

A DESCRIPTIVE STUDY OF THE INFORMATION PROGRAMS
OF THREE SUICIDE PREVENTION CENTERS IN KANSAS

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STATEMENT OF THE PROBLEM

A suicide prevention center, or any service, must be known to potential consumers of its services if it is to function.

Emile Durkheim defined suicide as "all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result."¹ He defined an attempt as such an act which falls short of death.² Other writers, however, argue that attempted suicide and completed suicide are separate phenomena.³

A suicide prevention center is, as used in this paper, a twenty-four hour telephone crisis intervention service. Its first responsibility is not so much counseling, but referral. These centers are often called upon, however, to prevent an immediate suicide, as well as to deal with other kinds of crisis and with people who want to avoid waiting lists for counseling services.

Three suicide prevention centers in Kansas, located at Wichita, Kansas City, and Topeka, were used in the study. The centers in Wichita and Kansas City are called Suicide Prevention Centers. The center in Topeka is called Can Help in order to avoid the implication that one must be suicidal to call. The Wichita and Kansas City centers are

operated as part of the activity of community mental health clinics. Can Help is staffed and budgeted under the Mental Health Association of Shawnee County and Shawnee County Mental Health Corporation.

The three centers are in operation twenty-four hours a day. None of them have contact with clients other than by phone, but they have agreements with other agencies to dispatch emergency services and follow-up. Can Help uses lay volunteers, trained by the Department of Psychiatry and Religion of the Menninger Foundation, to answer the telephone. Wichita and Kansas City centers use an answering service with professional back-up. Each of the three centers employ only one staff person. At the Wichita and Kansas City centers, the staff person has additional duties as an employee of the mental health clinics. At the Topeka center, she has additional duties at the Mental Health Association.

The purpose of the study is to investigate the methods of public information used, frequency of information approaches, personnel who carry out these functions, planning of the information program, obstacles to a more adequate information program, and the directors' evaluations of their information programs.

The study of mass communication of suicide prevention information is a contribution to the field of journalism and mass communications. A description of how these three centers communicate with the public will

be of interest to others interested in setting up information programs, and to those concerned about the communication of suicide prevention information.

METHODS AND PROCEDURES

Information was obtained by going to the centers and interviewing the staff of each center. Interviews were not standardized and questions were open-ended.

The following are questions asked:

1. Do you have a regular program of information?
2. Who is in charge of the information program?
3. Does anyone on the staff prepare news releases?
4. Do the media use the releases?
5. Do the media initiate publicity?
6. What ways other than through the news media does the suicide prevention center make itself known?
7. Does the suicide prevention center communicate through such facilities as doctor's offices, beauty salons, grocery stores, or public lavatories?
8. How adequate do you feel the information program to be?
9. What is the greatest obstacle to a better program?
10. How could the information program be improved?

Some additional questions were asked for general information about the centers. One question, how people who call find out about the service, would be of interest, but could not be taken up in this study. It would have been necessary to communicate to all volunteers in order to have them ask this question of callers. This was not

possible in the time schedule of the author or the directors of the centers.

REVIEW OF THE LITERATURE

Statistics

There are 20,000 recorded suicides a year nationally, but most authorities on the subject place the figure closer to 25,000. It is among the first ten causes of death, and the third cause for some age groups. There are eight to ten times as many attempts, perhaps 200,000 a year.⁴

The statistics indicate that attempts and completed suicides are separate phenomena. Three times as many men than women commit suicide. In old age, ten times as many men than women commit suicide. But three times as many women attempt suicide, although in old age the rate is lower. Most attemptors are young, although most successful suicides are middle-age or older. Three times as many whites than non-whites commit suicide.

The typical American suicide is a white male Protestant in his forties. He is married with two children, and is a taxpayer and breadwinner. Over the years, the community loses an estimated \$50,000 from a male suicide.⁶ In addition is the personal tragedy and stigma for his family.

Suicide figures are highest at the top of the occupational ladder, although they are also very high

among the unskilled and unemployed. Figures are lowest for married people, especially with children, and highest for divorced persons, especially men.⁷

Highest suicide rates are in apartment house districts in both advantaged and disadvantaged areas. One study demonstrated that suicide rates in any area are proportionate to the per cent of population in that area.⁸

About 25 per cent of suicides are alcoholics.⁹

These statistics on epidemiology give some implications as to target groups for suicide prevention information.

Prevention

Most potential suicides leave clues. In a study of 371 completed suicides, it was found that 60 per cent communicated their intentions to their spouses, 51 per cent to relatives and in-laws, 35 per cent to friends, and 18 per cent to physicians.¹⁰

In addition to outright threats, suicidal persons give disguised and subtle verbal clues, like "I don't want to be a burden," or "You'd be better off without me." They may also give nonverbal clues, like putting affairs in order or planning a trip. Behavior change and symptoms of depression may also signal a potential suicide.¹¹ Seventy-five per cent of successful suicides had seen a doctor within four months of the suicide.¹²

Information programs are needed for the lay public to learn to recognize these prodromal clues.

Suicide prevention stems from the sanctity of life and the wake of tragedy left behind. Suicide is not a free choice, but the product of an unwanted disease. A mentally healthy person can live through anything.¹³ Most people are suicidal for only a few hours, not weeks or months. During that time, they are ambivalent about dying.¹⁴

It is possible--indeed, it is almost always so--that an individual can drive toward suicide and make active plans for killing himself and at the same time have the strongest yearnings for intervention and rescue. . . .The typical suicidal person cuts his throat and cries for help at the same time.¹⁵

Many people who are saved after an attempt are grateful and gain renewed interest in life and in solving their problems.¹⁶

History and Functions

In 1955 the Los Angeles Suicide Prevention Center gained a grant for research from the National Institute of Mental Health as the national center for studies in suicidology. In 1958 the center opened its doors and telephone lines to the public as a suicide prevention service.¹⁷ It was then one of three such centers in the nation.¹⁸ Since that time, suicide prevention centers have been established in many locations across the country as part of the community mental health movement.

In 1963 the Community Mental Health Centers Act

established community-based centers for early detection and treatment and prevention of mental illness. The act was motivated at least in part by the Joint Commission on Mental Illness and Mental Health in 1961 which recommended prevention and treatment on a local level. The act was passed after President Kennedy made an unprecedented speech to Congress on mental health. The centers thus established must provide five services: inpatient treatment, out-patient treatment, partial hospitalization, consultation and education, and emergency twenty-four hour services.¹⁹

The suicide prevention centers at Wichita and Kansas City operate as emergency services for the community mental health centers in both locations. Can Help in Topeka is independent of the mental health center.

Edwin Schneidman, a psychologist at the Los Angeles Suicide Prevention Center, gives three functions of a suicide prevention center: (1) the prevention of suicidal crisis, (2) intervention during crisis, (3) postvention to reduce the effects of the attempt in the victim or survivors.²⁰

At the Los Angeles Suicide Prevention Center, only 1 per cent of the calls are cranks. One-third are in need of help, but are not suicidal, 10 per cent are suicidal, and 1 per cent are on the verge of death.²¹ These statistics are consistent with those of the Wichita Suicide Prevention Center, although 16.4 per cent at

Wichita are considered "seriously suicidal."

Robert Litman, also at the Los Angeles Suicide Prevention Center, reported that 64 per cent of patients in a follow-up study had followed the recommendations of the suicide prevention center. Within two weeks of the call to the center, 45 per cent initiated out-patient therapy; 18 per cent inpatient therapy, 11 per cent environmental change, and 26 per cent no action.²²

Schneidman pointed out four methods to reduce suicide rates: (1) increase recognition of potential suicides, (2) facilitate seeking help, (3) provide facilities and personnel for suicidal crisis, (4) educate the public about suicide. Number one is largely dependent on number four.²³

Effectiveness of a suicide prevention center, he said, may be judged by a reduction of suicide rates, and also by "outcomes short of or different from the clear-cut demonstration of the saving of a life. . . ." This may include increased cooperation with other agencies, increased dissemination of information relative to suicide prevention, and a decrease in the taboo or stigma of suicide.²⁴

Information-Education

There is little or no question about the existence of a taboo against suicide. Formerly suicide was anathema and was punished by mutilation of the corpse and

reprisals against the family. The Roman Catholic Church forbids burial of a suicide victim in consecrated ground. In nine states suicide is a crime.²⁵ Insurance companies refuse to pay for a suicidal death. Coroners are often reluctant to list a death as suicide because of the stigma to the family.

But Schneidman states that the taboo is ineffective in lowering suicide rates. "Indeed, quite the contrary seems to be true." Nor does study and research increase it, he says.²⁶ Lifting the taboo would result in more accurate statistics on suicide.²⁷

Dr. Stanley Yolles, then director of NIMH, has said:

Finally a key avenue to the reduction of suicide lies in dissemination of the facts about suicide. There is a giant body of mythology and erroneous folklore concerning it. One of the first tasks, therefore, in commencing a national suicide prevention program is to disseminate the solidly known facts--as opposed to the fables--to all citizens.²⁸

Correction of some of this folklore is crucial for suicide prevention. For example, the myth that people who talk about suicide don't do it, and improvement following a suicidal crisis means the suicidal risk is over.²⁹

Schneidman considers massive public education in training lay citizens in suicide detection the single most important element in suicide prevention,³⁰ by publishing clues to suicide, as has been done with cancer symptoms.³¹

In addition, there must be tailor-made programs

for "gatekeepers" of suicide, "who stand in the position early to recognize suicide or effectively to treat it." This would include physicians, police, nurses, social workers, and clergymen.³²

Other programs are needed for "opinion leaders"--those upon whom others rely for opinions. These are knowledgeable and successful people in professions, industry, and business who are consulted by others about issues of concern to them. They include editors, clergymen, educators, physicians, and judges.³³

It has been suggested that public education on suicide use the news media, plus usual gathering places such as schools and doctors' offices, as well as appropriate unusual places, such as pool halls and public lavatories.³⁴ Topics for which publicity would be appropriate might be reports of progress, long range plans, employment opportunities, and special news, such as appointments, awards, conferences, and untoward events, such as tragedies, scandals, or attacks on the services.³⁵

Antagonisms and obstacles

People cannot use a service they know nothing about. Unfortunately, many professionals in mental health and suicide prevention specifically are so fearful of adverse publicity through the press that they do not utilize it to further their cause.

The relationship of psychiatry and the press has

has not been a pleasant one. In the 1880's Nelly Bly wrote her series, "Horrors of the Mad House." Similar stories were written in the 1930's by another reporter who was admitted to a New York state mental hospital. (An interesting sidelight is that he had difficulty getting out. The psychiatrists said he needed treatment!)³⁶

The exposés offered no constructive suggestions and they made the doctors the scapegoats for the appalling conditions. Accordingly, the doctors developed an attitude that was almost a phobia of publicity.³⁷

More constructive exposés were written after World War II, often with the cooperation of superintendents and with blame placed on "an apathetic and ill-informed public and its legislative representatives."³⁸

In the 1940's the American Psychiatric Association opened its meetings and facilities to the press. In 1955 a conference on Special Problems in Communicating Psychiatric Subject Matter to the public was held in Massachusetts. Members of helping professions and journalism were invited.⁴⁰ One conclusion of the conference was that psychiatry and the press have joint responsibility for informing the public--and they must respect each other as professionals.⁴¹

Some of the obstacles cited in the conference and expanded by Everette Dennis, journalism professor at Kansas State University, include different objectives of psychiatrists and the press, lack of time, and breach of professionalism. The object of the press is to inform

the public and to find what is newsworthy, that is, having significance, human interest and timeliness. Psychiatrists want understanding and acceptance of the programs. Psychiatrists also often fail to consider the journalists' deadline, which often does not allow for an in-depth study and understanding of complex programs. Responsible for building up more hostility probably than these others, though, is the lack of trust implied in asking to check a story before publication.⁴²

Such attitudes and practices of mental health professionals toward the press hinder mutually beneficial relationships between agencies, such as suicide prevention centers, and the media.

Attitude Studies

Once information is printed or broadcast by the media, attitudes of the public may obstruct reception of the message. The Joint Commission on Mental illness and Health has pointed out the need for mental health information in general for the following purposes:

1. To overcome the general difficulty in thinking about recognizing mental illness as such--that is, a disorder with psychological as well as physiological, emotional as well as organic, social as well as individual causes and effects.
2. To overcome society's many-sided pattern of rejecting the mentally ill, by making it clear that the major mentally ill are singularly lacking in appeal, why this is so, and the need consciously to solve the rejection problem.
3. To make clear what mental illness is like as it occurs in its various forms and is seen in daily life and what the average person's reactions to it are like, as well as to elucidate means of coping with it in casual or in close contact.⁴³

Jum Nunnally, sociologist at Vanderbilt University, reported a study which found that the public holds negative opinions of the mentally ill. The public regards mentally ill persons as "relatively worthless, dirty, dangerous, cold, unpredictable, insincere, and so on." They were more negative toward psychotics than neurotics.⁴⁴

Psychiatrists Paul Lemkau and Guido Crocetti, however, report contradictory results of another study. They reported that 62 per cent of the subjects disagreed with the statement that, "Almost all persons who have a mental illness are dangerous." Most of the subjects stated non-rejecting attitudes.⁴⁵

Physicians in general were found by Nunnally to hold opinions on mental illness and health closer to those of mental health professionals than the public,⁴⁶ but they also view the mentally ill as "twisted, dirty, ineffective, and dangerous," as well as unpredictable and complicated.⁴⁷

It may be assumed that similar attitudes apply to suicidal persons. In addition, suicide is thought to be "evidence of weakness, a clear demonstration of being crazy, a sign of poor moral fiber and lack of courage, a declaration of sinfulness, inadequacy and guilt, or an inability to endure physical or emotional pain."⁴⁸

The chief difference between the mentally ill and the physically ill is felt to be that the mentally ill disturb and repel instead of evoking sympathy and

a desire to help.⁴⁹ The mentally ill stimulate fear-- fear of what the person might do, and "fear of what we ourselves might do if we acted out our impulses in a similar manner, fear arising from the power of suggestion that we, too, might suffer a similar fate."⁵⁰

This may particularly apply to suicides, Freud having delineated the death wish as a part of the psychological make-up of man. Probably everyone has had at least fleeting thought of suicide. The frank acknowledgement of suicidal impulses may be extremely threatening to another who is struggling with life.

Rationality and control are uniquely human qualities which the mentally ill lose. If the behavior of the mentally ill was made more predictable and understandable, it is hypothesized that it would not be so negatively regarded.⁵¹ Whether this would hold for suicidal impulses would make an interesting study.

In a national survey of a sample of 2,460 people, 20 per cent said they had felt they were going to have a nervous breakdown at some point in their lives.⁵² Nearly 25 per cent had had a problem in which professional help would have been useful. Fourteen per cent, most of whom were women, younger persons and more educated, had asked for help with some past problem.⁵³

Of the 20 per cent who felt they were having a nervous breakdown, 88 per cent saw a physician, 12 per cent a social service agency, 4 per cent a psychiatrist

or psychologist, and 3 per cent saw clergymen.⁵⁴

Of those who said they sought help for a problem, 42 per cent saw a clergyman 29 per cent a physician in general practice, 18 per cent a psychiatrist or psychologist, and 10 per cent social agencies or marriage clinics.⁵⁵

In a 1950 study in Louisville, most of those interviewed said they would see a general practitioner, clergyman, family or friends before resorting to seeing a psychiatrist.⁵⁶

Nunnally reported the finding, though, that the psychiatrist is considered the highest authority for mental problems. The more seriously the problem is stated as being, the greater is the tendency to choose a psychiatrist or psychologist over the family doctor as the person to consult. He also reported that the public does not associate mental problems with religion and would not seek help of clergy.⁵⁷ This is contradicted by survey researcher Gerald Gurin's finding of the 42 per cent of troubled persons who sought out clergymen, previously cited.

The Louisville study also revealed that most people regarded mental illness as a sickness, rather than deserving punishment or ridicule.⁵⁸ This is probably less true for suicide, considered by some to be the unforgiveable sin.

Nunnally reported that the public's information about mental illness is not crystallized. The public

is unsure about their beliefs and will readily change their opinions.⁵⁹ The public is not so much misinformed as uninformed.⁶⁰ The public holds opinions close to those held by mental health professionals,⁶¹ but part of the problem is the wide gaps in the knowledge of the experts. Another problem is the lack of vocabulary for discussing mental health concepts.⁶²

Nunnally found two groups of people who are misinformed: those with less than a high school education and those over 50. He found a positive correlation between agreement with mental health professions and years of formal education, and a negative correlation between agreement and age.⁶³

Interest in mental health topics, he reported, is about the same as for physical health topics, general information, and entertainment.⁶⁴ People are more interested in personal aspects than in mental health topics that don't concern them.⁶⁵ There is considerable interest in "danger signals" in mental illness.⁶⁶ This is especially the kind of information that is needed in suicide prevention.

Nunnally also found that interest is higher for messages that reduce anxiety and provide solutions to problems.⁶⁷ Low anxiety messages were found to be more interesting than high anxiety messages. Messages with a solution were more interesting than those with no solution.⁶⁸

Fear, guilt, anger, shame, and disgust act as drives and various behaviors are tried to reduce the emotional state, psychologist Carl Hovland reported. Any response that reduces the emotional state is reinforced.⁶⁹ Arousing fear and then offering solutions to avoid consequences is reinforcing.⁷⁰ However, threat must precede reassurances or the anxiety provoked will interfere with getting the point across.⁷¹ If the reassurances fail to reduce anxiety, the effect of the message could be something other than the intended one. The result might be magical or wishful thinking.⁷²

Nunnally found that high anxiety messages created unfavorable attitudes toward mental health concepts. Providing a solution promoted more favorable attitudes when anxiety was high, but not when it was low.⁷³

Hovland found the amount of conformity to a message was inversely related to the amount of fear aroused. Minimal threat appeal brought the most adherence and the most resistance to subsequent counter information, although strong threat appeal seemed to arouse the most interest.⁷⁴

Hovland also found high credibility sources more effective than low credibility sources.⁷⁵ Nunnally found the degree of certainty affects how favorably the message will be viewed. High certainty dissipates anxiety more than low certainty.⁷⁶

Nunnally warned of the danger of destroying information without supplying new information. He found the

result is more unfavorable attitudes. It appears that incorrect information is better than none.⁷⁷

IMPLICATIONS FROM THE LITERATURE FOR SUICIDE PREVENTION INFORMATION PROGRAMS

The success of a suicide prevention center to a great extent will depend on the success of its information program.

The literature suggests three kinds of information: information to other agencies and professionals--the gate-keepers who often work with suicidal persons--to promote cooperation and understanding of their roles; information for the lay citizenry relevant to suicide prevention, for persons concerned about a potential suicide victim, and for opinion leaders; information to decrease the taboo of suicide in order to gain more accurate recording of suicidal deaths and less opprobrium for families of suicides. Influencing opinion leaders is most crucial in decreasing the taboo.

There are a number of ways a suicide prevention center communicates with other agencies. This paper is concerned with communication to the lay public for suicide detection and to decrease the taboo.

Since the aim of a suicide prevention center is to prevent unsuccessful attempts as well as completed suicides, the statistics indicate that the information program must concern the old and the young, men and women,

professional people and the unemployed, and alcoholics. It should be especially aimed toward people living in apartment house districts and other densely populated areas. More attention should be given to white areas than non-white areas, based on higher rates of suicides for whites than non-whites.

The danger signals of suicide must be publicized, along with other indexes of lethality, such as divorce, alcoholism, a previous attempt, and aging for men.

Especially deserving concern are men over 50, who are both most misinformed and most susceptible to suicide.

Studies would also indicate the need for educating physicians, as well as laity. They are the most frequently consulted professional group by potential suicides.

Psychiatrists or psychologists should be the implied or stated source of the information.

The topic of suicide in any event will probably produce anxiety. Emphasis should be on the positive side of prevention--"Suicide can be prevented"--to reduce anxiety.

There is now a large amount of data on suicide. This information can now be disseminated as facts. What is unknown about suicide should be omitted from information programs. Care should be taken in destroying the myths of suicide that correct information be supplied.

Along with danger signals, information is needed about the rationale and psychodynamics of suicide in order to promote understanding of it. It should be made

clear that not all suicides are psychotics, that suicide notes are often rational and logical. Sympathy for the agony of suicide might well be invoked. Most people don't know the pain of holding a bottle of pills or a razor blade with the impulse to use them lethally. With a successful information program, fewer people will reach that point.

FINDINGS

The following information was obtained from the three centers:

1. Do you have a regular program of information?

A. Kansas City--When the center first opened, there were a number of articles about it. There is no regular program of information now. The center maintains a passive attitude toward publicity..

B. Wichita--Again, there was quite a lot of publicity through the media when the center first opened. There is now nothing in the daily papers. An underground paper runs the number regularly, and radio and television stations have donated spots for the center. Speeches and church bulletins bring the center to the attention of the public. Essentially, the information program is hit and miss.

C. Topeka--Can Help's information program is entirely another story. Their program of information is well-planned and executed through the efforts of a Public

Information Committee, made up of representatives of the press and advertising personnel. This committee acts as an advisory body to the center and has assured full cooperation with the press, and also non-press advertising establishment.

2. Who is in charge of the information program?

A. Kansas City--Natalie Hill, D.S.W., is the only paid staff member of the Kansas City center. As such, she is totally responsible for the information program, as well as her other duties as director of the center and as director of clinical services of the mental health center.

B. Wichita--Roma Allegrucci, intake social worker for the North Sedgwick County Mental Health Center, is the only paid staff member of the Suicide Prevention Center. She, however, uses the services of the person in charge of public relations for the mental health center.

C. Topeka--Although Joy Williams is the only paid staff member of Can Help, the information program is handled primarily by the Public Information Committee, with Mrs. Williams' approval.

3. Does anyone on the staff prepare news releases?

The staff member of each of these three centers has the capacity to prepare news releases. However, Kansas City and Wichita centers usually wait for the media to contact them to do a story. News releases for Can Help are prepared through the Public Information Committee.

Such releases are read and approved by Mrs. Williams before publication.

4. How cooperative are the media with the center?

A. Kansas City--Dr. Hill contacted media for coverage when the center first opened. Since then she has waited for the media to contact her. The media has shown interest in the center and has given it coverage. Dr. Hill has not tried to initiate further relations with the press.

B. Wichita--Wichita papers have told the Suicide Prevention Center staff they are "interested only in newsworthy items." The center has had to purchase space in the papers at commercial rates to advertise the phone number of the center. This has been discontinued since the staff did not feel such action increased the number of calls. The local radio and television stations donate time for spot announcements, and an underground newspaper runs the number.

C. Topeka--Because of the Public Information Committee, Can Help is guaranteed adequate press coverage. The number appears daily in the evening paper, and spots are run on radio and television. Conflicts with the press have been minimal.

5. Do the media initiate news coverage of the center?

A. Kansas City--At first publicity for the center was initiated by center staff. Press clippings now indicate

that three newspapers run about two or three stories a year about the center, initiated by the press. At the time of writing, there is no air coverage, although radio station KWKI has recently expressed interest in coverage.

B. Wichita--A daily newspaper has contacted them to do a story. Such stories run about once a year, sometimes initiated by the center and sometimes by the press. The center does not keep press clippings. Spot announcements on radio and television were initiated by the center.

C. Topeka--Publicity for Can Help is initiated and carried out by the Public Information Committee.

6. What ways other than through the news media does the center make itself known?

A. Kansas City--Cards with the emergency number are issued to all patients of the mental health center. Dr. Hill has tried to get the phone number listed with other emergency numbers in the front of the phone book, but this request has been turned down. The number is listed by other agencies' brochures. Dr. Hill also makes 20 to 25 speeches a year to various groups about the center.

B. Mrs. Allegrucci also speaks to groups about the Wichita center. In addition, several area churches run the emergency number.

C. Topeka--Mrs. Williams also makes speeches to groups. In addition to media coverage, Can Help uses posters and billboards to advertise the center. The

billboards are donated by an advertising firm. There are six billboards in prominent places around Topeka which are used at least part-time for Can Help. The center has distributed brochures through the Health Department and other agencies. Some churches run the emergency number in their bulletins.

7. Does the center communicate through public gathering places, such as doctors' offices, beauty salons, grocery stores or public lavatories?

The answer from all three centers is no. Wichita and Topeka centers are advertised in some church bulletins, initiated by the individual churches. This is the only way they try to communicate through public gathering places.

8. How adequate do the directors feel the information program to be?

A. Kansas City--Dr. Hill feels the information program to be inadequate. "Most people in Kansas City don't know the center exists," she said.

B. Wichita--Mrs. Allegrucci gave the same opinion of that Suicide Prevention Center's information program. "I guess it's not very adequate."

C. Topeka--Mrs. Williams feels all of their efforts to communicate with the public fall short of what is needed. "I'm certain we have not reached every segment," she said.

9. What is the greatest obstacle to a better information program?

A. Kansas City--Dr. Hill said the greatest obstacle is finance. There are no budget allowances for an information program.

B. Wichita--Mrs. Allegrucci feels the greatest obstacle is public attitudes. She said the public is not interested in suicide prevention. Increased publicity, she said, does not result in more calls.

C. Topeka--Mrs. Williams was not able to cite any obstacles.

10. How could the information program be improved?

A. Kansas City--Dr. Hill feels a central office is needed to disseminate information about several agencies and services. She would also like the number to be run daily in the press.

B. Wichita--Mrs. Allegrucci had no suggestions for improvement.

C. Topeka--Mrs. Williams said, "I don't see how the media could do more." The only improvement she would like to see would be more speeches.

SUMMARY AND CONCLUSIONS

Wichita and Kansas City suicide prevention centers have essentially no planned information program. The Topeka center, Can Help, on the other hand, has a very active, ongoing program of communication with the public.

Dr. Hill, director of the Kansas City Suicide Prevention Center, is also director of clinical services

at the mental health clinic, and she has sole responsibility for the information program. The director of the Wichita center uses the services of the person in charge of public relations for the mental health clinic.

It is not surprising, therefore, that the Kansas City Suicide Prevention Center maintains a passive attitude toward publicity. At first they ran the number in the paper and contacted newspapers for publicity. Now Dr. Hill waits until someone from a newspaper calls and asks to do a story. This amounts to two or three stories a year, which are largely rehashes of previous stories, in three newspapers. There is nothing on radio or television about the center, although radio station KWKI has expressed interest in publicity for the center. If the center's cooperation with this researcher is indicative of their cooperation with the media, it is not surprising they do not have more publicity.

A card with the number of the Suicide Prevention Center is given to all patients of the mental health clinic. The number is also run in other agencies' brochures. Dr. Hill is also called upon to make twenty to twenty-five speeches a year to various groups about the center. She said she has tried to get the number placed with other emergency numbers in the front of the phone book, but this request has been denied by the telephone company.

She said what is most needed is a central office

for information. The greatest obstacle to planning a more adequate program is finance. She feels that most people in the Kansas City area do not know about the center.

The Wichita center has about one news story a year. They do not keep press clippings. The newspapers have told them they are interested only in newsworthy items, and the center has had to buy space at commercial rates. A local underground paper runs the number. Radio and television stations have donated time for spot announcements about the center. In addition, the center communicates through speeches to groups and through church bulletins. Nothing is currently run in the newspapers since the center did not feel it was effective. The total information program is not thought to be very adequate.

The information program for Can Help in Topeka is planned and carried out by a Public Information Committee, composed of representatives of the mass media and advertising. This committee has assured full cooperation with the press. Numerous articles about the center have appeared in newspapers and been broadcast. In addition to the use of news media, Can Help has used posters and billboards, donated by an advertising firm. The number of the center is run daily by the evening paper, and it is listed in the phone book under Can Help and under Suicide. They have also tried to get it listed with other emergency numbers and been refused. The number is listed by a number

of church bulletins, and in speeches before groups. Brochures for Can Help have been distributed through other agencies. Asked about the adequacy of the program, the coordinator-director said she didn't think the mass media could do more. The only improvement suggested was more speeches.

None of the centers utilize doctors' offices, beauty salons, or other public gathering places for distributing information. Nor is any apparent effort being made to communicate through opinion leaders.

Information in the press is essentially positive, although there is a tendency to over-dramatize the lead. Stories have been run on the planning of the centers, inception, progress, recruitment for volunteers, and simply availability of the center. No attempt is being made to communicate with high-risk target groups. Whether the communication that is taking place decreases taboos could not be taken up in this paper.

It is interesting that Can Help, with the same lack of staff and budget, has been able to do so much more in the way of informing the public due to the efforts of the Public Information Committee. Other centers might well consider forming the same kind of organization for planning and carrying out a sound information program.

TABLE NUMBER 1
 INFORMATION ACTIVITIES OF THE THREE CENTERS

<u>Kansas City</u>	<u>Wichita</u>	<u>Topeka</u>
speeches	speeches	speeches
phone book	phone book	phone book
cards with number		
other agencies' brochures		brochures
	churches	churches
	radio and tv spots	radio and tv spots
		daily paper
		posters
		billboards
		news releases*

*through Public Information Committee as volunteer staff

FOOTNOTES

¹Emile Durkheim, Suicide: A Study in Sociology (Glencoe, Ill.: Free Press, 1951), p. 44.

²Ibid.

³H.L.P. Resnik, ed., Suicidal Behavior (London: Churchill 1968), p. 60.

⁴Louis Dublin, "Suicide: An Overview of a Health and Social Problem," Bulletin of Suicidology (Dec. 1967), p. 25.

⁵Ibid., p. 26.

⁶Edwin Schneidman, Norman Farberow, and Robert Litman, The Psychology of Suicide (New York: Science House, 1970), p. 126.

⁷Dublin, "An Overview," p. 26.

⁸Schneidman, Farberow, and Litman, Psychology, p. 233.

⁹H.L.P. Resnik, Suicidal Behavior, p. 168.

¹⁰Ibid., p. 165.

¹¹Edwin Schneidman and Norman Farberow, Some Facts About Suicide (U.S. Dept. of HEW-Public Health Service pamphlet0, pp. 9-10.

¹²Edwin Schneidman and Philip Mandelkorn, How to Prevent Suicide (Public Affairs Pamphlet # 406, 1967), p. 12.

¹³Stanley Yolles, The Tragedy of Suicide (Public Health Service Publication #1558), p. 3.

¹⁴Schneidman, Farberow, and Litman, Psychology, p. 98.

¹⁵Edwin Schneidman, "Some Current Developments in Suicide Prevention," Bulletin of Suicidology (Dec. 1967), p. 32.

¹⁶Resnik, Suicidal Behavior, p. 382.

¹⁷Schneidman, Farberow, and Litman, Psychology, p. 97.

- 18 Ibid. p. 132.
- 19 Stanley F. Yolles, "U.S. Community Mental Health Program," in Comprehensive textbook of Psychiatry, by Freedman and Kaplan, reprint. (Baltimore: Williams and Wilkins, 1967), p. 2.
- 20 Schneidman, Farberow, and Litman, Psychology, p. 147.
- 21 Schneidman and Mandelkorn, Prevent, pp. 14-15.
- 22 Robert Litman, "Suicide Prevention Center Patients: A. Follow-up Study," Bulletin of Suicidology (Spring 1970), p. 14.
- 23 Schneidman, "Current Developments," p. 34.
- 24 Schneidman, Farberow, and Litman, Psychology, p. 154.
- 25 Ibid., p. 511.
- 26 Ibid., p. 548.
- 27 Ibid., p. 545.
- 28 Resnik, Suicidal Behavior, p. 50.
- 29 Schneidman and Mandelkorn, Prevent, p. 8.
- 30 Schneidman, Farberow, and Litman, Psychology, p. 148.
- 31 Ibid., p. 99.
- 32 Ibid., p. 101.
- 33 Commission on Hospitals, Public Relations: A Responsibility of the Mental Hospital Administrator (New York: Group for the Advancement of Psychiatry Report #55, 1963), p. 84.
- 34 Schneidman, Farberow, and Litman, Psychology, p. 149.
- 35 Commission on Hospitals, Public Relations, p. 89.
- 36 Wilfred Bloomberg, ed., Psychiatry, the Press and the Public (Washington: American Psychiatric Association 1956) p. 24.
- 37 Ibid.
- 38 Ibid.
- 39 Ibid.

⁴⁰Ibid., p. xi.

⁴¹Ibid., p. 47.

⁴²Everette Dennis, "Improving Relations Between Mental Health Agencies and the Mass Media," Hospital and Community Psychiatry, June 1971, pp. 39-41.

⁴³Joint Commission on Mental Illness and Mental Health, Action for Mental Health (New York: Basic Books, Inc., 1961), p. xviii.

⁴⁴Jum Nunnally, Popular Conceptions of Mental Health (New York: Holt, Rinehart and Winston, 1969), p. 46.

⁴⁵Paul Lemkau and Guido Crocetti, "An Urban Population's Opinions and Knowledge About Mental Illness," American Journal of Psychiatry, 118 (1962) 696.

⁴⁶Nunnally, Popular Conceptions, p. 94.

⁴⁷Ibid., p. 105.

⁴⁸Norman L. Farberow, "Ten Years of Suicide Prevention--Past and Future," Bulletin of Suicidology (Spring 1970), pp. 9-10.

⁴⁹Joint Commission, Action, p. 279.

⁵⁰Ibid., p. 60.

⁵¹Harold Halpert, Public Opinions and Attitudes About Mental Health (U.S. Dept. of HEW pamphlet), p. 13.

⁵²Gerald Gurin, Joseph Veroff, and Sheila Feld, Americans View Their Mental Health (New York: Basic Books, Inc., 1960)

⁵³Ibid., p. xx.

⁵⁴Ibid., p. 310.

⁵⁵Ibid., p. 307.

⁵⁶Halpert, Public Opinions, p. 3.

⁵⁷Nunnally, Popular Conceptions, p. 61.

⁵⁸Halpert, Public Opinions, p. 1.

⁵⁹Nunnally, Popular Conceptions, p. 22.

⁶⁰Ibid., p. 28.

⁶¹Ibid., p. 22.

⁶²Ibid., p. 28.

⁶³Ibid., p. 26.

⁶⁴Ibid., p. 112.

⁶⁵Ibid., p. 113.

⁶⁶Ibid., p. 114.

⁶⁷Ibid.,

⁶⁸Ibid., p. 120.

⁶⁹Halpert, Public Opinions, pp. 61-62.

⁷⁰Ibid., pp. 63-63.

⁷¹Ibid., p. 77.

⁷²Ibid., p. 78.

⁷³Nunnally, Popular Conceptions, p. 137.

⁷⁴Carl I. Hovland, Irving Janis, and Harold Kelley, Communication and Persuasion (New Haven, Conn.: Yale Univ., Press, 1953), pp. 80-83.

⁷⁵Ibid., p. 270.

⁷⁶Nunnally, Popular Conceptions, p. 164.

⁷⁷Ibid., p. 165.

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A DESCRIPTIVE STUDY OF THE INFORMATION PROGRAMS
OF THREE SUICIDE PREVENTION CENTERS IN KANSAS

BY

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This is a study of the information programs of the suicide prevention centers in Kansas City, Wichita, and Topeka. The study concerns how these three centers make themselves known to the public, the methods of public information, frequency of information, personnel who carry out these functions, planning and obstacles to their program, and the directors' evaluation of the information programs.

Studies of epidemeology of suicide reveal high-risk target groups for suicide prevention information. Communication with the public regarding suicide is hindered by antagonism between mental health professionals and the press and by attitudes of the public. Studies indicate, however, that the public may be receptive to mental health information. These studies indicate some obstacles of reception and methods for improved reception.

Information is needed to communicate with gatekeepers of suicide and with the lay public for persons concerned about a potential suicide and potential suicide victims. Information is also needed to communicate with opinion leaders and to decrease the taboo against suicide.

The three centers are compared on the basis of ten questions. Conclusions are that Wichita and Kansas City centers have essentially no planned information

program, while Can Help in Topeka has a very active, on-going program of communication with the public. The difference is a Public Information Committee which plans and executes the information program of Can Help. However, all three centers could improve their information programs.