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# **Stretching the Paradigm: Crisis As A Problem In Mental Health Research**

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Crisis intervention is an established paradigm of community mental health theory and practice in which the nature and circumstances of crises are assumed to be well understood and the subject of established research findings and theory. Review of existing crisis research literature fails to support such assumptions. There is, in fact, little current evidence available on the nature and circumstances of mental health crises, despite the importance of crisis intervention in contemporary practice. This paper presents descriptive findings of a study of the frequency, duration and severity of mental health crises, based on analysis of more than 500 crisis incidents which originated with calls to the crisis hotline of a community mental health center.

## **Defining the Mental Health Crisis**

Crisis intervention has become an established paradigm of community mental health theory and practice, with particular importance in the deinstitutionalization of the chronically mentally ill. (Aguilera & Messick, 1974; Foxman, 1990; Getz, Wiesen, Sue and Ayers, 1974; Gilliland and James, 1988; Greenstone and Leviton, 1993; Lester and Brockopp, 1973; Roberts, 1993)

Anthony (1993) defines crisis intervention as “controlling and resolving critical or dangerous problems”. Crisis intervention is a model of practice which (erroneously) presumes a well-founded understanding of the basic etiology and epidemiology of the mental health crisis which is the presumed target of intervention. Most writers on crisis intervention have paid far greater attention to the theoretical and research problems of intervention than to the underlying problem which is the target of intervention. Almost three decades ago, Schulberg and Sheldon (1968) indicated that the concept of crisis was ambiguous and more attractive to those engaged in service delivery than to researchers and theorists. This remains largely true today.

The conventional paradigm of mental health practice in all disciplines presumes knowledgeable intervention based upon research-based knowledge and understanding of the problem in question. Application of this paradigm to the mental health crisis might lead one to assume that a large or established body of evidence exists somewhere clearly documenting the

nature and circumstances of the “mental health crisis” which is the chosen target of intervention in the crisis intervention modality. Such a conclusion would be largely unjustified, however.

While a significant body of research findings have been reported during the past three decades, the vast majority of studies have in fact investigated only a very narrow range of phenomena associated with crisis intervention situations. Most existing crisis research is psychometric in nature, positing that fluctuations in scores on a variety of standardized tests are essential to documenting and understanding the mental health crisis. One of the consequences of this assumptions has been that even relatively fundamental descriptive data on how often mentally ill persons experience crises, how long their crises last and how severe they are, as well as the circumstances under which crises occur and the events associated with their occurrence remain almost completely undocumented.

The question arises whether this exclusive preoccupation on the psychosocial characteristics of the individual client/patient is well-founded. Does it occur because no other important issues or questions can be raised? Focusing on the psychosocial characteristics of the mentally ill person may provide a sufficiently complete and satisfactory account of the circumstances of a mental health crisis that all remaining doubts are resolved. Or, does the exclusive focus on the psychosocial arise because of an unspoken (and thus, unjustified) bias in existing research which rules out of consideration attention on the situational and circumstantial aspects of mental health crises. This study will proceed on the assumptions that interesting questions can, in fact, be asked about the crisis situation and that these questions can be handled independently from questions

Narrow assumptions which exclude the interpersonal and social aspects of the crisis are only part of the question, however. Part of the difficulty with crisis research is conceptual, and part is related to inherent difficulties of measurement. According to Goldman, Gattozzi and Taube, “a crisis condition is characterized by a long duration of illness, which may include periods of seeming wellness interrupted by flare-ups of acute symptoms and secondary disabilities” (1981, 21). Any condition which, by definition is marked by periodic absence of symptoms and “secondary disabilities” may prove difficult to measure, and mental health crises certainly have proven to be so. Even identifying the population of past and present “crisis victims” would be a herculean task.

Yet, difficulties in measurement must be balanced against the obvious practical and policy importance of the concept of mental health crisis in contemporary practice settings. The 1987 NIMH publication *Toward A Model Plan For A Comprehensive Community-Based Mental Health System* outlines the basic case for crisis services: “On-going support and contact with the system, and client, family, and staff education and training can prevent

the onset of many crises. Because of the episodic nature of the illness, however, there will be instances that require acute care and quick response crisis stabilization services. The services should enable the client, family members, and others to cope with the emergency, while maintaining the client's status as a functioning community member to the greatest extent possible." (NIMH, 1987, 27)

## **Crisis in Crisis Intervention Theory**

The term crisis in mental health was borrowed largely from medicine, where it has traditionally been interpreted as a cusp, or turning point when the progression of a disease is reversed. (Caplan, 1964). The concept of a distinctive, identifiable mental health crisis is usually traced, instead, to the disaster studies of Lindemann in the 1940's. Conceiving of a mental health crisis as a largely private, individual cognitive, emotional event or experience marking the turning point in the recovery of a crisis victim who is the target of intervention has been one of the fundamental characteristics of the crisis intervention literature. However, the ability to clearly identify such intrapsychic events as turning points or to clearly associate them with evidence of recovery remains a difficult proposition, at best. No contemporary research or theory of mental health crises, however, appears to make any non-trivial use of cusp or turning point, despite the seemingly obvious reversals associated with suicide attempts and certain other mental health crises.

Following the famous Coconut Grove fire in Boston in 1942, Lindemann described three phases of mourning among victims and survivors of the fire: 1) shock and disbelief; 2) heightened awareness; and 3) resolving the loss. Nine years later, Tyhurst (1951) transformed the Lindemann grieving-process model into a dynamic model of mental health crisis: He described three "predictable" phases of an individual's reaction to disasters and other crisis situations to which he applied the mechanistic labels of impact and recoil and the rather nondescript "post-traumatic period".

In the following decade one of the pioneers of the Community Mental Health Movement, Gerald Kaplan, attached a psycho-dynamic explanation to explain movement through a series of crisis phases. According to Caplan (1961) insoluble problems give rise to internal tensions associated with a "crisis state". Caplan (1964) also described a crisis in terms of four predictable phases: impact; increased tension and behavior arising from failure of usual problem-solving methods; attempts to mobilize internal and external resources in new ways; and a fourth, post-traumatic period of symptom-freedom based upon the newly developed coping skills. The Kaplan model postulated two possible crisis outcomes: Successful mobilization would result in symptom-freedom, while failure in phase three will make phase four a period of continued tension and disorganization.

Schneidman (1973) offers a three-part developmental typology of emotional crises: *intratemporal* crises, which occur during a particular stage of life and are specific to that stage; *intertemporal* crises, which occur as the individual moves from one developmental stage to another; and *extratemporal* crises which occur independently of developmental stages. This approach has given rise to a considerable body of research. However, a great many questions about the nature and circumstances of mental health crises remain unanswered.

## West Virginia Crisis Studies

The West Virginia Crisis Studies are the product of an on-going, three-way collaboration between Valley Community Mental Health Center, a 4-county urban-rural community mental health center, the Community Services Division of the West Virginia Department of Health and Human Services, a state agency and the School of Social Work at West Virginia University, a land-grant university.

Findings reported here are part of a process evaluation study of a newly created mobile crisis unit. The purposes of the evaluation were formative in nature, and directed at gathering and systematizing descriptive data on the events and circumstances associated with mental health crisis situations and crisis interventions. Because of the absence of similar reports in the published literature on crisis research, it is hoped that they will also be of interest to others investigating similar problems.

The approach taken in this study should be seen as complementary to the more conventional psychometric study of mental health crisis. Data reported here are part of an independent line of investigation into the situational and interpersonal nature of mental health crisis. Rather than focusing exclusively on psychometric measurement of the mental health crisis as an intrapsychic event, this research attempts to identify some of the interpersonal and situational characteristics associated with reports by persons with identifiable diagnoses of mental illness that they are “having a crisis.”

The research reported here is based upon three fundamental assumptions:

- 1) A **mental health crisis** refers to a social and psychological (“psychosocial”) event which can be conceptually distinguished from **crisis intervention** which is any attempt at problem-solving to deal with a crisis event.
- 2) Understanding of the **dynamics of the crisis** (or problem) is an essential component of effective crisis intervention (or problem-solving).

- 3) The situational characteristics of a mental health crisis can be identified independently of personal characteristics of the **crisis victim** (such as prior diagnosis or current treatment status). “The crisis”, as such, is not unique to the victim, but can be located in the diverse experiences of victim(s), professionals who deal with them and significant others such as family members.

## Defining Crisis As Situation

For purposes of this research, a **crisis** is operationally defined as any disruption in a person’s normal level of daily functioning reported to a crisis hotline and labeled by a trained crisis worker as a genuine crisis. This approach is inherently descriptive and interpersonal: It requires both a claim of crisis by a crisis victim and verification or substantiation of that claim by the professional judgement of a crisis team member. Part of the issue which is addressed by this research, therefore, can be stated as the types of circumstances and conditions identified by callers and verified by MC team members as crises.

While the locus of any mental health crisis is the individual with an acute or chronic mental illness, care givers, family members, professional service providers, law enforcement officials and many others may become involved in crisis episodes at various points in time. Once involved, the situation is as much a crisis for them as for the person with the diagnosis of chronic mental illness. In the words of a recent NIMH publication, “the crisis often contains both clinical and social or environmental elements.” (Stoul, 19XX)

Issues of causation of mental health crises are beyond the scope of this investigation. For people with chronic mental illnesses, a crisis may be precipitated by exacerbations of the illness, problems related to medications or a broad range of situational or environmental stresses. Most likely, crises are created by a combination of factors related to inadequate social, economic or emotional supports.

A **crisis situation** is the broader pattern of events and circumstances within which a crisis takes on meaning. One of the important research questions arising from this approach is what kinds of acts, behaviors and events person with chronic mental illness, care providers and significant others define as crisis situations. Unfortunately, the existing published research on people with chronic mental illnesses and crisis intervention allows few confident generalizations on this issue.

A **crisis victim** is defined as the person(s) identified or designated by others in the situation as “having” the crisis. Certification or legitimation of the designated victim by mental health professionals, itself an important research issue, is accepted at face value in this study. The victim, therefore,

is the person the professional at the other end of the hotline taking the call designates.

The term **psychiatric emergency** is employed here to refer to the individual, intrapsychic aspects of a crisis situation, involving organic, neurological, cognitive, emotional, behavioral and other events . It is important to remember that psychiatric emergency may or may not be a central element in a particular crisis experience for a person with chronic mental illness living in the community. Loss of employment, housing or a care giver may represent crises regardless of whether they provoke any accompanying psychiatric emergencies. There is no *a priori* reason to assume that simply because a crisis involves a person bearing a diagnosis of acute or chronic mental illness that every problem they face *must* be accompanied by a psychiatric emergency. Hence, the need for two separate terms.

Indeed, the question of the proportion of crises experienced by persons with chronic mental illness crises which are *bone fide* psychiatric emergencies is an important research question which has been obscured by previous failures to distinguish these two types of crisis situations. For any person with acute or chronic mental illnesses, normal life in the community should not imply complete freedom from crises in daily living any more than it does for any one. From the vantage point of crisis, ‘normal’ mental health is less a matter of the complete absense of crises than it is of situational stability. From a crisis standpoint, such stability is characterized both in terms of adequately protective environments and sufficiently resilient individuals. Such stability should not be defined as the absense of crises, but as the adequate handling of crisis situations which arise by resilient person with chronic mental illness and/or protective forces in their environment.

*Crisis victims* are defined throughout as those individuals identified or labeled by others in a crisis situation as “having” or “experiencing” the crisis. Because of the approach to data collection taken here, the final determination of who was having a crisis was made by the mental health professional completing the Crisis Response Inventory.

Without reference to the diagnostic categories or other personal characteristics of the person at the center of a mental health crisis, any mental health crisis itself can be described in terms of three fundamental characteristics: frequency, duration and severity. *Frequency* of mental health crises involves the number of occurrences during a given time interval. In this study, crisis frequency was measured in terms of the number of crisis calls during the eight month duration of the study. *Duration* can be defined as the interval of time between the reported onset of the crisis and its resolution. *Onset* in this study was determined in the initial interview by asking the victim or other caller when the crisis began. *Crisis resolution* in this study means the point at which the Mobile Crisis Team relinquished

contact with the client, usually when a disposition (such as hospital placement, referral to a therapist or some other provision for continuity of care had been arranged.) *Contact* was defined as the initial time when the victim came face to face with a mental health professional between the point of onset and resolution. *Resolution* in this study could only be determined approximately by the point at which crisis workers relinquished involvement in the case (through referral, commitment, voluntary hospitalization or some other means). This measure of resolution corresponds not only to Anthony's suggested outcome measure, but also, in most instances, to an intuitive judgement that "the crisis has past." Finally, each crisis situation was evaluated by two separate measures of its *severity*, defined as the seriousness or gravity of the possible consequences arising from the crisis situation.

Taken together, onset, contact and resolution, frequency, duration and severity can be said to uniquely define a particular crisis situation: "It was a crisis which began at 8:30 this morning, was reported at 9 a.m., and resolved by noon. That is the fourth time this year this client has had a crisis, although they usually last longer, and are more severe." etc.

## **Sample**

Data for this study were collected using a specially designed Crisis Response Inventory to collect descriptive and defining information about a crisis situation, including when and where the crisis occurred and to categorize in various ways what happened. The Crisis Response Inventory was completed by members of a mobile crisis response team each time a crisis situation was reported to a crisis hotline. All of the members of the Mobile Crisis Team had received training in crisis intervention theory and practice before the unit began operation. The sample is composed of 100% of the 953 crisis-related calls coming in to the hotline in an 8-month period from February through September, 1993. On the variable of frequency of crisis reports, these data were also compared with a 12-month sample of crisis reports gathered in 1991-1992. The unit of analysis in this study is the telephone crisis report and the theoretical unit is the crisis event(s) and situation(s) reported. No attempt was made in the current phase of the study to investigate the personal characteristics of crisis victims, for reasons previously noted.

## **Measurements**

Several previously developed measures were employed in this study to investigate characteristics of crisis situations. For example, each crisis was characterized by the worker in terms of the Baldwin (1978) Classification of Emotional Crises. Three separate applications of the Crisis Triage Rating Scale (Bengelsdorf, et. al., 1984) were administered to estimate the

dangerousness, cooperation and support available to victims at the crisis *onset*, the point of first professional *contact* and *resolution* of the crisis. Axis IV of the DSM-III(R) was used to estimate the severity of each crisis, and identify stressors associated with its onset. In addition, estimated times of onset, professional contact and resolution were recorded in each case. These instruments were combined with a number of additional situational descriptors into a single Crisis Inventory which was completed by a worker. These data are considered descriptive only and no attempt is being made here to evaluate the effectiveness of interventions or to assess outcomes in these cases.

### **Findings**

During the study period, 953 reported calls were received through the crisis hotline, involving what were judged by crisis team members to be 404 (42%) actual crisis situations. This resulted in 147 recommendations that mobile crisis team members be dispatched, 168 referrals, 19 “on-site” resolutions of crisis situations, 198 psychiatric evaluations in the emergency room of a local hospital, 68 involuntary commitment hearings, and the issuance of 57 commitment orders.

Seventy four (74) percent of the crisis-related calls to the hotline were from victims themselves. (The percentage of victims calling is actually slightly higher, because in a small number of cases, crisis victims identified elsewhere in the study called on behalf of others who were currently experiencing a crisis.) Moreover, comparison of callers with a characterization of the crisis as “more” or “less” severe using ANOVA found a significant relationship at the .003 level between the type of caller and the level of severity.

Crisis victims in this sample did not generally call simply because they were alone. In fact, 75.1% (N=310) were with someone at the point of perceived crisis onset. Family members were more likely than anyone else to be present at the time of a crisis. In nearly two thirds (63.8%) of those instances where someone else in addition to the victim was present (N=229), that other person was a family member. In the remaining one-third (36.2%) of situations, the other(s) present were not related to the victim. Presumably, they were friends, neighbors or strangers, although no additional information on their relationship to the victim is available from this study.

A major situational characteristic of crisis situations is perceived dangerousness--a factor of considerable importance in involuntary commitment decisions in most states. Interestingly, it was found that perceived dangerousness consistently declined as crises unfolded: The mean level of perceived danger at crisis onset was 2.56 (1=extreme danger; 5=no danger). By the point of professional contact, estimated danger had declined to 2.98, and by the point of crisis resolution to 3.5. (Differences of means

were statistically significant at greater than the .99 level.) What this suggests is that uncertainties over the possible dangers in crisis situations may be reduced as workers learn more about the crisis. Given the obvious importance of danger as a criterion in commitment, greater attention needs to be played to the situational role of the unfolding crisis. A major null hypothesis worth exploring further is that inappropriate decisions to commit patients on the basis of dangerousness may result from assessing dangerousness too early in the crisis.

Workers were also asked to characterize each crisis situation as simple or complex, in terms of whether the crisis involved a single situation and/or occurred in a single location. Mental health crises are generally not simple events. Only one in four (24.7%) of 308 crisis situations involved only a single event. An additional one in four (24.4%) involved multiple events within a single situation, and slightly over half of all crises (50.9%) involved both multiple situations and multiple locations.

Crisis intervention, by its very nature, involves the insertion of a professional helper “into the middle” of an on-going, developing situation. Thus, crisis workers must be able to gather information quickly and try to understand unclear situations. At the time professional contact was first established with the victim, workers felt that the situation was simple and straightforward in only 24.4% of 308 crisis situations. Mobile crisis workers often work “in the dark” in the initial stages of a crisis. In one out of five instances (20.5%) the situation was not immediately clear to the workers at the time of professional contact. Workers often feel that they do not have the resources necessary to deal adequately with the situation. MC Team members felt they had everything needed to deal with the situation in only 7.8% the time when they first came into contact with crisis victims. Mobile crisis workers feel the need for additional resources at the point of initial contact with crisis victims. MC Team members indicated the need for additional resources in order to cope with the situation in 47.4% of 308 crisis situations.

### ***Frequency***

The crisis unit received an average of 4 crisis calls a day throughout the eight-month study period. By contrast, in the year immediately before implementation of the mobile crisis team, an average of less than one call per day was received.

Calls received varied from a low of 2.4 per day in the second month of operation of the hotline to a high of 5.6 per day in the seventh month. Further investigation of the fluctuations of calls by day of the week (Sunday...Saturday, etc.), day of the month, full-moons and other patterns has not yet been carried out.

The individual differences in patterns of crises reported to the crisis hotline are very dramatic: The vast majority of crisis victims (well over 90%) reported crises during the 8-month study period 1-3 times. In dramatic contrast, a very small number of crisis victims (less than one percent) commanded a very disproportionate share of crisis resources in this study. The heaviest single user reported a crisis a total of 19 times throughout the crisis periods, including the first day and last day of data collection! Two other heavy users also reported crises 12 times each, over extended periods. The respective durations of these two were two months and three months, respectively.

### ***Duration***

Study of the duration of crises in this sample suggests evidence for both the views that crisis experience is a short-term one, and that the mental health crisis is a long-term condition. It would appear from this study that for most crisis victims, the crisis experience is a short-term intermittent one, occurring at intervals greater than eight months, and preceded and followed by extended periods of stability. Most of the victims presented 1-3 crises in this study, for example, and reported them close together within a short period (> 1 month). On the other hand, a very small (but highly significant) number of crises in this study conform to the classic extended crisis experience described by Kaplan and others as lasting 3-6 months. A third (and only slightly larger) group presented 4-11 crises, usually clustered together suggesting 2-3 identifiably separate crises during the study period.

### ***Severity***

One of the key descriptors of any mental health crisis is the severity of the crisis. Two measures of severity were employed. One was a simple dichotomous rating of “more” or “less” severe. In addition, the more detailed, five-point ratings of Axis IV of the DSM III (R) were also used.

How severe were these crises initially? Approximately 42% of the crises reported to this hotline were rated “more” and 58% were rated “less” severe. These ratings are somewhat at variance with the more detailed DSMIII(R) ratings, by which 10.56% were rated “catastrophic”; 8.25% were said to be “extreme”; 47.85% were reported as “severe”; 29.37% were said to be “moderate”; less than 1 percent were said to be “mild” and 3.6% were rated “None.”

Another important measure of the level of severity of a mental health crisis is the danger involved in the situation. Indeed, Anthony (1993) suggests that the safety of the crisis victim is the principal outcome measure of crisis intervention. In this study, danger and the related dimensions of social support and victim-cooperation were assessed using the Crisis Triage Rating Scale developed by Bengelsdorf, Emerson, Levy and Barile (1984) The

data clearly suggest that danger in a crisis situation is a dynamic, rather than a static dimension, and that the danger involved is typically reduced as the crisis moves toward resolution.

The level of perceived dangerousness in a crisis situation declines gradually and continuously as a crisis unfolds. The mean level of perceived dangerousness at crisis onset was 2.56. (1=extreme danger; 5= no danger) By the point of professional contact, estimated dangerousness had declined to 2.98, and by the point of resolution to 3.5. (Differences of means are statistically significant at greater than the 99% level.)

The level of perceived support available to crisis victims also increases over the course of the crisis. The mean level of perceived support was 3.2 (out of a possible 5) at onset; 3.56 at the point of professional contact and 3.83 at the point of resolution. (Differences of means are statistically significant at greater than the 99% level.)

The level of perceived cooperation by crisis victims also increases as a crisis unfolds. The mean level of perceived cooperation at crisis onset was estimated at 2.56; at the point of professional contact, it was 3.02 and by the point of resolution 3.50. (Differences of means are statistically significant at greater than the 99% level.)

The method of recording each phone call resulted in two separate measurements of “the crisis interval” from onset to resolution. In the first case, each particular issue or problem which occasioned a particular call was resolved within a relatively short period of time. This was the most typical situation. In a smaller number of instances, involving multiple calls over a relatively concentrated period of time, “the crisis interval” might also be defined as the period from the initial onset of the problem which generated the first call to the particular problem resolution of the final call.

## Implications

These findings suggest two major conclusions: First, it is, indeed, feasible to describe the circumstances of mental health crisis situations in meaningful ways without reference exclusively to the condition or intrapsychic conditions of the primary victim. Moreover, these data appear to have a range of interesting applications in program development, management and planning, as well as in direct delivery of crisis services. This is not to suggest that any reasonable service provider would (or should) attempt to assess a crisis exclusively in situational terms. It does suggest, however, that situational analysis offers a supplementary line of inquiry which can profitably be pursued.

Regardless of the psychiatric and psychological characteristics displayed by mental health clients in crisis, a mental health crisis is also indubitably an interpersonal event as well. Clients are seldom alone at the onset of a crisis,

even when they report it themselves. The majority of crisis victims actively participate in the management of their crises, beginning with reporting them to professionals through crisis hotlines. As the crisis unfolds, the victim is perceived by professional workers as becoming less dangerous, more cooperative and attracting increasing levels of social support.

In communities like the one in this study, crises are a sufficiently infrequent occurrence that it should be possible to design and implement crisis response services capable of responding to the vast majority of them.