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CRISIS INTERVENTION WITH CLIENTS DISPLAYING THOUGHT DISORDERS: DEFINITION OF A TREATMENT MODEL

A Thesis

by

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February 1983

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A Thesis

by

ROSEMARY S. UNSWORTH

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ABSTRACT

CRISIS INTERVENTION WITH CLIENTS DISPLAYING THOUGHT DISORDERS: DEFINITION OF A TREATMENT MODEL. (February 1983)

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This study was designed to identify the framework of treatment that therapists in North Carolina are currently using with psychotic individuals that present to them in crisis. Some gaps in the knowledge and skills of mental health clinicians were also identified, as well as some needs for further research in crisis work with psychotic individuals.

One hundred and nine community mental health centers in North Carolina were contacted for this study. A two-part questionnaire was sent to the emergency services coordinator in each county to fill out according to how his/her staff would most often respond to each situation. In Part I, the respondents were asked to rank order possible steps they might take in handling a

crisis situation in four different cases. These brief descriptions varied from: (a) known precipitant, (b) no known precipitant, (c) dangerous to self, and (d) not dangerous to self. In Part II of the questionnaire, the respondents were asked to list in what aspects of emergency/crisis work their staff would most like training.

Of the 109 mental health centers surveyed, 65 returned the questionnaire. This reflected a return rate of approximately 69%. A transitional matrix was used to record the ranking order for Part I of each questionnaire. This procedure determined the most popular routes of decision-making in each of the four cases. As these graphs were complex in nature, a final graph was made reflecting only the most probable transitions of ranking in each case.

Visual inspection of the most popular rankings reflected that most therapists were consistent in their decision-making at the beginning of intervention and towards termination of treatment in all cases. The most striking deficits seemed to be: (a) the lack of follow-up with the client after a crisis hospitalization, and (b) the lack of referral for long-term therapy in the case of the known chronically psychotic individual.

In Part II of the questionnaire, it was apparent that the major concerns for the respondents in contact with psychotic individuals were working with the agitated or violent patient, determining correct diagnosis and/or doing an accurate mental status examination, and the uses and legal implications of psychotropic medications.

Several implications for North Carolina therapists are noted. More effective follow-up services are needed for hospitalized individuals. The need for long-term, supportive treatment with the psychotic individual needs to be emphasized. Appropriate resources to meet social and environmental needs of this client population need to be implemented where they are lacking. Other community agencies need to be educated in crisis techniques. Training needs for students who will be working in the mental health field with psychotics are also discussed.

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INTRODUCTION

Crisis intervention theory and practice is still in its infancy, and for this reason is still undergoing controversy and definition. It is the author's intent to acquaint the reader with historical development, current practices and problems, and literature regarding treatment of the psychotic patient in crisis, in order to present more clearly the focus of this bit of research. Therefore, this information has been included in the body of this paper so that a better understanding of crisis theory and technique with the psychotic individual can be obtained. In addition, this study will examine some current practices in the field.

Most of the studies that have been done using crisis intervention techniques have been outcome studies of effectiveness. The purpose of this study will be to define the framework of treatment that therapists in community mental health centers in North Carolina are currently using with psychotic individuals that present to them in crisis, and hopefully, to identify some gaps in the knowledge and skills of mental health clinicians that may be corrected by training.

It is felt that this study will provide a frame of reference (conceptual description) currently in use in North Carolina for treating psychosis and making appropriate decisions regarding the psychotic in crisis. This description may also illuminate some needs for further research in this area of crisis treatment. North Carolina mental health professionals will also identify some gaps in their knowledge base, and hopefully identify workshops and resources needed to more effectively treat the psychotic in crisis.

HISTORICAL DEVELOPMENT

Crisis intervention is a relatively new technique of psychiatric treatment. Not until the 1960's, did crisis intervention come into recognition along with the community health center movement. The term "crisis intervention" did not appear in the Psychiatric Dictionary until 1970 (Aguilera & Messick, 1974, p. 6). However, the groundwork for crisis intervention was laid long before.

In the early 1930's, the city of Amsterdam, facing a shortage of funds, hired a psychiatrist to reduce the number and length of stay of patients in the psychiatric hospitals. Arie Quirido was appointed to this role. Quirido established a psychiatric first-aid service which provided for on-the-spot contact and screening of any person experiencing emotional problems. Referrals came from many community agencies, allowing for communication and consultation. Quirido began to realize that many of the mentally disturbed individuals could live in the community rather than be hospitalized, "...provided certain conditions were realized ..." (Quirido, 1968, p. 293). Other agencies in the community helped to provide assistance needed for the

individuals to stabilize their environment, making it possible to function outside the psychiatric hospitals. In addition, staffings were held for those patients within hospitals, to make plans for their discharge in an attempt to further insure patient success rates.

Quirido opened the door for new concepts regarding mental health treatment. First, on-the-spot, 24-hour a day psychiatric intervention provided for better disposition of an emotional crisis. Secondly, Quirido introduced community responsibility for the patients. Thirdly, more active therapy was instituted, with the patient becoming more involved in their own treatment. Finally, Quirido established the basic premise of crisis theory--that of reestablishment of a norm or equilibrium for the patient, thereby reducing the stress of being set apart from the community in which he/she resides.

In 1943, Erich Lindemann observed and treated 101 relatives and survivors of the Coconut Grove Fire in Boston. Subsequently, he published a paper describing a pattern of behavior common to those suffering a tragedy. Lindemann's work on grief reactions provided an important conceptual frame of reference for dealing with others who had suffered a loss. It is important to note that Lindemann felt that immediate, prophylactic measures provided to persons suffering a severe loss,

would prevent "morbid grief reactions" and assist the individual in coping normally with the crisis.

Albert Glass (1954) presented a paper to the Symposium on Stress at Walter Reed Army Medical Center regarding treatment of "combat fatigue" or "shell shock." The number of psychiatric disabilities during combat in WWII was high. Men were being removed from combat and treated 24 to 48 hours later in psychiatric facilities away from the combat area. Disappointingly enough, only "15% of the men who were treated were salvaged for combat duty" (p. 727). Glass mentioned that the psychiatrists themselves were so far removed from the cause of the stress that it was difficult, if not impossible, to determine how best to help the soldiers.

However, in January of 1944, the military began to assign division psychiatrists to combat units. These psychiatrists found that "(a) the location or level where treatment is performed should be as near the battlefront or combat group as possible, preferably at the level of the battalion aid station, (b) best results of treatment (were) obtained by methods that combined simplicity and brevity..., (c) psychiatric facilities function more effectively if all assigned personnel (made) consistent efforts to create a therapeutic atmosphere that reflected positive motivation, (d) success in therapy was largely determined by the

degree with which the psychiatrist identified with the needs of the combat group..." (Glass, 1954, p. 731). Following the implementation of brief, immediate treatment, nearly 40% of the soldiers experiencing psychiatric disabilities were sufficiently recovered to return to combat duty.

Following WWII, the public began to be more aware of mental illness. More research was being done, and psychotropic drugs were discovered. In 1964, Erich Lindemann and Gerald Caplan began a community-wide program of mental health called the Wellesley Project. The goal of the Wellesley Project was to prevent mental illness by intervening when a crisis was obvious, in an attempt to prevent maladaptive coping. Caplan began to conceptualize the crisis process and emerged with many publications on crisis theory and methodology. He felt that the crisis states of individual and group development were important areas for mental health consideration as these periods were a dangerously vulnerable time for the ego as well as an opportunity for growth. Caplan also emphasized that crisis periods were self-limiting, from four to six weeks.

Leopold Bellack, drawing from Caplan's work and others, established a "Trouble-Shooting Clinic" in Elmhurst, New York in 1958. Bellack felt that it was neither "reasonable nor fair for the therapist in a

mental hygiene clinic or social agency to treat one patient for two years to the exclusion of 60 other patients" (Bellack, 1978, p. 3). Bellack realized that most people requested help in crisis. Therefore, in the Trouble-Shooting Clinic the patient was offered brief therapy of from one to six sessions. These brief, crisis periods were regarded as the most opportune time to effect change.

The 1960's brought many changes to the nation. Community mental health centers were established. Hotlines and suicide prevention centers were established as more and more authorities began to recognize the necessity of immediate treatment. Norman Farberow and Edwin Schneidman established the first suicide prevention telephone service. The Los Angeles Suicide Prevention Center was a 24-hour telephone intervention service. The establishment of this service in 1958 began the model for hundreds of other telephone services as well as procedures and methodologies for intervening in suicidal emergencies.

One problem the community mental health centers faced in the early 1960's was their public image. The mental health centers were considered "establishment" and therefore many youth did not frequent these services. Morton Bard (1969), began to recognize the need for training non-professionals in crisis techniques

in order to reach out to more people. Studies indicated that 62% of policemen, nationally, were either injured or killed in family disturbance situations. Bard noticed that the New York police were often the first to come in contact with family crisis, so he began to train police teams as specialists in family crisis. It was found that in the course of one year, not one of the 18 men trained in family crisis counseling sustained an injury, but that in a "neighborhood precinct, with fewer cases and with the work distributed among 250 men rather than 18, in that same period of time there were five reported instances of injuries to police sustained in responding to a family conflict" (p. 249). Many other non-professional crisis programs were introduced throughout the country in order to assist those who would not contact a mental health center.

When the community mental health centers were established, the emphasis of treatment began to shift from the psychiatric hospitals to the outpatient centers. This shift in treatment made for less frequent and shorter hospitalizations for those suffering from mental illness. However, studies of community mental health centers showed that the average number of sessions per client was four. Therefore, it was assumed that long-term therapy was not necessarily desired by many patients in crisis. In fact, several researchers

suggested that most clients wanted "...immediate psychiatric relief and <u>not</u> basis personality transformation" (Amada, 1972, p. 105) (Hoffman & Remmel, 1975, p. 259). Therefore, crisis intervention became more popular.

CURRENT STATUS OF THE FIELD

According to many researchers of crisis intervention, the term crisis has been ill-defined and vague. This point was best described by Bernard Bloom (1963). He submitted 14 case histories to eight expert judges and asked them to study the effects of five variables upon judgments of the presence or absence of crisis. These variables included:

a) Knowledge or lack of knowledge of a precipitation event,
b) Rapidity of onset of emotional reactions,
c) Awareness or lack of awareness on the part of the individual of inner discomfort,
d) Evidence of behavioral disorganization,
e) Rapidity of resolution.

Bloom's results indicated a lack of agreement among the expert judges as to what constituted a crisis situation. All judges agreed, however, that a crisis event began with some known precipitant and lasted a month or longer before resolution occurred. Bloom concluded that further refinement of the term, crisis, was needed (pp. 498-502).

Definition of Crisis

After 1963, there continued to be disagreement as to what constituted a crisis situation. Gerald Caplan (1964) defined crisis as an "upset in a steady state,

a situation in which there is a shift in social or psychological forces that cause an individual's relationship with others, or self, to change" (p. 40). He further stated that the primary determinant of a crisis event was an imbalance between the perception and significance of the difficulty (or hazardous event), and the resources available immediately for coping with the situation (1964). Caplan and Parad (1965) mentioned three sets of interrelated factors that can produce a crisis state: "(a) a hazardous event which is perceived as threatening; (b) a threat to instinctual need which is symbolically linked to earlier threats that resulted in vulnerability or conflict; (c) an inability to respond with adequate coping mechanisms" (pp. 66-67).

Aguilera and Messick (1964) point out that crisis is derived from the Greek word, Krisis, which means to separate, or a turning point. Lydia Rapoport (1962) goes further with this concept by indicating that crisis can be a turning point with growth-promoting potential. In other words, a crisis situation, with proper intervention, can be a challenge, sparking motivation and change or can function to cause emotional disequilibrium and long-term psychiatric disability. Factors contributing to emotional disequilibrium in crisis are: (a) inadequate cognition or preception of the hazardous situation; (b) inadequate social support systems; and

(c) inadequate coping mechanisms (Aguilera & Messick, 1974, p. 63-65).

<u>Characteristics of Crisis</u>

The crisis process begins with the perceived threat and ends with resolution of the problem, either by finding a solution or making a decision, learning to live with the problem, or by emotional decompensation. This process usually lasts from four to six weeks. The more hazardous a stressor is perceived by the individual, the more serious the emotional disorganization that occurs.

Caplan (1964), defines four general phases of the crisis period. First, upon onset of a hazardous event, individuals may experience a rise in tension. This is accompanied by the use of habitual problem-solving techniques. When habitual coping strategies fail, more discomfort is experienced. Thirdly, the increase in tension leads to mobilization of additional internal and external resources. The problem then may be redefined or certain goals may be discarded. Finally, major disorganization may ensue if the problem is not successfully resolved. (See Figure 1.)

Lindeman's (1944) work in the Coconut Grove Fire and Glass's (1954) work in World War II helped promote the commonly felt notion that the more immediate the intervention in crisis, the more effective adaptive

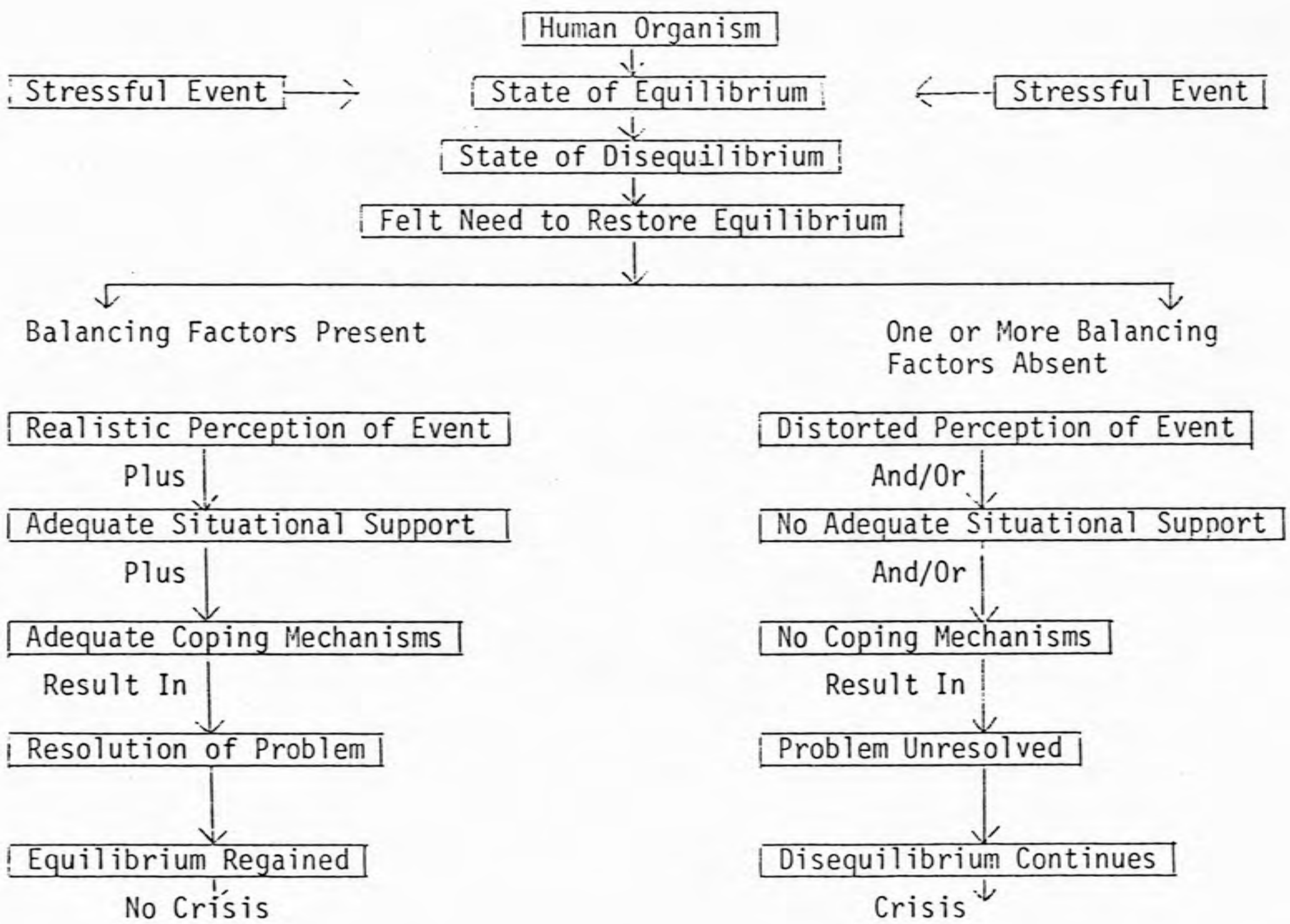

Figure 1. Effect of Balancing Factors in a Stressful Event (Aguilera & Messick, 1974, p. 61)

coping measures performed by the individual would be. Louis Paul (1966) further concluded from Caplan's phases of crisis, that certain corollaries are evident in crisis. When intervention is available, a small influence will produce great change quickly as individuals grope for resolution of their distress. Secondly, outcomes of crisis resolution are not conditional on old coping styles. Rather, new coping skills may be learned. Thirdly, when adaptive resolution occurs with proper intervention, individuals may be "healthier" than before, as they have learned new emotional skills (Paul, 1966, p. 142).

In crisis, symptoms of psychological and physiological stress may be readily observed. Individuals' efficiency may be lowered and their primary focus is to find relief. Attitudes of panic or defeat may occur. When the crisis remains unresolved or maladaptive coping is attempted, then emotional disorganization may follow. When disorganization occurs, magical thinking, regressive behavior, withdrawal from reality, and bodily complaints and preoccupation may develop. Individiuals may feel "out of control." On the other hand, adaptive crisis resolution is task-oriented, based in reality with appropriate perceptions of the situation, and the active seeking of support systems, and new skills are readily apparent (Rapoport, 1962, p. 216).

Several factors influence the way individuals handle crisis situations. Their maturity prior to the crisis is important. Social and emotional supports and the presence of additional stresses play a part in determining how they will handle a crisis situation. Lastly, the already existing coping skills individuals possess will influence the state of crisis in which they may find themselves (Wicks, Fine, & Platt, 1978, p. 14).

Types of Crisis

Jacobson et al. (1965) described two types of crisis commonly seen--generic and individual. Jacobson et al. described the generic crisis as having a predictable adjustment pattern of resolution. For example, Lindeman's (1944) work on grief predicted several stages of emotional work an individual had to process in order to effect resolution. It was evident that a particular process of resolution was seen in several different situations, for example, divorce adjustment, and death and dying.

Individual crisis was not definable as a specific process but rather was determined by individuals and their psychodynamics. The emphasis in individual crisis was to assist persons to regain equilibrium by whatever process was effective for them.

Aguilera and Messick (1974) divided crisis types into situational and maturational types. Situational crises were defined as those crises that occurred independent of developmental issues and were determined by a particular situation or sequence of events that provoked a stressful situation for individuals. These types of crises were the result of environmental factors and individuals' perception of the situation. An example of situational crisis was Glass's (1954) work during WWII with men in the combat zone suffering from "combat fatigue." These men found themselves in an emotionally charged situation with no effective coping skills.

Maturational crises, as defined by Aguilera and Messick (1974) were essentially "normal process of growth and development requiring many characterological changes" (p. 106). Other hazardous situations individuals found themselves in during this period could compound the crisis experienced. These developmental crisis periods were experienced by everyone, but the individuals' perceptions of the period and their unique coping abilities determined whether or not intervention need occur.

The most specific paradigm for classification of crises was developed by Dr. Bruce Baldwin in 1978. He divided types of crises into six major categories

commonly seen in mental health clinics. He stated that classifying crises in this manner assisted the mental health worker in a better cognitive understanding of individuals in crisis and a better understanding of specific intervention techniques. (See Appendix A.) This paradigm of classification also described a knowledge base needed for dealing with certain types of crises. As one moved from a Class 1 crisis to a Class 6 crisis, a greater level of clinical training and therapeutic skills were needed. (See Appendix A.)

CRISIS INTERVENTION AS THERAPY

Crisis intervention is a method of intensive work over a short period of time using established crisis theory principles in an attempt to modify maladaptive behaviors. Crisis intervention is not intended to effect major personality changes. It is designed to deal with the immediate crisis only and its minimal goal is to assist the individual in restoration to precrisis level of functioning.

Many researchers have criticized crisis intervention because they feel it is not a treatment modality in and of itself, but rather a "band-aid" technique. However, individuals are assisted in crisis to develop and strengthen already existing or new coping skills that will restore them to a precrisis level of functioning. What clients learn during this period should serve well in the event of another crisis. The therapist can always refer individuals for longer-term therapy or for hospitalization (Wales, 1978, p. 86). It is possible that the first therapy session may be the last, and using crisis techniques enables the therapist to get a great deal done, quickly.

Principles of Crisis Intervention

Many principles have emerged in crisis work to assist the therapist in dealing more effectively with a "hazardous event" or crisis situation. Immediate intervention is a necessary component of crisis work as it has been shown by Lindeman, Glass, and others that the sooner expedient assessment and intervention takes place, the easier it is to avoid maladaptive coping (i.e., suicide and psychosis). Waiting lists should be avoided because resolution (either adaptive or maladaptive) of a hazardous situation may have already taken place before individuals receive therapy. Intervening as quickly as possible following a crisis event serves to activate individuals, as they are motivated to seek some sort of solution to an intolerable predicament.

The therapist using crisis intervention takes an active role. Persons in crisis are ineffectual and the therapist actively works with clients to begin moving them in a goal-directed manner. The therapist may actively instill hope, provide support, strengthen ego, and give some appropriate directives initially.

Another principle of crisis intervention is understanding that goals are limited. The only goal is to deal directly with the current crisis and to restore the equilibrium of the client. Minimally, this means

to avoid maladaptive adjustment or destructive coping. Maximally, the goal is to assist individuals in learning more adaptive ways of dealing with their problems (Aguilera & Messick, 1974, p. 16). This limited goal setting necessitates the need for focused problem solving, including assessment, planning for specific intervention, and evaluation and anticipatory planning (Hitchcock, 1973, p. 1388).

Individuals in crisis have often exhausted coping skills known to them, and in treatment, often are dependent on the therapist for help with their problem. The crisis worker does not need to worry about fostering some dependence at this time. As individuals begin to deal with their crisis effectively, this dependency on the therapist will dissipate. It is more important that individuals in crisis be supported while preserving individual integrity, and be encouraged to express their feelings. Gerald Caplan (1970) stated that dependency is paradoxical, in other words, the more you satisfy dependency during crisis, the more independent persons will be following crisis.

Lastly, it is important to understand that crisis intervention treatment is a more educational than traditional therapy. Information is frequently provided about resources available to individuals. The therapist needs to assist individuals in recognizing their

emotional status and the steps they need to take to resolve their crisis.

Techniques of Crisis Intervention

Techniques of handling crisis have matured as more has been learned about crisis and management. Dr. Bruce Baldwin, in a paper presented to the Southeastern Psychological Association in 1978, describes two models that developed in an attempt to handle crisis situations and describes how these two models have since converged to form a new model that provides a more complete intervention strategy. This new convergent model is in wide usage today by academicians and practitioners of crisis intervention.

These two models are the screening/assessment model, which is primarily a medical model of evaluation and referral with little treatment; and the problem-solving model used by paraprofessional services. The screening/assessment model is very short-term (usually 1-2 sessions in length), and the emphasis is primarily diagnostic. The problem-solving model is not structured, has little emphasis on assessment, but is designed to assist individuals in coping with current crises (Baldwin, 1978, pp. 3-8).

A more complete model has emerged with Gerald Caplan's initial work in crisis intervention and has been described and improved upon by his successors.

This present day model emphasizes crisis intervention with the minimum goal being restoration of a precrisis level of functioning (Figure 2).

Initially, communication and rapport must be established with clients. This can be achieved through active listening, empathy, and simply by allowing individuals to ventilate their feelings with acceptance by the therapist. Taking charge in the sessions will also help to facilitate communication and rapport and will serve an added purpose of providing some relief to individuals (Puryear, 1979, pp. 66-67).

Assessment of the crisis situation and the individual must be done. This begins in the initial session and continues throughout the crisis resolution. Assessment includes defining the crisis situation or precipitating event of the crisis. This is usually done by eliciting why clients are seeking help (presenting problem) and what made them seek help at this particular time (precipitating event). The precipitating event is the focus of crisis intervention and using the precipitating event to delve into deeper problems is not called for in time-limited crisis work. When defining the precipitant it is also important to determine individuals' perceptions of precipitating events--are they realistic?

Assessment of individuals is done concurrently with assessment of the precipitant or crisis. It is

	SCREENING/ASSESSMENT MODEL	CONVERGENT MODEL*	PROBLEM-SOLVING MODEL
1. Time Orientation	Past-Present	Past-Present-Future	Present-Future
2. Assessment	Traditional Diagnostic	Crisis Assessment	Little Formal Assessment
3. Response to Client Psychodynamics	Broad Spectrum	Focal Emphasis on Precipitant	Minimal Response
4. Therapeutic Emphasis	Evaluation, Support, Emergency Services	Crisis Resolution	Present Problem-Solving
5. Time Frame	1-2 Sessions	1-8 Sessions	Open-Ended
6. Therapeutic Structure	Structured, Therapist Defined	Structured, Negotiated with Client	Relatively Unstructured
7. Outcome Criteria	Referral Facilitated, Service Coordinated	Restoration of or Increase in Pre-Crisis Functioning	Problem-Resolved
8. Common Problems	Little Treatment Beyond Client Support	Defining Time Frame/ Relevant Goals, Maintaining Focal Emphasis	Dependency/Regression Issues, Therapist Over-Involvement
9. Level of Training	Professional	Usually Professional	Usually Paraprofessional
10. Typical Clinical Context	Emergency Rooms, Walk-In Clinics	Outpatient Clinics, CMHC's	Switchboards, Suicide Prevention Services

Note: Variations in these models for crisis intervention are recognized, but are conceptualized as above to clarify the dimensions on which they differ from one another.

Figure 2. Models of Handling A Crisis (Baldwin, 1978).

important to note strengths and weaknesses, especially in regards to problem-solving abilities (Aguilera & Messick, 1974, p. 57). A current brief mental status examination should be done to determine whether or not individuals are suicidal or homicidal, their level of anxiety, cognitive abilities, medical problems, medication, and clarity of thought. Occasionally, individuals may present, either directly or indirectly, a high degree of dangerousness (seriously suicidal or homicidal). In this situation, individuals may be referred for hospitalization rather than continuing in outpatient treatment.

During the assessment, the therapist should also pay close attention to what individuals are seeking or requesting. This will aid the therapist in his/her approach to the crisis intervention and clarification of what can be provided. Some clients will present a need, directly or indirectly, for caretaking (ventilation, expressing a need for control, or a need for reality or personal contact). Another request is for therapeutic intervention (clarification or conflict resolution). Others may request an authority figure (need for social takeover, advice, education, healing, confession). Many needs asked for by individuals desiring an authority figure are inappropriate and will need to be clarified. Lastly, other requests by

individuals are initially undefinable. Some may request nothing and some may desire only community resource information (Burgess, 1980).

Following assessment, intervention planning is done with individuals in crisis. It is important at this time to determine how the crisis is affecting individuals' lives and those around them (Morley, Messick, & Aguilera, 1967, p. 539). Data is collected during this time to evaluate if significant others need to be included in the intervention process. When all information is gathered, a formalized contract should be established determining the exact problem focus (what will be worked on in therapy), number of sessions and frequency, client and therapist responsibilities, and inclusion of others if found to be necessary (Ewing, 1978, pp. 108-109).

Contracting for therapy goals has been found to be effective for several reasons. A contract helps to promote efficiency and establishes a failsafe mechanism for therapists and clients so that each understands exactly what is expected to happen (Montgomery & Montgomery, 1975, pp. 348-352). The intervention planning contract also aids therapists and clients in adhering to the limited goals agreed upon. Limiting the specific number of sessions in a contract may enhance clients' motivations to change by application of the

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principle of Parkinson's Law of Psychotherapy (the work expands to the time allotted for its completion) (Applebaum, 1975, pp. 426-436).

Following intervention planning, actual intervention is initiated. Clients are assisted in gaining a realistic perception of the crisis, including understanding what has happened and how they feel about it. Alternative solutions are explored with clients and a plan of action is decided upon before individuals leave the initial session. During the second session an evaluation of what has been attempted is done and if no effective solution has yet been found, clients and therapists explore further alternatives. Many other strategies can be used in the intervention process. Utilizing significant others as support for the client, referral to other resources (legal and medical), providing education or information, confrontation, and behavioral task assignments are all creative techniques that can be used in intervention (Ewing, 1978, pp. 110-115).

Lastly, in the intervention process, is the resolution of the crisis and anticipatory planning. Following an effective resolution of the crisis, a review of what has transpired is done. In this way, individuals can appraise what worked and learn new coping skills for the future. Appraisal by both therapists

and clients must be objective in order to ascertain whether individuals have, at the very least, returned to a precrisis level of functioning (Aguilera & Messick, 1974, p. 60).

Implications for the Crisis Therapist

Unfortunately, few academic institutions prepare mental health professionals to deal with actual crises. Most institutions instruct students in general crisis theory but do not provide "hands on" training or specific skills in crisis intervention. Dr. Bruce Baldwin noted that in the university setting, myths and misconceptions by various professionals in mental health tended to make it difficult to discuss crisis intervention as a specific treatment model. These misconceptions and subsequent lack of opportunities for upcoming professionals have also made it difficult to receive adequate training. (See Figure 3.)

Many specific skills and attitudes for effective crisis intervention work are needed by mental health professionals. It is important for therapists to believe in the effectiveness of this approach and not to see it as a palliative treatment (Aguilera & Messick, 1974, p. 19). Therapists need to have good clinical skills to be flexible enough to refer, educate, support, and take charge in the treatment. From what has already been said, it can be seen that crisis intervention

Myths and Misconceptions

* Crisis intervention is only for responding to psychiatric emergencies.
  Psychiatric emergencies are only one type of situation encountered by the crisis intervention therapist.

* Crisis intervention is a "one-shot" form of therapy.

* Crisis intervention is a form of therapy practiced only by paraprofessionals.
  In order to use the convergent model technique a high degree of professional skills are needed.

* Crisis intervention represents only a "holding action" until longer-term therapy can begin.
  Crisis intervention may frequently be the treatment of choice and should not be seen as a supportive measure.

* Crisis intervention is effective only for primary prevention programs.
  Crisis intervention can be used on all levels of prevention.

* Crisis intervention does not produce lasting change.
  Dealing effectively with a crisis may promote the learning of new coping skills available for future use by the individual.

* Crisis intervention requires no special skills for the well-trained therapist.
  Crisis intervention is not "easy" and new skills must be learned in conjunction with effective therapeutic skills already possessed by the mental health professional.

Figure 3. Myths and Misconceptions (Baldwin, 1977, pp. 660-662)

is a more active treatment because it requires more involvement and sharing by therapists.

Therapists must be skilled in rapid assessment techniques (mental status examination and assessment of the crisis), and know what questions to ask in order to obtain a good evaluation of the total person. According to Robert Lovitt, Ph.D. (1974) assessment skills are frequently lacking in psychology trainees due to lack of training experiences. He also states that students do not have experiences in which they learn to effectively deal with emotionally charged issues or to make rapid decisions affecting people's lives. These students, upon graduation, are then left to learn about crisis situations and the effective management of them, essentially on their own.

Therapists, in doing crisis work, must be able to see a person immediately in order to begin crisis intervention before maladaptive coping takes place. Therapists, therefore, must be able to be flexible in scheduling appointments. They must be able to focus on the limited goals of that crisis and not deviate toward underlying problems. Therapists must know when to refer an individual for long-term therapy and must be realistic, direct, and provide feedback as needed (Baldwin, 1977, pp. 666-667). It is also important to

be able to contract with individuals to deal with a specific precipitant in a limited number of sessions.

Treatment of the Psychotic Using Crisis Intervention

Almeida and Chapman (1972) have described psychosis as a group of disorders in which the patient has a marked disturbance of emotional functioning, some loss of contact with reality, and deterioration of social and economic adjustments. They further state that psychosis may be categorized as those illnesses caused by long-term interpersonal stresses, schizophrenia, severe depressions, and organic processes (p. 97). Delusions and hallucinations are commonly associated with psychosis.

Psychotic individuals have generally been treated with medical, psychological, and sociological measures. Medically, neuroleptic or anti-psychotic drugs have been prescribed. These drugs generally are a treatment of choice and tend to reduce the occurrence of hallucinations, delusions, agitation and withdrawal that are often present in the psychotic individual (Bassuk & Schoonover, 1978, p. 81). Other generally used treatments have included shock therapy (insulin or electroshock), and for the most severly disturbed, psychosurgery. Oftentimes, hospitalization is considered a treatment of choice. Psychological treatment of psychosis has been attempted using many therapeutic

techniques, however it has been argued as to whether or not severe psychosis can be "cured." Sociologically, psychotics have been encouraged to modify the stressful environment they find themselves in.

Decker and Stubblebine (1972) conducted a study of psychotic adolescents that had been admitted to inpatient units. They treated one group with traditional methods and the other group was treated with crisis intervention techniques. Members of the latter group were then hospitalized, if necessary. Decker and Stubblebine noted a significant reduction, and shorter duration of hospital stays in the adolescents treated with crisis intervention techniques. This study is felt to be significant because hospitalization, itself, can be considered a pathogenic experience. They concluded that:

> Social adaption cannot be equated with mental health in a simple way, but neither can hospitalization be simply equated with good treatment of a mental disorder. (p. 729)

Often the hospitalized individual considers hospitalization as "the" treatment, and when they are not hospitalized, they must be well and do not need outpatient treatment and medications (Parad, 1975, p. 78). Some patients are hospitalized simply because there are no other alternatives for them. This may be due to the patient's feeling of hopelessness and sense of

inability to cope or to the therapist's sense of not knowing what else to do. When hospitalized, however, the individual is less likely to be able to deal with difficulties encountered in his/her usual "everyday lives."

There are some situations, however, where hospitalization is an appropriate treatment. Legal commitment for treatment should be done when the individual is unable to care for himself/herself (unable to perform daily living requirements), when the client is dangerous to himself/herself (suicidal), or dangerous to someone else (homicidal).

With a chronic, psychotic individual who functions minimally, at best, crisis intervention techniques could restore equilibrium and avoid the trauma or inpatient treatment. It should not be assumed that the psychotic in crisis is simply experiencing an exacerbation of his/her psychotic state. Rather, crisis intervention with psychotic individuals should be considered equally as important as with "normal" individuals experiencing some stressful event. A legitimate goal of crisis work with the psychotic is a recompensated, reasonably well-functioning state.

<u>Specifics of Crisis Intervention With the Psychotic</u>

Most experts agree that crisis intervention techniques can be used with an individual experiencing

psychotic symptoms. The general model of crisis intervention includes established rapport with the client, assessment, defining the precipitant of the crisis, crisis intervention planning, intervention, and anticipatory planning. However, in working with psychotic individuals, several additional tasks should be noted.

During assessment of the individual a psychiatric emergency needs to be ruled out. It must be determined whether or not individuals seeking help are homicidal or suicidal and whether their psychotic processes are so severe as to impair their ability to perform necessary activities for survival (e.g., eating and sleeping). When determining these points with individuals, therapists need to be honest, clear, and direct. Therapists should not get caught up in an argument about whether or not individuals' hallucinations and/or delusions are real, but rather acknowledge that individuals believe them to be real (Puryear, 1979, p. 179). When it is determined that individuals are, in fact, dangerous to themselves or others, then they should be hospitalized.

In conjunction with an assessment of individuals' mental status, therapists should look into recent life history and environmental circumstances, and past psychiatric history. This information will provide many clues. If individuals need medication, their past

histories may be useful in determining the most appropriate medications. Historical information will also provide information about individuals' coping skills in the past, both adaptive and maladaptive. Assessment of individuals' recent life history and environmental circumstances will alert therapists as to what support systems are present.

Another important task for crisis therapists working with psychotic individuals is to be sure that enough support and structure is available. Family and friends may need to be involved and assist in strengthening individuals' reality defenses. Therapists may need to advise persons in crisis to avoid overpowering, fear-provoking situations for a while (Wicks, Fine, & Platt, 1978, p. 136). Therapists may need to correct misunderstandings or mispreceptions clients may have. These clarifications should be done in an honest, supportive manner.

In addition to dealing with the crisis, therapists must begin to prepare psychotic individuals for longer term treatment and facilitate a referral for this. If clients are successfully assisted with a crisis, they will be much more receptive to further therapy (Baldwin, 1978, p. 546).

If clients are hospitalized on an emergency basis, crisis therapists do not terminate their intervention.

It is important to establish rapport and become a co-ordinator of services once the acute phase is over (Baldwin, 1978, p. 548). Therapists will not only work on crisis intervention with the client but they will also facilitate referrals, work with family members or other support systems--and most importantly, facilitate reentry and adjustment for individuals to return to their community and social environment (Wicks, Fine, & Platt, 1978, pp. 145-153).

The primary goal of crisis intervention with psychotic individuals is a restoration of psychic equilibrium. Once this has been accomplished and referral for longer term therapy is instituted (e.g., medications and therapy), crisis intervention may still be a useful periodic treatment modality. "Chronic" individuals with long-term psychiatric problems may not experience major changes of a "cure." Periodically, they may experience a crisis state that will need immediate attention in order to prevent total decompensation and long-term hospitalization. In several studies of psychotic or schizophrenic patients, researchers have found that long-term treatment coupled with crisis services was effective in reducing the number of recidivists to institutions. Following a 15 year study with schizophrenic patients, Dr. Norris Hansell and Dr. Grant Willis (1977) indicated that "these individuals

do best with continuous administration of neuroleptics, counseling, and social and crisis services" (pp. 105-109). Crisis intervention appears to be part of the treatment plan for psychotic individuals and should be coupled with long-term therapy to provide support and counseling. In other, non-psychotic individuals, crisis intervention may be the only treatment needed.

In review, the purpose of this study is to investigate a frame of reference (conceptual description) currently being used in North Carolina for treating and making appropriate decisions regarding the psychotic in crisis. The study will also illuminate some needs for further research in this area of crisis treatment. North Carolina mental health professionals will also identify some gaps in their knowledge base, and hopefully, identify workshops and resources needed to more effectively treat the psychotic in crisis.

METHOD

Subjects

One hundred and nine community mental health centers in North Carolina were contacted for this study. Subjects targeted for this study were clinicians in the mental health centers. The Emergency Services Coordinator in each agency was surveyed via questionnaires because it was not feasible to study each individual clinician in the community mental health system. It was assumed that the Emergency Services Coordinator in each mental health center could answer the questionnaire according to how his/her emergency services staff would most often respond to each situation.

Questionnaire

In order to determine how mental health center workers in North Carolina were handling crisis work with psychotic individuals, a two-part questionnaire was used. (See Appendix C.) The first part of the questionnaire was closed-form and provided four brief descriptions of possible crisis situations. The four descriptions varied from; (a) known precipitant, (b) no known precipitant, (c) dangerous to self, and (d) not dangerous to self. Listed below each situation

were ten possible steps that could be taken in handling that particular crisis situation. These steps were extracted from the crisis intervention steps one would normally use in treatment (e.g., establishing communication and rapport, assessment of the precipitant, mental status, determining the problem focus and intervening, and contracting). Additional steps reflecting the particulars of working with the psychotic individual (e.g., hospitalize, have seen for psychotrophic medications, determining previous psychiatric history, calling in others for support and structure and referral for long-term therapy) were added. An extra blank was provided for the subject to write in any unanticipated response.

The second part of the questionnaire was an open-form design in order to determine in what aspects of emergency/crisis work mental health professionals would most like training. It was felt that the information elicited in this section would provide clues as to gaps in the knowledge base of clinicians regarding crisis intervention.

Procedure

A list was obtained of all mental health centers in North Carolina and their addresses. A questionnaire was sent to each mental health center addressed to the attention of the Emergency Services Coordinator.

Enclosed with each questionnaire was a self-addressed, stamped envelope to return the questionnaire to the researcher. A cover letter was also included describing the purpose of the study, and instructions for completing the questionnaire, and an assurance of confidentiality. (See Appendix C.) Initially, the Emergency Services Coordinator was advised that four situations were presented and below each situation were 10 possible steps one might take in working with each client. The respondent was asked to put a 1 beside what he/she would do first, a 2 beside what he/she would do second, etc. Steps the respondent felt were not applicable could be lined out. An 11th step was to be added if the respondent felt an additional step needed inclusion.

In Part II of the questionnaire, the respondent was asked to list four areas of crisis intervention work with psychotic individuals that his/her staff would like to see presented in a workshop. Space was provided for this listing.

Following completion of both parts of the questionnaire, the respondent was again assured of confidentiality and was asked to return the questionnaire in the self-addressed, stamped envelope by a specified time. The respondent was also asked to check whether or not he/she would like to receive a copy of the

results of this work. If so, he/she were asked to print their name and address on the lines provided. Each questionnaire was numbered by county in order to identify that county and facilitate follow-up should questionnaires not be returned. In the event that response was not obtained from a particular county, a follow-up letter was sent along with another numbered questionnaire requesting the Emergency Services Coordinator, who was primarily a psychologist, to please respond with his/her valuable input. (See Appendix D.) Confidentiality was again assured.

RESULTS

A transitional matrix was used to record the ranking order for Part I of each respondent's questionnaire. In recording the data, any questionnaire with items ranked the same (e.g., step #1 and #4 given a rank order of 3) were handled by randomly rolling a pair of dice to determine which step would be listed before the other in the ranking order.

For each respondent, the first ranked step would be found on the first horizontal row of the table. A tally mark was placed in the appropriate box. To mark the item ranked second, the researcher moved down the left-hand column to the row designated by the first response and placed a tally mark in the box indicating response two. To mark the third response, the researcher moved down the left-hand column to the row designated by the second response and placed a tally mark in the box indicating response three. This procedure was continued until all responses were recorded to represent the transition from the row item to the subsequent column item in the ranking (see Table 1). Following the recording of all tally marks, a percentage

TABLE 1

SAMPLE TRANSITIONAL MATRIX RECORDING

	Entry	1	2	3	4
Entry	-		1 (1st tally)		
1		-			1 (4th tally)
2			-	1 (2nd tally)	
3		1 (3rd tally)		-	
4					-

Note: Sample matrix reflects a rank order of 2, 3, 1, 4.

was obtained by dividing the count in each box in the row by the row total. These percentages indicated the probability of going from the row item to the column item.

Tabulating the data in a transitional matrix enabled the researcher to best determine in what order the respondents ranked each item. After tabulating the data and determining the percentages for each response, a table was designed for each case study indicating the routes of decision-making.

In order to determine the most popular routes of decision-making the researcher indicated as the first steps taken all steps in the first horizontal row that carried a percentage greater than or equal to ten percent. To determine the next most popular steps taken, the researcher went down the column on the left side of the table, to the row signified by the first response and pulled all steps greater than ten percent. In Table 2 the first step taken in most cases was #3. The second step was #1, and the third steps taken were #3 and #4. This procedure was continued until it was evident that the majority of respondents had ended their involvement in the crisis situation. With this information, the researcher was able to determine the probability of transition from one step to the next. (See Appendix E.)

TABLE 2

SAMPLE TRANSITIONAL MATRIX DATA COLLECTION

	Entry	1	2	3	4	5
Entry	_	1/2%	3/4%	10/80%	5/40%	1/2%
1	5/8%	_	2/3%	7/11%	7/11%	3/5%
2	3/4%	13/18%	-	3/4%	7/10%	6/25%
3	0	9/16%	5/9%	-	3/5%	4/7%
4	1/1%	0	2/5%	2/5%	-	12/17%
5	1/1%	5/8%	0	0	25/42%	-

A graph was made for each case study reflecting the most popular routes of decision-making. (See Appendix F.) As these graphs were complex in nature, a final graph, reflecting only the most probable transitions of ranking in each case was made. (See Figure 4.)

Discussion

Of the 109 mental health centers surveyed, 75 returned the questionnaire. This reflects a return rate of approximately 69%.

In a cursory examination of Figure 4, it should be noted that the first section and the last section reflect the most consistent transition of responses. The middle section reflects a more divergent transition of responses. On closer examination, therapists in North Carolina began by establishing communication and rapport (#10) with all cases, then moved to the mental status examination (#3). After doing a mental status examination, the previous psychiatric history was determined by reports from the patient or other sources (#8). As indicated in Figure 4, therapists began divergent courses of action after step #8. In cases A, B, and C most therapists determined the diagnosis (#6) and then referred for psychiatric evaluation for medications (#4). In cases B and C, the problem focus was defined and intervention instituted (#5), as well as

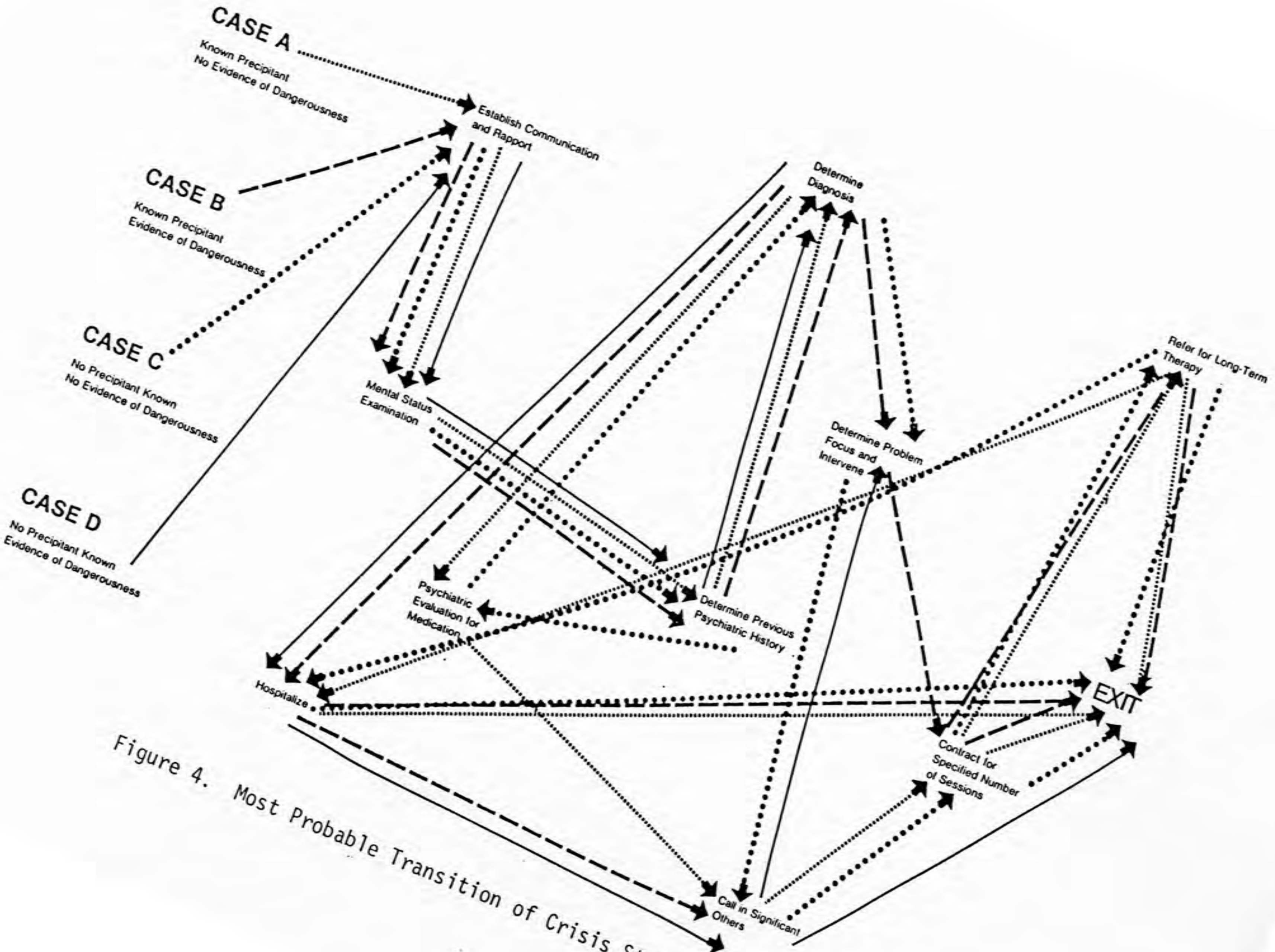

Figure 4. Most Probable Transition of Crisis Steps In All Cases

contracting for a specified number of therapy sessions (#7). This was not so in case A. The problem focus and therapeutic intervention were never dealt with. However, contracting for a specified number of sessions was done. Following contracting for sessions, in cases A, B, and C, some therapists ended their intervention. Other therapists referred the patient for long-term treatment and then ended treatment. In A, B, and C it was also noted that hospitalization was added as a possible last resort, following a referral for long-term treatment. In all cases, hospitalization generally signified a termination of intervention by the therapist.

In case D, it is of interest to note that most therapists referred the patient for hospitalization early in the treatment process after determining the diagnosis. Following/or in conjunction with hospitalization, significant others were called in for support and structure. Most therapists terminated treatment at this point. Some therapists, however, did proceed to define the problem focus and intervened before terminating treatment. This case was the only case in which the client was not referred for long-term treatment even though previous psychiatric history was known and the individual appeared to have a chronic psychotic disturbance.

The most striking deficits in therapists' crisis skills with psychotics, according to this research, appear to be: (1) the lack of follow-up with the client after a crisis hospitalization, and (2) the lack of referral for long-term therapy in the case of the known chronically psychotic individual. The literature points out that therapists should not end their interventions once an individual is hospitalized, but should coordinate services and facilitate re-entry into the community. Research has also shown that long-term treatment of psychotics, if only supportive in nature, coupled with medication therapy and crisis intervention, can successfully reduce the number of rehospitalizations for the chronic psychotic individual.

In Part II of the questionnaire, it is apparent that the major concerns for the respondents in contact with psychotic individuals were working with the agitated or violent patient, determining correct diagnosis and/or doing an accurate mental status examination, and the uses and legal implications of psychotropic medications. Examples of other, less frequently mentioned suggestions for workshops included compliance issues, dealing with suicidal clients, working with psychotics who abuse alcohol, and dealing with families of chronically psychotic patients. (See Appendix G.)

It should be noted that the sample size was small and this research only reflects what some North Carolina therapists are doing with crisis intervention work with psychotics. The case studies given were extremely brief to avoid any extenuating factors influencing the data. It is felt that if more comprehensive case studies had been given therapists could have answered the questionnaire more specifically. It was also assumed that the respondents had already developed therapeutic skills which would be essential to any method of working with patients. This may not have been the case, however, and would have influenced the data. A suggestion for future study would be an actual activities analysis of mental health workers intervening in crisis.

It appears, from the data gathered, that there are several implications for North Carolina therapists that should be mentioned here. Community mental health centers need to consider a more effective relationship with the psychiatric hospitals to promote follow-up with psychotic patients that are hospitalized. The community mental health worker can avoid further crises for the individual through working with family members and significant others and by making appropriate referrals to meet the supportive needs of the individual prior to discharge from the hospital.

The community mental health worker needs to consider the fact that for the psychotic individual, crisis intervention services are not enough. Long-term therapy should be instituted to provide support and clues throughout treatment as to coping skills the individual possesses. This support and knowledge of coping skills may assist the therapist in averting future crises and may serve to prevent revolving door admissions to hospitals that tend to occur with chronic psychotic individuals.

It may also be important for community mental health centers to consider resource needs for this class of individuals. If the social and environmental supports are not present for the psychotic, then resources such as the following need to be available to him/her. Half-way houses, partial hospitalization programs, and drop-in centers are just a few ways to provide these resources.

Community agencies need to be educated in crisis techniques. The community mental health center is an appropriate vehicle for this and can assist other agencies in dealing with crises of all kinds. In this way, some hospitalizations may be avoided and appropriate referrals for intervention can be made.

There are implications for the training of students as well. One-to-one contact in working with the

psychotic individual should be provided in practicums and internships so that the student will feel more comfortable in doing therapy with them. Students need to understand the techniques and usefulness of crisis intervention with the psychotic. Long-term, supportive treatment needs should also be emphasized and practiced by students. With long-term supportive therapy techniques, students should be made aware of the fact that this is a useful therapeutic modality and that personality change is not the only desirable goal. A good understanding of neuroleptic/psychotropic drugs needs to be made a part of training as medication treatment is often an integral part of the treatment plan in working with thought disordered clients. With thorough training in understanding and treating the psychotic individual, students will be able to more effectively assess the individual and the crisis situation and make the necessary decisions for intervention and treatment.

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APPENDIX A

A Paradigm for the Classification of Emotional Crisis

Classification of Crisis	Examples	General Intervention Techniques
CLASS I: Dispositional Crisis Distress resulting from a problematic situation in which the therapist responds in ways peripheral to a therapeutic role with the intervention not primarily at the emotional level.	Referrals Information Giving Administrative Education	Clarifying the client's problematic situation and providing the service required while ruling out indirect requests for therapeutic intervention by the client and more serious but unacknowledged emotional implications of the situation.
CLASS II: Crises of Anticipated Life Transitions A real or anticipated crisis situation related to a normative but anticipated life change or transition over which the client may or may not have substantial control.	Mid-life Career Changes Retirement Getting Married Becoming a Parent Divorce/Separation Terminal/Chronic Illness	After developing an understanding of the implications of the changes that will occur to the client, there is use of anticipatory guidance to help the client respond to the life transition in an adaptive and growth-enhancing manner.
CLASS III: Crisis Resulting From Sudden/Traumatic Stress A crisis precipitated by an externally imposed stressor that is unexpected and uncontrolled by the client and that is emotionally overwhelming	Sudden Death of Family Member/Spouse Rape Assaults Sudden Catastrophic Illness Sudden Loss of Job/Position War Combat Stress	Develop an understanding of the situation and its implications for the client while supporting present adaptive coping. Anticapatory guidance is then used to help the client to adaptively bring the crisis situation to resolution with preservation of healthy emotional functioning

Classification of Crisis		General Intervention Techniques
CLASS IV: Maturational/ Developmental Crisis A crisis situation resulting from past and present attempts to deal with a situation that reflects a struggle with a deeper (but usually circumscribed) developmental issue that the client has been unable to resolve adaptively in the past	Crisis with Focal Issues Involving Dependency Value Conflicts Sexual Identity Capacity for Emotional Intimacy Dealing with Authority Attaining Self-Discipline	To identify and conceptualize in the crisis situation the focal developmental issues that are unresolved and to use the present situation to the fullest extent possible as a vehicle for resolution of the underlying developmental issue.
CLASS V: Crisis Reflecting Psychopathology A crisis situation in which client psychopathology has been instrumental in precipitating the crisis and/or that significantly complicates or impairs resolution of the crisis	Clients with Borderline Adjustments Severe Neurosis Characterological Disorders Simple Schizophrenia	As the situation is clarified the client is supported in attempts to respond adaptively to the crisis situation with emphasis on reducing stress to at least a tolerable level. The psychopathology is diagnosed and the client is prepared for a referral to be made (if appropriate) for long-term therapy rather than the treating psychopathology during the crisis contact.

Classification of Crisis	Examples	General Intervention Techniques
CLASS VI: Psychiatric Emergencies A crisis situation in which the client's general functioning has been severely impaired with the client rendered incompetent or unable to assume personal responsibility for self as a result of the situation.	Acutely Suicidal Clients Drug Overdose Reactions to Hallucinogenic Drugs Acute Psychosis Uncontrollable Rage/Anger Alcohol Intoxication	Assess the client's condition while clarifying the situation using informants as appropriate, and then mobilize immediately all necessary medical and/or psychiatric resources while secluding the client. Follow-up treatment is planned as required by the situation.

A Paradigm for the Classification of Emotional Crisis
(Baldwin, 1978, pp. 540-548)

APPENDIX B

Questionnaire

CRISIS INTERVENTION WITH CLIENTS
DISPLAYING THOUGHT DISORDERS

Part I: Described below are four different descriptions of situations that might present to the crisis worker. Below each description are possible steps one might take in working with each client. Please put a 1 beside what you would do first, a 2 beside what you would do second, a 3 beside what you would do third, etc. If there are steps you feel are not applicable, please line them out (example: ~~Mental Status Exam~~). There is one blank line available to include a step you feel should be taken that does not appear in the list. Please be sure to identify each step you would take in your intervention.

A. This person lost his/her job two weeks ago, and since that time has become confused and is hearing voices.

____ 1. Hospitalize
____ 2. Call in significant others for support and structure
____ 3. Mental Status Exam
____ 4. Have seen for psychiatric evaluation for medications
____ 5. Define problem-focus and intervene
____ 6. Determine diagnosis
____ 7. Contract for specified number of therapy sessions
____ 8. Determine previous psychiatric history from client or other source
____ 9. Refer for long-term therapy
____ 10. Establish communication and rapport
____ 11. ____

____

B. This person's speech organization contains neologisms and is irrelevant. This person has just made an attempt to cut his/her wrist. You find out that six weeks ago this individual lost a parent.

____ 1. Hospitalize
____ 2. Call in significant others for support and structure
____ 3. Mental Status Exam
____ 4. Have seen for psychiatric evaluation for medications
____ 5. Define problem-focus and intervene
____ 6. Determine diagnosis

____ 7. Contract for specified number of therapy sessions
____ 8. Determine previous psychiatric history from the client or other source
____ 9. Refer for long-term therapy
____10. Establish communication and rapport
____11. ____

____

C. This person has recently developed delusions of grandeur, and is expressing looseness of associations. He/she states that others can read their mind. You do not get the impression that this person is dangerous to themselves or others.

____ 1. Hospitalize
____ 2. Call in significant others for support and structure
____ 3. Mental Status Exam
____ 4. Have seen for psychiatric evaluation for medications
____ 5. Define problem-focus and intervene
____ 6. Determine diagnosis
____ 7. Contract for specified number of therapy sessions
____ 8. Determine previous psychiatric history from the client or other source
____ 9. Refer for long-term therapy
____10. Establish communication and rapport
____11. ____

____

D. This person appears withdrawn and you note psychomotor retardation. He/she can attribute no cause for their feelings. Upon further questioning, this person states that he/she is being controlled by some external force that is telling them to kill themselves. Previous psychiatric history shows several serious suicidal attempts.

____ 1. Hospitalize
____ 2. Call in significant others for support and structure
____ 3. Mental Status Exam
____ 4. Have seen for psychiatric evaluation for medications
____ 5. Define problem-focus and intervene
____ 6. Determine diagnosis
____ 7. Contract for specified number of therapy sessions

____ 8. Determine previous psychiatric history from the client or other source
____ 9. Refer for long-term therapy
____ 10. Establish communication and rapport
____ 11. ____

____

PART II: Are there any areas of crisis intervention work with psychotic individuals that you or your staff would like to see presented in a workshop? If so, please list them below.

1. ____

____

____

2. ____

____

____

3. ____

____

____

4. ____

____

____

After filling out Part I and Part II of this questionnaire, would you please place it in the self-addressed return envelope and mail it by ____________. All individual results will remain confidential. Thank you for your cooperation.

**If you would be interested in obtaining a copy of the results of this research, please check here _____, and list your name and address below.

____

____

APPENDIX C

Initial Letter to Emergency Services Coordinator

Dear Emergency Services Coordinator:

I would like very much your expertise in a study of Crisis Intervention with Clients Displaying Thought Disorders. Your input will be used in my work as a coordinator of crisis intervention in the mental health center and also to contribute to my masters degree in psychology at Appalachian State University.

In order to determine what is currently being done with psychotic individuals in crisis, I have devised a questionnaire made up of four short descriptions. Below each description I have listed various steps that might be taken in crisis intervention. It would be most helpful to me if you would rank these steps, in the order that you feel that you and your co-workers would most feel appropriate.

This research will help me to define the treatment model that is currently being used in North Carolina. I would like to assure you that all information that you provide on the questionnaire will be kept completely confidential.

I would like to thank you for your cooperation.

Sincerely,

Rosemary Unsworth

APPENDIX D

Follow-up Letter to Emergency Services Coordinator

Dear Emergency Services Coordinator:

Recently I sent a questionnaire to you regarding crisis intervention with clients displaying thought disorders. I noticed that your county has not responded and am wondering if you could possibly take a few minutes to fill this out.

I understand that you are busy, but your valuable input would certainly be a great contribution to my study. I have enclosed another copy of the questionnaire in case you misplaced the material I sent previously.

I also understand that this questionnaire is somewhat difficult to fill out without knowing many other variables that play a part in making a decision about treatment. However, please attempt to rank order the items with the information that has been provided in each situation.

Thank you so much for your time. I would like to again assure you that all results will remain confidential.

Sincerely,

Rosemary Unsworth

APPENDIX E

North Carolina Area Programs by County

NORTH CAROLINA AREA PROGRAMS BY COUNTY

*Asterick indicates those counties that responded to this study.

Smoky Mountain Mental Health Center
P. O. Box 181
Bryson City, NC 28713

Smoky Mountain Mental Health Center
P. O. Box 2784
Cullowhee, NC 28723

Smoky Mountain Mental Health Center*
P. O. Box 692
Franklin, NC 28734

Smoky Mountain Mental Health Center*
P. O. Box 442
Hayesville, NC 28904

Smoky Mountain Mental Health Center
P. O. Box 278
Hazelwood, NC 28738

Smoky Mountain Mental Health Center
P. O. Box 313
Marble, NC 28905

Smoky Mountain Mental Health Center
P. O. Box 1130
Robbinsville, NC 28771

Blue Ridge Area MH/MR/SA Program*
356 Biltmore Avenue
Asheville, NC 28801

Blue Ridge Community Mental Health Center
Madison County Mental Health Program
P. O. Box 266
Marshall, NC 28753

Blue Ridge Community Mental Health Center
Mitchell County Mental Health Program
P. O. Box 732
Spruce Pine, NC 28777

Blue Ridge Community Mental Health Center
Yancey County Mental Health Program
P. O. Box 176
Burnsville, NC 28714

New River Mental Health Center*
P. O. Box 159
Sparta, NC 28675

New River Mental Health Center*
P. O. Box 216
Jefferson, NC 28640

New River Mental Health Center*
P. O. Box 93
Newland, NC 28657

New River Mental Health Center*
Route 1, Box 20-A
Boone, NC 28607

New River Mental Health Center*
P. O. Box 831
Wilkesboro, NC 28697

Trend Community Mental Health Services*
318 Fourth Avenue, East
Hendersonville, NC 28739

Trend Community Mental Health Services*
Morgan and Gaston Streets
Community Services Building
Brevard, NC 28712

Foothills Mental Health Center*
Human Resources Building
Parker Road
Morganton, NC 28655

Foothills Mental Health Center*
1006 Kirkwood Street, N.W.
Lenoir, NC 28645

Foothills Mental Health Center
P. O. Box 995
Taylorsville, NC 28681

Foothills Mental Health Center*
P. O. Box 699
Marion, NC 28752

Rutherford-Polk Area MH/MR/SA Program*
City Route 3, 311 Fairground Road
Spindale, NC 28160

Rutherford-Polk Mental Health Center*
P. O. Box 1158
Tryon, NC 28782

Cleveland Area MH/MR/SA Program*
222 Crawford Street
Shelby, NC 28150

Gaston-Lincoln Mental Health Center
2535 Court Drive
Gastonia, NC 28052

Lincoln County Mental Health Center*
P. O. Box 657
Lincolnton, NC 28092

Catawba Area MH/MR/SA Program*
Route 3, Box 339
Hickory, NC 28601

Mecklenburg Mental Health Services*
501 Billingsley Road
Charlotte, NC 28211

Tri-County Area MH/MR/SA Program*
165 Mahaley Avenue
Salisbury, NC 28144

Tri-County Mental Health Center*
130 Court Street
Statesville, NC 28677

Tri-County Mental Health Center*
416 Carpenter Avenue
Mooresville, NC 28115

Tri-County Mental Health Center*
717 North Main Street
Mocksville, NC 27028

Piedmont Area Mental Health Center
P. O. Box 1396
Albemarle, NC 28001

Piedmont Area Mental Health Center*
P. O. Box 1050, 457 Lake Concord Road
Concord, NC 28025

Piedmont Area Mental Health Center*
1310 McCray Street
Monroe, NC 28110

Surry-Yadkin Area MH/MR/SA Program
Rockford Street, P. O. Box 8
Mt. Airy, NC 27030

Surry-Yadkin Area MH/MR/SA Program
Community Services Building
P. O. Box 818
Yadkinville, NC 27055

Forsyth County Adult Mental Health Clinic*
725 Highland Avenue
Winston-Salem, NC 27101

Stokes County Mental Health Clinic
Stokes County Health Department
Danbury, NC 27016

Rockingham Area MH/MR/SA Program*
P. O. Box 55
Wentworth, NC 27375

Guilford County Mental Health Center*
300 North Edgeworth Street
Greensboro, NC 27401

Guilford County Mental Health Center*
236 Boulevard
High Point, NC 27262

Alamance-Caswell Area MH/MR/SA Program*
1946 Martin Street
Burlington, NC 27215

Caswell County Mental Health Clinic*
Caswell County Health Department
Yanceyville, NC 27279

Orange-Person-Chatham Area MH/MR/SA Program*
333 McMasters Street
Chapel Hill, NC 27514

Person County Mental Health Center*
214 Chub Lake Street
Roxboro, NC 27573

Chatham County Mental Health Center*
1101 East Cardinal Street
Siler City, NC 27344

Chatham County Mental Health Center
Route 1, Box 5, Old Graham Road
Pittsboro, NC 27212

Family Counseling Center*
125 East King Street
Hillsborough, NC 27278

Durham County Community Mental Health Center*
414 East Main Street
Durham, NC 27701

Vance-Warren-Granville-Franklin Area MH/MR/SA Program*
C-10 Ruin Creek Road
Henderson, NC 27536

Family Counseling and Education Center
Route 1, Box 1-X, West River Road
Louisburg, NC 27549

Jerry Hedrick Mental Health Clinic*
College Street Extension
Oxford, NC 27565

Warren County Mental Health Clinic*
544 Ridgeway Street
Warrenton, NC 27589

Davidson Area MH/MR/SA Program*
205 Old Lexington Road
Thomasville, NC 27360

Moore County Unit*
Sandhills Center for MH/MR/SAS
P. O. Drawer 639
Pinehurst, NC 28374

Hoke County Unit*
Sandhills Center for MH/MR/SAS
116 Campus Avenue
Raeford, NC 28376

Richmond County Unit*
Sandhills Center for MH/MR/SAS
P. O. Box 631
112 South Hancock Street
Rockingham, NC 28379

Montgomery County Unit*
Sandhills Center for MH/MR/SAS
217 South Main Street
Troy, NC 27371

Anson County Unit*
Sandhills Center for MH/MR/SAS
303 East View Street
Wadesboro, NC 28170

Robeson County Mental Health Center
P. O. Box 191
Lumberton, NC 28358

Bladen County Mental Health Center*
P. O. Box 1176
Elizabethtown, NC 28337

Scotland County Mental Health Center
1224 Biggs Street
Laurinburg, NC 28352

Columbus County Mental Health Center
P. O. Box 267
Whiteville, NC 28472

Cumberland Area MH/MR/SA Program*
P. O. Box 2068, Owen Drive
Fayetteville, NC 28302

Lee-Harnett Area MH/MR/SA Authority*
(Lee County)
130 Carbonton Road
Sanford, NC 27330

Lee-Harnett MH/MR/SA Authority*
(Harnett County)
P. O. Box 457
Buies Creek, NC 27506

Johnston Area MH/MR/SA Program*
P. O. Box 411
Smithfield, NC 27577

W. H. Trentman Mental Health Center
3010 Falstaff Road
Raleigh, NC 27610

Western Wake Mental Health Center
218 South Academy Street
Cary, NC 27511

Northern Wake Mental Health Center
Corner Owens Drive/Brooks Avenue
Wake Forest, NC 27587

Randolph Area MH/MR/SA Program*
204 East Academy Street
Asheboro, NC 27203

Southeastern Area MH/MR/SA Program
2023 South Seventeenth Street
Wilmington, NC 28401

Southeastern Mental Health Center*
Pender County Division
Box 962
Burgaw, NC 28425

Southeastern Mental Health Center*
Brunswick County Division
P. O. Box 246
Bolivia, NC 28422

Onslow Area MH/MR/SA Program*
215 Memorial Drive
Jacksonville, NC 28540

Wayne Area MH/MR/SA Program*
301 North Herman Street, Box DD
Goldsboro, NC 27530

Wilson-Greene Area MH/MR/SA Program*
1709 South Tarboro Street
P. O. Box 3756
Wilson, NC 27893

Wilson-Greene Mental Health Center
and Mental Retardation Services*
104 Hines Street
Snow Hill, NC 28580

Edgecombe-Nash Area MH/MR/SA Services
P. O. Box 4047
Rocky Mount, NC 27801

Edgecombe-Nash MH/MR/SA Services*
3007 North Main Street, Rocky Mount Road
Tarboro, NC 27886

Scotland Neck Mental Health Clinic
House Avenue
Scotland Neck, NC 27874

Halifax Area MH/MR/SA Program*
P. O. Box 1199
210 Smith Church Road
Roanoke Rapids, NC 27870

Enfield Mental Health Clinic
146 Dennis Street
Enfield, NC 27823

Hollister Mental Health Clinic
Hollister, NC 27844

Neuse Area MH/MR/SA Program*
2000 Neuse Boulevard
P. O. Box 1636
New Bern, NC 28560

Neuse Mental Health Center*
Carteret Division
1707 Arendell Street
Morehead City, NC 28557

Neuse Mental Health Center
P. O. Box 1005
Havelock, NC 28532

Lenoir Area MH/MR/SA Program*
1007 North College Street
Kinston, NC 28501

Pitt Area MH/MR/SA Program
Route 8, Box 289A
Greenville, NC 27834

Roanoke-Chowan Area MH/MR/SA Program*
Ahoskie, NC 27910

Roanoke-Chowan Mental Health Service*
P. O. Box 683
Jackson, NC 27845

Roanoke-Chowan Mental Health Service*
Gatesville, NC 27938

Roanoke-Chowan Mental Health Service
105 Barringer Street
Windsor, NC 27983

Tideland Area MH/MR/SA Program*
1308 HIghland Drive
Washington, NC 27889

Washington County Mental Health Clinic*
c/o Washington County Health Department
Highway 32
Plymouth, NC 27962

Tyrrell County Mental Health Clinic
c/o Tyrrell County Health Department
Broad Street
Columbia, NC 27925

Hyde County Mental Health Clinic
c/o Hyde County Health Department
P. O. Box 254
Swan Quarter, NC 27885

Martin County Mental Health Clinic*
Liberty-Street
Williamston, NC 27892

Albemarle Mental Health Center
113 North Elliott Street
Elizabeth City, NC 27909

Albemarle Mental Health Center
111 East King Street
P. O. Box 791
Edenton, NC 27932

Albemarle Mental Health Center*
203 Budleigh Street
P. O. Drawer 1000
Manteo, NC 27954

Albemarle Mental Health Center*
Camden, NC 27921

Albemarle Mental Health Center
103 Charles Street
Hertford, NC 27944

Albemarle Mental Health Center*
Highway 34
P. O. Box 136
Currituck, NC 27929

Duplin-Sampson Area MH/MR/SA Program*
P. O. Box 499
Duplin General Hospital
Kenansville, NC 28349

Duplin-Sampson Area MH/MR/SA Program
Wallace Division
P. O. Box 238
Teachey Road
Wallace, NC 28466

Duplin-Sampson Area MH/MR/SA Program*
P. O. Box 47
East Rowan Street
Clinton, NC 28328

APPENDIX F

Transitional Matrixes For Each Case Identified In Questionnaire

CASE A

	E	1	2	3	4	5	6	7	8	9	10	11	None After	Row Total
E	-	0	1/1%	12/16%	2/2%	3/4%	0	0	7/9%	0	50/67%	0	0	75
1	0	-	4/11%	0	4/11%	1/2%	1/2%	2/5%	1/2%	5/13%	0	1/2%	17/47%	36
2	0	9/12%	-	4/5%	8/10%	7/9%	6/8%	11/14%	8/10%	1/1%	5/6%	1/1%	5/6%	75
3	0	1/1%	5/7%	-	9/13%	8/12%	13/19%	1/1%	29/43%	0	2/3%	0	0	68
4	0	4/5%	19/28%	2/2%	-	7/10%	13/19%	6/8%	5/7%	0	1/1%	2/2%	8/11%	67
5	0	2/3%	13/21%	8/13%	13/21%	-	6/9%	7/11%	3/4%	1/1%	2/3%	0	6/9%	61
6	0	0	10/15%	1/1%	19/29%	8/12%	-	9/12%	5/7%	3/4%	2/3%	3/4%	5/7%	64
7	0	8/15%	2/3%	1/1%	3/5%	1/1%	4/7%	-	0	12/23%	3/5%	3/5%	14/27%	51
8	0	2/2%	6/8%	12/16%	8/11%	11/15%	20/28%	5/7%	-	2/2%	3/4%	0	2/2%	71
9	0	10/41%	1/4%	0	0	1/4%	1/4%	0	1/4%	-	0	0	10/41%	24
10	0	1/1%	4/5%	29/42%	1/1%	13/18%	0	4/5%	12/17%	2/2%	-	0	3/4%	69
11	0	0	0	0	0	0	0	4/40%	0	1/10%	0	-	5/50%	10

CASE B

	E	1	2	3	4	5	6	7	8	9	10	11	None After	Row Total
E	-	10/13%	1/2%	17/23%	0	5/7%	0	0	4/5%	0	38/51%	0	-	75
1	0	-	16/25%	2/3%	10/16%	3/4%	6/9%	4/6%	1/1%	4/6%	1/1%	0	15/24%	62
2	0	7/10%	-	5/7%	6/9%	6/9%	3/4%	3/4%	18/27%	5/7%	6/9%	1/1%	6/9%	66
3	0	6/9%	9/13%	-	11/16%	5/7%	15/22%	0	17/25%	0	2/3%	0	1/1%	66
4	0	12/18%	10/15%	2/3%	-	1/1%	13/20%	10/15%	8/12%	2/3%	1/1%	0	5/7%	64
5	0	5/9%	10/19%	6/11%	8/15%	-	6/11%	10/19%	3/5%	1/1%	0	1/1%	1/1%	51
6	0	13/21%	5/8%	0	11/18%	13/21%	-	6/10%	2/3%	3/5%	1/1%	1/1%	5/8%	60
7	0	2/5%	2/5%	0	0	1/2%	2/5%	-	1/2%	13/34%	1/2%	1/2%	15/39%	38
8	0	3/4%	10/14%	12/17%	13/19%	9/13%	13/19%	2/3%	-	1/1%	2/3%	0	3/4%	68
9	0	3/10%	0	0	1/3%	1/3%	1/3%	0	0	-	3/10%	0	19/67%	28
10	0	2/3%	2/3%	21/38%	3/5%	6/11%	1/1%	1/1%	13/24%	1/1%	-	2/3%	2/3%	54
11	0	-	-	1/16%	-	2/33%	-	-	-	-	-	-	3/50%	6

CASE C

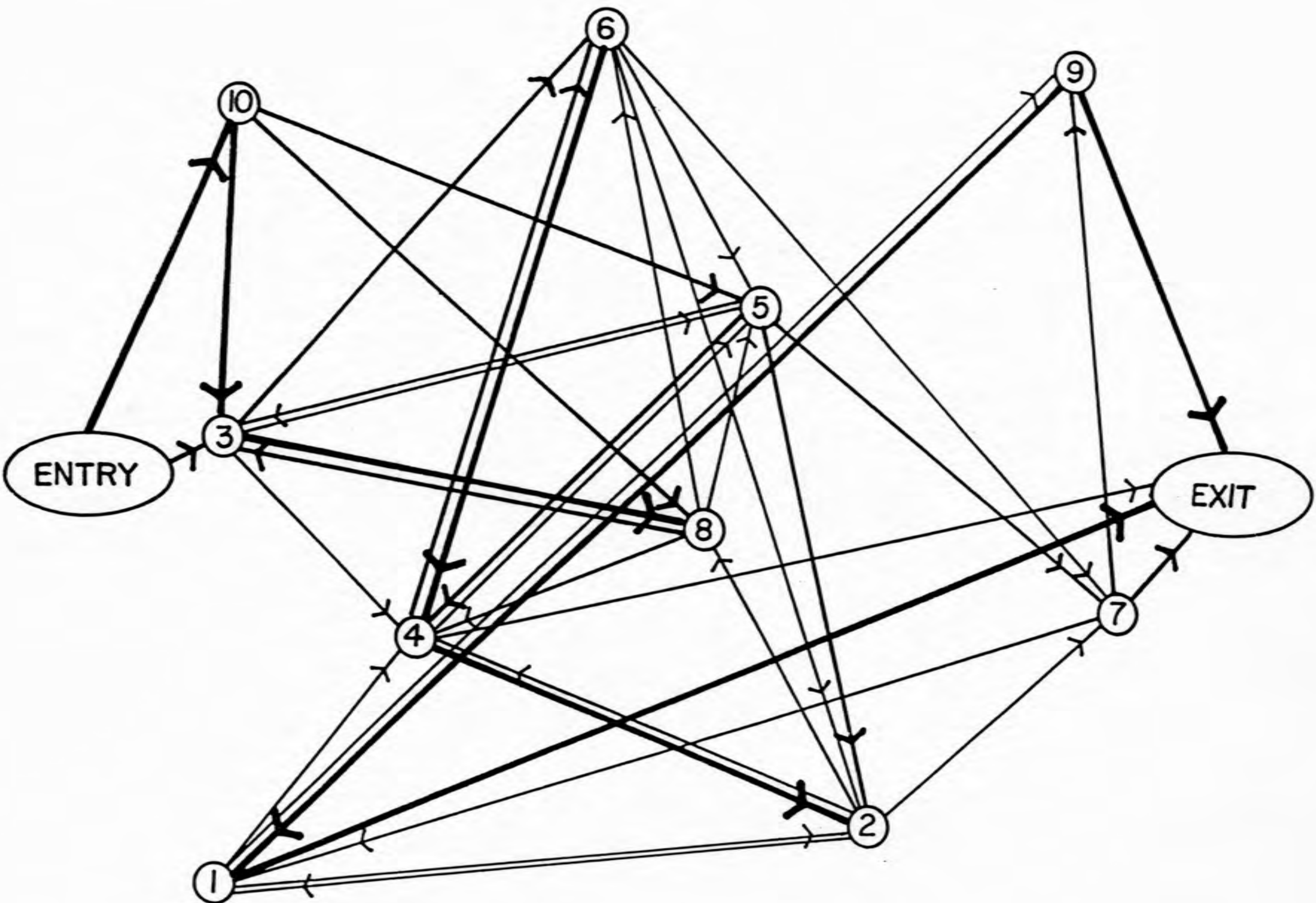
	E	1	2	3	4	5	6	7	8	9	10	11	None After	Row Total
E	0	1/2%	1/2%	21/28%	1/2%	2/3%	0	0	5/7%	0	44/59%	0	-	75
1	0	-	5/17%	0	0	1/3%	2/6%	1/3%	3/10%	4/13%	0	0	13/44%	29
2	0	5/8%	-	2/3%	7/11%	7/11%	3/5%	10/16%	10/16%	5/8%	3/5%	2/3%	6/10%	60
3	0	0	9/13%	-	13/18%	2/2%	20/28%	2/2%	23/33%	0	0	0	0	69
4	0	3/4%	13/18%	3/4%	-	7/10%	18/25%	10/14%	8/11%	3/4%	1/1%	1/1%	3/4%	70
5	0	0	9/16%	5/9%	15/27%	-	7/12%	8/14%	4/7%	3/5%	0	0	3/5%	54
6	0	6/9%	5/7%	1/1%	14/22%	15/23%	-	6/9%	3/4%	3/4%	4/6%	2/3%	4/6%	63
7	0	4/8%	6/12%	0	3/6%	1/2%	1/2%	-	0	14/29%	2/4%	0	16/34%	47
8	0	1/1%	5/7%	12/17%	16/22%	10/14%	12/17%	5/7%	-	0	5/7%	0	4/5%	70
9	0	8/23%	2/5%	0	0	2/5%	0	1/2%	0	-	0	1/2%	20/58%	34
10	0	1/1%	5/8%	25/42%	1/1%	7/11%	0	2/3%	13/22%	3/5%	-	0	2/3%	59
11	0	0	0	0	0	0	0	2/33%	0	0	0	0	4/66%	6

CASE D

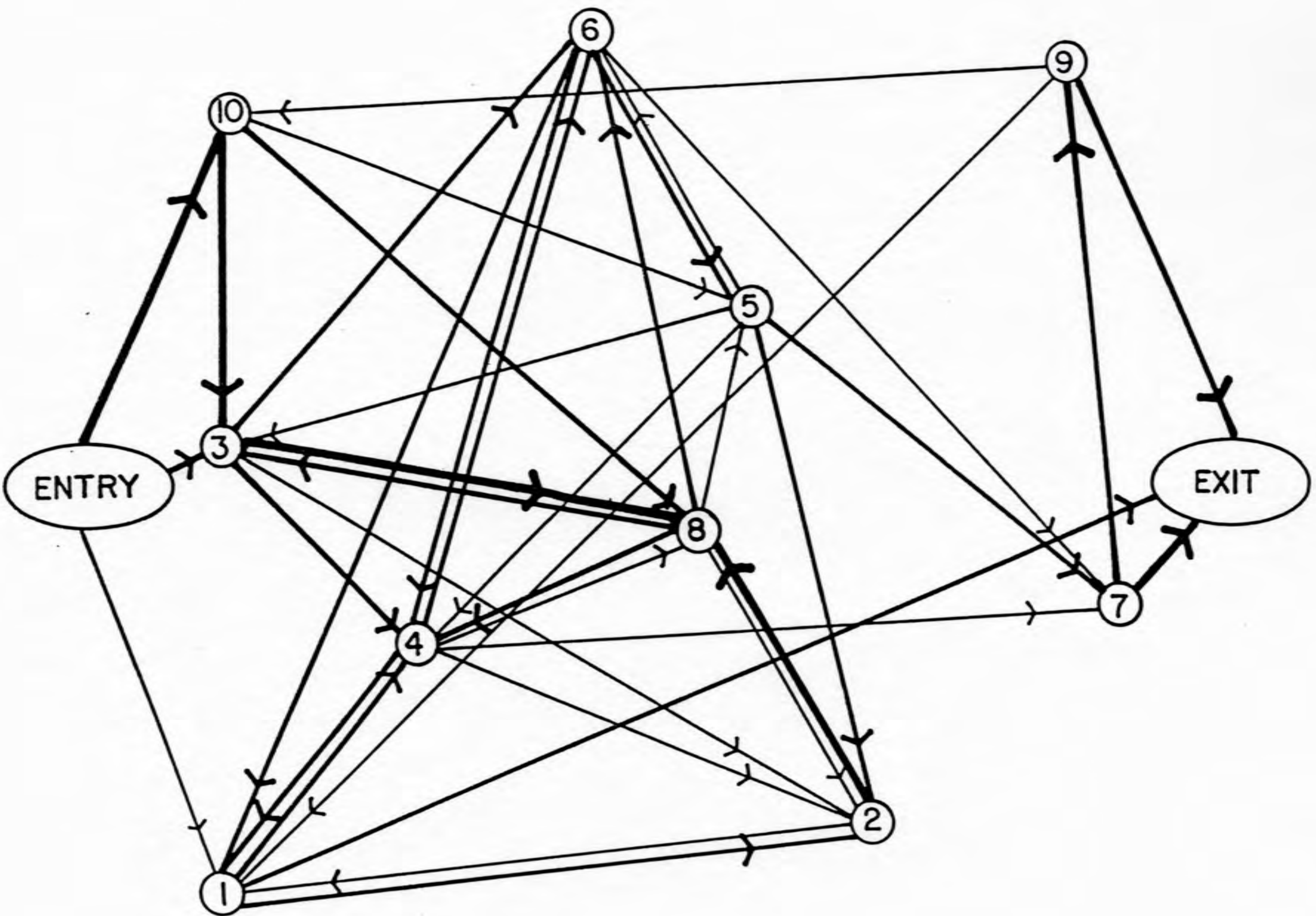
	E	1	2	3	4	5	6	7	8	9	10	11	None After	Row Total
E	-	11/15%	1/2%	16/21%	0	2/3%	0	0	1/2%	0	44/59%	0	0	75
1	0	-	19/28%	5/7%	14/20%	0	5/7%	1/1%	2/2%	5/7%	0	2/2%	14/20%	67
2	0	5/8%	-	2/3%	4/6%	9/15%	3/5%	5/8%	14/23%	4/6%	2/3%	2/3%	10/16%	60
3	0	7/10%	6/9%	-	14/21%	9/11%	11/17%	1/2%	18/27%	0	0	0	0	66
4	0	18/30%	4/6%	1/1%	-	4/6%	16/27%	3/5%	3/5%	1/1%	0	1/1%	8/13%	59
5	0	4/8%	8/17%	8/17%	7/15%	-	5/11%	3/6%	3/6%	3/6%	1/2%	1/2%	2/4%	45
6	0	15/26%	5/8%	1/1%	7/12%	7/12%	-	6/10%	3/5%	6/10%	2/3%	1/1%	3/5%	56
7	0	1/3%	2/6%	0	1/3%	0	1/3%	-	2/6%	9/30%	0	0	14/46%	30
8	0	4/7%	7/12%	8/14%	10/18%	5/9%	12/21%	3/5%	-	1/1%	3/5%	0	2/3%	55
9	0	1/3%	2/6%	0	0	2/6%	1/3%	6/18%	1/3%	-	3/9%	0	16/50%	32
10	0	0	6/11%	23/42%	2/3%	8/14%	2/3%	2/3%	9/16%	1/1%	-	0	1/1%	54
11	0	0	0	0	0	0	0	0	0	2/33%	0	-	4/66%	6

APPENDIX G

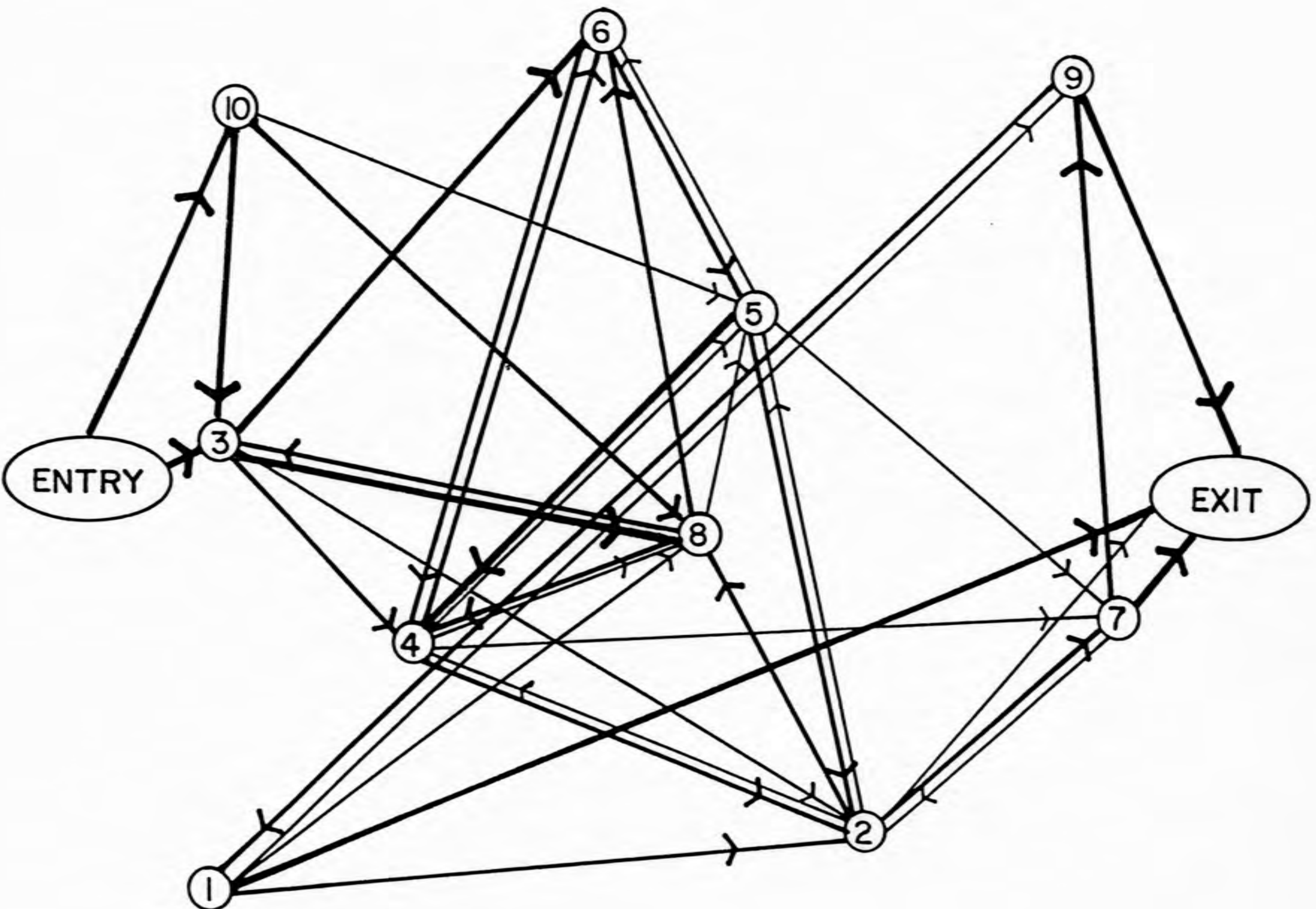
Routes of Decision-Making for Each Case Identified in Questionnaire



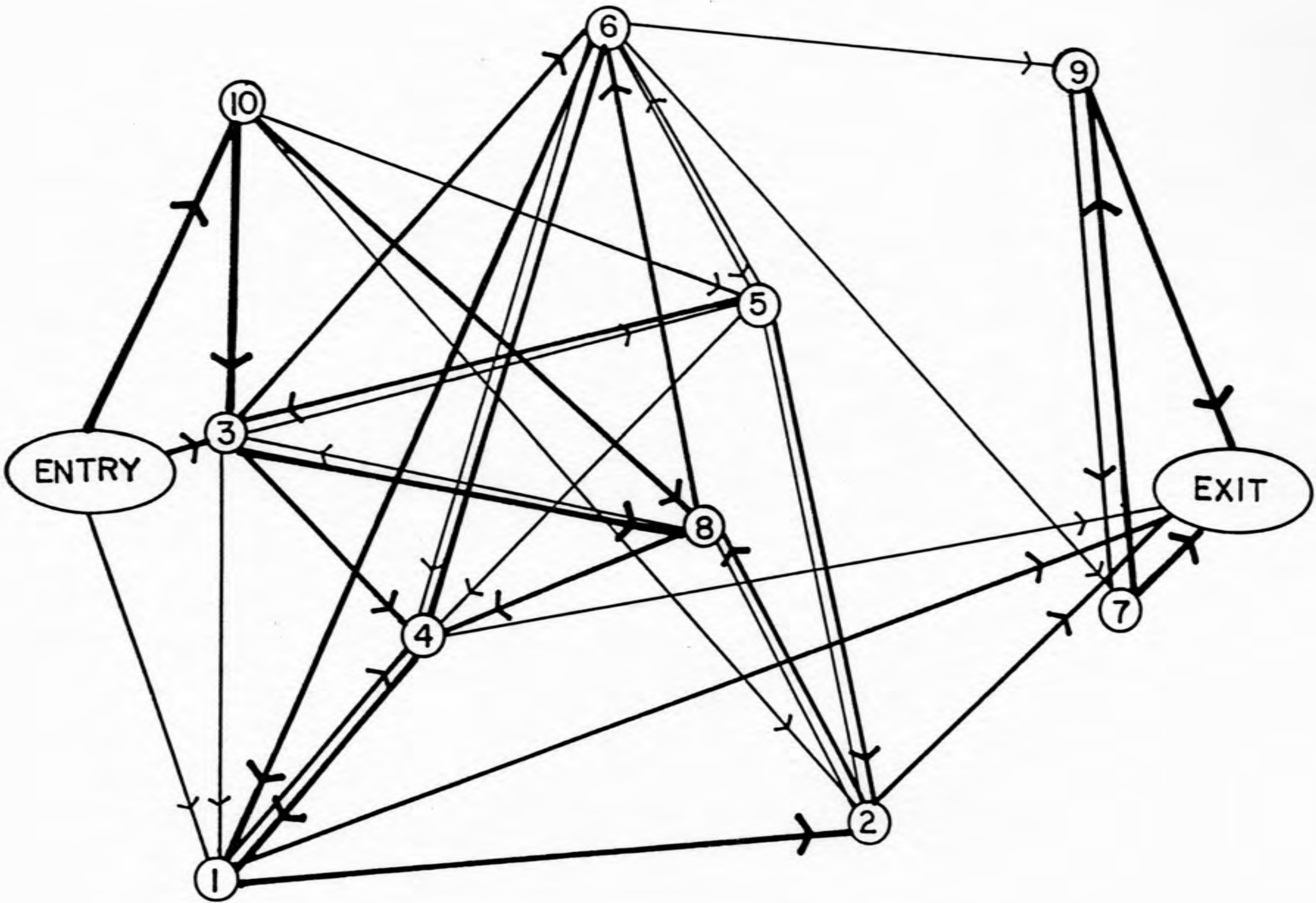
CASE A: —— = 10%-15% response rate; —— = 15%-25% response rate; —— = 25% and above response rate



CASE B: —— = 15%-15% response rate; —— = 15%-25% response rate; ▬▬ = 25% and above response rate



CASE C: —— = 10%-15% response rate; —— = 15%-25% response rate; —— = 25% and above response rate



CASE D: —— = 10%-15% response rate; —— = 15%-25% response rate; ▬▬ = 25% and above response rate

APPENDIX H

Crisis Intervention Information
Requested by Respondents

CRISIS INTERVENTION INFORMATION
REQUESTED BY RESPONDENTS

15%	How to Handle the Violent/Aggitated Patient
12%	How to Determine Correct Diagnosis/Mental Status
12%	Medications (Uses and Legal Implications)
5%	Compliance During and After Crisis
5%	Dealing With Suicidal Clients
3%	Working with Psychotics Abusing Alcohol
3%	Working with Manic-Depressed Patients Who Are Psychotic
3%	Working with Catotonic Schizophrenics
3%	Dealing with Families of Chronically Psychotic Patients
1%	Out-Patient Commitments
1%	Smooth Movement Through the Mental Health Center for Emergency Walk-Ins
1%	Reimbursement for Emergency Services
1%	Disaster Emergency Techniques
1%	Establishing a Short-Term Crisis Intervention In-Patient Service
1%	The Crisis Intervention Treatment Model

VITA

Rosemary Sink Unsworth was born in Raleigh, North Carolina on September 10, 1952. She attended elementary schools in that city and was graduated from Broughton High School in 1969. The following September she entered North Carolina State University in Raleigh, North Carolina. In September, 1971 she transferred to East Carolina University and in May, 1975 she received a Bachelor of Science Degree in Nursing.

After working for one year as assistant Director of an Intensive Care Unit, and two years as a Chronic Disease Educator, Ms. Unsworth began working with the New River Mental Health Center in Boone, North Carolina, as a psychiatric nurse. In 1978, she also entered Appalachian State University and began work on a Masters degree in Rehabilitation Psychology.

The author is a member of the North Carolina Psychological Association, the North Carolina Public Health Association, and Psi Chi (National Honor Society in Psychology).

The author's address is Route 6, Box 158, Boone, North Carolina 28607.

Her parents are Mr. and Mrs. Henry H. Sink of Raleigh, North Carolina. She is married to Robert Unsworth of Jackson, New Jersey.