Review

THE CONCEPT OF CRISIS*

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Introduction

'Crisis' is one of those notoriously difficult concepts which abound in the social sciences. Because of its wide usage the term lacks precision and specificity; so that even those who work in the area of crisis intervention and research are reluctant to commit themselves to a single definition. This paper reviews the existing literature on crisis in an attempt to clarify the term and to investigate its heuristic value. As we are primarily interested in making the concept operational for use in the Yorklea Study, the scope of this paper will not be as broad as that of a recent review by Darbonne (9), to which the reader is referred for its comprehensive bibliography. The reader is referred also to the bibliography by Rochman and Hindley (42) and to a useful collection of essays by Parad (35). Although the following discussion will be largely theoretical and methodological, it is hoped that it will also be useful to those engaged in crisis intervention in the evaluation and planning of their work.

The Relationship between Crisis and Stress

It may be illuminating to look at the parallel development of another term which is closely related to the concept of crisis — stress. Since the work of Selye, research into 'physiological stress' has progressed continuously. Physiological stress involves automatic homeostatic mechanisms activated by noxious stimuli, and more is now known about stressful agents in terms of time, intensity and so on. However, the same precision has not been achieved in the area of 'psychological stress'. Even the distinction between physiological and psychological stress is confused since it can be argued that responses to the former are mediated by the latter, and both produce the same physical reactions. Lazarus (30) distinguishes between two kinds of stress by using the term 'threat' to refer to psychological stress. This implies that the individual appraises a stimulus as potentially harmful, so that it is an anticipatory response involving cognition; whereas physiological stress is a response to present harm. The use of the term is still imprecise since there is a continual confusion between stimulus, non-specific response and rather specific response states under the general rubric of 'stress reaction'.

It must be considered whether or not it is useful to distinguish between crisis and stress. A review by Howard and Scott (26) suggests that, as applied to the individual organism, there is an exact parallel in usage. However, these authors go on to make a four-way classification of stressors based on those which are seen as being in an external or internal perceptual field from the point of view of the observer, and those which are symbolic or non-symbolic stresses. They offer a problem-solving model for crisis, assuming that a difficult problem-solving situation is accompanied by a tension state in the organism, which is the stress response.

Caplan (5) distinguishes between stress and crisis temporally, since crisis is characterized by a short-term period, while stress need not be. L. Rapoport (39) suggests that while stress has a pathogenic potential, crisis can be characterized by a growth-promoting potential.

In spite of these attempts to distinguish between the two terms, crisis and stress tend to be used interchangeably, although there is some suggestion that crisis is a special and acute kind of the more general class of stress.

Current Uses of the Term 'Crisis'

The following summary identifies six overlapping uses of the concept of crisis.

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1) Organismic
This approach to crisis makes use of the concept of physiological stress. Thus 'crisis' is applied to situations in which homeostatic limits are exceeded by continuing disruptive stimulations, which usually result in problem-solving or adaptive behaviour but may result in maladaptation and chronic stress reactions. Examples of this kind of approach can be seen in the studies of sensory bombardment or understimulation, psychosomatic illness (24, 38, 37), and in the stress experiments reviewed by Howard and Scott. Similarly, the Grinker and Speigel (20) study of war neurosis emphasizes the importance of physical health factors (e.g. fatigue, malnutrition, etc.) and invulnerability to acute environmental disturbances.

The organismic approach tends to emphasize environmental and situational factors, so that stress is regarded as a response to external forces. An example of this is the systems approach to the study of disasters (11).

2) Ego Integrative
The concept of equilibrium is also fundamental to the crisis theory originated by Lindemann (31) and developed by Caplan (3, 4, 7) and this has constituted the 'main stream' in crisis research.

They propose that people usually deal adequately with problem situations by using habitual responses in order to maintain equilibrium. Crisis occurs when there is an imbalance between the difficulty and importance of a problem and the resources available to deal with it. A hazardous situation (i.e. potentially crisis-producing) is one in which there is a threat to basic need satisfaction or a stimulus to basic need appetites. Habitual problem-solving responses are evoked but if these homeostatic mechanisms are inadequate they are followed by an organismic rise in tension. The organism attempts to reduce tension by trying new problem-solving behaviour, but if this is inappropriate the attempts to discharge tension may take precedence over the attempts to solve the problem. Thus crises are seen as critical turning points in the life cycle, in which the individual either increases his repertoire of reality-based adaptive problem-solving techniques or else takes a step towards non-reality-based maladaptive problem-solving techniques — i.e. mental disorder. In other words, crisis represents both a danger to and an opportunity for ego integration, and the main emphasis is placed on the influence of intrapersonal dynamics on crisis outcome.

3) Developmental
A developmental approach to crisis is associated mainly with the work of Erikson (14, 15, 16), R. Rapoport (40, 41) and more recently Dabrowski (8) and Furer (17). Erikson views personality development as a succession of differentiated phases of behaviour or transitional periods characterized by cognitive and affective changes. Here crises are seen as an integral element of personality growth since although they involve periods of increased vulnerability they also provide opportunities for the development of healthy adaptive reactions. Similarly, Rapoport distinguishes between normal crises which practically all individuals meet (e.g. getting married, going to school, etc.) and pathological crises such as disasters or wars, to which only some sections of the population will be exposed. The major difference is that the former provide for preparatory behaviour, while the latter cannot usually be anticipated.

This more optimistic view of crisis is similar to that outlined in the previous sections and is in opposition to the traditional view of regarding stress or crisis as an intrinsically harmful etiological factor in mental disorder. Successful coping in a crisis situation is seen as increasing the individual’s capacity to cope with future crises; only unresolved crises are seen as increasing the propensity to mental disorder.

4) Major Change in ‘Life Space’
This is a term proposed by Parkes (37) as an alternative to either stress or crisis since it avoids the circularity of defining either in terms of its outcome. Another advantage of this term is that it lacks
the negative connotations of both crisis and stress.

Parkes (37), in an unpublished working paper, maintained the clinical perspective but drew on Lewinian field theory to make all aspects of the crisis experience part of the subject's experiential field. He blurred the usual distinctions between past, present and future (outcome) and internal and external (as distinguished by Howard and Scott). This formulation approaches systems theory in that all aspects of experience can be interrelated without prior assumptions as to causal sequences in the phenomena studied. Parkes himself, as an investigator, has assembled study groups on the basis of experienced events, such as bereavement; he has drawn upon a wide range of reported experiential aspects, such as subjective stress, visits to physicians and prior personality; and has examined the contribution of a parsimonious selection of variables to the total patterning of the experience.

He states that changes in life space tend to be resisted and so explains the disruption of thought, perception and behaviour when major changes in the life space occur. Parkes' approach is similar to that of Erikson and R. Rapoport in its emphasis on critical role transitions in the life cycle.

5) Communications Model

Since most models of crisis involve reference to problem-solving activities, recent theories have stressed the role of information in crisis resolution. For example, Williams (48) suggests that "The general function of communication in crisis is to provide the actor with information which will enable him to make choices to avoid, minimize or remedy the consequences of the crisis." He illustrates this point by describing the reactions to mass disasters in cybernetic terms. Similarly, Hamburg et al. (21) also study the seeking and use of information during stress. Ruesch (43) categorizes crises into four kinds: input, anticipation and recollection, decision and output crises. Ruesch's model is more applicable at the intrapersonal and small group level, while Williams' model is suited to larger groups and societies.

6) Interpersonal and Sociocultural

Most of the above approaches to crisis are psychological in that they stress intrapersonal, individual adjustment to crisis situations. Recently, however, there has been more emphasis on the importance of the individual's relational milieu, his reference groups, social networks and community as some of the supports which influence crisis outcome. This kind of approach also places greater emphasis on the individual's present situation rather than on his past experiences and personality. The sociological approach to crisis is exemplified in Hill's study of family crisis and his excellent review of related research (22, 23) in which he demonstrates that when an individual family member is involved in a crisis the whole family must readjust.

The sociological approach also emphasizes the importance of cultural values in the definition of and reaction to crisis. For example, the difference in the Western and Japanese attitudes towards death; the institutionalization of rites de passage, which help individuals cope with major transitions in role relationships; the toleration of grief reactions and so on.

Is There A Crisis Syndrome?

What are the characteristics of crisis and how do we recognize that an individual is in a state of crisis? Parad and Caplan (34) suggest that the five essential features of crisis are as follows:

a) The stressful event poses a problem which is, by definition, seen as insoluble in the immediate future.

b) The problem taxes the resources of the individual or family since it is beyond their traditional problem-solving methods.

c) The situation is seen as a threat to the life goals of the individual or family.

d) There is a generalized physical tension which is symptomatic of anxiety, and this tension mounts to a peak and then falls.
e) The crisis situation awakens unresolved key problems from the near and distant past.

From a more clinical perspective, crisis can be recognized by the following symptoms (32):

a) Crisis is acute rather than chronic and extends from one to six weeks.

b) It produces marked changes in behaviour, which is commonly less efficient than usual.

c) There are subjective feelings of helplessness, ineffectiveness, anxiety, fear, guilt and defensiveness.

d) Although there are common crisis situations the individual's own perceptions of threat are unique, so that crisis is relativistic.

In order to assess the appropriateness of crisis therapy it is obviously essential that a crisis situation can be reliably identified. A clear description of a crisis syndrome is also a prerequisite of further research because of the need to match non-crisis control groups. Sifneos (45) attempts to do this when he discusses the generic features of one hundred and eight cases. He places great emphasis on an external, hazardous situation and a precipitating event. Bloom (1) found this to be the consensus among experienced clinicians. A recent paper by Golan (19) abstracts four components from Sifneos' study — a hazardous event, a vulnerable state, a precipitating factor and a state of active crisis (disequilibrium) as the major diagnostic features of crisis. He proposes a model intake interview, intended to elicit these features and to assist clinicians in the recognition of crisis. Yet even Golan admits that his model represents an ideal type.

A recurring theme in the empirical descriptions of the crisis syndrome is the idea that crises go through characteristic stages of development. Three writers discuss stages in the crisis syndrome — Caplan (5), Tyhurst (47) and Hill (23).

Caplan states that crisis results in physical tension which is characterized by four phases:

a) An initial rise in tension, which calls forth habitual problem-solving responses of homeostasis.

b) Lack of success leads to a further rise in tension, marked by feelings of helplessness, ineffectuality and emotional upset.

c) A further rise in tension stimulates the mobilization of emergency problem-solving mechanisms. The individual tries novel methods (e.g. redefinition, trial and error, or need resignation) which may solve the problem.

d) If the problem continues, tension mounts beyond a further threshold and major disorganization occurs.

Caplan writes in very general terms, but Tyhurst describes in some detail the typical reactions to three specific crises — disaster, immigration and retirement. For example, following disaster there is a typical reaction of regression and dependency which is rarely found in other types of crisis. So Tyhurst raises the question as to whether we should speak of one overall crisis syndrome or whether such a general term loses sight of important differences. Tyhurst feels that in spite of the differences all post-crisis reactions can be usefully described in three common stages — impact, recoil and post-traumatic. Each of these stages can be further described in terms of stress, time (duration and perspective) and psychological phenomena. Thus for all crises the subject's time perspective during the period of impact is on the present; during recoil it is on the past; while the final period is characterized by a return to a usual time perspective.

Hill likens the progress of family crisis to a 'roller coaster' — crisis — disorganization — recovery and reorganization; which is very similar to Tyhurst's classification. Hill makes an explicit distinction between the short and long term effects of crisis, which is usually implicit in other models. However, he provides no empirical evidence to demonstrate the usefulness of his typology.

The apparent differences between the crisis syndromes described above are due mainly to differences in emphasis. This
Caplan stresses the organismic, physiological reaction to crisis; while Tyhurst's interest lies in psychological reactions, such as changes in perception and emotional behaviour. Hill, on the other hand, is concerned with group reactions to crisis and therefore emphasizes changes in family solidarity and role relationships.

Other writers have included the pre-crisis period among the stages of crisis (see Davis, [10] — prelude/warning/impact/inventory/recovery), especially for those crises which can be anticipated: for example, Janis' (27) study of the relationship between pre-operative preparation and anxiety and post-operative adjustment.

However, the general impression is that the various sequential schemes which are offered are merely descriptive conveniences rather than being intrinsic to the concept of crisis; so that reliable categorization of crisis, as opposed to non-crisis situations, is still problematical.

Problems in Usage

1) Subjectivity

Many writers would argue that crisis is an essentially subjective concept because any trivial incident can provoke a crisis if an individual defines it as threatening.

However, a study by Bloom (1) casts doubt on this viewpoint. He attempted to clarify the definition of crisis by studying the nature of agreement between experienced clinicians. Eight experts judged whether fourteen hypothetical case histories constituted crisis situations or not. Two elements were found to be significantly related to a judgement of crisis: a) a known precipitating event, and b) a slow (one to two months) rather than a rapid (one week) resolution. This study implies that behavioural disturbance and a subjective awareness of tension are not fundamental characteristics of crisis. However, Bloom cautions against an oversimplified definition of crisis purely in terms of specific events since there are individual differences in vulnerability to the same event. His study is significant in that it constitutes the only attempt to derive a definition of crisis from an experimental study of its empirical usage.

Darbone points out that certain external events or hazardous situations tend to produce crisis in the majority of cases so that the individual, subjective nature of crisis is not an insoluble problem when studying these types of events. Waldfogel and Gardner's idea (3) of a continuum from externally precipitated to internally precipitated crises could be useful here since the former tend to be universally stressful. Holmes and Rahe (25) find a high degree of consensus amongst both Americans and Japanese as to those events which involve major life changes. If such a consensus exists it should be possible to select empirically some situations which are nearly always crisis-producing, such as the death of a spouse or serious illness.

2) Circularity

Closely related to the above problem is the danger of defining crisis tautologically, in terms of either its outcome or degree of disturbance; although, as already noted, a definition which relies completely on precipitating events is equally unsatisfactory.

To assess the diffuseness or otherwise of the crisis outcome it is necessary to undertake longitudinal studies which consider both healthy and pathological reactions to crisis, plus accidental and developmental crises. This would also help to resolve the stress versus selection debate (12). Thus validation requires the study of cohorts of large numbers of people experiencing the same situation or event. This type of data has not yet been forthcoming and those long-term studies which do exist tend to be rather descriptive (10). Some evidence suggests that only a small percentage of people experiencing a given crisis are left with residual impairments. It is possible that the consequences follow a normal distribution, so that a small number emerge permanently damaged while an equal number emerge strengthened, leaving the majority only temporarily disturbed.

An example of some good longitudinal studies is the series on premature birth by
Caplan, Mason, and Kaplan (6). The mother's immediate reaction and style of coping was classified as 'good' or 'bad', and the eventual mother-child relationship was successfully predicted on this basis. These are the only studies which attempt to test the crisis model by predicting crisis outcome from crisis behaviour, and to abstract meaningful classifications of different types of coping syndromes. But even the authors admit that one cannot tell if the outcome is caused by the coping style or if both are caused by another factor.

3) Personality and past experience versus current life situation and interpersonal relations.

Under the influence of psychoanalytic theory earlier writers attempted to isolate the characteristics of the 'crisis prone' individual analogously to studies of accident proneness and susceptibility to psychosomatic disorders. This view assumes that the individual personality is more important for predicting both the occurrence and outcome of crisis than the current relational milieu. The only relevant studies were of individual cases, until Grinker and Spiegel (20), starting from this vantage point, found that previous experience and personality were poor predictors of coping style. Similarly, Glass and Atriss (18) concluded that crisis behaviour is more influenced by practical circumstances and group support than by individual personality characteristics. Kaplan (28) also emphasizes the importance of current life situation and relationships; and Brown (2) found that the prognosis for schizophrenic patients was more dependent on the social environment of the discharged patient than either the clinical diagnosis or the patient's symptomatic state at discharge.

Two recent sociological studies further demonstrate the importance of situational factors. The first (46) found that team nursing provides a more supportive milieu than functional nursing; so that individual adjustment to the same stressful situation is strongly influenced by the social structure and organizational setting. The second study (29) found significant associations between personal crisis reactions and changes in the social structure of interpersonal relationships. Krause found that the time of greatest anomie and relative deprivation, and hence of crisis proneness, was different for the full-time residents and day clients at a rehabilitation centre.

Yet both these studies assume (rather than test) the idea that situational factors override individual personality differences. There are no systematic studies which attempt to assess the relative importance or weight of individual and situational factors for crisis behaviour. The question which should be posed is 'how much', rather than 'which?' In other words an interactional approach is needed.

Endler and Hunt (13) early concluded that the debate over the relative importance of individual personality versus situations versus mode of response was a pseudo issue. In a series of studies (limited only by a structured questionnaire approach) they examined the contribution of each of these aspects to experienced anxiety and hostility and demonstrated that although each of the three aspects taken singly accounted for only a small portion of the variance, the three taken in pairs and altogether accounted for much of the variance in the subjective state. These studies suggest a manner for handling the mass of data produced by studies such as Parkes advocates. They also suggest a future bridge between the probability model, in which weightings for frequency and implied hazard (based on a general population) might be applied to specific events, situations and modes of response. That is, they suggest a calculus which would at once allow for both the individual experience of the reporting person as well as the weighting factors of hazard and risk probability — the personal idiosyncratic state and the public partially-predictable one.

Responses to the Dilemmas

The foregoing discussion of problems in research usage defines a dilemma limiting both theoretical statements and empirical studies. Our discussion of subjectivity, for
The concept of crisis is often studied in the context of interpersonal relationships and psychological states. However, it is important to consider the role of situational factors in understanding crisis. For example, should have made clear that investigators were holding to a clinical model of crisis which, though it did justice to the patient's (or client's) world, did so at the expense of excluding the field of social and environmental interaction. However, a methodological innovation by Schulberg and Sheldon (44) (investigators associated with Caplan and the Laboratory of Community Psychiatry) offers a suggestion which will overcome the impasse.

A methodological approach consistent with a public health or preventive orientation is advocated by Schulberg and Sheldon (44), who suggest that the major omission in previous crisis theories was the failure to consider associations between risk event and personal reactions, that is the probability that the crisis would arise from the combination of hazardous events and personal vulnerability. They further divide the probability of a crisis event occurring into those which might be anticipated (for the individual or for a population at large), and those for which anticipation was impossible; for the former, high risk groups could be defined and the primary preventive programs attempted, whereas the latter might be approached through emergency helping programs and non-specific methods of strengthening coping style (ego strength).

They adequately stress the distinction between: 1) the probability of hazardous events occurring, and 2) the probability that the event will be hazardous to the individual. This reformulation of the problem results in a hypothetical equation $P = k F x H x V$, in which $P$ is the probability of a crisis response, $F$ is the frequency in the population at risk, $H$ is the hazard implied in the event, and $V$ is the individual's vulnerability.

The research task becomes the working out of indices for each of the three variables so that crisis-proneness may be predicted for subgroups or comparisons made between different population segments. This redefinition of variables in terms of public and experiential frequency vastly extends an earlier formulation of Hill that crisis = events x resources x labelling.

Several empirical investigations allow an approach to the Schulberg and Sheldon probability model. Holmes and Rahe (27) examined a standard list of life events (forty-five events) in terms of the amount of social readjustment which each implies. They showed that a wide range of respondents agree on the amount of social readjustment implied by the specific event which they study. Further, they have shown that the life events, both weighted (by degree of social readjustment) and unweighted, predict physical illness episodes in selected populations but they have not reported frequencies for life events. Myers et al. (33), in a community survey employed an event list of fifty-four items (many of them derived from Holmes and Rahe) to examine the inter-relationship between events, symptomatic disturbance, social role adjustment and dislocation. Similarly, the Yorklea Study is analyzing data on twenty-six to thirty events, interpersonal ties and reliance, the use of informal and formal helping resources and a broader range of respondent mental health parameters than other studies. The two studies have in common a present orientation and an attention to the possibility of identifying high risk groups in terms of events. We have made allowance for subjectivity by allowing respondents to define specific events as 'for better' or 'for worse', so that for each event, for example bereavement, the frequency both for the individual and the household and the 'hazard', retrospectively appraised, can be estimated.

**Conclusion**

The concept of crisis has been reviewed with emphasis on its evolution and empirical attempts to anchor it in both psychological and social situation models. Because of an interest in putting the concept into operation and testing its usefulness for research, particularly for predicting outcome and the vulnerability of individuals and groups, the review has done less than justice to the unifying function of the concept in bringing together several applied disciplines — psychiatry, social work, psychology and...
nursing — as well as to its central role in the emergent theory of community psychiatry. This diffusion stems from the dominant role played by Caplan and the Laboratory of Community Psychiatry at Harvard in the development of community psychiatry and the mental health centres.

With regard to the usefulness of the concept in treatment we must conclude, with Parad (36), that the effectiveness of short-term crisis therapy, though generally optimistic, remains uncertain since: 1) crisis intervention still has not been applied extensively enough to crisis situations (i.e. those defined by external precipitation and short duration), and 2) no adequate comparison between short-term crisis therapy and traditional open-ended therapy has been made. Studies of the effectiveness of crisis intervention contain all the hazards of psychotherapy research generally but because the conditions treated are by definition relatively minor and rapidly changing, the need to control for spontaneous remission is multiplied. This suggests the further need for extensive studies of crises, defined in a variety of ways, in normal populations.

Finally, it should be considered whether the concept of ‘crisis’ has heuristic value either for the understanding of mental disorder or for the design of productive research. A great deal of epidemiological and sociological evidence which has accumulated over the last twenty years (though not necessarily under the rubric ‘crisis’) can be seen; all of which attests to increasing emphasis on the rapidly changing nature of mental disorder and short-term distress states. From the earlier study of Grinker which showed that the majority of stress reactions were of brief duration when extensive support was provided, to Dohrenwend who reformulated the findings of the Stirling County and Midtown studies in terms of transient symptomatic states, to several present studies which examine short-term responses to dramatic life events, there is a shift in research which parallels the shift in clinical emphasis.

However, to the question of the use of crisis in productive research we have con-

cluded that the concept adds nothing to earlier usages, such as stress, coping, response, distress; and our own research practice is to employ these rather than the term ‘crisis’. It would seem that the present ambiguity of the term should be preserved, and that its current usage by clinicians to refer to the whole sequence of occurrences has advantages in emphasizing the uniformity in the total process, but that for research purposes crisis cannot be put into operation except by breaking it into components selected and interrelated to do justice to the global concept.

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