronic callers. Unfortunately, with further calls, the chronic
caller pattern of frequent calls over ever increasing days and
months may be set. Crisis line personnel would best initiate
management strategies earlier than later.

A Continued Cycle of Telephoning

Most callers mentioned negative experiences with telephone
crisis centres through time limits and focusing techniques used
to keep the call moving and short. Some even mentioned outright
abuse by inappropriate telephone workers and supervisors. These
negative experiences with crisis lines most often were mentioned
by the higher frequency chronic callers.

Yet all callers relayed the benefits and strengths of
telephoning crisis lines: the contact, the validation and
acknowledgement, the support and understanding, the new options
and perspectives, the resources, referrals and information.
Again, the higher frequency chronic callers often gave some of
the most glowing appraisals of crisis lines.

With all the disclosed mistreatment by crisis lines, one

could ask (as some centres and telephone workers have): What causes the callers to keep phoning?

Previous Research

Rudestam (1978) speculated that persistent callers were profoundly depressed and suicidal. The telephone workers become increasingly frustrated because these callers fail to improve quickly. But the workers still feel obligated to help. The callers remain unwilling to give up one of the few helping resources they have not totally alienated out of helper frustration. They keep phoning because they need the contact. However, the callers in this study did not report profound depression. Only two callers disclosed current treatment for manic-depression. They said their illness was very well managed, and they appeared emotionally level. Further, only two callers mentioned *rarely* telephoning crisis lines feeling suicidal. One was an identified manic-depressive caller.

A Cycle of Abuse

The callers' continued telephoning in spite of their reports of mistreatment by crisis lines. A possible answer for this could be the callers are trapped in a cycle of abuse. The cycle repeats the pattern of abuse and victimization they indicated they experienced in their lives.

For the callers, their family, friends or helpers frequently were the only places for contact and some support. The callers reported their family and friends often would neglect or abuse them. Particularly, the higher frequency chronic callers also

reported inconsistent and inappropriate therapeutic relationships with helpers. To maintain at least some connection with others, the callers endured the abuse. Further, because of their abusive family background, the callers may feel powerless to get support and help from anyone else. Therefore, in spite of the call restrictions imposed by crisis lines, the callers continue in a cycle where they receive some support and contact from persons they perceive as abusive and hurtful.

Therapeutic Trap

The higher frequency chronic callers showed that they used the crisis lines as a therapeutic resource. With a reported history of inconsistent and negative therapeutic experiences, they displayed a reluctance to engage other helping or therapeutic resources. However, they also reported the most and most severe negative responses to how crisis lines treated them and still continued telephoning at a high frequency. They appear trapped with one therapeutic resource and continue telephoning in spite of the mistreatment they report.

Crisis line personnel are trained to provide crisis intervention, not telephone therapy. Although the higher frequency chronic callers do find some benefit in the crisis line interventions of venting, empathy, referral and resource information, action planning, etc., they are looking for therapy from a resource that cannot provide therapy. Crisis line personnel do notice the change in the telephone relationship with these chronic callers. The crisis line workers then initiate

call management strategies that restructure the telephone
relationship toward crisis intervention again. Without other
therapeutic or helping resources, these chronic callers endure
their perceived mistreatment by call restrictions to maintain the
little therapeutic support they receive from the crisis lines.

A Repeated Pattern of Victimization

The chronic callers appear caught in a dependent-abusive
cycle with the crisis lines. They are dependent on crisis lines
as one of their few sources for support and contact. When they
begin to over use the service and/or show they are using the
crisis line as a therapeutic resource, crisis line personnel
impose call restrictions to reduce the callers telephoning
frequency. The telephone workers also work to restructure the
telephone relationship away from therapy. Afterwards, when the
callers do telephone with crisis concerns or other difficulties,
they are cut short and moved along, their power removed to get
the help they need. The callers then perceive another abuse has
occurred much like their family or therapeutic history. The
callers continue phoning because the crisis lines are the only
ongoing source of consistent help and support available to them.

Friendliness in the Caller-Worker Relationship

Chronic callers interpret the caller-telephone worker
relationship as more than just helping. Six callers reported
their connection and rapport with crisis line workers was like
friends. Additionally, all the callers reported some degree of
social banter with telephone workers, much like what friends

would do. From their interactions with telephone workers, the callers would appear to have misinterpreted the workers' interest, concern and understanding as friendship.

Although four callers clearly stated they knew their relationship with the workers was not true friendship, concern arises with the information that five chronic callers showed a limited ability to engage and use their support networks of friends and family. Two other callers indicated limited ability to engage support: one from family, and the other from friends. Additionally, six callers demonstrated a challenging relationship history. Usually living alone, these callers discussed previous abusive and non-supportive relationships. They also reported difficulties establishing intimacy and interdependency with their partners. Overall, seven callers have current difficulties with building and establishing intimacy and support in their relationships. Because they have difficulty with intimacy and limited skills to develop support from others, the callers can be expected to misinterpret helping behaviours as friendship.

Because the chronic callers are contacting crisis lines, the telephone workers would encourage the callers to discuss and disclose about themselves. The workers then would respond with appropriate listening, empathy and questioning to help the callers resolve their concerns. At no point would the caller be expected to respond to the worker with any degree of understanding and interest as is expected to be displayed by the telephone worker. An intimacy and rapport develop between the

chronic caller and the worker that are in one direction. Though the caller perceives the relationship like a friendship, the "friendship" is not reciprocated.

When the callers interpret the helping as friendliness, the telephone workers now must deal with callers that have developed different expectations about the telephone relationship. The expectations of friendship can operate openly, such as the caller requesting coffee with the worker, to covertly when the caller becomes upset because the worker requests to keep a social call short after they have chatted before to the time limit or over. The callers' perception of friendship does make the helping relationship more difficult and unclear. To maintain an effective and appropriate helping relationship, the crisis line workers need to eliminate the perception of friendliness. However, with the chronic callers reported background of abuse and victimization, telephone workers are in a difficult situation where their "rejection" of the friendship can be perceived as a rejection of the caller. The challenge exists to establish limits to the helping relationship that eliminate the misperception of friendliness and maintain the established contact and rapport.

Working with Chronic Callers

Chronic callers remain an ongoing challenge for telephone crisis centres. The callers mention many positive attributes about the crisis line services: supportive, friendly; there to listen, problem-solve and give resources. Still, the callers and

the crisis lines often deadlock over the frequency and nature of their contacts.

Contradictions in Service

When callers first start telephoning crisis lines in distress, the workers encouraged them to vent out their feelings and talk about their problems to deal with their concerns. However, when the callers began to telephone too frequently, they were placed on call restrictions. Also, the telephone workers started to focus and direct their calls to move the callers along and keep the callers from "wandering." Callers mentioned, even if they telephoned distressed, they were not given the opportunity to vent completely their feelings and concerns before the call is ended. They stated they felt hurt and abused because they were denied support and help that the crisis lines implicitly or explicitly agreed to provide.

Call Management

Call management did not seem to greatly reduce the callers' telephone frequency. They kept phoning up to four times a day, potentially across several different crisis lines. Though the callers may be limited to one call per day per crisis line, the callers have available several different crisis lines in the Lower Mainland and Fraser Valley area.

Some callers stated in their comments about crisis line service that the telephone workers be given the discretion to decide the length and content of the calls. The callers said they appreciated the telephone workers that listen for their

particular needs for each call, then "negotiate" the limits on the call. These workers asked in so many words, "It's been kind of busy tonight. I'd like to keep the call short and open the line up for others," after the workers determined the callers were not in distress or crisis.

The callers suggested they wanted more regard for their specific needs in a call. They indicated they had unique needs on a call by call basis and that uniform chronic caller procedures were not effective in helping with.

Call management does not appear to work effectively. Chronic callers continue to telephone frequently to many different crisis lines. Also, the callers report their particular needs for a call sometimes are missed with a uniform chronic caller policy. Callers and workers remain often frustrated by mismatched needs.

Crisis Intervention or Therapy?

All callers reported telephoning crisis centres for contact and support, even friendship, reasons different from the crisis intervention mandate of the centres. However, even more distance from crisis intervention, there existed a strong tendency for the higher frequency callers to use crisis lines therapeutically: in place of or to supplement inconsistent and inappropriate counselling, therapy or other treatment. These callers showed they were reluctant to engage other therapy and counselling because of their previously negative experiences with helping professionals. Additionally, the higher frequency chronic

callers reported limited financial resources. Because of this, these callers could not readily afford therapy or counselling even if they were interested in "therapy" other than the crisis lines. Therefore, to suggest these chronic callers get therapy or counselling elsewhere may be pointless.

Crisis line personnel's efforts to limit calling and to refocus chronic callers away from telephone therapy do not work effectively. The higher frequency chronic callers in particular continue to telephone in spite of initiated call management. Both callers and telephone workers continue to have negative and frustrating experiences through the continued contact and mismatched needs. The therapeutic use of crisis lines remains.

The phone lines have made the chronic callers aware that counselling or therapy is beyond the scope of telephone crisis intervention centres. Most callers also showed they recognized that the crisis lines cannot provide therapy or other treatment. Yet, they continue to call, implicitly or explicitly wanting a greater depth of service. Crisis lines are left providing for only some of their needs. Clearly telephone crisis intervention is not meeting the callers' needs for therapeutic assistance. Whether the crisis centres can or should provide additional services beyond the crisis intervention, or even the ongoing supportive contact already provided to most, remains.

<u>Recommendations</u>

1. <u>Flexible Call Management</u>. Chronic callers clearly perceive the imposition of call restrictions as inappropriate and

abusive. For the callers, the call restrictions revisit a pattern of victimization they have experienced through their lives where they have been abused and hurt by those whom the callers rely on for support, comfort and contact.

There is an implicit, if not explicit, agreement that callers should telephone when they are in distress to deal with their concerns. However, when they start to telephone too often, call restrictions are imposed on them. Sometimes, the callers then are cut short before they can vent their feelings and get resolve to their problems. Other times, telephone workers focus and direct the call away from what the callers consider important to the call.

All the chronic callers suggested they knew that they could not telephone the crisis lines all the time. They clearly acknowledged there existed practical limitations to their telephoning for support and contact consistently.

From the above information, call restrictions would be better negotiated between the telephone worker and the chronic caller on a call by call basis. Involving the caller in the process would help eliminate the callers' sense of victimization from the imposition of call restrictions on them. Also, with telephone workers having the discretion to negotiate call restrictions with callers, the workers can better respond to the immediate needs of the caller. With no pressing concerns, the crisis line workers even could suggest ending the call before the usual ten to fifteen minutes allotted to a chronic caller. The

phone lines then would be open for crisis callers.

    2. <u>Repeat the Limits of Crisis Intervention Service</u>. The
higher frequency chronic callers clearly indicated they used
crisis lines for therapeutic assistance. All these callers also
recognized the limitations of crisis lines as a therapeutic
resource. (As well, they all reported they had been told at
sometime by crisis line personnel that telephone crisis
intervention is not therapy.) However, these callers said their
negative therapeutic history and limited financial resources have
created limitations for them to engaging more appropriate therapy
than from crisis lines.

    Crisis line personnel are best to continue putting out to
chronic callers that telephone workers are not therapists,
counsellors, psychologists, etc. Chronic callers, especially
higher frequency chronic callers, need to be reminded of the
limits of crisis intervention services. If possible, these
callers also need encouragement to find other helping resources
that are better able to meet their needs for counselling or
therapy.

    3. <u>Better Understand How Crisis Lines Help Chronic Callers</u>.
Crisis lines provide effective interventions to chronic callers,
especially the lower frequency chronic callers. These callers
reported the crisis line interventions of venting, empathy,
resource and referral information, expanding perspectives, action
planning, etc. as beneficial to them. These interventions helped
these callers manage their problems. However, the higher

frequency chronic callers reported a therapeutic benefit in their crisis line contacts. These callers indicated they were less receptive to the usual crisis line interventions. They seemed to benefit more from the acknowledgement and validation they received in relationship with telephone workers.

Crisis line administrative staff would be best to consider further exactly how the telephone worker skills encourage lower frequency chronic callers to manage better their ongoing concerns. With this clarity, crisis line workers could better assist other callers in distress, not just crisis.

Perhaps even more essential, crisis centre personnel need to consider and understand how they are providing a therapeutic resource to higher frequency chronic callers. Once understood, crisis line personnel would be more able to adjust crisis line services and training to manage the higher frequency chronic callers' need for a therapeutic resource without wandering from their mandate of telephone crisis intervention.

4. Clarifying the Helping Relationship. Chronic callers showed they interpreted the telephone workers' interest, concern and understanding as friendship rather than part of the helping relationship. Six chronic callers stated they enjoyed their contact with the crisis line workers because the relationship was like friends. Also, seven of the callers showed difficulties with building and establishing intimacy and support with others. Further, with the chronic callers indicated pattern of victimization, telephone workers that "reject" the callers'

friendship could initiate the callers' sense of repeated abuse.

Crisis line personnel would best clarify the service and interventions they can provide directly with the callers. The callers' misconceptions around the crisis line relationship as friendship needs to be corrected and gentle limits around the helping relationship established to avoid initiating the callers' sense of victimization. Further, when any indications of caller friendship arise, they need to be immediately and gently confronted, and the telephone relationship clarified as helping.

5. Reduce Chit-Chat on Crisis Lines. Crisis lines do provide a beneficial service to those chronic callers socially isolated and telephoning just to chat. The callers' loneliness is eliminated for a brief while. However, rather than chatting extensively, or even for the callers' time limit, these chit-chat calls would be better handled similarly and reduced in time for *all* callers.

The expectation is that crisis lines provide telephone crisis intervention - not chat. After determining that no crisis or distress exists for the caller, the telephone workers would move to end the call. The workers could say words to the effect: "You seem to be doing alright. The crisis line is very busy tonight. I need to open the line for others in crisis." The workers would then end the call.

Ending the call after determining no crisis or distress exists would eliminate the possible frustration of socializing with a caller when the expectation is to resolve crises and

distress. Also, the number of chit-chat calls would be reduced
to the crisis lines as the chronic callers realized the purpose
of the telephone lines is crisis intervention.

6. <u>Therapeutic Management</u>. The higher frequency chronic
callers indicated they telephoned crisis lines wanting
therapeutic contact despite the crisis line workers' inability to
provide such service and imposed call restrictions. These
callers also reported that crisis lines are the only helping
resource they have a current and consistent contact with.

Because of their "privileged" position in the chronic
callers' helping network, crisis line personnel may want to
consider the therapeutic management of higher frequency chronic
callers. This management could be accomplished through assigning
a specific telephone worker to a chronic caller and arranging a
specific day, time and duration for the "session." The goals in
the therapeutic management would be: (a) reduce the number of
calls; (b) persuade the callers to become more specific when
discussing their problems; (c) establish and work toward specific
goals to resolve their problems; and (d) if and when appropriate,
connect the caller with a more appropriate and consistent
therapeutic resource. The participating telephone workers also
would require additional training and skills to therapeutically
manage the chronic callers.

The chronic caller therapeutic management would reduce and
restructure the callers' telephone contact. The chronic callers'
need for therapeutic support and assistance would be met while

eliminating and reducing telephoning frequency, caller wandering from topic to topic within the call, and the callers' problems in telephoning. Also, crisis line personnel would be handling these chronic callers more effectively and increasing the accessibility of the phone lines to other callers.

Limitations of the Research

The study had a small sample size. Only eight callers participated in the interview. Even with this small sample size, the researcher found some strong tendencies in the interview data consistent with previously identified chronic caller characteristics, like suicide history. Also, the callers showed strong support for the newly identified characteristics, such as an alcohol or other drug addicted family background. However, whether the chronic caller characteristics would hold with a larger sample requires further investigation.

More critically, the research had no comparison group of usual crisis line callers. Previous literature and research have discussed the usual or crisis caller to a crisis line (Auerbach & Kilman, 1977; Chimo Personal Distress Intervention Services in Richmond, 1993; Crisis Clinic, February, 1988; Langley Family Services Association, 1993; Lester & Brockopp, 1973; Rosenbaum & Calhoun, 1977; Slaikeu, 1990; Slaikeu & Leff-Simon, 1990). However, future research comparing the two groups would further clarify the identified chronic characteristics as unique to them.

Implications for Future Research

Because the researcher interviewed only chronic callers,

future research that investigated both the usual crisis line callers and chronic callers on identified characteristics is needed. This research would clarify whether particular characteristics are distinctive of usual crisis line callers or chronic callers.

Research investigating the specific chronic caller behaviours that crisis line personnel found challenging would be beneficial. From this research, crisis line staff could develop specific strategies and procedures around these behaviours to lessen their impact on the call dynamic. These strategies and procedures then could be applied across all callers exhibiting the same behaviours. The need to identify and label chronic callers would be reduced because behaviours would be directly dealt with instead.

Perhaps using recorded telephone conversations, studies specifically investigating the chronic caller-telephone worker relationship would give better information and understanding on this ongoing dynamic. This research would help clarify the continuous cycle of chronic caller telephoning and the caller-worker interactions maintaining the dynamic. Further, the telephone workers' behaviourial contribution to the call dynamic would be investigated and specific strategies and procedures to overcome these behaviours developed.

Additional research that investigated the identified chronic caller global themes of isolation, connection, victimization and esteem would be beneficial. The leitmotifs provided a context

for the callers' lives. Further, these leitmotifs appeared to operate on two different dimensions: isolation and connection, victimization and esteem. Studying these themes would provide additional information to understand better their influence on the chronic callers' contact and use of crisis lines.

Lastly, future studies that looked at other chronic populations, such as frequent attenders to a medical practice or the chronically mentally ill, could begin to investigate the connections between different chronic populations. A larger understanding of client chronicity in the helping services would then be built.

<div align="center">Summary</div>

Chronic callers reported they telephoned frequently and over many years. For the lower frequency chronic callers, they suggested the crisis lines were just another helping service. For the higher frequency chronic callers, they stated the crisis lines usually were their only helping resource. For all the callers, they said crisis line personnel provided support, contact, and friend-like relationships.

All callers shared a characteristic alcohol or other drug addicted family background. Coming from either severely abusive or neglectful families, a pattern of victimization seemed set in motion that repeated through out their lives in helping and other intimate relationships.

They all said they entered therapy and other treatment early in life, often forced into treatment for physical, emotional or

mental ills by their parents and families. Here the callers
began their long history with helping resources.

All callers reported prolonged health concerns, often
generating personal and physical limitations for them. With
their health limitations, they indicated limited employment and
reduced financial resources. These financial and physical
limitations then created a block for the callers to engaging a
social and support network.

All the callers reported some friends or acquaintances,
though very few said they had current special relationships.
They revealed a challenging relationship history and little
family contact. Most often they showed they felt isolated from
family and friends. Their ability to engage and use their
support network often appeared very limited.

Lower frequency chronic callers reported a history of
positive therapeutic experiences. They said they remained
involved with many helping services. Because they experienced
neglect and were usually ignored by their families, they tended
to report more positive experiences with helpers and the crisis
lines, these callers appreciating the contact and support they
receive. With more helping resources and continued positive
therapy, they indicated they telephoned crisis lines less often
and only for practical help.

Higher frequency chronic callers reported a history of
negative therapeutic experiences. Abused in their homes, they
suggested the victimization continued throughout their lives,

often into the helping relationships they established. They
frequently mentioned inconsistent and inappropriate therapy,
developing a reluctance for engaging other helping services.
They revealed the crisis lines had become a therapeutic resource
for them.

With increased telephoning, the higher frequency chronic
callers reported the crisis line workers responded with call
management. Restricted by the crisis lines, the callers regarded
the restrictions as another negative helping experience, like the
ones they had before. The callers said they were mistreated by
the crisis lines. However, when they complained about the
service, they said they were disregarded by the crisis line
personnel.

These characteristics can allow for the better
identification and more effective management of chronic caller
contacts. Crisis line personnel easily can screen for chronic
callers within the helping process for any first time, or more,
caller. Background information on the callers' support network
and their experience with other helping resources would be
appropriate to obtain from callers to help resolve the problems.
This information then could be used to identify potential
chronic callers from the characteristics. Crisis line personnel
could obtain additional information from further calls to more
confidentially identify chronic caller. However, further calls
may set a pattern of telephoning and interaction that is
difficult to break.

A continued cycle of telephoning is initiated with the chronic callers looking to the crisis lines to fulfil their needs for contact and therapeutic assistance. When crisis line personnel respond to the movement away from crisis intervention and initiate call restrictions, the chronic callers indicated they experienced a sense of victimization similar to their earlier life and previous therapeutic history. The telephone workers then struggle to overcome both the callers' sense of victimization and inappropriate use of crisis lines.

Both the callers and crisis line personnel are frustrated by the mismatch of caller needs to crisis line service. With earlier identification and intervention, crisis line personnel can respond better with management strategies that reduce and eliminate the most challenging aspects of chronic caller contact. Crisis line workers can inform the callers about the limits of the crisis line service while engaging them in the helping process. The chronic callers are respected and some of their needs met within the maintained and clarified boundaries of crisis line service.

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Footnotes

1. Johnson, Kay. Executive Director, Langley Hospice Society, Langley, BC.

2. Marshall, Dayna. Supervisor, Ishtar Transition House, Langley, BC.

3. Chand, Manjit. Supervisor of Volunteers, Richmond Crisis Centre, Chimo Personal Distress Intervention Service in Richmond, Richmond, BC.

4. Rawlyns, Joan. Supervisor, Langley Crisis Line, Langley Family Services, Langley, BC.

5. Lohnes, Tammy. Coordinator, Greater Coquitlam Crisis & Information Line, Share Family & Community Services, Coquitlam, BC.

6. Knight, Diane. Crisis Line Facilitator, Mission Crisis Line, Mission Community Services Society, Mission, BC.

7. The letters after the quotes identify specifc subjects. The letters correspond with the identification letters used in the tables and figures.

Appendix A

Sex Callers

The caller seeking sexual stimulation can be subdivided into two types of sex callers:
1. The caller who openly admits he wants to masturbate or is already in the process of masturbating. He pleads with the telephone counsellor to stay on the line until he is finished.
2. (a) The caller tells a fantasy problem presented as real. Usually, but not always, it is of an overt sexual nature. While talking with the telephone counsellor, he masturbates. (b) The caller tells a fantasy problem. However, rather than masturbating during the call, he uses the discussion as sexual stimulation and masturbates after completing the call.

Detecting the Sex Caller

The following characteristics need to be all considered when identifying a sex caller. A caller demonstrating one of these characteristics in isolation should not be deemed a sex caller. Rather, a combination of these characteristics is more indicative of a sex caller. A call exhibiting three of more of these characteristics is most often a sex caller.

Common Characteristics
1. Voice tone devoid of emotion
2. Hesitation in speaking
3. Gives first name immediately and/or asking for the telephone counsellor's name
4. Asks personal questions about the telephone counsellor
5. Great deal of caller silence
6. Resistance towards resolution of the problem
7. Presents self with innocence about sex
8. Uses the word "embarrassing" frequently
9. Asks the telephone counsellor's opinion about the "problem"
10. Gives detailes sexual description
11. Use of formal language in describing sex acts or body parts
12. Hangs up abruptly before call is completed
13. Resists talking about feelings
14. May sound like the caller is calling long distance
15. Uses a whispery tone of voice
16. States age as 17

Common Opening Lines
1. I want to talk.
2. Can I talk about anything?
3. Is there a man there that I can speak to?
4. I've never called before.
5. Are you understanding?
6. Will you talk to me?
7. I have an embarrassing problem.
8. I'm lonely.

9. Have we talked before?

Common Story Themes
1. Dominant woman
2. Asking for sexual information or advice
3. Penis is too large or too small
4. Sex with female members of the immediate or step-family
5. Lending girlfriend or wife to another man or woman
6. Multiple sexual participants
7. Enjoying sex with young boy or girl
8. Transvestism
9. Fetishism
10. Voyeurism
11. Nudity
12. Humiliation
13. Sado-masochism
14. Bladder control

Adapted from:
Wark, V. (1984). The sex caller and the telephone counseling center. Springfield, IL: Charles C. Thomas.

Appendix B

Protocol for Requesting Participation of
Return Callers by Telephone Workers

Before you go, [person's name if known], the crisis line would like to make a request of you. The request depends on whether you have called crisis lines before. If you have, you can help us out in better understanding how crisis lines are useful to return callers. Likewise, if you are a return caller, we believe if we know more about our callers, we would be better able to provide service to them. Have you used a crisis line before?

If no, thank them for listening to the request and hang up.

If yes, ...

Great! Since you have called crisis centres more than once, you can be very helpful to us. You really are in a unique situation.

The request we would like to make of you is written up. I need to read it pretty well word for word to make sure I tell you everything I need to.

We are part of study to understand how crisis lines are responding to return callers. Also, we believe if we know more about our return callers, we would be better able to provide telephone service to them. We would really appreciate your help with this. Are you interested in participating?

If no, thank them for their time and listening. Hang up.

If yes.....

Okay, thanks. Now let me give you a little more detail. This will take a couple of minutes because I need to tell you exactly what you may choose to help with.

The person who would be talking with you is Richard Kramer. Richard is the person doing the study. He is a student at the University of British Columbia. He is doing this research to finish a masters degree in counselling psychology. He's worked with crisis lines in the past for eight years.

Richard hopes to speak with return callers. The goal is improving crisis line service to return users, like yourself, by knowing you better and how crisis centres serve you.

Your participation is voluntary. The crisis line is <u>not</u> doing the research. You won't receive any extra time, special attention or special treatment from the crisis line if you help. Likewise, you won't lose anything if you don't help either. The

research findings <u>may</u> result in changes to crisis lines that could benefit you.

What do you think so far?

If any question comes up about how the research will be conducted, who will have the information, or what will the crisis line gets back from the research, say: "I believe I have the answer for that coming up", and continue with the protocol below.

If any other questions come up for the callers, use the scripted questions and answers below, and then continue with the protocol.

If no questions or other concerns come up, continue with the protocol below.

The interview would be done over the telephone. There would be no face-to-face contact with anyone.

The interview will take a hour and a half. This really would give you a chance to talk about the service you are getting and how the crisis lines could serve you better. However, the interview doesn't have to be done all at once. For whatever reason, another time to talk can be set up.

What you said would be confidential to the researcher, Richard. Only he would know your answers to any questions. We would not be told what you said about any service you have received or what you said about yourself. He is talking with a lot of different people. All we would be told is a general description of what our callers are like, and what they think about the service they're getting from crisis lines. Also, we would get suggestions on how we might be more helpful to return callers like yourself. We would find this information very useful and would appreciate your help.

Do you have any questions?

<<*possible questions and answers*>>

How many people are you talking to? OR How many other people have you asked so far?

Richard hopes to talk to around 15 or 20 people. The more people he talks to, the better the understanding of return callers to crisis lines. And the more helpful the study to the crisis lines to improve their service to return caller.

Is it going to be tape recorded?

Richard would like to record the interview. He doesn't want

> **<<options box continued>>**
>
> ***...or if interviewer phoning caller...***
>
> The interviewer, <u>Richard Kramer</u>, will telephone [<u>telephone number given</u>], and ask for [<u>name caller gave</u>]. Is that right?
>
> ***...and continue with protocol outside options box.***

After response from the caller, and corrections in any misunderstandings if needed....

Now, if you have any problem with the interview time or day, feel free to phone Richard about it.

Thanks again. Your help is appreciated. Take care.

Appendix C

Protocol for Requesting Participation of Return Callers by Telephone Workers, Workers not Scheduling Interview Times

Before you go, [person's name if known], the crisis line would like to make a request of you. The request depends on whether you have called crisis lines before. If you have, you can help us out in better understanding how crisis lines are useful to return callers. Likewise, if you are a return caller, we believe if we know more about our callers, we would be better able to provide service to them. Have you used a crisis line before?

If no, thank them for listening to the request and hang up.

If yes, ...

Great! Since you have called crisis centres more than once, you can be very helpful to us. You really are in a unique situation.

The request we would like to make of you is written up. I need to read it pretty well word for word to make sure I tell you everything I need to.

We are part of study to understand how crisis lines are responding to return callers. Also, we believe if we know more about our return callers, we would be better able to provide telephone service to them. We would really appreciate your help with this. Are you interested in participating?

If no, thank them for their time and listening. Hang up.

If yes.....

Okay, thanks. Now let me give you a little more detail. This will take a couple of minutes because I need to tell you exactly what you may choose to help with.

The person who would be talking with you is Richard Kramer. Richard is the person doing the study. He is a student at the University of British Columbia. He is doing this research to finish a masters degree in counselling psychology. He's worked with crisis lines in the past for eight years.

Richard hopes to speak with return callers. The goal is improving crisis line service to return users, like yourself, by knowing you better and how crisis centres serve you.

Your participation is voluntary. The crisis line is <u>not</u> doing the research. You won't receive any extra time, special attention or special treatment from the crisis line if you help. Likewise, you won't lose anything if you don't help either. The

research findings <u>may</u> result in changes to crisis lines that could benefit you.

What do you think so far?

If any question comes up about how the research will be conducted, who will have the information, or what will the crisis line gets back from the research, say: "I believe I have the answer for that coming up", and continue with the protocol below.

If any other questions come up for the callers, use the scripted questions and answers below, and then continue with the protocol.

If no questions or other concerns come up, continue with the protocol below.

The interview would be done over the telephone. There would be no face-to-face contact with anyone.

The interview will take a hour and a half. This really would give you a chance to talk about the service you are getting and how the crisis lines could serve you better. However, the interview doesn't have to be done all at once. For whatever reason, another time to talk can be set up.

What you said would be confidential to the researcher, Richard. Only he would know your answers to any questions. We would not be told what you said about any service you have received or what you said about yourself. He is talking with a lot of different people. All we would be told is a general description of what our callers are like, and what they think about the service they're getting from crisis lines. Also, we would get suggestions on how we might be more helpful to return callers like yourself. We would find this information very useful and would appreciate your help.

Do you have any questions?

<<*possible questions and answers*>>

How many people are you talking to? OR How many other people have you asked so far?

Richard hopes to talk to around 15 or 20 people. The more people he talks to, the better the understanding of return callers to crisis lines. And the more helpful the study to the crisis lines to improve their service to return callers.

So, if there are no more questions, are you still interested in participating?

If the caller is uncertain or says no, try to clarify the reasons and correct any misunderstandings, if possible. Thank him or her for the time and hang up.

If yes, ...

Great! All I need to give you now is the telephone number where you can call Richard to set up an interview time.

Do you have a pencil?

When yes...

Okay, the telephone number is 856-4274. If this phone number is long distance for you, please call collect.

You can pretty well call him anytime between 8:00 am and 11:00 pm to set up an interview time.

I want to say again your participation in this study will be very helpful to crisis lines. You really are in a unique situation to give valuable information to us.

Thanks again for your participation. Your help is appreciated. Take care.

Appendix D

<u>Protocol Confirming Participation of
Return Caller by Interviewer</u>

Hello. Is this [<u>name caller gave</u>]?

If no...

May I talk to with [<u>name</u>]?

If yes...

Oh, great! Thanks for agreeing to be interviewed for this study.
I'm Richard Kramer. I'm the interviewer.

Before we begin, I would like to say again what's going to
happen. I have it written up. I need to read it pretty well
word for word to make sure I tell you everything I need to.

The purpose of this interview is to get information that will
help crisis lines better help out return callers. As someone who
has used crisis line services before, you can be very helpful to
us. You can tell us what crisis lines do for you and how they
affect you. Also, crisis lines would benefit by knowing about
return callers so that they can better help and work with them.
That's what the interview is all about: your experiences with and
your thoughts about crisis lines. And what we need to
understand about you to give you better service.

The answers from all the people I interview, and I'm interviewing
about 15 to 20 people, will be put together for the report.
Nothing you say will ever be identified with you personally. You
will remain anonymous and unnamed in the final report.

Anything you tell me about yourself will remain only with me. No
identifying information about yourself will be given to anyone
else. And I want to mention specifically this includes the
crisis lines.

The interview may take a hour and a half, probably less. This
really would give you a chance to talk about the service you are
getting and how the crisis lines could serve you better.
However, the interview doesn't have to be done all at once. For
whatever reason, another time to talk can be set up.

I want to say you won't lose or gain anything by being part of
this study. Any special arrangement you may have with a crisis
line won't change whether you participate or not. The crisis
line is <u>not</u> doing the research. I'm responsible for what happens
during the interview, <u>not</u> the crisis line.

Appendix E

Interview Protocol

I would like to start with how you believe crisis lines are serving you. I really want to get a sense of what the service you are getting from them is like. I would like to know how often you telephone and what happens when you call. Also, how you believe crisis lines have influenced you.

Frequency and Duration of Ongoing Contact

1. You've said that you have phoned crisis lines more than once. The first thing I would like you to do is think about the different times you've telephoned. Can you go back and think about the times you've called in the last few days,...the last week,...the last few weeks? With this in mind...:
    a. How often do you phone crisis lines?
    b. How consistent is that contact? Like, do you phone everyday, every other day, three times a week for a few months, then not at all for awhile?
    c. When did you first start calling crisis lines?
    d. How did you first find out about crisis lines?

Reasons for Contacting the Crisis Line

2. I would like to talk about your use of crisis lines so that I can understand better how this fits into your everyday life.

Think of a fairly typical recent day that would give me a good picture of how you use crisis lines. Can you think of one?

Negotiate on the day

Now I would like you to tell me how calling crisis lines fits into the day. Like, what's going on for you when you call? What's your reasons for calling?

Callers Reactions - Likes and Dislikes - about Crisis Lines

3. Now that we talked about your usual call to the crisis line, overall...
    a. What do you like about crisis lines?
    b. How about the other side? What do you not like about crisis lines?

Caller Recognition by Crisis Line

4. I imagine that if you have phoned a crisis line more than once, with any frequency, the workers would begin to recognize you. Some people may find the recognition a relief. They feel more comfortable with someone that knows them and not having to

repeat their story. Others may find the recognition annoying.
They even may feel threatened because they didn't want to be
recognized.
>   a. How do you feel when they recognize you?
>   b. How does the telephone worker respond once he/she knows
it's you?
>   c. How do you feel when they don't recognize you?
>   d. What differences in service do you notice when the
workers don't recognize you?

Purpose in Telephoning Crisis Lines

5. Crisis lines help those callers in crisis or distress cope and
work through their problems. Others, besides those in crisis,
also telephone, perhaps for support or contact, perhaps to
problem-solve with another person.
>   a. Generally, what do you phone the crisis line for?

Life Changes and the Crisis Line

6. Crisis lines help people through their crises and provide
support to callers through difficult times. Besides this, crisis
lines hope to encourage change in the people who call.
>   a. In the time you have been telephoning crisis centres, how
has your life changed?
>   b. How have the crisis lines added to your life changes?

Helps and Hinders the Most from Crisis Lines

7. People phone crisis lines for many different reasons. Often,
they have pressing concerns, or they reach out for support in a
time of loneliness or distress. These people find crisis lines
helpful because of the workers that listen and understand,
provide support, and help find solutions to their problems.
Others find crisis lines frustrating because the workers only
want to help with the callers' problems. The workers don't seem
too friendly or willing just to talk. For yourself:
>   a. What do you think helps you the most from crisis lines?
>   b. What do you find not so helpful from crisis lines?

Caller Preferences on Crisis Centres

8. As you probably know, there is more than one crisis line in
the Lower Mainland and Fraser Valley area. Some people find it
useful to call some phone lines over others because of the
service they get, the workers they talk to, or just personal
likes or dislikes.
>   a.Which crisis lines do you like phoning?
>   follow-up probe: *What do they do that you like phoning*
them?
>   b. Which crisis lines don't you talk to, or don't find
useful phoning?

follow-up probe: What do they do (or have they done) that you don't find it useful to call them?

Crisis Line Changes to Serve the Caller Better

9.   a. How do you think crisis lines could change to serve you better?
       b. What do you think would be different in your life if these changes happen?

Caller Contact with other Community Services

10. We appreciate your feedback on how crisis centres serve you. Your return use tells us that in some way crisis lines are an important part of your present life. Still, we know that crisis centres aren't the only services available in the community. We know people have different needs met by other services.
       a. Besides crisis lines, what other services have you used or do you use in the community?
          follow-up probes: (i) How much contact do you have with these other services?
          (ii) How did you find out about these services?
       b. Crisis lines are a bit like counselling or support over the telephone. So, besides the community services you've mentioned, what has been your experience with counselling or therapy?
          ...if yes...follow-up probes: (i) When was that?
          (ii) What problems did you deal with?
       c. How does the crisis line service differ from the other services you have used or are using?

Before I ask you some questions about your life experiences, are there any other comments you would like to add about crisis lines?

This next set of questions is about your own life and experiences. The purpose in these questions is to help crisis lines understand the different people that have used their phone services more than once.

I want to get to know callers, like yourself, by asking about your background. This isn't meant to be a brain-picking exercise. You can answer the questions with as little detail as you want. And you don't have to answer any question you feel uncomfortable with.

A person's background is important to help better and to start needed services in the community. To use an example:

In the past school teachers had noticed that some students fell asleep in class, appeared distracted, and did poorly in school.

The original thought here was that the children were just bad students. When we started asking about their background, we started to see that some of these students came to school without breakfast. Hungry and lacking energy, they fell asleep and did poorly. Breakfast and lunch programs were started to feed the children ... and their attention and grades improved. With other students they found learning difficulties. They couldn't understand what was going on in the classroom and became distracted, bored and got poor grades. When special help and teachers were used to deal with the children's learning problems, the students attention and grades improved.

The example gives the idea behind asking questions about your current life and background. We are looking to understand your current and past life experiences so that phone services may be improved or changed or new services started to meet your needs.

Support Network: Current Friends

11. To start to get to know you better, I would like to ask about what support you have. That is, those persons you talk to, visit, and socialize with usually. We know from talking with callers that people often phone the crisis line when those they turn to for support are tire of hearing the callers' difficulties. Others phone when they feel their usual supports won't understand or will judge them. Some callers phone the crisis line looking for support because they are away from family and friends, or because they like being alone over having many people around. I'm interested in those relationships you have with your family and friends.
     a. How many different people do you see regularly?
     follow-up probes: (i) Who are they?
               (ii) How often do you see them?
               (iii) How would you describe your relationships with
them?
               (iv) How much about yourself do you tell them?
               (v) What are a few of the things you do together?

Support Network: Past Friendships

12. I'd like to talk about your past friendships for a bit.
     a. How were your relationships with your friends?

Support Network: Family

13. A person's family can be an everyday support. Likewise, they can be a major pain.
     a. When you think about your parents, your brothers and your sisters, how much contact do you have with your family?
     b. Where's your family now?
     c. How would you describe your current relationships with

your parents, brothers and sisters?
        follow-up probes: (i) How do you feel about that
relationship?
                (ii) What do you think about that relationship?
        d. As you were growing up, how would you describe the
relationships in your family?

Support Network: Current Relationships

14. I'd like ask about your current relationships to find out
about the support you have now.
        a. Do you have a special someone in your life right now?
        ...*if yes, probe: (i) What is that like?*
                (ii) What do you enjoy about your current relationship?
                (iii) What are some challenges in your current
relationship?
        b. What previous relationships have you had?
        ...*if yes, probe: (i) What did you enjoy about these*
relationships?
                (ii)How were they challenging?
                (iii) What happened that these relationships ended?
        c. If you have any children, what is your relationship with
them like?

Before I ask you a little bit more about your family background,
are there any comments you would like to add about your friends
or family support?

Okay, I'd like to ask some questions around your family
background. I come from the belief that what we are today, at
least a little bit, is part of our family background. The idea
here isn't to blame anyone in your family for anything happening
in your life today. The idea in asking about your family
background is to understand your better, and, perhaps, be able to
adapt crisis line service to help you better.

The family can be a sensitive area for some people. I'm not
looking for skeletons in the closet. All I would like is that
information that you are comfortable giving. You don't have to
answer any question you don't want to.

Changes in the Family

15. Sometimes major changes in our family can greatly influence
for the good or bad our family life. The changes can be very
disruptive, or they can bring the family closer together.
        a. For yourself, what were some major changes that occurred
in your family....like births, deaths, severe illness or injury,
marriages, separations or departures....that influences you?
        b. How did your family members react to these changes?

Mental Health and Substance Misuse in the Family

16.   Sometimes when we have a family member with a mental illness or alcohol or other drug problem, the family relationships can be thrown into chaos. Fights over someone's drinking. The mentally ill family member acting oddly around the home or in the neighbourhood. These experiences can have effects on other family members years after.
      a. What was the mental health of other family members like growing up?
            ...if yes...follow-up probe: (i) What was the affect of the mentally ill family member on the family?
      b. What has been your experience with alcoholism or drug addiction growing up in your family?
            follow-up probes: (i) Who was the alcoholic or drug addict?
            (ii) How do you believe that has affected you today?
      c. What has been your experience with mental illness or alcohol and other drug misuse in your family today?

Would Have Liked, and Never Received

17. One last question about your family - What would you have liked from your family you never received?

Before I ask you some questions about your health, are there any comments you would like to add about growing up in your family?

The next questions I would like to ask deal with mental health, alcohol and other drug use, and suicide. These can be sensitive issues for some people. I would like only that information you're comfortable talking about. Please don't answer anything you don't want to.

Mental Health

18. Crisis lines regularly refer callers to other services in the community. Also, community services such as doctors, mental health, alcohol and drug programs, et cetera, will recommend to their clients crisis lines as a place for between appointment support.

We know from experience and research with callers that many people using crisis lines have had previous contact with mental health. They also could be using mental health services presently. We understand that sometimes up to three quarters of our callers can be experiencing some type of mental illness - from panic attacks, to depression, to schizophrenia. Knowing a caller's mental health background really can help crisis lines give more useful service to the individual.
      a. What type of mental health support are you using?
            follow-up probes: (i) What type of treatment and

medications are you getting?
        (ii) What is that for?
    b. What has been your previous experience with mental health services?
        follow-up probe: (i) What was that for?

Suicide

19. Crisis centres often were started to help those people feeling suicidal. We know from research and experience with callers that many people telephoning crisis lines are suicidal or have been suicidal in the past.
    a. How often have you telephoned the crisis line feeling suicidal?
    b. Have you ever attempted suicide?
        ....if yes, probes: (i) When was that?
        (ii) What were the circumstances around your suicide
attempt?
        (iii) What type of help did you receive at the time?

I would like to talk about alcohol and other drug use next. Again, this can be a sensitive area for some. You don't have to answer any question you don't want to. Please just give what information you're comfortable giving.

Alcohol and Other Drug Use

20. Alcohol and other drug use is very common among people, and callers to crisis lines are no different. Frequently people telephone the crisis line having had some alcohol or drugs beforehand. Some of these people don't think their alcohol or drug use is a problem. Other callers worry about their use of drugs or alcohol.
    a. What do you think about your alcohol and other drug use?
    b. What type of difficulties have you had from using drugs or alcohol?

Are there any other comments you would like to add about your well-being or health?

Final comments

Is there anything else that you would like to add now that we are closing the interview?

Ending Protocol

Thanks a lot for your help.

Would you be interested in talking about your interview once it

was done up? I could call you back or you could call me back. I
would read you a summary of the interview. That way you could
hear what you said and if it was right.

> *If yes, schedule a call back time. Negotiate date and time as
necessary.*

<<options box>>

...for caller call back...

Okay, you can call me back on [date] at [time]. The telephone
number will be 856-4274.

...and continue with protocol outside options box.

...for interviewer call back...

Okay, can I call you back on [date] at [time]?

Once scheduled...

What number can I reach you at?

...and record telephone number with date and time...

...and continue with protocol outside options box.

> *If no...and to continue....*

Okay. Would you be interested in finding out how the study
turned out?

If yes...

Good. You can phone back in October to me, Richard Kramer, at
856-4274, my home, or 534-7921, my work. I'll tell you how it
turned out.

If no....

I want you to know, if you phone other centres, other crisis
lines are asking callers to participate in this study as well.
I'm telling you this so that you know that you may be asked
again.

And one last thing before I go. If you have any concerns over
what you said in the interview, or feel uncomfortable or upset by
how the interview went, please contact me, Richard Kramer, at
856-4274, my home, or 534-7921, my work. I'm the research person

and responsible for the study, <u>not</u> the crisis lines. I'm available to help you with your concerns and unease.

Again, thanks a lot. I really enjoyed getting to know you. Your help with this study is very much appreciated. Take care.

Appendix F

Initial Codes

DESCRIPTION	CODE	QUESTION
THE CALL OR CALLING	[CALL]	can be thru out
CALL: FREQUENCY OR REGULARITY	CALL-FRQ	1.a.b.
CALL: ORIGINS OR START	CALL-ORG	1.c.d.
CALL: ISSUES CALLER PHONING WITH	CALL-REAS	2
CALL: CALLER RECEIVING FROM CRISIS LINES	CALL-GETS	5.a.
THE CRISIS LINES	[LN]	can be thru out
LN: CALLER LIKES, FINDS HELPFUL OR POSITIVE	LN-POS	3.a., 7.a., 8.a.
LN: CALLER DISLIKES, FINDS HINDERING OR NEGATIVE	LN-NEG	3.b., 7.b., 8.b.
LN: CALLER HAS NEUTRAL OR UNCERTAIN REACTION REGARDING	LN-MIX	3., 7., 8.
LN: HOW THE CRISIS LINES COULD CHANGE	LN-CHNG	9.a.
....FOR THE PUBLIC	LN-CHNG/PUB	9.a.
....FOR THE CALLER SOLELY	LN-CHNG/PRIV	9.a.
LN: HOW CRISIS LINES ARE DIFFERENT FROM OTHER SERVICES	LN-DIFF	10.c.
LN: CALLERS' REACTIONS TO POSITIVE EXPERIENCE WITH CRISIS LINES	LN-POS/REAC	3.a., 7.a., 8.a
LN: CALLERS' REACTIONS TO NEGATIVE EXPERIENCE WITH CRISIS LINES	LN-NEG/REAC	3.b., 7.b., 8.b.
LN: HOW CALLERS' LIFE WOULD BE DIFFERENT IF CRISIS LINES CHANGED	LN-CHNG/LIFE	9.b.
RECOGNITION OF THE CALLER BY CRISIS LINES OR THE TELEPHONE WORKER	[KNOW]	4
KNOW: POSITIVES OF RECOGNITION	KNOW-POS	4.a.b.c.
KNOW: NEGATIVES OF RECOGNITION	KNOW-NEG	4.a.b.
KNOW: POSITIVES OF NOT BEING RECOGNIZED	KNOW-NOT/POS	4.c.
KNOW: NEGATIVES OF NOT BEING RECOGNIZED	KNOW-NOT/NEG	4.c.
KNOW: DIFFERENCES BETWEEN THE TIMES RECOGNIZED AND TIMES NOT	KNOW-DIFF	4.d.
THE CALLERS' LIFE	[LIFE]	can be thru out
LIFE: HOW CALLER'S LIFE HAS CHANGED SINCE PHONING CRISIS LINES	LIFE-CHNG	6.a.
LIFE: HOW CRISIS LINES CONTRIBUTED TO THESE LIFE CHANGES	LIFE-CHNG/LN	6.b.
LIFE: HOW OTHER SERVICES HAVE CONTRIBUTED TO THOSE LIFE CHANGES	LIFE-CHNG/OTH	6.
LIFE: HOW OR WHERE THE CALLER'S LIFE IS STUCK	LIFE-STCK	can be thru out
LIFE: HOW CALLER HOPES LIFE WILL CHANGE	LIFE-CHNG/FUT	can be thru out

DESCRIPTION	CODE	QUESTIONS
CALLER'S SOCIAL SUPPORT NETWORK OF FRIENDS	**[NET]**	**11, 12**
NET: CALLER'S SOCIAL AND SUPPORT NETWORK, AND RELATIONSHIPS WITH THOSE FRIENDS	NET-REL	11.a.(i)(iii)(iv) 12.a.
NET: RELATIONSHIPS WITH FRIENDS IN PAST	NET-REL/H$_x$	11.a.(ii)
NET: FREQUENCY OF CONTACT WITH SOCIAL AND SUPPORT NETWORK	NET-FRQ	
CALLER'S FAMILY	**[FM]**	**13, 15, 16, 17**
FM: RELATIONSHIPS IN FAMILY	FM-REL	13.a.b.c.
FM: RELATIONSHIPS IN FAMILY IN PAST	FM-REL/H$_x$	13.d.
FM: MENTAL HEALTH/ILLNESS OF FAMILY MEMBERS	FM-MHTH	16.c.
FM: MENTAL HEALTH/ILLNESS OF FAMILY MEMBERS IN PAST	FM-MHTH/H$_x$	16.a.
FM: VERBAL, EMOTIONAL, PHYSICAL, SEXUAL ABUSE AND NEGLECT IN FAMILY	FM-ABU	15 and thru out
FM: ALCOHOL AND OTHER DRUG USE IN FAMILY	FM-A&D	16.c.
FM: ALCOHOL AND OTHER DRUG USE IN FAMILY IN PAST	FM-A&D/H$_x$	16.b.
FM: WHAT CALLER NEVER GOT FROM FAMILY	FM-NOT	17
FM: CHANGES IN FAMILY AS GROWING UP	FM-CHNG	15.a.
FM: FAMILY'S REACTIONS TO CHANGES	FM-CHNG/REAC	15.b.
CALLER'S SPECIAL OR SIGNIFICANT OTHER	**[SOT]**	**14**
SOT: RELATIONSHIP WITH SPECIAL OTHER	SOT-REL	14.a.
SOT: PAST RELATIONSHIPS WITH SPECIAL OTHERS	SOT-REL/H$_x$	14.b.
SOT: NO CURRENT SPECIAL OTHER	SOT-NOT	14.a.
SOT: ABUSE BY SPECIAL OTHER	SOT-ABU	14 and elsewhere
CALLER'S CHILDREN	**[CHLD]**	**14.c.**
CHLD: RELATIONSHIP WITH CHILD(REN)	CHLD-REL	14.c.
CHLD: NO CHILDREN	CHLD-NOT	14.c.
CHLD: PAST RELATIONSHIP WITH CHILD(REN)	CHLD-REL/H$_x$	14.c.
THERAPY OR COUNSELLING	**[THPY]**	**10**
THPY: POSITIVE EXPERIENCES WITH THERAPY OR COUNSELLING	THPY-POS	10.b.
THPY: NEGATIVE EXPERIENCES WITH THERAPY OR COUNSELLING	THPY-NEG	10.b.
THPY: FREQUENCY OF CONTACT WITH THERAPY OR COUNSELLING	THPY-FRQ	10.a.b.
THPY: HOW THERAPY OR COUNSELLING DIFFERS FROM CRISIS LINES	THPY-DIFF/LN	10.c.
THPY: THERAPEUTIC ABUSE	THPY-ABU	10 and elsewhere

DESCRIPTION	CODE	QUESTION
CALLER'S EXPERIENCE WITH MENTAL HEALTH	**[MHTH]**	**10, 18**
MHTH: CALLER'S MENTAL HEALTH AND EXPERIENCE	MHTH	10.a.b., 18.a.
MHTH: PAST EXPERIENCES WITH MENTAL HEALTH	MHTH-H_x	18.b.
MHTH: FREQUENCY OF CONTACT WITH MENTAL HEALTH	MHTH-FRQ	10.a.(i), 18
MHTH: HOW MENTAL HEALTH DIFFERS FROM CRISIS LINE	MHTH-DIFF/LN	10.c.
CALLER'S PHYSICAL HEALTH OR EXPERIENCES WITH MEDICAL SERVICES	**[PHTH]**	**10**
PHTH: CALLER'S PHYSICAL HEALTH AND EXPERIENCE	PHTH	10.a.
PHTH: PAST EXPERIENCES WITH PHYSICAL HEALTH	PHTH-H_x	10.a.
PHTH: FREQUENCY OF CONTACT WITH HEALTH SERVICES	PHTH-FRQ	10.a.(i)
CALLER'S CONTACT WITH OTHER COMMUNITY SERVICES	**[COMY]**	**10.a.**
COMY: CALLER'S EXPERIENCE WITH OTHER COMMUNITY SERVICES	COMY-OTH	10.a.
COMY: FREQUENCY OF CONTACT WITH THESE SERVICES	COMY-OTH/FRQ	10.a.(i)
SUICIDE	**[SUI]**	**19**
SUI: FREQUENCY OF SUICIDAL THOUGHTS AND FEELINGS	SUI-FRQ	19.a.
SUI: SUICIDE ATTEMPTS	SUI-H_x	19.b.
CALLER'S ALCOHOL AND OTHER DRUG USE	**[A&D]**	**20**
A&D: CALLER'S PERSONAL EXPERIENCES WITH ALCOHOL AND OTHER DRUG USE	A&D	20.a.b.

Appendix G

Pattern Codes

CODES   **DESCRIPTION**

VICTIM   VICTIMIZATION: This includes those incidents where
            the callers are actually physically, verbally or
            emotionally abused by family, special others or
            helping professionals. This also includes where
            the callers are neglected. Also, this includes
            those circumstances where the callers are unable
            to get what they need, or denied a service, or
            have some service forced on them because of their
            real or perceived lack of power in the situation.

ESTEEM   SELF-ESTEEM BUILDING/ EMPOWERMENT: This
            encompasses those qualities and interactions that
            the callers have phone workers, professionals and
            significant others in their lives which enhance
            their self-esteem and empower them to healthier
            living. For example: validation, acceptance,
            acknowledgement of them and their experience,
            information and referrals, brain-storming and new
            perspectives on their concerns. Their actions
            imply empowerment and esteem when they are able to
            stand-up for themselves; take actions which
            improve their physical, mental or emotional
            health; and chose healthier, less dependent
            relationships for them selves.

LONELY   ISOLATION: This includes the callers expressions
            of loneliness and isolation from others due to
            their physical or financial limitations, their
            lack of appropriate social skills to engage their
            support network of family or friends, and their
            emotional or mental challenges. The isolation
            they have experienced is shown in the abusive and
            dysfunctional families that they have grown up in
            which hamper their connections with the family and
            a social network. Where their families and others
            are not available to them, the callers are
            isolated.

CODES	DESCRIPTION
CONNECT	CONNECTION: This encompasses the callers building relationships and connecting with others, like friends, crisis lines, family members, and helping professionals. Connecting with others is shown through having friendships and social time with others and having conversation and being listened to by helpers. Rapport and contact is there in the relationship with the friend, family or professional. Also, connection is implied by the callers being emotionally understood and understood generally, and where they share similar experiences with helpers.