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 ».

Antenna Foundation, Geneva, 2019
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 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
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 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).

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.

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”.
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.

**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.


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 around the 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.

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 »

**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 »

**Validate**

« In your're position I would feel the same way»

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

Doubtful « No », with ambiguous attitude

**Say**

«What you are going through is important »

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)

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

The patient is still in psychosis

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

**Encourage**

« I don’t think that anything important is going to happen.»

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

«Remember : It hasn’t always been like this. »

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 order 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:

<table>
<thead>
<tr>
<th>PSYCHOSE/SCHIZOPHRENIE</th>
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</thead>
<tbody>
<tr>
<td>Crisis dialogue memo card – English.</td>
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<tr>
<td>The “CRISIS DIALOGUE” -- Talking to a patient with probable acute psychosis.</td>
</tr>
<tr>
<td><strong>“Try to remember when it all began: did you find that you were somehow at the center of the world, ... in contact with everybody?”</strong></td>
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<tr>
<td>If the answer is a clear “No”, or of the type “I am not at that point ...”, stop and re-assess later.</td>
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<tr>
<td><strong>“In your place, I would feel the same way. Your experience is real and important.”</strong></td>
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<tr>
<td><strong>“We are all in touch with each other. Sometimes we don’t know who imitates whom, who influences whom.”</strong></td>
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<tr>
<td><strong>“I don’t think that anything important is going to happen. Remember: It hasn’t always been like this.”</strong></td>
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**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...

(Prepared by Antenna/mental health-Geneva, JADE/HUG; Hecvsanté & HEdS la Source, Lausanne, Switzerland)