Manufacturing a human drama from a psychiatric crisis: crisis intervention, family therapy and the work of R. D. Scott

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There has been a recent resurgence of interest in crisis intervention within psychiatry. The idea of crisis services is not, of course, a new thing, and there is a great deal to be learnt from returning to the innovative writings of those practitioners who developed similar services in the 1960s and 1970s. This article discusses the work of the psychiatrist and family therapist R. D. Scott, who developed a 24-hour family-orientated crisis intervention service in London during this era. Although under-utilized, the writings of Scott and his colleagues in this area continue to be of crucial relevance to mental health nurses and other psychiatric professionals.

Keywords: closure, crisis intervention, cultural beliefs, family therapy, R. D. Scott

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Introduction

As the shift towards community care has gathered momentum in Britain during the 1980s and 1990s, there has been an increase in public anxiety about how psychiatric services are responding to people identified as mentally ill. Public concern that people with severe difficulties have been left to fend for themselves, sometimes with disastrous consequences, has been exacerbated by the failure of central government to provide adequate funding for services. Media coverage over this period has tended to both reflect and provoke this anxiety by characterizing people with mental health problems as dangerous, unpredictable, and irresponsible (Johnstone 1994). In response, legislative initiatives have been introduced which strengthen the surveillance and coercive aspects of psychiatry's social function. While these initiatives were introduced with the aim of allaying public concern, they may also have the effect of generating further anxiety by unintentionally confirming the stereotypical perceptions of the 'mentally ill' as dangerous and irresponsible.

Our practice as mental health nurses is inevitably influenced by these powerful sociocultural discourses about mental illness. The relationships we form with individual service-users, their families, and our professional colleagues are strongly influenced by these dominant beliefs and attitudes, and the resulting political and legislative frameworks. Birch (1991), Johnstone (1994) and Parker *et al*. (1995) have explored the relationship between professional practice and these wider cultural perspectives on mental illness, and in his writings Scott (1973a) has analysed the constraining effects on psychiatric practice of these dominant cultural beliefs and attitudes. Scott also discusses the disabling processes that can occur when problems of living become defined as medical or psychiatric in nature, the 'closure' that occurs between the person who is labelled as ill and their wider social context, and the barrier to effective therapeutic intervention which is constructed as a consequence of this. These ideas will be discussed in some detail in this article, as they provided the theoretical rationale for the 24-hour crisis service which Scott and his coworkers developed.

Background

Dr Scott is a psychiatrist who initially trained in individual psychotherapy, and began to study family therapy in 1960, participating in regular seminars on communications theory and family studies in schizophrenia at the Tavistock Clinic in London, together with colleagues such as Laing, Esterson, Cooper and Lee, who were at the forefront of applying these ideas in the UK (Clay 1996). Scott also led a research team which carried out intensive studies, based on their clinical work with families using a systemic perspective (Scott & Ashworth 1967, 1969).

These early articles by Scott and his co-workers were of their time, in the sense that they were characterized by a concern with the aetiological factors associated with family dynamics. However, just as he had made an earlier shift from using individual therapy to a family-orientated approach, Scott later continued to widen the theoretical lens through which he viewed psychiatric disorders, to include sociocultural concerns. By the early 1970s, Scott had, to use his own words, 'emerged out of the family hinterland into the light of day, and seen how many abnormalities in family relationships are based on the cultural image of mental illness' (Scott 1973b, p. 65). Over this period he continued to apply these new ideas in his general psychiatric practice (Scott 1973a, 1980, Scott & Starr 1981), and the understanding that he developed of the significance of cultural beliefs about mental illness encouraged his shift towards the development of a community-orientated crisis intervention service.

Cultural beliefs about mental illness as a 'treatment barrier'

In order to understand how particular beliefs and attitudes towards mental illness have come to be predominant within contemporary Western society, it is helpful to consider the history and development of these ideas. Rosen (1994) offers an account of the ways in which perceptions of those viewed as insane have altered over time. He suggests that in prehistoric times society was organized into small communities with systems of extended kinship and that people who displayed strange or unusual behaviour would tend to remain included rather than be expelled. Such people were often regarded as having special spiritual abilities or gifts. Rosen argues that as a consequence of the widespread influence of Greek civilization during the 4th and 5th centuries BC, the Western Intellectual Tradition became established, which was characterized by the elevation of the concept of Reason. It was during this era that madness came to be regarded as a human failing rather than a state of heightened spirituality, and those people who were seen to be insane tended to be expelled from communities or allowed to wander, with no particular provision being made for them. During the period of the Enlightenment, from the mid-17th century onwards, the ideals of Rationality and Reason became further elevated, and it was during this period that the practice of locking away the mad in purpose-built institutions began. This is the period described by the French philosopher Michel Foucault as 'the Great Confinement' (Rosen 1994, p. 130).

Foucault argued that the inhabitants of these institutions did not come to be regarded as 'sick' until the end of the eighteenth century, when ideas about the moral treatment of people seen principally as weak or maladjusted gave way to medical understandings of insanity, and the birth of psychiatry as a specialist branch of medicine (Parker *et al*. 1995). The eventual dominance of the medical–psychiatric perspective was finally achieved with the advent of major tranquillizers in the 1950s. The effectiveness of these drugs has generally been regarded as a fundamental advance in the treatment of the mentally ill, which created the possibility of community care in its present form (Parker *et al*. 1995). The notion of madness as brain disease has subsequently reigned supreme. It is debatable, for instance, whether the radical critique of orthodox psychiatry provided by R. D. Laing and others (Laing 1967) in the 1960s and early 1970s impacted greatly on mainstream psychiatric practice. In relation to the field of psychiatric nursing, some recent evidence regarding the dominance of the biological perspective is provided by a study undertaken by the Sainsbury Centre for Mental Health (Warner *et al*. 1997). In this study a number of psychiatric nurses working in different NHS Trusts in England were asked to identify the specific skills that they felt mental health nurses needed in their work with people with severe mental health problems. All of the nurses who participated in the research identified dealing with medication as a key area of nursing practice, but few mentioned specific psychotherapeutic interventions such as cognitive therapy, and none mentioned family therapy.

In Western society the dominant societal beliefs about persons who are characterized as mentally ill therefore include the idea that psychiatric disorder occurs as a consequence of biochemical or genetic factors; that the problems are located 'inside' of the individual; and that the person who is afflicted lacks 'insight' into his or her true situation and lacks responsibility or personal agency (Scott 1973a,b). Once a diagnosis of mental illness is awarded to the individual, the problems are generally seen as unrelated to the social context in which the person has been living their life.

When an individual is defined as mentally ill in this way, 'illness' comes to be seen as an aspect of their identity, so that we describe a person as a 'schizophrenic' or an 'agoraphobic' in such a way that no space exists between the person and the illness that has been ascribed to them (White 1989). The traumatic event(s) associated with the crisis therefore come to define the person's identity, rather than being a life experience that he or she can relate to. The process whereby the person and those involved with him or her internalize the dominant societal discourses about mental illness has profound implications for their lives, as these internalized discourses:

> . . . have the effect of isolating persons from each other, and from the very contexts of their own lives. These discourses have provided for a way of speaking and thinking about life that erases context, that splits experience from the politics of local relationship (White 1993, p. 20).

Scott (1973a, 1991) argued that these cultural beliefs about mental illness create a powerful barrier to effective therapeutic intervention by severing the connections between the individual and the network of significant relationships which provide the context in which the crisis occurred, and by invoking the stereotypical notion of the mental patient as someone lacking in insight and personal agency.

Closure

These dominant sociocultural beliefs about mental illness therefore exert a powerful influence on the life and relationships of the person who receives a psychiatric diagnosis. Scott uses the term 'closure' to describe this process in which a person in crisis can become disconnected from the network of intimate family and social relationships in which they ordinarily live their lives, and which provides the context for the difficulties which have occurred (Scott & Ashworth 1967). Closure does not usually lead to family members abandoning one another in a physical sense; rather, a kind of dehumanizing process may follow. When a crisis is developing the family may be faced with an unbearable sense of hurt and pain. In the face of this, family members may cut off from the person who is regarded as ill. Scott & Ashworth (1967) argue that it is the bonds of love and affection which are severed, as it is these positive ties which are most painful. All of this begins to occur before the professional system is drawn into the situation, and psychiatric practice which fails to take account of the individual's social context may inadvertently exacerbate this rift: 'Closure can be a point of no return. A symptom . . . represents a partial death of that person as a social being. Being in the psychiatric space makes this death official' (Scott & Starr 1981, p. 183).

Scott believed that once the invisible line is crossed which divides the 'mad' from the 'sane', this can be a point of no return. The person will always be viewed as 'ill', regardless of how 'well' they behave. Chronic psychiatric invalidism can be a kind of prison from which there is little prospect of escape or release, even for 'well' behaviour. Similarly, once the person has been defined as mentally ill they are in danger of finding themselves becoming further marginalized from the broader social world as a consequence of the stigma associated with psychiatric problems within Western society (Goffman 1963, Ramon 1992).

Closure and professional complicity

When a crisis occurs within a family, the beliefs of the individuals concerned may be in a state of flux (Caplan 1964), and a number of commentators have argued that the intervention of professionals during this crucial time plays a major part in how the problem is subsequently viewed or defined within the family (Haley 1980, Dallos *et al*. 1997). When a situation becomes unbearably stressful for the members of a family or social group, a mental health professional may be invited into the situation to provide an 'expert' opinion. When this psychiatric interview leads to a diagnosis of mental illness being offered to a family member, then closure may ensue. Since the difficulties which the person is faced with are confirmed by the professional to be features of an illness over which the individual and their family have no influence or control, responsibility for managing the situation tends to be handed across to the professional system at this point.

The notion of the mental health professional as expert is particularly interesting in this context, as Scott (1973a) argues that, prior to the professional being invited into the crisis situation, it has already been decided within the community that the person's conduct is a consequence of psychiatric disorder. The professional who is intervening in the crisis situation may therefore discover that their status as 'expert' is dependent upon their confirming this psychiatric account; an unwillingness to do so might lead to their opinion being discredited or considerable pressure being brought to bear to encourage the professional to intervene in the expected manner. Scott and his colleagues found from clinical experience that when these cultural beliefs about mental illness are challenged, then powerful reactionary forces may be mobilized in order to reassert the status quo.

As psychiatric nurses we are, of course, deeply involved in all of this, and the process of closure may touch our lives as well as the lives of our clients. Discussing the impact of closure on the professionals involved, Scott (1995, p. 6) comments:

> We become imprinted in the same manner that we have imprinted closure in the patient. This shows up in psychiatric practice where we are almost exclusively drawn to the negative, to what is wrong and commonly fail to realize the primary importance of positive feeling. This is an imprint of the closed attitude. It runs throughout psychiatry.

A similar point is made powerfully by Deegan (cited in Rosen 1994), who warns that when psychiatric professionals stop seeing patients as people, they become a bit less human themselves.

One of the ways in which Scott proposed that professionals can avoid becoming complicit with the process of closure and the development of the treatment barrier is by refusing to talk in secret with relatives or significant others about the client in the person's absence (Scott 1973a, 1995). Secret talks of this nature are usually best avoided as they can easily reinforce the view of the client as unable to accept adult responsibilities or as lacking in 'insight' .

Hospitalization as a form of closure

When a severe crisis occurs in a person's life, a common professional response is to bring the person into hospital in order to try to contain the situation. The large majority of psychiatric admissions continue to occur on an unplanned basis in response to a perceived crisis or emergency (Moore 1998). Closure can occur regardless of whether the person who is labelled 'ill' is treated in the community or in the hospital, but Scott suggests that hospitalization exacerbates the process of disconnection (Scott & Starr 1981).

The importance of the concept of closure in relation to the experience of entering psychiatric hospital is supported by research undertaken by Whittle (1996), which examined the impact of admission on the causal beliefs of the people who were admitted, their families and the staff. This study suggests that following admission clients and their relatives became more attached to biological theories of causation, while psychosocial causal beliefs decreased significantly over the period of hospitalization. Those clients who had been admitted previously also tended to be more strongly orientated towards a biological perspective. This change in beliefs did not seem to be influenced by the causal beliefs of the staff, who in this study were less strongly orientated towards biological beliefs. Whittle therefore suggests that this change in beliefs for clients and their families may have been linked with wider cultural assumptions about why people need to go into hospital, rather than occurring as a consequence of ideas presented to families by the staff. Whittle goes on to suggest a link between causal beliefs and treatment beliefs: clients who held biological causal beliefs were more likely to regard medication as the most relevant treatment for their difficulties. The perceived relevance of psychotherapeutic approaches generally, and family therapy in particular, seemed to diminish for these clients and their families.

Whittle also refers to previous studies which have suggested that when a person has been admitted to hospital once, he or she is more likely to request admission when experiencing subsequent life crises. Hospital admission as a response to a crisis situation therefore seems to be a particularly relevant factor in facilitating a process of closure in relation to interpersonal factors, and in the formation of a treatment barrier where family therapy is concerned.

Crisis intervention

While the consequences of closure may be severe for the service-user, their family, and also for the professionals who are involved in this process, Scott (1995) argues that crisis intervention provides an opportunity for professionals to actively intervene in order to prevent this occurring, rather than simply reacting to the situation in a more passive way. By visiting the person in their home setting as rapidly as possible, hospital admission can often be avoided. The resources of the family and the staff team can be drawn upon collaboratively in addressing the problems which led to the crisis, and decisions are made on the spot in the energy of the person's living situation (Scott 1995). Scott also stresses the importance of involving the family or significant others from the outset (Scott & Starr 1981). When this happens, the family are more likely to remain actively involved in the therapeutic process, even in those situations where hospital admission occurs.

Crisis intervention work based on Scott's ideas of closure and the treatment barrier reduced first-time admissions by over 50 per cent (Ratna, cited in Johnstone 1993, Scott 1980). One of the features of this approach is the importance given by Scott to the quality of engagement between the professional and the person/family in crisis when contact is initially made (Scott 1995). When entering into a situation of great tension, the professional may feel pressurized into giving advice or making a treatment plan immediately. This feeling may be exacer-

bated for the professional by agency demands in terms of workload, efficiency and the importance of containing risk. However, Scott (1995) contends that a period of time spent with the service-user at the outset, in which the professional allows her or himself to listen attentively and tune into the concerns of the person in crisis, can save a great deal of time and money later, since it is the quality of the therapeutic relationship which is the most important factor in facilitating change (Andersen 1997). Alternatively, the premature imposition of a treatment strategy is a recipe for future chronicity (Scott 1995).

Within the field of psychiatry there has recently been a general resurgence of interest in the idea of crisis intervention teams, together with the related initiative of home treatment teams which can reduce reliance on hospital admission as a primary treatment strategy (Crompton 1997, Riseborough 1997). Based on research undertaken in Australia, Hoult and his colleagues have persuasively argued that intensive community treatment for people who are regarded as experiencing severe psychiatric problems can be more effective and cheaper than traditional hospital-based services, and seems to be preferred by people who access the service (Hoult *et al*. 1984). Like Scott, Hoult (1993) argues that rapid, intensive help should be provided as early as possible, in order to strengthen therapeutic alliances between the professional team, the identified client, and his or her relatives, and also to help clients resume their normal routines as quickly as possible.

An important difference between the work of Scott and his colleagues and the many of the more recently developed community models, however, is that those services developed in the 1980s and 1990s tend to be characterized by a strong allegiance to disease concepts of psychiatric disorder. Whereas Scott viewed early family-based intervention as an opportunity to prevent induction into a psychiatric career with the attendant processes of marginalization and stereotyping, more recent developments have tended to emphasize the importance of retaining a strong medical focus; for instance, by advocating the use of psychoeducational approaches to family work, which emphasize the importance of explaining theories of biochemical aetiology and medication compliance to families. The opportunities which crisis work may provide to undertake 'preventative' work, in the sense of avoiding the formation of a 'treatment barrier', is not featured to the same extent in more recent writings on the topic[1].

An important exception is the work of Seikkula and his colleagues, working in the Western Lapland area of Finland (Seikkula *et al*. 1995). Mobile crisis-intervention teams are the guiding principle of this team's service, and requests for psychiatric inpatient treatment are responded to by rapidly convening a meeting which includes the identified patient and those people who are closely involved with him or her, as well as any professionals involved in the situation. All decisions about treatment are taken within these meetings, and are agreed through open dialogue between all participants. The development of this systemically orientated networking approach to crisis situations has led to great reductions, both in the need to prescribe neuroleptic medication, and in admissions to hospital. Again, the full implications of this Finnish work are yet to be considered by purchasers and providers of services in the UK, perhaps because they require us to reconsider some long established beliefs about the treatment of schizophrenia; beliefs which are prevalent within the professional world and reinforced by perceptions about mental illness which are dominant in the society that commissions us.

Conclusion

The ideas of Scott and his colleagues continue to be of relevance and importance to mental health nurses and other psychiatric professionals. In recent years, issues such as underfunding of services and media coverage of community care 'failures' have led to increased public anxiety about people labelled mentally ill, and the levels and type of care they receive. Perceptions of the 'mentally ill' as irresponsible, dangerous and lacking in insight predominate in this context, and legislative initiatives have in turn been introduced which are aimed at increasing psychiatry's surveillance and monitoring roles, in order to protect the general public. In other words, these are cautious times, and perhaps as a consequence, biochemical theories of psychiatric disorder have become strongly profiled, with an attendant emphasis on the importance of psychiatric diagnosis and compliance with medication. At the same time, however, the need to develop more effective and comprehensive community psychiatric services has led to a resurgence of interest in the idea of crisis intervention (Crompton 1997, Riseborough 1997).

This renewed interest in crisis services creates potential

1 Within psychoeducational family therapy approaches, there tends to be an emphasis on inducting the family into a medicalized understanding of the situation, thus potentially creating the conditions for closure to occur. Since it is likely, however, that the family will already be viewing the situation in illness terms, Scott (personal communication) proposes that a psychoeducational approach might provide a useful starting point for therapy, when framed in a manner which both respects the current beliefs of the family while leaving an opening for different accounts to emerge.

new opportunities for mental health nurses and other practitioners working within psychiatry. Opportunities, for instance, to understand and work with psychiatric problems within the social and interpersonal context in which they initially arose, rather than simply view these problems as meaningless symptoms of an illness process; opportunities to work preventatively and reduce reliance on neuroleptics and hospital beds; and opportunities to avoid colluding with the social processes which marginalize those people who have been designated 'mentally ill'. Nurses wishing to develop these opportunities will find encouragement and inspiration through returning to the writings of earlier innovators such as R. D. Scott and his colleagues.

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