

CRITICAL INCIDENTS

My overarching framework for work in therapy can be expressed in the following form. Consider an individual's reaction to an event along perceptual, affective, cognitive, and behavioral dimensions. While any sequence is possible, e.g. affect may register before or after behavior, I want to limit the discussion to reactions that lead with perception and culminate in behaviors. Affect and cognition, i.e. assumptions, bridge the gap between them. I also want to limit the discussion to one cycle reactions, so we will ignore behavior as an initiating event for another perceptual response.

Consider an individual's reaction to an event as *closed* if it is characterized by all of the following: (1) it is perceived idiosyncratically as highly charged, e.g. threatening; (2) it generates affect too overwhelming to experience directly; (3) it triggers tacit assumptions about how to proceed that typically reflect unresolved childhood issues and; (4) it leads to constrained behaviors, i.e. the perception of no choice in how to act. I suggest that often clients go to therapy because they encounter too many events initiating closed reactions for which their affect is negative and for which their resulting automatic behavior gets them in trouble. They tend to be out of touch with the intervening tacit assumptions that complete a closed system.

A classic example of the impact of such assumptions is the macho "insult-insult back with escalation" cycle where the individuals involved focus solely on the initiating event as a threat and on their subsequent "no choice" response. Deviating from the closed system is seen as weak and cowardly rather than a sign of enlightenment, creativity, and growth. (True cowardice, on the other hand, is just as automatic a response as fighting back – so-called flight or fight – as opposed to suddenly seeing choices along the way and in one's ultimate actions).

Most therapies in one way or another attempt to increase an individual's openness. Again focusing on the four dimensions, they strive to reduce the power of events to be perceived as threatening. And even when perception of the event is initially stressful, they strive to help the client learn to tolerate, experience, and "own" charged negative affect, and to surface and then test heretofore tacit and conclusive assumptions. They also want clients to have behavioral choice, in part the result of the liberation from the previously binding beliefs.

This is a process of self-transformation. Different schools of thought have different protocols to enact this. In fact, therapists tend to label themselves as

though wearing badges that announce such an affiliation, be it Adlerian, Freudian, Jungian, Rogerian, etc.

On the other hand, the use of **critical incidents** to effect such transformations transcends any particular school of therapeutic thought; in fact, it transcends therapy altogether. The remainder of this brief essay will demonstrate this by first defining critical incident transformations using the four dimensional model and then offering examples both in treatment contexts and outside them.

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A critical incident is said to occur when an individual's response to a specific event is altered in one of the four dimensions in such a way as to reverberate throughout the other three, resulting in a quantum, robust systems change. While such happenings are relatively rare and defy planning, there are ways to induce them. It could be as simple as a directive from a therapist, or even a friend. Using an example from the 60s' transactional analysis: "don't say 'yes, but' when I offer you a suggestion to a problem you brought to me." In one instance, a young woman started to respond to that directive with her automatic "yes-but"; she caught herself in the middle, started to laugh, then cry. Eventually, she came up with significant insights into her favorite automatic behavior, i.e. the request for and immediate denial of any and all advice. The break in the behavioral dimension carried with it powerful affective and cognitive changes as she felt the frustration for her perceived plight in life and understood the way she had been unconsciously setting friends and counselors to fail – so she could then give the tacit message that she had been a victim all her life.

In this case of 'yes-but', the spontaneous eruption of emotion derived from the young woman seeing the falseness and futility of this pattern ruled by a set of assumptions that were no longer useful even though they had served her earlier in life. She had idiosyncratically perceived helping attempts as threats and insults, without realizing it.

The value of critical incidents is that just one can help a client turn the corner and make a quantum leap in his or her treatment. Some clients who undergo this experience report that for the first time they really had a feel for the therapy process. More specifically, others report that for the offending event, they were able to deal with it realistically and openly from then on, in particular on a behavioral level. A metaphor: they had been driving down a highway and acted as if once on it, they had to go all the way to the end, from A to Z; now, they realized there were side roads that they could access if needed and just go from A to B.

Stages involved in the process of critical incident transformation might be framed as follows: (1) information; (2) identification; (3) intervention; and (4) internalization. By “information,” I mean understanding some of the issues that call for change/growth (e.g., the concept of acting out) and having some sense on a cognitive level of the processes involved. By “identification,” I mean recognizing how they apply on an individual level (this is how I act out, for example). By “intervention,” I mean allowing someone else (or even oneself) to design an implementable shift in the behavioral or perceptual dimensions (e.g., don’t say “yes-but”). By “internalization,” I mean being able to recognize and choose when to make the shift on one’s own, so that eventually it represents one’s new “standard reaction.” We could rephrase as “knowing people have problems”; “knowing I have a problem and what it is”; “experiencing that problem in context and seeing a fork in the road”; “following the other fork.”

Not all critical incidents are initiated by a change in focus (perceptual) or a change in behavior. Sometimes, a spontaneous emotional outburst or a sudden realization leads the way. The key for both client and therapist – if the event occurs in treatment – to recognize these opportunities and capitalize on them.

EXAMPLE ONE: A couple in therapy was stuck in a pattern of blame, each seeking the therapist’s approval. They were also sitting on feelings of anger and hurt, but were saddled with assumptions that inhibited the direct expression of these emotions. One day, Donald, the therapist, suggested an experiment to Alan, the husband. Donald would chat with Mary, the wife, exclusively for five minutes, with Alan situated in a chair at the other end of the rather large treatment room. After the designated time, Donald asked Alan, who typically intellectualized his feelings, what he was experiencing. No sooner had Alan remarked, “I felt really excluded,” that tears rolled down his face and then he began sobbing, continuing for 20 minutes or so. Donald probed further and helped Alan get in touch with feelings of parental abandonment at the age of 3 (his mother had been heavily involved in the care of a sick relative for almost a year, coming home late each day, exhausted).

Alan was quite animated after this cathartic episode. He had repressed all the memories from that time and had lost access to many everyday feelings as a result. In this critical incident, Donald’s intervention, even though contrived, set up an event that threatened Alan. Because the threat was limited in time and in a friendly venue, Alan’s feelings could emerge. This led to changes in cognition based on his connections to childhood events and ultimately a reduction in the evocative power of potentially excluding events.

EXAMPLE TWO: I was interacting with a woman friend. She said something that hurt me. I snapped back, kneejerk style, in a defensive manner. She looked

at me and inquired as to why I had reacted in this manner, quite perplexed and hurt. I thought for a second and answered honestly, "Because I felt hurt (not because you hurt me, or tried to hurt me)." She looked at me again and after a couple of seconds, said the words that changed my life: "So suffer the ____ hurt!" I stopped dead in my tracks, buying into this logic of separation of feelings from reaction to them (acting out of them), and did just that. I experienced the hurt for the first time in situations like that and realized how much I was afraid of being wrong, how much I feared I would lose the other person's affection. This experience opened up new behavioral doors in addition to allowing me to "have" my feelings and in addition to understanding the assumptions that had ruled much of my reactions to incidents like that.

In this case, a shift in behavior led to powerful affective and cognitive changes. The behavioral change "took" and the event "being criticized" became less of an issue over time.

EXAMPLE THREE: I was observing a colleague arguing with family and friends the way he always did and the way I occasionally did. I suddenly had the insight that there were alternatives. I saw that my friend felt compelled to "follow the logic and the truth" as opposed to honoring relationships, not even realizing there was a choice. I saw that he was driven by a set of assumptions about "the truth." From that moment on, I chose to listen rather than to argue --- to listen and then to state my case, if I still needed to, after I fully absorbed what the situation meant to the other person. I was becoming a clinician in spirit.

In this instance, cognition leads the way as I became aware of a self-imposed restrictive assumption limiting both the colleague and me. This impacted behavior immediately and affect over time, linked to my clinical instincts and manifesting itself in greater compassion.

EXAMPLE FOUR: At the Primal Institute, a young man beginning therapy had a serious problem with the way he acted out: he would exhibit himself to women on street corners. He constantly ran the risk of being arrested – but the urge to act out pushed him to do so with ever increasing frequency. One day, in spite of the impetus to show himself, he drove to the Institute instead and asked for a special session. He was able to get in touch with very deep feelings about needing his mother to be there when he was little. This critical incident did not totally diminish his exhibitionism, but it gave him an alternative. And within a year or two, he reported almost no urges to exhibit himself while continuing to progress in therapy.

Here, a change in behavior led to an emotional catharsis, followed by cognitive connections and ending with perceptual choice.

Conclusion

Critical incidents can play a major role in both therapy and in life. Sometimes they can be set up if the individual is ready through a change in either perception or behavior. On other occasions, emotional catharsis and sudden insight lead the way. While one cannot plan for such growth experiences, knowing of their existence and being ready to “go with them” maximize one’s chances of taking advantage of these crucial growth opportunities.