Psychotherapy Guidebook

Family Crisis Therapy

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DEFINITION

Family Crisis Therapy is an active intervention technique to help a family (conjointly) resolve a crisis. The crisis is a state of increased tension, a suspension of long-term goals, and a revival of past conflicts. It is usually precipitated by stress and occurs in an individual or family that is especially susceptible. Very often the consequence of the crisis is regression, the development of psychiatric symptoms in one or more members of the family, and there may be a request for admission to a mental hospital. The crisis state may be resolved by efforts to master or remove the stresses that precipitated it.

Stresses may have sudden causes, such as an accidental death or the loss of a job. Other stresses occur around adolescence, a change in the composition of a family, or retirement. Stresses also occur when there is a change in role, the revelation of an old secret, or some other type of change requiring adaptation. The crisis can be resolved (and in most families usually is mastered) by taking some action to remove or master the stress, a change in role assignment, a change in rules, a change in goals, or even a change in

the way the family understands the past. The degree of maladaptive response is less related to the stress or the amount of change required than to the adaptive capacities of individual family members. Certain families avoid change, scapegoat individuals, or threaten dissolution. Tension increases and pressure may be placed on one member of the family to make impossible alterations. At this point a susceptible member of the family may become symptomatic or may seek escape through suicide, psychosis, and/or psychiatric hospitalization. The treatment is basically an effort to clarify the process to the family, to establish an atmosphere in which the member of the family identified as a patient may help the family reduce tension to the point where the immediate crisis is resolved. The family may learn to resolve similar problems more effectively in the future.

HISTORY

This crisis intervention technique was developed at the Colorado Psychiatric Hospital when I, along with Kaplan, postulated that those in need of immediate admission to a mental hospital could be treated by conjoint family interviews on an outpatient basis in order to avoid hospitalization. A full-time team was recruited in a five-year demonstration project carried on from 1964 to 1969. The results of Family Crisis Therapy in 150 families were compared with the results of mental hospital treatment for a similar size group of families. In all cases the families included an identified patient

judged in need of immediate admission. A variety of psychiatric illnesses were included, among them actively suicidal individuals, grossly psychotic persons, and the usual types of psychopathology seen in the population of an acute mental hospital population. The follow-up studies demonstrated that those treated by Family Crisis Therapy instead of hospitalization were far less likely to be admitted to a mental hospital in the future, were more effective at managing crises, and were functioning as well in terms of socialization, work, and absence of symptoms of mental illness as those hospitalized. The techniques are applicable to seriously disturbed individuals seen in mental health emergency services and also useful in somewhat modified fashion for predictable kinds of family crises seen by mental health professionals and other human services personnel. The principles of family crisis intervention are somewhat similar to those used in crisis intervention for individuals, though the more seriously disturbed are best treated in a conjoint family mode.

TECHNIQUE

This type of treatment is short-term and crisis-oriented. In the Denver experience the treatment consisted of an average of five office visits and one home visit over a three-week period. It can be described in a series of six steps, which may be simultaneous instead of consecutive:

1. **Immediate aid.** The family should be seen at once whenever the crisis occurs and help is requested. This may be at any hour of the day or night and the promise of immediate availability around the clock should be made from that time on.

2. **Define the problem as a family crisis.** The absent members of the household should be called in. Attempts to avoid defining the problem as a family crisis by considering the difficulty to be limited to one member should be blocked. The most convincing way of defining the problem as belonging within the family is to insist on conjoint meetings only and to refuse to see any member of the family individually. Hospitalizing any single member of the family gives the group a clear message about the locus of the problem.

3. **Focus on the present.** The history of events leading up to the crisis should be obtained. The past may be used to understand the present and past strengths are stressed. The history of the current problem serves to define the nature of the crisis and the problems that precipitated it.

4. **Reduce tension.** Block excessive regression by reassurance and support. Medication is used as needed for symptom relief in any member of the family, not just the identified patient.

5. **Resolution of the current crisis.** Tasks are assigned for resumption of functioning and for resolution of the crisis state. The therapist takes an active role in managing as a substitute executive until the family can take over necessary functions themselves. The conflicts in role assignment and

role performance as well as overt and covert family rules are negotiated with the family as a whole.

6. **Management of future crises.** The availability of crisis intervention for future problems is stressed. For long-term maladaptive behavioral problems referral may be made, but this should include direct contact with the agency to whom the referral is directed.

This type of treatment is one that requires an active type of intervention by the therapist. It is also different from long-term family therapy in which interactional conflicts of long-standing are the focus of attention. A great deal of flexibility is required. Meetings vary in length from a few minutes to two or three hours, but the average length of a session seems to be from one to one and a half hours. It could be carried on by one therapist, but there are often advantages to having co-therapists. The number of family members seen together ranges from two to as many as nine or ten. It is often useful to insist on all family members, including young children, being present while reserving the right to eliminate young children from the group at the time of later visits. The family, for purposes of this type of treatment, is defined as all of those who live under one roof, though extended family members who live nearby may also be included.

A home visit is highly useful in doing family crisis work because this gives the family opportunity to reveal strengths and to maintain freedom of

movement while yielding a great deal of information about family composition and current interaction. The telephone is used freely. After an initial contact in which therapist and patients view one another face to face, the telephone is a useful adjunct. Once a relationship is established there is little that can be done in the office that cannot be done by telephone, except perhaps giving medications or evaluating new symptoms.

It is sometimes helpful to focus immediately on the least involved member of the family while ignoring the identified patient. It is equally useful to avoid acknowledging psychopathology. The negotiations with the family must avoid blame and support must be constantly available. The ideal attitude toward the identified patient is one of ignoring or avoiding symptoms while maintaining sympathetic respect for the message that these symptoms transmit. Symptoms are translated as a comment on the problems in the current situation rather than evidence of sickness.

APPLICATIONS

The technique was developed for acute situations, particularly recent onset of dysfunction and symptom development. Acute schizophrenic reactions, depressions, or crisis situations in those who have been labeled as having personality disorders are often relieved in this type of therapy. The termination should include instructions about future crises as well as an

attitude of expecting them to occur. Telephone contact is often all that is necessary when the prior crisis intervention has resulted in rapid relief of symptoms and return to functioning.