CRISIS INTERVENTION WITH DEPRESSED INDIVIDUALS EXPERIENCING LOSS AND OTHER SITUATIONAL STRESSES

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We hereby recommend that the THESIS prepared under our supervision by DEBORAH YVONNE JACKSON BARRANCE entitled CRISIS INTERVENTION WITH DEPRESSED INDIVIDUALS EXPERIENCING LOSS AND OTHER SITUATIONAL STRESSES

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CHAPTER 1

INTRODUCTION

A significant area in the mental health field is the treatment of individuals diagnosed with depression. Depression is a disorder that affects a large number of individuals at least periodically throughout their lives, and many of these individuals seek treatment for their depression. These individuals present themselves at a crisis center, or call over telephone hotlines for psychiatric assistance.

Crisis centers presently are one form of treatment for individuals who are acutely depressed from sudden loss or from conflicts in interpersonal relationships with significant others. There seems to be two different groups of individuals who experience depression. One group is characterized as those individuals who suffer an actual loss of a significant other, such as death or divorce. The other group is characterized as those individuals who are suffering depression related to other situational factors, such as marital conflicts. The question that is conceptualized in dealing with these two groups is: Is the precipitating factor for

depression associated with the effectiveness of crisis intervention?

Problem of Study

The problem of this study was to determine if there is a difference in the level of depression after the institution of crisis intervention between persons experiencing depression associated with a loss and those experiencing depression associated with other situational factors.

Justification of the Problem

The concept of crisis has captured the attention of many mental health workers, and offers a real basis for psychosocial intervention in both physical and mental disorders. Dohrenwend and Dohrenwend (1974) noted that growing empirical literature identifies that times of crises are crucial and have definite impact on mental health.

A state of crisis is not merely stressful, nor is it merely an emergency where appropriate action is clear but time-limited. In order for a crisis to exist, then, the problem initially has to be beyond the individual's existing resources and usual problem-solving skills (Caplan, 1961).

The concept of crisis as described by Weiss (1976) is a state that is potentially a reversible effect of an event with time-limited impact, although according to Parkes (1971), the concept could cover lasting transition states such as bereavement, divorce, loss of a limb, etc., which have permanent effects that must be coped with over a period of time.

Research studies dealing with bereavement by Raphael (1977) pointed out the positive consequences of crisis involving effective intervention strategies. Wolkon (1972) pointed out the results of predictive research studies showing the effects of crisis and indicators of good or poor prognosis. Among the indicators of good prognosis were: (a) willingness to openly acknowledge personal conflicts, (b) the ability to slowly resume social roles after a period of decreased functioning, and (c) the availability of support systems. Unfortunately, there were limited studies to support the effectiveness of these strategies.

Langsley, Pittman, Machotka, and Flomenhaft (1968), Langsley, Flomenhaft, and Machotka (1969), and Langsley, Machotka, and Flomenhaft (1971) showed that crisis intervention could prevent psychiatric hospitalization without

harm to the client or family system. In another study done with 70 residents who were hospitalized in Canberra Hospital for the treatment of road trauma, Weiss (1976) found the majority of these subjects had fractured two legs and/or pelvises. The crisis events most often reported were their distressing injuries and illnesses, car accident, and hospitalization. All 70 subjects were exposed to all three stressors: (a) temporary separation from families; (b) temporary physical incapacity, pain, and disruption from work attendance; and (c) financial loss.

Weiss (1976) reported conclusions which were consistent with the proposition that mobilization of genuinely concerned and empathetic reactions from people was important and contributed a causal role in determining the outcome of crisis intervention with this population. Brief intervention was sufficient to facilitate the subjects' return to "normal," so that much could be done without major increase in staff.

Some studies have not shown crisis intervention to be effective, such as the study done by Williams and Polak (1979), which was conducted with bereaved families. It was concluded that this type of intervention was not effective or appropriate for that population.

Another study done by Rounsaville, Weissman, Prusoff, and Herceg-Baron (1979) used depressed women with marital disputes. The majority of the women made little improvement in their marriages during the course of psychotherapy.

A large number of individuals whose presenting problem is that of depression drop from treatment while they are receiving crisis intervention. There are several possible explanations for the attrition rate. This high dropout rate could be precipitated by the ineffectiveness of crisis intervention as a treatment modality for depression, or for depression resulting from different categories of stressors. On the other hand, the high dropout rate could be attributed to the client's having resolved the depression early in the treatment course. Other possibilities include factors relating to specific therapist-client dyads.

Although the literature generally supports the crisis intervention modality for depression of a situational nature, including loss of significant others, the limited number of research findings reported are not universally supportive of that position. Further research is needed to identify the conditions under

which crisis intervention is effective. One such condition is the etiology of depression.

This problem is relevant to nursing since nurses in a multitude of work situations encounter persons who are experiencing crisis and depression. Specifically, psychiatric clinical nurse specialists are employed as crisis team members. Clarification of the problems should be helpful in planning treatment.

Theoretical Framework

The theoretical framework used in this study is crisis intervention as defined by Caplan (1961) and Aguilera and Messick (1974). Caplan (1961) stated that in a crisis state, an individual is faced with insurmountable obstacles and the individual's problem-solving mechanisms do not work. A period of disorganization ensues, with the individual becoming upset. Many abortive attempts at solutions are made, and in the search for the solution, the individual has the possibility of moving toward a healthy adaptation or toward maladaptation. The period of time involved can last from 4 to 6 weeks. In attempting to move toward a healthy adaptation, the individual needs assistance immediately.

Caplan (1964) described four stages of crisis:

> (1) Tension escalates as the usual coping mechanisms and problem-solving techniques do not work.
>
> (2) Tension escalates due to the fact that usual coping mechanisms and problem-solving fall through and the individual becomes upset and perplexed.
>
> (3) The individual has to resort to emergency problem-solving assistance, utilizing strengths; a result, the individual may solve the problem, and the equilibrium may be restored.
>
> (4) If the attempt proves futile, tension and anxiety mount and major disorganization of the personality occur. (pp. 40-41)

The outcome of crisis is governed by the nature of interaction that occurs between the individual and significant others in the immediate environment. Crisis is characterized by its self-limiting aspect and usually lasts 4 to 6 weeks. The initial transitional phase consists of both the danger of increased vulnerability and opportunity for self-growth. The outcome is governed by the immediate availability of appropriate assistance with the situation (Caplan, 1961).

Intervention, as described by Aguilera and Messick (1974), consists of helping the client gain cognitive understanding of the crisis and insight into present feelings and the resolution of the crisis with anticipatory planning. Adaptive coping mechanisms should be reinforced by the therapist and utilized to successfully

deal with reduction of anxiety and tension. By assisting the client to make realistic plans for the future, the therapist facilitates the client's learning from the present experience to handle and cope with future problems.

Caplan (1964) suggested that the reintegration which occurs after a crisis facilitates new ego capacities and modification of adaptive styles. Without effective assistance, the individual resolves the crisis by adapting inadequately and by developing maladaptive patterns, thus making the individual more susceptible to future crises. In dealing with acutely depressive episodes, crisis intervention provides psychological support for the individual and also provides prompt availability of referral services.

Modlin (1979) suggested that after crisis intervention has been utilized, the individual feels less overwhelmed and is more receptive to suggestions about dealing with problems and looking for alternatives. Since acute depression is associated with anxiety in response to stressful situations, crisis intervention can be useful with the depressed individual. Crisis intervention may be useful for all episodes of

situational crisis whether due to loss or other situational factors.

Caplan's (1961) theory proposes that crisis intervention is useful in dealing with all episodes of situational crisis. If the theory is accurate, there should be no differences found in the level of depression resulting from the different stressors of loss or other situational factors, after the institution of crisis intervention.

Assumptions

The assumptions of this study were as follows:

1. Crisis situations occur periodically in the normal life span.

2. Crisis is time-limited, lasting 4 to 6 weeks.

3. The impact of crisis disturbs equilibrium and places the individual in a vulnerable state.

4. Depression is a common psychological response to crisis situations.

5. Depression can be detected and measured.

Hypothesis

The hypothesis tested in this study was:

There is no difference in the level of depression after the institution of crisis intervention, using

pretest scores as a covariant, between persons experiencing depression from loss and those experiencing depression because of other situational factors.

Definition of Terms

Terms identified in this study are:

1. Adjustment disorder with depressed mood--a category from the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980) used when the predominant features are a depressed mood, tearfulness, and hopelessness. These features are associated with an identifiable symptom that occurs 3 months after the stress occurs and there is impairment in social and occupational functioning. For the purpose of this study, presence of adjustment disorder with depressed mood was determined by the crisis counselor's assessment which was written on the clients' records.

2. Loss--self-report of separation from close attachments. For the purposes of this study, a loss has occurred if there is a death of a significant person, divorce, or geographic separation from a significant other. Determination of a loss was made by the investigator from information on the patients' records.

3. Other situational factors--self-report of feelings of distress over present life situations. For the purposes of this study, marital disputes, financial problems, physical illness, work conflicts, and developmental conflicts were considered situational factors. Determination was made by the investigator from information on the patients' records.

4. Crisis intervention--brief psychotherapy aimed at the treatment of adjustment disorder with depressed mood. For the purposes of this study, three crisis counseling sessions, with a here-and-now focus instituted by a member of the crisis team, constituted crisis intervention.

5. Crisis unit--an organizational unit used to deal with psychiatric emergencies. For the purposes of this study, it is the unit of a specific community mental health center that deals with psychiatric emergencies.

6. Crisis team--a designated group of individuals who assess and treat individuals experiencing crisis. For the purposes of this study, the team consists of three therapists: a psychologist, a social worker, and a registered nurse who are employed by the specific mental health center to staff the crisis unit.

Limitations

The limitations of this study were:

1. There was no randomization of the sample; therefore, the findings may not be generalized to all clients served by the crisis unit.

2. The individuals in this study were limited to one crisis unit; therefore, the findings cannot be generalized to other populations.

3. Participation in this study was voluntary.

4. The type of crisis intervention instituted was subjectively administered and may have varied among members of the crisis team.

Summary

Crisis centers provide a form of treatment for individuals experiencing acute depression. One group is characterized by those individuals experiencing depression because of a loss and the other group is characterized by those individuals experiencing depression from other situational factors.

Studies have been conducted with individuals in crisis using crisis intervention. Some of these studies have positive results, whereas others have found the intervention to be ineffective or inappropriate.

Crisis, as defined by Caplan (1961), is a state in which the individual is faced with insurmountable obstacles and the outcome is governed by available resources in the immediate environment. Although crisis theory does not suggest differential effects of treatment according to etiology, the variability of the research results suggests that there may be differences. This study was designed to investigate the hypothesis that clients with different etiological bases for their depressions will have different levels of depression after brief crisis intervention.

CHAPTER 2

REVIEW OF LITERATURE

There is an abundance of literature on the topics of crisis, depression, and crisis intervention, the major concepts of this study. However, most single studies have not dealt with all of these areas at one time and most have used inpatient populations. This chapter presents a review of studies dealing with crisis and different treatment modalities labeled crisis intervention. The first section reviews the history and specific studies in outcome research using intervention. The latter section deals with depression, including concepts of depression and research outcome depression studies.

Historical Treatment of Crisis

Jacobson (1974) suggested that the forerunners of the crisis theory were chiefly found in the literature of psychoanalysis. Freud (1950) whose work was often described as antithetical to considerations not related to infantile development, was aware that present life events as well as historical factors, were important in

precipitating neuroses, even though he left this aspect for others to develop. Erikson (1959) contributed the concept of developmental crises. Erikson examined the life cycle and described typically encountered "crises," each of which presented the developing individual with specific tasks which were or were not adaptively resolved during a critical period.

The individuals who are credited with the formulation of the crisis theory as a specific framework are Lindemann (1944) and Caplan (1961). Lindemann's (1944) classic grief study involved investigations of relatives of persons who had perished suddenly and tragically in fires. Lindemann described normal grief and distinguished it from maladaptive responses to bereavement. He observed that a 6-week crisis followed the bereavement. At the end of this time, there had been a working through of the grief, or in some instances, a maladaptive outcome leading to psychotic or psychosomatic illness. Crisis theory was subsequently elaborated by other workers (Aguilera & Messick, 1974; Jacobson, 1974, 1979; Modlin, 1979).

Jacobson (1979) perceived crisis-oriented treatment as offering support to individuals immediately. Jacobson

described crisis as being time-limited, with an outcome that is not predetermined initially during a crisis. He further described crisis as a matrix which can be defined as a period of several months to several years, during which time an individual is susceptible to multiple hazards as well as other crises. Jacobson described a person who is in crisis as one who is characterized by feelings of anxiety, depression, hopelessness, and helplessness. Most of Jacobson's research was conducted in an outpatient crisis unit in Los Angeles (Jacobson, Wilner, Morley, Schneider, Strickler, & Sommer, 1965). The goal of the unit was to restore individuals to previous levels of functioning.

Crisis Intervention

Caplan (1961) defined a crisis state as one in which there is an imbalance between the difficulty and the importance of the problem as well as the immediate resources available to deal with it. In the presence of an unexpected stressor, the normal routine of problem-solving capacities of the individual do not work, there is a perceived period of panic for the individual, and partial disorganization ensues. Caplan also suggested

that at this period, minimal effort from support systems facilitates a maximum amount of lasting response.

Caplan (1961) defined crisis as

> when a person faces an obstacle to important life goals that is, for the time, insurmountable through the utilization of customary methods of problem solving. (p. 18)

Both Lindemann (1944) and Caplan (1961) further suggested that if coping mechanisms usually available are ineffective to resolve the problem, an acute crisis is precipitated and symptoms of distress arise. The crisis is usually resolved in 4 to 6 weeks.

Jacobson (1979) pointed out that an individual who is in crisis and who cannot solve a problem after a period of time may regress. This individual may also temporarily function in a less rational manner as well as in a less reality-oriented manner. Jacobson further believed that during a course of crisis new coping skill gradually generates and equilibrium is reestablished. The new level of functioning may be somewhat better, the same, or at a lower level. Jacobson perceived crisis as having a natural termination and thought it unlikely that a crisis would be continuous.

Another researcher (Modlin, 1979) described the following basic steps in crisis intervention:

1. Providing immediate help
2. Defining the crisis stressor
3. Eliciting symptoms
4. Listening for the clues to the "real underlying problem"
5. Offering support and assurance
6. Getting the picture of the life context in which the crisis development occurred
7. Focusing on the main theme and suggesting tasks to the client
8. Marshalling supportive resources
9. Resolving the crisis
10. Investigating how and why the crisis was precipitated
11. Terminating
12. Continuing plans. (pp. 17-18)

These steps are not applicable to all clients, or, if and when applicable, are not necessarily followed in the same sequence (Modlin, 1979).

Strickler and LaSor (1970) described crisis as a situation providing motivation and opportunity for a distressed person of any psychosocial level to attempt new ways of coping with life hazards. Strickler and LaSor further stated that trainees in crisis intervention must be accustomed to several alterations in their style of therapeutic intervention according to individual needs.

In summary, Caplan (1964) described man as constantly being faced with a need to solve problems in order to maintain equilibrium. When the individual is faced with an imbalance between the difficulty associated

with the problem and the available resources of coping skills, a crisis is perceived. It is this difficulty on which crisis intervention is focused to assist the individual in returning to a precrisis, or higher level of functioning with newly developed ego strengths to assist the person in dealing with future crises.

Studies in Suicide and Crisis Intervention

In a study done by Lester (1974), there was an attempt made to match towns receiving suicide prevention service with comparison towns not receiving such services. Lester examined changes in the suicide rates between 1960 and 1969 for three types of cities: (a) those with suicide prevention centers established by 1967, (b) those with centers established by 1969 but not by 1967, and (c) those without centers through 1969.

No description of the preventive services was provided, although it was noted that they were probably heterogeneous. Suicide rates rose slightly in the first group of cities and rose significantly in the other two groups during the time period under study. According to Lester (1974), there was no differential increase in the rate across samples, indicating that the establishment of suicide centers had no effect on suicide rates.

In a study done by Greer and Bagley (1971), suicide attempts were used as a dependent variable. In this study, 204 patients presented themselves to the casualty department in a hospital "with deliberate self-poisoning or self-injury," (p. 308) and they were followed up after a mean interval of 18 months. Forty-seven of these patients did not receive psychiatric evaluation prior to discharge. These untreated subjects were compared to 76 patients who received brief contact with the psychiatrist, with contact limited to one or two interviews, and with another group of 88 patients who received prolonged intervention. There were subsequently significantly more suicide attempts among the untreated group than among the treated patients, with prolonged treatment associated with better prognosis.

The researchers concluded that "those results were indicative of psychiatric intervention being associated with significant reduction in suicidal behavior" (Greer & Bagley, 1971, p. 312). However, subjects were not randomly assigned to treatment groups and those in the nontreatment group were either self-selected or there was no reason given for a lack of referral. There was not a specified psychiatric intervention

given, nor was there a rationale for the administration or brief versus extended treatment.

In a review of the above studies, Auerbach and Kilmann (1977) concluded that there was insufficient data regarding the effectiveness of suicide/crisis intervention centers in the prevention of the incidence of suicide or suicide attempts. Investigation of the overall program impact suffered inherent deficiencies found in some of the ex post facto studies.

Knickerbocker and McGee (1973) suggested that suicide prevention was inappropriate as a major goal for crisis intervention programs and that suicide rates were impractical outcome measures. Suicide was further described by these investigators as an atypical event and the majority of problems dealt with by community suicide/crisis programs were unrelated to suicide.

Studies in Crisis Intervention in Psychiatric Settings

In an examination of studies dealing with crisis intervention in a psychiatric setting, Raphling and Lion (1970) noted an increasing number of psychiatric treatment facilities utilizing crisis intervention for individuals in psychological crises, often as a part of

general hospital emergency services. Brook (1973) investigated the efficacy of crisis therapy versus regular inpatient care for emergency psychiatric patients. Brook compared the adjustment of 49 patients in a "crisis hostel" for a maximum of 7 days, with a "control group" which consisted of the last 49 patients admitted to the inpatient unit before the hostel was opened. The latter received "traditional" treatment.

The hostel was described as a transitional living facility and treatment focused on the immediate problem that precipitated the crisis. Medication, in addition to other modalities, was a major aspect of the program for many of the residents. At a 6-month follow-up, six controls had been readmitted and only one of the hostel residents had been readmitted. According to the staff rating and self-rating, the hostel residents exhibited less remission of symptoms than did the controls. There were no group differences on 11 other unnamed outcome measures. Brook (1973) did not report post hoc data on the comparability of the two groups on possible relevant variables or the types of outcome measures. There was no analyses of the data reported, thereby making it impossible to duplicate this study.

Decker and Stubblebine (1972) attempted to evaluate on a post hoc basis the efficacy of crisis intervention versus inpatient psychiatric treatment. The subjects were divided into two groups of young adults, ages 18 to 30, who did not have primary organic diagnoses. One group was composed of 225 patients who received crisis intervention on admission during the last 6 months of 1967. The crisis approach was described as a team effort that included 24-hour inpatient care and emphasis was placed on assisting the patient in reestablishing a role in a social network outside of treatment. The second group was composed of 315 first-admission patients who received extensive psychiatric assessment and inpatient treatment. This group was admitted during the last 6 months of 1964 and contained more women and more chronic patients than did the crisis treatment group.

During the follow-up period which ranged from 2 years and 4 months to 2 years and 10 months after discharge, a smaller percentage of the first admissions who received crisis treatment had to be readmitted for psychiatric treatment than the comparison group that was composed of more women and more chronic patients. There was a small percentage of patients who subsequently

committed suicide or received welfare. Several components in this study prohibited attributing group outcome differences to treatment differences: (a) differences in subject characteristics across groups, (b) inpatient treatment averaged 5.9 days for the 1964 group and 11.5 days for the group receiving crisis intervention, and (c) insufficient information for evaluation of what and how treatment differed for the two groups.

Langsley et al. (1968) attempted to compare the effectiveness and efficacy of family crisis intervention with psychiatric inpatients. One hundred and fifty families who had one family member who would have ordinarily been admitted to an inpatient unit for psychiatric treatment were randomly selected from this population to receive crisis intervention for an average of 24.2 days. All of these clients remained with their families during the entire treatment period which consisted of a mean of 4.2 visits in the office, 1.3 home visits, 5.4 telephone contacts, and 1.2 contacts from social agencies for each family. Treatment techniques utilized were active reassurance, support, advice, chemotherapy, and assigned tasks. One hundred and fifty control cases, drawn from the same population as was the experimental group,

received inpatient treatment for an average of 28.6 days, including individual and group therapy, milieu therapy, and chemotherapy.

Post hoc analyses indicated no significant differences between the two groups on a range of demographic and mental health related variables. Outcome data were obtained at six 1-month intervals after treatment for the first 75 experimental and the first 75 control group patients. Significantly fewer crisis treatment patients than control patients had been hospitalized by the 6th posttreatment month, and when hospitalized, the crisis therapy patients had spent significantly less time in the hospital. The two groups exhibited comparable degrees of improvement on measure of personal adjustment and social adjustment. Crisis patients, however, returned to their jobs or to other primary levels of functioning 3 weeks prior to those who had received inpatient treatment. In addition, crisis intervention was estimated as costing one-sixth as much as inpatient services.

Similar results were reported by Langsley et al. (1969) for a sample of 300 patients. Langsley et al. (1971) reported on these same patients after a 12 and 18 month follow-up, and found the same differences in

the groups, but with reduced magnitude of difference in the number of patients hospitalized and in the total number of days hospitalized. The groups remained comparable on the measures of social adjustment and personal functioning at 18 months.

This study (Langsley et al., 1971) utilized controls so that the outcome differences could be attributed to the differences in treatment modalities, namely inpatient hospitalization versus outpatient treatment. Langsley et al. (1971) concluded that inpatient treatment was shown to be less effective in preventing readmission and more expensive than the crisis group.

In studies dealing with patients in a psychiatric setting, comparing the overall efficacy of crisis intervention versus "no treatment" or "traditional" psychotherapy, there were only three studies (Langsley et al., 1969; Langsley et al., 1971; Langsley et al., 1968) which demonstrated superiority of crisis intervention over traditional inpatient treatment. The major difficulty in ascertaining meaningful conclusions from research dealing with patients in psychiatric settings, was the failure on the part of the researchers to define operationally the process of crisis intervention that was applied.

Several investigators attempted to isolate treatment and/or subject factors associated with positive response to crisis intervention. One group, Gottschalk, Mayerson, and Gottlieb (1967), evaluated the effectiveness of short-term (maximum of six sessions, usually 25 to 50 minutes in length, once a week), "focal psychotherapy" in the treatment of acutely disturbed psychiatric patients. The treatment was described as dynamic in nature and aimed at crisis resolution, accompanied by minimal or no psychoactive medication, with the goal of alleviating symptoms and returning the client to premorbid levels of vocational, domestic, and physiological functioning. The effects of this therapy on outcome across two posttreatment follow-up intervals were evaluated for the two samples which totaled 53 patients.

The outcome measure in the Gottschalk et al. (1967) study was a psychiatric morbidity score based on the rating obtained from a standardized interview for which interrater reliability coefficients ranged between .76 and .93. This measure was administered prior to treatment and at both posttherapy follow-up periods. The first follow-up periods ranged from 0 to 28 days after

the end of the treatment and the second follow-up ranged from 67 to 290 days after the completion of the study.

There was a significant improvement in morbidity scores from before therapy until the first follow-up and these gains were maintained through the second follow-up session. The strength of the study was in its use of standardized measures on pretest and posttest basis to evaluate outcome and in the fact that follow-up data were obtained on most patients. Approximately 75% of the sample were interviewed for the first follow-up and more than 50% for the second follow-up. According to Auerbach and Kilmann (1977), limitations in this study were associated with the methodology. In general, insufficient information was presented on the nature of treatment procedures which would be significant if the study were to be replicated.

Wolkon (1972) evaluated the question of whether crisis intervention was more effective for individuals where there was the least amount of delay between their application for treatment and their first scheduled interview. There were 379 applicants for psychotherapy at either a state-supported psychiatric clinic (n = 255), a nonsectarian family service association (n = 81),

or a sectarian family service agency (n = 43). Patients were defined as being in crisis when they applied for psychological assistance. Wolkon (1972) concluded from the results that the least time between application for treatment and the initially scheduled appointment, the more likely the client was to improve. Wolkon also pointed out that these findings supported the crisis theory that the closer the intervention was to the crisis, the greater the improvement.

In a relatively controlled study done by Gottschalk, Fox, and Bates (1973), individuals came voluntarily to a crisis treatment group (n = 37) or to a waiting list group (n = 24). Assignments were initially made randomly, but group compositions needed to be shifted because some treatment subjects did not appear for treatment and some in the waiting list group obtained treatment elsewhere.

The primary outcome measure obtained 6 weeks after treatment consisted of scores on a psychiatric morbidity rating scale. The two groups demonstrated comparable pretherapy and posttherapy improvement on the rating scale. The overall results suggested that individuals in crisis respond as well to brief contact with non-clinical personnel and to the prospect of receiving

extended help in the future as to crisis intervention. Auerbach and Kilmann (1977) noted that a weakness of this study was that the researchers failed to specify the treatment components that were labeled crisis intervention.

Crisis Intervention with Surgical Patients

The final area of focus is crisis intervention with surgical patients. Auerbach (1973) noted that most individuals facing surgical procedures in which there is a need for hospitalization experience anxiety, and if there is a change in body image, there will be some adjustment after the operation. The surgical situation represents the stressor in a crisis situation, the crisis response is predictable, and there are opportunities to intervene during this pre-impact and post-impact period.

In 13 studies utilizing crisis intervention techniques with surgical patients, there was evidence of considerable variation regarding the type of surgical procedure ranging from open-heart surgery (Aiken & Henrichs, 1971; Gruen, 1975) to minor surgery (Wolfer & Visintainer, 1975). Only a few of these studies will be discussed because there were, according to Auerbach

and Kilmann (1977), major weaknesses in the treatment, consisting of multiple components, making it impossible to isolate and compare specific aspects of treatment.

In each study, patients were randomly assigned to experimental and control groups, to differing treatment groups, or were even matched or shown to differ post hoc on potentially important variables. In each case, treatment procedures were administered exclusively or partially prior to the operation. In most of these studies, the investigators concluded that there was a demonstrated need for intervention with this type of stress.

In studies conducted by Wolfer and Visintainer (1975) and Gruen (1975), there were extensive treatment modalities. Wolfer and Visintainer conducted a study with 45 experimental children scheduled for minor surgical procedures and their parents who were exposed to a treatment package consisting of accurate information about the events, sensory experiences, role expectations, play therapy, and supportive care. Intervention was conducted at five specific preoperative periods and once postoperatively. The 35 control children and their families were exposed only to procedures that were

routine, and treatment was limited to short-time with the nurse.

The results demonstrated that the two groups did not differ significantly in terms of demographic data. The results on each child's outcome measures were subjected to a three-way analysis of variance, and the children in the experimental group had significantly lower mean upset ratings and higher mean cooperation ratings at each of the stress points than the control group. Parents in the experimental group had significantly lower self-ratings of anxiety, higher ratings of the adequacy of information received, and greater satisfaction with care than the control group.

The limitations from this study were associated with observer bias and bias on the part of the parents in the experimental group. Closely associated with the results of the study is that the positive effects may have been associated with warmth and trusting rather than the actual crisis intervention.

In the study done by Gruen (1975), 35 myocardial infarction patients were given psychotherapy by a clinical psychologist preoperatively and postoperatively for an average of 1/2 hour, for 5 to 6 days per week, until they

were released from the hospital. The 35 matched controls received no psychological treatment and the results demonstrated no differences in anxiety feelings between the control and experimental groups. The anxiety scores among the treated cases clustered more narrowly around low to average anxiety and the control cases were spread out around the average, both into extremely low and into the extremely high ranges of scores.

In both of these studies (Gruen, 1975; Wolfer & Visintainer, 1975), it was difficult to attribute improvement to a particular treatment modality, or even to treatment as a whole, since there was no attempt to give control patients any interpersonal contact. This lack of interpersonal contact in itself may have had therapeutic benefit.

Auerbach and Kilmann (1977), in a review, stated that crisis intervention utilized with surgical patients was somewhat complex and different from that utilized in other contexts in which interpersonal contact was not necessary. These surgical studies have offered a single area in crisis intervention research in which the effects of systematic manipulation of some aspect of the intervention was evaluated.

In summary, this part of the review of literature has focused on research issues in three diverse areas. The major thrust of this review has been to determine the efficacy of crisis intervention as compared to traditional or no treatment. The greatest deterrent in interpreting the results in these studies has been in their failure to operationally define crisis intervention. Most of these studies have varied in the length of time the subjects have been in treatment. Overall, there has been some evidence of significant improvement in subjects who received crisis intervention and there has been meager evidence that those clients who receive crisis intervention improve better than those who receive no treatment. Perhaps this lack of improvement lies in the inconsistencies in the length of time spent in treatment, the definition of crisis intervention, and the client population.

The Nature of Depression

The syndrome of depression has existed and been identified for many years, and there have been numerous studies done investigating various aspects of this disorder. Seligman (1973) identified depression as the "common cold" of psychopathology. Depression is a

pervasive feature in the human existence. Woodruff (1974) believed that most individuals have experienced at least moments of depression every day of their lives. It has been estimated by the National Institute of Mental Health (1973) that 5% of men and 10% of women are pathologically depressed during their lifetimes, and that each year, approximately 15% of the adult population, ages 18 to 74 years, experience depressive episodes with symptoms serious enough to warrant treatment.

Slater and Roth (1970) identified depression as probably the most common presenting syndrome of psychiatric patients. Slater and Roth further described the depressed client as manifesting complete failure of insight, denial of illness, and a steadfast holding of ideas of guilt and punishment. Weissman and Paykel (1974) described depression as a disorder that precipitates a continuum of moods and behaviors which range from disappointment and sadness of normal life, to the bizarre suicidal acts manifested in melancholia. Depression is a universal phenomenon, a normal mood, and is familiar to all human existence. Characteristically, it is evoked by loss of close interpersonal relationships and blows to self-esteem. Its universality suggests

that depression performs important functions that have rendered its survival useful in evolutionary terms.

Freedman, Kaplan, and Sadock (1976) noted that trends in the findings of depression studies supported the idea that the adult clinical depression states occurred in relation to the balance between stresses on the individual and some considerations of vulnerability or predisposition. Environmental stresses seemed to play an important function in precipitating an acute episode. Freedman et al. further stressed that in adult populations, the most significant factor in the development of depression lay in the individual predisposition.

Predispositions included heredity, as supported by the bipolar-unipolar concept; early life events predisposing the individual to the severity and loss, as proposed in a developmental model; and more currently, the behaviorists' attempt to interpret depressive episodes as failure of coping and rewards of self-esteem and hopelessness (Freedman et al., 1976).

There seems to be no consensus among clinicians and investigators as to the etiology of depression. Neither has there been general agreement among these

individuals as to the boundary between normal mood and abnormal reactions of depression. The literature on the epidemiology of depression has been abundant, contradictory, vague, and confusing. Even though there is no consensus as to the etiology of depression, there is, however, a general agreement on the most common signs and symptoms of depression (Robins & Guze, 1970). These signs and symptoms are:

1. Sad, apathetic mood
2. Negative self-concept
3. Social isolation
4. Sleep and appetite disturbance
5. Changes in activity level
6. Recurrent ideations of death or self-destructiveness
7. Difficulty in concentration. (Robins & Guze, 1970, p. 190)

Seldom does a single individual exhibit all of these symptoms of depression. The diagnosis of depression is typically made if at least a few of these symptoms are present, particularly a mood of extreme sadness that is atypical of the individual's life situation. Robins and Guze (1970) further suggested that although depression is recurrent, it dissipates over time.

Psychological Theories of Depression

Davison and Neale (1978) suggested that there has been a consensus among theorists on depression that depression points to both psychological and physiological factors. An overview of theories of depression is essential in understanding the focuses of the treatment approaches that will be discussed later. These theories include psychoanalytic, cognitive, and learning of behavioral theories.

It is difficult to distinguish sadness, which is normal, from depression, which is not. Abraham (1927) postulated that depressed individuals unconsciously mourn for their lost capacity to love, later regressing to an earlier oral phase for gratification. Freud (1950) viewed susceptibility for depression as beginning in early childhood. Freud's theory was that during the oral stage in an individual's life, there was too little or too much gratification. The person, therefore, developmentally was not able to move from this stage. With this arrest in psychological maturation of fixation at the oral stage, the individual developed a tendency to become extremely dependent on other individuals for the maintenance of self-esteem (Freud, 1950).

Another theory of depression is the cognitive perspective which was developed by Beck (1967). Beck's focal thesis was that depressed people feel as they do because of committing characteristic logical errors in thinking. Beck further believed that his depressed patients distorted past events in the direction of self-blame and catastrophies. Beck viewed depression as drawing illogical conclusions based on self-evaluations. In other words, there is a cognitive distortion that facilitates a depressed mood.

Beck (1967) found that depression and cognitive distortions were correlated. The advantages of this theory, according to Beck (1976), are that it is testable and the therapist is able to utilize the theory by working with the depressed patient's thinking in order to change and decrease negative feelings.

A third theory on depression is the learning or behavioral view. The concept of reductions of reinforcements was a focal point in some of the learning theories. According to Eastman (1976), mourning processes at an unconscious level. Once individuals cease functioning as they did prior to the loss, when reinforcement was available, the lower level of functioning may be

reinforced (Ferster, 1973). The learning theory's conceptualization of depression is associated with a reduction in activity when reinforcement is lacking (MacPhillamy & Lewinsohn, 1974).

Treatment of Depression

Strategies for the treatment of depression were divided into those which were labeled psychotherapies and those labeled behavioral-cognitive approaches. Whitehead (1979) described psychotherapies as being derived from two main sources: (a) psychoanalytic, and (b) studies correlating depressions to impaired social and interpersonal events with the treatment being aimed toward amelioration of these symptoms.

Whitehead (1979) described the behavioral and cognitive therapies as being derived from four major models:

> (a) the depressive behavior as such constitutes the disorder and by manipulating appropriate reinforcers it can be modified.
> (b) depressive behavior is precipitated or maintained by reduced rate of positive reinforcement.
> (c) the depressed person fails to respond because there is a belief by this person of a lack of any environmental control; treatment then is directed toward exhibiting this person's capacity for this control.
> (d) depression results from an individual's negative self-image and circumstances and treatment is directed toward correcting these misconceptions. (pp. 495-496)

These strategies, Whitehead (1979) pointed out, were by no means exclusive nor all inclusive; but they provided a meaningful framework for existing studies.

There have been studies of the treatment of depression that have utilized these approaches. Among the studies utilizing the psychotherapeutic approaches, Wadsworth and Barker (1977) conducted an experimental study with depressives based on the psychoanalytic view that these individuals suffered an inability to externalize their anger. Wadsworth and Barker developed a procedure that involved the patient in an initial phase of repetitive meaningless tasks that they were pressured into doing until anger was evoked and there was a refusal to continue work. The individual then began psychotherapy. The comparison group used meaningful tasks with entry into the group psychotherapy after a similar delay and they received medication with imipramine.

The subjects were male depressives, diagnosed as neurotic or psychotic. The Zung-Rating (SDS) was given pretreatment and posttreatment after 1 and 3 weeks. For the psychotic patients, treatment was equivocal, but for the neurotics, the experimental manipulation yielded significantly better results. Implications from this

study pointed out that a few days of pointless activities led to productive anger which rendered more improvement in neurotics than engagement in meaningful tasks and imipramine. The methodological flaw in the study was that the experimental group was treated first, followed by the control group. This sequencing allowed the possibility of the results to have been an artifact of differences in patient admissions.

Additional psychotherapeutic approaches included studies (Paykel, Dimascio, Haskell, & Prushoff, 1975; Weissman & Paykel, 1974) done with depressed outpatients who had responded to amitriptyline and were randomly assigned to continue the amitriptyline or to discontinue it, and also to receive social casework (1 to 2 hours per week) or minimal support (1/4 hour per month). The 8-month study revealed a highly significant level of effect on self-ratings and social adjustment ratings correlated with the psychotherapy. The results demonstrated measurable effects on those functions which focused on intervention, but there was no demonstrated effect on depression.

Ferster (1973) defined depression from a behavioral view as being associated with a reduction in adaptive

responding and the individual has raised levels of maladaptive behaviors. Reisenger (1972) conducted a single-case study with a 20-year-old woman diagnosed with anxiety-depression, who cried without provocation, and felt everyone hated her. Crying was selected as a target behavior to be reduced in frequency.

The token system was utilized throughout the study period. The woman had to pay for crying behavior and she earned tokens for smiling. This study lasted 4 months. After several weeks, social reinforcements of smiling were introduced. At the end of the study, smiling was the sole reinforcer. Conclusions from this study showed improvement, with a reduction in frequency of crying which remained at low levels in the final phase.

The methodological deficiency in this study was assessment which was exclusively based on those behaviors under manipulation and no measure was made of any aspect of the affective state. And, finally, because of the information given, this patient seemed to have unusually circumscribed depressive behavior which lowered the potential for generalization to other patients.

In another study utilizing the single-case design, Hersen, Eisler, Alford, and Argas (1973) conducted

single-case studies with three hospitalized male neurotic depressives (all of whom were also receiving psychotrophic drugs). Patients were given tokens contingent upon satisfactory work and self-care performances. During the active phase, these tokens were exchanged for privileges. Instruments used in this study were the Behavioral Rating Scale assessing smiling, talking, and motor activity; the Beck Depression Inventory (BDI); and the Hamilton Rating Scale for Depression (HRS-D).

On these measures, all three patients showed improvement during active treatment, reverting to the baseline level again during reversal. These results were difficult to evaluate. The success of the reversal indicated the behavior changes were transient in the absence of external control and the treatment was only applied for a few days.

Lewinsohn (1975) defined depression as being a vicious circle of lowered positive reinforcement resulting in decreased activity and later even less reinforcement. In a study done by Hammen and Glass (1975), students were selected based on scores on various questionnaires in which they scored "mild to moderate" range of depression. The students were randomly selected and

assigned to one of four groups: (a) an experimental group where subjects were told to increase their activities, (b) an "expectancy" control group whose subjects were to increase their intake of protein relative to carbohydrates, (c) a "self-monitor" group, and (d) a waiting list group. Groups C and D were controls who were not told they were involved in treatment.

After 2 weeks, the experimental group subjects were found to have a higher activity score than the other two subjects, but there was no evidence of lesser depressed mood. These findings indicated that when instructed to increase participation in pleasant activities, depressed individuals can do this without a benefit to mood.

In another study conducted by Fuch and Rehm (1977), there was an assumption made that depressed individuals are inefficient in all aspects of self-control. They focus on negative events and set unrealistic, global standards for themselves, facilitating low self-rewards. The self-control treatment in this study was made of six weekly group sessions involving didactic explanations of the self-control principles, together with behavioral homework assignments for which there was self-evaluation and reinforcement for performance.

A control sample received nondirective group psychotherapy without homework assignments, and in addition, there was a waiting list--the control group. The subjects were depressed women and the sample was recruited by advertisement, followed by screening using the Minnesota Multiphasic Instrument (MMPI) and interview. In general, the results were consistent. On the Beck Depression Inventory at posttreatment, both active treatments were superior to the waiting list.

The final group of studies utilized the cognitive-behavioral approach. This approach was derived from Beck (1976) who defined depression as being maintained by cognitive factors, mainly misinterpretation and distortions. Treatment was aimed at persuading the patient to adopt a realistic approach. In a study using this approach, Rush, Beck, Kovac, and Hollow (1977) treated neurotic outpatient depressives (minimum BDI score 20) who were randomly assigned to treatment with either the cognitive-behavioral therapy or with the drug imipramine. The treatment lasted 12 weeks, during which the psycotherapy patients received up to 20 50-minute treatment sessions, while the pharmacotherapy patients were seen 20 minutes each week. The imipramine was discontinued after 12 weeks.

The results demonstrated there were significantly more treatment dropouts in the imipramine group and there were also significant group differences in the BDI scores and similar results on the HRS-D and the Raskin Depression Scale posttreatment in the psychotherapy group. At a 3-month follow-up, treatment differences were maintained, but the continuing trend was insignificant after 6 months. These results were difficult to interpret because a number of patients had reentered therapy, especially those from the imipramine group.

In a final study done by Taylor and Marshall (1977), there was an attempt made to examine various elements of treatment by comparing cognitive, behavioral, and mixed approaches. The subjects were obtained through advertisement on a university campus and were screened to insure depression had been present at least 2 weeks and that BDI scores were at least 13. The treatment was individual and consisted of six 40-minute sessions over a 4-week period. There was also a waiting list control group.

At posttreatment, it was demonstrated that the experimental treatments facilitated more improvement than the control, that the combined treatment was better

than either treatment alone, and that the two treatments administered singly did not differ between themselves. At follow-up, the original differences were maintained. This study indicated that mildly depressed subjects responded and benefited from both the cognitive and behavioral elements of treatment.

Conclusions that can be inferred from these studies include that there have been no fully adequate experimental investigations that have dealt with depressives. It does seem evident that psychological treatment may be successful in alleviating or reducing the level of depression and that the behavioral modality has measurable effect in alleviating depression and is enhanced with the cognitive approach.

Summary

The studies that were reviewed did not specifically deal with crisis intervention and measured depression. Crisis intervention has been tested in studies with the majority of them indicating there was little or no difference in groups that received crisis intervention, compared with those who received little or no treatment. There have been several studies which demonstrated

significant group differences when crisis intervention was compared to other treatment modalities.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The research design for this study is classified as an ex post facto approach. The approach is defined by Polit and Hungler (1978) as a design in which the independent variable is not directly manipulated by the researcher. The purpose of the design is to determine the relationship between the variables. The independent variable in this study was the category of the precipitating factors for depression, either loss or other situational factors. The dependent variable in this research was the depression scores from the Beck Depression Inventory (BDI).

Polit and Hungler (1978) further described this design as differing from the experimental design in that there is difficulty inferring causal relationships in the ex post facto design because of the lack of manipulation control of the independent variables. The positive quality of this design is in its predictability. It is useful in facilitating decision-making about individuals and in examination of the relationships

among variables in one group in order to make predictions about the behavior of another similar group.

Setting

The setting in this study was a mental health center located in the Southwestern part of the United States in a large urban area. The center offered the 10 essential services stipulated by the National Institute of Mental Health. The particular organizational unit in this study was the center's crisis unit which was part of the information, counseling, and referral services for mental health, providing emergency crisis intervention for individuals experiencing psychiatric crises. The inpatient unit provided voluntary and involuntary services. These units also provided individual and group therapy as well as medication.

Other services included day treatment, mental health screening, and the involuntary unit (court commitment), the mental diagnostic center. All services provided structured activities, counseling, clinical assessments, psychological testing, and emergency services with some services overlapping.

The population of clients varied socioeconomically and were ethnically mixed. The clients who came to the

center's crisis unit were in crisis and exhibited varying levels of depression, as well as other disorders, such as schizophrenia, neurosis, and personality disorders. The client's entry into the system initially began with the telephone counselor on the "hotline" in the information, counseling, and referral area, which was available 24 hours a day.

Telephone counselors had a minimum of a baccalaureate degree, either in social work or psychology. The clients were assessed at this entry point and given appointments to be seen by a member of the crisis team, either a master's level psychologist, a social worker, or a registered nurse, according to the schedules that were available. The approximate number of clients seen monthly in this unit was about 50, with approximately one-half diagnosed as adjustment disorder with depressed mood.

Population and Sample

The population in this study was individuals who met the delimitations of the study. The delimitations included those individuals who voluntarily entered the center seeking treatment and agreed to participate in

the study, and who were diagnosed as having an adjustment disorder with depressed mood. The convenience sample was composed of the first 31 persons who met the delimitations after the study began, between February 1981 and May 1981. The sample was divided into two groups according to the etiology of the depression as stated in the client's record, either loss of a significant other by death or separation or other situational factors. The loss group had 14 subjects and the other situational factors group had 17 subjects.

Protection of Human Subjects

This investigation complied with the rules and regulations of the Texas Woman's University Human Subjects Review Committee. Prior to the collection of data permission to conduct the study was obtained from Texas Woman's University Human Subjects Review Committee (Appendix A), the agency from which the subjects were obtained (Appendix B), and from each individual subject (Appendix C). All of the subjects were assured anonymity. Each subject was required to sign a consent form before the Beck Depression Inventory was administered and all consent forms were filed with the agency.

Each pretest and posttest was coded with a number, 1 to 31, to insure confidentiality and continuity by the investigator. A master list with the code numbers and corresponding names was known to the investigator only. After the inventories were administered by a designated research assistant, they were returned to the investigator who marked each with an A or B after the assessment was done by a member of the crisis team, designating either loss or other situational factors. After the third crisis counseling session the posttest was administered by the same research assistant, who was a secretary. The posttest was coded with the corresponding pretest number and alphabet. The master list was destroyed by the investigator after the post-tests were completed.

Instrument

The instrument used in this study was the Beck Depression Inventory (Appendix D), which can be used in combination with clinical ratings of the depth of depression. Beck (1967) described this instrument as meeting the problem of variability of clinical diagnoses. It provides a standardized, consistent measure that is not sensitive to biases of the individual administering

it. This instrument's thrust is to measure varying degrees of depression along a continuum. It is also valuable in reflecting the intensity of depression after an interval of time.

The inventory is composed of 21 categories and attitudes. Each category described a specific behavioral manifestation of depression, namely emotional, cognitive, and physical manifestations. The categories consisted of a graded series of four to five self-evaluative statements. The statements were ranked to reflect the range of the severity of the symptom, from neutral to maximal severity. Numerical values from 0 to 3 were assigned to each statement to indicate the level of severity. The range of possible total scores extended from 0 to 63, with scores of 0 to 9 being categorized by Beck (1967) as not depressed, 10 to 15 as mildly depressed, 16 to 23 as moderately depressed, and 24 to 63 as severely depressed.

The inventory was designed to include all the symptoms integral to the depressive constellation, and at the same time, to provide grading for the intensity of each. Each symptom category was constructed to include a series of statements reflecting varying degrees of

severity. The system of scoring took into account the number of symptoms reported by the subject by assigning a numerical score for each. The subject's total score represents a combination of the (a) number of symptom categories the individual endorsed and (b) the severity of the particular symptom. The items in the inventory were primarily clinically derived.

The inventory was a pencil and paper test. Subjects were asked to circle the number corresponding to the statement that best described how they felt and the test was scored by totaling the numerical value of the circled answers.

The inventory can be administered by a trained interviewer and it is economical. The inventory also has facilitated comparison with quantitative data and can be made available for various types of statistical manipulation. Finally, because of the wide range of scores the inventory is more sensitive in indicating changes in the depth of depression than clinical judgments based on psychiatric evaluations/assessments.

Two validation studies were reported by Beck, Ward, Mendelson, Mock, and Erbaugh (1961) which were conducted with psychiatric populations, with psychiatric

assessment of the depth of depression making up the criterion measure with which the depression inventory was compared. Biserial correlation coefficients of .56 and .67 were obtained (n = 226 and 183, respectively).

Two methods of measuring and evaluating the internal consistency of the instrument have been used, according to Beck (1967). Initially, the protocols of 200 consecutive cases were analyzed. The scores for the 21 categories were compared with the total scores on the Depression Inventory for each individual. The use of the Kruskal-Wallis Non-parametric Analysis of Variance by ranks found that all the categories showed a significant relationship to the total scores on the inventory. Significance was found beyond the .001 level on all of the categories except item 19 (weight loss category), which was significant at the .01 level. A later item analysis of 606 cases demonstrated that the categories correlated positively with the total depression inventory scores (range .31 to .68). These correlations were significant at the .001 level.

The second evaluation of internal consistency was the determination of the split-half reliability.

Ninety-seven cases in the first sample were selected for the analysis. The Pearson r between the odd and even categories was completed and yielded a reliability coefficient of .86. With the Spearman Brown correlates, the reliability coefficient increased to .93.

Two indirect methods estimating the stability of the instrument were accessible. The first was a variation of the test-retest method. The inventory was administered to a group of 38 subjects at two different times. Each time a clinical estimate of the depth of depression was made by a psychiatrist. The interval between the two tests varied from 2 to 6 weeks. The results demonstrated that changes in the scores on the inventory tended to parallel changes in the clinical ratings on the depth of depression, indicating a consistent relationship of the instrument to the subject's clinical states.

In the present study, the pretest was administered and after 3 weeks, the posttest was administered. This inventory has strength in measuring the level of depression over intervals of time which is the thrust of the pretest and posttest measurements.

Data Collection

The Beck Depression Inventory was administered by a research assistant (who was trained by the investigator) to each new client who agreed to participate in the study, before the initial crisis assessment. The actual data collection took place in the lobby next to the research assistant's office. Prior to the data collection the research assistant explained the study, obtained the subject's permission to participate, and provided instructions regarding filling out the questionnaire. This assistant was the sole collector of the data. After three crisis counseling sessions, which began with the initial assessment, lasting an hour each time with a week's interval between sessions, the posttest was again administered by the research assistant. After the subject completed the questionnaire, it was given to the investigator who added this individual to the master list.

All clients who entered the center during the study were asked to participate, except those who were psychotic. The psychotic condition was confirmed when the client was unable to give information. The assistant called the researcher if there were any questions.

Each of the two crisis team members was given an hour-long inservice education program by the researcher in order to promote some continuity of the treatment approach. This inservice program consisted of a discussion of general principles of crisis intervention (Caplan, 1961) and was done prior to the data collection.

The diagnosis was made among the three crisis team members and a staff psychiatrist during staff meeting, which occurred within a week of the initial assessment. The justification for using three sessions of treatment versus six, as recommended by Caplan (1961), was related to the high dropout rate in this crisis center after the third session. After a diagnosis was established and recorded for each patient, the investigator assigned the subjects to the appropriate group, or dropped them from the study.

Treatment of Data

After the data were collected, the mean scores were calculated from the subjects' pretest and posttest scores from the Beck Depression Inventory. An analysis of covariance was used to ascertain if there was any difference between the two groups. The pretest scores were a

covariant and the significance level for the acceptance of the hypothesis for this study was 0.05.

CHAPTER 4

ANALYSIS OF DATA

This study was an ex post facto study which focused on individuals diagnosed as having adjustment disorder with depressed mood, resulting from two categories of etiology. Group 1, loss of a significant other, had 14 subjects and Group 2, other situational factors, had 17 subjects. Data were obtained from the Beck Depression Inventory which measured levels of depression of subjects from each of the two groups. This inventory was administered prior to and after crisis intervention. The crisis intervention consisted of three sessions with intervals of 1 week between sessions. Demographic variables included sex, race, and ages of the subjects.

Description of Sample

The subjects ranged in age from 19 to 47 years. Group 1, the loss group, ranged in age from 19 to 44 years, and Group 2, the other situational factor group, ranged in age from 21 to 47 years. The mean age for Group 1 was 31.14 years, and the mean age for Group 2 was 31.10 years.

Table 1 presents the frequency of ethnicity and gender categorization for Group 1 and Group 2 subjects. There were 2 blacks and 29 whites in the sample; 1 black in each group. There were 5 males, 1 male in the loss group, and 4 in the other group. The total of 26 females was evenly divided, 13 in each group.

Table 1

Frequency of Ethnicity and Gender Categorization by Group Membership

Group Category	Ethnicity		Gender	
	Black	White	Male	Female
Loss	1	13	1	13
Other	1	16	4	13
Totals	2	29	5	26

Findings

Depression scores for each subject were obtained and means for the pretest and posttest were calculated for each group. The range for Group 1 on the pretest was 15 to 47 and for Group 2, the range was 3 to 85. The pretest mean for Group 1 was 30.3 and for Group 2, 30.4. These means were in the severely depressed group, according to Beck's categorizations. Posttest ranges

were 2 to 33 for Group 1 and 2 to 40 for Group 2. Group 1 posttest mean was 10.6, and Group 2 posttest mean was 10.5. Both means fall into the mildly depressed grouping and are reported in Table 2.

Test of Hypothesis

The hypothesis tested in this study was that there will be no difference in the level of depression, after the institution of crisis intervention and using pretest scores as a covariant between persons experiencing depression from loss and those experiencing depression because of other situational factors. In order to test the hypothesis, the data were analyzed by an analysis of covariance, utilizing pretest scores from the Beck Depression Inventory as the covariant, to determine if there were any differences between the two groups on levels of depression. The results of the analysis are presented in Table 3.

The analysis of the data produced an F ratio of 0.125 (p = 0.727) for the covariate, showing that pretest scores had no significant influence on the posttest scores. The analysis for the main effect produced an F ratio of 0.006 (p = 0.937), showing that there was

Table 2

Frequencies and Means of Depression Scores for Pretest and Posttest by Level of Depression for Each Group

Scores	Group 1 (n = 14)		Group 2 (n = 17)	
	Pretest	Posttest	Pretest	Posttest
Not depressed (0-9)	0	5	1	8
Mild (10-15)	1	3	0	1
Moderate (16-23)	3	3	3	3
Severe (24-63)	10	3	13	5
Group Mean	30.3	10.6	30.4	10.5

Table 3

Analysis of Covariance Results

Source of Variation	Sum of Squares	df	Mean Square	F	Significance of F
Covariance Pretest	17.033	1	17.033	0.125	0.727
Main Effects Group	0.863	1	0.863	0.006	0.937
Residual	3828.071	28	136.793		
Total	3846.968	30	128.232		

no significant difference between the groups. Therefore, the hypothesis was not rejected.

Additional Findings

Additional analysis of data was performed in order to determine if there was a significant difference between the pretest and posttest scores for all 31 subjects. The paired *t*-test was utilized to determine the significance of the differences. The mean difference between scores was 17.71, $t = 5.448$, with 30 *df* ($p < 0.001$), showing a significant difference between pretest and posttest scores.

Summary of Findings

There is one major finding and one additional finding from the analysis of data in this study. The major finding was that there was no difference in the level of depression between the two groups after the institution of crisis intervention. The additional finding was that there was a significant difference between the pretest and posttest scores among the 31 subjects.

CHAPTER 5

SUMMARY OF THE STUDY

This chapter will present the summary of the study, a discussion of the findings, conclusions, and the implications for nursing practice. Recommendations for future research will also be presented.

Summary

A significant area in the mental health field is the treatment of individuals diagnosed with depression. Depression is a disorder that affects a large number of individuals at least periodically throughout their lives, and many of these individuals seek treatment for their depression. These individuals often present themselves at a crisis center or call over telephone hotlines for psychiatric assistance.

There have been studies dealing with individuals in crisis using crisis intervention. Some of these studies have demonstrated improvement, whereas others have demonstrated that intervention was ineffective or inappropriate.

Crisis, as defined by Caplan (1961), is a state in which the individual is faced with insurmountable

obstacles, and the outcome is governed by available resources in the immediate environment. Although crisis theory does not suggest differential effects of treatment according to etiology, the variability of research results suggests that there may be differences.

Studies dealing with depression are common, and crisis intervention is a current treatment; however, the results from studies have not been clear. Depression apparently responds well to most treatment modalities, but no studies have specifically investigated the use of crisis intervention with depression.

The problem in this study was to determine if there is a difference in the level of depression after the institution of crisis intervention, between persons experiencing depression associated with loss of a significant other and those experiencing depression associated with other situational factors.

The setting in this study was a mental health center crisis unit located in Southwestern United States. A convenience sample was used and was composed of individuals who voluntarily sought treatment, agreed to participate in the study, and had a diagnosis of adjustment disorder with depressed mood. The sample was made up of 31 subjects, 14 in Group 1 and 17 in Group 2.

The hypothesis was there will be no difference in the level of depression, after the institution of crisis intervention, between persons experiencing depression from loss and those experiencing depression because of other situational factors (using pretest scores as a covariant). Analysis showed $F = 0.066$ ($p = 0.937$), and the hypothesis was not rejected. A paired t-test was used to determine differences between pretest and post-test, and showed $t = 5.448$ ($p < 0.001$), which was significant.

Discussion of Findings

The major finding from this study supported the theoretical framework of crisis theory that regardless of the etiology of the crisis, there are no differences in response to crisis intervention. On the other hand, this study was not supportive of a study conducted by Williams and Polak (1979) in which their findings demonstrated crisis intervention as being ineffective and inappropriate with individuals experiencing bereavement.

Even though this study's finding showed significant group differences between pretest and posttest scores, there were individuals who did not show improvement in the groups on the posttest scores, and there were some

individuals who had posttest scores higher than their pretest scores. A distinction was not made between those individuals who actually experienced a death and those who had other loss. It is possible then, that individuals who actually were bereaved did not have lowered posttest scores than those who experienced other losses. It is not clear who the persons were who did not show positive changes.

The finding that there were significant changes in depression levels from pretest to posttest is consistent with studies showing the effectiveness of crisis intervention (Langsley et al., 1969; Langsley et al., 1971). Since there was no control group in this study, nothing can be mentioned regarding the consistency with other studies (Gruen, 1975; Wolkon, 1972), which showed no differences between intervention groups and no treatment groups.

Conclusions and Implications

From the findings of this study, it can be concluded that for this sample persons diagnosed with adjustment disorder with depressed mood respond well to crisis intervention, regardless of the etiology of the depression. There was no randomization in this study;

therefore, these findings can be applied only to this sample. It is important to note that the subjects included only two blacks and five males, which is a limited representation of those groups.

Since there is a limited amount of money budgeted for mental health problems, it is important to be able to treat the maximum number of people in the minimum amount of time. There are two implications derived from the conclusions in this study. The first is, given the conclusion that crisis intervention is equally effective for depressed individuals, regardless of the etiology of depression, psychiatric nurses and other mental health professionals can institute a common crisis treatment plan. This commonality simplifies the therapeutic task of treating depressed individuals.

The second implication derived from this study's findings is that persons experiencing depression can obtain significant relief from other symptoms with only three treatment sessions. Mental health professionals can feel more confident limiting the number of treatment sessions and about the large number of clients who traditionally drop out of treatment after a few sessions.

Recommendations for Further Study

Based on this study's findings, conclusions, and implications, further studies can be recommended in order to:

1. Determine if these findings can be applied to various ethnic groups.

2. Conduct a study utilizing three sessions with a waiting list or no-treatment group for control.

3. Conduct a study to control for individual therapist effects, since each therapist administers crisis intervention subjectively.

4. Separate those subjects who are grieving a death from those with other types of loss.

APPENDIX A

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HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: DEBORAH YVONNE JACKSON BARRANCE Center: DALLAS

Address: 2531 CLUB MANOR Date: 10/21/80

DALLAS, TEXAS 75237

Dear MS. BARRANCE

Your study entitled CRISIS INTERVENTION WITH DEPRESSED INDIVIDUALS EXPERIENCING LOSS AND OTHER SITUATIONAL STRESSES

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

____ Other:

__X__ No special provisions apply.

Sincerely,

Estelle J. Kurtz

Chairman, Human Subjects Review Committee

at DALLAS

PK/smu/3/7/80

APPENDIX B

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Dallas County Mental Health/Mental Retardation

GRANTS TO Deborah Yvonne Jackson Barrance
a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Crisis Intervention With Individuals Experiencing Loss and Other Situational Stresses

The conditions mutually agreed upon are as follows:

1. The agency (may) (~~may not~~) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (~~may~~) (may not) be identified in the final report.
3. The agency (wants) (~~does not want~~) a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: 12/17/80

Signature of Agency Personnel

Deborah Barrance
Signature of Student

Estelle D. Kurtz
Signature of Faculty Advisor

*Fill out & sign three copies to be distributed as follows: Original - Student; First copy - Agency; Second copy - TWU College of Nursing.

APPENDIX C

Consent to Act as a Subject for Research and Investigation:

I hereby agree to voluntarily participate in a study done by
Deborah Barrance of Texas Woman's University
(Name of person who will perform the investigation)

After careful explanation, I agree to,

1. Answer 21 questions about the way I feel,
2. After three counseling sessions, answer the same 21 questions. I understand that there are no right or wrong answers,
3. My participation in this study is voluntary and I may withdraw at anytime without interference with my treatment at Dallas County Mental Health Mental Retardation,
4. My individual results will not be identified or reported; my individual name will not be associated with my answers. My answers will be listed on a master code list with an assigned number, this list will be kept by the researcher and destroyed immediately after the data is collected.

This procedure has been explained to me by _____
(Name)

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of possible benefits. An offer has been made to me to answer all questions about the study after its completion. I further understand that no medical service or compensation is provided to subjects by the university as result of injury from participation in this research.

_____ _____
(Signature) (Date)

_____ _____
(Witness) (Date)

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above person a description of the listed elements of informed consent.

_____ _____
(Signature) (Date)

_____ _____
(Position) (Date)

_____ _____
(Witness) (Date)

APPENDIX D

BECK DEPRESSION INVENTORY

NAME_____

DATE_____

(Instructions) On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group that best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If the several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

( ) A.
0 I do not feel sad
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy I can't stand it.

( ) B.
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

( ) C.
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

( ) D.
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

( ) E.
0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel guilty most of the time.
3 I feel guilty all of the time.

( ) F.
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

( ) G.
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

( ) H.
0 I don't feel that I am any worse than anyone else.
1 I am critical of myself for my weakness or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

( ) I.
0 I don't have any thought of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

( ) J.
0 I don't cry anymore than usual.
1 I cry now more than I used to.
2 I cry all the time.
3 I used to be able to cry, but now I can't cry even though I want to.

( ) K.
0 I am no more irritable now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated al all by the things that used to irritate me.

( ) L.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all interest in other people.

( ) M.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

( ) N.
0 I don't feel I look any worse than I used to look.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

( ) O.
0 I can work about well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

( ) P.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

( ) Q.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from almost anything.
3 I am too tired to do anything.

( ) R.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

( ) S.
0 I haven't lost much weight, it any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

( ) T.
0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems, that I cannot think about anything else.

( ) U.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

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