Psychotherapy Guidebook

Rational Stage-Directed Therapy & Crisis Intervention

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DEFINITION

Emotional crises occur when an individual's appraisal or interpretation of situational events reflect certain cognitive distortions or irrational ideas. Rational-Emotive Crisis Intervention Therapy (RECIT) was developed to correct irrational ideas and cognitive distortions. While many crises intervention approaches focus mainly on removing a person from a difficult situation, RECIT places a priority on assisting persons to reinterpret their situational experiences in a more rational and adaptive way. The client is exposed to an ABCDE model that puts into rational perspective the present crisis events (A), associated beliefs and appraisals (B), emotion affects, or emotional responses (C), bodily effects (D), and behavior (E). Criteria for rational thinking and behaving have been outlined by Ellis and Harper (1975) and Tosi (1974). A systematic exposition of basic irrational ideas may be found in Ellis and Harper (1975).

HISTORY

Tosi and Moleski (1975) formulated Rational Emotive Crisis Intervention Therapy (RECIT), an outgrowth of standard Rational Emotive Therapy (RET). The main theme of RECIT was to manage the clients' cognitive processes or beliefs about what is happening during a crisis situation. Tosi and Moleski proposed a model for understanding the person-in-crisis situation — The ABCDE's of Crisis Intervention. This early model depicts

(A) the situational or environmental conditions and events that elicit ,

(B) the person's interpretation (beliefs, ideas, appraisals) of the situation,

(C) his emotional reactions to the A and B events,

(D) physiological responses, and

(E) behavioral responses to any of the preceding events.

Recently, however, my colleagues and myself (Tosi, 1974; Tosi and Marzella, 1975; Tosi and Eshbaugh, 1976; and Reardon and Tosi, 1977) have developed and conducted numerous research and case studies on Rational Stage-Directed Imagery (RSDI) and Hypnotherapy (RSDH). While primarily psychotherapies, they also add a new dimension to RECIT. RSDI and RSDH maintain essentially a cognitive-behavioral orientation but are also heavily experiential and stage directed. The therapist

1) trains the client in the use of cognitive-restructuring;

2) induces a deeply relaxed or hypnotic state in the client;

3) instructs the client to focus attention on relevant ABCDE processes;

4) assists the client via imagery to restructure self-defeating cognitions, affect (emotions), bodily responses, and behavior; and

5) directs the cognitive restructuring processes through the developmental stages of awareness, exploration, commitment to rational action, implementation of rational thought and action, internalization, and finally change. The client is directed to experience via imagery the crisis intervention process at each stage while being in a deeply relaxed or hypnotic state.

The use of imagery or hypnosis in crisis intervention in particular and psychotherapy in general facilitates 1) the focusing of the client's attention on relevant problem areas; 2) cognitive restructuring; 3) cognitive control over bodily states — i.e., heart rate, blood pressure; 4) self-awareness; 5) gaining a realistic problem perspective; 6) deep muscular relaxation; and 7) the use of positive suggestions for future action.

TECHNIQUE

The ABCDE model in crises intervention permits the therapist to

determine the area(s) of the person's functioning which need to be managed or brought under control. The therapist then must raise several questions. First, what aspects of the crisis situation are modifiable? Second, what are the client's beliefs or ideas about the situation? Are they distorted or irrational? To what extent is the client aware of his beliefs? Third, what are the associated affective and physiological responses? Fourth, is the client's behavior in the situation appropriate or inappropriate? Therapists using RECIT need to attend to every aspect of the model, although they may be required to focus on some areas more than others. In RECIT the therapist most always tries to help clients gain an accurate cognitive perspective of their difficulties.

RECIT with RSDI and RSDH permits a systematic expansion of awareness of thought (cognitive awareness), affect (emotional awareness), bodily responses (physiological awareness), action (behavioral awareness), and the environment (environmental awareness). Through imagery and relaxation or hypnosis a person can more vividly experience the relationships between the social-psychological influences of the past, the here and now, and the future.

APPLICATIONS

RECIT with RSDI and RSDH has broad applications in the area of crisis-

related disorders. Whether these are affective (i.e., depression, emotional disability, anxiety, etc.), psychophysiological (i.e., palpitations), or behavioral (i.e., suicide), the use of the cognitively oriented RECIT is potentially helpful in symptom reduction and crisis resolution. A case history would be beneficial in understanding RECIT with RSDI and RSDH.

Karl A., a thirty-year-old white male, exhibited a serious agitated depression. Initially, Karl was encouraged to relate the situational event, A, that had "caused" his emotional crisis. Karl was deeply involved with a woman, who abruptly left him six months prior. He promptly became hypomanic depressed. Thus, the A was established. As the assessment continued, the behavioral aspects, E, of his hypomanic depression were found to be multiple and markedly self-defeating. For example, Karl quit his job and spent his days either talking obsessively to people or being in total isolation, ruminating about his loss. Drug use was prominent, and he tended to alienate people with his hostility. During periods of excessive rumination, he would entertain homicidal and suicidal ideas. The psychophysiologic aspect, D, could not at that time be assessed, and it was felt that it played a secondary role to the depression associated with Karl's homicidal/suicidal ideation.

Therapeutic intervention focused upon the belief or attitudinal system, B, associated with the hypomanic-depressive syndrome. Karl believed that it was awful that the woman should reject him and that she should be punished

for this "crime" committed against him. Karl's narcissistic rage, however, was frequently turned inward. On a more covert level, Karl believed himself to be quite worthless as a human being. Rejection of any sort affirmed that he was weak, dependent, and incapable of being able to live a normal life. At this point, the ABCDE analysis was sufficiently complete to relax/hypnotize the client. Using imagery and relaxation, Karl was made aware (awareness stage) of the relationship in relation to the situational event, his beliefs, his emotions, and his behavior.

The therapist then proceeded to help Karl explore (exploration stage) more constructive alternatives to his present crisis state. Cognitive restructuring was introduced here. Though initially resistive, merely getting Karl to focus attention on more constructive thoughts, feelings, and behavior tended to reduce his distress. The therapist helped Karl explore coping beliefs, such as "I am not a weak, dependent and worthless person just because one person rejects me"; "Believing that she must love and approve of me at my demand makes me depressed, so it would be in my best interest to believe that if she doesn't love me it is not a catastrophe"; "Her rejecting me is not the cause of my problem, it's really my belief about her rejecting me that is causing the problem", and "I cannot change her to make me feel better, but I can change my beliefs to make me feel better and accept my situation as it is." After exploring these and many other beliefs, Karl was guided into the commitment stage. Rational beliefs that he seemed to respond most favorably

to were repeated again and positively reinforced by the therapist. As Karl's distress gradually subsided, he was asked to see himself (via imagery) becoming committed to the implementation of more desirable ways of thinking and acting. Then he was asked to visualize himself implementing (implementation stage) more rational ways of functioning in real crisis situations. Finally, the therapist asked Karl to see and to feel himself internalizing (internalization stage) these more adaptive behaviors and bringing about substantive changes (change stage) in his behavior.

To assure maintenance of Karl's behavioral change, the therapist recommended that he come in the next day, which he did. He showed markedly fewer depressive symptoms. Noticing that Karl was in a more elated mood, the therapist suspected that Karl's hypomanic defenses were returning. The therapist recommended longer-term therapy, because of Karl's cyclical tendencies to become excessively depressed/ hypomanic. Confirming this, Karl decided to enter therapy. Essentially the same therapy was used as in the crisis intervention, except that more situations were used. In about six months, Karl was more able to cope with rejection, to minimize feelings of worthlessness, and was able to obtain employment in a sales job with moderate success (three months after therapy terminated). Homicidal and suicidal ideation was absent. The excessive rumination about his former woman-friend was markedly diminished, and drug abuse ceased. Finally, Karl's interpersonal hostility became less prominent and he entered into

more substantive relationships.