Psychotherapy Guidebook

Crisis Intervention

Donna C. Aguilera

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DEFINITION

The Chinese characters that represent the word "crisis" mean, appropriately, both danger and opportunity. Crisis is a danger because it threatens to overwhelm the individual or his family, and it may result in suicide or a psychotic break. It is also an opportunity because during times of crisis individuals are more receptive to the therapeutic influence. Prompt and skillful intervention may not only prevent the development of a serious long-term disability, but may also allow new coping patterns to emerge that can help the individual function at a higher level of equilibrium than before the crisis.

The outcome of a psychological crisis can be either growth or deterioration; it is a decisive moment. A person in crisis faces a problem that he cannot readily solve by using the coping mechanisms that have worked for him before. As a result, his tension and anxiety increase, and he becomes less able to find a solution. A person in this situation feels helpless; he is caught in a state of great emotional upset, and feels unable to take action on his own to solve his problem. Crisis Intervention can offer the immediate help that a

person in a crisis needs in order to reestablish equilibrium. This is an inexpensive, short-term therapy that focuses on solving the immediate problem.

HISTORY

The crisis approach to therapeutic intervention has developed only within the past few decades, and is based on a broad range of theories of human behavior, including those of Sigmund Freud, Heinz Hartmann, Sandor Rado, Erik Erikson, Lindemann, and Gerald Caplan. Its current acceptance as a recognized form of treatment cannot be directly related to any single theory of behavior; all have contributed to some degree. The following is a brief summary of some of the knowledge incorporated in the present practice of Crisis Intervention.

Sigmund Freud was the first to demonstrate and apply the principle of causality as it relates to psychic determinism. Simply put, this principle states that every act of human behavior has its cause, or source, in the history and experience of the individual. It follows that causality is operative, whether or not the individual is aware of the reason for his behavior.

An important outcome of Freud's deterministic position was his construction of a developmental, or "genetic," psychology. An individual's present behavior is understandable in terms of his life history or experience,

and the crucial foundations for all future behavior are laid down in infancy and early childhood.

Since the end of the nineteenth century the concept of determinism has undergone many changes. Although the ego-analytic theorists have tended to go along with much of the Freudian position, there are several respects in which they differ. As a group, they conclude that Freud had neglected the direct study of normal, or healthy, behavior.

Heinz Hartmann, an early ego-analyst, postulated that the psychoanalytic theories of Freud could prove valid for normal as well as abnormal behavior. He emphasized that man's adaptation in early childhood, as well as his ability to maintain his adaptation to his environment in later life, must be considered. Hartman also believed that although the behavior of the individual is strongly influenced by his culture, there is a part of the personality that remains relatively free.

Sandor Rado saw human behavior as based upon the principle of motivation and adaptation. He viewed behavior in terms of its effect upon the welfare of the individual, not just in terms of cause and effect. Rado's Adaptational Psychotherapy emphasizes the immediate present without neglecting the influence of the developmental past. The primary concern is with failures in adaptation today — what caused them and what the patient

must do to learn to overcome them.

Erik Erikson further developed the theories of ego-psychology, which complement those of Freud, Hartmann, and Rado, by focusing on the stages of development of the ego, and on the theory of reality. His theory of development is characterized by an orderly sequence of development at particular stages, each depending upon the other for successful completion. Erikson’s theory is important in that it offers an explanation of the individual’s social development as a result of his encounters with his social environment. His theories have provided a basis for the work of others who further developed the concept of maturational crisis, and began serious consideration of situational crisis and man’s adaptation to this current environmental dilemma.

Lindemann’s initial concern was in developing approaches that might contribute to the maintenance of good mental health and the prevention of emotional disorganization on a community-wide level. In his study of bereavement reactions among the survivors of those killed in a nightclub fire, he described both brief and abnormally prolonged reactions occurring in different individuals as a result of the loss of a significant person in their lives.

In his experiences in working with grief reactions, Lindemann concluded that it would be profitable to develop a frame of reference

constructed around the concept of an emotional crisis, as shown by the bereavement reactions. Lindemann's theoretical frame of reference led to the development of crisis-intervention techniques. In 1946, he and Gerald Caplan established a community-wide program of mental health in the Harvard area.

According to Caplan (1961) the most important aspects of mental health are: 1) the state of the ego, 2) the stage of its maturity, and 3) the quality of its structure. As a result of his work in Israel, and in Massachusetts with Lindemann, he evolved the concept of the importance of crisis periods in individual and group development.

TECHNIQUE

Why do some people go into a state of crisis and others do not? What factors decide whether an individual will regain a state of equilibrium or enter a state of crisis? There are three factors that seem to make the difference.

The first factor is the "perception of the event." The therapist asks the individual what the event means to him. How is it going to affect his future? Can he look at the event realistically, or does he distort its meaning? The second factor is termed "situational supports." In other words, what person in the environment can the client depend upon to help him? Who is available for him to talk to about this stressful event, and give him support? The third

factor is called “available coping mechanisms.” What does he usually do when he has a problem? Does he sit down and try to think it out? Does he cry it out? Does he get angry and try to get rid of his feelings of anger and hostility by swearing, kicking a chair, or the cat? Does he get into a verbal battle with a friend? Does he try to sit down and talk it out with someone? Does he need to temporarily withdraw from the situation in order to reassess the problem? These are just a few of the many coping skills people use to relieve their tension and anxiety when faced with a problem.

Some of the questions that should be asked for assessment are directed toward finding out the precipitating event — in other words, what happened — and the balancing factors. One of the first questions asked is: “Why did you come for help today?” Sometimes the client will try to avoid answering this question by saying: “I’ve been planning to come for some time.” This reluctance may be countered with, “Yes, but what happened that made you come in today?” Other questions the therapist should ask are: “What happened in your life that is different? When did it happen?”

In crisis, the precipitating event usually has occurred within ten days to two weeks before the individual seeks help. More often it is something that happened the day before, or the night before. It could be almost anything: the threat of divorce, discovery of a spouse’s extramarital relations, finding out a son or daughter is on drugs, loss of a boyfriend or girlfriend, loss of job or

status, an unwanted pregnancy, and so forth.

The therapist next focuses on the first factor, or how the individual perceives the event, by asking the questions noted above. Then the therapist can go into available situational supports. Who or what person in the environment can the therapist depend on to help the person? Who does he live with? Who is his best friend? Whom does he trust? Is there a member of the family that he feels particularly close to?

Because Crisis Intervention is limited to only six weeks or less, the more friends and relatives that are involved in helping the person the better. Also, if those involved are familiar with the problem, they can continue to give support when the Crisis Intervention therapy is terminated.

The third factor is finding out what the person usually does when he has a problem he can't solve. What are his coping skills? Questions asked would be: Has anything like this ever happened to him before? How does he usually get rid of tension, anxiety, or depression? Has he tried the same method this time? If not, why, since it usually works for him? If the individual has tried his usual method and it doesn't work, he may be asked why he thinks it doesn't work. What does the person feel he could do to reduce his symptoms of stress? Clients can usually come up with something the therapist hasn't thought of, and some will recall methods they haven't used in years.

One of the most important parts of the assessment is to find out if the individual is suicidal or homicidal. The questions must be very direct and specific: Is he planning to kill himself... or someone else? How? When? The therapist must find out and assess the lethality of the threat. Is he merely thinking about it, or, does he have a method picked out? Is it a lethal method, such as a loaded gun? Does he have a tall building or bridge picked out, but won't reveal where? Will he say when he plans to do it? — for example, a housewife may choose a time after the children leave for school. Usually, if the threat doesn't sound too immediate, the therapist can arrange for medication. If the suicidal intent is carefully planned and the details specific, the person is sent for psychiatric evaluation and hospitalization, in order to protect him or others in the community.

Experiences have verified that Crisis Intervention can be an effective therapy modality with chronic psychiatric patients. If a psychiatric patient with a history of repeated hospitalizations returns to the community and his family, his re-entry creates many stresses. While much has been accomplished to remove the stigma of mental illness, people are still wary and hypervigilant when they learn that a "former mental patient" has returned home to his community.

In his absence the family and community have, consciously or unconsciously, eliminated him from their usual life patterns and activities.

They then have to readjust to his presence and include him in activities and decision-making. If for any reason he does not conform to their expectations, they want him removed so that they can continue their lives without his possible disruptive behavior.

The first area to explore is to determine who is in crisis: the patient or his family. In many cases the family is overreacting because of its anxiety and are seeking some means of getting the "identified" patient back into the hospital. The patient is usually brought to the center by a family member because his original maladaptive symptoms have begun to reemerge. Questioning the patient or his family about medication he received from the hospital and determining if he is taking it as prescribed are essential. If the patient is unable to communicate with the therapist about what has happened or what has changed in his life, the family is questioned as to what might have precipitated his return to his former psychotic behavior.

There is usually a cause-and-effect relationship between a change, or anticipated change, in the routine patterns of life-style or family constellation and the beginnings of abnormal overt behavior in the identified patient. Often, families forget or ignore telling a former psychiatric patient when they are contemplating a change because "he wouldn't understand." Such changes could include moving or changing jobs. This is perceived by the patient as exclusion or rejection by the family and creates stress that he is unable to

cope with; thus, he retreats to his previous psychotic behavior. Such cases are frequent and can be dealt with through the theoretical framework of Crisis Intervention methodology.

Rubenstein (1972) stated that family-focused Crisis Intervention usually brings about the resolution of the patient's crisis without resorting to hospitalization. In a later article in 1974, he advocated that family Crisis Intervention can also be a viable alternative to rehospitalization. Here the emphasis is placed on the period immediately after the patient's release from the hospital. He suggested that conjoint family therapy begin in the hospital before the patient's release and then continue in an out-patient clinic after his release. His approach has also served to develop the concept that a family can and should share responsibility for the patient's treatment.

In Decker and Stubblebine's study (1972), two groups of young adults were followed for two and one-half years after their first psychiatric hospitalization. The first group was immediately hospitalized and received traditional modes of treatment, and the second group was hospitalized after the institution of a Crisis Intervention program. The results of the study indicated that Crisis Intervention reduced long-term hospital dependency without producing alternate forms of psychological or social dependency, and also reduced the number of rehospitalizations.

The following brief case study illustrates how one can work with a chronic psychiatric patient in a community mental health center using the crisis model.

Case Study: Chronic Patient in the Community

Jim, a man in his late thirties, was brought to a crisis center by his sister because, as she stated, “He was beginning to act crazy again.” Jim had many prior hospitalizations, with a diagnosis of paranoid schizophrenia. The only thing Jim would say was, “I don’t want to go back to the hospital.” He was told that our role was to help him stay out of the hospital if we possibly could. A medical consultation was arranged to determine if he needed to have his medication increased or possibly changed.

Information was then obtained from his sister to determine what had happened (the precipitating event) when his symptoms had started and, specifically, what she meant by his “acting crazy again.” His sister stated that he was “talking to the television set ... muttering things that made no sense ... staring into space ... prowling around the apartment at night,” and that “this behavior started about three days ago.” When questioned about anything that was different in their lives before the start of his disruptive behavior, she denied any change. When asked about any changes that were contemplated in the near future, she replied that she was planning to be married in two

months but that Jim did not know about it because she had not told him yet. When asked why she had not told him, she reluctantly answered that she wanted to wait until all of the arrangements had been made. She was asked if there was any way Jim could have found out about her plans. She remembered that she had discussed them on the telephone with a girl friend the week before.

She was asked what her plans for Jim were after she married. She said that her boyfriend had agreed, rather reluctantly, to let Jim live with them.

Since her boyfriend was reluctant about having Jim live with them, other alternatives were explored. She said that they had cousins living in a nearby suburb but that she did not know if they would want Jim to live with them.

It was suggested that Jim's sister call her cousins, tell them of her plans to get married and her concerns about Jim, and, in general, find out their feelings about him living with them. The call was placed, and she told them her plans and concerns. Fortunately, their response was a positive one. They had recently bought a fairly large apartment building and were having difficulty getting reliable help to take care of the yard work and minor repairs. They felt that Jim would be able to manage this, and they would let him live in a small apartment above the garage.

Jim was asked to come back into the office so that his sister could tell him of her plans to marry and the arrangements she had made for him with their cousins. He listened but had difficulty comprehending the information. He just kept saying, “I don’t want to go back to the hospital.”

He was asked if he had heard his sister talking about her wedding plans. He admitted that he had and that he knew her boyfriend would not want him around — “They would probably put me back in the hospital.” As the session ended, he still had not internalized the information he had heard. He was asked to continue therapy for five more weeks and to take his medication as prescribed. He agreed to do so.

By the end of the sixth week he had visited his cousins, seen the apartment where he would be living, and had discussed his new “job.” His disruptive behavior had ceased, and he was again functioning at his pre-crisis level.

Since Jim had had many previous hospitalizations and did not want to be rehospitalized, time was spent in discussing how this could be avoided in the future. He was given the name, address, and telephone number of a crisis center in his new community and told to visit it when he moved. He was assured that the center could supervise his medication and be available if he needed someone to talk to if he felt he again needed help.

Jim’s sister neglected to tell him about her impending marriage, which he perceived as rejection. Because of his numerous hospitalizations, he feared that his sister would have him rehospitalized “to get rid of him.” He was unable to verbalize his fears, retreated from reality, and experienced an exacerbation of his psychotic symptoms.

The therapist adhered to the crisis model by focusing the therapy sessions on the patient’s immediate problems, not on his chronic psychopathology. It is important to remember that the therapist’s role is to focus on the immediate problem. Both client and therapist must actively participate to solve the problem on a short-term basis. There is not enough time, nor is it necessary, to go into the patient’s past history in depth.

Crisis Intervention may seem easier and simpler than it is. It requires a knowledge of psychodynamics, and a lot of experience on the part of the therapist. Crisis Intervention requires the therapist’s total involvement, a commitment, and a keen sense of responsibility for the individual’s well-being.