Open Trial on Crisis Psychotherapy in Padova, Italy

L. Pavan, MD, E. Fusco, MD, F. Gambaro, MD, S. Granà, MD, M. Marini, MSc, W. Padoani, MD, C. Piovan, MD, and M. Semenzin, MD

Crisis psychotherapy is addressed to patients with feelings of impotence: a precise psychological correlate characteristic of the crisis situation. Associated with this picture are anxious-depressive and personality disorders. Prevention focuses on recovering previous level of functioning in order to forestall the evolution of maladaptive behaviors that may in turn lead to chronic pathology or suicide. The aim of this study was to preliminarily assess symptom outcome in 42 cases treated with the model adopted in Padua, Italy. Assessment was based on various instruments to explore depression (Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HRSD]), anxiety (State-Trait Anxiety Expression Inventory [STAI]), anger (State-Trait Anger Expression Inventory [STAXI]), global functioning (Global Assessment Scale [GAS]), social adjustment (Social Adaption Self Evaluation Scale [SASS]), stressful events, and personality (Structured Clinical Interview for DSM-IV [SCID II]). Depression and anxiety levels displayed a significant decrease at the end of treatment. There was also a significant reduction in levels of trait anxiety and anger, probably indicating a "return to baseline" after a destabilizing experience. These effects mark a "traumatic" impasse resulting from stressful life events that may be either real external events or subjectively traumatic psychological events. Other positive effects of the therapy were improvement in global functioning and renewed interest in social relations. Some degree of comorbidity with personality disorders emerged, especially from *DSM-IV* clusters C and B. Further controlled studies are warranted to assess the effect of spontaneous remission on this intervention technique. [*Brief Treatment and Crisis Intervention* 3:37–46 (2003)]

KEY WORDS: crisis, brief psychotherapy, efficacy, suicide.

The tradition of crisis psychotherapy began with the work of Lindemann (1944), who described intervention in cases of "acute mental pain" associated with grief and traumatic events, stemming from anxious-depressive spectrum disorders. Another theoretical-conceptual development in crisis intervention was proposed by Caplan (1961) through identification of the characteristic stages in the crisis experience, the approach to the treatment of acute psychiatric episodes, and reappraisal of intrapsychic aspects of the events.

The concept of crisis has been handed down through the mental health reforms introduced

across Western society, with their alternating goals of prevention or avoidance of patient hospitalization. One result has been a rather unclear overlap in specific intervention types such as urgency, emergency, and crisis itself (Asioli, 1984). Various authors have thus sought to explore the term's affinity with the psychotherapeutic approach within an applied medical setting (Andreoli, Lalive, & Garrone, 1986; Rossi, Mauzio, & Scarsi, 1985).

In psychotherapy, the concept of crisis has been widely used in time-limited approaches. Of the psychodynamically oriented authors, Flegenheimer (1978, 1982) helped to make a distinction between brief psychotherapy and crisis intervention, highlighting how feelings of impotence characterize crisis situations and developing treatment guidelines that have inspired the model applied by our group.

Specifically, crisis intervention consists of applying techniques drawn from Caplan's theory, which are conducted by specially trained professionals with a view to helping individuals modify states of mind, feelings, symptoms, or behaviors deemed maladaptive and leading them to seek help. In this respect, crisis intervention requires a relatively well-planned, structured client-therapist liaison, in which both are aware of and agree on the nature and therapeutic goals of their relationship (Pavan & Banon, 1999).

In recent years, there has been growing interest in crisis intervention (Reisch, Schlatter, & Tschacher, 1999), partly in response to the reduction in psychiatric beds and the consequent development of differentiated crisis intervention models (Dauwalder & Ciompi, 1995). Additionally, the need to estimate the cost-benefit ratios of intervention in relation to public health resource reorganization has stimulated research into the efficacy of psychotherapeutic treatments. The bulk of the literature on psychotherapy research refers to behavioral-cognitive and interpersonal approaches (Elkin et al., 1989; Frank et al., 1990; Frank, Kupfer, Wagner, McEachran, & Cornes, 1991; Hollon et al., 1992; Friedli, King, Lloyd, & Horder, 1997; Scott, Tacchi, Jones, & Scott, 1997). Conversely, only a few studies have compared the efficacy of specific forms of crisis intervention with conventional treatments (van der Sande et al., 1997).

Below is a presentation of the preliminary results of a study to assess the efficacy of emotional crisis intervention at the Department of Clinical Psychiatry in Padua.

Materials and Methods

Recruitment and Description of the Sample

The subjects were consecutively recruited from the patients attending the Crisis Psychotherapy outpatient center of the Department of Clinical Psychiatry of Padua University, Italy, between February 2001 and December 2001.

Fifty-five patients (14 males and 41 females) were evaluated in the first three assessment sessions. Three subjects were excluded, as their diagnoses did not correspond to Crisis Psychotherapy inclusion criteria, and three declined to take part. Hence, 49 subjects were actually included in the sample, but seven then dropped out before the end of treatment. Therefore, 42 of the subjects included in the study concluded treatment (10 males and 32 females),

From the Institute of Clinical Psychiatry, Department of Neurological and Psychiatric Sciences at the University of Padua.

Contact author: Luigi Pavan, MD, Dipartimento di Scienze Neurologiche e Psichiatriche, Università degli Studi di Padova, Via Giustiniani 5, 35128 Padova, Italia. E-mail crisi.studenti@unipd.it.

with a mean age of 30.9 years (SD = 9; range 17–58).

Most subjects had never been married (42.8%, n = 18) or were married (42.8%, n = 18), while the separated or divorced represented 14.2% (n = 6). Regarding educational qualifications, 47.6% had a senior high school diploma; fewer subjects were graduates (23.8%, n = 10), or had a junior high school (21.4%, n = 9) or primary school diploma (7.1%, n = 3); 54.7% (n = 23) reported having paid employment, while 23.8% (n = 10), were unemployed and 21.4% (n = 9) were economically inactive. Those living with others prevailed over subjects living alone and represented 88% (n = 37) of the total sample.

Referral sources were general practitioners (N = 15), emergency-room psychiatrists (N = 13), other community mental health facilities (N = 10), or direct contact by patients (N = 4).

The most frequently encountered diagnoses, according to *DSM-IV* criteria and formulated by psychiatrists during clinical consultation, were adjustment disorders (N = 17; 41.8%), especially with depressed mood; anxiety disorders (N = 14; 32.5%), particularly panic attack disorder, acute stress disorder and generalized anxiety disorder; and mood disorders (N = 11; 25.5%). Four subjects (9.5%) had attempted suicide by drug overdose.

Some subjects attending our outpatient service were already on medication (N = 13; 32.3%), particularly anxiolytics and antidepressants, with a mean treatment time of 1.3 weeks (SD 3.9; range: 1–24). Others were prescribed medication after the first three sessions (N = 10; 23.8%). Hence the total number of cases treated with anxiolytic or antidepressant medication in association with crisis treatment was n = 23 (54.7%).

The five therapists taking part in the research had regular individual supervision, after a previous year of specific training. They were three female and two male residents in psychiatry (mean age 29.2; SD = 0.83).

Crisis Intervention in Padua

Inclusion Criteria. The crisis intervention model adopted by the Department of Clinical Psychiatry of Padua University (Pavan & Banon, 1992, 1996) is primarily addressed to young adults experiencing an emotional crisis, often with an initial diagnosis of a mood or anxiety disorder who have not been under psychiatric supervision in the preceding 2 years and are capable of urgently seeking help.

Exclusion Criteria. Subjects with diagnoses of schizophrenia or other psychotic disorders and those with a psychiatric pathology demanding immediate hospitalization are excluded from treatment. Other exclusion criteria are the presence of severe, chronic, or debilitating physical illnesses, the dementias, and psychiatric disorders associated with a general medical condition.

Intervention. Intervention consists of 10 sessions, each lasting 45–50 minutes. The first three sessions serve to assess the patient, after which psychotherapy is prescribed or the patient is referred to the pertinent community mental health facility.

Intervention times are very rapid and there is practically no waiting list. Patients access primary evaluation within a week of initial contact. Treatment is in the outpatient setting, almost always on a weekly basis, but may in cases be increased according to circumstances and, in certain cases, where resources are not immediately available to users, it may be repeated. All cases presented in this study were treated over 10 sessions, including the first three clinical assessment sessions and excluding the ones in which the test batteries were administered.

Technique. Treatment is similar to a brief supportive psychotherapy whose goal is to help patients reestablish previous functioning level. The technique, which is eclectic with strong pedagogic orientation, uses rational and critical potentialities but also involves exploration and recognition of emotions, seeking any relationships between external and internal events, and encouraging patients to work through and reappraise own personal history. Interpretation and transference development are generally avoided, although the latter may be used in the relationship in some cases. Generally speaking, intervention is based on the following guidelines:

1. Containing feelings of impotence.
2. Helping maintain the boundaries to the inner/outer world.
3. Promoting object reintroduction and tolerating ambivalence.
4. Historicizing the event's fantasmatic dimension, using transference and helping the foreconscious to emerge.
5. Fostering the controlled experience of pain and depression.

At the end of therapy, patients may be referred for a course of longer-term psychotherapy where such requests emerge or develop during crisis intervention. Medication may also be prescribed, where necessary.

Assessment

During the first session, patients agreeing to take part in the study were administered the self-report questionnaires, including the Beck Depression Inventory 21-item (BDI; Beck, Ward, Mendelson, Moch, & Erbauch, 1961), the State-Trait Anxiety Inventory (STAI; Spielberger, 1970), the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988), and the Social Adaptation Self-Evaluation Scale (SASS; Bosc, 1997).

In the period between the first and third clinical session, patients were referred for diagnostic evaluation by an independent rater (clinical psychologist or trainee psychiatrist) with the aid of SCID II-version 2.0 based on *DSM-IV* criteria (Maffei et al., 1997), the Hamilton Depression Rating Scale 21-item (HDRS; Hamilton, 1960) and the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976), based on the Italian edition of *DSM-IV* (APA, 1994). The effect of stressful life events was also assessed according to the areas described by Paykel, Prusoff, and Uhlenhuth (1971; Fava and Osti, 1981).

All tests, except SCID II, were redone straight after the tenth session (posttest). HDRS and GAS were also administered at the same time by the therapist.

Statistical Analysis

Covariance analysis was used to assess the outcome of the scales, with alpha set at .05 and the baseline scores (pretest) set as the covariant (Kazdin, Bass, Siegel, & Thomas, 1989; Lambert & Hill, 1994). Standard distribution was controlled by the Kolmogorov-Smirnov test. Effect size was taken as the ratio between the difference in pre- and posttreatment means and the pooled standard deviations of pre- and postmeasurement.

Results

No statistically significant differences were found between the sociodemographic variables of included and excluded test subjects.

Results indicated a significant decrease in scores on the scales to assess depression (Table 1). A significant reduction was also displayed for anxiety as the STAI-State scale ($p < .0001$; ES = 1.1). Trait anxiety was found to have significantly fallen and to present a lower effect size ($p < .002$; ES = 0.62).

TABLE 1. Case Comparison in Relation to Scales, Prevalues, and Postvalues

	Prevalues (Week 0)[a]		Postvalues (Week 10)[a]				
Measure	**Mean**	***SD***	**Mean**	***SD***	***F***	***p***	**ES**
Self-rated							
BDI	20.10	12.63	9.59	7.93	22.1	.0001	1.02
STAI/state	54.64	13.32	41.38	10.69	17.7	.0001	1.10
STAI/trait	51.89	12.84	44.47	10.75	11.6	.002	0.62
STAXI/state	14.44	5.17	11.56	2.64	8.5	.006	0.73
STAXI/trait	20.85	6.62	17.94	5.35	36.5	.0001	0.48
SASS[b]	38.86	5.79	43.00	6.75	36.7	.0001	0.66
Rated by independent evaluator							
HDRS	16.18	6.25	6.85	4.41	6.6	.01	1.75
GAS[b]	66.90	8.05	80.90	8.99	4.3	.05	1.64

Note. Alpha set at .05.

[a]N = 42.

[b]Positive scales: An increase in score denotes an improvement in the scale.

A similar result was obtained on the STAXI (anger) scale, where there was a higher reduction in STAXI-State ($p < .006$; ES = 0.73) and a lower difference in STAXI-Trait scores ($p < .0001$; ES = 0.48). Generally, the GAS global functioning level displayed improvement with an increase in the mean score from 67.71 ($SD = 8.03$) to 81.86 ($SD = 5.79$) and an ES of 1.64.

A positive increase was also displayed on the Social Adaptation Self Evaluation Scale ($p < .0001$; ES = 0.66).

Baseline personality status (SCIC II, *DSM-IV*) indicated that 51.2% ($n = 22$) of cases presented at least one personality disorder. The most representative disorders were depressive (20.9%; $n = 9$), obsessive-compulsive (18.6; $n = 8$), and borderline (16.3%, $n = 7$) disorders. Avoidant, dependent, and schizotypal personality disorders each represented 9.3% ($n = 4$) of the sample (Figure 1).

More than one Axis II diagnosis was often present: 23% ($n = 10$) presented one diagnosis; 16.3% ($n = 7$) presented two; 4.7% ($n = 2$) presented three, and three cases (7%) presented four diagnoses. Distribution by cluster showed a prevalence of Cluster C and Cluster B disorders (Figure 1).

In the rater-administered scales (HDRS and GAS), interrater reliability, based on comparison of judgements by testers and therapists, was $\alpha = .70$ and .73.

Stressful life events were assessed according to Paykel et al.'s (1971) areas. The most representative areas were bereavement, $n = 15$ (35%); romance/love life, $n = 13$ (30%); family-married life, $n = 5$ (11.9%); followed by work, health, and education, with 0.7%, $n = 3$.

Discussion

Our results seem to confirm the association between crisis and symptoms of anxiety-depression. Comparison of baseline and endpoint scores on the BDI and HDRS scales suggests an improvement in depressive symptoms. It should be stressed that while effect size may be equal, different treatments may differ so much in type and characteristics as to preclude comparison. Our intervention protocol lasts longer than studies that envisage brief hospitalization and the latter patients may also be more severe. Furthermore, effect size also depends on psychopathological severity such that more

severe patients have a higher probability of improving (Lambert & Hill, 1994; Mintz & Kiesler, 1982). A perceptible improvement was also exhibited on the GAS, whose mean moved from the center of the 7th level at baseline to the boundary between the 8th and 9th level in the final test.

High pathological levels were found on both the STAI-S and STAI-T scales (pretest) (Spielberger, 1996). The same applied to anger (STAXI-S; STAXI-T), although deviation from standard Italian values was lower (Spielberger, 1992).

Traits should in fact be rather stable (Spielberger, 1983). In our study, endpoint trait anxiety and anger fell significantly. This result may hypothetically be attributable to generalized distress at baseline, emphasizing how the crisis situation may have a destabilizing effect on self-perception, in association with particularly stressful events, depression and severity of illness (Kennedy, Schwab, & Hyde, 2001; Kennedy, Schwab, Morns, & Beldia, 2001; van der Ent, Smorenburg, & Bonke, 1987). This outcome may depend on (internal-external) traumatic

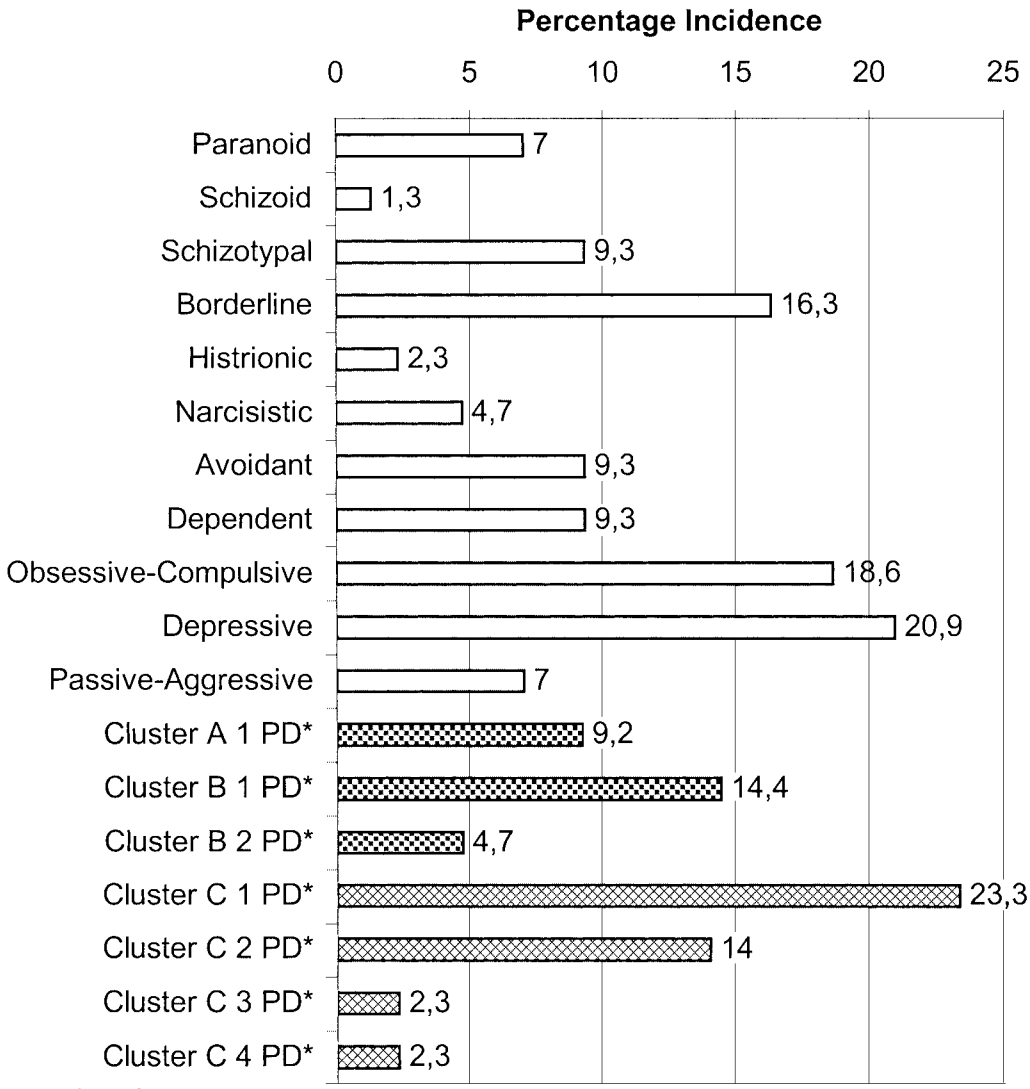

FIGURE 1
Percentage incidence in cases (N = 22) with personality disorder.
*One or more personality disorders by Cluster A, B, and C.

events whose severity depends in turn on the vulnerability of each subject, suggesting that crisis situations may be characterized by a subjectively destabilizing traumatic event. One important limit to this hypothesis is that subjects' precrisis status is not known and our study does not currently assess index stabilization at follow-up. It would in fact be worth examining whether subjects experiencing potentially dangerous crises are also prone to high anxiety and anger trait levels in conditions of higher stability. General personality status may have a key role in this respect.

Disturbed personality seems to be implicated in our sample, particularly "anxious" Cluster C disorders, which are often comorbid with Cluster B and to a lesser extent with Cluster A disorders. Caution is clearly needed in assessing these data since personological status prior to crisis onset is not known and reassessment is not envisaged at the end of treatment. At the end of intervention, symptoms of anxiety, depression, and anger returned to standard levels, although some subjects still presented residual symptoms. These confirm the results of other researchers (Dazord, Gerin, Reith, Iahns, & Andreoli, 1992; Möller, 1992; Reisch et al., 1999) and broach the problem of aftercare.

Some authors (Andreoli & Bonatti, 1992; Andreoli et al., 1986) emphasize how crisis-intervention patients are often severe and resistant to therapy and in some cases have previous experience of treatment and many relapses. Our intervention does not, however, restrict its objectives to symptom remission; rather, it seeks to obtain active patient cooperation through more effective negotiation of long-term treatment.

Conducting intervention in an outpatient setting means that the patient's drug regimen can, where necessary, be followed up over time by a specialist other than the therapist and helps promote transfer to local mental health facilities as part of a single ongoing program. In this case it may be worth taking advantage of psychotherapy-related compliance to renegotiate a long-term program with patients at high risk of relapse. In some cases, intervention can be repeated (Bloom, 2001); in others, a single cycle of therapy may encourage patients to seek longer-term psychotherapy.

While the crisis as described by Erikson (1959, 1968) potentially fosters growth, it is equally important to stress the risks related to a traumatic outcome. If the patient adopts maladaptive reactions, the pain may intensify, bringing about regressive decline potentially conducive to psychiatric symptoms, whose most catastrophic outcome is suicide (Kaplan, Sadock, & Grebb, 1997). The aim of our intervention is thus to support patients and promote recovery of "possible normal functioning" level by working through personal (in some cases painful) experience and fostering complementary continuity in both the therapeutic setting and own psychosocial milieu. Results showed moderate reactivation of social relations as per the SASS scale (ES = 0.66). It remains to be seen whether this is the cause or effect of symptom reduction and how far it is associated with the treatment or if it simply depends on spontaneous remission. The main limit to our study is the absence of a comparative control group and longitudinal assessment to evaluate long-term effects. Further controlled studies are therefore warranted to answer these questions, without which our results cannot be considered final.

Conclusion

Our study's preliminary results exhibit a pronounced reduction in symptoms. Other randomized studies are warranted to clarify the spontaneous effect of this remission and to assess the specific effect of the psychotherapy.

One of the difficulties in studying crisis intervention outcome is that symptoms are expressed very differently from one subject to the next,

depending on diagnostic picture. Different personality statuses may also be associated with various types of stressors, with a broad range of subjective responses. Available resources in terms of family or social support may also vary. This may lead to variance within the sample, precluding direct comparison with forms of structured psychotherapies in specific diagnostic clusters. Nonetheless, in the emotional crisis situation, apparently different clinical pictures all possess a very similar psychological correlate, characterized by a diffuse sense of impotence and an awareness that adequate coping strategies are lacking (Pavan & Banon, 1996). It is for this very reason that crisis intervention takes a rather eclectic form, focusing on the subjective, and in some respects universal, nature of the crisis experience, based on the array of symptomatological pictures and defensive styles that develop along the external event/internal event-personality-resource-distress axis. Accordingly, intervention rapidity becomes paramount and may sometimes avoid hospital admission or prevent maladaptive strategies from worsening.

Acknowledgment

The authors would like to thank Joanne Fleming for her help with the manuscript.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders.* (4th ed.). Washington, DC: Author.

Andreoli, A., & Bonatti, R. (1992). Intervento di crisi e trattamento combinato della depressione (Crisis intervention and combined treatment of depression). *Tribuna Medica Ticinese, 57,* 98–105.

Andreoli, A., Lalive, J., & Garrone, G. (1986). *Crise ed intervention de crise en psichiatrie* (Crisis and crisis intervention in psychiatry). Lyon: Simep.

Asioli, F. (1984). *Le emergenze in psichiatria* (The emergency in psychiatry). Roma: Il Pensiero Scientifico.

Beck, A. T., Ward, C. H., Mendelson, M., Moch, J., & Erbauch, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4,* 561–571.

Bloom, B. L. (2001). Planned short-term psychotherapy for depression: Recent controlled outcome studies. *Brief Treatment and Crisis Intervention, 1,* 169–189.

Bosc, M. (1997). Social Adaptation Self-Evaluation Scale. *European Neuropsychopharmacolgy, 7,* 57–70.

Caplan, G. (1961). *An approach to community mental health*. New York: Grune and Stratton.

Dauwalder, J. P., & Ciompi, L. (1995). Cost effectiveness over 10 years: A study of community-based social psychiatry in the 1980s. *Social Psychiatry and Psychiatric Epidemiology, 30,* 171–184.

Dazord, A., Gerin, P., Reith, B., Iahns, J. F., & Andreoli, A. (1992). Intervention de crise: Processus de focalisation et évolutions à long terme des patients (Crisis intervention: Process of focusing and long-term evolutions of the patients). *L'Encéphale, 28,* 639–645.

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., Glass, D. R., Pilkonis, P. A., Leber, W. R., Docherty, J. P., Fiester, S. J., & Parloff, M. B. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatment. *Archives of General Psychiatry, 40,* 971–982.

Endicott, J., Spitzer, R., Fleiss, J., & Cohen, J. (1976). The Global Assessment Scale. *Archives of General Psychiatry, 33,* 766–771.

Erikson, E. (1959). Identity and the life cycle. *Psychological Issues, 1,* 1–171.

Erikson, E. (1968). *Identity: Youth and crisis.* New York: Norton.

Fava, G. A., & Osti, R. M. A. (1981). *Versione italiana della scala di Paykel per gli eventi stressanti* (Italian version of the Paykel scale for stressful events). Florence, Italy: Organizzazioni Speciali.

Flegenheimer, W. M. (1978). The patient-therapist relationship in crisis intervention. *Journal of Clinical Psychiatry, 39,* 348–350.

Flegenheimer, W. M. (1982). *Techniques of brief psychotherapy.* New York: Grune and Stratton.

Frank, E., Kupfer, D. J., Perel, J. M., Cornes, C., Jarrett, D. B., Mallinger, A. G., Thase, M. E., McEachran, A. B., & Grochocinski, V. J. (1990). Three year outcomes for maintenance therapies in recurrent depression. *Archives of General Psychiatry, 47,* 1093–1099.

Frank, E., Kupfer, D. J., Wagner, E. F., McEachran, A. B., & Cornes, C. (1991). Efficacy of interpersonal psychotherapy as a maintenance treatment of recurrent depression: Contributing factors. *Archives of General Psychiatry, 48,* 1053–1059.

Friedli, K., King, M. B., Lloyd, M., & Horder, J. (1997). Randomised controlled assessment of non-directive psychotherapy versus routine general practitioner care. *The Lancet, 350,* 1662–1665.

Hamilton, M. A. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry, 23,* 56–62.

Hollon, S. D., DeRubeis, R. J., Evans, M. D., Wiemer, M. J., Garvey, M. J., Grove, W. M., & Tuason, V. B. (1992). Cognitive therapy and pharmacotherapy for depression: Singly or in combination. *Archives of General Psychiatry, 49,* 774–781.

Kaplan, H. I., Sadock, B. J., & Grebb, J. A. (1997). Brief psychotherapy and crisis intervention. In H. I. Kaplan, B. J. Sadock, & J. A. Grebb (Eds.), *Kaplan and Sadock's synopsis of psychiatry; behavioral sciences, clinical psychiatry* (pp. 833–837). Baltimore: Williams & Wilkins.

Kazdin, A. E., Bass, D., Siegel, T., & Thomas, C. (1989). Cognitive-behavioural therapy and relationship therapy in treatment of children referred for anti-social behaviour. *Journal of Consulting and Clinical Psychology, 57,* 522–535.

Kennedy, B. L., Schwab, J. J., & Hyde, J. A. (2001). Defense styles and personality dimension of research subjects with anxiety and depressive disorders. *The Psychiatric Quarterly, 72,* 251–262.

Kennedy, B. L., Schwab, J. J., Morris, R. L., & Beldia, G. (2001). Assessment of state and trait anxiety in subjects with anxiety and depressive disorders. *The Psychiatric Quarterly, 72,* 236–276.

Lambert, M. J., & Hill, C. E. (1994). Assesing psychotherapy outcomes and processes. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (pp. 72–113). New York: Wiley.

Lindemann, E. (1944). Symptomatology and managment of acute grief. *American Journal of Psychiatry, 101,* 141–148.

Maffei, C., Fossati, A., Agostoni, I., Barraco, A., Bagnato, M., et al. (1997). Interrater reliability and internal consistency of the Structured Clinical Interview for DSM IV Axis II Personality Disorders (SCID II), Version 2.0. *Journal of Personality Disorders, 11,* 279–284.

Mintz, J., & Kiesler, D. J. (1982). Individualized measures of psychotherapy outcome. In P. C. Kendall & J. N. Butcher (Eds.), *Handbook of research methods in clinical psychology* (pp. 491–534). New York: Wiley.

Möller, H. J. (1992). Attempted suicide: Efficacy of different aftercare strategies. *International Clinical Psychopharmacology, 6,* 58–69.

Pavan, L., & Banon, D. (1992). *L'intervento psicoterapico nelle situazioni di crisi* (Psychotherapy intervention in crisis situations). Padova, Italy: Kendall.

Pavan, L., & Banon, D. (1996). *Trauma vulnerabilità, crisi emozionale (l'intervento di crisi come psicoterapia breve di sostegno)* [Trauma vulnerability, emotional crisis (crisis intervention as brief supportive psychotherapy)]. Torino, Italy: Bollati Boringhieri.

Pavan, L., & Banon, D. (1999). Intervento di crisi come psicoterapia breve di sostegno (Crisis interventions as brief sustained psychotherapy). In G. B. Cassano, P. Pancheri, L. Pavan, A. Pazzagli, L. Ravizza, R. Rossi, E. Smeraldi, & V. Volterra, (Eds.), *Trattato Italiano di psichiatria* (Italian psychiatric treatment) (pp. 3629–3635). Milan, Italy: Masson.

Paykel, E. S., Prusoff, B. A., & Uhlenhuth, E. H. (1971). Scaling of life events. *Archives of General Psychiatry, 25,* 340.

Reisch, T., Schlatter, P., & Tschacher, W. (1999). Efficacy of crisis intervention. *Crisis, 20,* 78–85.

Rossi, R., Mauzio, M., & Scarsi, F. J. (1985). Percezione psicanalitica della crisi (Psychoanalytic perception of the crisis). In M. Casacchia (Ed.), *Urgenze in psichiatria* (pp. 345–389). Milan, Italy: Masson.

Scott, C., Tacchi, M. J., Jones, R., & Scott, J. (1997). Acute and one year outcome of a randomised controlled trial of brief cognitive therapy for major depressive disorder in primary care. *British Journal of Psychiatry, 171*, 131–134.

Spielberger, C. D. (1983). *State-Trait Anxiety Inventory. A comprehensive bibliography*. Palo Alto, CA: Consulting Psychologists Press.

Spielberger, C. D. (1988). *State-Trait Anger Expression Inventory (S.T.A.X.I.). Professional Manual*. New York: Psychological Assessment Resources.

Spielberger, C. D. (1992). *STAXI, State-Trait Anger Expression Inventory*. Adattamento Italiano a cura di A. L. Comunian. Florence, Italy: Organizzazioni Speciali.

Spielberger, C. D. (1996). *State-Trait Anxiety Inventory, Y form*. Adattamento Italiano a cura di L. Pedrabissi., & M. Santinello. Florence, Italy: Organizzazioni Speciali.

Spielberger, C. D., Gorsuch, R. L., Luchene, R., Vagg, P. R., & Jacobs, G. H. (1970). *Manual of the State-Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.

van der Ent, C. K., Smorenburg, J. M., & Bonke, B. (1987). The stability of the A-Trait subscale of the STAI for stress and passage of time. *Journal of Clinical Psychology, 4,* 379–385.

van der Sande, R., van Rooijen, L., Buskens, E., Allart, E., Hawton, K., et al. (1997). Intensive in-patient and community intervention versus routine care
after attempted suicide: a randomized controlled intervention study. *British Journal of Psychiatry, 171,* 35–41.