

	<p>XIII. Study unit: Crisis intervention. Recognizing suicidal inclination, and its psychotherapeutic treatment in practice Péter Osváth</p>
Aim	<p>The aim of this chapter is the recognition of the suicidal danger in everyday medical practice, providing an adequate response, and becoming acquainted with the theory and practice of crisis intervention.</p>
Introduction	<p>Introduction</p> <p>In this chapter you will become acquainted with those basic communicational and psychotherapeutic techniques, with the help of which the recognition and adequate treatment of suicidal danger may be accomplished effectively.</p> <p>Target group: general practitioners and medical students</p> <p>Key words: crisis intervention, suicidal attempt, psychological crisis</p> <p>Suggested study methods:</p>
Important	<p>Read the texts and the case illustrations. Following this, answer the comprehension questions. If you were not able to answer all the questions, survey the problematic parts in the texts again, and finally do the self-check tests.</p> <p>We suggest that the study material should be surveyed in one go. Total amount of study-time necessary: 4 hours</p>
Literature	<p>Content of chapter:</p> <p>XIII./1.: The suicide Introduction XIII./1.1.: Epidemiology XIII./1.2.: Aetiological factors XIII./1.3.: Psychological background factors of suicidal danger, and the difficulties of its recognition XIII./1.3.1.: The psychological crisis XIII./1.3.2.: Ringel's presuicidal syndrome XIII./1.3.3.: "Cry for help" communication XIII./1.3.4.: Communicational characteristics XIII./1.3.5.: Clinical – psychopathological characteristics XIII./1.4.: Summary</p> <p>XIII./2.: Psychological assistance – the possibilities of psychotherapeutic intervention XIII./2.1.: The theoretical background of crisis intervention XIII./2.1.1.: The definition of crisis intervention XIII./1.2.: Crisis support XIII./1.3.: Crisis intervention</p> <p>XIII./2.2.: The connection between crisis interventions and psychotherapies</p>

	<p>XIII./2.3.: The practice of crisis intervention</p> <p>XIII./2.3.1.: The aims of crisis intervention</p> <p>XIII./2.3.2.: The stages of crisis intervention:</p> <p>XIII./2.3.2.1.: The elements of the introductory stage</p> <p>XIII./2.3.2.2.: The central/work stage</p> <p>XIII./2.3.2.3.: The final stage of crisis intervention – termination</p> <p>XIII./3.: Summary</p>

<p>Important</p> <p>The prevalence and motives of suicidal behaviour</p>	<p><i>XIII./1. Suicide</i></p> <p>Péter Osváth</p> <p>Introduction</p> <ul style="list-style-type: none"> • Suicidal behaviour – completed as well as attempted self-destruction – is becoming a more and a more important national health issue these days. • Subsequent to a suicide attempt, or in the case of a psychological crisis, very often urgent care or general health-care service is provided. • In the terms of the recognition of suicidal danger, effective help and prevention only up-to-date and practical psychological and disease psychological knowledge may provide assistance. • For people working in the different fields of the medical profession comprehensive knowledge of the psychological, psychopathological regularities and communicational characteristics of suicidal behaviour as well as the methods of crisis intervention are indispensable. <p>XIII./1.1. Epidemiology</p> <ul style="list-style-type: none"> • Self-destructive forms of behaviour have a worldwide prevalence of growing significance; in the course of a year approximately 1 million people lose their lives as a result of suicide, and the number of attempts is almost ten times of this figure. • During the past decade in Hungary, nearly 2500 completed suicides have happened every year, which corresponds to a 32-24/100,000 persons (with males: between 50 and 40/100,000 persons; with females: between 15 and 10/100,000 persons) prevalence. • The number of attempted suicides may reach even thirty thousand a year. A
<p>Important</p> <p>The prevalence and motives of suicidal behaviour</p>	

Task

Question:

XIII./1.2. Aetiological factors

- ◆ Suicide is a complex – multi- and interdisciplinarily interpretable – human phenomenon, which is the result of the micro- (individual) and macro- (social) level interactions of different socio-cultural, psychological and biological factors.
- ◆ In the development of self-destructive behaviour the following may play a role:
 - Exogenous, environmental factors (negative life events, loss experiences, crisis state);
 - Biological vulnerability (genetic factors, neuroendocrine and neuroanatomical systems);
 - Various personality traits (impulsiveness, hostility, affective temperament);
 - Mental disorders (mainly affective diseases and psychotic conditions);
- ◆ The most important risk factors of suicide:
 - a previous suicide attempt;
 - various mental disorders:
 - primarily the affective diseases (particularly long-standing, recurrent and frequently untreated major depression);
 - socio-demographical characteristics (male sex, old age, unemployment, divorced or widowed, living alone etc.);
 - other factors (a childhood negative life event, actual psychosocial stressor, suicide in the family, chronic somatic disease etc.);
- ◆ Providers of support:
 - a stable emotional, family and social background
 - pregnancy, bringing up children
 - good state of health
 - practising a religion
- ◆ The above motives play their roles in the background of the suicidal act in a varying manner from individual to individual, thus the recognition and evaluation of the background factors have major importance, since the planning of adequate psychological first aid may only take place on the basis of this.

XIII./1.3. Psychological background factors of suicidal danger, and the difficulties of its recognition

There are several known psychological-communicational regularities in the background of suicidal danger or attempt, which every time occur during the establishment of contact with the patient.

XIII./1.3.1. The psychological crisis

- A psychological state, developed as a result of external events, in which the individual is confronted by circumstances severely endangering his psychological balance, and the impact of these becomes such a psychological problem for him that are more important than anything else.

made sure that they had sessions for revealing the patient's underlying psychological problems and for talking about the situation in detail together. During these discussions the suicidal crisis was revealed (The patient had already written a will and a farewell letter, planned to kill himself in the forest nearby with the sleeping pills and the spirits he would purchase during the day) which demanded an immediate hospitalisation into a psychiatric ward. As a result of the two-week-long treatment in a psychiatric ward and a three-month-long outpatient crisis intervention, the patient gave up his suicidal thoughts and regained his psychological stability.

XIII./1.3.5. Clinical – psychopathological characteristics

The characteristics of depressive mood disorder:

- Dejection, anhedonia (joylessness), apathy (indifference), anergia (feebleness), losing the capacity for joy, and various vegetative symptoms (sleeping, appetite and sexual function disorder, losing weight), hopelessness, death-wish.
- Cognitive distortion (Beck's cognitive triad: the patient's conception of the past, of the future and of himself (sample question: "looking back upon your life, how do you see the events of past years?" etc.) see case fragment 2. for the ascertaining of suicidal danger).

XIII./1.3.:

[P_2_supplement_XIII_chapter.jpg](#)

Legend: *Supplement 2.: Case fragment for the ascertaining of suicidal danger 2.*

Doctor: How do you see your own life?

Patient: I cannot say anything positive about it. I screwed up everything in my life, I have made mistakes on top of mistakes. I have not been successful in anything. It would be better for me if I did not live because then at least I would not harm anybody.

D: - I can see that you are very upset. Perhaps it has already occurred to you that it would be better for you if you were dead?

P: - Yes, it occurred to me many times that it would be better for everybody like that.

D: - Has it turned in your mind that you would end your life by your own hand?

P: - Yes, but it is very difficult to talk about it because I feel ashamed about it, since a normal person would not do something like that.

D: - This kind of thing occurs to lots of people in a difficult situation like this. Have you thought about a specific plan as well for ending your life?

P: - Yes, my father hanged himself, and that will do for me, too.

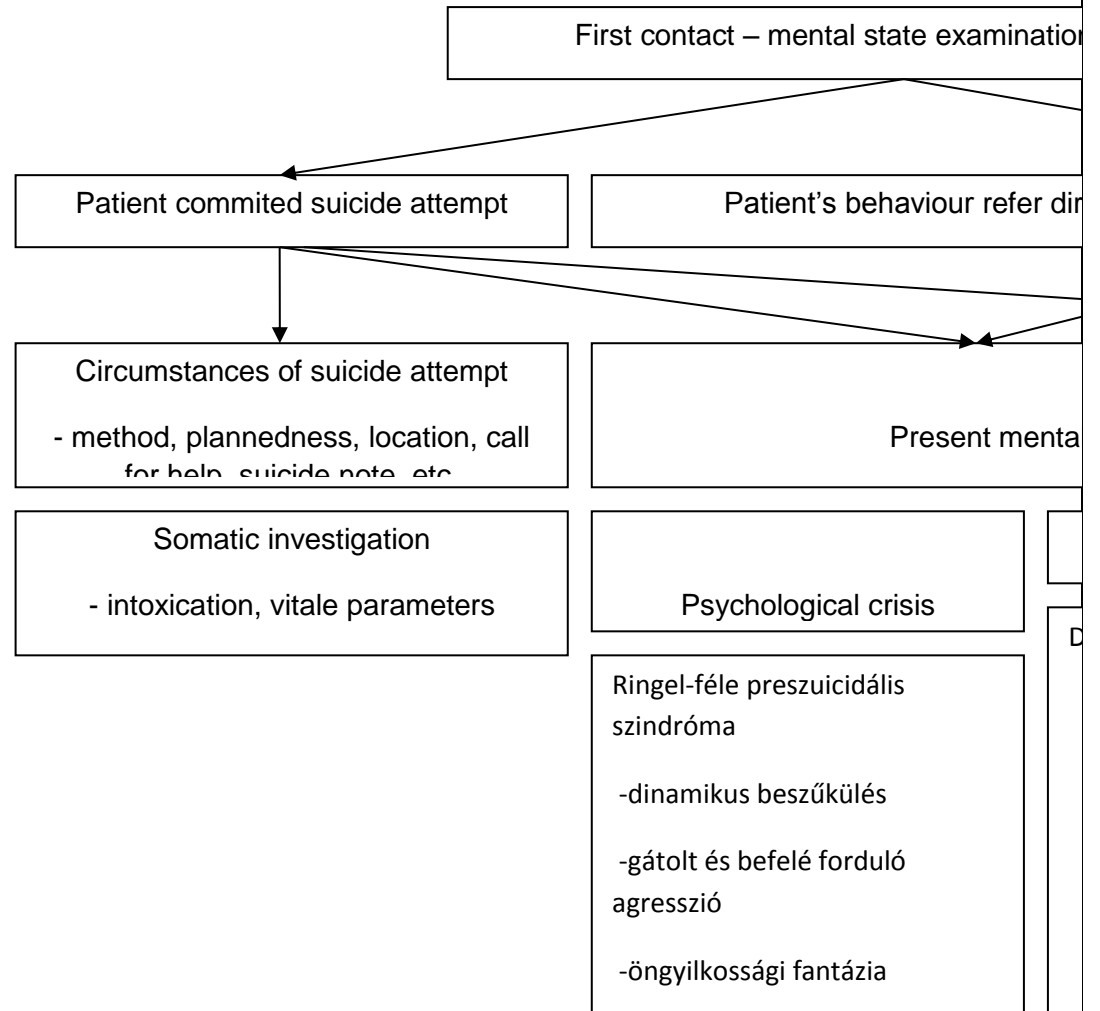
XIII./1.4. Summary

- ◆ Suicidal behaviour always develops as a peculiar individual process, which has stages possessing characteristic symptoms and communicational particularities.
- ◆ By recognising these characteristics, the specialist is able to assess the patient's actual psychological state, and through an adequate helping intervention self-destruction becomes preventable.
- ◆ The doctor's understanding and accepting attitude facilitates
 - the clarification of the background of the psychological crisis;
 - the establishment of an enduring therapeutic relationship;
 - by revealing and discussing the patient's problems, adequate solution possibilities may be delineated in lieu of self-destruction.
- ◆ Acute suicidal danger requires urgent care provision in all cases!

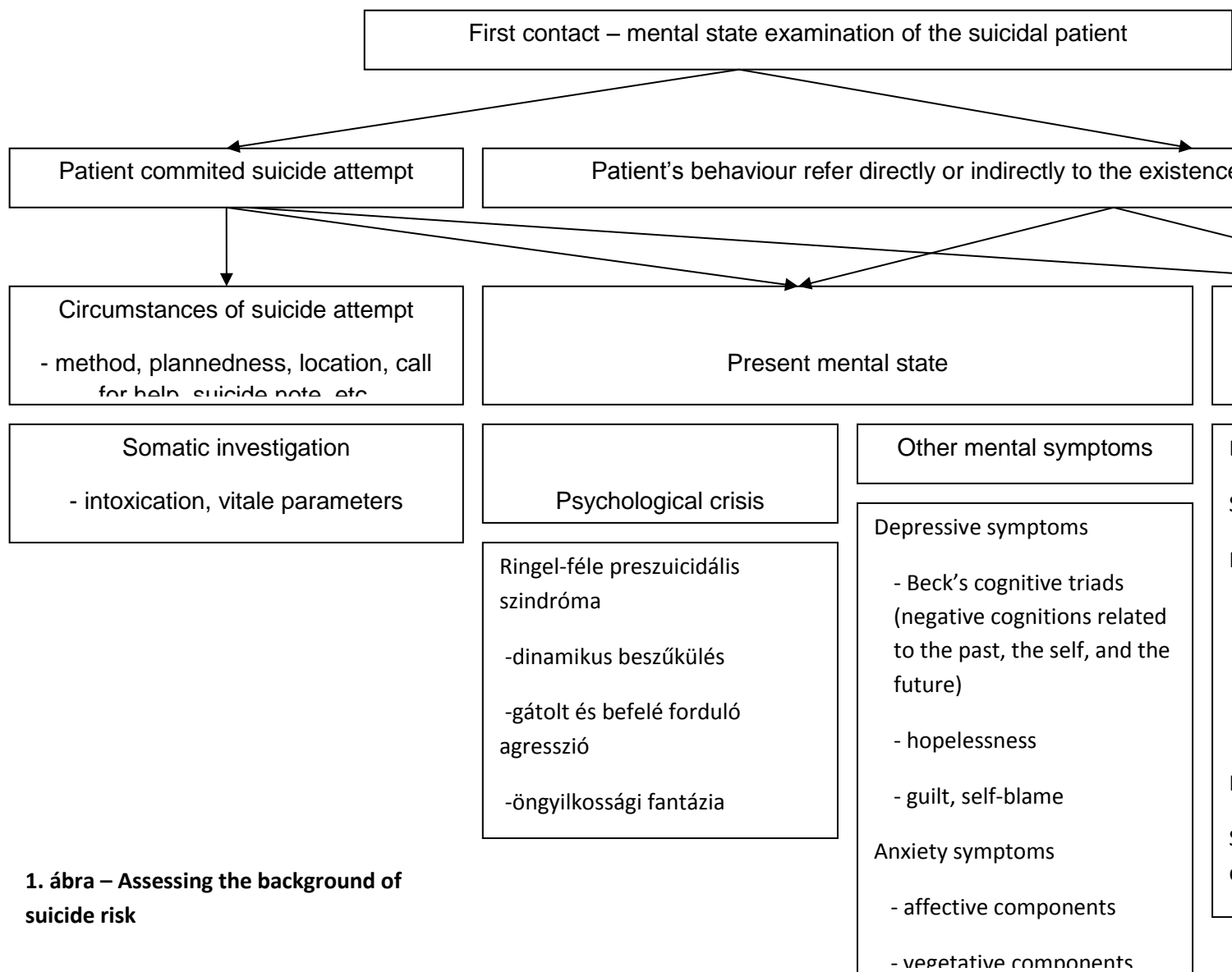
- ◆ Particularly when the emotional narrowing-down does not dissolve even during the conversation of crisis interventional approach.
- ◆ In such a case the most expedient is the acute psychiatric hospitalization and/or a previous consultation with a psychiatrist (Figure 1 helps recognition).

[A_P_1_figure_XIII_chapter.jpg](#)

Legend: *figure 1.: Assessment of the condition of the suicidal patient*



1. ábra – Assessing the background of suicide risk



1. ábra – Assessing the background of suicide risk

Task:
List the elements of the acute helping intervention.

XIII./2.: Psychological assistance – the possibilities of psychotherapeutic intervention

Introduction

In everyday practice it is the duty of the medical professional performing acute somatic provision to assess the patient's psychological condition and to plan further assistance as soon as possible.

The establishment of contact in a sympathetic and empathic way as well as mental support is of fundamental importance, because these mitigate acute suicidal danger and establish the patient's future compliance with the treatment.

Indispensable elements of acute helping interventions:

- the necessity of immediate intervention;
- attaining stability as soon as possible;
- facilitating understanding;
- focusing on problem solving;
- self-confidence, encouragement and genuine support of self-acceptance.

XIII./2.1. The theoretical background of crisis intervention

practical methodology and specific technical elements. Thus crisis intervention and the psychotherapies differ from each other in their aims, focuses, contexts, time frames, and in a part of their methods.

XIII./2.3. The practice of crisis intervention

XIII./2.3.1. The aims of crisis intervention

- ◆ providing psychological first aid;
- ◆ dissolving the crisis state and the psychological contractedness;
- ◆ restoring ineffective problem-solving tools;
- ◆ facilitating adaptation;
- ◆ setting the emotional balance and the functionality of the personality back to its original level, or integrating it onto a higher level;
- ◆ preventing the development of future crises;
- ◆ a secondary aim may be the preparation of the client for a psychotherapy subsequent to crisis intervention;
- ◆ according to the development-centred approach of the modern crisis paradigm, the primary aim of crisis intervention is that the client:
 - survives the acute stage of the crisis;
 - gets well and changes in the sub-acute stage;
 - then develops further, and finally becomes a more mature personality;
- ◆ recognized crisis intervention covers maximum 6-8 weeks and a corresponding number of meetings, since generally we meet the client once or twice a week.
- ◆ Besides the possibilities of psychological assistance (individual crisis intervention, couple consultation, family intervention, group therapy) adequately employed biological and pharmacological interventions have their place in crisis care in the same way as do the various modes of social assistance.

The establishment of contact in an emergency – in vivo – case is illustrated by case fragment 3.

P_3_supplement_XIII_chapter.jpg

Legend: Supplement 1.: „In vivo” establishment of contact – case analysis

3.

The medical team on duty was called by the neighbour who found the young man's door open and the young man smoking on his balcony. He was very tense and said that he would jump. When his neighbour offered some help he sat on the banisters of his balcony on the ninth floor. When the doctor stepped into his flat the young man yelled at him saying he should not get any nearer, to leave him alone because he would kill himself anyway.

Doctor: Good afternoon. I am the doctor on duty. I've come to help.

Patient: I don't need help. Nobody can help me. It will be the best for everybody if I jump from here. Then at least nothing will hurt anymore and everything will be over.

D.: I can see you are very upset and feel desperate. Something bad must have happened to you. I'd like you to tell me about it.

P.: There is no point in doing that. I am over everything, leave me alone, I will jump and that's it.

D.: I know that you are in a very difficult situation and you feel that it cannot be

Task:

Outline the aims of crisis intervention.

Task:

Describe helping behaviour.

<p>Question:</p> <p>What does container and holding function mean in the course of crisis intervention?</p>	<p>helped. I do not know what has happened but you must have gone through horrible things. I'd like you tell me about it.</p> <p>P.: Leave me alone. Don't come nearer because I am going to jump.</p> <p>D: I do not want to hurt you. I'd like to help because I feel you are in a difficult situation.</p> <p>P: You do not know anything and you won't find out anything because it cannot be talked about it. Not with a stranger.</p> <p>D.: I would be glad I you would try. I can see your cigarette is out. Can I light it for you?</p> <p>P: No, it is not necessary. It's my last cigarette.</p> <p>D: Then let's have a cigarette. Can I offer you one?</p> <p>After this the patient took one cigarette from the doctor's cigarette packet. They started smoking then the doctor closed the door. They both sat down opposite each other. The patient started to cry. After the acute life-threatening situation the crisis intervention started. During that the patient became more cooperative. He consented to being taken to a psychiatric ward. His psychic state stabilised after he had had adequate treatment.</p> <p><i>XIII./2.3.2. The stages of crisis intervention</i></p> <p>XIII./2.3.2.1. Introductory stage</p> <p>The elements of the introductory stage:</p> <ul style="list-style-type: none"> ▪ establishing connection ▪ defining the situation ▪ making an impression ▪ establishing trust ▪ delineation of the problem <p>Aims:</p> <ul style="list-style-type: none"> ▪ gaining the trust of the client; ▪ assessing the gravity of the crisis and the psychopathological condition; ▪ treating, understanding and tolerating ambivalent or hostile feelings, refusal and negative impulses; ▪ preparation for psychological work; <p>Assisting attitude:</p> <ul style="list-style-type: none"> ▪ Active and accepting, intense emotional attention and support, satisfying the need for ventilation and dependence, employing the Rogers variables, especially complete acceptance, understanding, support, reassurance and encouragement, giving concrete advice. ▪ The "container" and "holding" function of the helper: he is able to contain and hold the client's suffering, loss, negative and hostile feelings, so that later this – content which is temporarily contained and experienced by the helper – could be revealed jointly processed and formulated again. <p>The establishment of connection and the ascertaining of suicidal danger are illustrated in supplement 4.</p> <p>P_4_supplement_XIII_chapter.jpg</p> <p>Legend: <i>Supplement 4.: Case fragment.</i></p> <p>4.</p> <p>Patient: I cannot go on anymore and. I am so tired, I only want to sleep. Can you give me some good medicine?</p>
<p>Question:</p> <p>What therapeutic techniques do we use in the course of crisis intervention?</p>	

<p>Task:</p> <p>Outline the stages of crisis intervention.</p> <p>Important</p>	<p>Doctor: I'll help you. I know you are very tired since you went through so many things.</p> <p>P.: But I'd like such some pills so that I would never wake up again. Do you need a lot of drugs for that? Can you prescribe me so much of itsome?</p> <p>D.: Do you often think about death these days?</p> <p>P.: Yes, I do more and more because it seems very attractive because it solves everything.</p> <p>D.: Have you ever thought about harming yourself somehow?</p> <p>P.: Yes but I feel ashamed of it because it is such a selfish thing to do because I would free myself of the burdens, but what would happen to my children?</p> <p>D.: Lots of things occursoccur to oneself in this excruciating situation from which one hopes to relieve oneself. And have you thought about killing yourself as well?</p> <p>P.: Doing it with drugs seems simple, since I just go to sleep and everything bad ends. I do not know whether the amount of pills I have at home is enough or not. I am scared, what happens if I still wake up?</p> <p>D.: Hhave you ever had a suicide attempt before?</p> <p>P.: No, never but once I did collect a lot of pills. But finally I did not have enough courage to take them.</p> <p>D.: And now have you planned anything else as well?</p> <p>P.: Yes. I have found a strong rope in the attic I have made a knot on it so it will not get unbound. My grandfather taught me how to do it. It worked for him. It was terrible when he hanged himself and I found him.</p> <p>XIII./2.3.2.2. The central/work stage</p> <ul style="list-style-type: none"> ▪ instead of the events of the present situation, the situations directly preceding and inducing the crisis do stand in the centre; ▪ it has to be revealed why the thing that happened did happen, that is what has actually led to the crisis; <p>Besides discussing the actual happenings, it is essential: to understand the defective and non-adaptive problem-solving patterns of the biographic aspects of the latent intrapsychic and interpersonal dynamics hiding behind the manifest events.</p> <p>Techniques:</p> <ul style="list-style-type: none"> ▪ supportive feedback ▪ clarifying questions ▪ careful interpretations aiming at the understanding and reframing of connections and the assuming of personal responsibility ▪ promoting the cognitive, self-reflexive learning process ▪ intellectual, then emotional discretion ▪ correction of defective or non-adaptive problem-solving mechanisms. <p>The parts of the central/work stage:</p> <p>Characteristics of substage I.:</p> <ul style="list-style-type: none"> ▪ soliloquizing, "understanding" the ambivalence and the situation ▪ charting the inducing event, previous coping strategies, and the support system <p>Characteristics of substage II.:</p> <ul style="list-style-type: none"> ▪ dialogue, developing possible alternatives, their evaluation and testing <p>Its aim: facilitation of better adaptive coping mechanisms,</p> <ul style="list-style-type: none"> ▪ increasing the activation of the client, ▪ promotion of previous, efficient and new, innovative strategies. <p>Characteristics of substage III.:</p> <ul style="list-style-type: none"> ▪ developing adequate solutions ▪ reinforcing preformed decisions
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- discussing methods and tools of the execution.

XIII./2.3.3. The final stage of crisis intervention

Final stage – Termination

Aim:

- detachment,
- evaluation of the situation,
- redefinition and positive anticipation of the future,
- planning practical tasks,
- emphasizing favourable changes,
- reinforcing strivings for independence,
- instead of giving concrete advice, supporting performed decisions,
- clarifying the possibilities of further assistance and of future calls for help.

The steps of the discussion of concrete plans are illustrated in supplement 5.

[P_5_supplement_XIII_chapter.jpg](#)

Legend: *Supplement 5.: The steps of the discussion of concrete plans.*

5.

Doctor: I know that you've gone through lots of difficult things. I am glad that you were able to confide in me. How do you feel now?

Patient: I don't really know. I am so empty, as if all life has disappeared from me.

D.: I know that it must have been upsetting to talk about these things. What are you going to do now?

P.: I have no idea. I would prefer to sleep a lot; I am so tired.

D: It's a good idea. You look so haggard. Go home by bus and go to bed. When do you usually get up in the morning?

P: Usually at 6 but tomorrow I am not going to work. Perhaps I will only flounce roll about in bed all night again.

D.: You won't have any such a problem. You will sleep through the night. And in the morning when you wake up, you'll get the children ready for school. What are you going to do after that?

P.: I don't know. I would have a lot of things to do. I must do some shopping since there is nothing at home and I would have to pop in to see my mother as well.

D.: Very well, plan your day; don't burden yourself too much because you need a lot of rest. And call me in the morning after you wake up, and I am expecting you in the afternoon.

P.: Ok, I'll be here.

D.: After you had paid your mother a visit have visited your mother and had some lunch, get on the bus and I am going to wait for you here.

XIII./3. Summary

Patients who are in a psychological crisis or have attempted suicide are very often given health care provision. This is the reason why it is of emphatic importance

Summary	<p>that specialists working in general and emergency health care should possess those skills and capabilities which help in the adequate provision of these patients. This state of health constitutes acute life-danger in all cases. Urgent psychological first aid is a solution not just for this, but is of crucial importance in terms of the establishment of the therapeutic relationship, and thus of the improvement of the efficiency of subsequent psychic-psychotherapeutic treatment.</p> <p>Because of the above mentioned, all specialists should be acquainted with the notion and symptoms (presuicidal syndrome, “cry for help” communication) of psychological crisis, as well as the background of suicidal behaviour and the most important practical components of the helping behaviour. During the establishment of a connection, it is indispensable on behalf of the helper to employ – along with the Rogersian attitude (empathy, acceptance) – such technical elements as understanding, congruent communication, taking an active role in guiding the interview, mediating hope, emotional support, handling the exaggerated emotions of the patient, and tolerating his negative attitudes and impulses.</p> <p>At the beginning of crisis intervention a supportive attitude, container and holding functions and satisfying the client’s intense needs for ventilation, dependence and grasp are all in the foreground in order to gain the patient’s trust. Later the interventions aiming at the clarification and understanding of the situation (clarification, interpretation, reframing, cognitive and emotional discretion, increasing self-reflection) gain more prominence, then, during the termination stage, through supporting independence and promoting preformed decisions, redefining the future becomes also possible. Parallel with the easing of the crisis, the detailed elucidation of the psychological differences and personality characteristics hiding in the background (depression, anxiety, hopelessness, narrow-mindedness, impulsivity, suicidal fantasies, suicidal plans, self-protecting and coping mechanisms) is of fundamental importance, since only on the basis of these may the planning and organising of further assistance (outpatient or hospitalized psychiatric provision or redirection to other helping services) become possible.</p>
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