Handbook of Short-term Psychotherapy

Crisis Intervention

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In recent years a great deal of planning has been conducted in the United States in an attempt to lower the rate of admissions to mental institutions, diminish the incidence of suicides, quiet the outbreak of violence in the streets, and in general reduce psychiatric morbidity. One of the main developments toward these goals has been the evolvement of methodologies in the area of crisis intervention. The recognition that crises are so common in the lives of all people has encouraged the growth of walk- in clinics, psychiatric emergency units in general hospitals, suicide prevention hot-line telephone services, and a variety of other facilities whose aim is restoring, in as few sessions as possible, the psychological balance of persons in states of emotional excitement or collapse.

What has become painfully apparent is that practically every inpidual alive is a potential candidate for a breakdown in the adaptive equilibrium if the stressful pressures are sufficiently severe. A crisis may precipitate around any incident that overwhelms one's coping capacities. The crisis stimulus itself bears little relationship to the intensity of the victim's reaction. Some persons can tolerate with equanimity tremendous hardships and adversity. Others will show a catastrophic response to what seems like a minor mishap. A specifically important event, like abandonment by a love object, can touch off an explosive reaction in one who would respond much less drastically to bombings, hurricanes, cataclysmic floods, shipwreck, disastrous reverses of economic fortune, and major accidents. The two important variables are, first, the *meaning* to the inpidual of the calamity and, second, the *flexibility of one's defenses*, that is, the prevailing ego strength.

The immediate response to a situation that is interpreted as cataclysmic, such as the sudden death of a loved one, a violent accident, or an irretrievable shattering of security, is a dazed shock reaction. As if to safeguard oneself, a peculiar denial mechanism intervenes accompanied by numbness and detachment. This defensive maneuver, however, does not prevent the intrusion of upsetting fantasies or frightening nightmares from breaking through periodically. When this happens, denial and detachment may again intervene to reestablish a tenuous equilibrium, only to be followed by a repetition of fearsome ruminations. It is as if the inpidual is both denying and then trying somehow to acquire understanding

and to resolve anxiety and guilt. Various reactions to and defenses against anxiety may precipitate self-accusations, aggression, phobias, and excessive indulgence in alcohol or tranquilizers. Moreover, dormant past conflicts may be aroused, marshalling neurotic symptomatic and distorted characterologic displays. At the core of this confounding cycle of denial and twisted repetitive remembering is, first, the mind's attempt to protect itself by repressing what had happened and, second, to heal itself by reprocessing and working through the traumatic experience in order to reconcile it with the present reality situation. In an inpidual with good ego strength this struggle usually terminates in a successful resolution of the crisis event. Thus, following a crisis situation, most people are capable after a period of 4 to 6 weeks of picking up the pieces, putting themselves together, and resuming their lives along lines similar to before. People who come to a clinic or to a private practitioner are those who have failed to achieve resolution of stressful life events.

In some of these less fortunate inpiduals the outcome is dubious, eventuating in prolonged and even permanent crippling of functioning. To shorten the struggle and to bolster success in those who otherwise would be destined to a failing adaptation, psychotherapy offers the inpidual an excellent opportunity to deal constructively with the crisis.

In the psychotherapeutic treatment of crisis situations (crisis therapy) the goal is rapid emotional relief—and not basic personality modification. This does not mean that we neglect opportunities to effectuate personality change. Since such alterations will require time to provide for resolution of inner conflicts and the reshuffling of the intrapsychic structure, the most we can hope for is to bring the patient to some *awareness* of how underlying problems are related to the immediate crisis. It is gratifying how some patients will grasp the significance of this association and in the posttherapy period work toward a betterment of fundamental characterologic distortions. Obviously, where more than the usual six-session limit of crisis-oriented therapy can be offered, the greater will be the possibility of demonstrating the operative dynamics. Yet where the patient possesses a motivation for change—and the existing crisis often stimulates such a motivation—even six sessions may register a significant impact on the psychological status quo.

Variables Determining the Mode of Crisis Therapy

Catastrophic Symptoms Requiring Immediate Attention

Selection of techniques in crisis therapy are geared to four variables (Wolberg, 1972). The first variable we must consider relates to catastrophic symptoms that require immediate handling. The most common emergencies are severe depressions with strong suicidal tendencies, acute psychotic upsets with aggressive or bizarre behavior, intense anxiety and panic states, excited hysterical reactions, and drug and alcoholic intoxications. Occasionally, symptoms are sufficiently severe to constitute a portentous threat to the inpidual or others, under which circumstances it is essential to consider immediate hospitalization. Conferences with responsible relatives or friends will then be essential in order to make provision for the most adequate resource. Fortunately, this contingency is rare because of the availability of modern somatic therapy. Consultations with a psychiatrist skilled in the administration of somatic treatments will, of course, be in order. Electroconvulsive therapy may be necessary to interrupt suicidal depression or excitement. Acute psychotic attacks usually yield to a regimen of the neuroleptics in the medium of a supportive and sympathetic relationship. It may require almost superhuman forbearance to listen attentively to the patient's concerns, with minimal expressions of censure or incredulity for delusional or hallucinatory content. Panic reactions in the patient require not only fortitude on the part of the therapist, but also the ability to communicate compassion blended with hope. In an emergency room in a hospital it may be difficult to provide the quiet objective atmosphere that is needed, but an attentive sympathetic doctor or nurse can do much to reassure the patient. Later, frequent visits, even daily, do much to reassure a frightened patient who feels himself or herself to be out of control.

Less catastrophic symptoms are handled in accordance with the prevailing emotional state. Thus during the first stages of denial and detachment, techniques of confrontation and active interpretation of resistances may help to get the patient talking. Where there is extreme repression, hypnotic probing and narcoanalysis may be useful. On the other hand, where the patient is flooded by anxiety, tension, guilt, and ruminations concerning the stressful events, attempts are made to reestablish controls through relaxation methods (like meditation, autogenic training, relaxing hypnotherapy, and biofeedback), or by pharmacological tranquilization (Valium, Librium), or by rest, persions (like social activities, hobbies, and occupational therapy), or by behavioral desensitization and reassurance.

The Nature of the Precipitating Agency

Once troublesome symptoms are brought under reasonable restraint, attention can be focused on the second important variable in the crisis reaction, the nature of the precipitating agency. This is usually in the form of some environmental episode that threatens the inpidual's security or damages the self-esteem. A developmental crisis, broken love affair, rejection by or death of a love object, violent marital discord, persisting delinquent behavior and drug consumption by important family members, transportation or industrial and other accidents, development of an incapacitating or life-threatening illness, calamitous financial reverses, and many other provocative events may be the triggers that set off a crisis. It is rare that the external precipitants that the patient holds responsible for the present troubles are entirely or even most importantly the cause.

Indeed, the therapist will usually find that the patient participates actively in initiating and sustaining many of the environmental misfortunes that presumably are to blame. Yet respectful listening and questioning will give the therapist data regarding the character structure of the patient, the need for upsetting involvements, projective tendencies, and the legitimate hardships to which the patient is inescapably exposed. An assay of the existing and potential inner strengths in relation to the unavoidable stresses that must be endured and identification of remediable problem areas will enable the therapist better to focus the therapeutic efforts. Crucial is some kind of cognitive reprocessing that is most effectively accomplished by interpretation. The object is to help the patient find a different meaning for the upsetting events and to evolve more adequate ways of coping.

The Impact of the Family on the Patient

The third variable, the impact on the patient of the family system, is especially important in children and adolescents as well as in those living in a closely knit family system. The impact of the family may not be immediately apparent, but a crisis frequently indicates a collapsing family system, the end result of which is a breakdown in the identified patient's capacities for adaptation. Crisis theory assumes that the family is the basic unit and that an emotional illness in any family member connotes a disruption in the family homeostasis. Such a disruption is not altogether bad because through it opportunities are opened up for change with potential benefit to each member. Traditional

psychotherapy attempts to treat the inpidual patient and often relieves the family of responsibility for what is going on with the patient. Crisis theory, on the other hand, insists that change must involve more than the patient. The most frequently used modality, consequently, is family therapy, the object of which is the harnessing and expansion of the constructive elements in the family situation. The therapist does not attempt to halt the crisis by reassurance but rather to utilize the crisis as an instrument of change. During a crisis a family in distress may be willing to let a therapist enter into the picture, recognizing that it cannot by itself cope with the existing emergency. The boundaries are at the start fluid enough so that new consolidations become possible. The family system prior to the crisis and after the crisis usually seals off all points of entry. During the crisis, before new and perhaps even more destructive decisions have been made, a point is reached where we may introduce some new perspectives. This point may exist for only a short period of time; therefore it is vital that there be no delay in rendering service.

Thus a crisis will permit intervention that would not be acceptable before nor subsequent to the crisis explosion. One deterrent frequently is the family's insistence on hospitalization, no longer being able to cope with the identified patient's upsetting behavior. Alternatives to hospitalization will present themselves to an astute therapist who establishes contact with the family. Some of the operative dynamics may become startlingly apparent by listening to the interchanges of the patient and the family.

The most important responsibility of the therapist is to get the family to understand what is going on with the patient in the existing setting and to determine why the crisis has occurred now. Understandably there is a history to the crisis and a variety of solutions have been tried. The therapist may ask himself why these measures were attempted and why they failed, or at least why they have not succeeded sufficiently. The family should be involved in solutions to be utilized and should have an idea as to the reasons for this. Assignment of tasks for each member is an excellent method of getting people to work together and such assignments may be quite arbitrary ones. The important thing is to get every member involved in some way. This will bring out certain resistances which may have to be negotiated. Trades may be made with the object of securing better cooperation. Since crisis intervention is a short-term process, it should be made clear that visits are limited. This is to avoid dependencies and resentments about termination.

The Patient's Behavior and Its Roots

The fourth variable is often the crucial factor in initiating the crisis situation. Unresolved and demanding childhood needs, defenses and conflicts that obtrude themselves on adult adjustment, and compulsively dragoon the patient into activities that are bound to end in disaster, would seem to invite explorations that a therapist, trained in dynamic psychotherapeutic methodology, may with some probing be able to identify. The ability to relate the patient's outmoded and neurotic modes of behaving, and the circumstances of their development in early conditionings, as well as the recognition of how personality difficulties have brought about the crisis, would be highly desirable, probably constituting the difference between merely palliating the present problem and providing some permanent solution for it. Since the goals of crisis intervention are limited, however, to reestablishing the precrisis equilibrium, and the time allotted to therapy is circumscribed to the mere achievement of this goal, we may not be able to do much more than to merely point out the areas for further work and exploration. Because crisis therapy is goal limited, there is a tendency to veer away from insight therapies organized around psychodynamic models toward more active behavioral-learning techniques, which are directed at reinforcing appropriate and discouraging maladaptive behavior. The effort has been directed toward the treatment of couples, of entire families, and of groups of nonrelated people as primary therapeutic instruments. The basic therapeutic thrust is, as has been mentioned, on such practical areas as the immediate disturbing environmental situation and the patient's disruptive symptoms, employing a combination of active procedures like drug therapy and milieu therapy. The few sessions devoted to treatment in crisis intervention certainly prevent any extensive concern with the operations of unconscious conflict. Yet a great deal of data may be obtained by talking to the patient and by studying the interactions of the family, both in family therapy and through the observations of a psychiatric nurse, caseworker, or psychiatric team who visit the home. Such data will be helpful in crisis therapy planning or in a continuing therapeutic program.

In organizing a continuing program we must recognize, without minimizing the value of depth approaches, that not all persons, assuming that they can afford long-term therapy, are sufficiently well motivated, introspective, and possessed of qualities of sufficient ego strength to permit the use of other than expedient, workable, and goal-limited methods aimed at crisis resolution and symptom relief.

Technical Suggestions

The average patient applying for help generally complains about a disturbing symptom such as tension, anxiety, depression, insomnia, panicky feelings, physical problems, and so on. Associated life events are considered secondary circumstances even though it may become obvious that they are the primary etiological precipitating agencies. Sometimes the patient recognizes the importance of a traumatic situation, such as separation, porce, death of a family member, an accident, or financial disaster, and will focus discussions around painful associations to these. In approaching such a patient, empathic listening is the keynote. The most that can be done during the first two sessions is to identify the key trouble areas, and perhaps reassure the patient that there *are* ways of coping with the difficulty since others have also gone through similar upsetting events and with proper therapy have overcome them and even have gotten stronger in the process. The following is an excerpt from an early interview with a woman suffering from a reactive depression.

> Pt. It all seems hopeless. I just can't seem to pull myself together after Jack left me. I keep falling apart and can't interest myself in anything.
>
> Th. Your reaction is certainly understandable. Why shouldn't you feel indignant, hurt and angry, and depressed. But you would like to get over Jack, wouldn't you, and go on to be happy again?
>
> Pt. (*pause*) Do you think that's possible?
>
> Th. If I didn't, I wouldn't be sitting here with you. Other women have gone through similar desertions and have come out on top. And you can too.
>
> Pt. I'd like to start.
>
> Th. We have started.

In allowing a patient to focus on his presenting problem the therapist must always attempt to answer the questions Why now? Why did the difficulty break out at this time? Did the patient in any way participate in bringing about the crisis? Though the latter may seem obvious, the patient may not see this clearly, but through interviewing and clarification he may be helped to identify the sources of the crisis and one's personal participation in it.

It is important to be alert to how the crisis can be converted into an opportunity for change. Appraisal of the patient's ego strength, flexibility, and motivation are helpful, though this assay at first

may not be entirely accurate. The patient when first applying for help is at low ebb and may not present an optimistic picture of latent potentialities. These may filter through later on as hope penetrates the depressive fog in which the patient is enveloped.

As problems become clarified and identified through interviewing, the patient and the family in family therapy will better be able to deal with such problems constructively. The therapist may sometimes do nothing more than facilitate ventilation of thoughts and feelings among the family members. Verbalization and communication have great powers of healing. The therapist need not sit in judgment over what is being said nor always offer golden words of advice. By keeping communication open, by asking the right questions, one may help the family to productive decisions that will lead to problem solving and resolution. It may be difficult at the start to get the family members to open up after years of withdrawal and secret manipulations. A simple invitation like "I believe you will all feel better if you each tell me what is on your mind" may get the conversational process going. If none starts, the therapist may ask a pertinent question as an opener or make a simple statement such as "I'll bet each of you feels worried about what has happened. Why don't you each talk about this."

Some patients are extremely concerned with their physical symptoms that accompany or are manifestations of anxiety, and they may be convinced, in spite of negative physical findings, that they have a terminal disease. Where there is a preoccupation with these symptoms, an explanation such as the following may help:

> Th. When a person is upset emotionally every part of the body is affected. The heart goes faster; the muscles get tenser; headaches may occur; or the stomach may get upset. Practically every organ in the body may be affected. Fortunately, when the emotional upset passes, the organs will tend to recover.

Should the patient wonder why other people react less intensely to troubles than he does and blame himself for failing, he may be told that he can do something about it:

> Th. Children are born different—some are active, some less active. You have a sensitive nervous system, which is both good and bad; good because you are a responsive person to even nuances, but also bad for you since you react very actively to stress and suffer a good deal. You can do something about this to reduce your overreaction to stress.

The following is a summation of practical points to pursue in the practice of crisis intervention.

1. *See the patient within 24 hours of the calling for help* even if it means canceling an appointment. A crisis in the life of an inpidual is apt to motivate one to seek help from some outside agency that otherwise would be avoided. Should such aid be immediately unavailable, one may in desperation exploit spurious measures and defenses that abate the crisis but compromise an optimal adjustment. More insidiously, the incentive for therapy will vanish with resolution of the emergency. The therapist should, therefore, make every effort to see a person in crisis preferably on the very day that help is requested.

2. At the initial interview *alert yourself to patients at high risk for suicide*. These are (a) persons who have a previous history of attempting suicide, (b) endogenous depression (history of cyclic attacks, early morning awakening, loss of appetite, retardation, loss of energy or sex drive), (c) young drug abusers, (d) alcoholic female patients, (e) middle-aged men recently widowed, porced, or separated, (f) elderly isolated persons.

3. *Handle immediately any depression in the above patients*. Avoid hospitalization if possible except in deep depressions where attempts at suicide have been made recently or the past or are seriously threatened now. Electroconvulsive therapy is best for dangerous depressions. Institute antidepressant medications (Tofranil, Elavil, Sinequan) in adequate dosage where there is no immediate risk.

4. *Evaluate the stress situation*. Does it seem sufficiently adequate to account for the present crisis? What is the family situation, and how is it related to the patient's upset? What were past modes of dealing with crises, and how successful were they?

5. *Evaluate the existing support systems available to the patient* that you can utilize in the therapeutic plan. How solid and reliable are certain members of the family? What community resources are available? What are the strengths of the family with whom the patient will live?

6. *Estimate the patient's ego resources*. What ego resources does the patient have to depend on, estimated by successes and achievements in the past? Positive coping capacities are of greater importance than the prevailing pathology.

7. *Help the patient to an awareness of the factors involved in the reaction to the crisis*. The patient's interpersonal relations should be reviewed in the hope of understanding and reevaluating attitudes and patterns that get the patient into difficulty.

8. *Provide thoughtful, empathic listening and supportive reassurance*. These are essential to enhance the working relationship and to restore hope. The therapist must communicate awareness of the patient's difficulties. The patient should be helped to realize what problems are stress related and that with guidance one can learn to cope with or remove

the stress.

9. *Utilize tranquilizers only where anxiety is so great that the patient cannot make decisions*. When the patient is so concerned with fighting off anxiety that there is no cooperation with the treatment plan, prescribe an anxiolytic (Valium, Librium). This is a temporary expedient only. In the event a schizophrenic patient must continue to live with hostile or disturbed parents who fail to respond to or refuse exposure to family therapy, prescribe a neuroleptic and establish a way to see that medications are taken regularly.

10. *Deal with the immediate present and avoid probing of the past*. Our chief concern is the here and now. What is the patient's present life situation? Is trouble impending? The focus is on any immediate disruptive situation responsible for the crisis as well as on the corrective measures to be exploited. Historical material is considered only if it is directly linked to the current problem.

11. *Avoid exploring for dynamic factors*. Time in therapy is too short for this. Therapy must be reality oriented, geared toward problem solving. The goal is restoration of the precrisis stability. But if dynamic factors like transference produce resistance to therapy or to the therapist, deal rapidly with the resistances in order to dissipate them. Where dynamic material is "thrown" at the therapist, utilize it in treatment planning.

12. *Aim for increasing self-reliance and finding alternative constructive solutions for problems*. It is essential that the patient anticipate future sources of stress, learning how to cope with these by strengthening adaptive skills and eliminating habits and patterns that can lead to trouble.

13. *Always involve the family or significant others in the treatment plan*. A crisis represents both an inpidual and a family system collapse, and family therapy is helpful to alter the family system. A family member or significant friend should be assigned to supervise drug intake where prescribed and to share responsibility in depressed patients.

14. *Group therapy can also be helpful* both as a therapy in itself and as an adjunct to inpidual sessions. Contact with peers who are working through their difficulties is reassuring and educational. Some therapists consider short-term group therapy superior to inpidual therapy for crises.

15. *Terminate therapy within six sessions if possible and in extreme circumstances no later than 3 months after treatment has started* to avoid dependency. The patient is assured of further help in the future if required.

16. *Where the patient needs and is motivated for further help for purposes of greater personality*

development after the precrisis equilibrium has been restored, institute or refer for dynamically oriented short-term therapy. In most cases, however, further therapy is not sought and may not be needed. Mastery of a stressful life experience through crisis intervention itself may be followed by new learnings and at least some personality growth.

Common Questions About Crisis Intervention

What would you consider a crisis by definition?

What constitutes a crisis varies in definition. Some restrict the definition to only violent emergencies. Others regard a crisis as reactions to any situation that upsets the adaptive balance. Many consider that any inpidual applying for help is actually in some state of crisis.

How far back was crisis intervention organized as a structured technique? Are there useful readings?

Eric Lindemann (1944) was among the first to recognize the value of crisis intervention in his work with the victims of the Coconut Grove (Boston) fire disaster. The organization of emergency services in hospitals and community mental health centers to help persons undergoing critical adaptive breakdowns has contributed a body of literature out of which may be mined valuable ideas about short-term intervention (Butcher & Maudal, 1976; Caplan, 1961, 1964; Coleman & Zwerling, 1959; Darbonne & Allen, 1967; Harris et al, 1963; Jacobson, 1965; Jacobson et al, 1965; Kalis et al, 1961; Morley, 1965; Rusk, 1971; J. Swartz, 1971).

Can one apply the principles of crisis intervention to conditions other than emergencies?

Emergencies constitute only a small proportion of the conditions for which people seek help. Crises for the most part are of a lesser intensity, but, nonetheless, are in need of immediate services to insure the highest degree of therapeutic effectiveness.

Are one-session contacts for crisis intervention of any value?

Very much so, but most patients will require more sessions for an adequate work-up, institution of treatment, and follow-up. The average number of sessions is six; sometimes a few more sessions are

given.

Are community mental health concepts of any use in crisis intervention?

Drawing on community mental health concepts is considered by some to be of inestimable help in crisis intervention (Silverman, 1977), particularly when the goal is a servicing of sizable populations. Here a public health orientation employing systems theory and an ecological point of view may reduce the incidence of future crisis among target populations. Identification of potential users of mental health services, exploration of the kinds of problems that exist, and an assay of available support systems and service providers are important in planning educational programs as well as in fostering political activity to meet existing needs.

Is there any way of solving the waiting-list problem, which in many clinics prevents seeing crisis patients immediately?

How to reduce waiting lists is a problem in most clinics. Converting long-term therapeutic services to short-term services and the use of group therapy are often helpful. Some innovative programs have been devised to deal with this situation, for example, the screening evaluation technique described by Corney and Grey (1970) that allows in all cases an immediate access to professional help, eliminating the waiting list and serving as the first step in a crisis-oriented program.

What has the experience been with walk-in clinics as to the kinds of patients who seek crisis intervention?

There is general agreement on the need for a flexible policy of admitting patients for crisis therapy without exclusion irrespective of diagnosis, age, and socioeconomic status. Citing their experience in operating the Benjamin Rush Center, Jacobson et al (1965) list some interesting statistics. About one-third of the patients were diagnosed psychoneurotic, one- third personality disorders, one-fifth psychotic, and somewhat less transient situational disorders. Approximately 15 percent had mainly acute problems, and 63 percent had chronic problems with acute difficulties superimposed. In the first year and one-half of operation, 56.6 percent of patients saw their therapist for less than four sessions, almost one-half having one session. Only 1.8 percent had more than six visits. The improvement rate was estimated at two-thirds of those treated. More data on this question may be found in Chapter 1, “Models

of Short-term Therapy."

Don't social caseworkers do a good deal of crisis intervention in social agencies?

Crisis therapy is often appropriately managed by trained social workers, and its theoretical concepts as conceptualized by Lindemann (1944) Caplan (1961), and others are compatible with general social work theory (Rapaport, 1962). In many cases social casework by itself is more adequately designed for certain problems than psychiatry. Tyhurst (1957) has remarked that "turning to the psychiatrist may represent an impoverishment of resources in the relevant social environment as much as an indication of the type of severity of disorder."

Is behavior therapy ever used in family therapy for crisis?

A wide variety of techniques have been used many of them behaviorally oriented, for example, feedback, modeling and role playing, rehearsal, and reciprocal reinforcement (Eisler & Herson, 1973). Videotape replays are also used showing interactive sequences.

What team members are best in crisis intervention?

In a clinic setup a team approach is ideal. A good team for the handling of emergencies is a psychiatric nurse, a psychiatrist, and a psychiatric social worker who have had training in emergency psychiatry and crisis intervention. A multidisciplinary team can also include psychologists and members of other disciplines, such as rehabilitation workers, provided they are trained to work with people in crises.

Has anything been done with crisis intervention groups, and are there any leads as to technique?

Some work has been done with crisis intervention in a group setting (Berlin, 1970; Crary, 1968; Strickler & Allgeyer, 1967; Trakas & Lloyd, 1971). At the Benjamin Rush Center-Venice Branch (a pision of the Los Angeles Psychiatric Service) crisis group therapy is instituted with walk-in patients. The groups are open-ended and heterogeneous (Morley & Brown, 1969). The format allows one inpidual pregroup interview followed by five group sessions. Excluded from group therapy are serious suicidal or

homicidal risks and overt psychoses. At the first group session the patient is asked to tell the group what brought him to the clinic. The therapist encourages the patient to discuss the precipitating factor, the events of the crisis and what measures have been taken to solve it. The group explores alternate coping measures. Group support and the expression of opinions are often helpful. Unlike traditional group therapy there is no analysis made of the group process. Most of the time is spent focusing on each inpidual's presenting problem. A "going-around" procedure is employed to give each person a chance to talk. Transference interpretation is minimized due to the lack of time. In reviewing results with 1,300 patients it is claimed that a number of advantages are available to a crisis group as compared to inpidual therapy. Group support and reassurance have been valuable. Social relationships have developed between the members and good alternate coping measures seem to be more palatable to a patient when offered by a member who comes from the same subcultural milieu with knowledge of problems and defenses exploited within the culture that are better known to the group members than to the therapist. Expression of significant feelings is greater in the group than in inpidual therapy. The forces of modeling and desensitization are also more potent. One disadvantage is the greater difficulty of keeping discussions in focus.

Is it possible to select techniques in crisis intervention that are specially suited for certain patients?

Some attempts have been made to correlate responses to stressful events with the character structures of the victims (Shapiro, 1965) and then to choose techniques best suited for character styles. Horowitz (1976, 1977) has outlined the various ways that hysterical, obsessional, and narcissistic personalities respond to stress as a consequence of their unique conflicts, needs, and defenses. For example, preferred techniques in the hysteric are organized around dealing with impediments to processing; in the obsessive, with methods that support maintenance of control and substitution of realistic for magical thinking; in the narcissistic personality, with interviewing tactics that cautiously deflate the grandiosity of the patient and at the same time build up self-esteem.

In many cases, however, it is difficult, particularly in severe crises, to delineate sharply habitual personality styles that would make preferred techniques possible since the patient may be responding with emergency reactions that contaminate or conceal his basic patterns. All that the therapist may be able to do is to try to help the patient develop a clearer idea of the stress incident and its meaning to him,

with the hope of helping him understand his defensive maneuvers. The patient is encouraged to put into words his feelings and attitudes about the traumatic incident and its implications for him. Support, reassurance, confrontation, interpretation, and other techniques are utilized in relation to existing needs and as a way of countering obstructive defenses. The aim is to put the patient into a position where he can embark on a constructive course of action in line with the existing reality situation, hoping that he will accept the therapist's offerings irrespective of his personality style.

Doesn't a short period of hospitalization provide a breathing space for the patient in a crisis?

Hospitalization should be resorted to only as a last resort recognizing that it will solve little in the long run. Indeed, it will probably be used by the family as an escape from facing their involvement in the crisis and from altering the family climate that sponsored the crisis in the first place.

Since crisis intervention is a kind of holding operation to defuse a critical situation, shouldn't all cases receive more thorough treatment after the crisis is resolved?

It is a misconception to conceive of crisis intervention as a holding operation. Limited as it seems, it is a substantial form of treatment in its own right, and it may for many patients be the treatment of choice. The experience is that only a small number of patients receiving adequate crisis intervention need seek more intensive therapy, satisfactory results having been obtained with crisis therapy alone. Indeed, there is evidence that in some instances deep and lasting personality changes have been brought about by working through a crisis. Often the patient has gained enough so that there is no future incidence of crises.

Does crisis therapy require special training?

The key factor in this model of mental health service is the availability of trained and skilled personnel. Unfortunately, crisis intervention has been regarded as a second-best form of treatment that can be done by relatively untrained paraprofessionals. Appropriate professional training in this model is rarely given and is an essential need in psychiatric and psychological training programs. The usual training does not equip a professional to do crisis intervention. Additional skills related to the crisis model are required. As a matter of fact, the crisis model is best learned by professionals at an advanced

stage of training and supervision. Excessive anxiety and an erosion of confidence is often precipitated in students at lower levels of training when handling the problems of highly disturbed people in crisis. Supervision by experienced crisis therapists is also most important. Some literature on training methods and directions may be found in the writings of Baldwin (1977), Kapp and Weiss (1975), and Wallace and Morley (1970).

Isn't the main goal of crisis intervention namely the bringing of a person back to a previous dubious precrisis stability too superficial?

When one considers that a patient may reach habitual stability in from one to six sessions, we may consider such a goal quite an achievement. This is usually all a patient seeks from therapy. But in a considerable number of patients the working-through of the crisis starts a process that can lead to extensive change in patterns of behavior and perhaps even in alterations of the personality structure. And the fact that a patient stops therapy in six sessions or less does not mean that he cannot later seek further treatment aimed at more extensive goals, should he so desire.

Isn't the time devoted to therapy too limited in crisis intervention?

Experience shows that most people can be helped to resolve a crisis within the traditional time limitation of six sessions. A good therapist can accomplish more with a patient in six sessions than a bad therapist can in six hundred.

If a patient comes to an emergency room in a hospital in an agitated state saying he is afraid of giving in to an impulse to kill someone, what is the best way of handling this?

First, assure the patient that he will receive help to protect him from these fears. In an acute state it is obviously difficult to probe the sources of his fears of violence. Bringing him to some immediate stability is the aim. For this purpose neuroleptics should be administered in proper dosage to calm the patient down. The therapist will be wise to summon security personnel to aid him if violence breaks through. This measure not only can allay the therapist's fears, but also the patient often realizes that he will be protected from acting out his impulses, and this helps calm him down. The greatest help is rendered by the patient's ability to communicate to an understanding person; therefore, prior to giving the patient

intensive tranquilization, he should be allowed to verbalize freely. Hospitalization must be considered to protect the patient should violent tendencies reappear. Too frequently the patient's threats are taken lightly. The patient should be assured that it is essential that he be temporarily hospitalized for his own protection and that he will not need to stay in a hospital longer than is necessary. Even where the patient does not agree to hospitalization, he may still be willing to accept it if he feels that the therapist is sincere and concerned about his welfare. Transportation to another hospital should be done by ambulance with enough security attendants to manage violent displays should they occur. A proper diagnosis is necessary. Is the violence a manifestation of a neurological condition like a brain tumor or epilepsy, a breakthrough of psychosis, a consequence of a recent head injury, an indication of excessive alcohol or drug intake? Continuing therapy will be contingent on the proper diagnosis.

Even in crisis therapy of a very brief nature some therapists claim that it is possible to influence deeper parameters of personality. Are there techniques that can bring this desired result about?

No better way exists than to study the reactions of the patient to the techniques that are being utilized in the effort to resolve the crisis. The patient's reactions to the therapeutic situation, irrespective of the specific techniques employed, will reflect basic needs, defenses, and reaction patterns that embody interpersonal involvements dating back to formative experiences in the past. Responses to the current treatment experience, if one understands psychoanalytic theory and methodology and has the motivation to use this knowledge, are like a biopsy of the smoldering psychopathology. Patterns excited by therapy and the therapist will reveal both the sources and effects of faulty early programming. These effects are often expressed in the form of resistance. Because the patient has learned to operate with a social facade and because the more fundamental operations of repression shield him from anxiety, he may not manifest resistances openly. It is here that the trained and experienced therapist operates with advantage. From the patient's gestures, hesitations, manner of talking, slips of speech, dreams, and associations, one may gather sufficient information to help identify and deal directly and actively with resistances to techniques. These resistances embody fundamental defensive operations, and their resolution may influence many intrapsychic elements, initiating a chain reaction that ultimately results in reconstructive change. This change, started in relatively brief therapy focused on the existing crisis, may go on the remainder of the inpidual's life. If the patient has been able to establish a continuity between the crisis situation, his active participation in bringing it about, the forces in his character

organization that sustain his maladjustment, and their origin in his early conditionings, the opportunities for continued personality maturation are good.

Should time limits be set in advance in crisis intervention even if you don't know the direction treatment will take?

Definitely. Crisis intervention is one situation where advance setting of the number of sessions is required. Inexperienced therapists are usually hesitant about doing this. Where a termination date is not agreed on, the patient will usually settle back and wait for a miracle to happen no matter how long it takes.

What about the advance setting of goals in crisis intervention?

It is important to project achievable goals and to get the patient to agree to these. Where goals are too ambitious and will require extensive time to reach, or where they are unreachable irrespective of time, the therapist may undershoot his mark and at termination be left with a disgruntled and angry patient.

If on termination the patient still has unresolved problems, what do you do?

The goal of crisis intervention, from a purely pragmatic viewpoint, is to bring a patient to precrisis equilibrium. Once this is achieved, the chief aim of this model of therapy has been reached. Inexperienced therapists especially have difficulty discharging patients because the patients have some unresolved problems at termination. While goals are modest in crisis therapy, and while we may terminate therapy abruptly, it is often gratifying to see on follow-up how much progress has actually occurred after treatment as a result of the learnings acquired during the active treatment period. The therapist, therefore, should learn to handle his own separation symptoms and fears and let the patient go at the proper time. Naturally, if the patient is still seriously and dangerously sick, further treatment will be necessary.

Doesn't the traditional limited goal of crisis intervention in itself circumscribe the therapeutic effort and prevent more extensive personality growth?

This is an important point. The goal of precrisis homeostasis is, for better or worse, pragmatic; cost

effectiveness is the cursed term. Being pragmatic, however, does not mean that one cannot proceed beyond the patient's established precrisis neurotic homeostasis. If one accepts the dictum that a crisis is an opportunity for growth, a means of transgressing modes of coping that have failed, and an invitation to release spontaneous growth processes, it is possible within the prescribed few sessions available to bring an inpidual in crisis as well as the family to new potentialities. I believe this is where a dynamic orientation is so helpful. It is not necessary to delve too deeply in the unconscious during crisis; the unconscious with its wealth of encrusted needs and conflicts is already near the surface with the defenses shattered as they are. And latent creative drives may also be trying to surface. The therapist can, if alert, harness these forces and bring the patient to an awareness of how and why he is being victimized by some of his distortions and interpersonal shortcomings. If interpretations are presented skillfully in the context of the here and now, and identified underlying nuclear problems are related to the crisis situation, the therapist may promote changes far beyond pragmatic barriers.

Have telephone hot-lines for crises proven successful? Have any books been written on this subject?

On the whole, yes. But the adequacy of the service is entirely dependent on the quality of volunteer help available. Where volunteers are untrained and unskilled, the effect can be anti-therapeutic. A book on the subject has been edited by D. Lester and G. W. Brockopp (Crisis Intervention and Counseling by Telephone, Springfield, Ill., Thomas, 1976).

What is the best tactic in the case of a suicide risk?

A person who really is intent on taking his life will manage to do so stealthily. Endogenous depressions are especially disposed to do this; therefore, where in a depression there is a past history of a genuine suicidal attempt, or the patient has expressed a threat of suicide, electroconvulsive therapy should be instituted without delay. Temporary hospitalization may be essential in these cases unless the patient is consistently watched 24 hours a day. Suicide is especially possible as the patient begins to feel better and has more energy at his disposal.

Does a suicide threat call for immediate use of crisis intervention?

Suicide is often an angry communication and reflects an inability to resolve a personal crisis. Ruben

(1979) reports a study of 151 suicidal patients at the emergency department of a large general hospital over a 2-year period, 56 percent of whom acted impulsively and had no previous history of an emotional problem. He suggests that two-thirds of suicidal patients are excellent candidates for crisis intervention.

In the event of an actual suicidal attempt how should one proceed?

An assessment of the suicidal attempt is necessary. Was it motivated by a truly genuine desire to kill oneself or was it an appeal for understanding or help? Was there a revenge motif? If so, against whom—the people the patient is living with, parents, or whom else? Had there been threats of suicide prior to the attempt? What immediate events, if any, prompted the attempt? If the patient suffered a loss, is the loss permanent (such as the death of a mate)? Is there a chronic debilitating physical illness present, a desire to escape intractable pain, or evidence of a terminal illness like cancer? Was the method employed a well-designed and truly lethal method? Or was it poorly organized, and if so, was the attempt made with a hope to be rescued? How deeply depressed is the patient now? Is the depression recent, one of long-standing, or one that periodically appears? Has the patient received psychiatric help in the past, and if so, what kind of help and for what? What kind of support is now available to the patient (relatives, friends, organizations, etc.)? Is it possible for the therapist to establish a good contact with the patient and to communicate with him? How are relatives and friends reacting to the patient's attempt (angry, frightened, desire to be helpful, etc.)? Once answers to these questions are obtained, the therapist will be in a better position to deal constructively with what is behind the attempt. Should hospitalization be decided on, as when there is a possibility that the attempt may be repeated, the therapist should see to it that a responsible member of the family is brought into the picture immediately and follows through on recommendations protecting the patient from any lethal objects (drugs, knives, razors, etc.) and not permitting the patient to be alone until the patient is actually hospitalized. In the event hospitalization is not deemed necessary, the principles of crisis intervention with the patient and the family should immediately be instituted.

Are there any data on what happens to patients in a crisis who cannot be seen immediately and are put on a waiting list?

According to one study, fully one-third to one-half of the patients on a waiting list when contacted

later on will no longer be interested in treatment (Lazare et al, 1972). The reasons for this generally are that the patient having come for help in a crisis finds other resources to quiet him down or he works out the problems by himself even though some of the solutions prove to be poor compromises. Thus a man suffering from intense anxiety finds that drinking temporarily abates his suffering with the consequence that he becomes an alcoholic. A depressed woman who seeks companionship gets herself involved with and so dependent on a rejecting exploitative psychopath that she cannot break the relationship. A man having experienced several episodes of impotency detaches himself from women to avoid the challenge of sexuality. A youth out of college fearful of failing in an executive post with a good future decides to give up his job in favor of work as a laborer. To forestall such compromises it is important to interview the applicant if possible within 24 hours of the request for help. One way of circumventing a waiting list is to organize an intake group pending an opening in a therapist's schedule. Such an interim provision may surprisingly be all that some patients need.

Conclusion

Disruptive as a state of crisis may be, it can offer the victim an opportunity to develop new and healthier coping mechanisms. In initiating a state of disequilibrium that fails to clear up with habitual problem-solving methods, the crisis may energize old unresolved conflicts, reactivating regressive needs and defenses. Working out solutions for the crisis often will encourage more appropriate ways of coping. Thus, "the crisis with its mobilization of energy operates as a 'second chance' in correcting earlier faulty problem-solving" (Rapaport, 1962).

Studies of crisis states indicate that they usually last no longer than 6 weeks, during which time some solution, adaptive or maladaptive, is found to bring about equilibrium. The initial dazed shock reaction to a crisis is usually followed by great tension and mobilization of whatever resources inpiduals have at their command. Should efforts at resolution fail, they will exploit whatever contrivances or stratagems they can fabricate to resolve their troubles. The more flexible the person, the more versatile the maneuvering. Abatement of tension and cessation of the crisis state may eventually result in the restoration of the previous adaptional level and hopefully in the learning of more productive patterns of behavior. Failure to resolve the crisis, however, or continuance of unresolved conflicts may ultimately lead to more serious neurotic or psychotic solutions. Therapeutic intervention through crisis intervention

is required when patients cannot overcome difficulties by themselves and before there is entrenchment in pathological solutions.

Crisis therapy incorporates a number of active techniques implemented in the medium of a directive therapist relationship with the patient. It is essentially short term, oriented around two goals: (1) the immediate objective of modifying or removing the critical situation or symptom complaint for which help is being sought, and (2) the hoped-for objective of initiating some corrective influence on the inpidual's and family's customary behavior. The unbalancing of the family equation will optimistically institute changes in the behavioral patterns that have led up to the crisis. The theoretical framework governing the approach is problem solving. The methodologic strategies are eclectic in nature and recruit sundry tactics including interviewing, confrontation, environmental manipulation, drug therapy, hypnosis, group therapy, family therapy, and behavior therapy, depending on the needs and problems of the patient and the particular aptitude for working with a selected method.

The technique or techniques employed, while aimed at relieving the immediate crisis situation or symptomatic upset, will often set into motion certain resistances and defensive operations that if detected must be managed to prevent sabotage of the treatment process. In other words, even though the tactics may be nonanalytic, the patient's response to the techniques and to the therapist become a focus for exploration for the purpose of detecting and resolving resistances to change. Extensive personality modifications are not expected, but some modifications may eventuate as a serendipitous pidend, which often expands after therapy has ended. Follow-up interviews over a period of years have shown that this approach can score sustained symptomatic relief, freedom from further crises, and in some cases actual constructive personality alterations.