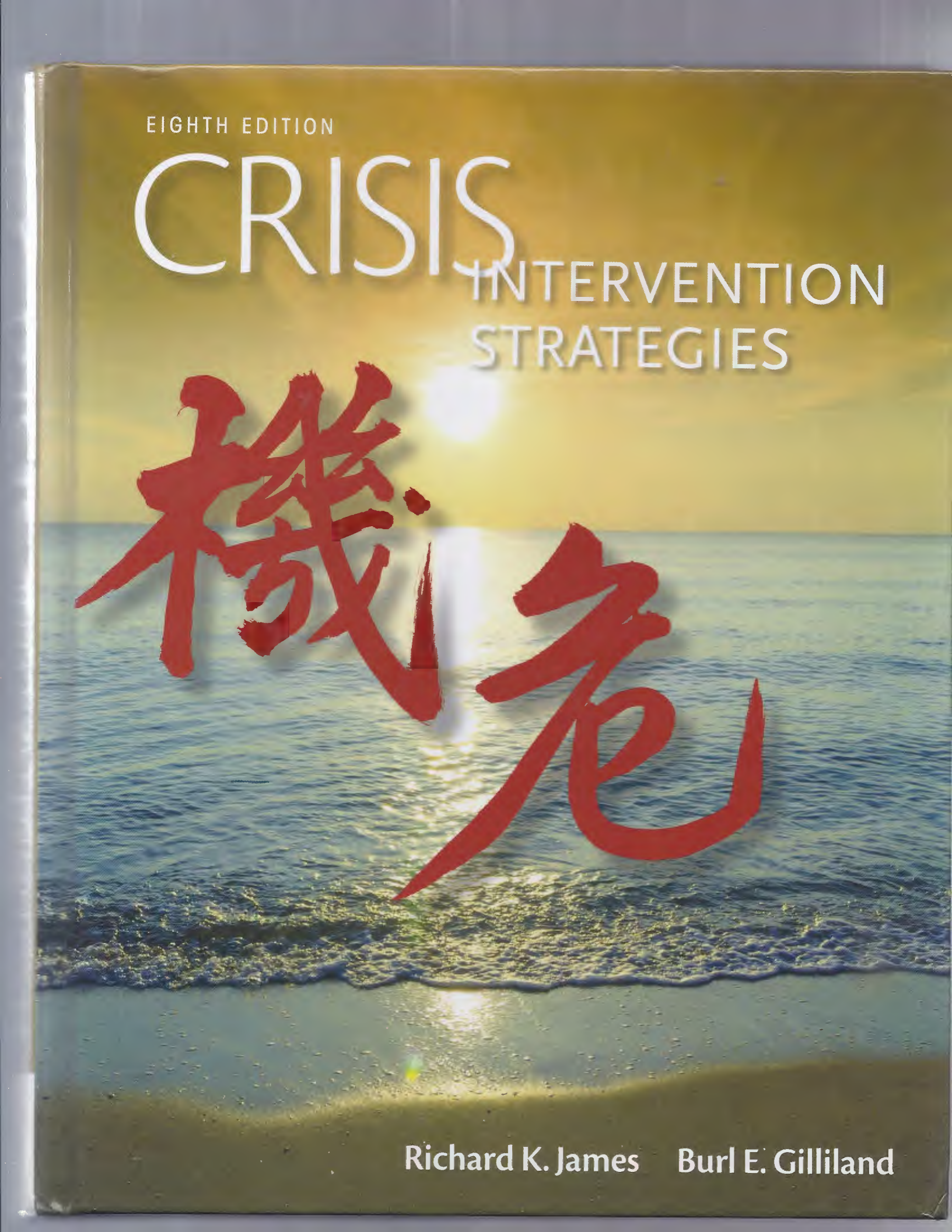
Book Reference

James, R. K. & Gilliland, B.E. (2017). *Crisis intervention strategies* (8th ed.). Boston, MA: Cengage Learning.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Crisis Case Handling

5

LEARNING OBJECTIVES

After studying this chapter, you should be able to:

1. Know the difference between handling long-term therapy and crisis intervention.
2. Understand how a walk-in mental health facility handles crises.
3. Understand what a police Crisis Intervention Team is, how it is trained, and what it does.
4. Understand what "suicide by cop" means.
5. Know the generic types of transcrisis in long-term therapy.
6. Identify and understand persons with borderline personality disorder.
7. Know the rules of the road for counseling difficult clients.

Handling Crisis Cases Versus Long-Term Cases

To understand crisis case handling, we need to LO1 distinguish between what crisis interventionists and long-term therapists do, the principles that underlie the two modes, their objectives, client functioning, and assessment procedures. On first glance, typical models for long-term therapy do not look radically different from a crisis intervention model. Our own long-term, eight-step systematic counseling model (James & Gilliland, 2003, pp. 376–381) incorporates predisposition, exploration, examining alternatives, planning courses of action, and obtaining client commitment in much the same operational format as crisis intervention.

What is radically different is that in long-term therapy, defining problems, identifying alternatives, and planning are much broader in scope, more methodological, and rely on continuous feedback loops to check effectiveness of intervention. A typical counseling session with a long-term client reviews progress since the previous session, collaboratively refines the plan of action if needed, processes the content of the session and the client's feelings about it, and then proposes a new homework assignment to be tried out before the next meeting. Crisis intervention models do not operate with such liberal time dimensions or problem scopes. In crisis intervention, exploring the problems, identifying alternatives, planning, and committing to a plan are all much more compressed in time and scope. What in long-term therapy may occur in a rather leisurely fashion over a period of weekly sessions, in crisis intervention may occur in a half-hour to 2 hours.

Whereas in long-term therapy a great deal of background exploration may provide the therapist a panoramic view of client dynamics, the crisis worker's exploration typically is narrow, starting and stopping with the specific presenting crisis. The long-term therapist's view of alternatives and planning a course of action commonly incorporate psychoeducational processes that seek to change residual, repressive, and chronic client modes of thinking, feeling, and acting. In contrast, the crisis worker seeks to quickly determine previous coping skills and environmental resources available to the client and use them in the present situation as a stopgap measure to gain time and provide a modicum of stability in an out-of-control situation. While crisis workers use psychoeducational techniques a great deal, they typically do so to solve immediate short-term problems that evolve from the crisis itself by providing specific information about what is going on with the client, such as PTSD symptoms, or specific information on how to access resources, such as getting help from FEMA for a housing loan after a tornado.

Whereas the long-term therapist would view comprehensive personality change as a necessary part of the therapeutic plan, the crisis worker endeavors to change personality only to the degree necessary for restoring precrisis functioning. A long-term therapist would look toward an evidence-based methodological manipulation of treatment variables, assess those variables on a variety of dimensions, and process the outcomes with the client. A crisis worker often uses a "best guess" based on previous experience with what does and does not work with a particular problem. Protocols for treatment in long-term therapy are typically evidence based and involve many tryouts as the protocol is fine-tuned to the individual's particular needs. Crisis intervention is a good deal more creative. Although it also operates from evidence-based techniques, it adapts and changes quickly as conditions warrant. Paradoxically, it is fairly rigid in that it employs set procedures for moving the client from an immobile to a mobilized state.

Finally, assessment and feedback of outcome measures in long-term therapy typically involve a great deal of processing between client and therapist as to the efficacy of treatment. If treatment outcomes are not as expected, a feedback loop is integrated into the model that will allow a return to any of the previous steps. Feedback and assessment in crisis intervention typically occur on a here-and-now basis, with emphasis on what changes have occurred in the previous minutes and what the client will do in the next few hours.

It should be clearly understood that in long-term therapy when a transcrisis state or point emerges, the therapist now becomes a crisis worker, and all the principles of crisis intervention are applied as crisis therapy until the client is stabilized. Beginning therapists are often blindsided by such transcrisis events and paralyzed as they try to get back to "normal" operating mode when "normal" went flying out the window and there is small chance of getting it back until the crisis is contained. Such events may particularly occur when therapy has been successful, the client is to be terminated, the client is frightened to death at the prospect of going out to face the world alone, and quickly deteriorates to the shock and chagrin of the therapist.

There are many approaches to long-term therapy. Although Thorne's (1968, pp. 11–13) approach is almost fifty years old, it is a classic representation of one of the most comprehensive and integrated systems to be found. To provide a clear delineation between crisis intervention and long-term therapy, we have compared our model of crisis intervention with Thorne's *principles, objectives, client functioning,* and *assessment* of case handling. Tables 5.1, 5.2, 5.3, and 5.4 summarize the contrasts.

Case Handling at Walk-In Crisis Facilities

Types of Presenting Crises

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Clients who present themselves for crisis counseling at walk-in facilities generally fall within one of three categories: those who are experiencing (1) chronic mental illness, (2) acute interpersonal problems in their social environment, or (3) a combination of the two. Most clients who avail themselves of community mental health clinics suffer from financial problems that prohibit them from seeking private therapy.

Chronic Crisis. Since the enactment of the federal Community Mental Health Act of 1963, the major responsibility for treatment of the mentally ill has fallen on community mental health centers. Although in theory the act was designed to deinstitutionalize patients and return those who are able to functional living, in fact the act has placed many people in chronic crisis.

In addition, increased drug abuse, a rise in crime, fragmentation of families, and a host of other societal ills have caused a tremendous upsurge in the need for mental health services. Originally focused on reintegrating long-term hospital patients into the community, mental health centers have tended to assign chronic cases a less-than-priority status. The unspoken reason is that these clients are extremely frustrating to mental health providers because they show little progress and are a constant financial and emotional drain on the resources of the agencies that come in contact with them. Many community mental health centers have de-emphasized this role and moved more toward dealing with developmental problems of "normal," more highly functioning people (Slaikeu, 1990, p. 284). Perhaps more ominously, funding cutbacks have forced community mental health centers to look more closely at a client's ability to pay as a precondition for treatment, which means that people who may most need service may be relegated to a waiting list. Furthermore, because of legal ramifications and funding problems, severely disturbed people who are committed to state hospitals typically have very brief stays and are turnstiled back onto the streets.

TABLE 5.1 Principles Compared Between Long-Term Therapy and Crisis Intervention

Long-Term Therapy Mode	Crisis Case-Handling Mode
1. *Diagnosis:* Complete diagnostic evaluation with observation; background of social, educational, and work history; intellectual, personality, and malady specific psychological testing.	1. *Diagnosis:* Rapid triage crisis assessment face-to-face.
2. *Treatment:* Focus on basic underlying causes; on the whole person with continuous individual and group work over an extended time.	2. *Treatment:* Solution-Focus on the immediate traumatized/crisis component of the person to stabilize and restore psychological equilibrium.
3. *Plan:* Personalized comprehensive prescription directed toward fulfilling long-term needs across work, academic, and social environments.	3. *Plan:* Individual problem-specific prescription focused on immediate needs to alleviate the crisis symptoms in the current environment.
4. *Methods:* Knowledge and use of a variety of techniques to systematically effect a wide array of short-term, intermediate-term, and long-term therapeutic gains.	4. *Methods:* Knowledge of time-limited brief therapy techniques used for immediate control and containment of the crisis/trauma.
5. *Evaluation of results:* Systematic behavioral validation of therapeutic outcomes in terms of the client's total functioning through testing, long-term observation, and supportive reports from significant others in work and social environments.	5. *Evaluation of results:* Target crisis- specific behavioral validation by client's return to precrisis level of equilibrium through observation of client actions.

TABLE 5.2 Objectives Compared Between Long-Term Therapy and Crisis Intervention

Long-Term Therapy Mode (Listed in No Particular Order, But Global in Scope)	Crisis Case-Handling Mode (Listed in Linear Order with a Crisis-Specific Focus)
1. *Prevent problems:* More basic than cure. Use preventive procedures whenever possible. Explore comprehensive future needs based on current assessment of intra- and interpersonal skills and social, vocational, and financial resources.	1. *Ensure client safety:* Always assess client lethality and provide for the physical and psychological safety of the client and significant others.
2. *Correct etiological factors:* Involves comprehensive evidence-based treatment of broad-based psychological and environmental factors in both the past and present.	2. *Predisposition.* Facilitate conditions for client–worker bonding. Reduce threat level.
3. *Provide systematic support:* Comprehensive measures directed toward improvement of the state of psychological and physical health and well-being of the individual. Across social and work environments.	3. *Define problem:* Clarify in concrete terms the issues that precipitated the crisis.
4. *Facilitate growth:* Treatment should ideally facilitate rather than interfere with natural environmental and developmental processes.	4. *Provide support:* Establish conditions, by either the crisis worker or significant others, whereby the client feels secure and free of threat or abandonment as the current crisis is resolved.
5. *Reeducate:* Treatment seeks to reeducate and teach new models of adjustment for lifelong coping.	5. *Examine alternatives:* Provide options for alleviating the immediate situational threat in relation to the crisis.
6. *Express and clarify emotional attitudes:* Major emphasis is on methods of securing emotional release and expression in a permissive and accepting environment.	6. *Develop a plan:* Formulate a stepwise procedure using client coping skills, crisis worker expertise, and systemic measures to energize the client to take immediate action.
7. *Resolve conflict and inconsistencies:* Therapy aims to help the client achieve insight and understanding into the causation and dynamic roots of the behavior and change.	7. *Obtain commitment:* Obtain agreement as to specific time, duration, and number of activities required to stabilize the client and/or crisis situation.
8. *Accept reality:* Help the client to accept what cannot be changed. Move forward into new realities and discard problematic histories.	8. *Follow-up.* Short-term follow-up to determine if crisis intervention strategies continue to work.
9. *Reorganize attitudes:* Move the person toward exhibiting a more positive view of life and more effective social integration.	
10. *Maximize intellectual resources:* Improve the functions of sensing, perceiving, remembering, communicating, thinking, behavior management, and self-control.	

TABLE 5.3 Client Functioning Compared Between Long-Term Therapy and Crisis Intervention

Long-Term Therapy Mode	Crisis Case-Handling Mode
1. Client shows sufficient *affect*; manifests some basis for experiencing and understanding his or her emotional state.	1. *Affectively,* the client is impaired to the extent that there is little understanding of his or her emotional state.
2. Client shows some ability to *cognitively* understand the connection between behavior and consequences—between what is rational and irrational.	2. *Cognitively,* the client shows inability to think linearly and logically and formulate strategies to alleviate the crisis. Irrationality is the norm.
3. There is some modicum of *behavioral* control.	3. *Behaviorally,* the client is out of control and may pose a danger to self or others.

TABLE 5.4 Assessment Compared Between Long-Term Therapy and Crisis Intervention

Long-Term Therapy Mode	Crisis Case-Handling Mode
1. *Intake data:* Client is stable enough to provide in-depth background regarding the problem. Lengthy intake form may contain details of the client's total history: family, medical history, drug use, education, therapy background, social history. Comprehensive personality and intellectual tests may be given.	1. *Intake data:* Client may not be able to fill out an intake form because of instability or time constraints; a verbal and/or visual evaluation of current maladaptive state may be the only data available.
2. *Safety:* Client safety is not the primary focus unless there are clues pointing toward imminent danger to self or others.	2. *Safety:* Crisis worker's first concern is client's and others' safety; determining whether client is suicidal, homicidal, or otherwise a danger or threat to someone by intentional or unintentional acts.
3. *Time:* The therapist has time to procure a variety of assessment data to confirm or contraindicate the hypothesized problem. Total case diagnosis and workups are gathered before the treatment plan is developed. Personality assessment indexes are generally gathered to compare client functioning against norm groups on standard pathology measures.	3. *Time:* Crisis worker has no time for administering formal instruments. Worker must rely on immediate verbal and nonverbal cues emitted by the client to make assessment of degree of pathology.
4. *Reality testing:* The therapist assumes the client is in touch with reality unless assessment data or other clues indicate otherwise.	4. *Reality testing:* Using simple questioning procedures, the crisis worker must determine whether the person is in touch with reality and how effectively the person is functioning in real time.
5. *Referrals:* Referral resources have implications for long-term development. Examples of referrals might be to family services, mental health centers, vocational/educational assistance, and job placement services.	5. *Referrals:* Referral resources have implications of immediacy in terms of getting the client to safety and some degree of stability. Examples of referrals might be to the police, hospital emergency room, psychiatric or medical evaluation, or immediate support people.
6. *Consultation:* Consultants and other backup resources are available as needed. Collaboration is normally initiated after consultation with the client and/or the therapist's supervisor.	6. *Consultation:* Professional consultants who are trained in the diagnosis of pathology may be on call for backup purposes. Police and mobile crisis teams are sometimes available. Most likely the worker is on his or her own.
7. *Drug use:* The therapist relies on data from the intake material and on information developed in the normal course of the therapy to ascertain the level and type of prescription medication or illicit drug or alcohol use.	7. *Drug use:* The crisis worker relies on verbal and visual responses to ascertain the level and type of prescription medication or illicit drug or alcohol use.
8. *Disposition:* Client typically starts and finishes with the same therapist over a course of months. May occasionally be referred to adjunctive therapeutic specialization during the course of therapy. Clients come and go voluntarily and return to home environment.	8. *Disposition:* Client typically starts and stops with the same worker over a course of hours or days. May be referred permanently to long-term treatment with a therapeutic specialization once stabilized. Client may be involuntarily committed, arrested and jailed, or released back to supervised care of custodians, guardians, or significant others.

The result is that a host of chronically mentally ill people who are poorly functioning, impoverished, homeless, victims or perpetrators of crime, and without support systems of any kind are left to fend for themselves. These people often have multiple problems besides a primary diagnosis of psychopathology. They may be noncompliant with treatment, disregard their medication, abuse alcohol and drugs, have other severe physical problems, and be victimized financially, physically, and psychologically by others (Bender, 1986; Nurius, 1984; Pope, 1991). It is easy to see why such people often wind up in crisis when understaffed and underfunded mental health clinics (Roberts, 1991, p. 31) and other social services agencies cannot care for them. The chronically mentally ill are often on a first-name basis with local police and personnel in emergency rooms, mental health clinics, and social services agencies.

Social/Environmental Crises. People with chronic mental health issues are not the only people who avail themselves of, or are brought to, walk-in facilities. Runaways, addicts, the battered, physically disabled, crime victims, survivors of violent events, the sexually abused, the terminally ill, veterans, the unemployed, and relatives of the chronically physically and mentally ill are some of the many participants in a drama of social crisis that is played out every day and night in mental health clinics, emergency rooms, student counseling centers, social services agencies, and police stations across the country. Many precipitating events may be unexpected and sudden and may have an impact far beyond the individual on families and communities, leaving these systems disorganized and out of control. Crises that are generated in the social environment are some of the most potent for mental health workers because of their ramifications across systems and the heightened emotionality and immediacy that accompany them for both clientele and workers.

Combination of Types. The foregoing crisis types rarely occur as discrete categories. Overlapping among types and problems that face crisis workers is the rule rather than the exception. Attempting to stabilize someone with chronic schizophrenia without providing food and shelter, treating a trauma survivor without first working on a drug addiction, or considering vocational exploration without handling the depression of a middle-aged executive who has just lost her job is a waste of valuable time. Handling multiple crises with the same client is the rule rather than the exception.

Case Handling at a Community Mental Health Clinic

We have chosen Midtown Mental Health Clinic in our hometown of Memphis, Tennessee, as a generic representation of how clients are taken care of who walk into or are brought to a community mental health facility. This clinic's catchment area includes a number of housing projects, the downtown area, the University of Tennessee medical facility, the city hospital, the Memphis Veterans Administration Hospital, the Memphis Mental Health Institute (a state psychiatric hospital), the county jail, several halfway shelters for drug addicts and homeless people, and a variety of other social services agencies. Furthermore, its catchment area has the highest crime rate and incidence of domestic violence in the city, a high percentage of school dropouts, and some of the most impoverished areas of the city.

Entry. Clients may come to the mental health clinic on their own, be brought by relatives or social services agencies, or be taken into custody by the police. At the moment of entry, disposition of the case begins. A person in crisis who walks in or is brought to Midtown may range across the triage scale from mildly to severely disturbed. If the person is severely disturbed, a senior clinician is summoned. An attempt is made to remove the client to an isolated office to reduce environmental stimuli and calm the client so that an assessment can proceed. The clinician tries to obtain a case history. If this is not possible, the clinician makes a visual and verbal assessment in regard to information-processing problems, tangential thinking, hallucinations, disassociation, threats to self or others, or severe drug abuse. If any of these symptoms is present, then a psychiatrist is called to evaluate the client and decide whether hospitalization is warranted.

Commitment. If the client is so mentally fragmented as to be clearly out of touch with reality or deemed an imminent danger to self or others, he or she is committed to an inpatient mental health facility. The person is asked to voluntarily commit to hospitalization. If he or she is unwilling to do so, a physician may write an involuntary commitment order. An officer of the Crisis Intervention Team, a special unit of the Memphis Police Department trained to deal with the mentally ill, is then called to transport the patient. Under no circumstances do mental health workers become involved in transportation, because of safety concerns and the possibility of stigmatizing themselves

as punitive agents in the patients' eyes. If patients are financially able, they may be transported to a private psychiatric facility. If they are indigent, they are taken to the city hospital psychiatric emergency unit for evaluation and subsequent placement at the Memphis Mental Health Institute state hospital.

Intake Interview. If the individual is coherent enough to provide verbal and written information, an intake interview is started. Following closely the crisis intervention model in Chapter 3, the intake worker first attempts to assess for client safety, define the problem, and apprise the client of his or her rights. In a patient and methodical manner, the intake worker goes through a standard intake interview sheet. Through open-ended questions and active listening, the worker tries to obtain as comprehensive a picture of the client as possible. The worker also attempts to determine the precipitating problem that brought the client to the clinic. The intake worker must be nonjudgmental, empathic, and caring and must also obtain concrete and specific information from a client who may not be able or willing to reciprocate.

Two critical components are always appraised in this initial assessment: degree of client lethality and drug use. It is a given that crisis situations either involve or have the possibility of acting-out behavior. Therefore, the intake worker evaluates clients in relation to their plans or intent to do harm to themselves or others. Because of the widespread use of prescription and illicit drugs, the worker checks to determine if drugs are involved in the presenting problem. Thus, intake workers need to have a copy of and familiarity with the *Physician's Desk Reference (PDR) or computer access to prescription drugs.* The intake worker must also have a working knowledge of the side effects of "street drugs" because of the high incidence of their use in the Midtown area.

Disposition. After the intake has been completed, the worker constructs and writes a proposed diagnosis and treatment recommendations. The intake worker discusses the treatment recommendations and possible services with the client. It is then the client's decision to accept or reject services. If services are accepted, the intake worker introduces the client to the therapist who will most likely be in charge of the case. A full clinical team meeting is held to confirm or alter the initial diagnosis and treatment recommendations. At that time a primary therapist is designated and assumes responsibility for the case.

Anchoring. On their initial visit, clients are never left alone. From their intake interview to disposition to a primary therapist, workers help clients feel that a personal interest is being taken in them and their problems. The worker takes and hands over the client to the therapist who will be in charge of the case. The therapist gives the client a verbal orientation about what is going to occur. The idea behind this methodical orientation is to demystify the world of mental health, familiarize clients with what their treatment will be, and provide them with a **psychological anchor** in the form of a real person who will act as their advocate, support, and contact person. Quickly establishing rapport with the primary therapist is helpful in forestalling future crisis and is extremely important to unstable clients, given the threatening implications of entering a mental health facility, possible loss of freedom, and the bureaucratic maze of the mental health system. It is also designed to immediately empower clients and make them feel they have taken a step in the right direction. In many instances, a compeer volunteer is assigned to the client. **Compeers** are trained volunteers who act as support and socializing agents for clients who do not have friends or relatives to assist and encourage them.

Short-Term Disposition. Many crises relate to the basic physical necessities of living. If that's the case, the intake worker makes short-term provisions for food, clothing, shelter, and other necessities while setting in motion the wheels of other social services agencies to provide long-term subsistence services. If clients are unable to care for themselves, the Tennessee Department of Family Services is appointed as a conservator to handle their money and look after their basic needs. Thus it is very important that the intake worker and other staff thoroughly understand and can access the local social services network.

Long-Term Disposition. An interdisciplinary team reviews and evaluates the intake worker's diagnosis and recommendations. If the team considers it necessary, a psychiatrist and a pharmacist conduct a psychiatric or pharmacological evaluation of the client. If a psychological evaluation is required, a psychologist evaluates the person on standardized personality and intellectual measures. Depending on the client's needs, people from various specialty units join the team. Once the team is complete, it formulates objectives and goals, and an evidence-based therapeutic plan is put into operation. The team reviews this plan on a regular basis and changes it if necessary.

Twenty-Four-Hour Service. Midtown operates 24 hours a day. After regular working hours, telephone relays are linked into the crisis hotline. Telephone workers there evaluate the call and make a decision on who should handle it. That may be a mobile crisis team or, in the city of Memphis, the Memphis Police Department Crisis Intervention Team, which we will examine at length later in this chapter.

Mobile Crisis Teams. MCTs have become an integral part of emergency psychiatric services (Ng, 2006). Mobile crisis teams (MCTs) operate for two distinct reasons. For certain clients, particularly geriatric or physically disabled clients, it may be necessary to make home visits to provide services. In other cases, when a client is out of control and unwilling or unable to go to the clinic, crisis workers go wherever the client is.

The Community Mental Health Act of 1963 mandated that those clinics receiving federal funds must provide 24-hour emergency service. The mobile crisis team has been one answer to that mandate. With the advent of the police department's Crisis Intervention Team, this need has diminished a good deal in Memphis. However, in many other cities these mobile teams are on call and often follow up either along with or after local police departments have contained the situation.

Typically a hotline or 911 mental disturbance call will ask for assistance. Either a police car with a mental health worker riding along will go to the scene, or mental health workers will follow up after police. These teams are typically equipped with sophisticated communication and information retrieval systems that can call up client mental health files or criminal records. In some instances, psychiatric nurses may be members of these teams and can administer psychotropic medication in consultation with psychiatrists (Ligon, 2000).

Depending on state statutes, either the police or licensed mental health workers in these mobile units have the power to take clients into protective custody and transport them to a hospital rather than to jail. There are three problems associated with this approach. First, most such units operate in urban areas; many rural counties in the United States have little provision for such emergency services, in regard to either staff or a mental health facility to transport a client to or the ability to administer on-site crisis intervention (Aron et al., 2009; Bain, 2011; Rouse, 1998; Rural Assistance Center, 2011). Second, no local police jurisdiction is going to transport someone 100 miles if it takes that police officer out of service for any length of time. The bottom line is that the mentally ill wind up in the place most convenient to put them—and that is usually jail, the very last place they need to be. Finally, although it has been purposed that MCTs are cost efficient and can reduce hospitalization (Bengelsdorf, Church, & Kaye, 1993), there is little current research on their ability to do "on the scene" emergency psychiatric services.

Police and Crisis Intervention

It may seem odd to many of you reading this section that we are going to spend a lot of time talking about police officers and crisis intervention since crisis workers generally fall into counseling, social work, psychology, nursing, and other medical and social service professions. So why cops? A fat lot they know about empathic responding to people in crisis, right? Just look at Ferguson, Missouri, New York City, and a host of other places where cops allegedly hurt and kill people for no good reason. We'd like you to now meet a different kind of cop from what you have been exposed to in the media.

Changing Role of the Police

The role of the police is rapidly changing and expanding. In most communities, police departments are being tasked with more and more responsibilities in addition to traditional law enforcement. Increasingly, crisis work with the mentally ill and emotionally disturbed is one of those responsibilities. It is commonly thought that patrol officers concern themselves mainly with **instrumental crimes** such as theft, robbery, and assault. The fact is that police officers deal with a multitude of **expressive** kinds of crime, in which individuals pose a serious threat to themselves or others because of their own anger, fear, vulnerability, depression, or lack of emotional control. Even though police departments do not relish investing much of their time away from providing for public safety and enforcing the law, they have found themselves more and more in a modality of law enforcement/crisis intervention (Borum, 2000; Miller, 2006; Saunders, 2010).

Police and the Mentally Ill/ Mentally Disturbed

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The problem has been ongoing and increasing since the advent of the Community Mental Health Act of 1963 and the changes it brought in releasing many mentally ill persons back into the community.

That change meant that the first institutional authority likely to have interaction with that mental ill person would not be a mental health professional but a police officer (Lamb, Weinberger, & DeCuir, 2002; Watson & Fulambarker, 2012). As a result, sadly, for many mentally ill individuals release into the "community" has actually meant release to jail as a holding facility. Survey research has revealed that among incarcerates, approximately 15% of men and 30% of women meet the criteria for a mental health disorder (Steadman, Osher, Robbins, Case, & Samuels, 2009). Latest figures estimate there are over 350,000 inmates with mental illness (OMI) in 2012 (Treatment Advocacy Center, 2014) because essentially there is no other place to house them and their first contact is the police officers who put them there. Gillig and associates (1990) studied a sample of 309 police officers in Cincinnati and Hamilton County, Ohio, and found that during a 1-month period, almost 60% of the officers had responded to at least one call in which a presumably mentally ill person had to be confronted. Almost half of the officers had responded to more than one such call during the 1-month period.

This dilemma puts a heavy responsibility on the shoulders of law enforcement officers, and although many dislike spending their time on crises of a social service nature, they are accepting encounters with the mentally ill as an appropriate aspect of modern police work and are more empathic to their illness (Bahora et al., 2008; Watson et al., 2010; Watson & Fulambarker, 2012). They are also requesting more information, training, and collaboration with mental health and crisis intervention agencies (Compton et al., 2006). The foregoing has highlighted a need to develop training models that include police crisis intervention training with the mentally ill (Compton et al., 2006; Erstling, 2006; Gillig et al., 1990; Luckett & Slaikeu, 1990; Vermette, Pinals, & Applebaum, 2005).

Because of that ongoing need, the Memphis Police Department developed the **Crisis Intervention Team** (CIT; James, 1994; James & Crews, 2014). CIT was developed specifically to train patrol officers to deal with the mentally ill and emotionally disturbed. The authors of this book were fortunate enough to be involved in that initial, innovative endeavor, which started in Memphis in 1987. Little did we realize at the time that this program, with its humble beginnings attempting to resolve a local problem, would catch fire nationally. Today, the program has come to be known as the Memphis Model for police crisis intervention with the mentally ill. In 2005 the first national convention for Crisis Intervention Team police officers was held in Columbus, Ohio. More than 1,000 police personnel came to that program from all over the country. It is with a good deal of pride that your authors had a hand in training many of those officers who came to Memphis from such diverse jurisdictions as Anchorage, Alaska; Ft. Lauderdale, Florida; Montgomery County, Maryland; Hutchinson, Kansas; Canada, Sweden, and Australia. Currently, in over 2,400 jurisdictions across the United States, law enforcement jurisdictions are establishing CITs, and thousands of police officers are being trained along the lines of what you are about to read in the next few paragraphs (Addy & James, 2005; CIT International, 2014).

The Crisis Intervention Team (CIT) Program

Because budget constraints, economic factors, and social problems have generated enormous numbers of homeless people, dumped-onto-the-streets mental patients who formerly would have been hospitalized as inpatients, many more mentally disturbed people now come into contact with the general public than ever before. Consequently, the Memphis city government, the mental health community, and the police department realized that incidents of police involvement with the mentally ill had resulted in the mentally ill themselves being vulnerable to serious harm and the increased possibility of police officers, untrained in dealing with the mentally ill, getting seriously injured or even killed. Why can't mental health workers take care of the enormous numbers of emotionally out-of-control people on the streets? Because it is a physical and fiscal impossibility to put enough mental health workers onto the streets to monitor and serve the needs of these out-of-control people and to do so in accordance with the "least restrictive environment" movement in a democratic society.

Spearheaded by the local affiliate of the Alliance for the Mentally Ill, the Memphis Police Department, the mental health community, the city government, and the counselor education and social work departments of two local universities formed a unique and creative alliance for the purpose of developing and implementing proactive and preventive methods of containing emotionally explosive situations in the streets that frequently lead to violence. Because the police were the first and often the only responsible officials on the scene of an out-of-control situation, calling in outside consultants proved unworkable. Therefore, the unique and cohesive alliance of several important community groups determined that highly

trained and motivated police officers were the logical personnel to form a frontline defense against the crisis of dangerously expressive, out-of-control persons in the streets. This massive alliance effort resulted in the CIT program's becoming an example of how a successful program can work to accomplish the objectives of public safety and welfare, economic feasibility, and police accountability (James & Crews, 2014).

The Concept. To comprehend what a difficult and delicate task it has been to bring to fruition a successful and workable CIT program, one must understand how the alliance network functions. If your community does not have such a program, and you think it would be a good idea to get one started, read the following very carefully. The problem of the mentally ill, particularly the homeless mentally ill, is endemic and pervades all jurisdictions that attempt to establish CIT programs. Major Sam Cochran, who was the longtime coordinator of the Memphis CIT program and has been instrumental in helping disseminate the Memphis Model all over the country, puts it very well when he says, "It is not just a program to train police officers to deal with the mentally ill. It is a concept that brings all kinds of interest groups together in a network, and if that concept is not nourished, the program will fail."

The network behind the Memphis CIT program consists of the Memphis city government and the Memphis Police Department (hereafter just referred to as the police); the Alliance for the Mentally Ill; five of the six local community mental health centers; the emergency room components of public hospitals; academic educators from the Department of Counseling, Educational Psychology and Research at the University of Memphis and the School of Social Work at the University of Tennessee; the YWCA Abused Women's Services; the Sexual Assault Resource Center; and several private practice psychologists (hereafter referred to as the mental health community). The power, force, and success of the alliance derive from the process and fundamental working relationship that the police and mental health community have used to both form and maintain the CIT program. The alliance was formed because both the police and the mental health community realized that the problem of crisis in the streets was too severe for either to handle alone and that working together would make life much easier and safer for both as well as provide improved and safer service for clients and the community (James & Crews, 2014).

The alliance conducted a great many collaborative, systematic, and democratic meetings over a period of several months to hammer out a workable CIT blueprint. As a result of these meetings, key individuals from all segments of both police and the mental health community developed effective working relationships with one another and learned a great deal about each other's problems, competencies, rules, and boundaries.

Police were brought into mental health facilities for orientation into the world of mental health. Mental health personnel were brought into the police academy and accompanied police on patrols to learn about the problems, procedures, competencies, roles, and boundaries that law enforcement officers face in their everyday work. Then formal training was developed to ensure that not only the CIT officer selectees but also all supervisory-level police personnel understood the problems, objectives, and operational procedures of the CIT program (James, 1994, p. 187; James & Crews, 2014). The development and training phases provided some essential attitudinal and professional understanding between the police and the mental health community. As a result, CIT officers and their superiors know precisely what training and consultation resources the mental health community can provide. And the mental health professionals know what competencies and resources the police in general and the CIT officers in particular have to offer.

This model is not just about training cops, but developing collaborative efforts among police, the mental health community, and consumer advocates to provide first response mental health help to acutely ill individuals (Kasick & Bowling, 2013). Concomitantly, all sides develop mutual respect, understanding, trust, and cooperation. A CIT officer intervening with a distraught mental patient will likely listen empathically to the patient's feelings and concerns, be familiar with the mental health services available (will possibly know the patient's caseworker personally), and will, within the boundaries of professional ethics, communicate to the patient an understanding of the short-term needs of that person as well as a desire to provide for the immediate safety and referral requirements to contain and stabilize the patient's current crisis. The mental health center caseworker will also understand and have confidence in the CIT officer's ability to be a stabilizing and safe influence on the patient and will, if needed, likely call on the CIT officer for emergency assistance with a particular client. The mental health caseworker may collaborate

with the CIT officer in obtaining anecdotal information needed to enhance the patient's treatment plan and prevent the recurrence of that particular patient's crisis in the streets (James, 1994, p. 191). All of the foregoing happens with consumer advocates such as the local Alliance for the Mentally Ill playing a critical advisory role in the process.

Based on the trust and confidence built through the powerful and cohesive alliance just described, the police department opted to select experienced police patrol officers to receive training and then serve in the dual role of police officers and Crisis Intervention Team specialists. Volunteers for the program had to have good records as officers, pass personality tests for maturity and mental stability, and be recommended, interviewed, screened, and selected to receive CIT training. The police department committed itself to putting trained CIT officers on duty in every precinct in the city, 24 hours every day. All upper-echelon supervisory officers received formal orientation about the role and function of CIT officers so that whenever any call involving a suspected mentally disturbed person anywhere in the city is received, the CIT officer is the designated responsible law enforcement official at the scene—regardless of rank—and all other officers at the scene serve as backups to the CIT officer who handles the case (James, 1994, p. 194; James & Crews, 2014).

CIT Training Using Mental Health Experts and Providers. An integral part of the CIT program is the special preservice training provided for the officers. The importance of effective training by competent, committed, motivated professionals cannot be overemphasized. We also insist that they ride with experienced CIT officers on a Friday or Saturday evening shift prior to the scheduled training of each new group of CIT officers. As Erstling (2006) states, spending 8 hours in a patrol car together goes a long way toward learning to trust and understand one another.

The following topics are covered in the 40 hours of CIT training:

1. Cultural awareness of the mentally ill
2. Substance abuse and co-occurring disorders
3. Developmental disabilities
4. Treatment strategies and mental health resources
5. Patient rights, civil commitment, and legal aspects of crisis intervention
6. Suicide intervention
7. Using the mobile crisis team and community resources
8. Psychotropic medications and their side effects
9. Verbal defusing and de-escalating techniques
10. Borderline and other personality disorders
11. Family and consumer perspectives
12. Fishbowl discussion on-site with mentally ill patients on patient perceptions of the police

While most of these training components are in a lecture-discussion format, two are not. These two components are considered absolutely critical in the training of police officers who do crisis intervention with the mentally ill. They are verbal de-escalation and defusing, and the client fishbowl.

De-escalation and Defusing Techniques. Verbal de-escalation and defusing techniques are taught throughout the weeklong training. These skills are considered so critical that four different trainers are used for 12 hours of training. Basic introductory techniques are taught first. How do you introduce yourself? What is the nonverbal message you convey by your body posture and language? What voice tone do you use? These skills are taught on the second day of training.

Next come basic exploratory skills and establishing a relationship. Skills taught include (1) how and when to use open-ended and closed-ended questions, (2) what owning statements are and why they are important, (3) how to keep clients secure without cornering them (see Chapter 14, Violent Behavior in Institutions), (4) officer and client safety, (5) crowd control, (6) when and when not to use reflection of feelings or thinking, and (7) a summary recapping techniques and restatement for client and officer understanding and communication. These skills are taught on the third day of training.

The training is also greatly enhanced if it can skillfully integrate the conceptual with the experiential. Realistic role play, video technology, playback, and discussion are essential. On the fourth day, 4 hours of training are devoted to role plays of actual police–client encounters. Veteran CIT officers role-play clients. These officers bring many valuable first-hand experiences into the learning environment that heighten interest, enhance motivation, and provide realism (James, 1994, p. 187). Trainees are divided into teams of four, and each member of the team is given 4 minutes onstage to attempt to defuse and de-escalate the client. The rest of the trainees (there

are usually about 24–30) watch all of the teams perform and hear their critiques. The idea is that by watching others perform, trainees learn from the others' successes and failures. Scenarios range from clients with senile dementia to schizophrenics to diabetic psychosis to enraged jilted lovers. The role players escalate or de-escalate their violent behavior depending on how and what trainees do. Each team segment is videotaped, and after all four trainees have performed the videotape is played back, during which veteran CIT officers comment honestly and objectively on both positive and negative aspects of trainees' performance.

On the fifth day of training, complex CIT scenarios are demonstrated. All of the verbal skills used in preceding sessions are integrated to deal with very difficult clients. Such difficult scenarios as suicidal and severely psychotic clients are demonstrated, and then intervention techniques are broken down and analyzed as to appropriate and inappropriate responses. At the end of the week, trainees are in possession of the basic skills necessary to intervene with the mentally ill. Like most beginners, the new CIT officers are a little unsure of themselves. However, one of our most rewarding experiences in this business has been seeing these officers come back to aid in training, having developed some of the most outstanding crisis intervention skills we have seen in the 40-plus years we have been doing this work.

Fishbowls With Clients. Fishbowl discussions are unique and powerful sessions for CIT trainees. During this component of the training, trainees are brought into a mental health facility to meet in a discussion group circle with selected mental health patients. A mental health professional, who also serves as an instructor in the CIT training program, sits in the center of the circle with the patients surrounded by the CIT trainees. The professional engages in interviews and dialogues with the mental health patients, in the "fishbowl," so to speak. CIT trainees observe and hear what the mental patients have to say about their own personal needs and about their prior interactions, experiences, and perceptions of the police. After the fishbowl interview and dialogue, trainees who had been observing the professional–patient dialogue have an opportunity to ask questions and interact directly with the patients. The fishbowl discussion has been described by CIT trainees as profoundly motivational and an essential part of their learning, orientation, and training.

The Success of CIT. In more than two decades since its start in Memphis, CIT has grown exponentially, with training centers now located throughout the country and thousands of police officers trained in its protocols (Saunders, 2010). It is noteworthy that the CIT concept is now international, with its own newsletter and convention. *The Team News*, the newsletter of CIT International, is available at http://www.citinternational.org. CIT programs can now be found across the United States, Canada, Australia, and Sweden. But is there any evidence it really works?

In its first 16 months of operation in 1987–1988, Memphis CIT officers responded to 5,831 mental disturbance calls and transported 3,424 cases to mental health facilities without any patient fatalities. Both calls and transports have increased significantly over the 20-plus years the program has been in operation. This increase in "mental disturbance" service calls happens in other jurisdictions as well (Kisely et al., 2010; Teller et al., 2006) and is most likely attributable to increased awareness by the public of the CIT program. That increased awareness is particularly true of relatives and others responsible for the care and well-being of the mentally ill. Publication and support by the National Alliance on Mental Illness (2011) for CIT officers has led to the belief that caregivers' loved ones will be handled in a sensitive manner and not be killed or injured by the police.

Along with increased calls, there appears to be a reduction in the use of force, more diversion from jail to hospitals (Compton et al., 2014b; Lamb, Weinberger, & Gross, 2004; Ritter et al., 2011; Skeem & Bibeau, 2008), decreases in time spent on each call, and increased cooperation between mental health service providers and police (Kisely et al., 2010). In a comprehensive review of research outcomes, Compton and associates (2008) found that there was indeed a reduction in the use of force by CIT officers, more sensitivity toward the mentally ill with commensurate diversion instead of arrest, fewer officer injuries, and reduced hostage team callouts. In Memphis it is noteworthy that only two fatalities have occurred to a recipient of service by CIT officers during the more than 20 years the Memphis Police Department CIT has been in operation, and in both of those cases police officers were found to be justified in killing the person.

Suicide by Cop. Indeed, it is extremely significant that the death toll is so low when CIT officers make the scene. A fairly common phenomenon called "suicide by cop" has been well established. In essence,

LO4

people who do not quite have the courage to kill themselves engage in some activity that gains the attention of the police. Once the police arrive, they engage the police in a threatening manner and succeed in getting themselves shot. In short, the cops complete the suicide (Lindsay & Lester, 2004). We will speak to this phenomena more in Chapter 8, Crisis of Lethality. Police are highly aware of this dangerous phenomenon and are also very interested in learning how to handle it (Lindsay & Lester, 2004; Vermette, Pinals, & Applebaum, 2005). Indeed, the research suggests that tighter bonds and coordination between police and mental health providers such as occurs in CIT programs can reduce this phenomenon (Dewey, Allwood, Fava, Arias, Pinizzotto, & Schlesinger, 2013). At least in Memphis we believe the ability of the police to avoid helping complete this suicidal act and to reduce other mortalities is directly attributable to CIT training. Although no figures exist to determine how many persons have been injured while being taken into protective custody during the 20-plus years CIT has been in operation, statistics indicate that injuries to officers have been reduced significantly. Furthermore, barricade situations have also been reduced significantly. The advent of the CIT program has almost put the Memphis Police Department hostage negotiation team out of business because CIT officers arriving on the scene are often able to defuse and control the situation before the hostage team arrives (James, 1994, pp. 189–190).

Why is this so? A number of studies (Bonfine, Ritter, & Munetz, 2014; Compton et.al., 2006, 2014a; Ellis, 2014) have examined a number of variables of CIT officers immediately before and after undergoing CIT training. After training, those officers demonstrated much-improved attitudes, more support for treatment, more knowledge, less social distancing, more confidence in dealing with the mentally ill, and less stigmatization of them. In summary, besides their increased skill at defusing and de-escalating the violent mentally ill and emotionally disturbed, CIT police officers have become some of the most caring and concerned crisis workers the mentally ill have.

Transcrisis Handling in Long-Term Therapy

LO5

Clients in long-term therapy are not immune from crisis. Therapy tends to move in developmental stages with psychological troughs, crests, and plateaus. Even though clients have success in meeting therapeutic goals, each new stage brings with it what are seen in many instances to be even more formidable obstacles. The beginning therapist who has seen a client make excellent progress is often in for a rude awakening when the client's progress comes completely undone and behavior regresses to pretherapeutic functioning—or worse!

Anxiety Reactions

A puzzling aspect of therapy occurs when clients are highly successful in achieving tremendously difficult goals and then are completely undone by a task that to the objective observer does not seem all that difficult. Although it seems cognitively irrational, the fear of failure to achieve this minor goal becomes a self-fulfilling prophecy. The client fears that others will see through her or his sham of competence and irrationally thinks that any real progress is a delusion. At such times, clients engage in various types of flight behavior. Severe anxiety is one way of escaping the threatening situation. Consider Melanie's present dilemma. Melanie has escaped from an alcoholic marriage and subsequently completed 2 years of secretarial science at a community college, but she has fallen apart when faced with an interview for a job she desperately wants.

Melanie: (*extremely anxious and agitated, calling her therapist at 1 A.M.*) I hated to call you, but I'm so scared. I've thrown up twice, and I've got the shakes. This hasn't happened since I walked out on Bill over 3 years ago. God, I can't get a grip, and I need to do my best tomorrow. I know I'll just blow it. I can't think straight, and I can't remember a thing about interviewing. Everything's just running together.

The therapist puts Melanie at a 5 on the triage scale for cognitive and behavioral threat and a 6 for affective anxiety/fear. If the therapist does not help diminish the anxiety, the potential is that Melanie may move upward to 8–9 on these scales by the time she goes for her job interview.

TH: Just do this for a minute, Melanie. Take a deep breath, and let it out slo-o-owly. That's right! Now take another! OK, again. (*Continues in a patient, calm voice for about 2 minutes, taking Melanie through a brief deep-breathing exercise to calm her anxiety attack.*)

After the deep-breathing exercise, when Melanie has regained some semblance of control, the therapist paces with her through the role play they had conducted the previous session, has her write down her blunders and strong points, discusses those with her, determines that

her attack is receding, and assesses her as now being between a 2 and a 3 on the subscales. A quick review of the client's other successes reinforces and further buttresses the positive change in current functioning.

TH: Now notice the change in your voice. I'll bet you've also calmed down to where you aren't shaking. Did you notice how much more you're in control now? Remember what you're there for. Although a lot depends on this for you, you've also done even bigger, more threatening and scary things in your life like getting the hell out of that malignant marriage. Remember! You've become very good in secretarial science. They need you as much or more than you need them. I want you to put that up as a big signboard in your head, in Day-Glo pink: THEY NEED YOU JUST AS MUCH AS YOU NEED THEM!

By role-playing the scene, the therapist puts Melanie back on familiar ground and puts the problem back into context—getting a job as opposed to having a free-floating anxiety attack. By marshaling the client's resources and very specifically and objectively reminding her of what her strengths are, the therapist concretizes the vague dread she feels at having to face the interview. The therapist's exhortation about who needs whom is not placating here. It is realistic. Melanie's ego needs to be reminded of these facts so that she will have a positive mental set toward both her personhood and her skills as she enters the interview. Finally, the therapist offers her the opportunity to have a safety net.

TH: Melanie, I think you're ready to get some sleep and go knock their socks off tomorrow. However, if you wake up tomorrow morning and really have some questions or think you need to role-play that interview once more, give me a call. I've got some free time before your interview, and we can go over it once more. Now go to bed, get some sleep, and dream about that Day-Glo pink billboard.

By leaving her with a positive injunction and making time for her the next day, the therapist continues to provide a support system and a security net for Melanie.

Regression

The risk of taking the next step in therapeutic development may become too overwhelming even though clients have been highly successful in attaining prior goals. When clients are overwhelmed, they may regress in their behavior, retreating to maladaptive but familiar ways of behaving, feeling, and thinking (Stewart, 2012).

Melanie: (*somewhat embarrassed and mumbling in a childlike voice*) I know what you're going to say, but I was thinking I really couldn't cut this, and Bill made that offer even after I got him arrested that he still loved me and was getting help, and I know he doesn't drink much anymore.

TH: (*interpreting the dynamics*) What you're really saying is the prospect of that interview is scaring the hell out of you, and it's so scary that you'd give up 3 years of hard work and sacrifice to go back to a really lousy, not to mention dangerous, way of living, when you're about to get the gold ring. I'm wondering why you've decided to sabotage yourself now.

By interpreting the dependency needs of the client, the therapist welds regressive thinking to the current threat of becoming independent as manifested in the job interview. Although the client's behavior and affect are not blatant, she is moving insidiously higher on the triage cognitive loss subscale. Left alone, that negative self-talk could convince the client to give up her new self-identity and go back to the long-dead and dangerous marriage.

Melanie: Oh, I just knew you'd say that, but I'm not sure I can do this. I mean a big outfit like United Techtronic.

TH: (*in a cool, clear, no-nonsense, but not condemning, voice*) Big or small, United Techtronic is not the question. The question is, Are you going to choose to blow this before you even see if you can cut it? That's one way of never finding out if you're good enough. You can make that choice, although you've now been making a different one for 3 years. I'd hope you wouldn't do that—I believe you are good enough—but then, it's your choice.

This reality-based approach directly confronts the client with the underlying and unwarranted irrational decision she is about to make and vividly points out how she is trying to delude herself into buying back into a dependent status and revictimizing herself.

Problems of Termination

When clients have met their goals for therapy, are fully functioning, and are ready to get back to the business of living their own lives, they may suddenly produce terrible problems that only their therapist can solve. Whatever these problems are, it is an excellent bet that they have been told that it's time to terminate,

or they have figured out that termination is about to happen. At such times it is a common occurrence for dependency issues to arise. These problems generally can be resolved by successively approximating the client to termination. For example, instead of every week, the therapist schedules the client every 2 weeks, then once a month, and then for a 6-month follow-up. The other option is to clearly discuss the possibility that this issue will arise.

TH: Melanie, I think it's time we discussed your spreading your wings and flying away from here. You landed that job and . . .

Melanie: (*interrupts*) But I couldn't have done that without you. You give me the courage to try those things. You've been so wonderful. I just couldn't have done any of this without you. And there's still the problem with the kids and . . .

TH: (*gently interrupting*) I appreciate those compliments. They mean a lot to me. Yet although we've worked together on those things, it's been you who's done it, not I. What I want to talk about with you now is some of those fears and really being on your own, like what you just said. That's pretty normal to have those feelings; lots of people do. Sort of like when you left home the first time. I want you to know I'll be here if you need me, but I want you also to know that I think it's time for you to be on your own. I'd like to discuss this with you in today's session.

Crisis in the Therapy Session

One of the scariest times for a therapist occurs when a technique has done its job exceedingly well, and the client gains insight or release from a deeply buried traumatic experience—and then completely loses control. This unexpected turn of events can unsettle the most experienced therapist. As this wellspring of affect emerges, it may go far beyond cathartic insight and leave the client in a severe state of disequilibrium.

At this point it is absolutely mandatory to stay in control of the situation and take a firm and directive stance, no matter how frightening the client's actions or how personally repulsive the uncovered material may be. Our own admonition to students is, "You may feel physically sick, start to break out in a sweat, and wish to be anyplace else but in that room. After the session is over, you can have a world-class anxiety attack if you wish—you probably deserve it—but right now you are the therapist, and you are going to stick with the client." By demonstrating cool levelheadedness to the client, the therapist is modeling behavior that the client can emulate.

TH: I'm just wondering if the reason you ever got into that abusive marriage is that sometimes your father might have abused your mother, and that's what was modeled as the way a marriage ought to be.

Melanie: (*recoils in a shocked state*) He never did have intercourse with me.

TH: (*taken aback*) I'm not quite sure what you said— "intercourse"?

Melanie: (*breaking down and sobbing*) For 12 years that bastard would mess with me and my sister, and Momma knew. She knew and wouldn't do anything about it. (*completely breaks down*) I . . . God . . . he beat us if we didn't do . . . he'd make us masturbate him . . . oh Lord . . . how could he . . . I've kept this secret . . . I can't handle this. I should have done something . . . killed him . . . (*uncontrolled and wracked sobbing and shaking*).

TH: (*recomposing herself and gently touching Melanie's arm and quietly talking in a consoling and affirming voice*) I am truly sorry for uncovering that old wound, but you *can* handle it. You've finally got it out. You lived with that hell as a child and another hell as an adult. You are a survivor.

Psychotic Breaks

Staying calm and cool is even more important when a person is having a psychotic break with reality. No matter how delusional or dissociative the client becomes, the central thesis is that the client can maintain contact with reality and take constructive action.

Manuel: (*walks into the therapist's office unannounced and unknown*) I need help, and they recommend you. But no telephones, they listen to me through the telephone. (*Picks up the telephone in a threatening manner.*)

TH: (*in a slow, even voice*) I need for you to put that telephone down before we go any further. I will help you, but I want you to put the telephone back on the stand. We've never had the pleasure of meeting. What is your name?

Manuel: It's Manuel. (*hesitates*) I'm just coming apart. They won't leave me alone.

TH: I understand that, but I need you to put the phone down and keep it together, so you can tell me who's after you. Go ahead and sit down and tell me what's bothering you.

Manuel: It's my supervisor. He wants to fire me and catch me stealing, so he listens in on my phone conversations. He's in league with Satan, and he's probably in this room. I can smell the brimstone. (*Starts to become agitated and mumble about Hell.*)

TH: (*calmly but in an assertive voice*) OK! You're having trouble with your supervisor. Now we're getting somewhere. That's good, but stay with me, I personally guarantee Satan is not here. I want to know about your supervisor and how long this has been going on. I also want to get you to a safe place where nobody can hurt you, but to do that I need your help, and I need you to stay in contact, so I can help you.

Manuel: OK. (*Sits down and starts to talk about his supervisor.*)

The therapist immediately seeks to establish contact by obtaining the client's name, while at the same time establishing ground rules for conduct in the therapist's office. When the young man starts to dissociate and talk incoherently, the therapist directively seeks to keep Manuel in contact with reality by focusing discussion on his grievance with his supervisor. While he validates the client's fear, the only acknowledgment he gives to evil spirits is his concern for the client's safety. The therapist reinforces the client for staying in contact with him and repeats his request to put the telephone down. Because psychotic clients may have difficulty hearing others because of the intrusive hallucinations assailing them, the therapist slowly and clearly repeats his requests for compliance. By staying in control, the therapist turns a potentially violent situation with an unknown client into a satisfactory resolution.

People With Borderline Personality Disorder

LO6

Most clients try to manipulate their therapists during the course of therapy for a variety of reasons. These reasons may range from avoiding engagement in new behaviors to testing the therapist's credibility. Clients with personality disorders are the ultimate test of the therapist's ability to handle manipulative behavior, and can create severe crises for themselves and the therapist if not dealt with in very specific ways (Kocmur & Zavasnik, 1993). In 1938, Adolph Stern, an American psychotherapist, described a group of clients who did not respond well to treatment and in fact generally got worse. He labeled them as a "borderline group" that lay somewhere between neurosis and psychosis (Stern, 1938). While that notion is no longer deemed valid (Paris, 2008, p. 3), no one has yet come up with a better way to describe clients who have some of the most intractable, stubborn character pathology imaginable and has been named borderline personality disorder (BPD). Current estimates are that about 2.7% of the adult population in the United States are candidates for a BPD diagnoses and also are likely to have co-occurring mood, anxiety, and substance abuse disorders (Tomko, Trull, Wood, & Sher, 2014).

Personality implies stable and enduring patterns of thinking, feeling, and acting across time and situation (Reyes, Elhai, & Ford, 2008). The borderline personality is the antithesis of that construct, and this particular disorder of personality is a handmaiden to many of the crises in this book—particularly if the traumatic event occurred during childhood (Zanarini, 2000). Indeed, a whole field of therapy called **mentalization** (Bateman & Fognagy, 2006; Kvarstein et al., 2015) has developed that specifically targets trauma in childhood and lack of attachment to significant positive parenting figures as a major precursor to "getting" BPD.

Probably the best way to describe this disorder is through the title of Kreisman and Straus's (2010) classic book for people attempting to live and deal with borderline personalities: *I Hate You—Don't Leave Me*. There is good reason for this ambivalence. Indeed, there is a good deal of evidence that many individuals with borderline personality disorder have had a rogues' gallery of childhood horrors of physical and sexual abuse and long-term parental neglect (Allen, 2001; Brown, 2009; Herman, Perry, & van der Kolk, 1989; Sroufe et al., 2005; Stalker & Davies, 1995). The rate of childhood sexual assault has been estimated to be a staggering 75% in people with borderline personality disorder (Battle et al., 2004). As a result, they are likely candidates for what many practitioners and researchers refer to as "complex PTSD" (Briere & Scott, 2006; Courtois & Ford, 2009), a concept we will examine in Chapter 7, Posttraumatic Stress Disorder, and Chapter 9, Sexual Assault. So while they are tough customers and can be extremely trying, there are some pretty good reasons that persons with borderline diagnoses act the way they do and are the hallmark of the client who is in transcrisis. Because of these early experiences with trusted others who could not be trusted, the borderline personality has

serious attachment problems that can rapidly surface in therapy. There is evidence that these individuals also harbor a deep sense of betrayal (Kaehler & Freyd, 2009). As you can readily see, there is good reason for this mistrust, sense of betrayal, and thus the constant vigilance, testing of the relationship, and paranoia that mark therapy with these individuals.

All-pro, all-star, and all-world therapists have trouble dealing with these individuals, so why in the world are we exposing you rookies to them? First of all, they provide a good example of how manipulative clients can work you over and lead you into being a case example in our chapter on burnout. More important perhaps, they are clients you will run into that manifest many of the crises in this book. Among other maladies, they abuse drugs, become violent, are suicidal, are sexually promiscuous, practice self-mutilation, get raped, have PTSD, and on and on, so here is a snapshot of a client who can blindside you if you are not careful. The saying goes that "You haven't won your spurs as a therapist until you have dealt with a person with BPD."

The borderline personality type in therapy is an open Pandora's box of crises, in terms of the presenting problems and issues that occur in therapy, as graphically described by numerous researchers, therapists, and family members (Bagge et al., 2004; Beck & Freeman, 1990; Belling, Bozzatello, De Grandi, & Bogetto, 2014; Borschmann et al., 2013; Borschmann & Moran, 2011; Brockian, 2002; Chatham, 1989; Drapeau & Perry, 2004; Fonagy, Luyten, & Strathearn, 2011; Freidel, 2004; Jimenez, 2013; Kreisman & Straus, 2004; Kroger, Roepke, & Kliem, 2014; Lachkar, 2011; Lawrence, Allen, & Chanen, 2011; Leichsenring et al., 2011; Paris, 2008; Sansone, Chu, & Wiederman, 2011; Wirth-Cauchon, 2001; Zeigler-Hill & Abraham, 2006) and summarized below.

Presenting Problems. People with borderline personality disorder have problems like no other client has. They include the following in therapy:

1. A wide variety of presenting problems that may shift from day to day and week to week
2. Unusual combinations of symptoms ranging across a wide array of neurotic to subpsychotic behaviors
3. Continuous self-destructive and self-punitive behavior ranging from self-mutilation to suicide attempts
4. Impulsive and poorly planned behavior that shifts through infantile, narcissistic, or antisocial behavior
5. Intense emotional reactions out of all proportion to the situation
6. Confusion regarding goals, priorities, feelings, sexual orientation, and so on
7. A constant feeling of emptiness with chronic free-floating anxiety
8. Unstable low self-esteem and high and unstable negative affect
9. Poor academic, work, and social adjustment
10. Extreme approach and avoidance behavior to social relationships
11. Chronic suicidal and/or homicidal ideation
12. Paranoid ideation
13. Depersonalization and hallucinations
14. Drug abuse including alcohol
15. Sexual promiscuity and sexual victimization
16. High dropout rate from therapy and poor therapeutic alliance

Therapeutic Relationship. People with borderline personality disorder do everything in their power to turn the therapeutic relationship upside down. They have:

1. Frequent crises such as suicide threats, abuse of drugs, sexual acting out, financial irresponsibility, and problems with the law.
2. Extreme or frequent misinterpretations of the therapist's statements, intentions, or feelings with strong transference issues that can illicit even stronger countertransference issues in the therapist.
3. Unusually strong, negative, acting-out reactions to changes in appointment time, room changes, vacations, fees, or termination in therapy.
4. Low tolerance for direct eye contact, physical contact, or close proximity in therapy.
5. Unusually strong ambivalence on issues.
6. Fear of and resistance to change with inability or resistance to carry out therapeutic assignments.
7. Frequent phone calls to, spying on, and demands for special attention and treatment from the therapist.
8. Inordinate hypersensitivity to significant others including the therapist.

People with borderline personality disorder vacillate between autonomy and dependence, view the world in black-and-white terms, are ever vigilant for perceived danger, have chronic tension and anxiety, are guarded in their interpersonal relationships, and are uncomfortable with emotions (Beck & Freeman, 1990, pp. 186–187; Lachkar, 2011; Linehand, 1993; Paris, 2008). Because of these personality traits, they are apt to continuously

test the therapeutic relationship to affirm that the therapist, like everybody else, is untrustworthy and not capable of living up to their expectations, while at the same time they desperately crave attention, love, and respect (Brockian, 2002; Freidel, 2004; Kreisman & Straus, 2004; Lachkar, 2011; Linehand, 1993; McHenry, 1994; Paris, 2008; Yeomans, 1993). Do you start to get the picture of why they can become psychological albatrosses around therapists' necks?

When dealing with someone with borderline personality disorder, it is important to set clear limits, structure specific therapeutic goals, provide empathic support, validate the client's actions as understandable, model a safe environment, caringly confront manipulative and maladaptive behavior, and rigorously stick with these guiding principles (Briere & Scott, 2006; Chatham, 1989; Kreisman & Straus, 2004; Lachkar, 2011; Linehand, 1993; Paris, 2008). This is easier said than done because of the dramatic kinds of problems and emotions that these people display. The following dialogue with Tommy, a college student, depicts such problematic behavior.

Tommy: (*calling the therapist at 2 A.M.*) I can't take this any longer. Nobody cares about me. I think I'm going crazy again—all these weird voices keep coming into my mind. It'd just be easier if I got a gun and blew myself away.

TH: I can understand the belief that nobody cares about you, considering how you were put in foster care as a kid and how that uncaring attitude of others seems to follow you wherever you go. If that's the case that those abandonment fears are driving you to this point, then I'm concerned enough about your welfare to call 911 and get the police there immediately to take you to the hospital. (*Wise in the ways of people with borderline personality disorder, the therapist immediately confronts Tommy's statement while validating his fears.*) If things are that serious, a phone conversation won't get the job done.

Tommy: Well, I didn't say I was going to kill myself right now! You always jump to conclusions. I just couldn't sleep or study because of all these voices, and I really need to talk about them.

TH: I'm willing to talk for 15 minutes, but if I don't see you calmed down and functional by that time, I'll feel warranted in calling 911.

Setting limits and monitoring client safety is critical (Kreisman & Straus, 2004; Paris, 2008). By voicing legitimate concerns about the client's safety and setting a specific time limit on the conversation, the therapist reaffirms therapeutic control and does not become engaged in a rambling dialogue. The latter would serve nothing other than to reinforce maladaptive client behavior and cause a sleepless therapist to be angry and irritable the next day! No special considerations other than those normally given to any other clients should be given to those with borderline personality disorder.

Tommy: But Dr. James, I really need to change the appointment and see you tomorrow. I've got this research presentation, and my group's meeting during our appointment time. Can't you move somebody else around?

TH: I have an appointment with another client at that time, Tommy. As I told you, to reschedule I need to know 48 hours in advance. It wouldn't be fair to him anymore than it would be fair to you if I did that to your regular time.

Tommy: (*sarcastically*) You just really don't give a damn about me, do you?

TH: The fact is, I do give a damn, and that's why I'm not going to cave in and change the appointment time. We're not talking about rejection here; we're talking about a reasonable policy that I use on everybody. I know lots of times it would be easy for you to believe I'm blowing you off. At times you certainly aren't the easiest client to deal with, but I knew that going in, and I committed to see this through with you. I'll expect you at our regular Thursday time.

The therapist owns both his positive and his negative feelings about the client and directly interprets and confronts the client's underlying fear of rejection (Chatham, 1989). Finally, by reminding the client of his regular appointment, the therapist targets behavior rather than affect. Focusing on behavior is far less problematic than dealing with relational issues, either inside or outside therapy, because of the client's low tolerance for intimacy (Beck & Freeman, 1990; Drapeau & Perry, 2004; Freidel, 2004).

Treatment noncompliance is par for the course with clients with borderline personality disorder.

TH: So how did your assignment go in thought stopping and not arbitrarily categorizing women as saints or prostitutes?

Tommy: Well, I was real busy this week. Besides which, you didn't really make that thought stopping stuff very clear. And then the rubber band reminder on my wrist broke.

TH: (*frustrated, voice raised, and becoming agitated*) This is the sixth week I've gone through this with you. You continuously put women in those one-up or one-down positions. Yet you continuously complain that no females are interested in you. How do you ever expect to have an equitable relationship unless you change your thinking?

Tommy: (*flushed and shouting*) Oh yeah? You're so perfect? I'll bet your supervisor would like to know the way you verbally harass your clients. Screw you! Who needs therapy or bitches, anyway? They're all sluts anyway. (*Storms out of the room and slams the door.*)

Maintaining professional detachment and keeping one's cool are critical and difficult (Kreisman & Straus, 2004). The therapist's frustration may turn to anger if the therapist ascribes malicious intentions to the client's nonperformance, particularly when trying to change the client's black-and-white thinking. Overt frustration often results in reciprocal acting out by the client. The client's passive noncompliance is a balancing act between fear of change and fear of offending the therapist through outright refusal to comply with therapeutic requests. When noncompliance is consistently the normative response, the therapist needs to step back from the situation, seek outside consultation, confront these issues openly, and acknowledge freely the client's right to refuse an assignment rather than doggedly proceeding (Beck & Freeman, 1990).

TH: Tommy, I feel really frustrated right now. We've been going at this one assignment for six sessions. Maybe I'm the problem—pushing too fast. On the other hand, I feel you maybe don't want to make me disappointed, so you go through the motions. You've always got the right to say no to an assignment, and we can certainly discuss the pros and cons of that. What do you want to do about this assignment?

A favorite ploy of people with borderline personality disorder and other dependent types of clients is to externalize and project their problems onto others. They then attempt to get the therapist to intercede for them by acting as an intermediary or otherwise "fixing" the problem.

Tommy: If you could just write my econ professor a note telling him I'm under your care. I've only missed five classes, and he's threatening to flunk me.

TH: School and therapy are separate, and I won't get into that.

Tommy: (*whining and pleading*) But you know how bad off I've been.

TH: If you are sick enough to miss class, perhaps you should consider an academic withdrawal for medical reasons.

Tommy: Well, I'm not that bad off that I need to quit school.

TH: How has getting others to make excuses for you helped in the past?

In refusing to be used by the client, the therapist avoids a pitfall that would invariably lead to more dependent behavior and the continuation of cyclical, self-reinforcing, dependent, and manipulative behavior. Finally, the watchword with people with borderline personality disorders and other clients who consciously or unconsciously seek to manipulate the therapist is: Remain calm throughout therapy, and do not respond to each new crisis as an emergency. The key question therapists must ask themselves is, "Who's doing the majority of work here?" If the answer is, "Not the client!" then there is a good chance the therapist is being manipulated.

Counseling Difficult Clients

Crisis workers must be prepared to deal with LO7 many different types of clients, some of whom are "difficult." To assist in coping with such clients, here are some examples of appropriate ground rules as well as suggestions for confronting difficult clients.

Ground Rules for Counseling Difficult Clients

Workers who must deal with difficult clients regularly may wish to print a set of ground rules to place in the hands of clients at the initial session or before the first meeting. The following rules may be used with individuals, couples, or groups:

1. We start on time and quit on time. If couples are involved, both parties must be present; we will not meet unless both parties are present.
2. There will be no physical violence or threats of violence.
3. Everyone speaks for himself or herself.
4. Everyone has a chance to be fully heard.
5. We deal mainly with the here and now; we try to steer clear of getting bogged down in the past and in blaming others.
6. Everyone faces all the issues brought up—nobody gets up and leaves just because the topic is

uncomfortable, and everyone stays for the entire session.
7. Everyone gets an opportunity to define the current problems, suggest realistic solutions, and make at least one commitment to do something positive. At least one positive action step is desired from each person present.
8. Limits to graphic descriptions, abusive language, and swearing and cursing need to be clear as to what will and will not be tolerated.
9. Everyone belongs, because he or she is a human being and because he or she is here.
10. The crisis worker will not take sides.
11. There will be no retribution, retaliation, or grudges over what is said in the session. Whatever is said in the session belongs and stays in the session.
12. The time we spend together is for working on the concerns of the person or people in the group—not for playing games, making personal points, diversion, ulterior purposes, or carrying tales or gossip outside the session.
13. When we know things are a certain way, we will not pretend they are another way—we will confront and deal with each other as honestly and objectively as we possibly can.
14. We will not ignore the nonverbal or body messages that are emitted—we will deal with them openly if they occur.
15. If words or messages need to be expressed to clear the air, we will say them either directly or with role playing—we will not put them off until later.
16. We will not expect each other to be perfect.
17. Being drunk or otherwise drug intoxicated is not acceptable in therapy. We do not work with "wet" clients.
18. In the event the ground rules are broken, the consequences will be discussed by the persons involved immediately with the crisis worker. People who comply with the rules will not be denied services because one person disobeys the rules.

The crisis worker may go over the ground rules, in person or over the phone, before the first session. If this is not possible, a brief orientation that includes the ground rules is advisable at the start of the first meeting.

Confronting Difficult Clients

In dealing with difficult clients, the worker may have to *confront* such behavior directly. We must be able and ready to use confrontation, assertion, and directive tactics, such as saying, "I will not permit you to violate our ground rules by attacking her that way." There is a possibility that a client may be so difficult that the session may have to be terminated. (This should happen very, very infrequently.) In such a rare case, the worker would openly admit, "We're getting nowhere, so let's adjourn and see if we can figure out a way to try again." Consultation with a professional colleague for suggestions would be one of the first steps the therapist would take after such an adjournment.

Confidentiality in Case Handling

One benchmark of crisis is the dramatic onset of potentially violent behavior. Although we deal extensively with the control and containment of such behavior in Chapter 14, a particular admonition to the crisis interventionist is appropriate here in discussing case handling. That admonition involves the issues of confidentiality and privileged communication, and the legal and moral dilemmas that swirl within many crisis settings will be discussed in Chapter 15, Ethical and Legal Issues for Crisis Intervention.

SUMMARY

Case handling in crisis intervention differs from long-term therapy. Although crisis intervention deals with many of the same components as long-term therapy, crisis work can be differentiated by its emphasis on expediency and efficiency in attempting to stabilize maladaptive client functioning, as opposed to fundamental restructuring of the client's personality. Case handling in crisis intervention emphasizes concern for client safety, brevity in assessment, rapid intervention, compressed treatment time, and termination or referral once equilibrium has been restored. Case handling in crisis intervention can occur both at walk-in facilities and in long-term therapy settings.

Since the Community Mental Health Act of 1963, the major responsibility for treating the mentally ill has fallen on community mental health centers. Such

centers, along with a wide variety of other community social services agencies, are on the front lines in dealing with crises of chronic mental illness, severe developmental problems, and social and environmental issues that afflict individuals. Because of the wide variety of clientele seeking services, walk-in facilities must have close linkages with other social services agencies, the legal system, and both short-term and long-term mental health facilities. Mental health workers who staff such facilities must have a broad background in dealing with a wide variety of psychological problems and be ready and able to deal with whatever crisis walks in the door.

Because of the consequences of the Community Mental Health Act of 1963, police departments have assumed greater and greater responsibility for initial contact and disposition of the mentally ill. Creation of the Memphis Model of the Crisis Intervention Team (CIT) has resulted in the development and use of regular patrol officers to defuse and de-escalate the mentally ill and other emotionally violent clients. Variations of this model are now in use throughout the United States.

Clients in long-term therapy may also experience crises as they move through the therapeutic process. These crises may be instigated by situational events in the client's environment; by attempts to engage in new, more adaptive behaviors; or by past traumatic material that is uncovered in the therapy session. When such crises occur, therapy may degenerate to the point that clients undergo severe traumatic stress and revert to pretherapeutic functioning levels. At these points in therapy, long-term work must be suspended, and the therapist must concentrate on the emergent crisis until the client has achieved success in overcoming the current stumbling block. The borderline personality disorder is probably the archetype of difficult and crisis-prone clients with which the therapist will work in long-term therapy.