Thoughts on crisis and crisis intervention

There are countless notions for the analysis of crisis theory. The expression 'crisis' is of Greek origin. Its meaning is equivalent with the sense of "turn" in medication, which is often experienced during the course of physical diseases. It was observed during serious epidemics, that the patients' worsening state seemed to be suddenly changing from the nadir of their irreversible state. Perhaps the other meaning of this word is also interesting because it can be expressed as trauma. This modern use of the word denotes mental, economic, social and natural situations where turning points appear. General psychology, sociology, psychiatry and economy deal with crisis situations.

Psychical symptoms and the possibilities for assistance to the physically and mentally traumatized started to be concerned more intensively in the second half of the past century. Lindeman dealt with people (with grief reaction and the processing of loss) whose relatives were involved in a fire in Boston in 1944, and it turned out, that the ability of families to process trauma had improved. The psychological background was founded by Ericson (1950) with his dynamic model of development including the phases of adulthood. He was the first who explained the notion of the developmental crisis – and he did not restrict his analysis to childhood as his predecessor, Sigmund Freud did, but considered the adult way of life as a constantly changing, developing, and shaping period.

The other electrophysiological, psychological researcher, János Selye claimed that the human organism similarly reacts to the non-specific damaging effects with an adaptation syndrome in stress theory. Its first phase is the alarm (an emergency reaction), followed by the phase of resistance, and finally the period of exhaustion. Cannon, whose research experiences can also be traced in the background of this theory, analyzed emergency reaction in detail. By this time it was obvious, that a certain amount of stress is necessary for development. The author referred to his own research results with the phrase: "stress is the quintessence of life." Controlled and overcome difficulties, as well as the undercurrent excitement can sustain one's personality and self-esteem.

Cumming (1962) differentiates three groups of crises: there are biologically founded ones, which cannot be avoided, for instance puberty. The second one is evoked by environmental and social factors. These can be partly avoided, for example crises evoked by migration. Finally, unintentional accidents or catastrophic situations belong to the third group of crises.

Lasarus (1966) called those adaptation attempts confrontation or coping that aim to overcome the above mentioned stress situations. Problem-centered and emotion-centered approaches are differentiated. If the person focuses on the solution and the change instead of the problem, we call it a problem-centered approach. When the person's aim is mainly levelled at reducing the emotional reaction connected to the crisis or stress situation – including anxiety, fear, or depression-, and does not want to solve, or change the situation itself because it is beyond his/her power, or he/she is unable to do so, then it is an emotion-centered approach.

The purpose of emotion-centered strategies is to protect the person from destructive impulses, emotions, or to reduce negative emotions in uncontrollable or similarly qualified situations, so they can help adaptation, and the reduction of stress.

Attila Oláh (1966) talks about so called coping potential dimensions, which indicate those personality factors that contribute to the individual's coping ability through influencing primary and secondary evaluations. Such features are controllability, learned inventiveness, or the complex notion of

psychical hardiness, which includes the appropriate self-confidence, frustration tolerance, commitment, active reaction to challenges, and controllability. Positive thinking or optimism is necessary for the individual to engage in a task and to be able to imagine and fantasize about its fortunate outcome. The other thing is the sense of coherence which provides the efficiency of solutions by promoting rationality and the understanding of coherence. One of the most important factors in self-efficiency is proper self-knowledge, psychological knowledge, and the ability to learn a lesson from something in the course of coping. The application of particular coping methods depends on both the individual's current physical and psychological states. These can be acquired on the first and second levels of socialization.

Finding stress management mechanisms continually generate a broader scale of knowledge. The definition of stress management mechanisms is the following: series of activities menacing our safety and initiated by situations threatening our self-esteem. For example:

1. Defensive techniques: we try not to notice something, or we start a danger-seeking behavior anticipating the solution.
2. Preventive techniques: we mainly apply avoidance and delay, and try to solve the situation by passive acceptance, by blaming the circumstances, or by accusation.
3. Autoplastic restoration techniques: when we try to find a solution by ourselves from our self-supporting powers. Apprehension, desertion, rephrasing of the situation, relabeling and acknowledgement of dangerous situations belong here. Recognition of necessity serves the initiation of self-supporting powers to get into motion.
4. Alloplastic transplantation techniques: when an individual tries to draw mainly from external and partner-supporting forces. It can be a knowledge broadening activity, information extension, learning, affiliation, reinforcement, or direct activities. The main goal is to develop proper behavior methods from the existing behavioral repertoire.

Individual directions and choices can be highly influenced and defined by the supportive relationship. It is required to help orient the individual toward data-fact solutions during support, and it holds for telephone operated work, as well.

Based on client analysis after the above mentioned fire catastrophe, E. Lindeman emphasizes the following as the criterion for the course of normal mourning reaction:

1. independence from death
2. readjustment of those situations, circumstances where the deceased person is missing from
3. the individual is able to establish new relationships which satisfy him/her

It is apparent, that familiarity with the stages of mourning is necessary for the supportive relationship in crisis.

War crisis situations discussed by several authors (Pinker, Spiegel, Rado, Holdstein, Glass), appear in refugee sustenance situations, in terror attacks, and in the large scale migration in Europe nowadays.

According to Lindeman, in case of crisis – connected to grief and the loss of a relative –, the most important points to be applied in supportive communication are the following:

1. A somatic physical distress syndrome evolves. In today's sense, it is similar to the vegetative symptoms of panic disorder.

2. With the help of fantasy connected to the lost relative, the mourner tries to fill this loss with hallucination.
3. Sense of guilt – regarding the mourner –, that is especially expressed when ambivalent, controversial emotions and failure are connected to the lost relative. This can also cause a pathological mourning reaction.
4. Hostile feelings emerge toward the deceased, when similarly ambivalent sides, signs or guilt motivate the mourner.
5. The individual experiences that he/she loses control over events, if they happen independently and beyond his/her control.

Gerard Caplan further develops crisis theory in the 1970s. He tries to summarize its tenets, the psychological situation, crises and attempts to put down its major points in the supportive model. Its formerly mentioned features are the following:

1. The person is unable to face events and circumstances menacing his/her psychical state;
2. Closeness of the problem is the central question of his/her life and it becomes more important than anything else;
3. The evolved situation cannot be avoided, or solved with the usual method;
4. He/she cannot control problem solving, stress managing methods that formerly proved to be efficient in behavioral therapy, so he/she requires external support.

In fact, there are three criteria which are very important. Individual solution capacity is insufficient, thus external support becomes a central question. Many authors, including Sifne Boss (1972) and others emphasize the feeling of intense threat, which in a psychological sense stand for concurrent hopelessness, disorientation and a painful psychic state. Choice and decision are experienced as a possibility to move to good and bad directions, thereby the capacity of problem solving is overcharged and a sense of deficiency is experienced. Most of the negative life events, which trigger crisis, are oftentimes family related experiences, close to emotional states (Holmes's colleagues 1967). The course of crises and their stages are stirring in regard to the supporter, including telephone work.

Sifne Boss created the notion of emotional crisis in 1972 in view of the Caplanian crisis theory. It is such a tense and painful state of mind, in which the possibility for development, for the right to a more harmonic existence – rather than relapse, that is to get into a strict, narrowed, disharmonic state – is given. It emerges after a dangerous life event happens to the individual but it does not necessarily turn into a crisis situation in each case. Jacobson's (1979) crisis matrix theory developed from these ideas: he merged accidental and developmental crises. In his words, the crisis matrix is a longer period (lasting for months, or years) – generally a transition between life phases –, when the individual experiences many emotionally disturbing, critical situations, thus he/she becomes more receptive, more vulnerable to the emergence of crises.

Turning back to the idea of those events that evoked crisis, we can conclude, that they are often unexpected, and characterized by the traits of failure, loss, and danger. Emotionally they are considerably stressed for the individual in a given moment, and they reach the person through a system of relations, which emphasize defenselessness, restraint, provocation of distress and helplessness. Their common feature is that events – or so called experiences of loss – frequently appear collectively. Events are structured in layers and it causes the existing conflict solving

techniques to be paralyzed, and the individual wants to destroy himself/herself instead of the problem. In 1949 the psychiatrist, T.H. Holmes started to examine if there was a connection between the individual's significant life events and his/her serious illnesses that occurred during this period. He created the social readjustment rating scale, listing 43 remarkable events, including joyful and static ones. Numbers denote the extent of crisis situations connected to life events, which determine stages to the risk of illness: events above 50 points are all critical but it is not sure if they provoke a psychic state.

Due to the deficiencies of socializing processes, several inclinations to crisis originate from unprocessed failures and experiences of loss. There are intergenerational crises, where mysteriously returning traumas cause the same problems in the families from generation to generation. However, returning crises are when the same life situations, breaking of relationships, experiences of loss return in the person's life. Life turning crises are also well-known phenomena of crisis literature. Crisis states can be divided into specific phases. In the first period of the crisis state – returning to stress theory – there is an alarm reaction, an emergency state, then comes the period of coping, and the third period is panic. This is an emotion-controlled, non-rationally operating state. It tries several techniques but uneasiness, anger, upset emotions characterize this state. If strained efforts do not solve the crisis, the phase of breakdown follows in the fourth period. In this case affectivity, emotions, impulses take over the control. Momentary flow of ideas and impulses define activities. Narrowing could become dangerous because destructive behavioral patterns may appear. It can also bear the risk of suicide.

Models describing crisis states illustrate triggering factors and the procession of crises. Causes for such situations could emerge during crisis hours. Dread and unease last for a few days, then adaptation develops in some weeks. This theory is Hirschowitz's crisis model (1973). Crisis situations force the individual to change in all cases. Differentiation of personality and emergence of empathy are appropriate for the growth of commiseration that evolves in critical situations.

The outcome of a crisis situation can be seen as the possibility for reaching a developed balance state: more developed coping techniques come into prominence, learning to handle losses, gaining new self-expressive techniques, while the differentiation of personality begins, self-confidence increases. These are creative or positive crises. The other direction is finding balance through dysfunctional operation. Appearance of adaptation disorder, symptoms of anxiety, posttraumatic stress – frequently present on wartime areas nowadays –, depressive symptoms, emergence of addictions (alcohol, medicine, drugs), emergence of toxicomania, or psychosomatic disorder, psychotic state, suicidal crisis may be the outcome.

Nothing is going to be the same after crisis situations. There is a possibility for development and differentiation as a result of individual suffering. In a less fortunate case, balance is restored through dysfunctional operation. Psychic illnesses may evolve as it was mentioned above. From this point of view, coping strategies are very important in supportive work.

From the mid-twentieth century Lasarus (1960) and his colleagues introduced a new notion, coping, as it was mentioned before. Coping means confrontation, management and domination over difficulties. In contrast with instincts, it is not a spontaneous, not an instinctive but a conscious strategy resolution construction. It is worthwhile to mention catastrophes, where accumulated and condense crises take place. Not only individuals but communities and masses can also be involved. In other words, catastrophes are special crisis situations which affect communities, not only an

individual. There is opportunity for reliance, cooperation and sharing one's burdens with others. These emergency cases must be thwarted, in order to avoid the emergence of post-traumatic stress preventively. Catastrophes can be divided into different phases according to the order and time of events, and the participants' behavior.

1. The first phase is the period of the burst of emergency. 15-25% of affected individuals show intense anxiety, panic, depression. Just a small proportion (one quarter) of the community is capable of keeping real control and facing the situation.
2. The second phase follows right after the emergency period has ceased. When the situation starts to get back to normal, and it is rearranged, subjects start to react to events and the early period of processing the problem begins but the trauma still remains in the center. This phase could last for weeks.
3. The third phase is the post-traumatic period. Everyday life returns to its usual routine but sleeping disorder, nightmares, anxiety, sense of fear, depression, and incapability of breaking with the trauma characterize this state.

Pataki (1998) divides panic situations into four phases.

1. The first is the **pre-critical** phase, when perception and awareness of the crisis happens. e.g.: flood or earthquake
2. The second is the **critical** phase. Perception and apprehension of actions characterize it. Escape and activity attempts come up. Old strategies are reinforced. Informal leaders are chosen.
3. The third is the **post-critical** phase. Rational activities dominate. Cooperation is more intensive and the restoration of regular behavioral patterns begins.
4. The fourth phase is the **return to the state before the panic occurred**. Assimilation of new adaptation techniques.

Averill differentiates three stages based on his research: the state of shock, the period of loss of object and the phase of recovery. It was emphasized in the introduction, that crisis states are very similar to mourning reactions, or accumulated crises, and chaotic states. The supporter must advocate even adolescent realignment, the possibility for broadening of repertoire, and have to find a way out of crises, for which several solutions are offered. Any stress decreasing mechanism is appropriate. One of these solutions in psychoanalytic thinking is sublimation, where release of unconscious powers and contents can be satisfied through any activity or creation (several creative techniques are welcome to be applied in work and in arts).

Teréz Virág (1993) compared the role of Winnicottian transitional objects to the function of compensational activity, and she found many similarities and resemblances. Suffering and trauma are transformed into active thinking and creativity. It is important during the processing of traumatic experiences that events of trauma appear in an acceptable, verbalized form in the continuity of personality development. They should be conveyable and communicable to the external world. It is very important, that the above mentioned traumatic experience should appropriately become the part of self-development, and it should not turn into a self-estranged process. It can become separated with its emotions and contents if it does not fit and integrate into the personality as a whole.

Crisis processing is characterized by extremities of duality and ambivalence: despair and search for

resolution, hopelessness and hope, acceptance and objection. Creative creation has reward and integrational function during processing. It tries to reintegrate the traumatizing part of the self through activity and creativity, and carries the maintenance of double consciousness and ambivalence.

Lindemann's idea of grief and loss, Caplan's concept of crisis, Ericson's crisis theory regarding life-phase turning points, and Rappaport's emphasis on role change considered the core of crisis in different ways. Cullberg thoroughly analyzed trauma induced crises. There are also biological, somatic crises but it is difficult to separate accumulated crises. The merger of bio-, psycho- and social dimensions may appear during telephone work, in the dimensions of crisis. Biologically difficult life phases (hormonal changes in puberty, menopause, pregnancy, and aging) raise critical changes, causing imbalance. They are highly important in supportive work and telephone work.

Distinctive phases can be differentiated in Cullberg's ideas about trauma induced crisis. He emphasizes the phase of shock, the reaction to shock and its chronic turn, where danger of suicide is remarkable. It is followed by the processing of the experience, then rearrangement and reorganization of the situation.

If we examine the course of crises, the following factors must be considered extensively: in what age, which life period did the crisis emerge? What is the individual's problem solving capacity and the repertoire of behavior like in this life phase? How far is this crisis from the necessary stages of resolution?

The other situation for examination is when we focus on the quality of the individual's problem solving capacity, what kind of working methods he/she uses, to what extent he/she is able to apply systematic methods, how can he/she tolerate chaos and uncertainty.

Conclusion: it is necessary to define the minimal purpose of general crisis therapy, which aims at the psychological resolution of the crisis. Only this point must be focused on and be discussed during the conversation.

However, the ultimate aim is to improve the psychological and mental levels before the crisis, so we arrive at the barriers and limits of assistance, and the extreme edges of telecommunication.

Purposes aimed at the resolution of the crisis state, which intend to help the individual in the achievement of ordinate psychic state, is called crisis intervention. In a medical sense, an emergency event is one which requires immediate intervention. The laical environment can also help with crisis intervention. The person in crisis is especially responsive to intervention, he/she is strongly suggestible, emotion controlled, volatile, troubled and narrowed to the provoking event. Not only is the person's suggestibility strong, but his/her motivation to be supported, and to talk about his/her feelings, thoughts and fantasies.

Rapport skill must be established by turning to the subject. Mental breaks of the person in crisis will ease; he/she is prone to impulse directed solutions. The task of the supporter is to recognize danger, to try to save the subject from actions that he/she would regret later on, what he/she does not take willingly, or what is also dangerous for his/her environment.

Decision is especially important in our work – including phone service –, whether the extent of the client's inordinateness and narrowed consciousness affect the control of reality, or if he/she has a

psychic illness, which require medical treatment. In this case direct efforts must be made to forward him/her to a specialist. Direct client delivery-reception technique must be applied in this case, and the time of contact making should be as short as possible. The environment must be involved but carefully and thoughtfully, in order to avoid distrust.

Steps of crisis intervention:

1. Mapping the causes, finding relief, building an accepted, strong relationship. (Building rapport)
2. Offering support, following, listening, intensive emotional attention, unconditional acceptance.
3. Reservation of certain emotional reality.
4. Careful expansion of narrowness, involving other aspects and merits.
5. Reduction of tension and impulsiveness, reality control, representation of multiple perspective thinking, protection of the subject from ill-advised acts.
6. Upholding hope, focusing on the problem at hand, self-strengthening, gradual restoration of self-esteem, positive attitude.
7. Active intervention if auto- or hetero-destructive tendencies are observed.
8. Support and motivation in turning to a specialist, evoking the need for personal intervention, or hospitalization.
9. If it is necessary, trauma treatment in the family and in the close environment.
10. Involvement of those people who can help to ease narrowness and offer support and acceptance: involvement of the environment and authorization of the appropriate client, proceeding tactfully.
11. The subject's dependence should be avoided; analysis of deeper dynamic correlations and the transition into psychotherapy are not recommended. They should be offered later.

All in all it is obvious, that in crisis situation management it is important to close the steps of crisis intervention as soon as possible. It could be followed by psychological consultation, tracking, or psychotherapy. There are some specialists, who simplify crisis intervention and crisis therapy and they differentiate only four phases:

1. Judgment of the individual and the problem
2. Construction of therapeutic intervention
3. Realization of intervention (bringing emotion to the surface, re-starting and re-opening the world)
4. Anticipatory planning (accomplishment, elaboration of small details of fantasies of action)

If the crisis is not solved, if these phases of crisis therapy cannot be implemented, then hospitalization or redirection to special crises ambulances is necessary.

Comparison of the Freudian psychosexual development theory and the Ericsonian ideas of psychosocial development theory is a stirring question – even in telephone work –, where identity or confusion of roles are remarkably emphasized. In fact, it generated James Marcia's (1980) identity status examination, which analyses, whether identity crisis happened, or if commitment was established (identity becomes a considerably central question, which is going to be the greatest problem of the 21st century later on). Laufer's emergency signals, the adolescent breakdown signals are even more emphasized from this aspect. The most frequently occurring crises during the period

of puberty in 1975 were identity crises, achievement crisis, authority crisis, eating and sleeping disorders, drug-addiction, and suicidal problems. All of them bear accumulative crises.

Personally, I think that the problem of suicide should have had high priority in telephone work. Professor Ringel from Vienna has reached the greatest breakthrough in the field of suicide in his research. He analyzed the common symptoms through psychological dissection after saving 146 patients, who tried to commit suicide. He recognized three groups of symptoms. One of them is the phenomenon of narrowness, which consists of emotional, mood, dynamic and affective narrowing: thinking, movement and communication are narrowed. This may last for weeks, or months. The next group is the appearance of suicidal fantasies, which characterized the examined population for weeks. The third group is the conscious intention for death. We analyze the presence of these three groups of symptoms or phenomena on a time axis in the pre-suicidal period. In case of psychotic individuals in old age or patients who suffer from dementia, the phenomenon of pre-suicidal syndrome can hardly be discovered preceding the suicide.

The phenomenon of "cry for help" is a stirring question. The person tries to ask for help through indirect signs and the question is, whether these signs can be decoded, whether we will be able to recognize them, or help them. Communication through the channel of telephone provides possibilities for transmission: the speaker's tone, the person's speech characteristics, and emotions influence it, while anxiety and internal tension signal change. Tone and speed are influenced by psychic properties and temper; an emotionally high-spirited person is faster, while a depressed person produces slower speed in communication. Transmission and function of emotional charge is the highest during pauses, so the dynamic of silence must be well known in telephone work. Tone and volume must be considered as the release of tension, from which we can draw conclusions to the extent of emotional influence. Intonation must be interpreted as a phenomenon generated by emotional changes. In vocal communication seven basic emotions (love, anger, boredom, happiness, impatience, anxiety, satisfaction) can be perceived with certainty based on four acoustic variants (volume, pitch, speed, rhythm). The vocal channel itself is the most sensitive factor in the dysfunction of psychic processes. They speak about signs of confusion, while incorrect pronunciation, verbal mistake, too long pauses, incorrect word order, omission or repetition of words, or unfinished sentences allude to serious disorders. There are signs of communicational disorder, which can exclude the partner, for example: absence of linguistic socialization (it is hard for the person to form words about his/her feelings), or the use of jargon. The flow of words may cause tension in communication; generalization and the use of clichés can stand for sleaziness or disrespect. Barriers of transmission thwart communication. These are order, command, warning, threat, preaching, polarization, advice-giving, listing advices for solution, logical argumentation, persuasion, judgment, critique, qualification, accusation, praise, understanding, dishonor, travesty, and condemnation. All of these are capable of evoking a block in communication which is important in the course of supportive conversation. "Who takes the time and is able to keep up the conversation saves a life" – as we usually phrase it.

Montun's idea of four ears: communication operates on four stages, it consists of four types of messages, so "four ears are present in communication". One statement can have more messages and it can lead to inner conflict. The four aspects are theoretically equal. The layers are:

1. Matter layer: informational side of the message based on criterion (true or false, appropriateness, relevance, importance, sufficiency, adequacy).
2. Information about us, revelation of personality, mood, orientation, the level of our relation

to the role.

3. Relationship layer, where the message reveals the relation between the two speakers. It is a sign, how the speaker relates to the listener.
4. Appeal: the speaker's intention is revealed, what he/she wants to achieve.

Listening is a complex phenomenon in a communicational supportive relationship. It is two-directional, the aim is to listen to the calling person, reinforce and help him/her to find a solution to the problem. The timeframe is limited and controlled by the caller. Methodologically the conversation is controlled by the approving person. The directed, guided phase in the course of supportive conversation, or stimulation of self-revelation in crisis intervention shall be concerned. Active listening and comprehensive attention contain both of them.

As Alfred Vanes said, "listening with the ears of another" is the hardest part of our work. The point is, how we can give feedback to the appropriate type and intensity of feeling, how comprehensive attention can be developed (discreetness is a very important part of reaction to emotions). Here are some sentences which are typical to our work:

- You feel/believe/think, that…
- It seems to you, that…
- From your point of view…
- I suppose from your words, that …
- It seems to me that you …
- Perhaps you …
- If I understand it correctly, you feel/believe/think, that

All of them signal that we represent a comprehensive attention. Admitting but not initiative, freely floating attention and interest are required in a good supportive relation. The supporter listens to the speaker's experiences, he/she is curious and capable of waiting without judgment. He/she is committed, authentic, tolerant, objective, takes responsibility for the relationship, respects the supported person, facilitates disclosure and uses silence. The supporter makes himself/herself understood by the supported through his/her own language, he/she uses the caller's terms, regards both his/her own and the caller's reactions; the supporter is free from pressure, he/she is controlled, emotionally stable; he/she manages and guides the conversation, keeps the limits, gives an opportunity for the supported to decide what and how much he/she wants to share about himself/herself. The supporter tries to ease resistance, listens acceptably, highlights important feelings that the caller has disclosed. He/she is authentic and if it is necessary, he/she reveals his/her feelings regarding the relation. He/she creates an accepting, reliable atmosphere.

All of these complex communicational phenomena are present in the context of support. Regarding these situations, we collected training exercises based on more than a decade of training, supervisor and telephone supporting work experience, for which we try to make our newly employed supporters more affected and trained.

With the help of Rogers's triad, the supporter has to learn and acquire constant communicational presence, and the significant messages of the sanctuary of humanistic psychology. The supporter acquires the method of sequencing, layering the pre-history of crises according to age, and the disclosure of life crises through timeline technique. This technique gives such a foundation of self-knowledge, where supporters can help others to clear turning points in their lives and to get rid of blind spots in their self-

image.

With the help of self-exploration scales we try to acquire the discreteness of helices of self-revelation and the importance of sequences, and that these stages must not be arbitrarily violated by pulling back the individual, or forcing him/her to a faster progress.

The Asist model is a very practical sensitizing program for beginners. It is vital to prepare as much amateur supporters, volunteer communities, community protecting guards in our environment as possible, with the help of these methods.

The risk of suicide is greater if:

- somebody loses a close person or an intimate relationship breaks up
- when health or circumstances change to the worse, or presumably will change, for example: retirement, financial problems
- painful and/or disability-causing disease occurs
- in case of alcohol abuse, or alcohol or drug addiction
- the person has had suicidal attempts before
- there has been a suicide in the family
- in case of depression

People usually indicate their suicidal feelings if:

- they withdraw and they are unable to build any relationship
- they have an imagination about how to commit suicide
- perhaps they talk about arranging their issues, or show any other signs that they are preparing for suicide
- they talk about that they feel lonely and isolated
- they express that they are useless, unsuccessful, and they feel desperate and hopeless, they lose self-esteem
- they constantly reflect on problems, for which there is no resolution
- they express the absence of positive life philosophy, e.g.: lack of religious belief

In practice we decide on the possibility of suicide with the help of the following scale:

- 0: the person does not have any thoughts about the intention of suicide
- 1: the person has had thoughts about suicide but he/she has not imagined how and when to commit it: “I can’t take it anymore,” or “I wish I would die”
- 2: the person has thoughts and a plan for suicide but he/she says he/she is not going to commit it right now. “I have my sleeping pills with me and if the situation won’t get better …”
- 3: the person is preparing for suicide (a knife or pills are behind him/her) or he/she has already committed it (has used the knife or has taken the pills) before he/she connected the supporter.

The turnover of above mentioned ideas into practice is a really complicated endeavor but from the point of view of training, supportive relation and attendant supervision, unified case treatment and crisis management techniques can emerge, which make our work safer. We tried to help this work with the mentioned methods.

HELPING CONVERSATION

1. **What will you achieve with this exercise?**
   The individual person standing amidst the challenges of life often feels that these challenges are problems. The aim is to treat the problem as a situation that can be examined and responded to…

   A helping conversation consists of three phases:

   - following
   - emphatic reflections
   - guided conversation.

2. **How does it work?**

First phase: FOLLOWING

Duration: 8-10 minutes.

The client tells an average of 4-5, or at most 6-7 sentences as a part of the whole story, trying to stay on the same line. At the end of this phase his/her motivation for speaking gets slower, the power of communication looses strength.

Should we interrupt the client too early, we'll hear: "But I haven't told you, that..."

In case we take the first step too late, we'll get: "What do You think about it?". This means, that we are passive listeners and do not notice that it's time for stepping into the next phase.

Second phase: EMPHATIC REFLECTIONS

This phase is a very important, central part of the helping conversation, which is very difficult to be executed professionally.

Duration: 1-2 minutes.

It has got two functions:

transmitting empathy: "I understand You", "I can imagine myself in your situation"

reflecting: "For me it's clear that..." "This situation reflects that...", "It has a message that..."

Similar sentences can be delivered to the client aiming to summarize what has heard. Do not use foreign words, because these key-sentences will be the starting point of the conversation hereafter.

You should say something even in the most blocking situations as well, like “For me the facts are...”, “The problem is that...”, “The situation is that...” or anything else you may feel.

Afterwards, this phase is to be closed by a fix sentence like “And what do you think about it?”, by which you confidently make the client keep on speaking, without generating any conflicts or disputes. This behaviour indicates that it’s time to evolve the details and dimensions of the problem.

Third phase: GUIDED CONVERSATION

Duration: 25-30 minutes

The issues to be cleared are as follows:

Why did you called right NOW?

Why did you called US?

Have you ever turned to any other helpline services? What happened then? What

do you expect from us? What can we offer?

Who are your supporters/resources? Who are your enemies? What

are the difficulties? How can you overcome?

What are your strongest fears?

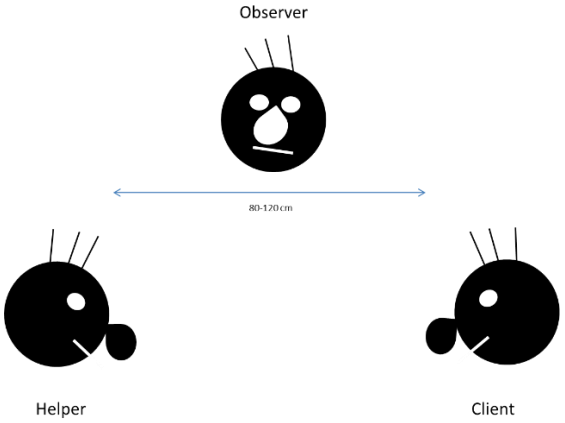
What is the worst thing that could happen?

So our aim is to create an action plan. During this work, we have to proceed according to the scale of self-exploration by Tringer & Pintér. We have to go ahead strictly step by step as people often feel fear and anxiety for intimacy and self-exploration. Sometimes we have to apply the brakes, sometimes we have to speed up the process.

Braking question: “How would you specify...?”, “Let’s try to think it over together...”

Speed-up question: “How would you describe the next step?”

3. **What do you need?**
40 minutes for role-play. We need 3 participants acting as observer, client and helper.



4. Reflection

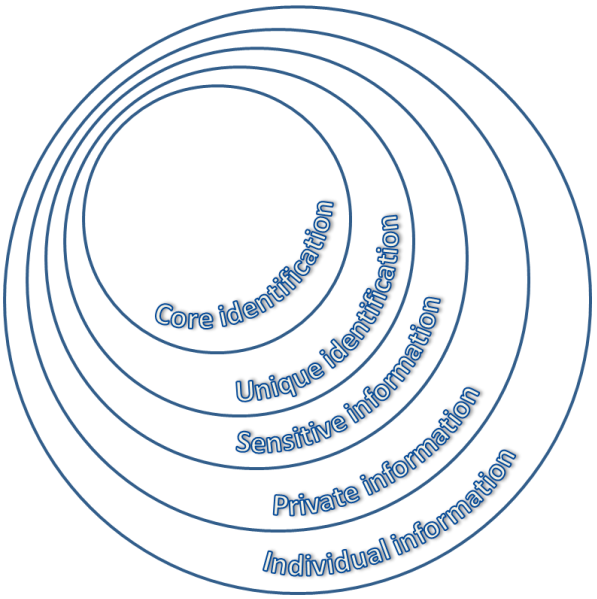
At the end we have to explore whether there is anything important left from the story that hides the substance. The crisis is usually defined by this time, for which the helping conversation is no more suitable, it is beyond its efficiency. Now focal crisis therapy or crisis intervention is necessary.

SELF-EXPLORATION SCALE BY TRINGER & PINTÉR

1. **What will you achieve with this exercise?**
   Self-exploration happens consequently in a row of circles of intimacy. It is very important to strictly observe these stages not to generate distress or shame during self-exploration.

2. **How does it work?**
   You have to adjust the rhythm of your questions to the client's self-exploration's level. Keep the optimal time for the conversation in order to avoid that the client feels pressed or fails to reach the honest thoughts of actions or the deepest emotions of intimacy.

   For the above, Tringer & Pintér has worked up a self-exploration scale. Communication units shall be recorded in a thematic way, then replayed to the group who will give points for such units (a unit can consist of one or more sentence joint together by a same message).



3. **What do you need?**
   30 minutes roleplay. Printed sheets of Self-exploration scale (Tringer & Pintér).

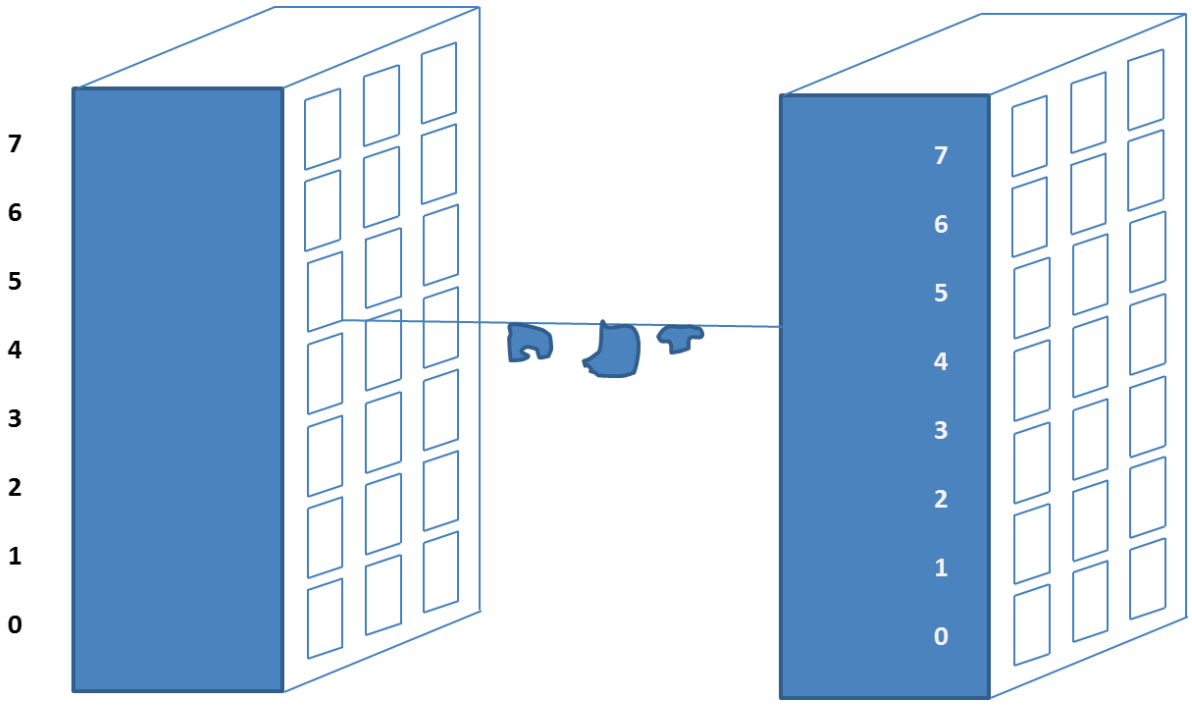
4. **Reflection**
   The group will learn to analyse, evaluate, and classify the units according to the following rules:

   - Do not step from the general line directly up to the higher level of intimacy!
   - Do not turn from the zone of intimacy back to the general level! Do not be afraid of the whirl of self-exploration! It would slow down the effective communication as well as the process of self-exploitation.

   The above rules of this spiral method can make the communication with clients more effective.

Self-exploration scale (Tringer & Pintér)

7	The client – in possession of the new knowledge about him/herself – aims to change his/her behaviour or adopt new attitudes.
6	The client intensively deals with his/her emotions and observes new relations that give him/her a more realistic and wider range of knowledge about him/herself.
5	The client mostly talks about his/her emotions, evaluating him/herself.
4	The client mostly talks about his/her emotions.
3	The client's emotions come up in references or can be suspected.
2	The client speaks about his/her own behaviour, without emotions.
1	The client complains all the time about his/her physical or mental status.
0	The client does not talk about him/herself, rather describes events or other people.



THE TRIAD GAME BY ROGERS

1. **What will you achieve with this exercise?**
   In Rogers' triad model a real encounter (meeting) consists of three main components: the empathy, the unconditional acceptance and the congruency (credibility).

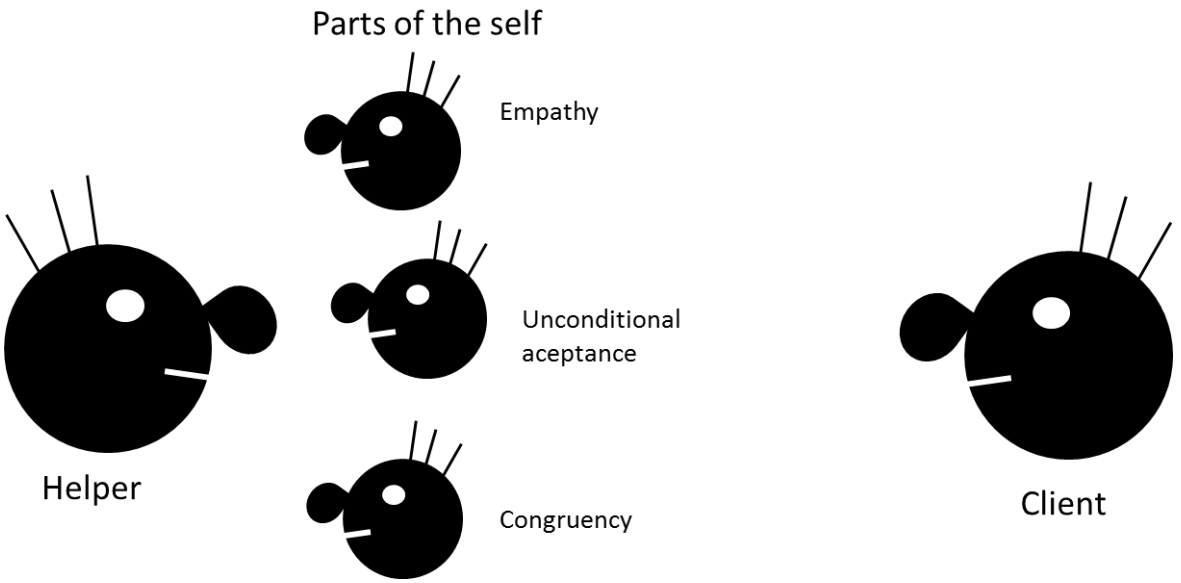
   The helper will live through the importance of their sequence and parallelism in different phases, and learn how to use and synchronise these three functions.

2. **How does it work?**
   The three main component as above will be the base of the following game, where the helper has to choose three performers representing the PARTS OF THE SELF, as follows:

   - a person acting as EMPATHY
   - a person acting as UNCONDITIONAL ACCEPTANCE
   - a person acting as CONGRUENCY.

   The helper is sitting facing to the selected three persons and listening to the client (caller). The performers' task is to give reactions to the client's sentences according to their role.

   Afterwards the group commonly analyze the sentences or the communicational units of empathy, unconditional acceptance and congruency.



3. **What do you need?**

30 minutes for role-play. A pen and a sheet of paper with the following content, on which the participants can record their thoughts:

Typical sentences of empathy:

Typical sentences of unconditional acceptance:

Typical sentences of congruency:

4. **Reflection**

Processing:

Sharing

The key sentence: „Have you ever gone through such a situation in your life?" "Have you ever had any experience that raised similar emotions in you? "

Role feedback

„What did you feel in that role?" "What kind of thoughts did you have in that particular period of life?"

Identification feedback

The question is not only for the performers bust for the whole group as well; anyone who feels being equal to any of the performers: „What kind of thoughts grew up in your mind?" "Did you feel empathy?"

TIMELINE TECHNIQUE WITH PSYCHODRAMA METHOD

1. **What will you achieve with this exercise?**
   This method helps to explore effectively any and all important stages of life, as well as the tendencies and the breaking- or turning points. It is like making a soul inventory. The emotions, experiences and blockings can be processed by a flash or the aha-experience according to the method of Mihály Bálint.

2. **How does it work?**
   The helper (protagonist) gets a piece of paper with the instruction to put the most important events of his/her life onto the timeline.

   The helper indicates the dates of these events, and links some thoughts, messages, experiences, which were significant and influenced the future.

   When ready, the group will have to imagine the long timeline in the room. Their task is to choose some persons who will represent the important resources or thoughts. These persons will get and memorize the key sentences and repeat them step by step.

   Changing roles may enrich and deepen the game, combining with the protagonist centred psychodrama model of Jacob-Lewy-Moreno.

   At the end of this game, the important messages and governing thoughts will be emphasized and repeated while moving forward on timeline.

3. **What do you need?**
   30 minutes for role-play. A pen and a sheet of paper with TIMELINE.

4. **Reflection**
   At the end, the group and the protagonist will be asked to evaluate the task in three steps according to the processing model of psychodrama:

   Sharing
   The key sentence: „Have you ever gone through such a situation in your life?" "Have you ever had any experience that raised similar emotions in you?"

   Role feedback
   „What did you feel in that role?" "What kind of thoughts did you have in that particular period of life?"

   Identification feedback
   The question is not only for the performers bust for the whole group as well; anyone who feels being equal to any of the performers: „What kind of thoughts grew up in your mind?" "Did you feel empathy?"