

A CRISIS-ORIENTED APPROACH TO THE REHABILITATION OF
MYOCARDIAL INFARCTION PATIENTS

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ABSTRACT

Myocardial infarction is introduced as a medical syndrome in which psychosocial factors are thought to have significant bearing on the etiology and outcome of the disease.

An outline of the epidemiology, pathophysiological process, etiology and prognosis is provided in order to highlight the many psychological implications in each of these areas.

The study aims at proposing a model for psychological intervention with myocardial infarction patients that is both economical and effective. Crisis intervention has been chosen as the theoretical basis, as it is felt that many of its concepts apply in this case. Myocardial infarction is seen primarily as a "shock" type crisis as described by Korner (1973) followed by a succession of vulnerable points at which certain individuals descend into crisis.

The therapeutic programme suggested makes use of several key elements of crisis intervention theory: the concept of "tasks";

promoting "situational support" and correct "cognitive perception"; "management of affect"; and monitoring of "coping mechanisms". These are integrated in a framework for intervention which applies them as the background for dealing with an extensive range of psychosocial problems.

SECTION ONEAIM OF THE STUDY

This study is located in the growing area of common concern between doctors and psychologists, reflected in hospitals and medical schools by the use of such terms as "holistic medicine", "behavioural medicine", "environmental medicine". In his preface to "Psychology and Medicine", H.J. Eysenck describes an important part of the area of common interest:

Many problems which are at the moment classified as 'medical' are in fact largely behavioural, demanding re-education rather than treatment, and for these psychologists have worked out ways of modifying behaviour which are quite independent of medicine as ordinarily understood. In many other cases the patient's complaint lies on the borderline between medicine and psychology requiring co-operation between doctor and psychologist. *In yet other cases the underlying problem is clearly medical, but associated with it are psychological problems which must be solved in order to give the medical treatment the best chance of success.*

(Rachman and Philips, 1975, p.11)

The present study focuses on the lastmentioned category (present author's italics) i.e., clearly medical conditions with strong psychological components. Clinical psychologists have been involved in the treatment of this category of medical patients in several ways.

- (a) Psychological assessment of medical patients which assists planning for the patient's future after discharge.
- (b) Assessment of suitability for special medical procedures (e.g., renal dialysis, heart transplantation).
- (c) Planning and execution of special intervention programmes related to a particular medical problem (e.g., care of the dying, post-operative care, mastectomy). The present study describes an approach of this nature.

The study aims to provide a framework for psychological intervention in the rehabilitation of patients following myocardial infarction (or heart attack). This problem is universally recognised as one in which psychosocial factors have a profound influence on both etiology and rehabilitation.

Emotional reactions to coronary heart disease are as predictable and as characteristic as changes in the ECG (electrocardiograph)... the psychological reactions of patients to this injury are prominent in almost every case, and in many cases constitute the major disability (Hellerstein and Ford, 1960, p.1167).

The preconditions of such a psychological intervention programme are

- (1) that it has maximal effectiveness in achieving a mentally healthy outcome and reduction of "disability" among heart patients passing through hospital-based treatment, and yet

- (2) that it remains realistic in the light of scarce therapeutic resources. It is proposed to examine Crisis Theory as a model upon which to base the formulation of the programme, as it is felt that this theory may fulfil the above preconditions. The degree to which the myocardial infarction experience is consistent with "crisis" as described in the theory must be analysed. The framework being proposed should take account of any particular definition of crisis arising from this analysis.

As a foundation for this framework, a review of myocardial infarction - (pathophysiological process, epidemiology, etiology, treatment and prognosis) - is provided in some detail. This is justified on the following grounds:

- (1) that any mental health professional working in a medical field should possess a working knowledge of the syndrome he is dealing with in order to engender the confidence of patients and members of the medical team.
- (2) that this basic information is the foundation around which intervention strategies are planned.

SECTION TWO

MYOCARDIAL INFARCTION - INTRODUCTION

2.1 THE PATHOPHYSIOLOGICAL PROCESS IN MYOCARDIAL INFARCTION

What follows is a brief introduction to the main features of this process, and is based on the work of Goldenson, Dunham and Dunham (1978).

In common with all other muscular tissue in the body, the heart muscle depends for its survival on regular supplies of oxygen-bearing blood. This blood is supplied to the heart muscle through the three main coronary arteries and a network of smaller branches leading from them.

Like other arteries, the coronary arteries may become coated with fatty deposits or 'plaques', thus narrowing or hardening (losing flexibility to expand or contract), a process known as atherosclerosis. As a consequence of this, the blood supply to an area of the heart may become restricted; the patient may experience pain known as angina pectoris, particularly during times of increased oxygen demand.

Myocardial infarction (M.I.) occurs when the coronary artery is completely blocked (or occluded) and a portion of the heart muscle is deprived of blood, and dies. This is usually

manifested by severe and prolonged chest pain, spreading to neck and shoulders, and may be accompanied by sweating, weakness and shock. (Up to 20 per cent of patients, however, have so-called "silent heart attacks" with minimal symptoms (Miller, 1971). Following this infarction, under optimal conditions of rest and care, the injured area heals, forming scar tissue, over a period of about six weeks.

Following a myocardial infarction, a patient is at risk for developing any one of the following:

- (a) angina
- (b) various forms of arrhythmia (disturbance of regular heart rhythm).
- (c) reinfarction
- (d) cardiac arrest. This refers to termination of heart function due to a complete cessation of electrical activity (asystole) or excessive electrical activity (ventricular fibrillation) - both potentially reversible conditions with resuscitation procedures.
- (e) death may occur after any of the above occurrences (see prognosis - section 5).

(A note on terminology)

The lay terms "heart attack", "coronary" are used in some quotations interchangeably with the term "myocardial infarction" which is from now on abbreviated to M.I.

"Coronary heart disease", "ischaemic heart disease" or "coronary artery disease" refers to the condition of advanced atherosclerosis, usually in the context of a person who has suffered ~~his~~ first M.I.

2.2 EPIDEMIOLOGY

It is widely acknowledged that coronary disease is a major cause of illness and death in the industrialised world of today (Gentry and Williams, 1979). South Africa has the unfortunate distinction of being called the "heart attack capital of the world" - (Cape Times 30/5/1980).

Males of two South African racial groups consistently head the list of mortality rates as indicated in Table 1. When considering heart disease compared to other causes of death Wyndham (1979) reports that ischaemic heart disease accounts for 35 per cent of deaths of white males in the economically active years (20-65 years). It should be noted that Wyndham's figures including Table 1 are based on 1970 statistics. Stern (1979) reports that overall mortality declined by 20,7 per cent in the United States between 1968 and 1976 (in both sexes in all age groups and in three major race groups). Wyndham (1978) quotes a study in South Africa comparing mortality of white males between 1970 and 1975 and notes a similar trend.

If the South African populations of all age groups are analysed

Table 1

Mortality rates per 100 000 from Ischaemic Heart Disease for South African populations, and selected other populations, by age range and sex (for 1970)

(adapted from Wyndham, C.H., 1978, 1979).

AGE BRACKET:	25-34		35-44		45-54		55-64	
	M.R.	Rank	M.R.	Rank	M.R.	Rank	M.R.	Rank
S.A.Asian males	28.1	1	171.6	1	600.3	1	1064.1	1
S.A. White males	22.5	2	158.5	2	485.8	2	1047.4	2
Finland males	6.7	6	113.3	3	401.1	3	1005.3	3
U.S.A. males	9.3	4	87.3	4	336	5	910	4
Scotland males	8.6	5	81.2	6	343.2	4	900.5	5
Holland males	4.2	9=	48.1	7	201.4	7	564.0	6
S.A. Asian females	4.2	9=	38.5	8	193.1	8	561.6	7
S.A. Coloured males	19.5	3	83.3	5	252.3	6	493.7	8
S.A. White females	4.9	7	26.1	10	112.8	10	349.7	9
Scotland females	1.9	13	18.4	13	81.0	12	313.5	10
U.S.A. females	3.2	11	20.8	12	83.4	11	300.1	11
S.A. Coloured females	4.6	8	31.8	9	121.9	9	265.9	12
Finland females	0.3	18	10.7	14	46.4	14	227.7	13
France males	2.5	12	21.1	11	65.8	12	206.3	14
Holland females	0.5	16=	7.8	16	24.9	16	135.4	15
France females	0.5	16=	2.5	18	11.6	18	55.1	16
S.A.Black males	1.4	14	8.7	15	26.5	15	51.2	17
S.A. Black females	1.3	15	5.7	17	16.8	17	50.5	18

by sex, it is found that the overall mortality ratio is 2,52 males : 1 female. In the younger age groups (under 44 years) for whites and Asians, ratios vary from 4 : 1 to 6 : 1.

Antonovsky (1968) reports that studies throughout the United States and other Western countries indicate that M.I. is equally distributed among all social classes. In South Africa there would be vast differences in M.I. mortality rates between social classes if the South African population groups were viewed as a whole (as will be indicated by an inspection of the relatively low mortality rate among Black South Africans in Table 1). No data is yet available regarding class differences within population groups.

SECTION THREEETIOLOGY3.1 INTRODUCTION TO THE STATE OF THE FIELD

The problem of determining the etiology of M.I. has long been the focus of massive research efforts in various countries, the most frequently quoted example being the Framingham Study which began in the U.S.A. in 1949 (Dawber and Kannel, 1958).

A consistent finding has been the strong relationship between certain psychological and physiological factors (now known as "coronary risk factors") and the incidence of ischaemic heart disease. This relationship has been primarily correlational however, and insights into specific causal links have thus to date eluded researchers. A variety of complex links are thought to exist between these risk factors (and the interaction between them), and M.I., involving as yet unidentified psychophysiological mediating mechanisms.

In this field there are a number of unresolved issues of which the following may serve as examples:

- (i) there are thought to be different risk factor patterns involved in the various phases of M.I., i.e., the conditions involved in the acceleration of the athero-

sclerotic process are distinct from the set of conditions which convert underlying atherosclerosis into clinical disease (Sokolow and McIlroy, 1979). More simply, there are different risk factors which predispose, as opposed to precipitate, M.I.

- (ii) there is doubt that the 'established' risk factors for the first M.I. apply with the same relative strengths to the prediction of subsequent M.I.'s (Jenkins et al, 1976).
- (iii) more than 35 individual risk factors have been suggested (Croog and Leine, 1977). Despite the consistent identification of several better known risk factors it is suggested that certain others accounting for considerable variance in the incidence of M.I. remain unidentified (Pollock and Schmidt, 1979).

Although there are uncertainties, it is clear that clinical practice has accepted the validity of these risk factors (Aronow, 1979). Orleans' (1979) pragmatic approach could be considered typical:

The emphasis here would be on taking positive action regarding the possible life-saving therapeutic effect(s) of life-style change, rather than focusing entirely on the fact that much more research remains to be done before we can prove the actual benefits (p.173).

The well known risk factors have formed the basis for multifactorial intervention projects aimed at the diminution

of these risk factors, e.g. the Belgian Heart Disease Prevention Project (Kornitzer, De Backer, Dramaix and Thilly, 1980). These factors have been synthesized into "cardiovascular risk profiles" which are of use in the prediction of disease with "reasonable precision" (Kannel, 1979, p.17).

In dealing with individual patients, attention is given to encouraging patients to lead a "prophylactic life style" by the reduction of behaviours that increase risk potential. Halhuber and Halhuber (1978) have noted that elimination or control of these risk factors lowers the probability of a heart attack or its recurrence. They believe, too, that "in the majority of cases no single risk factor but instead the interplay of various risk factors causes the heart attack" (p.30) with the implication that all risk factors must be treated simultaneously.

3.2 "PHYSIOLOGICAL" RISK FACTORS

The following are the most often-quoted risk factors in this category.

1. High Blood Pressure (Hypertension)

Hypertension is considered one of the most important of the known risk factors (Kochar and Daniels, 1978), the main complication being raised arterial pressure with associated

atherosclerosis. The compliance with medication regimens post-infarction is especially important but is often disregarded by patients as there are seldom uncomfortable symptoms of the condition (Orleans, 1979).

2. Cigarette Smoking

The frequency of coronary disease is three times higher among cigarette smokers than among non- or ex-smokers or non-inhaling cigar or pipe smokers (Halhuber and Halhuber, 1978).

A further argument is provided by examining the decline (from 1964 to 1975) in percentage of cigarette smokers in the U.S.A. (from 53 per cent of the population to 37 per cent (males) and from 32 per cent to 29 per cent (females)), and noting the links with the mortality decline of 20,7 per cent between 1968 and 1976 (see Stern in Section 2.1) although other risks have declined in this period as well.

Further, according to Halhuber and Halhuber, continued smoking is the most important risk factor for reinfarction and sudden death following a M.I.

3. High Serum Cholestrol levels

The contribution that high serum cholestrol levels makes to the process of atherosclerosis can be minimised by dietary control, weight reduction and cessation of smoking.

4. Physical Inactivity

Data is available showing that physically active persons have a lower incidence of M.I., and that if they do succumb, there is a lesser chance of fatal complications.

5. Overweight

Although it is not proven that obesity is an 'independent' risk factor, its interaction with other factors such as hypertension, diabetes, and high serum cholesterol is of sufficient concern to warrant specific attention.

6. Diabetes

The Framingham Study (op cit) has indicated that every second diabetic suffers from coronary disease, emphasising the danger of this condition remaining undiagnosed or untreated.

7. Genetic Factors

The observation of a higher incidence of heart disease in certain families has frequently been made, yet the precise operation of this factor remained unclear. "It is very likely that hereditary factors play an important role in arteriosclerosis, hypertension, abnormal fat (cholesterol) levels in the blood as well as in diabetes" (Halhuber and Halhuber, 1978).

3.3 "PSYCHOLOGICAL" RISK FACTORS

1. "Critical life events"

Garrity and Marx (1979) examine the conventional wisdom that significant events in the life of an individual may precipitate cardiac illness. They hypothesize that "life changes stress the person, causing the organism to struggle emotionally and physically to cope with the change; this struggle frequently results in a breakdown of health.

These authors review studies of sudden death following emotionally significant life events, and further reports of M.I. in patients who have experienced a single, or a succession of life change situations. In these studies, use was made of the "Social Readjustment Rating Scale" (Holmes and Rahe, 1967) which measures the degree of stress attached to commonly reported life change events. They conclude that there is increasing evidence of an association between disruption in the lifestyle of the patient in the premorbid period, and subsequent cardiac illness, (although there are many mediating factors that require study for this phenomenon to be fully understood).

2. Personality factors

Particular types of personality and lifestyle have long been associated with the development of heart disease.

Thus Sir Williams Osler wrote in 1897 "I believe that the high pressure at which men live and the habit of working the machine to its maximum capacity are responsible for (arterial degeneration) rather than excess in eating and drinking" (quoted by Jenkins, 1979, p.5).

The most intensive studies in this area have been made over the last 20 years by Friedman and Rosenman (Friedman, 1979) who have identified a coronary-prone behaviour pattern. The features of this behaviour pattern - known as Type A are:

- a high drive toward poorly defined goals; persistence of work toward recognition and advancement; eagerness to compete; continuous involvement in activities at a high rate; a heightened mental and physical alertness; problems in the management of hostile and aggressive impulses, and difficulty with authority figures in general. (From Suinn, Brock and Edie, 1975, and Friedman, 1979).

Jenkins (1979) reports several studies showing the mounting evidence of association between Type A behaviour and M.I., including prospective studies which lend stronger evidence of a presumed 'causal' association (p.10), and Jenkins, Zyzanski and Rosenman (1976) show that psychosocial factors (with a focus on Type A behaviour) play an even more prominent role in recurrent episodes of M.I. than they do in the first episode, with obvious implications for therapeutic interventions.

SECTION FOUR

USUAL TREATMENT PROCEDURE

4.0 INTRODUCTION

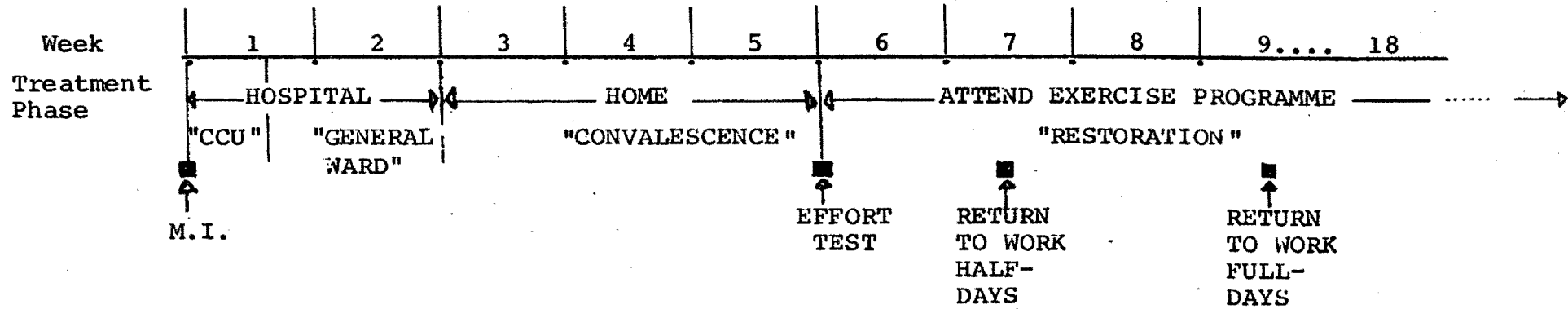
This section outlines the usual medical treatment program for M.I. (or suspected M.I.) patients brought to hospital. Many M.I. patients are treated in private clinics or smaller state hospitals which do not have the facilities of intensive care units nor exercise rehabilitation programmes. Despite debates as to the usefulness of both these facilities most hospitals that have the resources use this procedure described as "the ideal treatment approach" (Sokolow and McIlroy, 1979, p.151).

The outline (which is based on current practice at Groote Schuur Hospital) is provided as a background for the understanding of the subjective experience of the heart patient, and is illustrated in Figure 1.

4.1 ASSESSMENT AND DIAGNOSIS

The first assessment of the patient is made at the hospital's casualty department. If the combination of clinical presentation, description of symptoms, electrocardiograph (ECG) and chest X-ray is suggestive of M.I., the patient is immediately transferred to the Coronary (Intensive) Care Unit (CCU).

FIGURE 1 : TREATMENT PROCEDURE IN
CASES OF "UNCOMPLICATED" MYOCARDIAL INFARCTION



The most definitive diagnostic indicator of M.I. is the presence in the blood of certain enzymes released following the death of cardiac cells. Confirmation of the diagnosis may only be available in certain cases by the second or third day after admission, (following blood analysis).

4.2 THE CORONARY CARE UNIT (CCU)

In the CCU electronic equipment continually monitors ECG, blood pressure and pulse rate. The particular concern during this period is the appearance of life-threatening arrhythmias. The patient is under intensive medical and nursing supervision (usually a 1:1 patient/nurse ratio) directed towards complete bed rest for the patient, so that minimal demands are made on the damaged heart. The treatment regimen commonly includes the following medication:

- anxiolytics
- anticoagulants
- coronary vasodilators

Oxygen is fed by tube for the first 48 hours.

4.3 GENERAL WARD

Following his discharge from the CCU, which is usually within 3/4 days in the case of a steady and uncomplicated recovery,

the patient is sent to a "general ward". Here the emphasis is on gradual mobilisation, plus consolidation of condition over a period of 7-10 days. While observation is maintained, it is not as intense, nursing staff have more patients to look after, and the patient is no longer attached to electronic monitors.

During this phase, contact is made with a nursing sister responsible for rehabilitation. Explanation is given regarding the programme of physical exercises, the rehabilitation programme arranged by the hospital and follow-up appointments. An information sheet is given out which contains guidelines as to permissible activities and exercise, diet, the avoidance of tension-laden situations, rest periods, as well as an explanation of symptoms and pathophysiological process of M.I. Obese patients are referred to a dietician for specialised counselling.

4.4. CONVALESCENCE

Patients are discharged from hospital for a three-week period of home convalescence. Contact with the hospital during this period is at the initiative of the patient or his family only. During this period the patient is encouraged to adhere to the instructions for light graduated exercises and activities in the guide mentioned above.

4.5 RESTORATION PHASE

After three weeks at home, the patient visits the hospital for a medical examination and an effort test (monitoring of heart functions while on a treadmill) in order to assess the functional capacity of the heart and, therefore, his readiness for an exercise programme. During the medical consultation, the patient is advised by the physician about the resumption of activities, and notably, the phasing of his return to work. The physician takes into account physical condition, nature of the work to be performed and the urgency of the patient's desire to return. Commonly, in the case of white-collar workers, permission is given to return to work at this point, for half-days for a period of two to three weeks, with full return thereafter. Special cautions are observed in the case of manual workers, or those whose jobs involve the safety of not only themselves, but others - e.g., lorry or bus-drivers. If medical approval is given, the patient simultaneously commences his 12-week exercise programme which involves attendance three times weekly for approximately one hour. These exercises are graduated and are conducted under nursing and medical supervision. Exercise programmes, with emphasis on dynamic as opposed to isometric exercises have been shown to be "safe and helpful in that they foster a sense of well-being, decrease anxiety and induce a healthier emotional response to the life-threatening event" although they have not yet "been shown to prolong life or decrease the frequency of recurrence of M.I." (Sokolow and McIlroy, 1979, p.162).

Provided there are no medical complications, this concludes the patient's formal contact with the hospital. The patient is counselled regarding the specific risk factors in his case and given guidelines for the leading of a prophylactic life-style. He is then referred back to his General Practitioner or other referral source, to whom the hospital forwards a report.

SECTION FIVEPROGNOSIS

Prognosis for the M.I. patient is an issue of central importance and soon becomes the focus of concern by patients and their families. Thus, knowledge of prognosis, the "hard facts" and more especially the approach to presenting them in a helpful way is of importance to those concerned with the psychological effects of the illness. Prognosis is discussed with two emphases: - firstly, the prognosis for survival, reinfarction and symptoms from a purely statistical, or global perspective, and secondly, a perspective focussing on the prognosis in individual cases.

Survival

Harris, Harrell, Lee, Behar and Rosati (1979) estimate that of the total incidence of new cases of M.I., 20-25 per cent die within the first two months, the majority before reaching hospital. Sokolow and McIlroy (1977) estimate this figure at 30 per cent. They remark that one quarter of these die from ventricular fibrillation (since this is a potentially reversible condition this has important implications for training of the public in recognition and resuscitation procedures). It is estimated that a further 10 per cent die within the first year, and 5 per cent die each year thereafter.

Risk of Reinfarction

Of all existing M.I. patients, 15 per cent can expect to have a further infarction each year (some of them fatal). There is an increasing risk with each M.I., of suffering a fatal attack on the following occasion.

Risk of symptoms

It is estimated that 30 - 50 per cent of patients will experience angina within a year.

Assessing the individual case

Two 'objective' scales of assessing prognosis, the Peel Prognostic Index, and the Norris Index (Meltzer and Dunning, 1972) are in use based on factors such as age (increasingly poor prognosis in older patients), size and location of the infarcted area, the presence of arrhythmias in the post-infarction period, dysfunction of the left ventricle, pre-existing cardiac damage from both infarction or other causes. Croog and Levine (1977) remark that it is still the experienced cardiologist's judgement which has proved the best predictor of prognosis.

The modern physician acknowledges the possibilities of reinfarction, death and symptoms; however, the physician is encouraged to stress to patient and family the most optimistic possibilities in each case (which stems from an ideology based on

such adages as "adding life to years, rather than years to life"). He is frequently faced with examples of individuals whose good condition defies the poor prognoses that were made from objective assessments at the time. Hence he should in no way destroy the individual's hope by excessive reliance on gloomy statistics.

However, objective factors (such as the above-mentioned, and an effort test) are taken into account when prognosticating the patient's future level of physical activity, and appropriate guidelines and physiological limits are defined. Patients are encouraged to explore their limits and to be guided by what they can comfortably achieve before the onset of pain.

Meltzer and Dunning (1972) hold a broad perspective on the issues discussed:

whether or not a patient leads a full, active and happy life after a Myocardial Infarction depends to a large extent on his medical management. The efficiency of this depends in turn on the amount of insight that the doctor has into the problems that post-infarction patients face and his realisation that the most important problems are often in the mind rather than in the heart (p.185).

SECTION SIX

CRISIS THEORY AND THE MYOCARDIAL INFARCTION PATIENT

In this section the theoretical basis underlying the proposed intervention programme is introduced. A general introduction to Crisis Theory is provided, which outlines the central concepts involved. This is followed by an examination of the applicability of these concepts to the myocardial infarction experience.

6.1 INTRODUCTION TO CRISIS THEORY

6.1.1 Definition and state of the field

Crisis theory is a body of theoretical concepts, applied approaches and clinical insights synthesised from a variety of influences in the human sciences. It exists as "a framework for viewing individuals and families in situations of urgency and stress and as an approach it leads to the generation of useful practice principles applicable to both clinical work and modes of primary prevention in mental health work" (Rapoport, 1970, p.267).

Its central theoretician has been Gerald Caplan (1961, 1964)

working in a social psychiatric context. Its roots, however, are traceable to earlier influences in psychodynamic theory (especially ego psychology with its focus on the regulation of the organism in its environment; and also Erikson's developmental theory outlining maturational stages, each with its potential for crisis), learning theory, experimental psychology, and sociology. Much of the theoretical development has originated from studies of reaction to upheavals or disasters that have affected large numbers of people (the prototype being Lindemann's (1944) study of bereavement following a nightclub fire in Boston). Added impetus has been given by the 'economic' pressure to develop briefer forms of intervention, allowing scarce therapeutic resources to reach larger numbers of people. Current theoretical development of crisis intervention is located mainly in the field of social work, with important contributions from allied fields.

Crisis intervention is currently used as the treatment of choice in a wide range of problems in the fields of mental health and social work. Golan (1978) remarks that with regard to the theoretical foundations of the crisis approach there seems to be general agreement "irrespective of setting, discipline or situation" (although this is not matched by similar agreement about the tactics and techniques which "tend to be haphazard and not carefully thought-out, on the one hand, or overspecified on the other" (p.4)).

Cautionary notes have been sounded regarding the lack of clarity, and systematic validation of concepts, Rapaport (1970)

arguing that it was probably "premature to dignify it with the term 'theory' " (p.267). These criticisms seem to have spurred on other writers (e.g. Smith, 1976, and notably Golan, 1978) to propose basic practice models which aim at increasing clarity and definition.

6.1.2 Key features of a crisis

Caplan (1961) has described a crisis as "an upset in a steady state". This is based on the systems-theory concept that an individual/ family ~~maintains equilibrium~~ through a sequence of characteristic problem-solving activities aimed at basic need fulfilment. Crisis arises "when an individual faces an obstacle to important life goals that is, for a time unsurmountable through the utilisation of his customary methods of problem solving" (p.18).

A crisis is not an illness (Rapoport, 1965) but is a normative psychological event that occurs at any stage, even among the well-adjusted, and should not be viewed as a sign of psychopathology. "However, it may reactivate earlier unresolved or partially resolved conflicts so that (the person) responds in an inappropriate or exaggerated fashion" (Golan, 1978, p.8). Golan emphasizes that the same external situation does not necessarily produce a crisis in different persons, or families, although certain occurrences are of such magnitude that the probability of a "crisis reaction" can be considered high in all cases.

Most theorists stress that crisis can be a turning point which could lead to an improvement or deterioration in level of mental health. Thus Morrice (1976) defines it as "an opportunity for either achieving mastery and growth, or facing the risk of vulnerability and mental breakdown" (p.20).

It is further described as a period of lowered defences with a consequent greater openness to therapeutic intervention (Jacobson, 1965), and several theorists remark that this intervention, if effective and timeously applied, produces faster growth and learning than expected under conditions of lesser emotional accessibility.

6.1.3 The crisis sequence

This section is based on the work of Caplan (1961), Golan (1978), Jacobson et al (1968), and Rapaport (1965). It introduces five elements encountered in the crisis sequence: the hazardous event, the vulnerable state, the precipitating factor, the state of active crisis, and the reintegration phase. Golan emphasizes that these are diagnostic abstractions, "the phases to which they refer overlap and cannot actually be isolated" (p.64).

The point of departure is that of the healthy individual in a state of equilibrium, who maintains this state by a series of homeostatic mechanisms of both an intrapsychic and an

interpersonal nature. His state of equilibrium is frequently disturbed by a variety of situations, the majority of which are successfully resolved by his coping mechanisms, and he is restored to a balanced state.

The hazardous event

This refers to a stressful occurrence, either an external blow or an internal occurrence which disrupts the equilibrium of the individual. (Examples would be: termination of a love relationship, physical injury, death of a parent, marriage, childbirth).

The vulnerable state

This refers to the emotional response of the individual following the hazardous event. Depending on the individual's particular perceptions of the hazardous event;

- (a) he may experience it as a THREAT to his instinctual needs or his sense of integrity or autonomy (reacting with anxiety)
- (b) he may see it as a LOSS of a person or of an ability (reacting with depression)
- (c) he may feel it as a CHALLENGE to survival, growth, mastery or self expression (reacting with moderate

anxiety plus elements of hope, excitement and positive expectation).

There is an attempt to maintain homeostasis by habitual problem-solving or anxiety reducing mechanisms. If these fail, there is an increase in the level of anxiety and, according to Rapaport (1965), "emergency problem-solving mechanisms" are called forth. This may produce one of three results:

1. the problem may actually be solved
2. there may be a redefinition of the problem in order to achieve need satisfaction
3. the problem may be avoided through need resignation and the relinquishment of goals

(p.26)

If none of these alternatives are achievable there is a continuing rise in tension which may be accompanied by disorganisation of functioning, feelings of helplessness "with some regression of ego functions to a primitive level and to more childlike types of behavior" (Golan, 1978, p.66).

The precipitating factor

If the now vulnerable individual is faced with a further identifiable stress (or 'precipitating factor') he may be plunged into a crisis state. The precipitant may be an occurrence of varying magnitude - from a relatively minor "straw that breaks the camel's back" (Golan, 1978, p.66) to more serious events. In some situations the original hazardous event is of sufficient force to create a crisis

state with no further precipitant.

The state of active crisis

A person in a crisis state usually experiences disruption in four main areas, viz:

emotionally (where the principal feelings are high anxiety and depression, and frequently, helplessness, hostility, guilt).

cognitively (confusion, poor judgement and concentration, preoccupation with current circumstances, and in extreme cases, "perceptual confusion in the spatial, temporal or interpersonal sphere" (Rapoport, 1965, p.281)

behaviourally - by aimless activity or even immobilisation.

somatically - by physical tiredness and weakness, or disturbance in bodily functions.

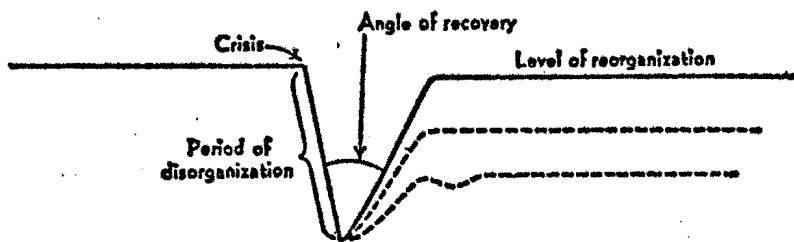
Reintegration phase

Most theorists comment on the time-limited nature of crisis. Caplan (1961) has indicated that the state of high tension and disorganisation comes to an end in four to six weeks. Smith (1976) believes that most crises are resolved within six to eight weeks. This does not indicate that the solution

is necessarily successfully negotiated, merely that 'active crisis' is resolved. This is illustrated by Hill's (1965) "roller coaster" diagram.

FIGURE 2. THE COURSE OF ADJUSTMENT TO CRISIS

(from R. Hill, 1965)



Clearly, as indicated above, the conclusion of the crisis may leave the individual functioning at lower levels of psychological adjustment. If the crisis had been resolved maladaptively (e.g., by the excessive use of defence mechanisms such as denial, projection) the individual remains vulnerable for the same, or similar, precipitants to set in motion a vicious circle. Conversely, if the reintegration phase has been marked by adaptive solutions, (including the resumption of problem solving behaviour, and anxiety management), the individual gains in self-esteem and may attain a level of adjustment higher than his precrisis level.

6.1.4 Classification of crises

Crisis theorists have provided a variety of classifications based on a number of different dimensions, e.g.,

- i) the source of the hazardous event (Viney, 1976).
- ii) the relationship of the hazardous event to the developmental phase of the individual (Schneidman, 1973)
- iii) the degree of "expectedness" of the hazardous event (Aguilera and Messick, 1974; Morrice, 1976).

As an in-depth exploration of this area is beyond the scope of this paper, an outline of two systems, those of Baldwin and Korner, will be given, the former because it illustrates many of the above dimensions, the latter because it adds a further dimension which is of central importance to the M.I. situation.

Baldwin (1978) described six categories:

1. Dispositional crises - defined by distress ... in which the therapist responds to the client in ways peripheral to a

therapeutic role; the intervention is not primarily directed at the emotional level, e.g. providing information, administrative action and education (usually as a preliminary to referral to specialist agencies such as alcoholism treatment centres, sex therapists).

2. Crisis of anticipated life transitions - crises that reflect anticipated, but usually normative life transitions over which the client may or may not have substantial control, e.g. retirement, divorce.
3. Crises resulting from traumatic stress - emotional crises precipitated by externally imposed stressors or situations that are unexpected and uncontrolled, and that are emotionally overwhelming, e.g. death of a family member, assault, catastrophic illness.
4. Maturational/Developmental crises - emotional crises resulting from attempts to deal with an interpersonal situation reflecting a struggle with a deeper (but usually circumscribed) issue that has not been resolved adaptively in the past and that represents an attempt to attain emotional maturity, e.g. crises involving value conflicts, sexual identity.
5. Crises reflecting psychopathology - emotional crises in which pre-existing psychopathology has been instrumental in precipitating the crisis or in which psychopathology significantly impairs or complicates adaptive resolution.
6. Psychiatric emergencies - crisis situations in which general functioning has been severely impaired and the individual

rendered incompetent or unable to assume personal responsibility, e.g. acutely suicidal clients, reactions to hallucinogenic drugs.

Korner's system

Korner's (1973) distinction between Shock Crises and Exhaustion Crises defines the differing pattern of onset of crisis in various situations.

Thus, a shock crisis occurs in the following ways:

A sudden change ... creates an explosive release of emotions which overwhelms the available coping mechanism. An individual who can cope with adversity provided he has the time to assimilate the impact may be unable to do so when events occur rapidly and without forewarning; he goes into emotional shock" (Korner, 1973, p.32).

Exhaustion crises occur when

the individual (has) coped effectively for some time under prolonged conditions of emergency, when he suddenly reaches the point of exhaustion. There is simply not enough strength to sustain the available coping resources, and the result is a quasi-unglueing of the total coping structure (Korner, 1973, p.32).

6.1.5 Determinants of the severity of crisis reactions

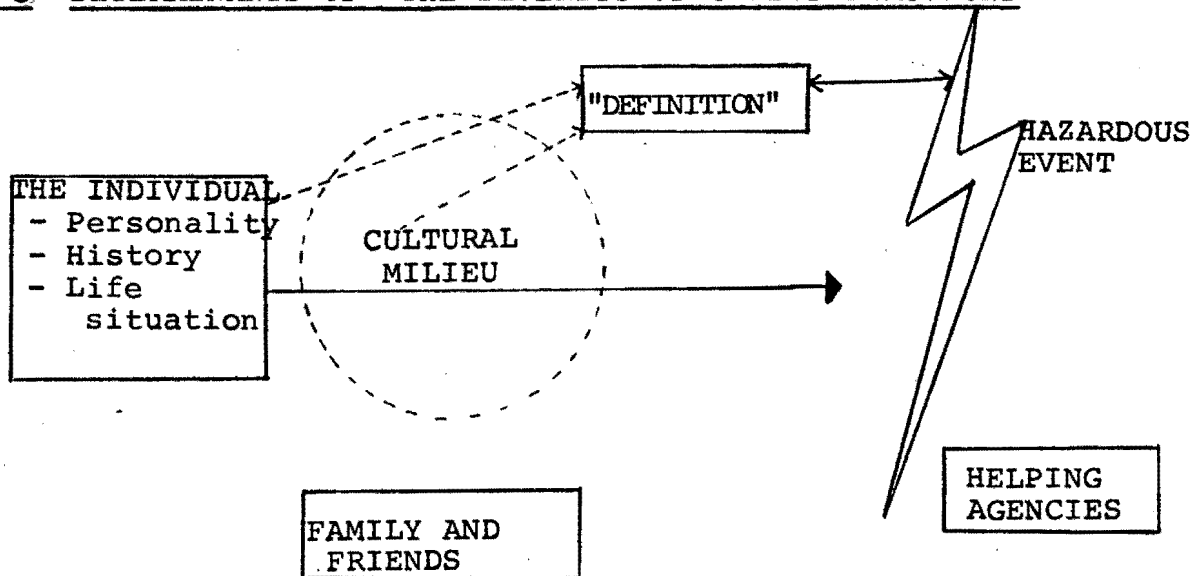
Golan (1978) remarks that "different people faced with the same

situation, or the same person at different stages of life or in other sets of interacting circumstances may not necessarily display the same reactions or be similarly affected" (p.62).

Several factors have a bearing on whether or not an individual will experience a state of active crisis after being confronted by a hazardous event. Further, these factors influence the course, intensity, and duration of the individual's direct response to the event. These factors fall naturally into four categories:

- (i) factors within the individual
- (ii) environmental factors
- (iii) nature of the hazardous event
- (iv) "definition" of the event.

FIGURE 3) DETERMINANTS OF THE SEVERITY OF CRISIS REACTIONS



- (i) Factors within the individual can be considered in three areas:

Firstly, the degree of generalised personality development, or "ego strength" of the person. This would be reflected in such attributes as maturity, steadiness, persistence, emotional calmness, realism about problems, absence of neurotic fatigue (Cattell, 1965). It would include the individual's traditional "coping" style - his problem-solving skills, and use made of anxiety-relieving defence mechanisms.

Secondly, relevant aspects of the person's history; e.g., the frequency of occurrence of earlier crises, how these were coped with, and whether adaptive outcomes were achieved. These crises and other stresses in the history of the individual determine whether the current crisis revived "memories and fantasies of loss or failure, with associated fear and guilt" (Jacobson, Strickler and Morley, 1968).

Thirdly, the individual's current life situation. Of importance here would be pressures from sources other than the identified "hazardous event" which would compound its effects, or whether the individual was negotiating some specific developmental task.

(ii) Factors within the person's environment.

"the person's pre-stress personality is likely to influence his response to a crisis, but his personality alone does not determine the outcome, which is markedly affected by his current relationships." Thus Kaplan (1968, p.152)

emphasises the importance of "situational support" (Aguilera and Messick, 1974) - the amount and kind of support available from persons in the environment who can help solve the problem; i.e., friends, family, employers, helping agencies, etc.

The influence of strengths and structure within the family on crisis resolution has been a focus of attention by Hill (1965). He quotes Angell's view of well-functioning families, (characterised by the features of "integration" and "adaptability") which are in a stronger position to overcome a crisis successfully. By integration Angell means "bonds of coherence and unity running through family life, of which common interests, affection and a sense of economic interdependence are perhaps the most prominent." Adaptability is defined as the "capacity to meet obstacles and shift courses" (p.41).

These families are further characterised by satisfaction based on successfully meeting the physical and emotional needs of its members, agreement on role structure, and the subordination of personal ambitions to family goals.

"Cultural and socio-economic prescriptions" are mentioned by Jacobson et al (1968), e.g. the loss of R100 would be greeted differently by two families at extremes of the income level spectrum, as would the announcement of an unmarried daughter's pregnancy in families located in either restrictive or permissive cultural milieus.

(iii) Nature of the hazardous event

This refers to the extent of the real threat to effective functioning. Objective 'seriousness' of an event remains difficult to quantify (although Holmes and Rahe (1967) - see section 3.3 - have attempted this task by a consensus-based rating scale measuring life change events). As Hill (1965) points out, the impact of an event on an individual varies according to the hardships that accompany it.

(iv) The "definition" of the event

Following the interaction of the hazardous event and the crisis-meeting resources of the individual (based on internal and environmental factors, as described above), a definition of the event is made by the individual. This definition, or subjective 'labelling' of the event as either severe, moderate or mild is an important variable in determining subsequent reactions.

6.2 MYOCARDIAL INFARCTION AS A CRISIS

There is much emphasis in the research literature on identifying and defining the "hazardous event". Therapists dealing with the M.I. patient do not have this problem. Clearly M.I. is a hazardous event causing severe disruption to his "biopsychosocial field" (Jacobson et al, 1968). In a matter of hours it abruptly interrupts his homeostatic exchanges with his usual environment, exposes him to a severe threat of death and his family to shock and anxiety, and places him in an environment which reinforces the sense of emergency. The insistence on stillness and severe physical restriction of the Coronary Care Unit rapidly convinces him of his helplessness to influence his condition. This situation creates an emotionally vulnerable state marked by anxiety and depression in virtually all patients (Hellerstein and Ford, 1960).

At this stage of our knowledge, there can be no precise indication of what proportion of patients do experience a "state of crisis" following M.I. as, firstly, the features of what constitutes a crisis have not been rigorously defined, and secondly, the few research studies to date have not measured the same dimensions of disturbance at similar stages. Nevertheless, the studies do indicate that this proportion may be considerable. Thus for example, Cassem and Hackett (1971) found 32,7 per cent of their sample of 441 patients justified psychiatric referral during the Coronary Care Unit period, predominantly for depression

and anxiety; Cay, Vetter, Philip and Dugard (1972) found 30 per cent of first-time M.I. patients and 42 per cent of subsequent M.I. patients to be in the "severely-emotionally-upset category" (p.428) when measured about ten days after admission on a scale of personal emotional disturbance. Mayou, Williamson and Foster (1978) found 30 per cent of their patients reporting moderate or severe psychological symptoms at 2 months, and 32 per cent reporting marked psychological distress after one year.

Of those that do experience a state of active crisis following M.I., the largest group (as is suggested by the work of Cassem and Hackett in Section 8.1 below) do so on, or soon after, admission. Disruptions, as described, in the emotional, cognitive, behavioural and somatic areas are regularly reported (and will be illustrated in greater detail). Crises at this (Coronary Care Unit) point are consistent with Korner's concept of "shock crisis". It is suggested that there are several other potential crisis points later in the process of rehabilitation following M.I., when the patient, still in a vulnerable state, encounters an additional stress, or precipitating factor. These may be the entry into a phase, or the encounter with an experience which exposes particular vulnerabilities: e.g., crisis may be precipitated by the discharge from hospital, or in a person with a prior tenuous sexual adjustment who discovers himself impotent at the first attempt at intercourse after infarction, or the return to work by someone convinced that work precipitated his M.I. These crises, occurring subsequent to a M.I.

induced vulnerable state, will be referred to as "reactive crisis". In yet another possibility, there may be instances of Korner's "exhaustion crisis" in which there is no apparent single precipitant.

It is suggested that many of the wives of myocardial infarction patients (who have had to endure the stresses posed by the patient's admission, return home and struggles towards reintegration) experience crises of this nature (Mayou, Foster and Williamson, 1978 (i)).

Certain medical conditions may be atypical of established crisis theory insofar as the duration of crisis is concerned. While there is general agreement that crises are of short duration, some writers believe that the hypothesized four to eight weeks is unrealistically short. Lewis, Gottesman and Gutstein (1979) found that the adaptation of a group of cancer surgical patients was not achieved before twenty eight weeks. According to Viney (1976), each type of crisis has a different course and "to plot these different courses becomes the immediate task of mental health researchers" (p.389).

Figure 3 represents the hypothesized course and duration of crisis for M.I. patients.

FIGURE 4. THE ONSET AND DURATION OF M.I.-RELATED CRISES

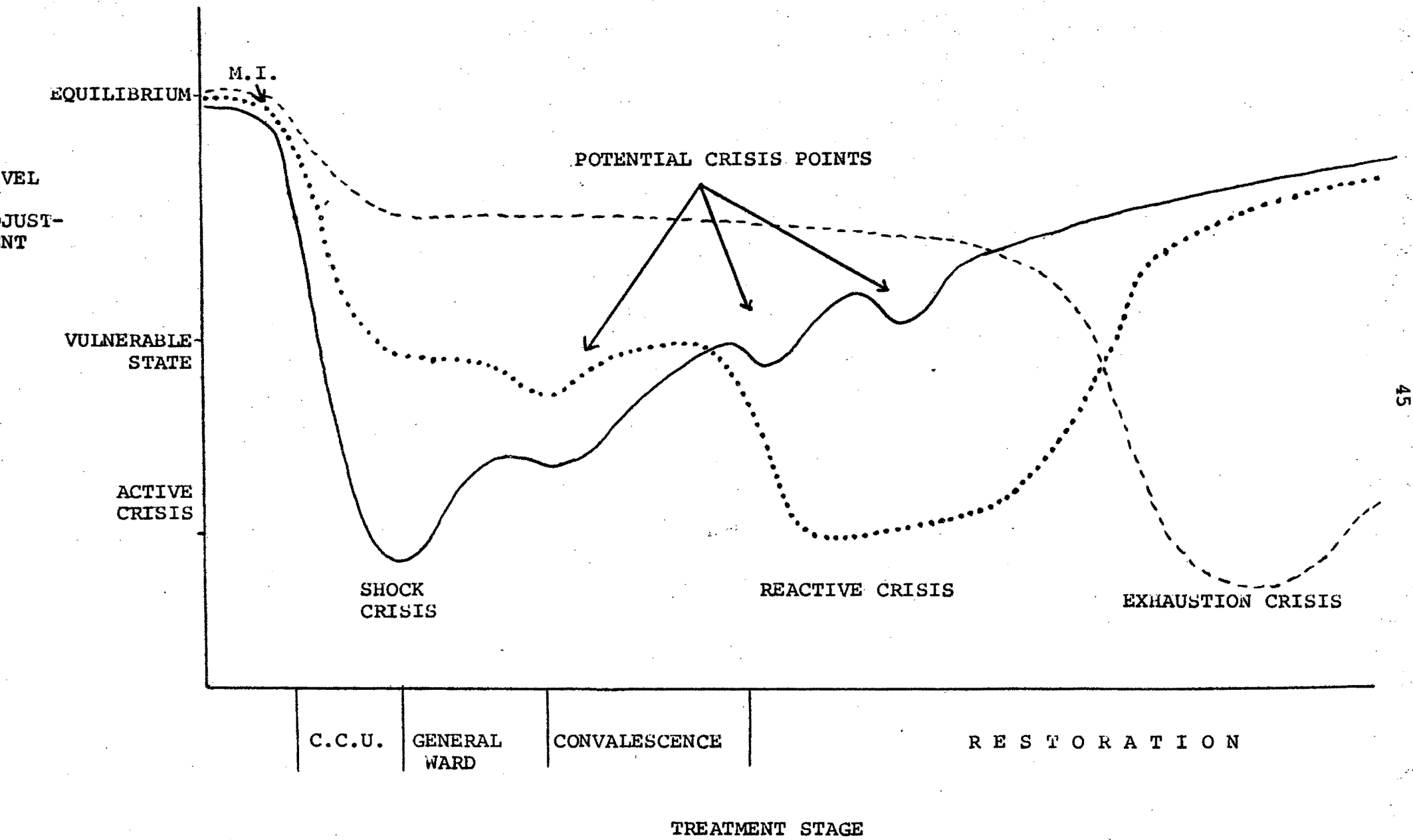


Figure 4 plots three possible courses of reactions to the hazardous event.

- a) ——— The solid line represents persons in shock crisis whose severe disequilibrium may last for the first two to three weeks, with gradual reintegration thereafter. Some slight reversals are shown at the potential reactive crisis points.
- b) The dotted line represents persons who become vulnerable following the M.I., but who do not experience a full crisis reaction until a precipitant at one (or more) of the potential crisis points provokes a reactive crisis.
- c) ---- The interrupted line represents those who, after enduring the stresses of the M.I., and all the potential crisis points without a crisis reaction, descend into an exhaustion crisis.

The above illustrates the difficulty of defining the duration of M.I.-related crises, as many combinations of the courses shown are possible. It is suggested, however, that for the majority of patients, the vulnerable period persists until midway through the restoration phase, i.e., twelve to fourteen weeks after infarction.

SECTION SEVENINTRODUCTION TO CRISIS INTERVENTION WITH M.I. PATIENTS

The previous section has examined the concept of crisis and has highlighted several features of the M.I. experience that are consistent with it. In order to consider the implications for clinical practice, we consider in this section certain central features of crisis intervention methodology. Discussion regarding their relevance to a M.I. intervention programme is presented in italics.

Parad (1965) defines crisis intervention as "entering into the life situation of an individual, family, or group to alleviate the impact of a crisis-inducing stress, in order to help mobilise the resources of those directly affected, as well as those who are in the significant social orbit" (p.2). Parad thus emphasises the secondary prevention aspects of crisis intervention - i.e., applicable when the event is already perceived as a crisis.

With his "public health model" perspective, Caplan (1964) has stressed the utility of crisis intervention principles in primary prevention. Here "the intervenor may direct his efforts towards eliminating or minimizing events capable of inducing crisis" (Pasewark and Albers, 1972, p.74); i.e., a preventive perspective in "at-risk" populations.

On this basis, the secondary prevention effort in the case of M.I. patients is directed at those who experience either a Shock crisis or a Reactive crisis as indicated by Figure 3. The primary preventitive effort is directed at the others who are in the "Vulnerable State" (see Figure 3) with a focus on potential crisis points.

7.1 GOALS OF CRISIS INTERVENTION

The limited, but specific nature of the goals of crisis intervention is reflected in the following four listed by Rapaport (1970):

- (a) relief of symptoms
- (b) restoration to a previous level of functioning
- (c) some understanding of the relevant precipitating events which led up to the state of disequilibrium
- (d) identification of remedial measures which the client or family can take or that are available through community resources.

Jacobson et al (1968) propose that:

- (e) the renewal of intrapsychic equilibrium should be without neurotic manifestation and marked by the acceptance of what is inevitable, and reality-oriented solutions.

The intervention programme being proposed for M.I. patients could clearly embrace goals (a) to (e) with the following riders:

Firstly, that relief of symptoms (goal a) be understood to be confined to the relief of psychosocial problems, not medical symptoms.

Secondly, there should be a clearer understanding of the term "restoration". This goal as stated (b) may be simplistic in the case of M.I. There are cases in which "restoration" (i.e., returning the patient to premorbid vocational, social and family roles) is neither possible nor desirable on medical or other grounds. While clearly restoration would be a worthy goal (in the absence of any obvious medical contraindications) it makes no reference to the "prophylactic life style" (Matheson, Selvester and Rice, 1975) which is advocated as it gives attention to the modification of risk factors thus potentially modifying the course of the disease. This concept could be expressed more appropriately in the M.I. context by the use of two goals of rehabilitation as expressed by Matheson *et al.*

1. Preventive life style change that includes the modification of risk factors.
2. The restoration of the cardiac patient to his optimal level of functioning within the boundaries of the above life-style change (p.367).

7.2 THE CONCEPT OF "TASKS"

Golan (1978) emphasises the importance, in crisis situations, of "thinking clearly about what must be done so that re-equilibrium will be achieved and who is in the best position

to do it" (p.74). This is facilitated by the concept of "tasks". Treatment can be conceptualised in terms of tasks that have to be accomplished (by the therapist or client) in order to achieve mastery of stress situations. Bartlett (1970) defines tasks as "demands made upon people by various life situations... (which)... call for responses in the form of attitudes or actions from the people involved" (p.96). These may relate to predictable demands of daily living, (analogous to Erikson's (1963) theory of the surmounting crises at the right developmental stages) or to common traumatic situations, e.g., financial difficulties, bereavement, illness. Golan subdivides these tasks into (a) material arrangemental which "entail the provision of material assistance and the carrying out of substantive arrangements and service provisions" (p.75), and (b) psycho-social in which the individual must adjust to new roles and deal with a broad spectrum of feelings which arise under stress.

Tasks of different types have been delineated in several studies on a variety of problem areas (e.g., surgical patients (Janis, 1958), premature birth (Kaplan, 1968), immigration (Goan and Gruschka, 1971), widowhood (Golan, 1975), and mastectomy (Klein, 1971) which have formed the basis for intervention procedures.

In the present study, tasks occupy a central role in the model being proposed. The concept of crisis intervention has not been introduced in a formalised way in the area of M.I. before (although there have been frequent references to M.I. as a crisis, e.g. Aguilera and Messick (1974), Croog *et al* (1968)). The tasks, therefore, have been formulated from a study of research literature on the subjects of M.I., crisis theory and psychological aspects of physical illness, as well as the writers' experiences in the rehabilitation section of the Groote Schuur Hospital Cardiology Department. The tasks should be regarded at this stage as hypotheses (and, indeed, the whole model being proposed should be viewed as one of hypothesis generation) which need to be tested out by empirical application and research. The specific M.I.-related tasks will be considered more fully in a later section.

7.3 LEVELS OF INTERVENTION

Morley (quoted in Baldwin, 1978) has defined a hierarchy of four different levels of therapist involvement - which require progressively increasing levels of therapeutic skills and sophistication. Thus the first level

- (a) "Environmental Manipulation" emphasises referral for additional services, or helping the client withdraw from a stressful situation.

- (b) At the second level - "General Support" - there is greater personal involvement in which the therapist becomes an active listener, functioning as a sounding board while encouraging abreaction.
- (c) The "Generic Approach" focuses on the recognisable patterns that follow a particular type of crisis. (The most quoted example of this approach is Lindemann's (1944) study on grief reactions following bereavement, in which he traces several sequential phases of "grief work"). The aim in this approach is to build up a body of knowledge regarding reactions to a particular crisis and to implement "specific measures designed to be effective for the target group as a whole" (Jacobson et al, 1968, p.340). Rapaport (1970) sees it being "more in keeping with a primary prevention effort" (p.310) with especially vulnerable populations. The consensus of these writers is that non-mental-health professionals can be successfully trained in the generic approach. Their experience and familiarity with specific populations is a useful foundation on which to base a programme of instruction in the knowledge of, and certain of the techniques of crisis intervention.
- (d) The "Individual Approach". Here there is an assessment by a mental health professional, of the specific intrapsychic and interpersonal processes of the person. An intensive effort is then directed towards a solution of the individual's unique circumstances.

Jacobson et al (1968) believe that this approach should

be used selectively with those for whom the generic approach is inadequate.

Economy is clearly a reason for the absence of full-time mental health professionals in most M.I. rehabilitation programmes (although some programmes boast the participation of no less than ten disciplines - Matheson et al (1975)). For this reason too, there would be advantages in an approach which could comfortably be carried out by, e.g., a nursing sister or social workers, i.e., the generic approach to crisis intervention. Such a person (referred to in this study as "the therapist") would ideally be a permanent member of the rehabilitation team with the necessary access to medical staff and ready availability to the patient and his family. Their training would enable them to discern whether a patient needs referral to a mental health professional for an "individual approach". This study, therefore, describes a programme the major part of which could be implemented at the "generic" level. It should be stressed, however, that training of staff to reach the desired level of competence would involve the presence of a mental health professional (psychologist, psychiatrist, social worker) with experience in crisis intervention.

7.4

A "VALUE SYSTEM" FOR CRISIS THERAPISTS

Crisis intervention differs in many ways from more orthodox psychotherapeutic systems, - a fact that may pose some

adaptational difficulties for those trained in the traditional psychiatric environment. Some of these differences are discussed below with their implications for clinical practice.

Crisis intervention has a more restricted temporal focus. There is a greater focus on the nature of the current emotional crisis rather than the traditional psychiatric longitudinal view. The therapist has to accept that the correction of long-standing negative personality traits is beyond the scope of the current therapeutic endeavour.

In crisis intervention there is a lesser focus on the therapist-client relationship. Thus Rapaport (1965) remarks that "the helping person needs to view himself as intervening in a social system - as part of a network of relationships - and not as single resource" (p.30). The therapist's involvement and competence are seen as the basis for successful therapy rather than a focus on transference factors.

Crisis intervention requires greater therapist flexibility in time allocated to patients, and in the roles he performs. The nature of crisis requires the therapist to be available to the patient at short notice, and for extended sessions when judged necessary. Similar flexibility is required in the range of activities the therapist performs. As Siporin notes ... (quoted by Golan, 1978) he may fulfil any one or combination of the following roles: "Counsellor, adviser, enabler, expert problem-solver, troubleshooter, broker, referrer, expeditor, arbitrator, discussion leader, gatekeeper,

resource person, co-ordinator, administrator, work manager and consultant" (p.97) which illustrates how the crisis therapist is both active and direct , particularly in the early phases of the crisis sequence.

SECTION EIGHTINTERVENTION STRATEGIES8.1 THE IMPLEMENTATION OF AN INTERVENTION PROGRAMME

The proposed model for crisis intervention is based on the recognition made earlier (Section 6.2) that M.I.-related crises occur predominantly as "shock"-type crises soon after occurrence of the M.I. - followed by a state of vulnerability during which there is a series of potential "reactive-crisis" points (see Figure 4). It is hypothesized that these latter potential crisis points occur mainly at the stages at which the patient attempts to resume role performance in key areas (e.g., family, vocational, sexual) or at which the patient experiences a relapse in his medical condition.

The implication of this understanding is that crisis intervention with M.I. patients is two-pronged - there is a secondary intervention effort aimed at those who are experiencing a 'shock-crisis', which runs parallel with a primary preventive effort aimed at limiting the onset of "reactive crises" at the above-mentioned points of particular vulnerability. (The terms "primary" and "secondary" are used in the sense described by Pasewark and Albers (1972). Primary prevention aims to reduce the susceptibility of the individual to crisis. Secondary prevention is "dealing with the intervenor's role when an event is already experienced as a crisis")

A framework accommodating the above has been designed to structure and guide the therapist's activity. (There has been some reliance on Golan's (1978) "basic practice model", and Korner's (1973) guidelines regarding the solution of shock crises). In considering the subdivision of crisis intervention functions into consecutive stages, Golan emphasises that crisis intervention does not "lend itself into neat marking off into the study, diagnosis, treatment planning, treatment and termination/evaluation steps of the casework process". Instead she speaks simply of beginning, middle and ending phases which "may all take place within a single three-hour interview, or may be spaced out over several months" (p.81).

This enjoinder towards flexibility of approach should be born in mind; and the therapist's clinical judgement should supercede where necessary the confines of a model. The theoretical base for the intervention programme has been formed by weaving together five main thrusts of therapeutic activity into the above-mentioned framework.

Firstly the identification of tasks to be performed for successful resolution (or prevention) of M.I.-related crises and the positioning of these in approximate chronological order (see section 7.2).

Secondly: Assisting the correct cognitive perception of the event by all concerned "which is furthered by seeking new knowledge and by keeping the problem in consciousness"

(Rapaport, 1970, p.23).

Thirdly: Assisting the individual or family with "management of affect" through awareness of feelings and appropriate verbalisation leading towards tension discharge and mastery" (Rapaport, 1970, p.23).

Fourthly: The provision of "situational support" by "establishing or facilitating communication" with individuals or agencies (Pasewark and Albers, 1972, p.76).

Fifthly: The encouragement of effective coping mechanisms and the identification of maladaptive patterns.

For each of the four stages in the treatment process (C.C.U., General Ward, Convalescence, Restoration), the following will be presented:

- (1) an outline of the common psychosocial problems encountered.
- (2) an identification of the patient tasks necessary for the successful "emotional resolution" of the stage.

Thereafter, the main therapist functions are discussed and presented, and are finally arranged in schematic form.

8.2 THE CORONARY CARE UNIT

8.2.1 Common psychosocial problems

The patient's arrival in the C.C.U. often follows several hours of emergency conditions marked by severe and painful symptoms, shock, hurried seeking of medical help, transportation by ambulance, and in some cases cardiac arrest and resuscitation. The predominant psychological symptom is usually extreme anxiety, and preoccupation with survival (Sokolow and McIlroy, 1979). Cassem and Hackett (1971) analysing psychiatric referrals from a C.C.U. confirm that anxiety heads the list of referral problems during the first two days following admission. They remark that while sedation is uniformly administered, in some cases this increases anxiety by adding to the patient's sense of "losing his grip on life or sanity" (p.11).

Awareness of the gravity of their illness is reinforced by the intensity of nursing supervision, the early insistence on stillness and severe physical restriction, and the formidable array of electronic monitoring equipment, (Wynn, 1967) although these factors clearly give confidence regarding treatment. Patients must "consciously or unconsciously review their feelings regarding death" (Obier and Heywood, 1972, p.15).

As Wynn (1967) points out, events in the patient's environment can compound anxiety, such as being exposed to the sight of

someone in a neighbouring bed experiencing severe symptoms or a cardiac arrest, and the resulting medical emergency, and possible death. Experiencing symptoms or even a cardiac arrest himself will renew his fears. Additionally, patients have reported anxiety in relation to the monitoring equipment: uncertainty as to its function, and concern about movement artefacts and false alarms (Thomas and Lynch, 1979).

Some patients are reportedly fearful of going to sleep, as a result of a popular misconception that sleep is a more vulnerable period.

The implications of their absence from their usual responsibilities is a source of worry. Patients are concerned about their absence from home, (whether the spouse is able to cope with responsibilities; the welfare and security of the family) and from their employment (how urgent business matters will be coped with - especially in the case of self-employed people; possible financial problems).

The third and fourth days, (according to Cassem and Mackett, 1971) are characterised by psychiatric referrals for depression. At this stage, when the immediate threat of death has subsided, patients tend to dwell on the implications of the illness for their future life. They dwell on the symbolic importance of the heart, and depressive content centres around their view of M.I. as "a blow struck at the source and generator of energy, power, potency and pleasure" (Cassem and Mackett, 1971, p.11). Obier and Heywood (1972) add that some patients

experience a feeling of being "different" now that an essential part of their selves - their hearts - are damaged. Thus they tend to foresee dismal consequences of heart impairment: a curtailed life-span; loss of autonomy; a future as an invalid; severely circumscribed pleasures and activities (Goldenson et al, 1978). The depressive reaction can be seen as the commencement of mourning a loss of bodily integrity and a feeling of helplessness to influence their situation.

Instances occur where a patient's psychological well-being is adversely affected by actions or omissions of members of the medical team - due, conceivably, either to pressure of time or unintended ambiguity. Wynn (1967) points out that it is the symbolic significance of the physician's statements rather than the words that sometimes do harm. Thus "lie still and you will be all right" often signifies "move and you will die" to the patient (p.849).

Miller and Brewer (1969) stress especially the harmful effects of lack of adequate explanation of the nature and consequences of the illness, at this and subsequent stages of treatment. Without such explanation, (which may have to be repeated several times) the patient may formulate his own bizarre or frightening concepts of his condition. These may be based to an extent on some of the many societal myths regarding heart illness. Examples of these are listed below.

1. After heart attacks, the patient is unfit for any form of remunerative work.
2. Heart attacks are the "end of the road", and all that can be hoped for is a few years of sheltered retirement.
3. The prognosis after a coronary occlusion is poor, and death usually follows within five years.
4. After a coronary occlusion, the patient has to wait five years before he is fit to return to work.
5. After a coronary occlusion, a patient is liable to drop dead at any time without warning (and therefore, he is forbidden to drive or operate any form of machinery). He is also liable to drop dead if (a) he has intercourse; (b) he indulges in physical exertion; (c) he climbs steps; (d) he runs; (e) he lifts with his left hand; (f) he sleeps on his left side; (g) he lifts his arms above his head, particularly the left arm.
6. A third coronary occlusion is invariably fatal.
7. Anginal attacks are minor forms of heart attacks.

(Miller and Brewer, 1969, p.14)

Failure to discuss prognosis is taken by the patient as a bad sign and an indication of the doctor's desire to avoid a distressing topic (Seldon, 1963). Sometimes prognosis is discussed in terms too guarded to be accepted by the patient.

Several references are made to C.C.U. patients' loss of self-esteem (Obier and Heywood, 1972). This may be the result, firstly, of the excessive dependency on the staff, having to passively permit himself to be handled and assisted with excretory functions, and secondly, of feeling overwhelmed by, and having little control over his emotions. Field (1963) has found certain seriously ill patients fear

that illness robs them of their worth and dignity.

Ezra (1969) points out that as a result of the efficacy of modern treatment methods, the grosser symptoms of M.I. are quickly brought under control. This may account for some patients' bewilderment at the diagnosis and be the source of some of the severer manifestations of denial. Cassem and Hackett noted that patients threaten to leave the C.C.U., deny the seriousness of their illness, and contest the diagnosis.

Other behaviours of C.C.U. patients that are observed include overt aggression towards staff or family, withdrawal, sexually-laden comments to nurses, and conflicts of a hostile/dependent nature (exceeding limits or protesting against them on the one hand, or extreme passivity on the other).

Faced with the sudden life-threatening illness of a spouse or parent, family members have been observed going through six stages in reaction to the severe stress.

1. Initially the reaction is one of severe anxiety and shock, and fears for the survival of the patient.
2. This is followed by denial of the reality of the situation (the diagnosis, severity of condition and the effect of these on the patient's and family's immediate future).
3. Anger is directed towards a variety of objects; either towards self, employers or other family members for

their role in causing the patient stress, towards the hospital medical staff for assumed negligence, delay, or a more diffuse anger that lashes out at society or at life in general. More difficult is the bringing into awareness of anger towards the patient for being the subject of, or 'causing' the distress.

4. Remorse - contains the element of both guilt (for feeling angry towards the patient) and sorrow.
5. Grief - an intense period of sadness when their sense of loss (albeit temporary or threatened) becomes overwhelming.
6. Reconciliation - an integration of the total experience, in which is included a realistic sense of hope regarding the future (Epperson, 1977).

Additionally, practical difficulties facing the family members at this time, particularly the spouse, include coping alone with household and parenting responsibilities, attending to duties normally performed by the patient and trying to minimise the distress of younger children. Coupled with this are the demands of visiting schedules, and the burden of fulfilling the expectation to remain supportive and optimistic in the presence of the patient.

8.2.2 Tasks at the Coronary Care Unit stage

Patient

- (1) Progression towards emotional calmness following the shock of admission.
- (2) Acceptance of the diagnosis of M.I. and progression towards correct cognitive perception.
- (3) Acceptance of temporary dependency and co-operation with the medical regimen.

Family

- (1) Commencement of working through shock and grief reactions and ventilation of emotions.
- (2) Integration of the diagnosis and a realistic appraisal of the consequences.
- (3) Short-term readjustments to life-style and coping with the "practical tasks" arising out of the patient's admission.

8.3 THE GENERAL WARD

8.3.1 Common psychosocial problems

Transfer from the C.C.U. confirms to the patient that he is out of immediate danger, and the majority of patients are reported to feel relieved, more alert and communicative. However, some patients may continue to experience severe emotional lability and are distressed by their apparent inability to control depressive affect. Others experience a sense of abandonment, complaining of loneliness and depression at the loss of the close mechanical monitoring and the intensive nursing care. Additionally, links with the C.C.U. staff have been severed and the patient has to acclimatise himself to new human and physical surroundings (Thomas and Lynch, 1979).

The general ward phase signals the start of his mobilisation programme. Actual movement is reportedly approached with some hesitation and concern about the reappearance of symptoms. The vast majority of patients show distress at the feelings of physical weakness (Meltzer and Dunning, 1972). While denial continues to be manifested in some patients, others display an 'opposite' maladaptation - excessive helplessness and dependency (Gulledge, 1979).

Cognitively there is less confusion and the patient is able to consider more rationally the many implications of his illness. As he gains more knowledge regarding the influence of life-

style on the development of M.I., there is a growing realisation of having been partly responsible for the attack, which (according to Rahe, Tuffli, Suchor and Arthur, 1973) is frequently a source of depressive affect, as is the thought of dependence on medication and the limitations of his future life-style.

M.I. represents a threat to what is a primary source of status in Westernised nations, viz. the satisfactory performance of a job or profession. Thus, the patient may not only fear the loss of income from the interruption of, or possible decrease in, his earning power, but also how this may affect his standing with his family or community.

A range of further reactions has been reported: Some patients may be fearful of the harm that return to work would cause to their medical condition. Others focus on the possible effects of the illness on their potential for work, and how this in turn may affect their status, job security, and prospects for promotion. Yet others are concerned about changed attitudes to them and problems with fellow workers (Croog and Levine, 1977).

While patients need to have the reassurance from their physicians regarding their work potential, indications are that this support is not always forthcoming at this stage.

In Croog and Levine's (1977) sample of 345 male patients, 40 per cent reported that at the time of hospital discharge, the physician had not discussed the question of returning to work.

Cognisance of the complex and profound link between satisfactory sexual functioning and feelings of personal adequacy is not always taken, as a similar lack of counselling has been reported in relation to sexual activity. A minority of patients reported that doctors initiated a discussion regarding sex in studies by Bilodeau and Hackett (1971) and Croog and Levine (1977). This is clearly a subject of concern to patients - McLane, Krop and Mehta (1980) assessed patients on the day of hospital discharge finding that 51 per cent of the sample expected that their marital relationships would be affected by their cardiac condition. Fears centred around the prospect of reduction of activity and the possibility of death during intercourse.

Family. Mayou, Foster and Williamson (1978, (ii)) report on the distress experienced by wives during their husbands hospitalisation. Only 5 per cent of their sample denied any anxiety - crying, sleep and appetite disturbance were the commonest symptoms reported. The family's attention may at this point shift somewhat from concern with the patient's survival to the implications of how his illness will affect the functioning of the family, how they will cope with his rehabilitation and what sacrifices this will represent.

8.3.2 Tasks at the General Ward Stage

Patient

- (1) Commencement of appropriate mourning process, and recognition of loss, with ventilation of feeling.
- (2) Further progression towards emotional calmness, and increasingly realistic perception of the M.I. and its consequences.
- (3) The adoption of a future-oriented approach, including planning and emotional preparation for discharge from hospital.

Family

- (1) Continuation of emotional working through, and coming to terms with own losses.
- (2) Preparation for patient's discharge and convalescence.

8.4 CONVALESCENCE

8.4.1 Common psychosocial problems

The return home from hospital is an event eagerly awaited by most patients, who are, however, confronted with a variety of problems. Nearly half of the patients reviewed by Wishnie, Hackett and Cassem (1971) felt "totally unprepared for the physical limitations", many of them wishing they were back in hospital. The most common problem was that of physical weakness, which many interpret as harbingers of cardiac decline (Wishnie et al, 1971). As indicated in Section 5, a large proportion of patients experience angina or other chest pain. Sleep disturbance was reported (persisting up to several months) in many patients.

Mone (1970) reported that certain patients reacted with excessive fear to even that physical activity sanctioned by their doctors, leading them to avoid: leaving their homes unaccompanied unless absolutely necessary; the minimum exercise prescribed; and any sexual activity.

Conversely, Wynn (1967) has observed other patients who show undue denial of anxiety, displayed by excessive physical activity "in an attempt to prove to themselves just how strong their hearts are" and who show little adherence to medical prescriptions regarding exercise, smoking, diet and medication.

Many reports exist of disagreements and tensions at home following the patient's discharge with resulting stresses on the marital relationship. Families have reported patients to be irritable, quick to take offence and occasionally "unstable" (Wishnie et al, 1971). Disagreements tend to focus on the specific meaning of the physician's instructions.

Wives are almost universally reported as being over-protective, and the excessive surveillance over activities, diet and smoking has caused aggravation and frustration (Bilodeau and Hackett, 1971). Ambivalence is apparent however, because the necessity of family concern for their well-being is recognised.

Field (1963) points out that overprotectiveness is often interpreted by the patient as a form of exclusion, as "it cuts him off from the joys and sorrows that constitute everyday living. It serves as a denial of his rights as a family member" (p.194) and patients may react with feelings of hopelessness and despondency.

Difficulty in the expression of hostility towards their husbands has been reported by wives (Adsett and Bruhn, 1968) as they feared the repercussions on their husband's health. Wishnie et al (1971) report that the solicitousness of the wives in their sample "took on a punitive quality which was thought to represent an indirect expression of suppressed anger".

8.4.2 Tasks at the Convalescence Stage

Patient

- (1) Commencement of progressive increase of activities under guidance from hospital, and in accordance with "prophylactic life style".
- (2) Gradual resumption of family roles where possible, with surmounting of emotional issues involved.

Family

- (1) Provision of stress-free environment and the achievement of consensus regarding patient's activities.
- (2) Show understanding of patient's feelings, but balance this by not inhibiting own needs.

8.5 RESTORATION

8.5.1 Common psychosocial problems

In this period the patients attempt to recommence functioning in the significant roles that they performed prior to the M.I., of which the sexual and vocational areas are usually the most significant. These attempts, in certain cases, may take place in an environment of continuing family stress (see 8.4.1). The family has thus far had to meet many of the emotional and physical costs of the patient's illness, to consider the patient's needs first, and to suppress ~~its~~ own. The patients' moves towards independent activity are, in some cases, limited by their wives' overprotectiveness. This continued even up to a year post infarction (Mayou et al, 1978 (i)) manifested by wives taking over jobs the patients used to do, or reminding them of limits, and almost half of the families were protective in 'concealed ways'. Most patients accepted their families' care and protectiveness but 18 per cent rejected it outright. 25 Per cent felt less satisfied with their role within the family.

Mayou, Williamson and Foster (1979) surveying outcome at eight weeks after M.I., found fatigue, anxiety and depression the commonest symptoms, as well as irritability and poor concentration. Stein et al (1969) reported that patients were distressed by deficiencies of concentration and memory (however transient) which seemed to reactivate fears of a

generalised deterioration. Only 28 per cent of Mayou et al's sample were free of physical symptoms (pain or breathlessness) and 9 per cent were readmitted to hospital for cardiac complications.

The early 'restoration' phase (six to eight weeks post M.I.) is the usual recommended time for the resumption of sexual activity. As indicated, concern about intercourse has existed since the hospitalisation phase, and the actual resumption is often plagued by many tensions.

Many husbands and wives of post-coronary patients find themselves in a psychologically traumatic situation, wanting to reassure their spouses of their love and concern, yet fearing the consequences of sexual activity (Scalzi and Dracup, 1979, p.164).

Severe anxiety and diminished libido is reported in patients and their wives, leading to considerable reduction in frequency of intercourse (studies reported by McLane et al (1980) show that frequency of intercourse within the year following M.I. declined by between 40 per cent and 60 per cent from premorbid levels, with some total cessation.) Dysfunctions of impotence and ejaculation in males, and inorgasmia in females are frequently reported (Scalzi and Dracup, 1979). McLane et al (1980) mention the ongoing interaction between prominent anxiety and depression, and sexual dysfunction, and additionally, the side-effects of regularly used medication - particularly for hypertension

and diabetes that result in impotence and ejaculatory dysfunction.

8.5.2 Tasks at the restoration phase

Patient

- (1) Gradual planned reintegration into work situation, appropriate to physical limits.
- (2) Resumption of sexual activity in accordance with guidelines.
- (3) Achieve measure of value change, including coming to terms with uncertainty and potential recurrence.
- (4) Achieve independence from treatment milieu, and resume self-directed independent life-style with full social participation.

Family

- (1) Give unintrusive support and discontinue protection, avoid exclusion and isolation of patient.
- (2) Redefine family goals, adjust to changes.
- (3) Reinforce patient's autonomy.

8.6 THERAPIST FUNCTIONS

8.6.1 Initial contacts

During the course of the hospital contact with the patient, the focus of therapist attention is frequently the family, and particularly the spouse. Some of the many tensions to which families are subjected are illustrated above. On this basis not only do family members merit support as individuals who may be in a crisis, or crisis-potential state, themselves, but also to render them more effective as "situational supports" for the patient. Intervention should potentially be directed at the whole family constellation, the therapist flexibly moving from individual, to dyad, to family as the situation warrants.

The first example of this occurs soon after the patient's admission when relatives are anxiously awaiting news of the patient's progress. The therapist introduces himself as a member of the team and by indicating his concern and offering his time, supports them in their working through of the emotional reaction. He may aid in eliciting information from the medical team regarding the patient's condition, and give what explanation and reassurance he can about the treatment the patient is receiving, at the same time as exploring the emotional issues.

Ventilation is encouraged by asking about the circumstances of symptom onset, and how these were responded to;

the individual responses of denial, guilt, anger, grief, if and when they occur, should be met with supportive acceptance, "giving permission" to ventilate, but with the maintenance of a reality emphasis. Epperson (1977) stresses that anger, if it is felt towards the patient (e.g., for "over-doing" things, not taking medication) needs to be expressed, as unless this is "expressed and dealt with, it can cause further destruction to the family system by being later expressed in passive-aggressive behaviour towards the patient during his rehabilitation" (p.371).

In introducing himself to the patient, the therapist should stress the routine nature of his contact with all patients, so as to dispel any alarm about having been 'singled out'. Reassurance of the patient that this contact will last "until he is back in his usual routine again" (with a realistic estimate of how long that is likely to be - based on prior discussion between therapist and physician) serves several purposes: It introduces a supportive figure who will be in continuous contact; it orients him to reality; it indicates faith in his being able to become independent and well again.

If the patient is still waiting for the diagnosis, there should be a special supportive effort. Klein (1971) has remarked on the fearful aspect of uncertainty which lends itself to fantasy that can be much more devastating than the truth.

8.6.2 Anxiety reduction in the Coronary Care Unit patient

One of the means of reducing patient anxiety is to offer him an opportunity for the expression of feelings. Since the advisability of this is an area of dispute in the literature, some discussion of the rationale behind the current approach will follow.

A fundamental guideline in medical social work is to emphasise the value in most instances of helping people to express their sadness/apprehension/anger rather than spending a large proportion of inner resources to suppress these emotions (Butrym, 1967). However, the idea of emotional catharsis in C.C.U. patients has been of concern to writers such as Cassem and Hackett (1971) who operate from the premise that "in the setting of the C.C.U., psychological states are treated on the assumption that emotional turbulence is a cardiac hazard" and that they therefore "support the suppression of stressful anticipations" (p.14). While clearly "turbulence" should be avoided, it is suggested that "suppression" of preoccupations could be equally harmful to the patient. A rule of thumb for the C.C.U. might be that of remaining within the limits of the patient's level of emotional expression.

Thus Obier and Haywood (1972) have suggested that "If the patient chooses to discuss emotionally-laden material such as his fear of disability or death, or his anger towards his current circumstances, he should be given this opportunity.

Expressing such feelings within the context of a supportive relationship will help relieve the patient's anxiety" (p.17). Field (1963) adds that the subject of fear of death should not be avoided, as the denial by others of what he is trying to say is a negating experience.

In the writer's view the appropriate 'level' would be achieved by experienced clinical judgement taking into account the treatment stage, (with fewer restrictions on emotional expression as treatment progresses), physical condition, and his assessment of the patient's emotional strength.

8.6.3 Learning the diagnosis

Learning the diagnosis is commonly thought to come as a severe shock to patients and their families. The therapist's function is to try to share the grief and fears and by aiding the patient to perceive correctly the implications to aid the emotional acceptance of his illness. The therapist should have up-to-date information about the patient's condition and prognosis and be able to repeat and clarify, where he is able, the information and reassurance given by the physician. The therapist should discover any myths regarding heart illness, attempt to dispel them, and inform the patient's physician, as

Medical advice, if not given with great care and recognition of what is already believed by the patient is interpreted in the context of his folk beliefs and may

harm rather than help him (Goble, Adey and Bullen, 1963, p.80).

Klein (1971) comments on the necessity for facts about the diagnosis, prognosis and treatment to be explained repeatedly in patients trying to find stability, as a combination of anxiety and cognitive confusion may inhibit the absorption of information.

The patient can be guided towards correct cognitive perception of the situation, if he is able to trust the information given to him. This implies that no false reassurances about his condition are given, and that the information is consistent from all staff members.

Hill (1965) remarks that "foreknowledge and preparation for a critical event mitigates the hardships and improves the chances of recovery" - thus patients should be prepared for feelings of physical weakness, depression or irritation.

8.6.4 Practical issues

The therapist can directly (or indirectly through third parties such as social workers, personnel officers, etc.) take varied action in order to relieve anxiety about practical issues that the patient cannot attend to, e.g., finding out about the patient's entitlement with regard to sick leave, unemployment insurance; informing the patient's employer of

his absence, the treatment plan, and attempting to gain some reassurance from the employer about his future job security; assisting the patient by conveying messages, instructions, etc; making contingency plans about cases of financial hardship.

Active assistance at this level should be offered only if the patient or family request this. Clearly, if family members are able to attend to these functions themselves, there should be no attempt to undermine them, nor deprive them of a source of active diversion. However, the therapist's awareness of these practical issues is of extreme importance as is suggested by the work of Spelman and Ley (1966).

They conducted an investigation into the relationship between an extensive range of psychosocial factors and rehabilitation status, finding that those whose admission to hospital had caused difficulties in their work, financial or domestic affairs, were less likely to be successfully rehabilitated.

8.6.5 Assessment

The initial contact with patient and family will be the opportunity for the therapist to commence his assessment, which, despite being an ongoing process is concentrated at the early stages. Rapaport (1970) stresses that the crucial factors of time and the need to intervene quickly prevent the assessment of personality and defense structure from a lengthy and involved history-taking procedure. And yet "some appraisal of basic personality structure and identification

of basic defences as well as habitual adaptive patterns is relevant and important in crisis intervention in order to be able to designate more sharply both the appropriate goals and the techniques for intervention" (p.279). This then is achievable by the "experienced and skilled clinician who can generate and test hypotheses on the basis of clinical experience, knowledge of personality organisation and the ability to appraise the significance of the client's behaviour in reference to himself, his problem and.... to the beginning interaction that is generated in the interview" (p.280).

Assessment and the appropriate follow-up can be seen as the cornerstones of the 'primary prevention effort' inasmuch as they are aimed at identifying individuals who are at risk for deterioration into crisis states at particular vulnerable points (see Section 6.2) and at taking preventive action. As Figure 3 (page 38) indicates, it is the person-in-his environment that determines the crisis reaction, and it should be emphasised that while the assessment functions are concentrated at the early stages, assessment is an ongoing process. In the case of M.I., most notably "factors within the individual" (the patient's medical condition) and "factors in the environment" (support of the hospital, supportive ability of the family) are changing consistently and require constant re-evaluation. Certain categories of patients are identifiable as vulnerable, for example:

- (a) men in the 50-60 year age bracket. Rosen and Bibring (1966) feel M.I. provokes the greatest crisis in these

patients as the demands for passivity represent the position towards which advancing age has begun to propel them, but which they are not yet able to accept. These patients illustrate how the M.I.-related crisis can occur simultaneously with other crises - in this case an example of Baldwin's category (see page 36) - "crises of anticipated life transitions" - (in this case, retirement) compounding its effects.

- (b) those who had tendencies towards depression prior to the M.I. Croog and Levine (1977) report that this category is particularly likely to have emotional difficulties following M.I.
- (c) semi-skilled or unskilled patients are likely to have work or financial problems.
- (d) those patients who have experienced considerable recent life changes (see Section 3.3) the effects and tensions of which are likely to continue to be felt, adding an additional burden to the stress of the M.I. (and may predispose to an "exhaustion crisis").
- (e) elderly patients who live alone who fear for the loss of an independent way of life.
- (f) divorced or widowed women who have dependent children (Ezra, 1969) and are fearful of limitations of activity, ability to cope with childrens' demands, and financial problems.

Wishnie et al (1971) report that premorbid personality traits

(such as aggressiveness, cautiousness, tendency to depression) are exacerbated during the convalescent period. Tentative predictions of potential crisis in particular cases may be made on the basis of assessment of personality or usual activity. For example

- (a) Those assessed as "Type A" might experience the limitation on activity during the home convalescent period as extremely frustrating, and excessive conflict with a spouse's attempts to restrain his activity could be expected.
- (b) Those men who place excessive importance on physical prowess, or who believe their status to be conditional on physical strength (e.g., those whose sport or work activities are excessively physically demanding) may show a severe depressive reaction in the restoration phase when the reality of their deprivation is felt.

Examples of other instances in which the M.I. event might be "defined" as a crisis are:

- (a) when feelings (such as guilt) about the illness experience of other family members (e.g., patient's or spouse's parents) remain unresolved, or there is excessive identification with somebody else's illness experience.
- (b) when the M.I. disrupts, or threatens to disrupt, any highly valued plan or aspiration (e.g., a long-awaited holiday, or the purchase of a new home).

Of central importance is the assessment of the strengths and weakness of individual family members (especially the wife) and the structure of the family as a whole (as indicated in Section 6.1.5 (ii)). This will give an indication of the strength of the situational support the patient will receive on discharge, from which the therapist plans the necessary extent of his own involvement.

8.6.6 "Interpretive" functions

An important therapist function is to promote understanding amongst the medical team of the patient's behaviour in response to his environment and treatment in the C.C.U. Certain emotional or behavioural responses (as mentioned in Section 8.2) including aggression or sexual provocation of nurses might be perplexing and alienating to, perhaps, younger or less experienced staff, e.g.

- (a) Field (1963) comments on the difficulties for the patient having to accept such a high degree of enforced dependency presented by the C.C.U. situation. There is likely to be a conflict between the recognition, on the one hand, of "having to surrender at least part of himself to his illness" (p.46) (by dependency on the medical team and the treatment program) for the sake of his own survival, and on the other, the lifelong pattern of acquiring independence which has been "fostered and even forced upon him". A range of responses to dependency may be possible. An example of "reactivation of earlier

unresolved conflicts (see Section 6.1.5) is explained by Butrym (1967): "Most people have strong ambivalent feelings about dependency which are derived from their experience of dependency in childhood" (p.43). Whether dependency is associated with satisfaction and security, or deprivation and pain (or if experiences in the interim have counter-balanced these early impressions) determines the nature of the patient's response (e.g., aggression, or regression).

- (b) Stein, Murdaugh and McLeod (1969) explain that some of the angry, or hostile feelings shown to others (family or staff) by M.I. patients may be due to the "narcissistic injury" to the patient, or "blow to their concept of wholeness" (p.1045). These reactions are frequently the result of displacement of anger (for which the patient has difficulty in finding the appropriate object - this may be himself, his "luck", others who "caused" the M.I., God).
- (c) Attention seeking behaviour, or sexualised behaviour may be seen as devices to compensate for the patient's self-doubt regarding his self-worth or potency.

The therapist's response in these situations could be twofold. Firstly, he should attempt to interpret to the staff or family his understanding of what feelings may underlie the patient's reaction, and to reassure them that they are not the real precipitant of his feeling. In so doing he would help to reduce the alienation felt by valuable sources of

"situational support". Secondly, by empathising with the patient's underlying feeling, the therapist may aid him to understand his intense emotions and to ventilate. In this way he can begin to accept his situation and the restraints imposed by the treatment milieu.

8.6.7 Dealing with denial

Reference has already been made to the spectrum of response styles to M.I. varying from extremes of denial to extremes of helpless, dependent hypochondriasis (the "cardiac invalid syndrome"). Denial is the response most regularly reported in the early stages of treatment. Denial, in classical parlance is seen as an unconscious defense mechanism (Freedman, Kaplan and Sadock, 1976), although writers in this field commonly refer to a conscious aspect, as typified by the definition of Hackett and Cassem (1972): Denial is "a conscious or unconscious repudiation of part or all of the total available meaning of an event to allay fear, anxiety, or other unpleasant affects" (p.451).

Its helpfulness at certain stages of the patient's experience is acknowledged by some writers. Hackett and Cassem (1979) studied patients who exhibited a range of denial responses which they categorised in terms of the extent of usage of the mechanism. Their "major denial category" led them to conclude that "the patient who can deny painful effects such as

anxiety and depression may have a better chance for survival in both the short and the long run" and therefore that "physician-engendered denial would be altogether in the service of the patient" (p.452).

Contrary views are presented by (a) Olin and Hackett who discuss the mechanism of denial of pain and remark "in the acute phase of M.I., one cannot help but wonder how many patients die simply because they have no one available to correct the flaw, created by denial, in their perception of reality" (quoted in Croog et al, 1968, p.127); and (b) Croog, Shapiro and Levine (1971) who emphasise that it may affect the level of co-operation in the subsequent therapeutic regimen.

Stein et al (1969) agree that denial has an important protective purpose in the early phases of treatment, but point out the dangers of the mechanism being maintained after the need for it has passed, thus preventing reality assessment. They caution too, that if the denial mechanism breaks down exaggerated feelings of pessimism and hopelessness may set in.

It is suggested that an appropriate therapeutic response to denial amongst heart patients takes into account the "success" of the mechanism - i.e., whether it really is reducing anxiety - and simple verbal denial (of, for example, feelings of depression, tension in the marital relationship or anxiety about work performance) is insufficient evidence. There must be an accompanying affect consistent with what is

verbalised. If this is not the case, the therapist might try to point out the contradiction to the patient and offer the opportunity for exploration of the unacknowledged feelings. If denial is operating "successfully" and the therapist feels the patient is strong enough to commence greater reality contact, an effort can be made to commence denial reduction. In attempting to reduce denial, the therapist should be aware of the anxiety that may be unleashed in the process. Such activity should be approached with caution, with gradual introduction of reality and heavy emphasis on the supportive therapeutic alliance - "to help the acceptance of reality without overwhelming the ego in the process" (Stein et al, 1969, p.1044).

8.6.8 Grief work

The therapist can take advantage of the patient's lessening anxiety, and improving alertness (usually at the late C.C.U. or early General Ward stage) to spend more time with him. (In the General Ward he forms the one continuous link with the C.C.U, and may to some extent alleviate the reported feelings of abandonment).

The therapist reinforces the most optimistic prognosis given to the patient by his physician regarding his prospects for resumption of activities. However, some loss is undeniable (even if, in the case of patients with good prognoses, it is only short-term) and in most cases is experienced as overwhelming. It is suggested that the therapist explore the

patient's feelings about this loss, in order to stimulate grief work, and counter denial.

That this "grief work" (Lindemann, 1944) is necessary is born out by a study by Caron of patients with recent M.I. After an initial period of denial of the significance of the illness (which was almost universal), the patients fell about equally into two main groups, those who continued to deny or minimise their illness, and those who recognised the seriousness of the situation and displayed distinctly depressive reactions. A year later the patients who had shown the depressive reaction were less disabled than those continued to deny their illness (Hellerstein and Ford, 1960).

Caplan (1944) provides a further example (in another context). In a study of maternal reactions to the birth of a premature infant, Caplan and his associates were "struck by the fact that women who had been the most upset during the critical days when their babies hovered between life and death were the ones who survived the crisis best" (p.290).

8.6.9 Responding to sexual concerns

Section 8 has illustrated the problems surrounding early contemplation of future sexual activity as well as actual resumption. Since these problems take place against a background of frequently noted reluctance or discomfort on the part of both physician and patient about discussion of this

area, (Croog and Levine, 1977), it is considered vital to institute a routine approach undertaken by both physician and therapist.

It is suggested that the general ward phase is appropriate for the topic to be introduced by a member of the team. The inclusion of the topic as part of a routine discussion on physical activities may assist the patient in verbalising his questions, fantasies, or fears, and forms part of the effort to achieve correct cognitive perception. Patients should be informed that most individuals who have had M.I. are able to return to usual or modified activities after convalescence. Specific reassurance about death fears, or physical capacity can be given by the provision of factual information.

Evidence of the low incidence of coital deaths can be provided by drawing on information based on studies such as that of Houd (1978) who analysed 5 559 cases of sudden cardiac deaths finding 34 coital deaths (.06 per cent) amongst them. Of these, 24 were extra-marital and were associated with excessive alcohol consumption. Houd concluded that there is little risk to the patient who has sex within a compatible and sustained relationship, while the risk is somewhat increased if a stressful environment, alcohol or "performance anxiety" are involved.

Similarly, information can be given regarding energy expenditure.

Kent (1975) confirms that the majority of cardiac patients are able to tolerate with ease the average energy expenditure (6 calories per minute during orgasm and 4,5 calories per minute before and after orgasm). Focussing on heart rate, Kent showed that for the patients in his study, on average, heart rate was 117 beats/minute at orgasm which was only 81 per cent of the predicted maximum capacity before the development of angina symptoms.

The patient should be reassured that more specific information, which takes into account his physical capacity will be provided when he returns for his effort test (see Figure 1). Scalzi and Dracup (1979) advise that separate counselling sessions for the patient and the spouse are of advantage, and permit each partner to express concerns they may not feel comfortable about stating in each other's presence. These counselling sessions should include guidelines regarding coital positions, use of medication, warning signals, and circumstances (e.g., tiredness, after heavy meals) in which sex should be avoided.

At the restoration phase, should dysfunction, or excessive fear preclude the gradual resumption of sexual activity, intervention should focus on promoting communication between the spouses, and reassurance that such initial difficulties are common. It is only if these difficulties prove resistant to change that the suggestion of referral to a sex therapist be made.

8.6.10 Planning for the future

The patient's "future oriented thinking" (Obier and Heywood 1972) should be promoted by encouraging him to plan for the future, to continue to see himself as productive, and to consider that his rehabilitation will be firmly established with appropriate modifications in his lifestyle. The patient's return to work should be carefully planned, on the basis of physical and psychological factors. Croog and Levine (1977) remark that even in the case of white collar workers, physicians took physical rather than emotional stress more seriously as a basis for recommending a job change. Prior to the medical interview at which the patient's return to work is discussed, the therapist's impressions of the patient's premorbid emotional functioning in his work situation, as well as his current attitude to work should be communicated to the physician, so that the physician's guidance will be more broadly based. If the patient anticipates problems in any area of the employer's response to him, direct contact with the employer could be considered.

8.6.11 Later onset crises

A modified therapeutic approach is necessary in dealing with crises of the exhaustion type. The therapist should be aware that such individuals respond less easily to efforts to engage them actively in their reintegration, - efforts are often met with apathy, impotence and indifference. According to Korner (1973), the ideal is to allow such a person "slow replenishment in a

benign environment" (p.37)

Crises of the reactive type should involve the therapist in careful assessment of the "precipitating factor", in order to identify the particular set of circumstances that produced the crisis situation. The real precipitants are not necessarily those reported by the patient, e.g., he may describe an inability to concentrate at work, with resulting fears for his job security; underlying this may be the fear of the implications of anginal symptoms which he may not have reported to his physician. The active crisis state is assessed to determine what areas of his functioning have been most disequilibrated, and therefore form the basis for a decision of therapeutic priorities.

Of all reactive crises, lapses of medical condition are likely to demand the most therapeutic time, since the depression produced by the loss of hope for a complete recovery instilled since the M.I. may be devastating, and the task of remotivating a person is that much more strenuous.

This study has not focussed on the contact with families of patients who have died, as the topic is extensively covered in a crisis context by Lindeman (1944). Clearly, therapists in a cardiology department will be involved in offering support in these situations.

8.6.12 Promoting "peer support"

It has been stressed that a feeling of 'group membership' is important for effective coping with crisis (Viney, 1976). The general ward could be the starting point for contact with other M.I. patients. As has been regularly reported, (e.g., by Donovan, Bennet and McElroy, 1979), the knowledge that others are in the same situation and share similar anxieties reduces depression. Informal contacts could be promoted between patients at the General Ward stage.

In an attempt to use role models to promote healthy identification by their patients, the experiences of well-known people who had had M.I.'s and returned to useful work were cited by physicians; and in a situation similar to M.I. in its post-depressive phase, viz. mastectomy patients, use has been made of a programme whereby a rehabilitated patient visits the hospital patient, at the request of the attending physician, under the auspices of the lay-organised "Reach for Recovery Programme" (Healey, 1971). The use of resources in this way could be considered.

An additional source of support for the patient during the convalescent and restoration phases could be his participation in a structured therapeutic group, consisting of M.I. patients at approximately the same stage of treatment and led by the therapist. Groups of this nature have been reported on by workers in the M.I. field (Adsett and Bruhn, 1968; Mone, 1970; Rahe et al, 1973; Ibrahim, Feldman, Sultz,

Staiman, Young and Dean, 1974). Although no evidence of group efficacy has been shown to date, these writers comment on positive patient response to group therapy, with improvements in mental state, decrease in hypochondriasis and a quicker return to normal functioning.

Benefits to patients from group participation have included help with "resocialisation", (following the isolating illness experience) and mutual support and encouragement in dealing with several ongoing sources of anxiety, i.e., family problems, the responses of friends and employers to their illness, concerns about further M.I.'s, problems of domestic, vocational and sexual readjustment, feelings of inadequacy. There was a focus on adhering to risk factor reduction in Rahe et al's group where "the admonitions of others struggling with these same temptations usually supported the "offending" patient's efforts to take concrete steps to cut out smoking altogether, to achieve a weight reduction or to solidify his physical training programme" (p.85).

Additionally, groups could be used for more specific objectives in dealing with "reactive" crisis situations. For example, the group might focus on problems pertaining to returning to work and in this regard the comments of Donovan et al (1979), that crisis groups should aim at problem-solving and a return to independent living are relevant. Strickler and Allgeyer (1967) remark that the individual's functioning in the group often reveals the type of faulty coping that has that has caused his current difficulty. Mone's (1970)

group challenged the maladaptive defenses of those who "want to deny everything related to their illness" or "who use their illness for secondary gain" (p.107).

Strickler and Allgeyer (1967) advise therapists leading crisis-oriented groups to discourage the focus on chronic character problems which can detour from the main focus of treatment. Regression can be promoted in this way, resulting in possible retardation of crisis resolution.

Groups for wives of heart patients have been held (Adsett and Bruhn, 1968) with similarly encouraging results, which if resources permit could be included as part of the programme.

8.6.13 Promoting the "prophylactic life style"

It is commonly felt that there is an ideal level of adherence to the "prophylactic life style", i.e., where the patient steadily reduces his risk-factor behaviour, but is neither overzealous in his interpretation of instructions (resulting in unnecessary inhibition of activities, and deconditioning) nor too casual, (in which case he is continually exposed to higher risk of reinfarction). In order to achieve this 'ideal' level of adherence, the physician will have to pitch his instructions at different levels for different personalities. Thus a cautious and dependent person will require a much 'lighter touch' than someone who is aggressive, passive-aggressive, or continuing to deny his illness.

It is suggested that the therapist can be of assistance in this respect:

- (a) by providing feedback about the patient's personality to assist the physician, and to suggest ways of approaching the patient.
- (b) by reinforcing the physician's instructions to the patient and supplementing this with exploration of the patient's feelings about the "deprivations" involved, and
- (c) by discussion of relevant substitutes, or aids to risk factor reduction (e.g., programmes for reduction of cigarette smoking, exercise facilities).

The therapist should empathise with the difficulty of "maintaining a regimen indefinitely that never provides positive or unequivocal proof of its possible therapeutic effectiveness (Friedman, 1979, p.552).

Data from the social sciences indicate that upper socio-economic status persons tend to adopt health innovations more readily than do lower status persons (Stern, 1979) which indicates the need for additional therapeutic alertness with lower class patients.

8.6.14 Family support at the restoration phase

The therapist can continue to play a valuable role by contact with the family during the restoration phase. The main focus of this contact will be on assuring the family of the hospital's continued interest and concern, and on promoting communication between family members. The following points in addition should be emphasised.

Ezra (1969) advises that helping efforts should aim at maintaining pre-existing family roles - as permanent role changes have been shown to presage poor adjustment. In those instances where permanent role changes are unavoidable, additional therapist support is called for. E.g., if a patient's physical condition is such that he is prevented from returning to any form of work, loss of self-esteem is likely to follow. This could be alleviated in some way by therapist or family persuading him that preservation of his status does not depend entirely on his ability to provide; that status can be maintained by the quality of his relationships, his parenting functions, and the support, love and guidance he is able to give.

The maintenance of the wife at a level of functioning at which she is able to project optimism and provide strong emotional support for her husband is contingent on her own needs for support being met. She needs opportunities for the ventilation of her fears and concerns, and advice as to how to respond in a helpful way.

Cautions to her and the rest of the family about overprotecting

and excluding the patient (see page 71) should be stressed. While clearly at the early convalescent phase the patient's wife will have many demands made on her, she should be encouraged to resume her usual life-style where possible. Mayou et al (1978 (i)) reported that the wives who were least distressed one year after the M.I. were those who continued to work and enjoy their leisure activities.

The therapist must remain aware and sensitive at this stage of how the family attempts to dispel anxiety, particularly as a consequence of any role changes. One of the maladaptive solutions has been the scapegoating of a family member, e.g., a child. Caplan (1961) described this as "a vicarious solution by projection and displacement at the emotional expense of someone within the family orbit" (p.18).

8.6.15 Termination of contact with the patient and family

Crisis intervention ends most appropriately when the "client begins to find solutions to his problems" (Rapaport, 1970, p.302). This does not imply that all related problems have been worked through, but rather that the client's coping mechanisms are again functioning and he is equipped to solve problems on his own. In the case of the M.I. patient this would generally occur when his family has achieved a degree of open communication, when he has returned to work and adopted a strategy of resumption of activities in a series of gradual, self-reinforcing steps. Termination should be discussed and agreed upon beforehand with client and family to allow emotional preparation.

Termination should include an assessment of particular needs that the therapist has not been able to fulfil, and for which resources may be available in the community. Consideration should be given by patient and therapist in appropriate cases for referral to psychotherapists for longer term therapy, marriage guidance, sex therapy, or community programmes focussing on weight or smoking reduction. Suinn et al (1975) have reported on a behaviour modification programme aimed at the Type A behaviour pattern, which is a combination of anxiety management and visuo-motor behaviour rehearsal (adaptive patterns are acquired under controlled imagery conditions). The therapist must be acquainted with useful resources of this nature.

There should be particular regard for the patient who lives alone. Thomas and Lynch (1979) report on studies that "point to the conclusion that human loneliness contributed to the development of coronary disease" (p.86). This may involve the therapist continuing his contact for longer than indicated, but should also involve efforts at stimulating social or supportive contacts.

While there may be reluctance on the part of the therapist to terminate (particularly if the patient's adaptation is still 'shaky'), continuing "the concern and care situation" (Korner, 1973, p.37) is an invitation to the patient to remain dependent, and is in conflict with the aims of strengthening patient self-directedness.

At the final interview with the patient, his progress should be reviewed and the positive steps he has made be reinforced and encouraged. The therapist should discuss plans and anticipate future stresses. Korner (1973) remarks that "even under the best conditions of recovery, the individual needs some assurance against reoccurrence of crisis conditions" (p.39). While no guarantees about his medical condition can be given the therapist should express optimism about his progress and confidence in his ability to deal with the future.

8.6.16 Tables.

Table 2, in three sections overleaf, summarises the therapist functions at each of the four treatment stages. They are categorised into the main "thrusts" discussed earlier page(57).

It should be born in mind that such classification is for logical presentation purposes, and that in practice the functions clearly overlap and interrelate.

THERAPIST FUNCTIONS	CORONARY CARE UNIT	GENERAL WARD	CONVALESCENCE	RESTORATION
<p>assisting correct cognitive perception</p>	<ul style="list-style-type: none"> -control of negative fantasy -counter beliefs in myths re M.I. -ensure diagnosis is understood and seen in perspective 	<ul style="list-style-type: none"> -reassurance re likelihood of resumption of functioning in key areas-work, sex -institute routine discussion regarding sexual activity and the provision of factual information -reinforce optimistic prognosis 	<ul style="list-style-type: none"> -ensure patient has awareness of possible permissible activity and is not unduly restrictive -aid patient in adaptation to value change 	<ul style="list-style-type: none"> -reinforce optimistic attitude -express confidence in patients recovery
<p>providing situational support</p>	<ul style="list-style-type: none"> -promotion of understanding by staff of patients behaviour -feedback to staff about patient's interpretation of information about his condition, prognosis, etc. -practical help to relieve concerns about absence 	<ul style="list-style-type: none"> -encourage mobilisation efforts in the ward -act as liaison to obtain further medical information where patient requires it -use of role models -promote contact between individual patients 	<ul style="list-style-type: none"> -encourage prophylactic lifestyle and suggest ways of coping and range of alternatives to consider -additional supportive effort at reactive crisis points -advising wife and family about obtaining consensus re permissible activity to avoid disagreements 	<ul style="list-style-type: none"> -encourage resocialisation and stimulate patients autonomy

USE OF GROUP THERAPY



THERAPIST FUNCTIONS	CORONARY CARE UNIT	GENERAL WARD	CONVALESCENCE	RESTORATION
<p>Assessment functions</p>	<ul style="list-style-type: none"> -assess "determinants" (p.38) and identify individuals at risk -ensure awareness of medical prognosis 	<ul style="list-style-type: none"> -assess family structure: integration and adaptability -family's view of illness -nature of situational support available 	<ul style="list-style-type: none"> -communication patterns in family -degree of disruption of family goals and changes in role structure 	<ul style="list-style-type: none"> -problems with sexual adjustment -particular vulnerability for exhaustion crises -illness being used for secondary gain? -suitable stage for termination -need for referral to other agencies
<p>assisting management of affect</p>	<ul style="list-style-type: none"> -aid in anxiety reduction and patient's ventilation of death fears, etc -empathise with feelings of helplessness, but stress their temporary nature 	<ul style="list-style-type: none"> -support patient during grief work and encourage ventilation -stress normality of grief feelings 	<ul style="list-style-type: none"> -provide opportunity for support of wife and allow ventilation of feeling -wives group? 	<ul style="list-style-type: none"> -encourage open communication in the family to avoid resentment

THERAPIST FUNCTIONS	CORONARY CARE UNIT	GENERAL WARD	CONVALESCENCE	RESTORATION
Monitoring coping mechanisms	<ul style="list-style-type: none"> -regression and excessive dependency -patient displaces anger on to staff or family: attempt working through with real object of anger 	<ul style="list-style-type: none"> -countering withdrawal tendencies -gradual confrontation of denial while providing support 	<ul style="list-style-type: none"> -scapegoating in the family? -excessive timidity? - the "coronary invalid" syndrome? 	<ul style="list-style-type: none"> -is denial resulting in excessive and dangerous activity level? -is patient being isolated or excluded by the family because communication is poor?
"preventive" functions	<ul style="list-style-type: none"> -plan intervention for "at risk" individuals -identify excessive use of denial or regression -preparation for feelings of weakness or abandonment when patient leaves CCU 	<ul style="list-style-type: none"> -explanation of, and preparation for possible stresses at home, and the possible feelings of weakness, irritability and frustration -give assurance of the continuing support of the hospital 	<ul style="list-style-type: none"> -thorough assessment of anticipated psychological problems in the work situation, and exploration of fears. Report this to the physician. -direct contact with employer -give support to prevent hospital discharge crisis -encourage the maintenance of the role structure that existed in the family before the M.I. 	<ul style="list-style-type: none"> -encouragement and guidance for patients who have become fearful of work -additional support for those that face particular difficulties e.g. Type A persons -special support for socially isolated patients -ongoing support for wives to prevent exhaustion crises

SECTION NINE

OVERVIEW AND CONCLUSIONS

This study has illustrated the vast numbers of problems and stresses with which the M.I. patient is faced, and the many opportunities for helpful psychosocial intervention. Whether or not psychotherapeutic efforts are considered to have directly measurable beneficial effects on the morbidity or mortality of the illness, it is believed that they are worth undertaking alone for the improvement in psychosocial functioning that they can effect.

The institution of a formalised programme in a hospital setting, if approached with goodwill by the medical team and by the mental health professional, can lead to an increasing "psychological awareness" and resultant benefit to the patient. Underlying this goodwill, is the essential of sound communication between the two disciplines. From the therapist's point of view this entails courteous communication, consultation, regular provision of feedback and recognition of the pressures faced by the medical team. From the physician's point of view an attitude such as that described by Hellerstein and Ford (1960) would be helpful:

When it comes to filling social and emotional needs, however, the physician's role changes from that of

a diagnostician-therapist to that of a diagnostician planner. The same orderly thought process that derives a diagnosis and therapeutic plan from the data of the history and physical examination can also define the patient's social and psychological problems and point to the most effective solutions. But here it becomes crucial for the physician to recognize that the limits of his professional skill do not necessarily coincide with the extent of the needs related to this particular illness. If he recognizes both his own limitations and the variety of the patient's difficulties he will welcome the assistance of the patient's family and friends and of specialists in psychiatry, social work, or vocational counselling. When a physician turns to others for appropriate help in managing problems in which he is not highly skilled, he does not restrict his role or abdicate his authority: rather he makes it clear to the patient that he remains in a central position as guide and counsellor, seeing the problem whole, rendering the kind of help he is trained to give, and delegating that for which others have more time and training" (p.1176).

The crisis approach as outlined, in the author's view does fulfil the requirements of economy stated in section 1, particularly if many of the therapist functions are performed in a group context. Moreover, its "brief therapy" focus consisting of a period of intensive therapeutic involvement in which many of the predictable issues are dealt with, is infinitely preferable to the prolongation of contact and support and the resulting perpetuation of the coronary role beyond its appropriate limits.

There should be no illusion that the crisis approach is a panacea for all problems following M.I. It is suggested that the techniques of crisis intervention be used to focus on rapid resolution of the crisis aspects of the disturbance, and that ongoing help may be necessary. Clearly much of the distress in the M.I. situation is not always the consequence of the acute physical illness, for as Cay et al (1972) suggest, a population with a high incidence of premorbid stress is being dealt with.

The crisis approach, therefore, can be seen as a suitable, but limited, structure around which the therapeutic activity can be planned and conceptualised. Its value lies, in the writer's view, in the emphasis on constantly reassessing the total situation -- i.e. all significant areas of the patient's functioning. This may be useful in an environment where the focus is usually concentrated on the "bio" part of the individuals "biopsychosocial" field, and in dealing with a syndrome in which the psychosocial aspects seem so intimately linked. It focusses attention on the coping mechanisms used by patients, challenging them towards more adaptive behaviour, and on improving the quality of situational support. Further refinements are necessary, and possible. As generic knowledge is accumulated, and greater sophistication is introduced, particularly with regard to the identification of more indicators of vulnerability, primary preventive efforts will be increasingly successful.

While providing a structure, intervention should not limit the creativity of the therapist, nor his approach to therapy.

It makes no claim to being a theory of personality, nor a school of psychotherapy, and within the somewhat broad outlines given, the therapist continues to use his own preferred orientation in the crisis context. (Baldwin 1977)

Crisis is often conceived of as an opportunity for growth, and instils in the practitioner of crisis intervention an attitude of optimism—the theory is based on the tacit assumption that the crisis situation is reversible, and that from crisis can emerge a stronger adaptive ability. This attitude may prove an asset in dealing with a syndrome, understandably characterised more by the losses it causes than by the benefits it provides.

It is hoped that this study can go some way towards promoting an awareness of the possibilities that a crisis approach can offer. The writer believes that with the refinements and adaptations that practical implementation of these proposals can stimulate, a further useful contribution to holistic medicine can be made.

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