Brit. J. Psychiat. (1968), **114**, 169–174

Crisis and Confrontation

By MAXWELL JONES and PAUL POLAK

It is part of the magical aura of the physician that he must have some omnipotent tool with which he dramatically makes patients better. In individual psychotherapy the individual interview and the interpretation, like the surgeon's scalpel, provides such an omnipotent instrument. In therapeutic community practice it is often group therapy in the form of the daily ward meeting and the review that plays the role of the omnipotent therapeutic tool. But in our opinion it is the daily living situation and not the formally organized therapeutic meeting which provides the greatest potential for learning and growth on the part of patients and staff. We have found the crisis situation and its resolution to be potentially the most useful of these daily living situations.

Various workers have studied the characteristics of disaster (3, 5). We define crisis as an intolerable situation which threatens to become a disaster or calamity if certain organizational and psychological steps do not take place immediately. A crisis may lead to regression or disintegration, it may be resolved or partially resolved, and it may lead to growth and learning on the part of the participants. Crisis situations provide unique opportunities for sudden shifts in direction and for growth or regression; these have not presented themselves previously and may never appear again.

Crisis situations, of course, are not unique to psychiatric hospitals. They play a vital part in the development of nations, cultural groups, families and individuals. The importance of crises and their resolutions in such everyday life situations as separation, bereavement, marriage, pregnancy, surgery and retirement has been clearly described by many authors. The pertinent literature has been summarized by Tyhurst (5) and by Caplan (1).

Each crisis has a history. The series of events that precedes the crisis and the resulting role relationship of the participants forms the structure in which the crisis takes place. The crisis itself produces in exaggerated and stark relief the subtle themes and conflicts which have slowly evolved in the preceding months. The family crisis, for example, which often precipitates the admission of an individual to a psychiatric hospital, highlights the conflicts, communication blocks and role relationships which have evolved over the preceding months.

The psychiatric hospital in many ways provides a laboratory situation for experimentation with methods of productively resolving crisis situations. Admission to hospital, and discharge from it, are common examples of crises involving psychiatric patients; so is the transposition of the patient's social problem from the outside to the ward environment, with a building up of tension till a ward crisis occurs. Similarly, inappropriate emotional involvement with patients, conflicts about roles and role changes, and rivalry situations result in typical crises among staff members.

These crisis situations in the psychiatric hospital setting differ from many of the crises described in the literature in that they often do not involve major environmental change. Rather they are produced by growing conflicts among individuals. These conflicts commonly involve the roles of the individuals concerned, and often are intensified by blocks in communications between them.

Working within a therapeutic community framework, we have evolved a procedure of face to face confrontation for dealing with hospital crisis situations which aims at resolution of the crisis with maximal growth and learning on the part of the patients and staff involved. This model for crisis resolution has five basic principles.

1. *Face to Face Confrontation.* A face to face confrontation at the earliest possible moment

involving all the major participants in the crisis situation is essential to its productive resolution. We are impressed with the distorted communications that regularly occur in the emotionally charged atmosphere of the crisis situation. Only by looking at the many contributing factors to the crisis, from the different points of view of all the major participants, in the dispassionate setting created by strong neutral leadership, can each participant in the crisis obtain a more objective understanding of his own involvement in the conflict. When major participants in the crisis are left out of the confrontation situation, the distortions produced by the other participants are not corrected.

2. *Strong Skilled Leadership.* Crisis situations are often dealt with by denial. The first task of those who practise social intervention in crisis situations must therefore be to recognize the crisis for what it is. Secondly, bearing in mind the other four principles, the most appropriate timing for the first and succeeding confrontations (if any) must be determined. Thirdly, decisions must be made about who should participate. One or more participants in the actual confrontation should be skilled in group methods and have no personal involvement in the crisis situation. We have found that leaderless confrontations or poorly led confrontations are often unproductive.

3. *Open Communication.* Productive resolution of a crisis situation often involves extremely painful communication about feelings between people. The setting in which the confrontation takes place must be such that these feelings can be openly expressed without fear of reprisal.

4. *Appropriate Level of Feeling.* If the feeling around a crisis is too strong or too overwhelming, growth and resolution does not take place. If, on the other hand, there is not a sufficient level of anxiety about the crisis the participants may be insufficiently motivated for change to occur.

5. *Attitudes of Participants Conducive to Growth.* The major participants in the crisis situation must be prepared to look at themselves and examine their roles, to express themselves openly and to listen to other points of view. They must be willing to change.

At this point it may be useful to give examples of hospital crisis situations and their resolution which illustrates the application of these principles to both treatment and training.

John, who was 49 at the time of his most recent admission to hospital, has experienced hallucinations in the form of voices for the greater part of his adult life. For 20 years he has lived with his married brother, a meek man who shows many of John's personality traits but is not psychotic. The brother's wife is the strong person in the family; she takes care of both brothers, runs the family business and at times complains bitterly of having married two brothers instead of one husband. On several occasions when she has become overwhelmed by her role in the family, John has required admission to a psychiatric hospital. During these admissions, the sister-in-law has refused any significant contact with the hospital, but she has often complained that John was discharged prematurely and that the hospital has never cured him.

John's most recent admission was preceded by the admission of his brother to a medical hospital for a minor surgical procedure. The sister-in-law, who was now left alone in the house with John, became distraught and insisted on John's readmission to hospital. When seen, John had the classical signs and symptoms of a chronic schizophrenic illness. It would be a mistake to assume, however, that the cause of admission to hospital was his schizophrenic illness, which had remained basically unaltered for many years. The real reason for John's admission was a crisis in the group with whom John lived, which resulted in their being less able to tolerate John's behaviour. The chief aim of the hospital staff in this instance was, therefore, not the treatment of John's schizophrenia but the resolution of the crisis resulting in his extrusion into the hospital.

Looking at the ensuing series of confrontations from the point of view of the principles outlined above, it is clear that the first step towards crisis resolution depended on competent leadership. It was essential that a member of the hospital staff should first diagnose the family predicament as a crisis, secondly decide that a confrontation should be held, and thirdly,

insist that the sister-in-law be one of the participants. In point of fact, the ward psychiatrist made the sister-in-law's participation a condition of John's return to hospital.

It was essential that *all* the participants in the crisis be involved in the confrontation. The key figure in the family crisis was John's sister-in-law, and a confrontation would have had little value in her absence. The first confrontation was also attended by John, by the sister-in-law's married son who was a source of support for her, and by the hospital social worker, the ward psychiatrist and the admission ward nurse. Later confrontations included John's brother when he had recovered from his operation, and other family members.

Open communication in the family was encouraged. The sister-in-law expressed her anger at the hospital for not curing John, but was then able to communicate her anxieties about her husband's operation, the pertinent facts of which were explained to her. She was able to give up some of her scapegoating of the hospital and more realistically face the fact that John's symptoms were not likely to disappear. John's family discussed in his presence the difficulties in caring for a mentally ill relative. At this point John voiced his own complaints about always being the one who had to be taken care of, and raised the possibility of living in a semi-sheltered environment away from his family. It soon became clear, however, that taking care of John met some of the sister-in-law's own needs, since she began to find all kinds of reasons why John would not get on well anywhere but in her home.

The appropriate level of feeling for effective confrontation was present at the height of the family crisis around the patient's admission, and it was important that the confrontation took place at that time. Admission in itself relieved a good deal of the tension, and confrontation at a later date would therefore have had less chance of being effective.

The attitudes of the participants were also most conducive to change at the height of the crisis at the time of John's admission. At that time, John and his family were ready to move in any direction that would relieve some of the intense discomfort they felt.

John was discharged after his brother returned from hospital. The family doctor has informed us that the family seems happier and more stable since John's recent admission, and the sister-in-law recently called on the hospital for help in moving to a new home.

Confrontation can be usefully employed in staff training. Recently three comparatively new Assistant Principal Nursing Officers (A.P.N.O.s) observed that one of the hospital wards was in a very untidy state. The A.P.N.O. responsible for this particular ward made a comment to the Charge Nurse about the situation. This new A.P.N.O. had relatively little awareness of the therapeutic culture of the hospital and had behaved as his previous training had dictated. The Charge Nurse was very angry, because according to the current practice on his ward the question of untidiness should be dealt with in the daily ward meeting with all patients and staff present. In such a setting the untidiness could be looked at as a form of communication, and discussion could lead to a better understanding of the factors behind the disorder. The Charge Nurse referred the matter to the doctor in charge of the ward who in turn spoke to the Superintendent Physician, and it was agreed to have a confrontation immediately, while the crisis was at its peak. A face to face meeting was set up which included the three A.P.N.O.s, the doctor in charge of the ward, the Principal Nursing Officer and the Superintendent Physician, who provided objective leadership. These individuals participated in this initial confrontation because of its focus on problems in nursing administration roles, and clinical identification. A subsequent confrontation involved ward staff. The confrontation lasted almost 90 minutes. After discussing the situation relatively calmly, the ward doctor and the Principal Nursing Officer who, although he had been a member of the hospital staff for some time, had only recently been elevated to his present rank became engaged in angry exchanges. It became clear that the P.N.O. was adopting a protective attitude towards his relatively new assistants. The tension was eased somewhat when the Superintendent pointed out that there was some confusion about roles and the existing culture on the ward in question. The A.P.N.O.s, being

new, were understandably eager to please the head of the nursing department. He, for his part, wanted the loyalty of his assistants, who would to a large extent determine his own feelings of security in his professional role. At the same time the P.N.O. had to identify himself with the hospital as a whole, while his assistants had to identify themselves with their own particular clinical area. In both cases at least two identifications were called for, and this amounted to having two separate roles which sometimes were in conflict. The professional identity was comparatively easy and was the one which was used at the time of crisis, as it afforded greater familiarity and comfort. During the confrontation we examined the problems of ward identification and explored ways in which the A.P.N.O. could become accepted within the ward culture and play a leadership role. The difficulties facing a new Principal Nursing Officer were also touched on, as was the tendency to be over-cautious in response to the anxiety created by his new highly responsible role. Finally it was pointed out that the doctor in charge of the ward was too much identified with his own clinical team. This was seen as one of the most progressive units in the hospital, and produced mixed feelings of respect and envy in the rest of the hospital. However, there was a tendency for the ward to see its problems through its own particular frame of reference and resent the transfer of a nurse to another ward, no matter how necessary this might be. There was also a tendency to devalue the work of the other wards, and so on. Nothing should be done to interfere with the high morale and enterprising outlook in this ward, but at the same time they had to try to become more sensitive to the overall needs of the hospital. The meeting ended in a comparatively relaxed atmosphere with the general feeling that there was a lot to learn by looking at the various points of view and examining one's own subjective feelings. New possibilities in terms of roles, role relationships and the resolution of crisis situations became apparent to the various individuals.

Discussion

Tyhurst (5) divides disaster into three overlapping phases. (*a*) The period of impact, lasting usually a few minutes—until the initial stresses are no longer operating on the individual or the group. This phase is usually characterized by restriction of the field of attention and by automatic or reflex behaviour. (*b*) The period of recoil, characterized by a suspension of the initial stresses and a gradual return of self-consciousness and awareness of the immediate past. (*c*) The post-traumatic period, during which the individual first becomes aware of the full implications of the loss, whether it be home, belongings, financial security, etc.; this period lasts hypothetically for the rest of the individual's life. Tyhurst stresses the importance of the period of recoil, which he sees as a crucial period of adjustment and the successful handling of this transition state is seen by him as an opportunity for growth. He points out that psychiatrists are seldom involved in treatment in the early stages following a disaster, and our tendency is to focus on the treatment of symptoms in the post-traumatic period. Broadening his discussion to transition states and crisis situations such as migration and retirement, he says: "Our tendency to regard the appearance of symptoms as invariable signs of illness and therefore as indications for psychiatric treatment needs revision. It would probably be more appropriate if we regarded the transition state and its accompanying disturbance as an opportunity for growth." The five principles of the confrontation techniques described in the present paper provide one approach for active intervention at the time of the crisis or transition state, aimed at producing growth as suggested by Tyhurst.

Caplan (1) has added enormously to our knowledge in this field, and bases his concept of "primary prevention" in psychiatry largely on the handling of crisis situations in everyday life. "The changes may be towards increased health and maturity, in which case the crisis was a period of opportunity. The changes may be toward reduced capacity to deal effectively with life's problems, and in that case the crisis was a harmful episode."

The lessons of war psychiatry all point in the direction of immediate attention to the individual as soon as possible after the breakdown

under stress, if perpetuation of symptoms is to be avoided. Experience with action research aimed at facilitating productive resolution of hospital crises also suggests that intervention must take place at the height of the crisis if it is to be effective (4). We must try to view crisis situations in a new perspective and not in the rigid formalized concepts of "illness", which not only prevent the situation from being seen as it really is but also pre-determines all roles, role relationships and procedures under the disguise of medical treatment. The concept of the trauma itself being potentially an opportunity for growth, and the determination of appropriate procedures as a function of the interaction between the subject, significant others in his social world and socially skilled professional workers during the period of stress, seems to be eminently reasonable.

In this article we have focused on the day to day crises which are part of the life of any psychiatric hospital and the community it serves. Our concern here is to make a plea for the much greater use of crisis situations, whether involving patients and their families, staff or both, to enhance social learning. Learning is seen as a social process, as distinct from teaching where knowledge is imparted to the students (memorized) without any significant interaction between pupil and teacher. In social learning there is two-way communication, with opportunity for discussion and exploring new ways of perceiving situations and resolving conflicts.

We believe that to apply the theory of social learning to psychiatric practice, there is need to increase our awareness of social organization as the matrix in which social learning can be practised. The concept of a therapeutic community (2) stresses the importance of social structure and the need to focus on roles and role relationships, and to evolve a therapeutic culture. This concept applies equally intramurally and extramurally. It does not amount to a treatment methodology in its own right, but complements other recognized psychotherapeutic and pharmacological treatment procedures. The social organization inherent in therapeutic community settings, both inside and outside the hospital, strongly facilitates the productive resolution of crisis situations by confrontation. What we are now suggesting is that crisis groups should be formed when appropriate, and that more attention should be focused on timing than previously. A crisis calls for immediate intervention if it is to be used constructively—to wait until tomorrow or to use a later ward meeting is to lose the momentum inherent in a living learning situation. By the next day the individuals concerned have built up various ego defences and the opportunity for social learning is lost or at least diminished.

We do not know of any term that conveys the idea of a "crisis group", and in our own therapeutic culture we have coined the term "living learning situation". We feel it is important that such situations should be utilized while the emotions are still alive and not in a retrospective way which tends to characterize much of psychiatric treatment and case work supervision in social work, or the psychiatrist's supervision of a student in a diadic treatment relationship. We have found the greatest stumbling block to the application of such an approach to be the threat which this approach holds for authority figures. It is very difficult for a person in authority, whether he be a doctor, university professor, teacher, social worker, senior nurse or any trained professional to give up the protection afforded by his professional identity. The approach which is advocated here implies that the professional is willing to become the subject when this is appropriate. In other words, his performance in situations involving crisis may be subject to scrutiny with a view to learning. Living learning situations are, of course, equally important with the people in the lower status positions. In general, it could be said that our culture acts against free communication of feeling, and it is very difficult to get people to express their feelings unless they have security and are free from fear of reprisals, particularly by authority figures.

In the meantime, we believe that confrontation or living learning situations could be employed with much greater frequency than at present. For such treatment and/or training to occur, much greater attention than previously will have to be given to the social organization of psychiatric hospitals or other milieu in which treatment and learning occurs.

Summary

Crises in a hospital setting can form an important adjunct to treatment and/or training if certain conditions are met. These include immediate face to face confrontation of the people involved, two-way communication with expression of feeling, and skilled neutral leadership. Discussion of the factors which lie behind behaviour can lead to a better understanding of dynamics, including interpersonal difficulties. As a result of this process new perspectives and wider parameters may emerge and afford new ways to resolve the crisis. The term "social learning" has been used to describe this process, and the development of a therapeutic community structure is essential if crisis situations are to be utilized for learning.

Acknowledgment

We wish to express our appreciation to the staff and patients of Dingleton Hospital who participated in the evolution of the clinical methods described in this paper.

References

1. Caplan, Gerald (1964). *Principles of Preventive Psychiatry*. Tavistock Publications, London.
2. Jones, Maxwell (1962). *Social Psychiatry in the Community, in Hospitals and in Prisons*. Chas. C. Thomas, Springfield, Illinois.
3. Lindemann, E. (1944). "Symptomatology and management of acute grief." *Amer. J. Psychiat.*, **101**, 141–148.
4. Polak, Paul (1966). "Unclean research and clinical change." *Milbank Memorial Fund Quarterly*, Jan. 1966, XLIV, 337–350.
5. Tyhurst, J. S. (1958). "The role of transition states including disaster in mental illness." *Symposium on Preventive and Social Psychiatry*. The Walter Reed Army Institute of Research and the National Research Council. U.S. Govt. Printing Office, Washington D.C., Pages 149–167.

Maxwell Jones, C.B.E., M.D., M.R.C.P.E., D.P.M., *Physician Superintendent, Dingleton Hospital, Melrose, Roxburghshire*

Paul R. Polak, M.D., *Psychiatrist. Now at Fort Logan Mental Health Center, Denver, Colorado, U.S.A., as Director of Research*

(*Received 17 February, 1967*)