American Handbook of Psychiatry

PROGRAMS AND TECHNIQUES OF CRISIS INTERVENTION

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e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 2* edited by Silvano Arieti, Gerald Caplan

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PROGRAMS AND TECHNIQUES OF CRISIS INTERVENTION

The dictionary definition of “crisis” is “a decisive or vitally important stage in the course of anything; a turning point.” As such, its great importance in human existence has been known since the beginning of recorded time. Yet, though man has long known that crucial periods do affect his destiny, psychiatrists and other mental health professionals have shown little recognition of the significance of crisis until very recently.

The present state of the field is one of rapid growth; as often occurs when progress is rapid, different areas of the field are not fully integrated with one another. In order to organize the material for purposes of this presentation, three major areas will now be defined and briefly described: (1) crisis intervention programs, (2) crisis theory, and (3) crisis intervention techniques.

1. For purposes of this chapter, crisis intervention programs will be defined as organized facilities[1] (such as clinics) or components of organized facilities (such as crisis units of community mental health centers), staffed by mental health professionals and offering early-access, brief treatment to non-hospitalized persons.[2] Early access means no or minimal delay; brief treatment means limits on total length of treatment or on number of visits. A

frequent limit is six visits. For purposes of this essay, crisis intervention programs may or may not use crisis theory as their major theoretical base.

2. Crisis theory is defined as an important and recently developed theoretical framework, originally based on the work of Lindemann and Caplan and subsequently further developed by others, including Bloom, Harris et al. Jacobson, Kalis, Kaplan and Mason, Klein and Boss, Langsley and Kaplan, Morley and Brown, Parad and Parad, L. Rapoport, R. and R. N. Rapoport, Strickler, and others.

3. Crisis intervention techniques are defined here as treatment techniques based on crisis theory and used by mental health professionals. Thus, while crisis intervention programs will be discussed regardless of their theoretical base, techniques will only be considered when they relate to crisis theory.[3] I will discuss crisis intervention programs, crisis theory, and crisis intervention techniques, concluding with a consideration of other subjects and current frontiers.

The experience at the Benjamin Rush centers in Los Angeles[4] is the source of significant parts of this chapter. The Rush centers offer treatment on the day of application if possible, and always within one week. Treatment is offered to anyone who desires it without regard to financial or diagnostic status, unless the applicant is already in treatment with a mental health

professional elsewhere. Treatment is limited to six visits, and the average number of visits is four. Crisis intervention is carried out by a multidisciplinary staff, including psychiatrists, psychologists, social workers, and nurses, as well as trainees in all these disciplines. The methodology will be described in the section on crisis intervention techniques. At the conclusion of crisis intervention, referral is made to other facilities if necessary. The Rush centers are administratively independent divisions of the Los Angeles Psychiatric Service, a nonhospital community facility supported by private and public funds, which also operates ongoing outpatient treatment clinics and specialized programs for black and Spanish-speaking minorities. The Rush centers serve both middle- to lower-middle-class whites and a significant number of members of minority (black and Spanish-speaking) groups and of the poor of all races. One of the Rush centers is located in the Venice district of Los Angeles, sometimes described as "Appalachia-by-the-Sea." To date, approximately 12,000 different persons have been seen since the Rush centers began in 1962; the current rate is 2,400 different persons seen per year. The Rush centers have been described in a number of publications.

Crisis Intervention Programs

Crisis intervention programs are a recent and rapidly growing addition to the psychiatric scene. Only a limited number of reports have yet appeared

in the literature. Table 55-1 summarizes eleven programs. This list undoubtedly contains omissions of program, either because they were overlooked or because they are too recent. A few reports have been omitted because the authors state that their program was in large part based on some of the programs that are listed. The table intentionally omits programs offering evaluation and referral services only. This omission does not reflect on the contribution of these programs, some of which provide comprehensive assessment followed by referral. They do not offer treatment. Emergency services that also offer treatment are included.

Table 55-1. Crisis Intervention Programs in the United States

PROGRAM	LOCATION	YEAR STARTED
Wellesley Human Relations Service	Wellesley, Mass.	1948
Walk-In Clinic of the Bronx Municipal Hospital	Bronx, N.Y.	1956
Precipitating Stress Project, Langley Porter Neuropsychiatric Institute	San Francisco, Cal.	1958
Trouble-Shooting Clinic at Elmhurst City Hospital	New York, N.Y.	1958
Greater Lawrence Guidance Center	Lawrence, Mass.	1960
Emergency Psychiatric Treatment Service, Kings County Psychiatric Hospital	New York, N.Y.	1961
Benjamin Rush Center for Problems of	Los Angeles, Cal.	1962

Living		
Walk-In Clinic at Metropolitan Hospital	New York, N.Y. (East Harlem)	1962
Family Treatment Unit, Colorado Psychiatric Hospital	Denver, Colo.	1964
Mental Health Clinic, Maine Medical Center	Portland, Me.	1964
Intake Reception Clinic, Maimonides Hospital of Brooklyn	Brooklyn, N.Y.	1964

Goals and Rationale

Goals and rationale of crisis intervention programs relate to two characteristics of these programs: ready access and brief treatment. They also relate to the kinds of persons who are served.

Ready access—immediately if possible, and always within a few days and with no waiting list—is offered in the expectation that the earlier a disturbance is treated, the less likely it is to result in more chronic and more severe malfunction. This is the same principle involved in prevention and early treatment of medical illness. To the extent that crisis intervention can prevent later and more serious disability, it helps to reduce human suffering and also results in more economic use of money and manpower. This preventive function is an important aspect of crisis intervention programs. Also, a crisis lasts up to six weeks, so that crisis intervention programs based

on crisis theory can only be used if treatment is offered without delay.

Brief treatment usually consists of up to six visits. The rationale for brief treatment is that many people do not want and/or do not need longer term treatment, but do want and need help in resolving immediate issues. Also, intervention at what Small called "crisis—the propitious moment" can provide maximum impact per unit of mental health manpower because there is greater responsiveness to intervention and because rapid changes for better or worse occur in the course of a short period of time. Brief treatment, to be most effective, should not be an abbreviated or second-rate version of what some feel is the only real treatment, namely, longer-term therapy. Rather it should be of such a nature that it not only can be carried out within a brief time period but that it cannot possibly be extended without changing it qualitatively. Crisis intervention techniques that meet this requirement are discussed later.

The third goal is that of offering treatment to all types of persons who need help and are not receiving it, with few if any exclusions. The rationale is the view that there are many persons who in subtle or obvious ways are excluded from mental health settings, except those of last resort, such as state hospitals. Hollingshead and Redlich pointed out that those psychiatric services considered most prestigious, such as dynamically oriented outpatient treatment, are more readily available the higher the person's social

class status. The poor are more likely to receive somatic treatment or drugs and, we may add, a round robin of referrals from one facility to the other without any treatment. The same type of overt or covert selection tends to apply to other groups, such as the aged, the less well educated, and, regardless of demographic characteristics, to persons severely disturbed and to those wishing help with immediate problems rather than character change. Crisis intervention programs can and do serve all population groups. If any discrimination is legitimate in crisis intervention programs, it will favor those less likely to get treatment, such as the poor or the psychologically most severely disturbed.

Organization

A number of organizational models for crisis intervention programs exist. In some cases they are administratively part of a hospital emergency room or of either the inpatient or outpatient services. Elsewhere, crisis intervention programs may be independent units. In my opinion, the optimum organization may be the last mentioned: a crisis intervention service independent of, and on a par with, inpatient, outpatient, partial hospitalization and other services. The need for a new component in the spectrum of mental health services has been reflected by the requirement that emergency services be one of the five required components of federally funded community mental health centers. (The other services are inpatient,

outpatient, partial hospitalization, and consultation and education.)

Some advantages of autonomous status are as follows: When crisis intervention or emergency services are part of inpatient services, a conflict of interest is possible when staff are required to work actively for alternatives to hospitalization, particularly in instances where there is no shortage of beds. If there is a shortage of beds and an overworked staff, on the other hand, emergency services that are part of the inpatient service may not have the staff or time to provide more than evaluation for admission and more or less thorough referral to other units in the facility or community. When crisis intervention services are administratively part of the outpatient service, it is possible that ongoing treatment may be considered the preferred modality by many professionals and that crisis intervention may not receive the professional investment it requires to be successful.

It is desirable for crisis intervention programs to have as their primary function the provision of ready access, brief treatment. While they must, of course, be able to refer to other services, they should if possible be more than an entry control point that turns some people back and directs others to various services.

The physical location should follow from the above considerations. If the internal administrative arrangements and the attitude of the community

make it feasible, all new cases coming to a facility (such as a community mental health center) may first be seen in the crisis intervention program. In that case, the crisis intervention program is also the emergency service, and it is available twenty-four hours a day. If this is done, it is desirable that the program have the authority to determine whether the person should be treated by crisis intervention techniques and whether and when he should be referred elsewhere in the facility or community.

In many cases it will not be feasible for the crisis intervention program to receive all admissions. When that is the situation, other ways must be found to decide who is seen in the crisis intervention program and who is seen elsewhere. At the Benjamin Rush centers we have solved our problem by placing the Rush center around the corner from the psychiatric clinic, which has a different name, street address, and application procedure. Admission to one clinic does not mean admission to the other. The names and functions of the different clinics are widely known in the community. With this arrangement the applicant decides whether to apply for crisis intervention or ongoing treatment.

In other settings there might, in addition, be need of a central intake office, which directs applicants to any service, including the crisis intervention program. In such a case it is important not to lose the walk-in feature, which allows direct access to the crisis intervention program. If the

crisis intervention service does not itself function as the twenty-four-hour emergency service, it must have a close working relation with a twenty-four-hour service in the facility or the community.

The question of what the maximum number of visits should be touches on many of the same issues. Some clinics have no firm maximum; some use the early-access, brief treatment clinic to see long-term cases who come regularly but infrequently. There is a definite case to be made for a firm time limit. The reason is similar to that for recommending an autonomous status for the clinic. We have already said that longer treatment is both easier and conforms more to the values of many psychiatrists and other professionals than crisis intervention services. Therefore, placing a firm limit on the number of visits assures that crisis intervention alone remains the focus of professional activity. At the same time, a firm limit is also helpful to the person in crisis, since he knows he must address himself to the current issues in his life without procrastination.

Any form of longer treatment, including low-frequency treatment, is in our experience more effectively carried out within the framework of a more conventional outpatient clinic. On the other hand, we have found, as did Raphling and Lion, that some people use crisis intervention programs when they need them, and function on their own the rest of the time. We feel that this use of crisis intervention may sometimes be preferable to long-term

treatment, especially for people with borderline states and severe character disorder. At the other end of the spectrum, intermittent use of crisis intervention may be helpful to people who function well except for occasional crises. The difference between ongoing treatment and repeated admissions is not so difficult to define as we thought it would be; rarely does one person have more than two admissions per year, and then they are usually around quite distinct issues. If someone applies more often, an attempt is made to refer to longer-term treatment.

Problems

Crisis intervention programs must deal with a number of difficulties. Compared to more traditional outpatient facilities, they require new skills from professionals. In addition, work in crisis intervention programs is demanding, because the turnover means that the professional must deal with a succession of different people and problems rather than with a few familiar ones, as is the case in ongoing treatment. Also, it is hard to be continuously involved with acute problems. Further, crisis intervention programs challenge some of the value systems of psychiatrists and other mental health professionals, which include the belief that their goal should be to cure patients, rather than to help resolve circumscribed problems, however urgent. Coleman and Gelb and Ullman addressed themselves to some of these issues. For the above described reasons, there is a constant tendency on the

part of many mental health professionals to revert to other models. This tendency must be counteracted if the crisis intervention program is to remain viable.

To deal with these problems, the crisis intervention program should provide a high degree of professional satisfaction to the staff and trainees involved. There should be adequate financial compensation; and there should be a recognition of the difficulty of the work. In addition, professionals in crisis intervention programs should have considerable supervision, both to deal with their inevitable anxieties about their clinical work and to assure that a change to ongoing treatment models does not occur.

Crisis Theory

Origins

Crisis theory has evolved from a number of sources, the two most important of which are psychoanalysis and social work/sociology. The contributions of psychoanalysis are usually traced back to Freud's use of brief treatment and his prediction, in 1919, that new techniques modifying psychoanalysis would be available when the poor man, as well as the rich, would receive help for his mental suffering. The psychoanalytic contribution was further enhanced by Erikson's concept of developmental crisis, with the

crisis of adolescence as its prototype. Psychoanalytic concepts have made a major contribution to crisis theory as it exists today. Among components of crisis theory either derived from or significantly influenced by psychoanalytic theory is that of an equilibrium involving various forces and maintained by homeostatic processes. This concept is derived from that of the dynamic point of view in psychoanalysis, which is one of its four major viewpoints.® Also derived from psychoanalytic theory is the concept of coping, at least insofar as it reflects defense mechanisms. A comprehensive discussion of the relation of crisis theory to psychoanalysis is beyond the scope of this chapter.

Social work and sociology contributed some of the concepts relating to crisis as an important response to changes in the social orbit, that is, family, friends, work, religion, and so on. The concept of social role, which is sometimes used in crisis theory, also comes from sociology. Social role relates to society’s expectation that an individual carries out roles in relation to a social group, such as the family, work, or religion. When there is a sudden or major change involving one of these roles, a crisis may ensue. For example, the death of a spouse, in addition to its psychological meaning, also means the loss of the social role of spouse and a need to learn a new social role, that of widow or widower.

Some of the contributions of social work include the setting of limited goals related to enhancing adaptive abilities in dealing with specific life

problems. The worker elicits the cooperation of the conscious ego in focusing on certain circumscribed issues, including those of role dysfunction. The importance of precipitating events is recognized. Character change, though it may occur, is not the caseworker's main goal. Support is offered for those defenses that are used adaptively.

Some contributions have also come from psychology. The focus on individual strengths and growth potential in Rogerian counseling psychology is similar to the emphasis on the opportunity for growth afforded by crisis. There are some similarities but also significant differences between the brief treatment approach of crisis intervention and the brief treatment approach of behavior therapy.

One of the major original contributions to crisis theory is the work done by Lindemann on grief reactions, first published in 1944. Lindemann found that there were distinguishable patterns of normal grief different from maladaptive responses to bereavement and that the latter could lead to long-term disturbances and in some cases to psychiatric illness. He noted that the first six weeks after the bereavement were crucial in determining whether normal grief or a more maladaptive resolution was likely to occur. Crisis theory was subsequently greatly advanced by the work of Lindemann and Caplan at the Wellesley Human Relations Service, established during 1948, and by their work at Harvard University. Many of the formulations in this

discussion derive from the writings of Gerald Caplan.

Major Principles

In the following, crisis theory will be defined as relating to individuals mainly; some concepts of crisis theory also apply to families and small and large groups.

The special contributions of crisis theory can be summarized by three major principles. (1) Crisis theory involves a high degree of attention to the phenomenon of psychological crisis, including its etiology, course, and outcome, and it involves a correspondingly intentional relative neglect of other psychological processes. Conventional psychiatric theory, on the other hand, emphasizes life-long psychological phenomena and may further selectively emphasize the phenomena of early childhood. Using the analogy of a microscopic examination of a given slide, most psychiatric theories use high magnification of the childhood period; crisis intervention uses high magnification of the phenomena of the current crisis. So conceptualized, crisis theory has no conflict with other approaches; rather it constitutes a selective emphasis on phenomena heretofore neglected. (2) Crisis theory emphasizes the potential of crisis not only for pathology but also for growth and development. This concept, early proposed by Erikson, looks at crisis as both a danger and an opportunity. It is a danger because existing coping

mechanisms are inadequate to deal with the current problem; it is an opportunity because new coping mechanisms may develop that can be used in both the present and future crises.[5] (3) Crisis theory, to a greater extent than most psychiatric theories, views men in the ecological perspective of himself in his human and natural environment. It is concerned with what goes on in the world around us, as well as within ourselves, and it conceptualizes the effects, for better or worse, of the interaction between these inner and outer worlds.

Crisis Phenomena

Crisis is described by Caplan as "an upset in a steady state." When an individual is not in crisis, an equilibrium exists that is maintained with minimal awareness by the use of habitual problem-solving (or coping) mechanisms. Certain events may pose an actual or potential threat to fundamental need satisfactions and thus upset the equilibrium.[6] Events that threaten these needed satisfactions are defined as emotional hazards or, simply, hazards. They may relate to changes in the physical surroundings, social sphere, or biological function of an individual.

Whether or not a given event constitutes a hazard depends both on the event and on its meaning to the individual. Some events are uniformly hazardous, such as bereavement. Others, such as marriage or promotion, are

hazardous to persons whose previously learned coping mechanisms are not adequate to meet the tasks involved in the new situation. Strickler and LaSor distinguished between the precipitating event, its emotional meaning, and the specific loss it threatens or implies.

A significant emotional hazard can trigger a crisis that, as Caplan defined it, “Is provoked when a person faces an obstacle to important life goals that is for a time insurmountable through the utilization of customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many different abortive attempts at solution are made. Eventually some kind of adaptation is achieved, which may or may not be in the best interests of that person or his fellows.”

Caplan described four stages of crisis: (1) an initial rise in tension calling forth habitual problem-solving responses; (2) a further rise in tension and a condition of ineffectiveness; (3) a still further rise in tension accompanied by mobilization of external and internal resources; and (4) if all fails, a last stage of a major breaking point with disorganization of the personality. The latter stages are characterized by mounting anxiety and depression and by a sense of helplessness (being trapped) and hopelessness. They also involve varying degrees of regression of ego functions to more primitive levels than existed during more stable periods. This regression is reversible once the crisis is resolved. At any stage, the crisis can end if the

hazard disappears or if a solution is found involving different ways to obtain the need satisfactions whose loss is threatened or, if this is not possible, if the loss is recognized and accepted. Most authors agree that the acute stage of crisis lasts no longer than four to six weeks after onset.

As already noted, one of the key points in crisis theory is that there is a range of possible outcomes in relation to adaptiveness. A diagram adapted from Hill (see Figure 55-1) helps illustrate this point. The vertical axes illustrate degree of adaptiveness of outcome; the horizontal axes represent time. Regardless of the level of adaptiveness of initial functioning, considerable variation in the end position of the adaptiveness scale exists.

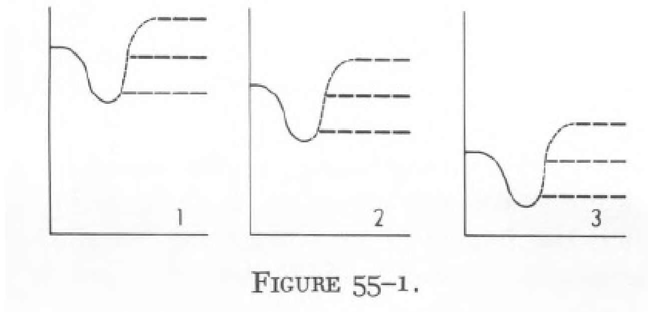

FIGURE 55–1.

Factors affecting crisis outcome include social and cultural prescriptions of behavior; influence of family and friends; influence of community caretakers, such as physicians and clergymen; and, of course, the effect of crisis intervention programs.

General criteria for adaptive outcomes of crisis have rarely been reported, though they have been described for particular crises, such as that of premature birth. One important aspect of maladaptive outcome has received deserved attention: the role of crisis in psychiatric illness. Caplan pointed out that while crisis is not pathological in itself, it may constitute a turning point in the history of psychiatric patients. Confirming this view, Harris, Kalis, and Freeman found that precipitating events were important factors in bringing people to seek outpatient treatment and Adamson and Schmale found recent important losses in forty-five out of fifty admissions to an acute psychiatric service. The events precipitating the losses or threats of losses ranged from doctor's departure to broken romance to hysterectomy to sister's marriage.

In addition to psychiatric illness, maladaptive outcome of crisis at least as often, I believe, results in the deterioration of interpersonal relations. The ego regression characteristics of crisis result in increased use of the primitive mechanisms of projection, introjection, and denial. Hostility in the self is projected onto others and expressed in suspicious and hostile behavior. This behavior provokes at least partly realistic hostility from others. These others, perceived as hostile, both realistically and due to projection, are then introjected, resulting in further lowering of already low self-esteem. The low self-esteem is intolerable and leads to further projection. This vicious cycle may continue to suicide, psychosis, or the deterioration or dissolution of

relationship. On the other hand, adaptive resolution results in a corresponding benign cycle, consisting of projection of one's own positive feelings of mastery and self-esteem, resulting in positive feedback and introjection of the positively viewed others. In practice, the outcome of any given crisis may include both positive and negative aspects. Deterioration or growth of long-term relationships may be characterized by repeated crises with varying outcomes, determined by whether positive or negative outcomes predominated the various crises that occurred during the course of that relationship.

Before leaving the subject of crisis theory, reference should be made to a volume edited by Parad, containing many contributions to the subject, and to a summary article by Darbonne.

Crisis Intervention Techniques

We have discussed in the above section how crisis may, on the one hand, precipitate new or exacerbated psychiatric illness and deterioration of relationships, and how, on the other hand, it may result in increased effectiveness of functioning. These considerations make it clear that crisis intervention techniques have an important role to play. This section will describe crisis intervention techniques used by mental health professionals and based in significant part on crisis theory. This definition does not include

two important areas: the first relates to techniques based on other theoretical frameworks; the second deals with techniques that in whole or significant part are used by non-mental health professionals. I have elsewhere referred to and discussed some techniques in this last group.

Who is the person in crisis who should be treated? Considerable difficulty can be avoided by assuming that the person in crisis is the person who phones or comes for help, regardless of who is designated by that person as having the problem. Thus the person who calls or comes should be involved whenever possible; a tactful approach that does not imply that anyone is sick is necessary to involve someone who does not overtly seek help. A related recommendation is to see all people who come together, at least initially, since they are often involved in a common crisis.

Some activities carried out in crisis intervention programs and not specifically related to crisis intervention include the assessment of indications for hospitalization. These are usually limited to life-threatening behavior, since avoidance of hospitalization is an important goal.[7] Psychiatric diagnosis is necessary to the extent of ruling out organic factors and noting the nature and intensity of symptoms and of determining the general diagnostic category. Adjunctive drug treatment is used for the management of psychotic symptoms, severe depression, and overwhelming anxiety, with the clear understanding that it is not the main modality.

The remainder of this section deals with the specifics of crisis intervention techniques.

Principles

The principles and goals of crisis intervention parallel the three principles of crisis theory discussed above. The first principle of crisis theory is that which involves a high degree of attention to the phenomena of the current crisis, with a relatively intentional neglect of life-long psychological phenomena. Crisis intervention correspondingly selectively emphasizes the goal of achieving optimal crisis resolution. Chronic problems are deliberately disregarded during crisis intervention, sometimes a difficult task for the mental health professional, who feels he must cure everyone.

The second principle is that crisis represents a danger as well as an opportunity. Crisis intervention aims at arresting and reversing ego regression and thus averting the danger of new or exacerbated psychiatric illness and/or deterioration of relationships. It seeks to return the individual to at least the pre-crisis level of functioning, and hopefully to a better one.

The third principle relates to the ecological perspective of man in his world. Crisis intervention aims at improving the relationship of the individual with the world in which he lives by helping him take appropriate action in solving specific problems.

The above conceptualization and the description of individual crisis intervention that follows is based on the application of crisis theory to the treatment program developed at the Benjamin Rush centers.

Individual Crisis Intervention

Some of the features of individual crisis intervention also apply to family and group crisis intervention methods, which are discussed below. The first step of the intervention is to identify the event that has disturbed the previously existing equilibrium. Sometimes the event is obvious, such as a separation or bereavement. Somewhat more often the person presents with the feelings of upset, helplessness, and hopelessness characteristic of crisis, but without identifying any important change in his life. In that case, the first task of the intervenor is to identify the event that has upset the equilibrium. With a diligent search it is almost always possible to find such an event within two weeks prior to the application for help. We find that unless a person's level of tension has risen to the point where he seeks help within two weeks after a given event, it is not likely that he will do so. Once this event is found it becomes the central point of the formulation of the crisis. Events before and after the key events are investigated and integrated into the overall formulation insofar as they are relevant to the key, or precipitating, event.

The search for the precipitating event is veritable detective work. The

intervenor is guided by a knowledge of the events that are generally hazardous for anyone. The most serious hazard overall is probably the loss of a spouse by death, separation, or divorce. Other generally hazardous events include death of a family member other than the spouse; jail terms for family members; serious physical illness; lengthy unemployment or retirement.[8] In addition to knowing which hazards are important regardless of age and sex, the intervenor should also know which areas are most important in producing hazards at different ages and for either sex. For example, emancipation of young adults from parents is an important source of hazard for all concerned; dating, engagement, marriage, and child-bearing are sources of hazards for young adults; successes and failures in work life may be sources of hazards at any age for men, and increasingly for women; hazards involving illness, bereavement, and aging occur in later life.

In addition to identifying the actual event, the intervenor must understand its emotional meaning in order to determine whether it constitutes a hazard. A bereavement, for example, may have a number of meanings, including the loss of emotional support, financial support, sexual satisfaction, or social role of spouse. The birth of a child may constitute a hazard for a man because he fears loss of dependent gratification from his wife and/or because he fears to compete with his own father and/or because he wanted a child of a different sex. In determining the meaning of a precipitating event, the intervenor looks for real or symbolic relationships

with significant events in the past. For example, the loss of children by marriage may be especially difficult for persons who have never reconciled themselves to the loss of their parents.

Next, the intervenor formulates the dynamics of the current crisis. In doing so he will use the theoretical framework with which he is familiar. If he is psychoanalytically trained or oriented, the formulation will include reference to unconscious instinctual and superego forces, as well as to ego functions and to reality.[9] If the intervenor is primarily oriented to reality considerations, as in the case of some (though not all) social workers, most of the emphasis will be on reality factors and on ego functions, including changes in social roles. Keep in mind that we are discussing the conceptualization in the intervenor's mind, and not necessarily what will be shared with the person in crisis. Whatever his theoretical framework, the intervenor will arrive at as clear as possible an understanding of the nature of the psychological disturbance resulting from the hazard and of the possible new equilibrium that may result. For example, a man may respond to his wife's taking a job with a crisis involving feelings of pathological jealousy. The intervenor may recognize an upsurge of homosexual impulses. He will also recognize, on the ego level, a felt threat to the masculine role of provider. He may decide that the outcome may range from development of a psychosis to the taking of action that enhances the masculine self-image,, such as an increase in heterosexual activity or achievement in competitive sports, or a

redefinition of the relationship with the wife that results in renewed reassurance about his masculinity.

Treatment can be divided into cognitive, affective, and behavioral aspects. The cognitive aspects consist of communicating the intervenor's understanding to the person in crisis in language the latter can understand. He stays relatively close to the surface, so that the formulations can be assimilated within the available time. Interpretations relating to ego functions and to reality are usually preferred; only rarely (especially with persons who have had previous treatment) can so-called deeper material be fruitfully integrated into crisis intervention. The intervenor must keep in mind that the goal of his comments is not to resolve long-standing conflicts but to help the person to understand better what his choices are now. It goes without saying that sensitivity, warmth, and empathy are necessary in crisis intervention, as in all psychotherapy.

It is not unusual for a person in crisis to react with an audible sigh of relief to the identification of the precipitating event and to a clear formulation of hazard and crisis. Dynamically, I believe this is due to an interruption of the regressive process which occurs as soon as the person in crisis recognizes a specific and therefore manageable problem in the present.

If the situation does involve a real loss, the next step consists of helping

the person express appropriate affect, including grief. Other crisis-related affects, particularly anger, should also be ventilated, but care should be taken that the person deal with guilt over anger before expressing it and also that he be helped to direct his anger into appropriate, reality-oriented channels. Regressive, infantile affect should not be mobilized or encouraged.

Finally, work is done on finding new ways of coping with the changed reality situation. The intervenor rarely needs to give advice; with better cognitive understanding and with affective release, the person in crisis can mobilize his resources to find the solution best for him. Character change cannot usually be expected in crisis resolution, but some new coping can be learned, and existing coping can be modified and combined in new ways.

Coping mechanisms as usually defined include but are not limited to defense mechanisms. The classification of coping mechanisms is one of the areas in crisis intervention where much progress can still be made.[10] This limitation is not a grave one as far as practice is concerned, however. The intervenor conceptualizes usual coping behavior in everyday language, and in so doing makes reference to the thinking, feeling, and behavior of the person in crisis in relation to the person(s) and/or life areas involved in the crisis. A few examples derived from actual case material include coping with a difficult boss alternately by submission and by rebellion; coping with the need to get enough heroin to satisfy an addiction by stealing in the company of a friend;

coping with overwhelming rage by excessive drinking; coping with feelings of inadequacy by belonging to a motorcycle gang.

Having defined the significant coping mechanism, the reason why it is no longer available is determined. In the above examples, rebellion against the supervisor may have resulted in loss of a job; the friend who made the heroin addict's stealing possible was arrested; excessive drinking has led to serious physical illness; an accident made motorcycle riding impossible. The last step is the exploration of which of the available coping patterns is the most adaptive. The rebellious person may shift his rebellion to social issues and get his job back; the motorcycle rider may get recognition for artistic accomplishment, and so on. Adaptive coping also includes an acceptance of what is inevitable. Naturally, the development of new ways of coping does not occur overnight; but the outcome of the crisis will determine the direction that will be pursued.

The closing phase of crisis intervention consists of a review of gains made and of anticipatory planning in regard to the handling of future hazards. The question is then asked whether there are indications for referral to ongoing treatment. This question has intentionally been ignored until crisis resolution was complete. Now, for the first time, chronic disturbances are considered, with reference to the question whether there is need and motivation for longer-term treatment and whether appropriate treatment

facilities are available. If so, referral for further treatment is made. As already mentioned, we found that some very disturbed persons either do not want further treatment or the very long-term treatment they need is not available. In such cases, the use of a crisis intervention facility when needed may be the best disposition.

The following case example illustrates individual crisis intervention; this was a case in which it took considerable work to understand the hazard. A wife complained of increased drinking by her husband. Nothing had apparently changed in the marital relationship. However, there was a shift in the wife's work situation, which had resulted in decreasing satisfactions for her there. This had caused her to put increased pressure on her husband, which in turn had increased his drinking. Intervention consisted of eliciting and then pointing out this chain of events and also of helping her recognize and express the disappointment of her job, while understanding that she was inappropriately displacing that disappointment onto her husband. The marital situation and the husband's drinking both improved after the wife—the only person seen—received crisis intervention.

Family Crisis Intervention

Emphasis on the family has been an important part of crisis intervention from its inception. The most extensive report on family crisis

intervention comes from the Colorado Psychiatric Hospital, as reported by Langsley and Kaplan. Family treatment was used there as a successful alternative to psychiatric hospitalization. The principles of intervention included immediate aid, defining the crisis as a family problem, and focusing on the current crisis. The intervention included the identification of psychotic symptoms as an attempt to communicate and specific prescriptions for the family designed to bring about such changes of role assignments within the family as are required to restore the homeostasis disturbed by a particular event, such as the birth of a child. Tasks are assigned to the family, such as working out of dating rules for adolescents, if the adolescent's dating is part of the crisis. Home visits are frequently used, as are drugs. Occasionally, overnight hospitalization in a general hospital emergency room is employed.

Crisis intervention for this selected population of families of immediate candidates for hospitalization differs somewhat from other forms of crisis intervention. At the Rush centers, family members are automatically involved only when they present themselves on their own initiative, if the intervenor feels that the crisis involves more than one person, or because the resolution of the crisis for one person requires the cooperation of family members or may precipitate a crisis in other family members. As the above cited case shows, family problems may sometimes be treated by individual crisis intervention. When family crisis intervention is used, it is technically harder than individual crisis intervention. The hazards and coping pattern must be

elicited for each family member separately and their interaction traced. The tendency to take sides in family disputes is one of the risks of family crisis intervention. Another is the tendency to become involved with chronic problems. This is a risk in individual treatment also, but it is more difficult to manage with families who wish to bring up conflicts and grievances accumulated over the years. The intervenor must sometimes forcefully bring them back to current issues.

Group Crisis Intervention

There are very few reports on the use of non-family crisis groups. Rosenberg conducted crisis groups with nursing students, as reported by Klein and Lindemann. Peck and Kaplan discussed crises in existing therapy groups, and Bloch described an open-ended crisis group for patients in the lower socioeconomic classes.

Crisis groups make up an important part of the crisis intervention at the Rush centers. Strickler and Allgeyer formulated the methodology used in most cases: The hazard and crisis are assessed in an initial individual interview, and the person in crisis is then referred to a crisis group whose members explore ways in which each of them can cope with his specific problem. Crisis group attendance is limited to the same six sessions used in individual crisis intervention. Therefore, any group session has members who

have progressed to varying stages of crisis resolution. The progress of older members is often very encouraging to those joining the group.

Morley and Brown reviewed advantages and disadvantages of the use of crisis groups and concluded that it is highly effective with certain population groups, problems, and individuals. They described the manner in which members of a specific group help each other with such diverse problems as the arrest of one woman's children for theft, cessation of financial support of a psychotic patient by her mother, the breaking off of a relationship with a boyfriend, a bad lysergic acid "trip," and the loss of a job. Allgeyer recently emphasized the unique usefulness of the crisis group for the disadvantaged.

Social Class and Crisis Intervention

One of the goals of crisis intervention facilities is to reach population subgroups not served in traditional psychiatric outpatient clinics. Dynamically oriented outpatient clinics particularly have not historically been responsive to the needs of the seriously disturbed, the aged, or the poor. As has been pointed out elsewhere, crisis and crisis intervention represent a meeting ground on which patients and therapists from divergent cultural and social classes can and do meet. Crisis is rooted in those universally shared childhood experiences that precede the differentiation of individuals into cultural and social subgroups.

Experience has borne out the expectation that persons not characteristically referred to psychiatric clinics are indeed seen in crisis intervention facilities. Bellak and Small noted that the Trouble-Shooting Clinic served a larger proportion of nonwhites than the proportion residing in the community. One of the key aspects of the walk-in clinic at the Metropolitan Hospital is their service to a deprived community. Bloch used his crisis group selectively for people from the lower socioeconomic classes. Persons from social classes 4 and 5, according to the Hollingshead and Redlich classification, represent between one-half and two-thirds of the population of the Rush centers. Further, the less educated as well as those over forty-five came as a result of newspaper publicity in significantly greater numbers than they did as a result of professional referral.

Outcome Studies

There have been only a very few research studies related to outcome of crisis intervention. Langsley and Kaplan reported on 150 cases treated by family crisis intervention at the family treatment unit, compared with an equal number of controls. The cases were compared in regard to whether psychiatric hospitalization occurred. Cases were randomly assigned, and there was no difference between test and control groups on fifteen population characteristics, including diagnosis and history of previous hospitalization. The results showed that none of the family treatment unit group was

hospitalized for the presenting crisis. At six-months' follow up 83 percent of the experimental group still had not been admitted to a mental hospital. When subsequent hospitalization occurred it was briefer for the family treatment unit group than for controls, and there was no evidence that patients treated outside the hospital were more likely to become suicidal or homicidal or were more chronically disabled than patients treated in a hospital.

Bellak and Small reported on 1,414 patients seen during a twelve-month period, of which 472 were followed up by both interview and rating scales. Seventy percent received brief psychotherapy and 8.8 percent required hospitalization. A symptom checklist showed a decrease in the mean score between just before and at the end of treatment, which was significant at the 0.001 level. The score remained unchanged at six-months' follow up.

At present a study of crisis intervention outcome is in progress at the Benjamin Rush centers.[11] This study will include experimental and control groups. Ratings will be made retrospectively, pretreatment, immediate posttreatment, and six-months posttreatment. Ratings will be done along dimensions of symptoms, affective disturbances, response to treatment, level of functioning, and coping behavior.

Current Frontiers

Crisis intervention is now early in its second decade as a major component of the armamentarium of mental health programs. Some new areas of importance are beginning to emerge. One of these is the use of crisis intervention for alcoholics and drug abusers. Crisis intervention is not helpful in cases of the long-term drug user or alcoholic who has no acute conflicts about the use of drugs or alcohol. It appears to be highly effective if there has been a recent change in the person's life which resulted in difficulties in connection with their use. Such events include arrest and being placed on probation, "bad trips" with lysergic acid, and negative feedback from important others such as occurs when a wife or close friend seriously threatens to separate if the drinking or drug-abuse pattern continues. Crisis groups have been particularly helpful for drug abusers.

Lastly, the issue of identification of large populations at risk is important for the purpose both of preventing hazards and of implementing early intervention when such hazards do occur. Kalis recently addressed herself to some of these issues. Thus crisis theory and crisis intervention are approaching the time when they must address themselves to the individual, his family, and the community and society in which he lives.

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Notes

1 Strictly speaking, “program” refers to function; “facility” refers to the organization rendering the function. Both terms are used here interchangeably.

2 For reasons discussed below, the term “patient” will not be used in relation to persons using crisis services. In spite of a recognized inconsistency, the term “treatment” will be used for lack of another readily available one in describing services rendered to a person in crisis.

3 This omission is due to the necessity to keep this chapter brief and cohesive and with full recognition that some important contributions have come from clinics using other theoretical frameworks, such as the “Trouble-Shooting Clinic” at Elmhurst Municipal Hospital.6 For a full discussion of brief psychotherapy in general, including some material on early-access, brief treatment centers using a different theoretical framework, the reader is directed to Small’s *The Briefer Psychotherapies*.

4 The development of theory and practice at the Rush centers has been a team effort. I wish to acknowledge the important contributions that have been made by all of my coworkers, and most particularly by Dr. Wilbur Morley, Deputy Director, Los Angeles Psychiatric Service and Director, Venice/Oakwood Divisions, and Martin Strickler, A.C.S.W., Deputy Director, Los Angeles Psychiatric Service and Director, Whitworth and Robertson Divisions.

5 As Nietzsche said, “What does not kill you will make you stronger,” or in Benjamin Franklin’s words, “Crosses and losses make us stronger and wiser.”

6 Caplan stated that lists of needs are usually somewhat arbitrary. He proposed as “ a useful working list” of needs one that would take into account three main areas: needs for exchange of

love and affection, needs for limitation and control, and needs for participation in joint activity.

7 Suicide prevention is an important part of crisis intervention. It will not be discussed in this chapter, except to say that the methods of crisis intervention described here may be very effective with suicidal persons.

8 The above list is drawn from a list of hazards by Holmes and Rahe, used by Langsley et al.

9 The ability to understand unconscious material may be a two-edged sword in crisis intervention. It can be helpful if the intervenor can use it to improve the clarity of his perception of the crisis. It can be a hindrance if he feels impelled to use too much of what he knows as part of the intervention.

10 An attempt to classify coping is currently under way as part of a research study at the Rush centers.

11 This study is supported by a grant from the National Institute of Mental Health, No. MH 18846-01. Dr. Wilbur E. Morley is principal investigator.