CLINICAL PRACTICE WITH INDIVIDUALS

College of Health and Public Affairs at the University of Central Florida

SOW 6348 – Clinical Practice with Individuals

WORKING WITH PEOPLE IN CRISIS

Crisis is ubiquitous in the 21st Century, so that crisis interventions are a prominent feature of clinician and agency work. Crisis intervention has much in common with other forms of clinical work. It requires the same careful, culturally relevant assessment and contracting processes. It utilizes familiar skills of attending and listening, providing support and empathy, and using exploration and elaboration to help clients tell their stories. It is distinguished from other work by its intentionally time-limited scope; its intense focus on crisis-related reactions, needs, plans, and linkages with helpful

resources; its flexible timing and use of sessions; and its goal of restoring client and community capacity and locus of control as quickly as possible. Trauma is an intensely affecting form of crisis that can overwhelm and/or destabilize both those who experience it directly and other hearing about, witnessing, or working with it. The definition of trauma has been broadened to include overt and subtle oppression-based intimidation, epithets, exclusions, and assaults--- "microaggressions" ---that can denigrate, unsettle, and enrage people on a daily basis. Cumulative memories of over and insidious aggressions can be traumatic as well. Suicide is a form of trauma affecting everyone involved with the client or in the interventions aimed at preventing its completion. Whether threatened or completed,

work with suicide calls for empathy, commitment, advanced skills, patience, persistence, and backup.

- ☐ Suicide Clues
  - Nearly all suicidal/homicidal people offer some kind of clues (verbal, behavioral, situational, or syndromatic)
  - Warning Signs
    - IS PATH WARM
      - Ideation
      - Substance abuse
      - Purposelessness
      - Anxiety and agitation
      - Feeling Trapped
      - Hopelessness
      - Withdrawal
      - Anger
      - Recklessness
      - Mood fluctuations

INTERVENTION STRATEGIES:

- ☐ The goal is to change at least one of the "Three I's."
    - ■ Inescapable
    - ■ Intolerable
    - ■ Interminable
- ☐ Explore existing problem-solving skills or generate new skills.
- ☐ Recognize that emotional pain will not be constantly intense and interminable.
- ☐ Cognitive behavioral therapy techniques are commonly used.
    - ■ Cognitive restructuring
    - ■ Emotional regulation
    - ■ Changing destructive behaviors through psychoeducation
- ☐ "No harm" contracts
    - ■ Controversial
    - ■ Traditional vs. alternative format

SOME DON'TS

- ☐ Don't lecture, blame, or judge.
- ☐ Don't debate the pros/cons of suicide.
- ☐ Don't be misled by the client saying that the crisis is in the past.
- ☐ Don't try to challenge for shock effect.
- ☐ Don't be passive or overreact.
- ☐ Don't glamorize, martyrize, or deify suicidal behavior.
- ☐ Don't forget to follow-up.
- ☐ Don't be embarrassed to consult.
- ☐ Don't rush.
- ☐ Don't forget about countertransference.
- ☐ Don't be manipulated into giving into a client's demands.

Online resources

Interest in both the cause and cure of PTSD has initiated a tremendous upsurge in research in the past few years. For any human services worker who would like more firsthand information from practitioners, the veterans' centers and veterans' hospitals scattered throughout the United States are an excellent resource. Three websites have what we believe is pertinent and reliable information about PTSD. They are:

1. International Society for Traumatic Stress Studies. http://www.istss.org/

   The society publishes treatment guidelines and other pertinent information on PTSD.

2. National Center for PTSD. http://www.ptsd.va.gov/

   Sponsored by the U.S. Department of Veterans Affairs, this site covers a broad array of research, training, and public information,

3. The Sidran Foundation. http://www.sidran.org/
   Sidran is a nonprofit foundation devoted to education, advocacy, and research to benefit people who are suffering from traumatic stress.

GESTALT THERAPY:

Therapy aims to:

- ⊡ Help individuals incorporate a variety of behaviors into daily functioning.
- ⊡ Encourage accountability and self-responsibility.
- ⊡ Incorporate experiential learning
- ⊡ Actively address past experiences that were traumatic or disturbing by bringing them into the "here and now"
- ⊡ Help clients to utilize opportunities that lead to self-empowerment.

CASE STUDY RITA: James Text

Rita is a 35-year-old businesswoman. She is a graduate of high school and a post–high school vocational-technical institute. She holds a certificate in auto mechanics. She has never been to a counselor before, and has come to the crisis worker at the suggestion of a close friend who is a school counselor. Rita owns and operates an automobile tune-up and service shop. She employs and supervises a crew of mechanics, tune-up specialists, and helpers. She works very hard and keeps long hours but maintains some flexibility by employing a manager. Rita's husband, Jake, is a college-educated accountant. They have two children: a daughter who is 13, and a son who is 8. The family rarely attends church, and they don't consider themselves religious, but they are church members. Their close friends are neither from their church nor from their work.

Rita's problem is complex. She constantly feels depressed and unfulfilled. She craves attention but has difficulty getting it in appropriate ways. For diversion, she participates in a dance group that practices three nights a week and performs on many Friday and Saturday evenings. Rita, Jake, and their children spend most Sundays at their lake cottage, which is an hour-long drive from their home. Their circle of friends is mainly their neighbors at the lake.

Rita's marriage has been going downhill for several years. She has become sexually involved with Sam, a wealthy wholesaler of used automobiles. She met him through a business deal in which she contracted to do the tune-up and service work on a large number of cars for Sam's company. Sam's contracts enable Rita's business to be very successful. Rita states that the "chemistry" between her and Sam is unique and electrifying. She says she and Sam are "head over heels in love with each other." While she still lives with Jake, she no longer feels any love for him.

According to Rita, Sam is also unhappily married, and Sam and his current wife have two small children. Rita states that she and Sam want to get married, but she doesn't want to subject her two children to a divorce right now. She is very fearful of her own mother's wrath if she files for a divorce. Sam fears his wife will "take him to the cleaners" if he leaves her for Rita right now. Lately, Sam has been providing Rita with expensive automobiles, clothing, jewelry, and trips out of town. Also, Sam has been greatly overpaying Rita's service contracts, making her business flourish. Jake doesn't know the details of Rita's business dealings with Sam, but he is puzzled, jealous, frustrated, impulsive, and violent. Jake used to slap Rita occasionally. In the last few months, he has beaten Rita several times. Last night he beat her worse than he ever has. Rita has no broken bones, but she has several bruises on her body, legs, and arms. The bruises do not show as long as she wears pantsuits.

Rita has told her problems only to her school counselor friend. She fears that her boyfriend would kill her husband if he found out about the beatings. Rita is frustrated because she cannot participate with the dance group until her bruises go away. Rita is feeling very guilty and depressed. She is not particularly suicidal, however. She is feeling a great deal of anger and hatred toward Jake, and she suffers from very low self-esteem.

She is feeling stress and pressure from her children, from her mother, from Jake, and

even from Sam, who wants to spend more and more time with her. Recently, Rita and Sam have been taking more and more risks in their meetings. Rita's depression is getting to the point where she doesn't care. She has come to the crisis worker in a state of lethargy—almost in a state of emotional immobility. Rita has decided to share her entire story with the worker because she feels she is at her "wit's end," and she wouldn't dare talk with her minister, her physician, or other acquaintances. Rita has never met the crisis worker, and she feels this is the best approach, even though she is uncomfortable sharing all of this with a stranger.

Narrative of Rita's Case

First and foremost, we would be in the Predispositioning/Engaging/Initiating Contact business. Since this is Rita's first contact with a therapist, we want to articulate to her what we are going to be doing. There are no mysteries about the crisis intervention business, so we want the client to be fully aware of what we are going to attempt to do and how we are going to go about doing it once we have completed a comprehensive exploration of his/her dilemma. At the moment, as we listen to her story, we need to seek to stop the emotional avalanche she is currently experiencing. We also want to be able to motivate her to move from a Contemplation stage of thinking and worrying about the problem to a determination to something about the problem, and then to taking action on it. We will use a variety of "I" statements, from actively reinforcing her for coming in—"I believe that takes a lot of courage" and "I am amazed at how well you have held it together given the pressure you are under"—to what we do: "Right now I want to help you get some control and stability back in your life, and here's how I am going to go about that."

We would then explore and define Rita's problem from her point of view. We would use active listening techniques. Initially, we would avoid closed questions, and instead use "how," "what," and "Tell me more!" open leads. Apparently, Rita is feeling trapped because of several situational conditions: her marriage, her relationship with Sam, her own web of unfulfilling activity, and the beatings by her husband Jake. We would try to identify the one area that precipitated the crisis and immediately focus on that. After Rita's whole story has been fully examined, we might say, "Rita, what one thing caused you to come to see me today?" We would start with that one event or stressor. Active listening would bring us to that point.

Second, we would take whatever steps deemed necessary to ensure Rita's safety if we felt she was in danger. From the case data, we might assume that Jake does not physically abuse the children, although he might do so. If our assessment indicated that Rita was in imminent danger, we would refer her to Domestic Abuse Services and inform her of their shelter options. Other safe places could be explored with Rita to ensure the safety of both herself and her children.

Third, we would offer assistance as an immediate-support person. During the session we would attempt to develop other viable support people to whom Rita could turn, especially in an emergency. We would assume that Rita's school counselor friend is a positive-support person,

and we would encourage Rita to maintain that relationship as well as explore others.

Fourth, we would encourage Rita to examine the various alternatives available to her. We would give special attention to the options that Rita could own, and what she could do for herself in a way that would contribute directly to restoring her pre-crisis level of equilibrium.

Fifth, we would try to help Rita develop a plan of action that she could own and that would represent a positive action step toward her pre-crisis level of equilibrium. The plan would be concrete, positive, realistic, and clearly oriented toward alleviating her crisis. If her stress level were high, we might immediately use relaxation techniques to help her through her current stressful and anxious state. This could be one method by which Rita might begin to learn to deal with future stresses as she encounters them.

Sixth, before the end of the session with Rita, we would try to get a commitment from her to carry out some action that would be positive and that would help her either restore her equilibrium or make a step toward it. We would ask her to summarize the commitment as a means of helping to solidify it in her mind as an immediate objective and to motivate her toward attainment of the stated goal. I would assure Rita of my support and encouragement and make arrangements for the two of us to check back with each other to follow up on her progress.

In terms of problem solving, we would covertly brainstorm two important components while we listened and responded to Rita: (1) We would make a mental list of adequate situational supports; and (2) We would make a mental list of adequate coping mechanisms. We would not disclose all these to Rita. The mental options would be available to us to effect referrals or to ask appropriate open-ended questions in helping her to discover the alternatives available to her. We would take care not to impose our own solutions, alternatives, or plans on Rita unless she was completely paralyzed, didn't have information that would be helpful to her, or was in immediate danger.

Throughout the crisis intervention session, we would be engaged in assessing Rita's situation using a variety of criteria described in chapter three, including the Triage Assessment Form (TAF). Given the information in the case description, we would judge her scores on the Affective Severity Scale to be in the 7-8 range (she is angry, depressed, and lethargic); her Behavioral Severity Scale scores to be in the 4-5 range (she is behaviorally mobile enough to present herself for intervention and to describe her situation in candid detail); and her Cognitive Severity Scale scores to be in the 2-4 range (her thinking is pretty clear and in sync with reality). Rita's overall TAF Severity Scale score is therefore estimated to be in the 13-16 range, which places her in the moderate impairment range.

During the support, alternative and planning task phases of the session, we would be highly active with Rita. Our degree of action would depend on our assessment of Rita's mobility or immobility. If Rita were assessed as immobile, we would be quite directive; if she were partially mobile, we would be collaborative. If she were totally mobile, we would be nondirective. Based on a score of 13-16, we may assume she has a fair amount of mobility, and thus we would work more collaboratively with her, except in places where she needed information, guidance, expansion of options, or focus on details. At those points we might become very directive if she was unable to produce clear, concrete steps to take.

We would try to have her concentrate on what she wants to do; that is, we would focus

on doable, short-term alternatives. We would hope to get her to consider as many realistic alternatives as possible, and would assist her in brainstorming these alternatives. From the resulting set of choices, we would ask her to pick the one or two best options. The optimum plan would be simple and realistic. We would not be trying to get her to solve all her situational problems. Our first goal would be to help her get the present crisis under control and then work toward having the mobility to independently take charge of her life.

In problem-solving Rita's case with her, we would start with a list of support people gleaned from the case data. In crisis intervention, a support person is someone whom the client trusts and who is always available. That person or persons can be an acquaintance, a friend, a relative, a coworker—anyone who could be called on to provide temporary comfort, encouragement, or support. In Rita's case, the most likely support people would be the crisis worker, her school counselor friend, her own children, other dancers in her dance group, her "lake" friends, her shop manager and shop employees, and her former vocational-technical instructors. Other possible supports include her mother, her physician, other members of her family, and even former classmates from school. These are the kinds of people who would be identified and remembered by the crisis worker as possible appropriate supports for Rita to consider. Normally, we recommend using only one or two support persons at a time, not a whole host of people, and thus Rita would be encouraged to choose and contact one or two appropriate support people.

Adequate coping mechanisms stored in the crisis worker's mental repertory for possible assistance to Rita could be: leaving Jake the next time he beats her; breaking off the relationship with Sam; setting priorities on the amount of time she is spending on various activities; devising better or different ways to obtain positive attention when she needs it; calling a support person on the phone; calling the Crisis Center or Domestic Violence Services; calling us (the crisis worker); consulting an attorney for legal advice; consulting her physician for a complete physical examination, diagnosis, and advice; initiating marriage counseling with Jake (if he agrees); initiating couples' counseling with Sam, (if he agrees); planning ways to spend time with and engage in activities with her school counselor friend; entering individual counseling on a continuing basis; doing something that is recreational or relaxing for herself, such as working on cars or developing a new dance routine; enrolling in an assertiveness training course to enhance her self-esteem and improve her coping behaviors; wearing tights or colored hose to her dance rehearsals until the bruises heal; and thinking of something innovative and creative that she would enjoy to get away from the turmoil.

We would seek to involve Rita in prioritizing any of the alternatives, plans, support persons, or coping mechanisms she might wish to pursue. If the chosen action steps could truly represent Rita's own priorities, the chances of success would be greatly increased. Finally, and most importantly, we would reemphasize getting Rita to commit herself to one or more of the actions that we collaboratively developed as her plan, and ask her to summarize her plan so that we could both agree on what she was committing herself to. We would try to respond to her during the commitment phase in a way in which she would feel supported but not dependent on us.

Finally we would be engaging in short term follow-up to see how well the plan was

working and whether or not it needed to be fine-tuned. “Short term” in this case would be defined as two or three days at most, rather than the standard once-a-week therapy program. To keep her from becoming discouraged, we would focus on the idea that plans might fail, but people don’t.