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ABSTRACT

It was proposed that existing therapeutic procedures may influence attributions about emotional states. Therefore an attributional analysis of crisis intervention, a model of community-based, short-term consultation, was presented. This analysis suggested that crisis intervention provides attributionally-relevant information about both the source of the crisis state and the source of the crisis resolution. Structural and process features of the consultation facilitate attributing the crisis state to an external source and attributing the crisis resolution to an internal source. Implications of this analysis for the role of the crisis consultant, for the setting of goals in crisis work and in the training of consultants, and for the further extension of attributional analysis were discussed. (Author)

Attribution Theory and Crisis intervention Therapy

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Attribution theory (Kelley, 1967), developed as an approach to social perception, is concerned with analyzing the cognitive processes which underlie causal explanations. It is a theory of the ways people try to "make sense of" events by setting them in a causal framework. For the clinical professional, an important aspect of attribution theory is its application to the problem of how individuals interpret their emotional states. Schachter (1964), for example, has demonstrated that subjects attach specific emotional labels to states of physiological arousal only when the arousal is consistent with emotionally relevant environmental cues. Ross, Rodin, and Zimbardo (1969) have subsequently implicated attributional processes as the link between physiological arousal and emotional responding. Attributions, mediating between physiological states and emotional responses, can therefore be seen to play a potentially crucial role in the etiology and maintenance of both normal and disturbed emotional behavior. Further, certain kinds of emotional attributions may become maladaptive, and are a potentially appropriate focus for therapeutic intervention.

Anecdotal and case-study evidence (e.g., Davison, 1966; Valins & Nisbett, 1971) indicates that procedures can be designed to successfully change undesirable attributions and the emotional behavior associated with them. Experimental work lends further support to the feasibility of altering undesirable emotional behavior through attributional change. In one demonstration

of the therapeutic potential of attributional management, Ross, et al. (1969) were able to suppress emotional responding by inducing subjects to misattribute physiological arousal due to fear of shock to an emotionally irrelevant loud noise. In somewhat more clinical contexts, similar attributional change techniques have been used to reduce the time reportedly needed by insomniacs to fall asleep (Storms & Nisbett, 1969), and to reduce test-taking anxiety in text-anxious subjects (Beaman, Diener, Tefft, & Fraser, 1973). Using a different paradigm, but one consistent with an attributional interpretation, Valins and Ray (1967) were able to induce approach to snakes in inexperienced snake-fearful subjects through the systematic control of information about their physiological arousal in the presence of snakes.

Unfortunately, however, this work has been largely restricted to novel therapeutic procedures which bear little resemblance to traditional clinical techniques. Thus the attributional significance of existing procedures has not received much attention. The demonstrated importance of attributions across a wide range of social situations (Jones, Kanouse, Kelley, Nisbett, Valins, & Weiner, 1972) suggests the potential value of applying attributional analysis to existing forms of clinical practice.

In this presentation, the focus is to be on the attributional implications of crisis intervention (Jacobson, Wilner, Morley, Schneider, Strickler, & Sommer, 1965; Morley, 1965), a model of community-based, time-limited consultation. Crisis intervention constitutes an attractive initial choice for analyzing the attributional implications of existing therapies since its brief, limited focus parallels the brief, limited focus of experimentally-devised attribution treatments. Its short duration and high degree of structure make it easier to generalize about this procedure than most clinical approaches. Further,

its growing use and its value for lower-class utilizers (Gottschalk, Mayerson, & Gottlieb, 1967) makes it especially important to examine every aspect of its effects.

An Attributional Analysis of Crisis Intervention

An initial distinction needs to be drawn between attributions about the source of the crisis and attributions about the source of crisis resolution, as these are perceived by the consultee in crisis. An attributional dilemma--that is, an uncertainty about the cause to which an event is attributable--is faced when the crisis consultee attempts to identify the source of crisis arousal: To what should the feelings of crisis be attributed? A second attributional dilemma is faced later when the consultee attempts to attribute the resolution of the crisis: To what should the relief from crisis disturbance be attributed? This presentation will suggest that crisis intervention provides the kind of information that helps the individual in crisis answer these two attributional questions in ways which minimize his emotional disturbance and maximize his internalization of constructive changes made in resolving the crisis.

A second distinction to be drawn is that between the process of crisis intervention and its structure. Some of the most innovative aspects of crisis work can be found in how it is structured, yet this aspect of the intervention is rarely emphasized. Perhaps the effects of crisis intervention can best be understood as an interaction between the consultation process and structure.

Structural Features

Easy access and non-psychiatric image

While many outpatient clinics accept clients only after criteria of acceptability have been met and time on a waiting list spent, crisis intervention

facilities typically provide maximally easy access (Gottschalk, et al., 1965; Jacobson, et al., 1965; Pittman, DeYoung, Flomenhaft, Kaplan, & Langsley, 1971). Evening hours, community location, and immediate treatment all serve to augment the accessibility of crisis intervention.

Crisis facilities also typically project a non-psychiatric image by accentuating a "problems of living" or "trouble shooting" image (Morley, 1965). Terms such as "treatment," "therapist," and "patient" are consciously excluded from formal usage, in order to appeal to those who can benefit from professional mental health assistance but are reluctant to identify their problems as "psychiatric" (Jacobson, et al., 1965). It has been shown that crisis facilities tend to draw populations underrepresented in traditional settings (Strickler, et al., 1965), and that these populations show substantial benefit from crisis contact (Gottschalk, et al., 1967).

Attributional implications: The major effects of this feature impinge on attributions about the source of the crisis. The unavailability of acceptable non-professional reference groups can influence an individual to enter therapy (Strong, 1970; Valins & Nisbett, 1971). The accessibility and non-psychiatric image of crisis facilities may serve the function of bringing people to crisis centers before they have formed stable attributions about what has produced the crisis. People tend to seek help for the specific kinds of problems they infer to exist (Garner, 1965), and many individuals are unwilling to infer that they have psychiatric problems (Morley, 1965). By structuring crisis facilities as they have been, it becomes possible for people to obtain professional help early in the course of crisis without the need to re-define their problems as psychiatric. It is relevant for this

point that many crisis consultants report that a significant number of consultees enter crisis consultation without having identified the precipitant of their crisis (e.g., Jacobson, 1967; Strickler & LaSor, 1970). Crisis consultation may thus be used by the consultee as a way of attributing the crisis state as well as providing relief from its effects.

The accessibility and image of crisis facilities also serve to undermine the formation of maladaptive attributions of internal pathology. Ready acceptance into consultation for "problems of living" provides little basis for attributing the crisis state to deeply-rooted, highly unusual, or unchangeable problems.

Time limitation

Crisis intervention is provided for a limited time only, with most facilities setting an upper limit of about 10 contacts usually spread over a similar number of weeks (Jacobson, 1965; Saucier, 1968). These figures reflect studies of the natural course of crisis which indicate that natural resolution, for better or worse, will occur within 4-6 weeks of the onset of crisis (Caplan, 1961; Lindemann, 1944). It is reasoned that only during this period of "psychological disequilibrium" can professional intervention maximally facilitate the adaptiveness of the crisis resolution.

Attributional implications: The major effects of this feature are also on attributions about the source of the crisis. One important source of information a person has about his emotional problems is the nature and extent of treatment required to alleviate them (see Frank, 1961). Acceptance into crisis consultation provides validation for attributing the crisis to a problem of living, while the short course of treatment facilitates seeing the problem as quickly changeable.

McGuire (1965) has noted that brief therapy often leads to the conclusion that "very little must be troubling me" if only a few hours of therapy are prescribed" (p. 220). Smith (1970) has applied a similar line of reasoning directly to crisis intervention, arguing that the time limitation may arouse an expectation of rapid restoration of internal control over problems, while long-term therapy may arouse an expectation of slow, effortful change.

Minimal use of medication and hospitalization

Most crisis facilities rely little on the use of medication or hospitalization (e.g., Pittman, et al., 1971). Resolution of the crisis in these ways is seen as relatively maladaptive and is reserved for instances where other alternatives are severely limited.

Attributional implications: This feature offers implications for attributions about both the source of the crisis and the source of crisis resolution. Attributing the crisis to severe psychopathology is made less likely when such culturally "strong" forms of intervention such as psychiatric medication and hospitalization are avoided. But further, and perhaps more importantly, it should be noted that medication and hospitalization are highly salient ways of explaining any changes that occur during the intervention--e.g., "I feel better because of my medication (hospitalization)." attributing improvement to such external sources is not likely to lead to internalization and maintenance of any new behavior patterns and attitudes which have been established during the crisis resolution (Collins, 1975; Davison & Valins, 1969). Since change in crisis disturbance occurs reliably within a few weeks of its onset, a person will be able to attribute this change to himself--his own effort, the fact that he is a capable person, etc.--as long as no more

salient explanatory source comes along to interfere. And, since the heart of crisis intervention involves the learning of new and better ways of dealing with stress, it is desireable that these changes are maintained and internalized.

In summary, then, the very way that crisis intervention is structured provides attributionally-relevant information about both what has caused the crisis, and what has caused a change in the crisis state as it is resolved. The crisis intervention process features which are now to be looked at provide information which reinforces the attributions facilitated by this structure.

Process Features: The Crisis Intervention Sequence

The process of crisis intervention follows a rather consistent sequence which, for present purposes, can be grouped into three steps: The clarification and definition of the crisis background, the restoration of functioning, and the consolidation of change (see Jacobson, et al., 1965; Saucier, 1968).

Clarification and definition of the crisis background

During the first stage of the intervention, the primary focus is on the events surrounding the onset of crisis. The goal is to identify the single recent stress which precipitated the crisis. Following this identification, the consultee's individual patterns of dealing with stress are explored and their inadequacy in the present examined. When the psychological meaning of the precipitant has been found, a formulation of the crisis is made and shared with the consultee. This formulation includes a review of the crisis stress, the reasons for the failure of usual ways of coping, the psychological meaning of the precipitant for the consultee, and the effects which the crisis has produced.

Attributional implications: The major impact of this stage is on attributions about the source of the crisis. This initial stage of the intervention provides the consultant with an understanding of the attributional state of the consultee. It also provides the consultant with an attributionally ideal definition of the precipitating stress, one which externalizes the source of the crisis and makes it a single, recent event. The formulation of the crisis can be interpreted as a way of ensuring that the consultee attributes his state to this precipitant. Since the consultant is a powerful social comparison figure (Strong & Matross, 1973), it is unlikely that this attributionally crucial identification will be ignored. The stage as a whole provides an excellent modeling process for thinking of the crisis in specific, recent, cause-effect terms.

Restoration of functioning

The second phase of the intervention focuses on developing and implementing new strategies for handling the crisis stress. The role of the consultant in this process is to facilitate the development and critical evaluation of all possible alternatives, but not to make decisions for the consultee. Once a course of action has been decided on, the consultant works to see that it is implemented as quickly as possible.

Attributional implications: This stage has an impact on attributions about both the source of the crisis and the source of the crisis resolution. It undermines any attempt to attribute the crisis to unalterable personal inadequacies, since the development of alternatives provides evidence that change is possible and the implementation of an alternative demonstrates that this change can be produced by the consultee himself. Attributions about the locus of change in the crisis state are going to be strongly influenced by the consultant's limited participation in decisions about which alternative to adopt. The

focus on the consultee's ability to make his own decisions increases the salience of the consultee as the source of change. By limiting his participation, the consultant facilitates a self-attribution by the consultee to explain change.

Consolidation of change

During the final stage of the intervention, the value of changes which have been made is pointed out by the consultant and the need to maintain these changes is stressed. The entire process of the intervention is then reviewed, reinstating the role of the crisis precipitant in producing the crisis and the role of the consultee is producing constructive changes. Finally, the consultant helps the consultee make plans which anticipate the best possible handling of potentially crisis-producing events which may occur in the future.

Attributional implications: This stage carries implications for both "source" and "resolution" attributions. The review of the crisis keeps salient the external, specific, recent causal stress which precipitated the crisis. The review of the role of the consultee in making changes increases his salience as the source of the resolution of the crisis. The use of anticipatory planning at the end of the intervention can be seen as a kind of "attributional innoculation," in which attributions about future problems are directed in relatively useful ways well ahead of time.

In summary, then, many aspects of crisis intervention structure and process can be seen to interact in facilitating external attributions about the cause of the crisis and internal ones about the cause of the crisis resolution. This pattern of attributions should minimize the disruptive effects of the crisis and maximize maintenance and generalization of new behaviors and attitudes which were used in the crisis resolution.

Discussion

Attributional analysis offers a valuable new way of conceptualizing the effects of crisis intervention on the cognitive processes of the consultee. Many aspects of crisis intervention structure and process make good attributional sense, minimizing the disruption of crisis while maximizing the ability of the consultee to deal more effectively with future stress. A number of points of convergence can be seen between the realities of crisis therapy and the goals of attribution therapy. This certainly supports the need for further work to clarify the causal role of cognitive changes in the effectiveness of crisis intervention and to extend attributional analysis to more procedurally complex forms of clinical intervention.

As well as offering an alternative conceptualization of the process and structural effects of crisis intervention, attributional analysis raises a number of interesting points, only two of which will be considered here. First, it highlights the need for the crisis consultant to take an active role in helping the consultee understand his experience in cause-effect terms. An over-eagerness to attribute many difficult but normal life experiences to psychopathology is a common clinical fact of life; this attributional error seems to arise from a societal fascination with the fact of psychopathology which leaves people more than ready to find it lurking in many innocent corners (see Valins & Nisbett, 1971) In the light of such a potentially harmful predisposition, the crisis consultant has the task of helping the consultee recognize the contribution of precipitating external stress in producing his state. He also has the task of helping the consultee to recognize and use his own resources in dealing effectively with the crisis.

Second, it strongly suggests the importance of how those in crisis cognitively

structure their experience. Although crisis theorists have acknowledged cognitive reorganization as one way of resolving crisis (e.g., Paul, 1966), they have not given it the high priority and universality implied by this analysis. This issue would seem to justify further consideration on the part of crisis therapists. If cognitive change is an important facet of crisis intervention, and the work of Smith (1970) among others would suggest that it is, then a greater emphasis on the need for crisis workers to be sensitive to the attributional implications of their work can be profitably built into existing crisis intervention training programs.

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