# Crisis dialogue

## Psychiatric emergency,

## psychosis and therapeutic alliance.

This guide is for the use of health professionals. It is designed as a complement to the WHO manual « mhGAP ».

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# Prelude

In psychiatric emergencies, health professionals have a complex task as they meet the patient In case of psychosis, The strangeness of the experience lived by the patient at the height of a crisis sometimes induces behaviour and attitudes which disrupt the possibility of a significant interaction between the two. In the therapeutic process, if the psychotic experience is not comprehensible to the patient, then it is likely that the therapeutic response will seem equally incomprehensible.

People affected by a psychotic decompensation are difficult of access: often found to be fearful, agitated or on the contrary prostrated or even exalted. Any possibility of talk is usually seriously reduced. If it is possible to work through the patients' experience enough so that they worry about what's happening to them, their speech becomes confusing. In return, the patients read our misunderstanding or, even worse, the confirmation that their very words condemn them to the diagnostic sentence : psychotic! This may be a valuable concept in psychopathology, but a mysterious one for the people directly concerned.

In this situation it is necessary to diminish the strangeness of the experience lived by the patient. Outlining a description of their state to which they can relate, reassures them and, in the best cases, highlights elements which can then in turn help them to deconstruct the delirium in their minds or hinder à re-occurence .

Health professionals, faced with a person in a psychotic state, are often impressed and sometimes confused. In return, patients may imagine what is not said aloud: "he is completely crazy, he must be psychotic!" This first impression often has a diagnostic value in itself.

Then the interview often focuses on signs and symptoms which may confirm or invalidate the diagnostic impression made upon first contact.

With experience, health professionals develop a real sense of psychotic states and easily locate diagnostic categories they based upon the symptoms presented to them - without lengthy interviews. They quickly perceive auras as described by the Dutch psychiatrist Rümke the as Praecox Gefühl, a kind of intuitive diagnosis. The symptomatic tools used to asses mental states and make a diagnosis are not questioned, but this essential medical work does not require the patient's account of what has changed in his relationship with others.

It is sometimes difficult to establish a real dialogue. 'Crisis Dialogue' is the name given to a communication technique that facilitates communication and opens the possibility of deconstructing a delusion. This technique was developed with the French psychiatrist Henri Grivois who directed the psychiatric emergencies department of the Hôtel-Dieu hospital in Paris.

Speaking the same language

The Crisis Dialogue begins with a focus on a specific moment in the history of the psychotic patient: the moment the psychotic crisis began. What words could best describe the patient's experience ? What is the minimum agreement the interlocutors require to begin talking? These two questions are the base upon which the Dialogue was established. With them, its purpose is to show the patient that what he is experiencing is not "inhuman", but profoundly humane.

The Dialogue provides an intersubjective space in which the effects of psychosis are able to unfold. If the psychotic patient has an overwhelming idea that something terrible or great is going to happen

the search for clues explaining the exceptional character of the present moment becomes obsessive. Nothing is fortuitous and the moment ibecomes an image of destiny, more and more precise. It must be talked about and the Crisis Dialogue proposes to return closer to normality by remembering the inaugural experience.

The most remarkable thing in this type of interaction is that the patient does not demand help from the professional. Very often, even though he may perceive his own tension and agitation , he attributes it not to a disorder but to an event to occur in the future, of which he will be both actor and privileged witness. The patient does not think in terms of treatment or medicine but intervention of public or spiritual forces. This is far from a typical dialogue where the patient identifies an issue from within and then shares it with the caregiver. The Crisis Dialogue should allow the patient to return to the beginning of the episode, and perhaps identify the inaugural phenomenon that triggered all the trouble in the first place.

The Crisis Dialogue should enable the patient to become aware of what happened between the outbreak of the event to the present, an objective awareness of what sparked this delusional construct -- and ways in which it can be deconstructed.

In this sense the Dialogue becomes a sort of preoperative treatment. The rest will largely be the responsibility of the patient himself, his ability to abandon the secondary benefits of delirium and resume a path of reality normally shared by free and responsible human beings.

# Definition of an acute psychotic state

## Initial approach: Is the patient in acute psychosis?

If several of these symptoms are present, then a psychosis is likely:

- Inconsistent or irrelevant speech
- Delirium
- Hallucinations
- Withdrawal
- Very strange agitations
- Severely disorganised behaviour
- Impression that thoughts are introduced into or emitted from one's brain

If these symptoms appear for

- The first time or
- Have reappeared or
- Are an intensification of pre-existing psychotic symptoms

This is most likely an acute psychotic episode (= acute psychosis) according to the criteria of the World Health Organization (WHO). In this case, a good therapeutic alliance can be facilitated through the Crisis Dialogue.

# How to use the Crisis Dialogue:

The Crisis Dialogue helps to establish a first contact with a patient in acute psychosis and encourages the re-establishment of links with reality.

The Crisis Dialogue is meant to be integrated into normal psychiatric care.

The Crisis Dialogue can be terminated at any time, whenever the health professional realises that the patient is clearly not in acute psychosis. During the discussion it is always favourable to reserve time for short breaks. Even if the patient does not reply to questions, the Crisis Dialogue can still be used, leaving pauses between each sentence. This allows the « mute » patient to take his time, to reply after a few moments of reflection. On the other hand, the monologue should not be feared: even a patient who says nothing is usually listening. Finally, if the patient is logorrheic, one should be interrupted him in order to introduce the Crisis Dialogue. In all these situations the basic attitude is to admit the reality of the patient's living experience.

The aim is to conduct short sessions of Crisis Dialogue (a few minutes) 2 - 3 times a day. Spontaneous remission can occur in the course of a psychotic crisis, and does not mean total recovery. The Crisis Dialogue does not seek to replace usual care but to complement it.

In the remainder of this manual the **phrases in quotation marks (" " ) and in bold** type are given as examples. It is recommended to use them verbatim, as each word has been carefully chosen and assessed (see below for possible elaborations later).

## Starting the discussion

Begin the interview with the patient in the usual manner, by stating your name and position in the facility, asking the reason for the present discussion etc. In case of strong suspicion that the patient is living an acute psychotic episode (see previous page: "Initial approach: is the patient in acute psychosis?"), insist on the patient's attention and start with the first step of Crisis Dialogue, "Approach" .

## Approach

After having obtained the patient's attention, start directly with the sentence "Try to remember when it all began: did you find that you were somehow at the center of the world, in communication with everyone?"

- An alternative :
- *It is really an experience, an event in your life, an experience that people have sometimes, some have already lived through it, some will do so in the future.*

The experience of centrality (considering oneself at the center of the world) is not a symptom for the patient but a real experience. Therefore, all phrases such as "do you feel like ..." "do you believe that ..." etc. should be avoided. At this stage it is necessary to accept the experience as being real and avoid any mention of possible disease.

In the case where the patient expresses a clear “no” or words such as "I am not yet at that point", give him time . After a few hours, reassess the situation and, if the impression of acute psychosis remains, start again with the first question of the Crisis Dialogue("Approach").

## Validate

What the patient is living through is a real experience which could happen to absolutely anyone. This can first be addressed by the phrase "In your place I would feel the same way". This sentence can provide a sense of understanding which will be important for the following care; it insists on our role as a human being, and not only as a professional. Following on with the phrase “what you are going through is important”, can not only give the feeling of understanding, and for the patient of being understood, but also validate the experience as being important and confirming that it will be addressed during later interviews.

- An alternative :
- *When you contact someone else, you are not always sure who started .*
- *In a crowd, in the cinema or in the underground, people send signals; you know that all these signals are for you; that may seem strange but that is the way it is.*

## Say

Following on from the validation of the experience as being lived and, in this sense real, tackle the role of mimicry in the phenomenon of acute psychosis by saying the phrase: “We are all in touch with each other. Sometimes we don’t know who imitates whom, who influences whom“. From infancy we learn through imitating our environment and the people around us. In this tuning and inter-sharing of the understanding of the world, as Minkowski would say, a specific modification of the general structure of subjectivity must be sought as a generating disorder of the psychotic state. Other authors speak of a loss of vital contact with reality, a distortion of the individual's ability to "resonate in agreement with the world".

The end of the phrase ("Saying") addresses the experience of this phenomenon.

On this essential aspect see the chapter on "invariants" below.

## Encourage

The next step in the Crisis Dialogue encourages patients to think of the times when they were not in a state of psychosis and seeks to reassure them. Patients are often frightened and their impression is that something dangerous will happen ; it is for the professional to contain this fear.

On the other hand, patients are sometimes waiting for a grand event where they will play a central part. The sentence beginning with “I don’t think anything important is going to happen” addresses both situations. Then continue with the phrase "Remember, it has not always been this way." Patients know that there have been less intense phases in their lives, where they were ordinary persons.

- Alternatively :
- What has been happening recently is surprising, perhaps frightening, but i think nothing serious is going to happen

## Patient follow up

In the acute phase the Crisis Dialogue helps to initiate patient care. It can facilitate earlier treatment and sometime shorten the acute phase. In addition it can also be used after the patient has left the state of acute psychosis. In this case, the first phase (“Approach”) can be used to detect a possible relapse. However it is important to provide full follow-up care for the patient, with appropriate treatment and, if possible, advanced psychological intervention when needed.

# The science behind the crisis dialogue

The Crisis Dialogue was developed by a team of health professionals in the French-speaking part of Switzerland, the Antenna foundation in Geneva and Professor Henri Grivois in Paris. On the one hand this work is related to Elisabeth Pacherie's theory of agentivity based on observations of disruption in the ability to correctly assign intention during psychotic crises.

On the other, the Crisis Dialogue can be understood on a physiological basis, in particular that of mirror neurons which are activated in the same manner when a person acts or observes action being carried out by others. Salvador paints from this a mimetic and attributional model of the self-agent by combining the mechanical facts of imitation and the tendency to reproduce mental or behavioural activity. This model is derived from the concept of the “social mirror.” In addition, it is also possible that psychosis develops from a superposition of activated cortical areas.

Henri Grivois himself describes psychosis as a "birth into madness". This means that the patient is not necessarily more likely than anyone else to enter acute psychosis but that anyone can enter it at any time. With patients in acute psychosis it has often been observed that they try to explain their inter-individual disorder by projecting this disorder on other people ("It is not me who makes this impression on them so it must come from the others ").

By intervening early, it is possible to create a harmonious therapeutic relationship with the patient. This will facilitate the following phase and as much as possible the deconstruction of delusions.

É. Pacherie « Représentations motrices, imitation et théorie de l’esprit. Le cas de l’autisme », *Subjectivité et conscience d’agir. Approches cognitive et clinique de la psychose,* 1998, 207-243.

L.L. Salvador « La construction mimétique du soi-agent et les phénomènes de schizophrénie débutante », *Annales Médico Psychologiques*, 2008, 166, 620–626

B. Graz, G. Bangerter, A. Stantzos, H. Grivois, «Crisis Dialogue for Acute Psychotic State and Ethical Difficulties: What Do You Do When Trials Are Interrupted Because Clinicians Find the Intervention Too Effective?”, *Ethical Human Psychology and Psychiatry*, Volume 17, Number 1, 2015

**The invariants of psychosis**

Henri Grivois describes three “invariants” of psychosis. These invariants are a synthesis drawn from accounts of patients about the onset of their psychosis:

- **The trouble of mimicry**

Addressing the question: “who is imitating whom?”

Normally, mimicry remains largely unconscious. It represents a fundamental ability to learn and coordinate interpersonal relationships. In a psychotic state, mimicry becomes a conscious and dysfunctional act that leads to the next invariant: subjective indifferentiation.

- **Subjective indifferentiation**

Addressing the question: "Who --me or others -- is at the origin of my thoughts and actions? "

Patients, although aware of their actions, experience having no authority over their actions and ideas. This experience is usually traumatic but sometimes exciting. It comes from the impossibility for the patient to know who triggered their thoughts, they themselves or other people: Hence the disappearance of the subjective differentiation.

- **General concern**

addresses the experience of feeling *" I am at the centre of everyone's attention, everywhere. "*

The patient, invaded by the universal phenomenon of mimicry, feels that all other human beings are in some sort of relationship with him; he has become the centre of attention, the "centre of the world", influenced by and/or influencing everyone else. At that moment, he sees signs confirming this new point of view, often with delusional interpretations which include an exceptional and unique destiny. The specificity of the psychotic experience consists in a concern that affects not only the people aroundthe patient but the whole world.

# Crisis dialogue – a method of communication in cases of acute psychosis

**Start of the conversation**

**Presentation if there is a strong suspicion of psychosis + I would like to tell you something**

During 2 to 3 contacts throughout the day, try Crisis Dialogue.

Become involved with a genuine attitude (continuity, reliability, predictability). Reassure the patient whenever it seems necessary

**Approach**

**"Try to remember when it all began: did you find that you were somehow at the centre of the world, in communication with everyone?"**

Accept that this experience of centrality is not for him/her a symptom but a real experience

The patient answers a frank and clear « No »

Stop the Crisis Dialogue*
Re-evaluate and, if appropriate, try again later

Doubtful « No », with ambiguous attitude

Re-evaluate and, if appropriate, try again later

**Validate**

**« In you're position I would feel the same way»**
**«What you are going through is important »**

The aim here is to explain that it is a known experience, that human beomgs sometimes have – and that it is recognised as of great importance for the patient

**Say**

**«We are all in touch with each other. Sometimes we don't know who imitates whom, who influences whom. »**

This sentence tries to explicit, in a very concise way, the intuition of the universal link between human beings --and addresses the experience of loss of agentivity (of who decides what)

The patient is still in psychosis

**Encourage**

**« I don't think that anything important is going to happen.»**
**«Remember : It hasn't always been like this. »**

The aim here is to reassure the patient and pave the way to de-construct the delusion and distinguish what comes from within and from outside.

The patient no longer finds himself in acute psychosis and shows clear signs of improvement.

Stop the Crisis dialogue and do the following:

Elaborate from the Crisis Dialogue by explaining the concepts behind each phase of the Dialogue to the patient (see the manual) , in ordet to:

-- Work on memories of the onset of psychosis
--Deconstruct delirium/delusions by returning to the experience of centrality as its origin
--Prevent the reconstruction of delirium and ensure future care, if necessary, as soon as possible--Manage the patient in an integrated process (e.g. mhGAP, WHO): medication, rehabilitation in the social environment, follow-up, advanced psychosocial interventions if possible.
--Maintain a realistic and optimistic hope

# Annex

Summary card of the Crisis Dialogue: can be cut up, laminated and kept in your pocket:

PSYCHOSE/SCHIZOPHRÉNIE :

Crisis dialogue memo card– English.

The **“CRISIS DIALOGUE**” -- Talking to a patient with probable acute psychosis.

- **“Try to remember when it all began: did you find that you were somehow at the center of the world, … in contact with everybody?”**

*If the answer is a clear « No », or of the type « I am not at that point … », stop and re-assess later*.

- **“In your place, I would feel the same way. Your experience is real and important.”**

- **“We are all in touch with each other. Sometimes we don’t know who imitates whom, who influences whom.”**

- **“I don’t think that anything important is going to happen.**

**Remember : It hasn’t always been like this.”**

Instructions

- Use CD as soon as possible after having introduced yourself (e.g.: “May I ask you a question?” – then start)
- Read the sentences **“in bold”** exactly as they are. Avoid any expression like "do you have the impression that ... "or "do you believe that...".
- Repeat CD 1-3 times a day, 3 or more days, always shortly after the beginning of the encounter.
- If a patient is logorrhoeic (speaks endlessly), do not hesitate to interrupt him/her.
- If a patient is mute (does not say a word), go through the CD anyway.
- Towards the end of the crisis, CD can be used less frequently and in parts.
- With experience, a more flexible utilisation of CD becomes possible..

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