Applicability of Crisis Intervention in Family Practice

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Crisis intervention is a specialized approach useful to family physicians who frequently are called upon to deal with patients in psychosocial crisis. The use of a systematic method of evaluation and treatment will aid physicians in helping patients with their problems in a fashion that is constructive for both patient and physician.

A crisis may occur as a result of a change in an important social role or relationship. Appropriate intervention which is immediately available can result in a marked reduction in physical and emotional symptoms that are stress related. This paper reviews the need for crisis intervention, its historical development, theory and technique, and several examples of crises familiar to all family physicians. A case illustration is presented as a demonstration of crisis intervention in family practice.

Family physicians are frequently confronted by patients in crises of various types. In the Virginia study of family practice,[1] four percent of all patient visits were for problems that could be defined as crises of a psychiatric or social nature. Of these, one quarter (one percent of *all* patient visits) were for acute psychosocial crises, including child maturational disorders, adult situational adjustment problems, acute psychoses, drug and alcohol abuse, pregnancy outside of marriage, and legal problems. Family physicians, because of their special relationship with the family, have often used both supportive and/or directive counseling to help patients through these crises.

However, crisis intervention (CI) is a specialized approach which, when appropriately applied in selected cases, can provide a therapeutic and preventive resolution to symptom formation.

With large numbers of patients in crisis presenting to community mental health centers, the goal of crisis services is to respond immediately, at a time when a person is receptive to change and growth. The design is a focused, time limited yet psychodynamically based psychotherapy.

The crises which patients bring to the mental health centers are often those with which family physicians are confronted in their everyday practices, yet the use of crisis intervention has not been adopted by family physicians to any large extent. The purpose of this paper is to discuss crisis intervention, including its historical development, theory and methodology, technique, and potential uses in family practice.

Historical Development

Contemporary crisis intervention has its roots in the treatment of soldiers during World War II. Treatment near the front lines focused on the im-

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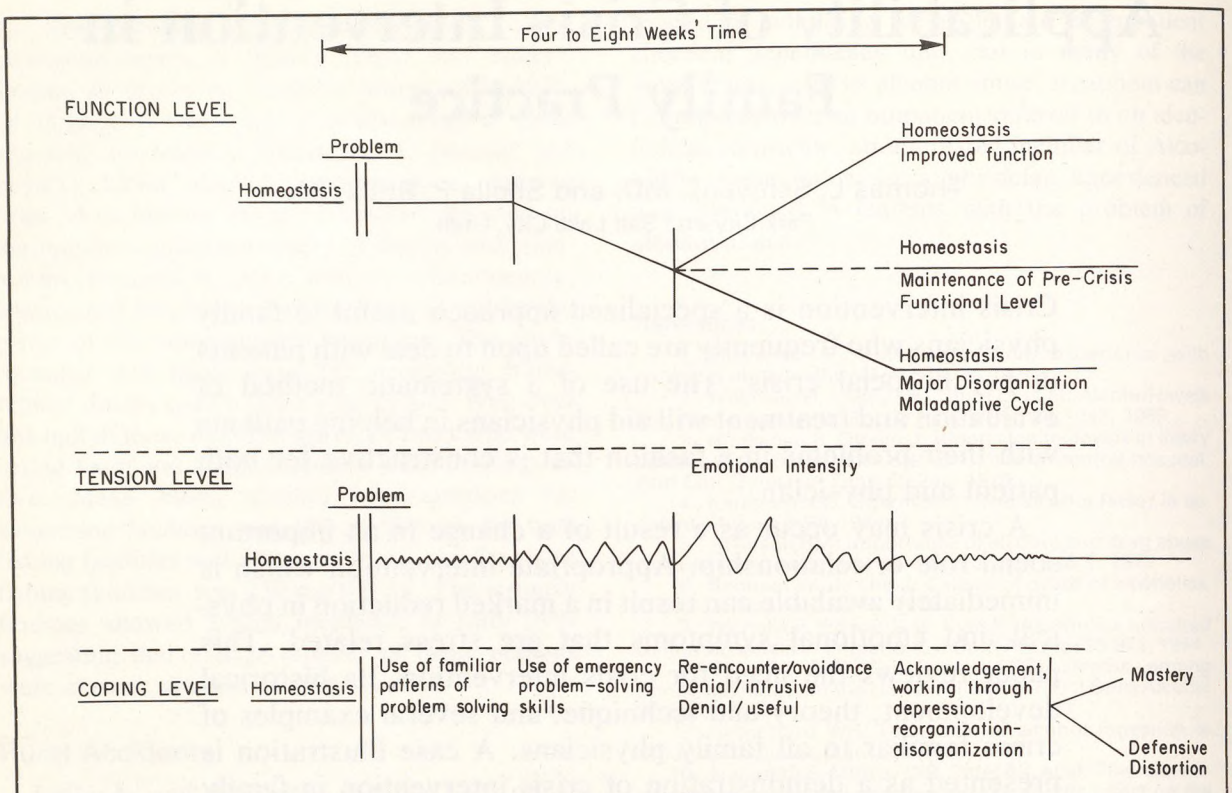

Figure 1. Characteristics of function and tension in crisis

mediate crisis, and the invoked feelings and behavior often avoided regressive and more entrenched patterns of psychiatric illness. More importantly, by beginning the psychotherapy with the immediate goal of returning the soldier to his combat unit, the need to identify the soldier as a psychiatric "casualty" was eliminated. The stated expectation that the soldier in crisis was essentially intact and functional appeared to have positive therapeutic implications.[2]

Lindemann[3] contributed the next step in the development of CI with his study of characteristic patterns of response to acute grief in the 1943 Coconut Grove fire in Boston. This work drew a comparison between those survivors who actively worked through the grief and loss and those who did not, resulting in later symptom formation and psychological vulnerability to loss.

Behavior patterns resulting from life stresses, such as premature birth[4] or the diagnosis of chronic medical disease,[5] suggested certain "generic" patterns of response to varied life crises.[6] Thus developed a conceptual framework and therapeutic model specific to treating patients in a crisis.

Definition of Crisis

A crisis can be defined as a time "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 abortive attempts at solution are made." Caplan has described the process of crisis in four phases[7] (Figure 1).

Phase 1

The precipitating event acts to stimulate an initial rise in tension within the individual, which, in

turn, elicits certain habitual problem solving attempts, consistent with previous successful attempts.

Phase 2

If the initial attempts at problem solving with previously used behaviors are unsuccessful, *and* if the stimulus persists, a further increase in tension occurs.

Phase 3

At this stage, according to Caplan, a tension threshold exists beyond which further tension stimulates the development and utilization of new problem solving behaviors, to whatever extent the individual is capable. He/she may mobilize inner reserves of strength or adaptation, utilize new external sources of support, or redefine the problem (perhaps choosing to ignore certain aspects). If the problem is resolved, the individual will resume his/her individual and group roles, although these may perhaps be new ones. If the problem is not resolved, Phase 4 ensues.

Phase 4

If the problem cannot be resolved, redefined, or ignored, tension increases beyond yet another threshold and reaches a breaking point. As Caplan says, "Major disorganization of the individual with drastic results then occurs."[7]

Cumming and Cumming[8] have described three basic kinds of crises: (1) those that are "*biologically tinged,*" such as menopause, which are part of the life cycle and inevitable for all people to experience to some extent; (2) those that are "*environmentally tinged*," such as divorce, which are certainly not inevitable, but are part of the common experience; and (3) those that are "*adventitious*," such as rape, which occur in a totally random fashion.

Concepts of Loss and Crisis

Strickler and LaSor[9] have delineated a feature common to all crises, that is, a sense of loss by the individual that stimulates the rise in tension described by Caplan. All crises can be viewed as resulting from one of three types of losses: self-esteem, sexual role mastery, or nurturing. An individual maintains his/her sense of self-worth by receiving positive recognition from external sources. People have a certain capability of providing this recognition from within, of validating their own roles and their attendant abilities and achievements as worthwhile, but essentially everyone needs a certain degree of confirmation from outside sources as well. For example, a woman who delivers a child with physical or mental abnormalities may *know* intellectually that she did nothing to cause this, but cannot help but *feel* she is somehow responsible and is therefore less than a competent mother. The loss of self-esteem engenders a feeling of guilt with which the woman may not be able to cope, and a crisis ensues. For example, the premature birth of a child with resulting medical complications frequently precipitates such a crisis.[4]

The second type of loss, sexual role mastery, is a variant on the loss of self-esteem. Adults have certain male/female roles that are determined by family and societal traditions, and the adult ego eventually develops certain decisions regarding its ability to respond to, and succeed in fulfilling, these tradition imposed roles. When an individual perceives that external events demand new roles (actual, potential, or even fantasized), the stress may result in increasing tension. A middle-aged man recovering from a myocardial infarction may not be able to continue a physically demanding occupation, participate in certain sports with his son, or perform sexually at a certain level, all of which may have constituted his internalized concept of "male." This loss of sexual role mastery may precipitate a crisis.

The third type of loss is that of nurturing, or love. As Strickler has said, "A prime need of human beings is to be nurtured, and this requires the adult to find his own comfortable balance in the inter-relatedness between independence and dependence."[9] This society is becoming increasingly competitive and striving, at the same time that the emotional supports of the extended family are degenerating. An individual comes to certain decisions regarding his/her suitable balance of independence/dependence, and external events may cause an upset in this balance. The new widow, the recent divorcee, the suddenly motherless adolescent, and the executive recently promoted to a position of greater responsibility may

all experience sufficient stress, from their loss of previous nurturing, to precipitate a crisis.

Holmes[10] and his associates have determined that people who experience change, either positive or negative, in sufficient amounts become sick. Out of this research has come the Social Readjustment Rating Scale which gives numerical value to 43 life events. When Life Crisis Units for life events experienced in a two-year period are tabulated, one can predict the potential for illness:

0-150—No significant problems

150-199—Mild life crisis (33 percent chance of illness)

200-299—Moderate life crisis (50 percent chance of illness)

300 or over—Major life crisis (80 percent chance of illness)

It can be seen from the foregoing that the concept of "crisis" is very precise. A crisis is not merely a "problem," because problems may or may not cause the disorganization that characterizes a crisis. In fact, Caplan[7] has been able to define the crisis process as lasting no more than six, and usually four, weeks. It is during this time that the individual in crisis is often in a state of chaos, with the potential for developing either entrenched dysfunctional behavior or functional, problem solving behavior. A crisis, then, can be viewed in a *potentially* positive light, since it is a time of "dangerous opportunity" during which the individual may be much more amenable to, and benefit more from, appropriate therapeutic intervention.

Technique of Crisis Intervention

The purposes of CI, as derived from several authors,[6-8] are to (1) actively focus on the present state of upset, the precipitating event, and its perception by the individual; (2) to assess the hazards and risks for the individual in altering his/her present role relationships and to assess the real or potential losses for the individual; (3) to probe the individual's history only so far as is necessary to search for analagous painful events, memories of which may be evoked by present events; (4) to conceptualize the crisis and "package" it for the patient in more manageable parts; (5) to actively participate in developing new coping and problem solving behaviors, including assessing and recruiting appropriate external supports, such as friends, relatives, or agencies; (6) to assign certain tasks for the patient to accomplish, while avoiding advice giving; and (7) to begin planning for termination of the therapy at its inception. This sequence is designed to take advantage of the opportunity for change during the time that the level of anxiety maintains the individual in a state of relative receptivity. The obvious secondary benefit is that these new behaviors may contribute to a new level of psychological functioning that persists.

The First Interview

Patients in crisis present to family physicians in a variety of ways. Sometimes physical symptoms predominate, as the "ticket of admission" to a medical doctor's office. Family physicians are also confronted with patients who describe various states of emotional distress, such as acute anxiety or depression. By virtue of the family physician's previous contacts with the patient, an acute problem may be readily identified and the concepts of CI can be applied.

A crisis by definition lasts for only four to six weeks; because of this time limitation, each CI session is of maximum importance. The first interview is perhaps even more crucial. At this time, the physician must quickly focus on the immediate situation and the precipitating event by answering these questions:

Why is the patient coming for help *now*?

When did the patient begin feeling upset?

What happened to upset the patient?

What real or potential loss of a role or relationship has occurred?

How does the patient interpret this loss?

What verbal/nonverbal cues does the patient exhibit in the discussion of recent events that communicate their impact and importance?

What reminders have there been of previous upsetting situations?

The next step in the initial interview is to assess the patient's past and present coping behaviors.

How did the patient try to cope with the stress produced by the precipitating event?

What coping behaviors has the patient used in past similar situations?

Why is there a lack of "fit" between this present crisis and the coping behaviors tried so far?

Who are the significant individuals in the patient's life that may have been used in past solutions or might be mobilized for future ones?

The next task is to conceptualize the crisis in a form that is understandable to the patient. Data obtained by the previous questioning are formed into significant parts which are tied together by crisis theory, then presented to the patient in a form that is more understandable and manageable for the patient. Once the crisis is conceptualized, the physician and patient work together to develop tasks for the patient.

What are the immediate goals?

What different solutions might be feasible?

What new plan of action can be tested *now*?

Throughout the initial interview session, as well as at the end, care is taken to continue focusing on the *present*, on the precipitating event, in order to maintain sufficient anxiety so that the patient remains receptive to change. Care should also be taken to avoid discussing chronic problems ("old business") that have no relevance to the present. *Focus must be maintained on the present crisis.*

Succeeding Interviews

Succeeding interviews, which may number from three to five, are similar to the initial interview. By breaking the problem into parts for which solutions may be more easily found, interviews can focus on the more difficult parts first, or on the parts that appear to create the most tension in the patient. By exploring with the patient the tasks assigned during the preceding interview that were most difficult or created the most tension, further definition of the crisis may occur. As described previously, the most important job (and the most difficult) is to maintain focus on the precipitating event and on the present state of crisis. The temptation in succeeding interviews is to allow the tension to resolve by catharsis and by the passage of time, thereby missing an opportunity for the patient to develop new coping behaviors that may have a permanent place in his/her repertoire.

The other important job of succeeding interviews is to carefully note changes in the patient's behavior and coping abilities, and to take great care to "feed" these changes back to the patient for positive reinforcement effect. During a time of crisis, when all other external supports and resources are perhaps unavailable to the patient, the physician becomes a source of positive reinforcement and affirmation of the patient's more functional behaviors. It is also during the succeeding interviews that external supports and resources are further defined and then mobilized to help the patient. This mobilization might involve inviting a patient's spouse, parent, school counselor, employer, or other significant person in the patient's milieu to the session. As has been stressed, the termination of the psychotherapeutic intervention is planned from its inception, and this principle must be kept in mind during the subsequent interviews.

As a practical point for family physicians, the frequency and length of interviews are determined by the nature of the crisis. Pathological grief reactions, or guilt over the premature birth of a child, are crises which may span several weeks, and interviews may be scheduled weekly. An acute psychosis, however, may need to be dealt with daily for a time. Whatever the frequency, however, the length of interview need not be more than 30 minutes with perhaps a longer interview initially. These may be most easily scheduled at the end of a day for a busy family physician, but it is important to note that, since CI is a time limited intervention, focus must be aggressively maintained on goals and tasks. If interviews are relatively short and to the point, then the time burden will not be so great.

Termination of Crisis Intervention

Since the termination of CI begins with the initial interview, certain questions need to be answered along the way.

What worked and what did not work in the patient's experimentation with new approaches to problem resolution?

What additional efforts might lead to some improvement?

When does the patient begin to show signs of relief, improved ego functioning, and a readiness to continue the problem solving effort alone?

What is the patient's perception of the end

point, such that he/she will know when the crisis is resolved?

What are the physician's and patient's perceptions of the patient's abilities to cope with future stress?

Case Illustration

The following is an example of a patient treated recently by one of the authors (T.S.) in which the precepts of CI are adhered to very closely.

S.O. is a 24-year-old Caucasian mother of two girls, aged two and six years. She visited the University of Utah Family Practice Center with the chief complaint of obesity. The patient's weight had fluctuated moderately during her life, but recently, in about three months, had increased 30 pounds from 185 to 215 pounds, precipitating the patient's visit. She had not been seen previously. Further history and a physical examination led to the diagnosis of exogenous obesity. Brief questioning revealed that her increased caloric intake and decreased exercise was due to anxiety and depression over her younger daughter's health. It became quickly apparent that the weight gain was merely a symptom of the patient's underlying depression.

The patient's daughter, C., suffered from a congenital central nervous system (CNS) disease that resulted in severe psychomotor and growth retardation, as well as an intractable seizure disorder (the exact diagnosis was not known to the physician at the time because C. was cared for by pediatric neurologists at another hospital). The result of her CNS disease was that the patient, S.O., was caring, at home, for a two-year-old child who weighed approximately 20 pounds, required continual nursing care, and had an increasing number of grand mal seizures (sometimes partially aborted) each day. The mother had accepted this situation since the child's birth, but the child's condition was deteriorating and the neurologists had approached the mother regarding institutionalization. The depressive reaction (including excessive eating) coincided with this suggestion by the neurologists.

The patient's social milieu consisted of the two children at home, and her mother who occasionally helped care for the children. Since the child's condition frightened the grandmother (and other potential babysitters), the patient devoted most of her time to home care of C. Although the patient and her husband were legally separated and he was confined to a prison psychiatric diagnostic center, they did maintain contact.

Symptoms described included excessive eating behavior, inability to initiate activities, and emotional lability with frequent spontaneous episodes of crying. Sleep was not disturbed. When asked how she felt about the proposed institutionalization, she stated that, while objectively she knew it was probably best for both of them, she could not help but feel inadequate as a mother and felt like she was abandoning the child. Her entire life was organized around the care of C. (perhaps to the exclusion of the older daughter and certainly to the exclusion of her own needs). Despite the increasing difficulty of properly caring for her, she could not imagine C. being away from home, and doubted the proposed facility's ability to care for C. She hesitantly suggested possible ways she might spend the time previously devoted to C., such as a return to school to prepare for a better job, but immediately thought this sounded selfish and she felt guilty that she might be benefiting at C.'s expense.

The crisis concept can be formulated as follows. The precipitating event was the suggestion by the neurologists that the patient institutionalize her daughter, C. The type of crisis is probably best characterized as "adventitious," a catastrophic event that occurs randomly and cannot be related to environmental influences. The type of loss is primarily in the area of self-esteem in that the patient's view of herself was at odds with the need to institutionalize and "abandon" (in her mind) her daughter. A secondary loss is one of nurturing, since the patient experienced some degree of love from her daughter as part of caring for her, and this would be lost to some extent if they were separated.

The first interview consisted primarily of data gathering, and the information described above, including a complete medical history and physical examination, was obtained in the hour scheduled for her. In the last few minutes of this first appointment, the crisis was summarized for the patient, in a way that allowed her to view her presenting complaint of obesity in a markedly differ-

ent light. The physician and patient agreed to meet every two weeks for a maximum of six times.

Finally, the following goals for the ensuing crisis intervention were negotiated: (1) to determine the medical necessity of institutionalization such that it could be viewed as a "win-win" situation whereby both patient and daughter benefited; (2) to help the patient internalize the very real benefits and necessity of the institutionalization so as to eliminate the presently felt loss of self-esteem as a mother; (3) to help the patient develop a more realistic attitude towards the care to be provided by the institution; (4) to support the patient's hesitantly stated desire to make some plans for her own future; and (5) to develop and implement a plan for weight reduction. As a start toward achieving goals, the following tasks were assigned for the patient to complete before the next appointment: (1) to talk with the neurologists regarding the exact nursing care requirements of a suitable institution; (2) to visit at least one possible institution; and (3) to keep a complete food-intake and exercise log. It is important to note that these goals and tasks were not determined by the physician, but rather, she was encouraged as she developed them herself.

The second and succeeding visits were for only about 15 minutes each. At the second visit, several patient behaviors were worth noting. First, the patient reported a remarkable improvement in problem solving, which she attributed to the delineation of specific tasks, each of which were not as overwhelming as the whole situation. She had completed all the tasks assigned and, while keeping her own diet log, had recognized and modified certain problematic eating behaviors, resulting in a five pound weight loss. She also reported a marked reduction in guilt after having visited one institution that appeared to provide care that was satisfactory to her. She proudly recognized that she had provided her daughter excellent care up to this point. Simply being told by the physician that it was quite normal to experience this guilt was very reassuring to her and contributed to her improved self-esteem. Other self-assigned tasks for succeeding visits included exercise prescriptions and modifications in her diet.

An interesting event occurred between the third and fourth visits. When S. was visited by her husband, who had been released from prison, he requested a divorce, told her she was an inadequate mother, and considered her very selfish in making future plans while she was arranging to "put her daughter away." The patient confidently reported that she recognized as "ridiculous" her husband's charges. The proposed divorce was welcomed because her "loser" husband had greatly contributed to her chronic feelings of inadequacy.

At the time of this writing, the patient has completed arrangements with an institution for the care of her child, made application to a school for vocational training, negotiated a divorce settlement, and lost 20 pounds. The contract of six visits had ended, and the patient knows she can return at any future time should the need arise.

Types of Crises

Table 1 lists a number of situations which are amenable to crisis intervention and which are familiar to all family physicians. The situations themselves are not at all new; they are redefined according to CI theories so that the applicability and use of CI may be more readily seen. It is hoped that this list will stimulate family physicians to view many crises and problems which patients experience in a new light, and offer a new understanding of these crises that will suggest a more organized and effective approach to helping these patients.

Summary

This paper reviews the technique of crisis intervention, its historical development, and its theory and methodology, and presents several examples of crises familiar to all family physicians which are amenable to solution by the use of CI. Family physicians have a unique role in initially evaluating, and then treating, patients who present with a multitude of psychosocial crises. It is the authors' hope that the use of an organized method of evaluation and treatment, such as crisis intervention, will help physicians cope with these patients in a fashion that is most constructive for both patient and physician.

Table 1. Crises Amenable to Crisis Intervention

Precipitating Event	Classification (Cumming and Cumming[8])			Type of Loss (Stricker and LaSor[9])		
	Biological	Environmental	Adventitious	Self-Esteem	Sexual Role Mastery	Nurturing
Small child starting school	X					X
Adolescent maturation (pubertal)	X				X	X
Death of a close relative	X					X
Menopause	X			X	X	
Retirement	X			X	X	
Child outside of marriage		X		X	X	X
Promotion to new job		X				X
Adopted child		X		X		
Divorce		X		X		X
Birth of premature child			X	X	X	
Diagnosis of chronic illness			X	X		
Rape			X	X	X	
Alcoholism in parent			X			X
Impotence			X	X	X	
Myocardial infarction			X		X	
Attempted suicide in relative			X	X		X

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