
The Nature of Existential Crisis

THIS IS NOT A BOOK ABOUT CRISIS INTERVENTION, BUT IN STUDYING short-term existential intervention, it is important to emphasize the ways in which a person's basic purposes in life may be threatened by any type of emotional problem situation. For this reason we begin with a review of the nature of crisis, with a special consideration of the ways in which many clients experience an existential crisis when they face a variety of internal, interpersonal, and resource problems. Later chapters will focus specifically on how short-term existential intervention builds on these ideas.

A *crisis* can be defined as the perception or experience of an event (genuine harm, the threat of harm, or a challenge) as an intolerable difficulty (James & Gilliland, 2001). The crisis is an aberration from the person's typical pattern of functioning, and he or she cannot manage the event through usual methods of coping. The person either lacks knowledge about how to manage the situation or, due to feeling overwhelmed, lacks the ability to focus his or her energies on it. All people experience crises at times in their lives. A crisis often results when we face a serious stressor with which we have no prior experience. The stressor may be biological (a major illness), interpersonal (the sudden loss of a loved one), or environmental (unemployment or a natural disaster). The Chinese characters that represent the word *crisis* are the one that means danger and another that means opportunity. From this point of view, a crisis can be defined as a "dangerous opportunity." An existential crisis is dangerous because it often feels overwhelming, but it is an opportunity because it often forces us to look for strengths, meanings, and solutions that are outside of our normal range of awareness.

ORIGINS OF CRISIS THEORY

Over the last forty years many definitions of a crisis situation have been proposed, as well as an equally large number of descriptions of *crisis intervention* (Dixon, 1979; Ell, 1996; Frankl, 2000; Greene, 1996; Wolberg, 1965). In some definitions a crisis is considered to be any emergency situation. In other definitions a crisis is considered to be an emergency, but an emergency is not always considered a crisis. In some approaches to crisis intervention the crisis approach is always short

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term, and in other crisis orientations intervention can be appropriately provided over a short or a longer period of time.

Social workers have practiced crisis intervention since the profession's earliest years (Golan, 1978). In fact, the social work profession emerged in response to socially identified needs to help growing numbers of citizens who experienced high-stress situations. Smith College offered its first summer program in 1918 to train workers in skills for rehabilitating shell-shocked soldiers. Social workers also provided services in the first suicide prevention center, the National Save-a-Life League in New York City, in 1906. Through the years caseworkers assisted families experiencing disruption during the Great Depression; homeless, runaway, and impoverished people (through the Traveler's Aid Societies); and people dealing with life disruptions during World War II (through family service agencies). Social workers generally preferred long-term interventions during those years, but as caseloads and waiting lists increased, they effectively adopted short-term approaches as well (Parad, 1965).

Formal crisis theory was developed in the fields of psychiatry, psychology, and sociology. It first emerged during the 1940s, primarily through the work of psychiatrists Erich Lindemann and Gerald Caplan, both of whom had been affiliated with Massachusetts General Hospital (Roberts, 2000). Lindemann and his associates developed concepts of crisis intervention in the aftermath of Boston's Coconut Grove nightclub fire, in which 493 people died. Their ideas were based on observations of the grief reactions of survivors and the friends and relatives of those who died. Lindemann identified common crisis (grief) reactions of somatic distress, guilt, anger, disrupted patterns of conduct, and preoccupation with images of the deceased. He concluded that the length and outcome of a grief reaction was dependent on the person's having time to mourn, to adjust to the changed environment, and to eventually develop new relationships.

Military psychiatrists have always tried to predict the behavior of soldiers in field situations, and to quickly rehabilitate those who become overwhelmed. Lindemann's ideas were adapted to military intervention methods during World War II. Crisis outcomes were found to be most positive when soldiers were treated close to the setting of the precipitating event (the front lines), when the psychiatrist focused only on the immediate situation, and when the soldier was returned to the combat situation in a relatively short time (Golan, 1987).

Caplan (1990) expanded on Lindemann's work in the 1940s and 1950s. His ideas were influenced by his work with immigrant mothers and children. Among his major contributions to crisis theory was the idea that all people are vulnerable to crisis reactions during developmental transitions, such as moving into adolescence and adulthood. Caplan specified two types of crises: normal life transitions and hazardous events. He was the first to relate the concept of homeostasis to crisis intervention and to describe stages of a crisis reaction, which will be presented later. It is

noteworthy that developmental theorists such as Erikson (1968) also postulated the normalcy of psychosocial crises in human development at this time. Further, the field of sociology made important contributions to crisis theory with studies on the effects of stressful family events such as marriage, parenthood, and old age on family structure and member interaction.

In the 1960s the social worker Lydia Rapoport wrote about the importance of adapting various clinical intervention modalities to crisis intervention such as ego psychology and learning theory. She emphasized the importance of rapid assessment and the practitioner's ready access to the victim. Later, Naomi Golan (1978) emphasized that people were most receptive to receiving help during the most difficult period of a crisis, and that intensive, brief interventions were more successful when the client was motivated in this way.

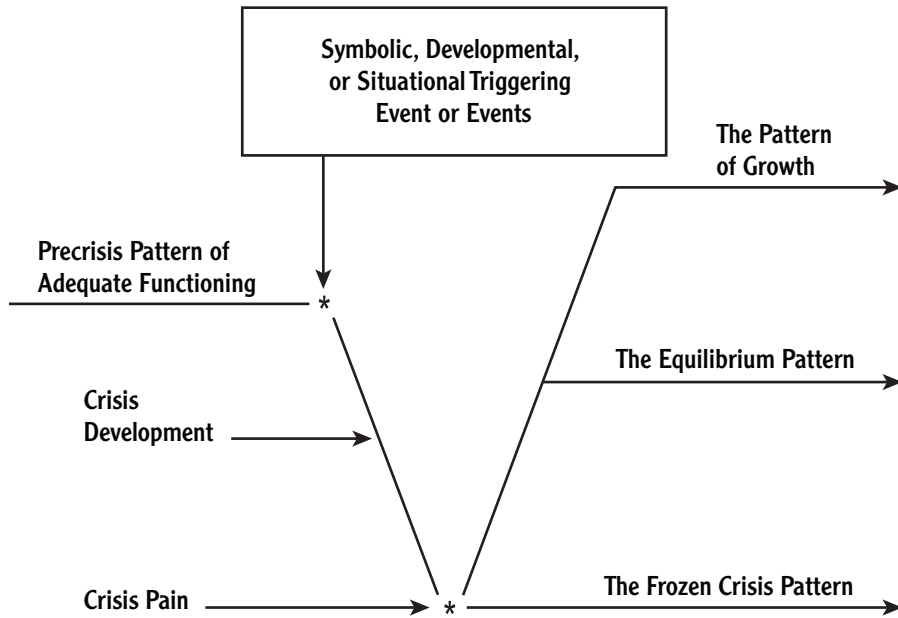
The suicide prevention movement arose in the 1960s, initially with telephone hotlines. Between 1966 and 1972 the number of these centers grew from twenty-eight to almost two hundred. The greatest boost to crisis intervention programs came with the community mental health movement, for which twenty-four-hour crisis programs were a required component. The number of centers with these units grew to almost eight hundred by 1980.

Social interest in providing crisis intervention services exploded during the 1970s for two major reasons (Myer, 2001). One was the increase in geographic mobility in the United States and other modern countries, and many people's subsequent lack of ties to nuclear families and other primary supports. Myer cites evidence of 130 million situational crisis episodes occurring annually in the United States. A second reason is the awareness in science of links between psychological trauma and long-term neurological disorders (Nelson & Carver, 1998). Today, crisis programs continue to be found in mental health centers and hospitals. Most social workers receive training in crisis intervention in schools or their agencies, as it is recognized that clients of all types may experience crises.

Today, crisis intervention can be used with a range of presenting problems such as sexual assault, medical illness, combat stress, post-traumatic stress, migration, suicidal ideation, chemical dependence, personal loss, school violence, partner violence, and family stress (James & Gilliland, 2001). It represents a strengths approach because it underscores the possibility of client growth even in horrible situations. The social worker must build upon clients' strengths in order to help them adapt to, and grow from, the experience.

In this book a clinical situation will be considered to be a crisis if and when an individual, couple, or family develops a significant disruption in physical, psychosocial, or spiritual functioning following both a history of adequate functioning and the occurrence of a crisis-triggering event or events (Lantz, 1978; Lindemann, 1944; Wolberg, 1965). This type of crisis is illustrated in figure 1.1.

Figure 1.1 The nature of crisis.



MAJOR CONCEPTS IN CRISIS THEORY

While this book presents a unique approach to existential intervention, it is useful to present several major ideas that are generally considered to be important to the practitioner's understanding of crisis situations.

Stress

Stress can be defined as an event in which environmental or internal demands tax or exceed a person's coping resources (Lazarus & Lazarus, 1994). The event may be *biological* (a disturbance in body systems, such as the experience of a disease), *psychological* (cognitive and emotional factors involved in the evaluation of a stressor, such as the fear of an important relationship ending), *social* (the disruption of a social unit; for example, the closing of a town's major industrial plant), or *existential* (a threat to one's sense of meaning or purpose). Stress can be summarized into three categories (Rapoport, 1965):

1. *Harm* refers to the effects of a damaging event that has already occurred.
2. *Threat* is probably the most common form of psychological and existential stress, in that the person perceives a potential for harm in an event that has not yet happened.

3. *Challenge* consists of events that a person appraises as opportunities rather than occasions for alarm. The person is mobilized to struggle against the obstacle, as with a threat, but with a different attitude. Faced with a threat, a person is likely to act defensively. In a state of challenge the person is excited and confident about the task to be undertaken. The challenge may be perceived as a productive experience.

The nature of a person's experience of stress is related to biological constitution and previous experiences in managing stress (Aldwin, 1994). Vulnerability to stress is also related to one's position in the social structure, with some social positions (including poverty, racism, and blocked opportunities) exposed to a greater number of adverse situations than others (Lupien, King, Meaney, & McEwen, 2000). Although a single event may pose a crisis for one person but not another, some stressors are so severe that they are almost universally experienced as crises.

Traumatic stress refers to events that involve actual or threatened severe injury or death to oneself or to significant others (APA, 2000). These include *natural* (such as flood, tornado, earthquake) and *technological* (such as nuclear) disasters; *war and related problems*; and *individual* traumas, such as being raped or assaulted (Aldwin, 1994). Many trauma survivors experience a set of symptoms known as post-traumatic stress disorder (PTSD; APA, 2000). These symptoms include persistent reliving of the traumatic event, persistent avoidance of stimuli associated with the traumatic event, and a persistently high state of arousal. The symptoms of PTSD may occur as soon as one week after the event, and as much as thirty years afterward. Complete or partial recovery from symptoms is possible but not certain (almost 50% of survivors continue to experience some long-term symptoms), which supports the importance of timely professional intervention (Sadock & Sadock, 2003).

Crisis

The term *crisis* was defined earlier. To elaborate, the experience of crisis occurs in three stages (Caplan, 1990). First, there is a sharp and sudden increase in the person's level of tension. Second, the person tries but fails to cope with the stress, which further increases tension and contributes to the sense of being overwhelmed. At this point the person is highly receptive to accepting help. Third, within approximately four weeks the crisis resolves, either negatively (with an unhealthy coping solution) or positively (with successful management of the crisis and perhaps an enhanced sense of personal competence). The emotions most likely to emerge in a person's experience of crisis include anxiety, guilt, shame, sadness, envy, jealousy, and disgust (Lazarus, 1993).

TYPES OF CRISES

Crisis can be classified into three types. *Developmental* crises occur as events in the normal flow of life create dramatic changes that produce extreme responses.

Examples include the birth of one's child, college graduation, a midlife career change, and retirement from work. People may experience these types of crises if they have difficulty negotiating the typical challenges outlined by Erikson (1968) and Germain and Gitterman (1996). *Situational* crises refer to uncommon and extraordinary events that a person has no way of forecasting or controlling. Examples include physical injuries, sexual assault, loss of a job, illness, and the death of a loved one. *Existential* crises are characterized by escalating inner conflicts related to issues of purpose in life, responsibility, independence, freedom, and commitment. Examples include remorse over past life choices, a feeling that one's life has no meaning, and a questioning of one's basic values or spiritual beliefs.

A PERSON'S RESPONSE TO A CRISIS

A client in crisis may follow three general courses (James & Gilliland, 2001). In the *growth* pattern the client recovers from the event and then, often with the help of a practitioner, develops new skills and strengths. In the *equilibrium* pattern the client returns to the precrisis level of functioning but does not experience enhanced social functioning. In the *frozen crisis* pattern the client does not improve but makes adjustments that involve harmful strategies (such as substance abuse) that keep him or her in a chronically troubled state. Whether a stress experience becomes a crisis depends on the person's coping capacities, so we now turn to a discussion of that concept.

Coping and Adaptation

Coping is a person's efforts to master the demands of stress (Lazarus, 1993). It consists of the thoughts, feelings, and actions that constitute those efforts. *Adaptation* involves related adjustments the person makes in biological responses, perceptions, or lifestyle.

Biological Coping

The biological view of stress and coping emphasizes the body's attempts to maintain physical equilibrium, or a steady state of functioning (Seyle, 1991). Stress results from any demand on the body, specifically the nervous and hormonal systems, during perceived emergencies. The body's response to a stressor is called the *general adaptation syndrome*. It occurs in three stages. In the state of *alarm*, the body becomes aware of a threat. During *resistance* the body attempts to maintain or restore homeostasis. This is an active response of the body in which endorphins and specialized cells of the immune system fight off stress and infection. In the third stage, *exhaustion*, the body terminates coping efforts because of its inability to physically sustain the state of disequilibrium. The immune system is constructed for adaptation to stress, but the cumulative wear and tear of stress episodes can gradually deplete its resources. Common outcomes of chronic stress include stom-

ach and intestinal disorders, high blood pressure, heart problems, and some emotional disorders.

Psychological Coping

The psychological aspect of managing stress can be viewed in two different ways. Some theorists consider coping ability to be a stable personality characteristic, or *trait*; others see it instead as a transient *state*—a process that changes over time depending on the context (Lazarus, 1993). Those who consider coping to be a trait see it as an acquired defensive style, a set of automatic responses that enable us to minimize perceived threats. Those who see coping as a state, or process, observe that coping strategies change depending on our perceptions of the threats. The context has an impact on our perceived and actual abilities to apply effective coping mechanisms. The trait and state approaches can be combined. That is, coping can be conceptualized as a general pattern of managing stress that incorporates flexibility across diverse contexts.

A person's coping efforts may be *problem focused* or *emotion focused* (Lazarus, 1993). The function of problem-focused coping, which includes confrontation and problem-solving strategies, is to change the stressful situation. This method tends to dominate when the person views the situation as controllable by action. In emotion-focused coping (distancing, avoidance, and reappraisal of the threat), the external situation does not change, but the person's behavior or attitudes change with respect to it. When a person views stressful conditions as unchangeable, emotion-focused coping may dominate. People may productively use either of these general approaches at different times.

American culture tends to venerate problem-focused coping and the independently functioning self, and to distrust emotion-focused coping and what may be called relational coping. Relational coping takes into account actions that maximize the survival of others—such as families, children, and friends—as well as the self (Banyard & Graham-Bermann, 1993). Feminist theorists propose that women are more likely than men to employ the relational coping strategies of negotiation and forbearance. Further, power imbalances and social forces such as racism and sexism affect the coping strategies of individuals. Social workers must be careful not to assume that one type of coping is superior to the other.

People exhibit some similarities between the ways in which they cope with crises and the ways in which they cope with everyday stress, but there are also differences (Aldwin, 1994). Because people tend to have less control in crisis situations, a primary coping strategy is emotional numbing, or the constriction of emotional expression. They also make greater use of the defense mechanism of denial. Confiding in others takes on greater importance. The process of coping takes a longer time, and reactions may be delayed for months. The search for ultimate values and life meanings takes on greater importance, and personal identity transformations are more common. Despite the many negative consequences of traumatic

stress, however it is important to recognize that survivors sometimes report the experience as one that is positive. In this growth pattern clients utilize their experience to discover new strengths, skills, behavioral patterns, insights, and meaning potentials in their lives.

As described next, a strong system of social support helps a person to avoid or recover from crises and other problem situations.

Social Support

Social support can be defined as the interpersonal interactions and relationships that provide people with assistance or positive feelings of attachment (Hobfoll, Freedy, Lane, & Geller, 1990). A key function of crisis intervention should involve the client's linkage with formal or natural social support resources. (The topic of formal support is addressed in detail in chapter 2.) The utilization of natural supports by clients is important because of limits in the scope and availability of formal services. Most importantly, natural supports promote normalcy in clients' lives.

There are many possible indicators of social support. Examples include the client's subjective perceptions of support from family and friends (Procidano & Heller, 1983) and the availability of others who can provide listening, task appreciation, task challenge, emotional support, emotional challenge, reality confirmation, and personal assistance (Richman, Rosenfeld, & Hardy, 1993). One relatively simple system with utility for crisis intervention focuses on the availability of *material* support (food, clothing, shelter, and other concrete items), *emotional* support (all interpersonal supports), and *instrumental* support (services provided by casual contacts, such as grocers, hairstylists, and landlords) (Walsh & Connelly, 1996). Supportive relationships often occur in clusters, distinct categories of interaction such as the nuclear family, extended family, friends, neighbors, formal community relationships, school peers, work peers, church associates, recreational groups, and professional associations (Vaux, 1990). Having contacts in a variety of clusters is desirable, as it indicates that a person is supported in many areas of life.

How Social Support Aids Coping

The experience of emotional stress creates an emotional arousal in a person that reduces the efficiency of his or her cognitive functioning (Caplan, 1990). When under stress, a person becomes less effective at focusing attention and negotiating the environment. Social supports help to compensate for these deficits by nurturing and promoting an ordered worldview, promoting hope, promoting timely withdrawal and initiative, providing guidance, providing a communication channel with the social world, affirming personal identity, providing material help, containing distress through reassurance and affirmation, ensuring adequate rest, and mobilizing other personal supports.

There is no consensus about how practitioners can evaluate a client's level of social support, but one useful model suggests gathering information in three areas

(Vaux, 1988). The practitioner asks the client to list all the people with whom he or she has interacted in the past one or two weeks. Next, the practitioner asks the client to draw from that list the people he or she perceives to be supportive in significant ways. The client is then asked to describe specific recent acts of support provided by those individuals. Finally, the practitioner asks the client to evaluate the adequacy of the support received from each source. Based on this assessment, the practitioner can identify the client's supports and target certain areas for development.

HISTORY OF ADEQUATE FUNCTIONING

In a crisis situation the individual, couple, or family has usually had a lengthy period of adequate human functioning prior to the onset of the problem (Dixon, 1979; Whitaker, 1989). That is, the client experiencing the crisis has functioned well in the past and has demonstrated strengths, capacities, and resiliencies in a variety of difficult situations. The period of adequate functioning prior to the development of the crisis is proof of the crisis client's capacities and strengths (Golan, 1978). His or her strengths are the very reason that intervention can often be brief, short term, time limited, and growth oriented.

THE TRIGGERING EVENT

In a problem situation, the individual, couple, or family's experience of a significant disruption in physical, psychosocial, or spiritual functioning follows the occurrence of a significant triggering event or events (Berger, 1984). At times this is a situational event such as a car accident, death of a loved one, development of a physical disease, divorce, fire, rape, tornado, or loss of one's job. At other times the triggering event can be a life stage change such as the birth of a child, getting married, a young adult leaving home for either work or college, or an older adult who loses his or her aging partner to death. Although the triggering event is most frequently a specific, concrete, and fairly obvious situation or difficulty, sometimes the event is more difficult to identify, because it is subtle and perhaps symbolic (Greene & Lee, 2002). One example of a symbolic event that led to a crisis is described here:

Mr. Jackson is an African American combat veteran who developed panic attacks, crying spells, and depression shortly after his son turned thirteen years old. Mr. Jackson was a Gulf Storm combat veteran who had made an excellent adjustment on a surface level when he returned home from the Middle East. In Mr. Jackson's crisis situation, his son's thirteenth birthday stimulated his memory of a combat event that he had repressed for many years. His son's birthday helped him to remember that in combat he had killed a young soldier who was about the age of his son. Mr. Jackson's recovery of this combat memory stimulated a crisis. He had not worked through the original painful event but had instead repressed it. After many years of repression and apparent adequate functioning, Mr. Jackson developed a crisis shortly after his son's birthday. In this situation the symbolic crisis event gave Mr. Jackson a new opportunity to work through his pain and feelings of guilt about a horrible combat experience.

CRISIS PAIN

Crisis pain is an individual, couple, or family's negative emotional reaction to the occurrence of a stressful and difficult triggering event (Lantz, 1978; Walsh, 2003). When crisis pain is greater than the person's ability to tolerate and process the pain, the person will use defense methods to cover or cloud the experience of crisis pain (Lantz & Gyamerah, 2002; Walsh, 2000). Defense mechanisms that are frequently utilized by people in crisis pain include avoidance, dependency, and aggression; these can also be understood more positively as coping mechanisms (Lantz, 1978, 2000; Yalom, 1980). These three defense methods protect the person from awareness of his or her crisis pain but also disrupt the person's ability to work through the crisis pain at the physical, psychosocial, and spiritual dimensions of existence (Lantz, 2001; Lantz & Gregoire, 2003; Wolberg, 1965).

HUMAN RESPONSES TO THE CRISIS SITUATION

There are three basic patterns of response that people manifest after they experience a crisis-triggering event, crisis pain, and their own use of defense mechanisms. These include the patterns (introduced earlier) of growth, equilibrium, and frozen crisis, or continuous dysfunction. These three patterns include behavior at the physical, psychosocial, and spiritual dimensions of existence (Frankl, 1969, 2001; see figure 1.1).

The Growth Pattern

In the growth pattern the individual, couple, or family initially demonstrates deterioration in functioning in response to the crisis situation (Dixon, 1979; Wolberg, 1965). After this initial period of deterioration and despair, the client or client system is able to find a way not only to return to the previous level of functioning level, but to move beyond it. That is, they utilize their crisis experience to discover new strengths, skills, behavioral patterns, ways of thinking, insights, and meaning potentials in their lives. They are able to grow and develop in a way that is even more effective than before their crisis experience (Greene, 1996; Grove & Burnaugh, 2002; Lantz & Gomia, 1995; Walsh, 1999). The primary intervention goal in short-term existential intervention is to help the client turn his or her experience of crisis into an experience of growth and "becoming" as rapidly as is safely possible (Frankl, 1975; Lantz, 2000; Lantz & Gyamerah, 2002; Walsh, 2003).

The Equilibrium Pattern

In the equilibrium pattern the person or people in crisis initially demonstrate a deterioration in functioning following the triggering event. The client system is able to respond to the crisis by eventually returning to their precrisis level of functioning, but they are not able to utilize the experience in a way that results in growth

and improved functioning (Frankl, 1978; Lantz, 2000; Lantz & Thorward, 1985; Walsh, 2003). In the equilibrium pattern little or no growth occurs in the life of the client and, at times, much time and effort are required to return to an equilibrium state. Again, the primary treatment goal is to help the client find a way to turn the crisis experience into a process of growth rather than simply to return to the equilibrium state (Frankl, 1978; Lantz, 2002).

The Frozen Crisis Pattern

In the frozen crisis pattern the client system also demonstrates a long-term pattern of adequate functioning prior to the occurrence of a triggering event, and then a deterioration of functioning at the physical, psychosocial, and spiritual dimensions of existence (Lantz, 1978; Wolberg, 1965). What is different about this pattern is that the client does not rebound or return to either a growth pattern or an equilibrium pattern. In the frozen pattern the client stays in the dysfunctional pattern and may stay frozen for years. The client system's response to the triggering event or events is a long-term pattern of dysfunctional behavior that crystallizes into a consistent pattern of depression, anxiety, and despair. Many clients who are diagnosed as a traumatized client (PTSD) or as having a personality disorder are in a frozen crisis pattern. In working with this type of client, the goal is to disturb the long-term pattern of dysfunctional behavior and to help the person or persons develop into a growth-pattern client (Frankl, 1997, 2000; Lantz, 1978, 2000; Yalom, 1980). It is important to take a thorough social history to identify past strengths in this crisis situation, and to utilize a strengths perspective even when the client is functioning poorly.

THE PRACTICE SITUATION

Although the goal of the practitioner in short-term existential intervention is to help the client or client system turn the crisis from a process of pain and despair into a process of growth and becoming, mental health funding sources such as insurance agencies, private charity organizations, and government funding and planning boards are not always so comprehensive in their thinking about what is possible. In many situations, funding sources only desire that the crisis client return to a pattern of equilibrium in as short a time as possible. These funding sources do not generally believe that they have an obligation to fund a growth-centered intervention approach (Lantz, 2000). This is unfortunate for clients in crisis and for society at large. Every crisis situation provides considerable opportunity for the client in crisis to find new solutions, new patterns, new meanings, and new opportunities to become more complete than he or she has been in the past (Berg & Dolan, 2001). When a client is helped to consider and take advantage of these opportunities, he or she is much more likely to avoid crises and other types of significant problems in living in the future.

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Every practitioner must decide whether or not he or she is willing to focus on equilibrium work or will attempt to help clients develop new patterns of growth. This is a clinical but also a moral decision that must be faced in every situation where a client requests help and must rely on some form of external funding to pay for the intervention (Lantz, 2000). It is more ethically sound to try to help every client reach the maximum of his or her potential by turning a crisis into a pattern of growth.

SUMMARY

In this first chapter a number of important concepts have been presented, including the nature of crisis, the origins of crisis theory, and the human response to crisis situations. The short-term existential intervention approach can properly be called both a strengths perspective and an existential approach. Short-term existential intervention represents a strengths approach because it believes in the real possibility of client growth even in horrible situations and because the practitioner must be able to identify client strengths in order to help them change. It is also an existential approach in that the practitioner must be able to fully hear the client's pain in an empathic way. With this level of understanding, the client can use the practitioner's support in a way that facilitates change (Lantz & Lantz, 2001).

The next chapter discusses the importance of environmental modification in existential intervention. The remaining chapters in part 1 present the nature of short-term existential intervention.