

INTRODUCTION TO THE THEORY AND PRACTICE OF CRISIS INTERVENTION

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RESUMEN

En los años transcurridos desde que Lindemann publicó su estudio clásico sobre las reacciones de duelo, la teoría de las crisis emocionales y las formas de intervención psicológica en situaciones de crisis se han desarrollado de forma significativa. En este trabajo se analiza la contribución de varios autores al desarrollo de una teoría de las crisis emocionales y se describen los tipos, elementos y etapas de una crisis. Se revisa la relación entre la teoría de las crisis emocionales y la intervención psicológica en situaciones de crisis, se hace un análisis de los modelos, niveles y objetivos de la intervención terapéutica y se discuten algunos de los problemas metodológicos asociados a la investigación de las formas de intervención. Por último, se hace una evaluación de la teoría de las crisis y de la intervención psicológica en situaciones de crisis, subrayando la función preventiva de la intervención en crisis en el marco de la psicología comunitaria.

ABSTRACT

This article is an introduction to the theoretical and practical aspects of crisis intervention. The literature describing the most relevant contributions in the development of crisis theory is reviewed and alternative definitions of crisis are considered. The characteristics, types and stages of a crisis are described and the crisis components analyzed. The connection

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between crisis theory and therapeutic intervention is discussed, together with the levels, goals, and technical aspects of the intervention. Comments are made on the research strategies in the study of crisis intervention. Finally, an evaluation of crisis theory and intervention is attempted, with crisis intervention being conceptualized as a form of preventive intervention in the context of community psychology.

INTRODUCTION

The term crisis derives from the greek word «krisis» which means decision or turning point. This definition of the word as a decisive stage that has important consequences in the future of an individual or a system, has been preserved up to our days and has provided the framework for the development of the theory and practice of crisis intervention.

Crisis intervention is a relatively new field in community psychology. Its origins are usually dated in the 1940's and 1950's with Lindemann's pioneering work on grief and bereavement after the Coconut Grove Club fire in Boston and with the work of Caplan at Harvard University. The 1960's and 1970's were periods of further elaboration of crisis theory and intervention with the development of suicide prevention centers, «hot lines», crisis centers and other agencies. New conceptualizations of services and important innovations in the intervention area were developed during this period (MCGEE, 1974). In the last few years, efforts have concentrated on the evaluation crisis intervention programs and on further developing crisis intervention practice.

Crisis intervention was initially developed as a response to the growing demand for services in situations where immediate assistance was required for large numbers of individuals. The shortage of personnel and the fact that most therapies are, in practice, short term (average of 4.7 contacts with therapist according to the National Center for Health Statistics, 1974) have further contributed to the development of crisis intervention and to its becoming the treatment of choice for many clients.

The purpose of this paper is to review some of the most relevant contributions to the theory and practice of crisis intervention. Several definitions of crisis will be described and the crisis stages and types of crisis will be reviewed. The levels and models of crisis intervention will

be discussed together with the goals and process of the intervention. A description of some technical characteristics of crisis treatment and a brief comment on crisis intervention research will follow. Finally, an overall evaluation of crisis theory and intervention will be attempted.

CRISIS THEORY

Definition of Crisis

The origins of crisis theory are usually attributed to Lindemann's classic study of grief reactions. LINDEMANN (1944) established the basic framework for defining the symptomatology of a crisis. He reported on the evaluation and treatment of 101 persons who had experienced a recent death of a close relative, a number of whom were connected to the victims of the Boston's Coconut Grove Club fire. He observed that acute grief was a normal reaction to a distressing situation and noted that such reaction presented some characteristic features that appeared to form a distinct syndrome. According to Lindemann, persons experiencing acute grief display one or more of the following symptoms: 1. somatic distress; 2. preoccupation with the image of the deceased; 3. guilt, 4. hostile reactions, and 5. loss of patterns of conduct. Sometimes the person experiencing crisis of bereavement may have distorted or delayed grief reactions. Lindemann also stated that the grief work includes achieving emancipation from the deceased, readjustment to the environment in which the deceased is missing and formation of new relationships. His contribution has been considered the starting point for the development of crisis theory.

While the origins of crisis theory are attributed to Lindemann, the work of Gerald Caplan and his colleagues at Harvard University provided the foundations for the development of crisis intervention theory and practice. Caplan's interest in crises resulted from his work with families immigrating to Israel following World War II. Caplan has provided various definitions of crisis (1964, 1974): he considers that a crisis is provoked when a person faces a problem for which he appears not to have an immediate solution and that is for a time insurmountable through the utilization of usual methods of problem solving. A period of upset and tension follows during which the person makes many attempts at the solution of the problem. Eventually, some kind of adaptation and equi-

librium is achieved which may leave the person in a better or worse condition than prior to the crisis. Caplan suggests that the essential factor determining the occurrence of a crisis is an imbalance between the perceived difficulty and importance of the threatening situation and the resources immediately available to deal with it; the crisis refers to the person's emotional reaction not to the threatening situation itself. Caplan's crisis-theory is grounded in the concept of homeostasis. According to him, the organism constantly endeavors to maintain a homeostatic balance with the outside environment. When this balance is threatened either by physiological or psychological forces, the individual engages in problem solving activities designed to restore this homeostatic balance. A crisis is considered an upset of a steady or homeostatic state.

The application of the homeostasis concept of psychological functioning hasn't been accepted by all theorists. TAPLIN (1971) argues that its acceptance limits the man to the status of reactor and that the concept of homeostasis doesn't distinguish between adaptive and maladaptive imbalance. Moreover, he believes that homeostatic balance cannot effectively characterize essential aspects of human behavior such as growth, development, change or actualization. He recommends to define the state of crisis in cognitive terms and states that the person in crisis is suffering a temporary interruption of his cognitive processes besides reacting to an upsetting stimuli.

Also following a cognitive perspective, HALPERN (1973) proposes a definition of crisis using Lazarus description of 2 kinds of appraisal processes. According to LAZARUS (1968) the nature of an emotional response is determined by the cognitive processes by means of which stimulus configurations are evaluated, that is, the appraisal of its personal significance. Primary appraisal deals with the issue of threat or non threat. Secondary appraisal has to do with alternate ways of coping with the threat. Halpern defines an individual in crisis as a person who appraises a given situation as extremely threatening and who, in his secondary appraisal, can find no way of coping with his situation.

RAPOPORT (1962, 1967, 1970) has followed Lindemann and Caplan's approach to crisis theory and made important contributions to the theory and practice of crisis intervention. She defines a crisis as «an upset in a steady state» where an individual finds himself in a hazardous situation. The crisis creates a problem that can be perceived as a threat, a loss or a challenge. Rapoport argues that 3 interrelated factors usually produce

a state of crisis: a hazardous event, a threat to life goals and the inability to respond with adequate coping mechanisms.

PARAD (1965, 1966) has also adopted Lindemann's and Caplan's definition of crisis, but stresses the importance of the individual's perception of what constitutes a crisis. According to him, the crisis is characterized by the following phenomena: 1. specific and identifiable stressful event, 2. perception of that event as meaningful and threatening, 3. the response to the event and 4. coping tasks involved in successful adaptation. The event precipitating the crisis must be perceived by the person as a stressful situation before it becomes a crisis.

FRANCE (1982) points out that there is a great variety of events that have the potential of being hazardous. Even events generally thought of as being positive may have stresses associated with them. He also states that individuals facing similar environmental challenges may react very differently in front of a hazardous event, since the subjective evaluation of the stressfulness of an event involves both personality traits and the nature of the situation.

Most of these definitions of crisis stem from the initial contribution of Lindemann and Caplan, although important additions and refinements have been made by later theorists.

Components of a Crisis

SIFNEOS (1960) has identified 4 components of an emotional crisis: 1) The hazardous event that starts the chain of reactions that lead to the crisis. Sometimes it is a sudden unexpected event, while other times it can be a developmental change. 2) A vulnerable state of the individual which is essential for the crisis to develop. 3) The precipitating factor that is the final event or circumstance that makes the hazardous event unbearable and results in the crisis, and 4. The state of active crisis.

A different approach has been taken by JACOBSON (1968) who refers to social, intrapsychic and somatic components of a crisis. The social aspects of the crisis include any role changes or other alterations in the interpersonal behavior that occur during a crisis, the intrapsychic factors of the crisis emphasize the changes in conscious and unconscious processes brought about by the crisis, while the somatic aspects of the crisis refer to somatic illnesses that might develop as a result of the crisis.

SHULBERG & SHELDON (1968) have developed a probability formula

for a crisis: the probability of a crisis situation occurring because of a hazardous event is a function of the interaction between the hazardous event, the exposure of the individual to the event and the vulnerability of the individual:

$$P \text{ Crisis} = f(\text{hazardous event exposure vulnerability})$$

Characteristics of a Crisis

Various theorists have included some of the characteristics of a crisis in their definitions of the state of crisis; therefore we won't refer again to those covered in the previous section of the paper. There are, however, other characteristics that deserve mention, some of which were initially described by Caplan and that have been further elaborated by other authors.

An important characteristic of crisis reactions is that they are time limited. Most of them are resolved for better or for worse within 6-8 weeks. As Lindemann pointed out behavior in crisis is unique; it is related mainly to the crisis itself and not so much to the premorbid personality. The outcome of the crisis is not determined by its antecedent factors, such as the nature of the problem, the individual's personality or his experiences, although these factors do have an important influence on the outcome. What actually occurs depends on the interplay of internal and external forces during the crisis, the actions of the subject and the intervention of others. During the crisis the individual experiences an increased desire to be helped by others and is more open and amenable to outside intervention than at times of stable functioning (CAPLAN, 1964).

Crisis Stages

Caplan was the first to describe the main stages of a crisis reaction. The contributions of later theorists have been based on Caplan's work and have basically consisted on a restatement of his phases. According to CAPLAN (1964) most crisis reactions follow 4 distinct phases:

1. In the initial phase the individual is confronted by a problem that poses a threat to his homeostatic state: the person responds to feelings

of increased tension by calling forth the habitual problem-solving measures in an effort to restore his emotional equilibrium.

2. There is a rise in tension due to the failure of habitual problem-solving measures and the persistence of the threat and problem. The person's functioning becomes disorganized and the individual senses feelings of upset and ineffectuality.

3. With the continued failure of the individual's efforts, a further rise in tension acts as a stimuli for the mobilization of emergency and novel problem-solving measures. At this stage, the problem may be redefined, the individual may resign himself to the problem or he may find a solution to it.

4. If the problem continues, the tension mounts beyond a further threshold or its burden increases over time to a breaking point. The result may be a major breakdown in the individual's mental and social functioning.

Rapoport's (1962) three phases of a crisis reaction overlap with Caplan's stages, with the difference that Rapoport has merged Caplan's phases 1 and 2 and considered them the initial phase of crisis. She also points out that some type of equilibrium is restored during the end phase of the crisis; yet this equilibrium can be lower, the same or higher than the one previous to the crisis.

France's (1982) three stages of crisis basically coincide with Rapoport's, with the incorporation of some of Caplan's more recent contributions. During the impact phase, the individual reacts to what has suddenly become an unavoidable problem. The person's usual strategies have failed to solve the problem brought about by the precipitating event. Many people at this stage experience some degree of helplessness; other feelings during this phase are anxiety, frustration, inadequacy and depression (CAPLAN, 1974). The coping phase includes all the new attempts directed toward alleviating tension. At this stage the person's willingness to consider alternatives together with his increased receptivity make more likely his seeking help. The withdrawal phase evolves when none of the adaptive or maladaptive coping attempts have worked. The individual withdraws and ceases attempts to solve the problems.

As pointed out earlier, the individual is more susceptible to accept help during the second stage of crisis. However, the consideration of the different stages of crisis and the characteristic reactions of the individual during each of them, provide very helpful information in order to implement a treatment strategy at any phases of the crisis.

Types of Crisis

Most crisis theorists have used Erikson's classification of developmental and situational crises (ERIKSON, 1956). Maturational or developmental crisis are transitional periods in personality development characterized by cognitive and affective upset (e.g. adolescence); situational or accidental crisis are periods of psychological and behavioral upset precipitated by life hazards that usually inflict significant losses on the individual (e.g. accident). Caplan has used Erikson's classification in his theoretical development of crisis reactions. He has emphasized that developmental and accidental crises are transitional periods that present the individual with both an opportunity for personal growth as well as for deterioration.

RAPOPORT (1967, 1970) has classified crises into three different categories: *a*) developmental crisis which are biopsychosocial in nature, *b*) crisis of role transition (e.g. retirement) and *c*) accidental crisis, termed hazardous events. HARPER & PETERSON (1982) consider two types of crisis: predictable, which are part of planned, expected or normal processes of life, and unpredictable such as natural disasters, accidents or sudden losses.

BALDWIN (1978) has developed a classification of emotional crises that includes six types of crisis situations:

1. Dispositional crises produced by problematic situations that can be remediated through an appropriate management such as making a referral, providing information and/or education, making administrative changes, etc.
2. Crises of anticipated life transitions, that reflect normal life transitions over which the person may have little control.
3. Crises resulting from traumatizing stress, which are precipitated by external stressors or situations that are unexpected, uncontrolled and emotionally overwhelming.
4. Maturational/developmental crises, that result from attempts to deal with interpersonal situations that reflect internal unresolved problems.
5. Crises reflecting psychopathology, in which pre-existing or current psychopathology complicates their resolution.
6. Psychiatric emergencies, in which general functioning is severely impaired.

Identifying the type of crisis that a person is going through is an important step of the crisis intervention process, that facilitates to a great extent the therapist's work with the person in crisis.

CRISIS INTERVENTION

Lindemann, Caplan and other theorists have provided a firm theoretical basis for what has come to be known as crisis intervention. However, as EWING (1978) points out, for most part the architects of crisis theory have not explicitly spelled out specific modes of intervention, even though they have referred to them. Many of the techniques and principles of crisis intervention have developed through the efforts to meet more effectively the specific needs of particular populations.

BUTCHER, STELMACHERS & MAUDAL (1983) have discussed the historical origins of crisis intervention. The high incidence of traumatic neuroses in World War II created a great need for expanded psychological services: as a result of it, new treatment approaches were developed to meet the needs of the soldiers who experienced stress related neuroses. The treatment was given to them in the Unit as soon as possible after the breakdown and its aim was mainly to relieve the symptoms. Lindemann's grief work and the development of early crisis clinics are cited by Butcher *et al.* as other important historical origins of crisis intervention, as well the suicide prevention movement. As they point out, the successful management of suicide related crises was made possible by some innovative movement; these included the development of the telephone as a means of communicating with people who needed help, the initiation of 24 hours service, and the introduction of non professional personal into the role of helpers. Butcher *et al.*, also cite the free clinic movement as being influential in the development of crisis intervention.

EWING (1978) has defined crisis intervention as the informed and planful application of techniques derived from the established principles of crisis theory, by persons qualified through training and experience to understand these principles, with the intention of assisting individuals or families to modify personal characteristics such as feelings, attitudes and behaviors that are judged to be maladaptive or maladjustive. HAFER and PETERSON (1982), in a less formal definition, refer to crisis intervention as the kind of psychological first aid that enables to help an

individual or group experiencing a temporary loss of ability to cope with a problem or situation.

Crisis intervention programs originated as an attempt to serve unmet treatment needs of individuals, but now they have come into their own as an important treatment alternative (BUTCHER *et al.*, 1983).

Levels of Crisis Treatment

JACOBSEN, STRICKLER & MORLEY (1968) and MORLEY (1970) have discussed different levels of crisis treatment:

a) Environmental manipulation. In this case the helper serves as a referral source, getting the client in touch with a resource person or facility.

b) General support. It consists basically of active listening in a non threatening manner, allowing the person to speak in some detail about his problem without challenging him.

c) Generic manipulation. It is helping the person resolve a crisis by accomplishing certain psychological tasks that are the same for all the people experiencing the same crisis regardless of individual differences.

d) Individual approach. It focuses on the specific needs of the person in crisis and emphasizes the assessment of the psychological and psychosocial processes that are influencing the client. It looks at the specific psychological tasks and problem solving activities that each person must accomplish in resolving a particular crisis.

These levels of intervention are not mutually exclusive although there is usually one that is predominantly used in the treatment process. Therefore, it is possible to use an environmental manipulation and at the same time use a generic or individual approach or other combinations of treatment strategies.

Models of Crisis Intervention

LANGSLEY & KAPLAN (1968) have classified crisis intervention models according to their main focus:

a) Recompensation Model. It is a patient-oriented model, that is, it focuses on the patient exclusively. The main goal of the treatment inter-

vention is to stop the decompensation, get the symptoms under control and return the patient to his pre-crisis level of functioning. The model does not aim at explaining the failure to cope nor at understanding the past dynamics of the person that led him to the crisis. Moreover, there is not much concern about the person's future adjustment. The military treatment of the traumatic neuroses is a typical example of the recompensation approach to treatment.

b) *Stress-Oriented Model*. It takes into account the stress event. The goal of the intervention is to achieve successful resolution of the specific tasks posed by the stress event. It emphasizes the development of problem-solving strategies and coping skills and it is concerned with the future adjustment of the individual to other stressful situations. This model has been developed to great extent by Lindemann and Caplan.

c) *System-Oriented Model*. It is the one advocated by Langsley and Kaplan; it takes into account the social field in which the person deals with the crisis. It is based on the belief that not only the development but also the outcome of the crisis depend in part on the social field of the person in crisis, and therefore emphasizes the systems approach to intervention. Family-Oriented crisis treatment is an important development of this model, which is based on the assumption that the symptoms of the family member who seeks treatment are usually an expression of family conflicts.

These are the three basic models on which most of the crisis intervention strategies are based. While all of them seek a resolution of the crisis state, they focus on different aspects, namely the individual, the stress event and the system, in their attempt to deal with the crisis situation.

Goals of Crisis Intervention

Although the goals of the crisis treatment have been stated in various ways by different authors, there seems to be some agreement with respect to the main focuses of the intervention. FRANCE (1982) states that restoring or improving the adjustment of the individual can be considered one of the main aims of crisis intervention. He points out that crises are distressing timelimited episodes, which means that they end with or without outside help. Crisis intervention aims at limiting the duration and severity of these episodes.

PURYEAR (1979) defines the minimum goals of crisis intervention as alleviating the immediate pressure and restoring the individual to at least his pre-crisis level of functioning. He points out that ideally the resolution of the crisis should be a growth experience that leaves the person better equipped to cope with future difficulties.

RAPOPORT (1970) has discussed 4 main goals for crisis intervention:

- a) Relief of symptoms.
- b) Restoration to the optimal level of functioning that existed before the present crisis.
- c) Understanding of the relevant precipitating events that contributed to the state of desequilibrium.
- d) Identification of remedial measures that can be taken by the client or family that are available through community resources.

BUTCHER's *et al.* (1983) description of the goals of crisis intervention has some points in common with Rapoport's but they have added gaining the knowledge of the origin of the crisis in past experiences and preventing personality problems as goals of the treatment.

The Process of Crisis Intervention

Various authors have attempted to describe the process of crisis intervention; some have focused in the succession of psychological tasks that the individual follows during the treatment, others on the problem-solving activities in which the person in crisis needs to be involved. Most authors cover to a certain extent the different functions of the crisis therapist during the treatment process.

LINDEMANN (1944) stated that any person in the crisis of bereavement should complete the following tasks or problem-solving activities.

- a) Accept the pain of bereavement.
- b) Review his relationship with the deceased and become acquainted with the alterations in his own modes of emotional release.
- c) Express sorrow and sense of loss.
- d) Find an acceptable formulation of his future relation to the deceased.
- e) Verbalize his feelings of guilt and find persons around him who he can use as primers for the acquisition of new patterns of conduct.

AGUILERA (1970) has discussed what he considers to be the specific strategies to follow in the treatment process. He considers that first of all the client should be helped to gain an intellectual understanding of the crisis; next the client is helped in expressing his present feelings towards the crisis. At a third stage the client and therapist explore alternative ways of coping with the crisis and finally both of them work on anticipatory planning. The anticipatory planning or guidance basically involves the therapist's reinforcing of those coping skills and problem-solving activities that the person has successfully used in resolving the crisis; it is supposed to help the client prepare for any future crises that he may encounter.

According to KALAFAT (1983) the strategies to follow in the treatment of emotional crisis include: 1. Establish a therapeutic relationship with the client, 2. Define the problem, 3. Explore the feelings associated to it, 4. Review previous attempts to resolve the problem, 5. Explore the alternatives and develop a plan of action.

SMITH (1973) has also discussed the tasks to accomplish during the process of treatment:

- a) Identify with the client the precipitating event.
- b) Discuss how the client feels about the crisis, allowing emotional catharsis.
- c) Explore with the client how he has tried to cope with the crisis, that is the problem-solving activities and coping skills that he has used.
- d) Assess whether or not the client can be helped on an outpatient basis; this is particularly important in those crises in which there is a suicidal and/or homicidal risk.
- e) Explain to the client why he is in a state of crisis.
- f) Discuss with the client tasks that he can accomplish in successfully resolving the crisis.

PURYEAR (1979) and FRANCE (1982) have emphasized the focus on problem-solving during the treatment process. According to France problem-solving begins with the therapist recognizing the client's distressing emotions and seeking to clarify the reasons that led to the initial contact with the therapist. The release of tension is achieved through the client's sharing of feelings; relating them to conditions that influenced the development of the crisis, increases the emotional insight and control of the client. Considering the alternatives to the problem and developing an

action plan that describes the behaviors intended to alleviate the problem are the last steps of the problem-solving process.

BUTCHER *et al.* (1983) have developed a comprehensive list of tactics of crisis intervention that cover many important functions of the crisis therapist. Some of these functions are:

- Offering emotional support.
- Providing opportunities for catharsis.
- Listening selectively for workable material.
- Providing factual information and clearing up misconceptions when necessary.
- Formulating the problem situation.
- Being empathic and to the point.
- Predicting future consequences if the patient follows his present course of action.
- Clarifying and reinforcing adaptive mechanisms.
- Working out a contract with the client.
- Follow-up of the client's progress after termination of treatment.

Technical Characteristics of Crisis Intervention

a) Promptness of Intervention. CAPLAN (1964) pointed out the heightened susceptibility of a person to intervention during a crisis period. This has been one of the reasons for the emphasis on the immediate access to the person in a crisis. As RAPOPORT (1967) points out, a little help rationally directed and purposively focused at a strategic time is more effective than more extensive help given at a time of less emotional accessibility. It is therefore important to take advantage of the person's readiness to work (FRANCE, 1982). The availability of crisis intervention within 24 hours of the client's initial contact has been regarded as optimal (EWING, 1978).

b) Present Centeredness. Crisis intervention is focused on the client's present problems, particularly those that precipitated his request for help (EWING, 1978). It is important to maintain this narrow focus in order to utilize the treatment more effectively. BUTCHER & KOSS (1978) consider that the achievement and maintenance of focus is one of the most important technical aspects of crisis intervention. While past conflicts and personality factors influence how the stress manifests itself, it

is important to emphasize the present symptoms and problems in the attempt to master the current crisis (LANGSLEY & KAPLAN, 1968).

c) Time Limits. It is important to set time limits on the treatment (EWING, 1974). As a Result of the time constraints, the treatment goals are limited. PATTERSON & O'SULLIVAN (1974) have stated that the goals of most crisis intervention programs can be achieved in 3-12 sessions. The client's awareness of it enhances and maintains the client's motivation and speeds up the change process.

d) Preventive Emphasis. Crisis intervention seeks not only to resolve the present crisis and to relieve the symptoms, but also help the clients develop new problem-solving procedures and more adaptive mechanisms for coping with future problems and crisis (EWING, 1978). Some times crisis intervention may serve as a stepping stone to other therapeutic services, preparing the client for further treatment.

e) Reality Orientation. BUTCHER & MAUDAL (1976) consider that sometimes it is helpful to confront the client with the unrealistic or maladaptive nature of his beliefs or behaviors and to point out the possible negative consequences of the perseverance of current patterns. It is important to help the client develop and maintain clear and correct cognitive perceptions of his situation and problems (RAPOPORT, 1962).

f) Family and Community Involvement. PARAD & CAPLAN (1960) have noted that a crisis is usually also experienced to some extent by the family and social network of the referred person. Therefore it becomes very important to involve the family and the community in the treatment process as soon as possible, in order to facilitate not only the resolution of the crisis but also the post-crisis adaptation of the individual.

g) Therapist Role. The time limitation of crisis intervention forces the crisis therapist to be much more active and directive than he would be in «traditional» psychotherapy. BUTCHER & MAUDAL (1976) have noted that traditional attitudes of therapists such as objectivity, uninvolvement and non-directiveness are not appropriate in the crisis context. The therapist must be able to actively explore areas of interest and to direct the conversation toward those topics that might help in the resolution of the crisis. BUTCHER & KOSS (1978) have stressed the importance of the therapist's flexibility, ability to use various therapeutic techniques and adapt his interventions to meet the patient's needs. As LANGSLEY & KAPLAN (1968) have pointed out, whatever works is useful.

h) Therapeutic Relationship. Developing a working relationship quickly becomes a critical aspect of the intervention due to the time

limitation of the treatment. Therefore positive transference is essential in crisis intervention. The client should have at least a somewhat hopeful expectation that the therapist may be able to help him (BELLAK & SMALL, 1965).

i) *Therapeutic Tools.* The use of reflection is often helpful at the initial stages of the intervention, since it communicates understanding, gives the client an opportunity to clarify his feelings and keeps the focus of the interaction on the client (FRANCE, 1982). Interpretations aimed at the achievement of insight can be pursued but with caution (SMALL, 1972). Problem-solving techniques are some of the most important tools used in the intervention process. Analysis, advice or interrogation can also be used in appropriate circumstances.

j) *Selection of Patients.* FRANCE (1982) has noted that crisis intervention is most effective with essentially «normal» people who are experiencing overburdening problems. Traditionally it has been considered that the clients best suited for crisis intervention programs were: those in whom the behavior problem is of acute onset, those whose previous adjustment has been good, those with good ability to relate and those with high initial motivation (BUTCHER & KOSS, 1978). Duration and severity of the problem, diagnosis and motivation for treatment are the criteria cited by EWING (1978) as being most often used in the selection process. LANG (1974), however, believes that crisis intervention can be used with chronic or deeply entrenched problems too.

k) *Use of lay therapists.* There is a growing trend toward the use of para-professionals and non-professionals as crisis therapists. While at one time their use was considered the answer to a critical manpower shortage, their contribution has proved to be extremely valuable. As MCGEE (1974) points out 80% of suicide prevention and crisis intervention centers are operating with non-professionals as their primary staff resource. Professional people are often used in the role of consultants. It is important to develop valid criteria for screening and evaluating the effectiveness of lay therapists in doing crisis work.

Crisis Intervention Research

Research findings in crisis intervention are quite limited and often inconclusive. Most crisis theorists have not developed models of crisis intervention that can be rigorously tested (SMITH, 1973). Much of the

research done in the field has focused on the characteristics of the crisis reaction, and relatively few efforts have been made to evaluate crisis intervention. Studies of the outcome of crisis intervention have shown different results depending on the type of patients and the measures of outcome used. Crisis intervention research is often plagued with problems of control and other methodological difficulties precluding any unequivocal interpretation of the findings (EWING, 1978). A serious methodological problem in outcome studies of crisis intervention is the mobility of the population resulting in loss of sample. Other difficulties that cause problems comparing studies are the great heterogeneity of the samples, which makes difficult their specification and the use of different outcome measures (BUTCHER & KOSS, 1978). The use of non-professionals as primary staff resource, who differ in their training, experience and many other significant variables, has also contributed to the inconclusiveness of many research findings (AUERBACH & KILMANN, 1977).

A good example of crisis intervention research is the work of Langsley and Kaplan with families in crisis. They have developed a theory of treatment for family crisis and a research design to evaluate the effectiveness of their treatment. They randomly assign families to different treatment programs, and record on tape the treatment sessions and keep detailed records of the application of the treatment. The outcome is assessed by using psychological tests along with the opinions of experienced clinicians who were not directly involved with either treatment group. Their research findings have shown that crisis treatment was more successful and durable than traditional psychiatric services in helping families in crisis.

CONCLUSION

Lindemann and Caplan developed the conceptual framework of crisis theory and practice. Later theorists have been strongly influenced by them and have basically further elaborated and refined Lindemann and Caplan's pioneering work. At this point, crisis theory is fairly well articulated and has provided the grounds for the philosophy of crisis intervention. While a general theory of crisis intervention has been developed, there is still the need to further conceptualize a crisis practice based on the results of well designed research.

Crisis intervention can be viewed as a form of preventive intervention.

It can be considered a type of secondary prevention, since it attempts to alleviate ongoing problems before they result in serious impairment. Psychopathology and personality disturbances can be prevented by providing help at early stages of the development of a crisis. Appropriate use of crisis intervention can therefore minimize the pathological sequelae of a crisis. Crisis avoidance and crisis rehabilitation can be considered as forms of primary and tertiary prevention respectively.

The Report of the Joint Commission on Mental Illness and Health noted that 17 million people in the U.S. had emotional problems which required treatment. Crisis intervention can provide help to those with the most urgent problems and meet the mental health needs of many people that otherwise wouldn't be served. Crisis intervention offers an effective and relatively economical alternative to traditional psychotherapeutic approaches and is the treatment of choice for persons experiencing acute distress and crisis.

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