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Medical Crisis Counseling: A New Service Delivery Model

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The diagnosis or exacerbation of a chronic illness, the aftermath of a serious accident, or worries about future in the context of illness or debilitating injury are all examples of medical crises that pose significant coping challenges. Too often, traditional approaches to psychotherapy have been unable to respond the most urgent needs of people confronting such crises. Medical crisis counseling is a specialized approach to addressing the needs of individuals and families confronted by the difficulties of coping with losses or changes, as well as the challenge of living with long-term illness. This paper describes the medical crisis counseling model in contrast with other more traditional intervention approaches.

KEY WORDS: crisis counseling; health psychology; medical illness; family health.

INTRODUCTION

Ten days following a drowning accident Mary Williams' 6 year-old child is unconscious and ventilator-dependent on a pediatric intensive care unit. She enters a psychiatrists office and explains that she and her husband have stopped talking, and she is suffering from insomnia and migraine headaches, as well as feeling depressed an anxious. Without saying a word, the physician reaches for a prescription pad. Mrs. Williams leaves the office thirty minutes later with four prescriptions (i.e., Halcion, Percocet, Elavil, and Xanax). She thinks to herself, "This is enough medicine to kill myself."

Alberto Sanchez is intensely proud of his accomplishments. There were times, while he was growing up in Spanish Harlem, that he doubted he would ever attain

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his goal of becoming a lawyer. Now, just 5 years after graduation at the top of his class from a first-rate law school, he has been made a partner in a well-regarded firm and is the doting parent of 4-year-old twin boys. On awakening one morning, he experiences a loss of feelings in his hands and feet, along with tingling sensations in his arms and strange sensations in his tongue. In the context of an otherwise rewarding life, the diagnosis of multiple sclerosis came as a severe emotional jolt. Alberto has never been one to share his worries, and although he was given the diagnosis 3 weeks ago, he has not yet told his wife about it or shared his fears that his abilities as a wage-earner are threatened. The neurologist who made the diagnosis is rather taciturn and Mr. Sanchez has not dared to ask him more about what he can expect regarding the course of the illness. He knows only that he has been feeling exhausted and unable to keep up with the pace and demands he has set for himself. Finally, he takes a big step and makes an appointment on his own to talk to a psychologist, Dr. Jones, about these concerns. After listening for a while the clinician tells Mr. Sanchez, "We need to talk more about your childhood and explore the source of your self-defeating emotional withholding behavior and communication problems."

Although the names are different, the experiences of Mary and Alberto are all too real and too common. Traditional models of psychotherapy and medical training have not prepared clinicians to meet the needs of people caught up in the maelstrom of a medical crisis. The usual training of psychotherapists and physicians involves a heavy component of human psychopathology taught from a framework that is inevitably reductionistic in focus. The student-therapist is taught to conduct an assessment, identify the problem behaviors, and break them into component parts. In many ways the source of the problem is viewed as though it were the heart of an artichoke or onion, buried beneath layers to be slowly peeled back and stripped away in quest of some inner kernel of emotional conflict to be interpreted or altered.

Such strategies are of little help to the 37 million Americans living with arthritis, 14 million coping with diabetes, 6 million with a history of heart disease, more than a million with new cases of cancer diagnosed each year, and over 250,000 under treatment for multiple sclerosis and renal failure, not to mention those dealing with other equally serious but less prevalent illnesses such as AIDS, asthma, cystic fibrosis, emphysema, lupus, and sickle cell disease.

Medical crisis counseling (Pollin with Golant, 1994; Pollin with Kinaan, 1995) is based on an integrative theoretical approach that focuses on the manner in which chronic illness disrupts normal developmental tasks and trajectories. The intervention involves the use of cognitive coping strategies, enhancement of social support, and basic concepts of several therapeutic systems including self-psychology, along with behavioral, client-centered, and rational-emotive elements.

The fundamental ideas of crisis theory have been expounded in classic terms by scholars such as Lindemann (1944), Erikson (1963), Caplan

(1964), and Moos (1977). Lindemann articulately described the process of grief and mourning following a disastrous nightclub fire. He focused on the positive role community caretakers could play in helping the bereaved to adapt and cope with the loss of loved ones. Erikson's well-known work focused on developmental "crises" across the life span, illustrating transition points that provide critical opportunities for growth or failure experiences. Caplan went on to develop a general formulation of crisis theory, and Moos pulled together one of the earliest sets of edited papers to focus on the application of assorted psychosocial approaches to facilitate coping with medical conditions. Many other edited volumes of this sort have followed (e.g., Turk & Kerns, 1985; Rosen & Solomon, 1985; Akamatsu, Stephens, Hobfoll, & Crowther, 1992), tracing varieties of coping problems and psychosocial intervention strategies across illness categories and life-span intervals.

Regrettably, few of the existing models of psychosocial intervention with medical patients have involved a focal short-term approach. Most describe open-ended global approaches or focus narrowly on particular symptoms or behaviors (e.g., nonadherence). Few of the existing models focus on the integration of psychosocial intervention with the delivery of medical care. In contrast, Pollin's model of medical crisis counseling (1994, 1995) delineates a systematic approach that is both highly focused and of limited duration. This approach has several particular advantages. First, the patient is not presumed to suffer from psychopathology and is not asked to make an open-ended commitment to psychotherapy. Second, the patient's concerns become the primary focus of the intervention. Third, a systematic, pragmatic, problem-solving approach assures that key issues related to the patient's coping with the illness will be explored and addressed. Finally, linkages with the health care delivery system assure that psychosocial intervention interfaces with medical care for the patient's benefit.

This approach to psychotherapy is focused on both symptom relief and prevention. In this approach the therapist is not seeking basic character change, focusing on psychopathology, or needing to be present as the patient makes changes and progress. The treatment is not regarded as an intrinsic good to be maintained for its own sake. The therapist does not see therapy as the most important part of the patient's life (Budman & Gurman, 1988) but, rather, sees the patient's functioning in the world as most important. The overall goal is seeking pragmatic change that emphasizes the patient's own strengths and builds on these, so that the patient can continue to make personal gains on his/her own "after therapy." When patients are successfully engaged in active problem-solving strategies, they continue to progress even after therapy has formally ended.

WHAT IS A CRISIS?

A medical crisis is certainly defined in the mind of the patient and the patient's family members. However, it is possible to identify a number of stress points in the natural course of a chronic illness that qualify as a crisis in the sense that an adaptive response is necessitated. The diagnosis of a chronic illness, an exacerbation or significant loss of function, a troubling or disfiguring side effect, a hospital discharge, elective cessation of treatment, and anniversary phenomena are all examples. In the case of many illnesses, adjustment crises are predictable.

For example, a cancer patient has completed 18 months of noxious chemotherapy and is advised by her oncologist that treatment can now be electively stopped. The patient should feel great relief, right? Many patients do, but others carry a strong measure residual anxiety, thinking, "I'm glad to be off treatment, but while I was on, the malignancy was kept at bay. Will it come back now that my treatments have ended?"

Another patient recalls that an exacerbation of his muscular sclerosis occurred just before Christmas. Although his condition is now stable, he finds a foreboding anxiety rising inside him after the Thanksgiving holiday that seems to build in intensity as Christmas approaches. Such anniversary phenomena are not at all uncommon when a season or other recurring event is associated with a medical crisis.

BASIC STRATEGIES

Although the crises are temporary, they offer opportunities for learning about coping. The intervention is focused on providing an adaptive structure within which to address the stressors that accompany the medical crisis. The central core of the intervention focuses on the eight fears or concerns, summarized in Table I, that are nearly always of concern to patients in such circumstances.

These fears often emerge in sequence, but the order may vary as a function of the individual's personality, his/her life circumstances, the particular illness, and other similar factors. Several fears may manifest themselves simultaneously. Some may be addressed early in treatment, only to reemerge as intensely stressful issues soon afterward. Confrontation of the issues raised by each fear present coping challenges that can be immobilizing, disrupt interpersonal relationships, and impair communication with medical care providers. Symptoms of depression, social withdrawal, and anxiety may result. In some approaches to treatment, the therapist will wait passively for such fears to emerge and then seek

Table I. Eight Fears Nearly Always of Concern to Individuals Dealing with a Medical Crisis

Fear of loss of control
Fear of loss of self-image
Fear of dependency
Fear of stigma
Fear of abandonment
Fear of expressing anger
Fear of isolation
Fear of death

to explore them in depth, seeking insight into their origins The therapist in the medical crisis counseling model will more often be guided by a strategy for eliciting expressions of these fears in assisting the patient to take charge of initiating steps toward their resolution.

THE UNIT OF TREATMENT

The focus of treatment will generally be individual adult or adolescent medical patients, because mobilization of personal coping resources is central to the intervention. However, there are times when the involvement of spouses, parents, adult children, or other sources of social support (or tensions) may be brought into the session with the patient's permission. In the case of child clients, parents or other caretakers will invariably be drawn into the intervention at appropriate times in order to advance and maintain the patient's progress. The unit of treatment may therefore be a couple, a family, a set of parents, a parent–child dyad, or an individual patient, depending on the clinical need and family circumstances.

Initial consultations will generally involve the individual patient, unless a child is the medical patient. In such cases the parents will generally be interviewed first to assure their consent and cooperation with the intervention. At some points during the intervention, involvement of siblings may be warranted. Attention should be given to resolving obstacles to patients' coping, with a flexible approach that involves people significant to the patient at appropriate times during the intervention.

THE THERAPIST'S INTENDED ROLE

The therapist's role is that of a facilitator, problem-solver, health educator, and coach to the patient. Empathic listening and helping the patient to frame his/her concerns are the central role, although the therapist must also be prepared to assume an active problem-focused orientation to help patients progress when they are feeling "stuck." The therapist also serves as a validator of the patient's experiences to the extent that emotional reactions are placed in the context of normal responses to abnormal circumstances.

A TRIPARTITE INTERVENTION

Setting the Stage for Assessment and Intervention: The First Session

At the outset, it is critical that the therapist convey a particular orientation to the patient or family members being worked with. The emphasis should be placed on framing the distress being experienced as a normal reaction to serious illness, as opposed to reflecting psychopathology. The patient needs to hear the message, "You may feel out of control, but that doesn't mean you're going crazy. It means you're experiencing the normal reaction of people in similar circumstances." It is also important too that clients be encouraged to articulate their personal goals for dealing with the illness. The therapist should take careful note of these in the clients' own words. Within this frame of reference, it is important for the therapist to evidence both empathy and a sense of confidence that the interventions to follow can make a difference. Therapists will also convey their role as a supportive consultant to the client who will assist the client in gaining a renewed sense of personal control in coping with the illness.

Techniques and Strategies for the Main Intervention

During the intermediate sessions (between number 2 and number 9), it is important to assist the client in addressing the eight most common sources of potential anxiety and depression related to his/her medical condition (e.g., fear of loss of control, fear of loss of self-image, fear of dependency, fear of stigma, fear of abandonment, fear of expressing anger, fear of isolation, and fear of death). The patient can be helped to recognize each as it emerges, identify it as an issue, and actively strategize about how to address and overcome the coping challenges presented.

How Many Sessions?

Some patients may show significant benefit and progress is fewer than 10 sessions. In such cases it is perfectly appropriate to conclude the intervention with a summary session (see the next section) and advise the patient that he/she is welcome to return should a new crisis emerge or an exacerbation follow. It is not unusual for some patients to require brief intermittent "tune up" sessions, especially when the illness is prolonged or has a highly variable course.

The key factor in determining whether to terminate is the ability of the patient to express and address the issues of most concern to him/her. With the patient's consent, communication with significant others in their care (e.g., family members and medical care providers) can provide external validity to confirm that things are indeed going well.

With some patients it may soon become clear that more extended treatment is needed (e.g., patients who acknowledge significant histories of depression or anxiety disorders or who display signs of suicide risk). Consider referral for medication consults as warranted. Consider referrals for more intensive or extensive treatment as dictated by the patient's condition. At the point of termination it may also be appropriate to refer some clients for other services (e.g., rehabilitation counseling, vocational guidance, etc.).

Summing Up: The Final Intervention Session

Session 10 (or the final session, if fewer than 10 session are needed) should provide a forum to review the progress of previous sessions and to consolidate an integration of the coping strategies to assist the patient over the long haul. This is the ideal time to review the patient's goals in his/her own words, as recorded in the initial consultation session. Progress and results can then be understood in terms of goals met and insights learned. Patients can be helped to integrate how they feel now as opposed to when they first came for help. This includes considering how they are feeling physically and emotionally. Patients should have the clear sense that they can return for additional consultation or treatment, as needed, in response to changes in their condition or new stressors.

NEW APPLICATIONS

This approach to treatment is easily taught to experienced psychotherapists who are not uneasy around medical patients. A treatment manual

is now under development for use in a clinical trial to be conducted collaboratively in a health maintenance organization setting. In this context, the treatment manual represents a technical guideline for the conduct of medical crisis counseling in a comparatively homogeneous or systematic manner. The clinical trial will be conducted in collaboration with the Fallon Health Care Plan of central Massachusetts. The manualized treatment protocol is intended to enhance the internal validity of the study by describing treatment that is easily differentiable from more traditional, open-ended varieties. The manual is also intended as a means to facilitate training and enable others to replicate the techniques used. The ultimate goal is to enable competent psychotherapists to implement the interventions described systematically and with good fidelity (see Dobson & Shaw, 1988).

Previous research (e.g., Rounsaville, O'Malley, Foley, & Weissman, 1988) demonstrated that experienced psychotherapists could achieve a high level of competence in providing short-term, interpersonal psychotherapy with comparatively brief training using a manual-guided program. Their work supports the feasibility of using such training for purposes of clinical trials. The strategies described link the integrated theoretical approach to specific actions that the therapist can initiate and assist the patient in completing.

Dependent measures including patient satisfaction, quality of life, psychological symptom formation, and medical cost offset will be used to assess the effectiveness of the program. In the end, we hope to establish the efficacy of such interventions with sufficient merit and credibility that they will prove desirable and adoptable as routine medical interventions, as opposed to psychiatric "carve out" services.

REFERENCES

Akamatsu, T. J., Stephens, M. A. P., Hobfoll, S. E., & Crowther, J. H. (Eds.) (1992). *Family health psychology*. Washington, DC: Hemisphere.

Budman, S. H., & Gurman, A. S. (1988). *Theory and practice of brief therapy*. New York: Guilford.

Caplan, G. (1964). *Principles of preventive psychiatry*. New York: Basic Books.

Dobson, K. S., & Shaw, B. F. (1988). The use of treatment manuals in cognitive therapy: Experience and issues. *Journal of Consulting and Clinical Psychology, 56*, 673-680.

Erikson, E. H. (1963). *Childhood and society* (2nd ed.). New York: W. W. Norton.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry, 101*, 1-11.

Moos, R. H. (1977). *Coping with physical illness*. New York: Plenum.

National Center for Health Statistics (1990). *Vital and health statistics. Current Estimates from the National Health Interview Survey, 1989*, Series 10, No. 176, DHHS Pub. No. (PHS) 90-1504, Hyattsville, MD: PHS.

Pollin, I., with Golant, S. K. (1994). *Taking charge: overcoming the challenges of long-term illness*. New York: Times Books, a Division of Random House.

Pollin, I., with Kanaan, S. (1995) *Medical crisis counseling: short-term treatment for long-term illness.* Evanston, IL: W. W. Norton.

Rosen, J. C., & Solomon, L. J. (Eds.) (1985). *Prevention in health psychology.* Hanover, NH: University Press of New England.

Rounsaville, B. J., O'Malley, S., Foley, S., & Weissman, M. M. (1988). Role of manual-guided training in the conduct and efficacy of interpersonal psychotherapy for depression. *Journal of Consulting and Clinical Psychology, 56,* 661-688.

Turk, D. C., & Kerns, R. D. (Eds.) (1985). *Health, illness, and families: A life-span perspective.* New York: Wiley-Interscience.