

CRISIS SITUATION / CRISIS INTERVENTION MODEL

Lidia NICA UDANGIU, Costin Emilian ROVENȚA, Dan TEODORESCU

Abstract:

Crisis situation is defined by a rise in psychic tension, psychosomatic discomfort, intervention of coping mechanisms, major disorganization and psychic disequilibrium if the problem continues and can not be solved. The reaction determined by the stressful event is divided into immediate, intermediate and long term responses. Crisis intervention involves some specific steps: clinical assessment, planning therapeutic intervention, intervention, resolution and anticipatory planning.

Keywords: crisis situation, crisis intervention, problem-solving

According to the American School of Psychiatry [1], a person is constantly faced in everyday life with a series of problems that need to be solved efficiently in order to maintain psychic functionality and somatic equilibrium.

When he is confronted with an imbalance between the difficulty (as he perceives it) of a problem and his available repertoire of coping skills, a crisis may be precipitated.

A crisis has four developmental phases:

1. There is an initial rise in tension as the stimulus continues and the psychosomatic discomfort begins.
2. The existence of inefficient or maladaptative coping mechanisms associated with the rise in the intensity of the stimulus determines escalation in tension.
3. This discomfort acts at the onset of the crisis as a powerful internal stimulus that mobilizes internal and external resources. These coping skills redefine the problem and find the most suitable strategies in solving it.
4. If the problem continues and can be neither solved nor avoided, tension increases and produces major disorganization and psychic disequilibrium.

When a stressful event occurs, certain recognized balancing factors can effect a return to equilibrium. Among these factors we can mention:

- perception of the event
- available situational supports
- coping mechanisms

In case the stressful event can be clearly defined and perceived, the emotional response may vary in intensity, being influenced by a series of internal and external factors that can determine a return to psychic and somatic equilibrium. [Fig. 1]

According to Robinson, the reaction determined by the stressful event is divided into three phases [2]:

- Immediate physiological processes: The autonomic nervous system is activated when an individual perceives a new developed situation as a threat. In the stress response, the hypothalamus stimulates the sympathetic nervous system and the body prepares for "fight or flight". The effect of sympathetic stimulation occur within 2 to 3 seconds and last between 5 and 10 minutes. Sympathetic nerve fibers release the catecholamines (epinephrine and norepinephrine). The person experiences anxiety that can be both described by the patient and observed through clinical signs, including perspiration, tremulousness, and rapid pulse and breathing.

- Intermediate response: The mentioned neurotransmitters travel to the end organs, where they maintain the processes already initiated for 1 to 2 hours. The catecholamines also stimulate gluconeogenesis, which provides the body with additional energy.

- Long-term response: There are three factors that perpetuate the long-term effects of stress:
 - the adrenal cortex, that secretes two types of corticoids: aldosterone, that raises the systemic blood pressure and cortisol, that is pivotal to the breakdown of fats and proteins to energy. Their prolonged secretion, however, has negative effects.

- Thyroxine increases the body's metabolism as much as 60% to 100%. It reaches a peak at about the tenth day after the stressful event and the effect may last 6 to 8 weeks.

- Vasopressin elevates blood pressure.

Crisis intervention must be swift and involves certain specific steps:

1. Clinical assessment of the individual requires the therapist to make a careful case history and to clearly identify the precipitating event. The therapist may have to judge whether the person presents a high suicidal or homicidal lethality. If the patient is thought to show a high level of danger to himself or to others, it is recommended to be taken into consideration for hospitalization. In general, crisis intervention can take place at the scene of the event and in many cases hospitalization is not necessary.

The first psychiatric interview of a patient in crisis situation also represents the first psychotherapy session, and it is directed toward finding out what the crisis precipitating event was and what factors are affecting the individual's coping abilities to solve problems. An important objective of the interview consists in clearly defining the situation through a series of questions: "What was the stressful event that determined the crisis?", "What must be done in order to regain the equilibrium?".

The therapist alongside the patient will try to obtain as much information about the stressful event as possible, in order to obtain factual knowledge about the problem area.

Observations are made to determine:

- a. The patient's level of anxiety
- b. Expressive movements
- c. Emotional tone
- d. Verbal and emotional responses
- e. Attitudinal changes

The therapist will focus on the immediate trauma that determined the current crisis, paying less interest to the patient's history in depth.

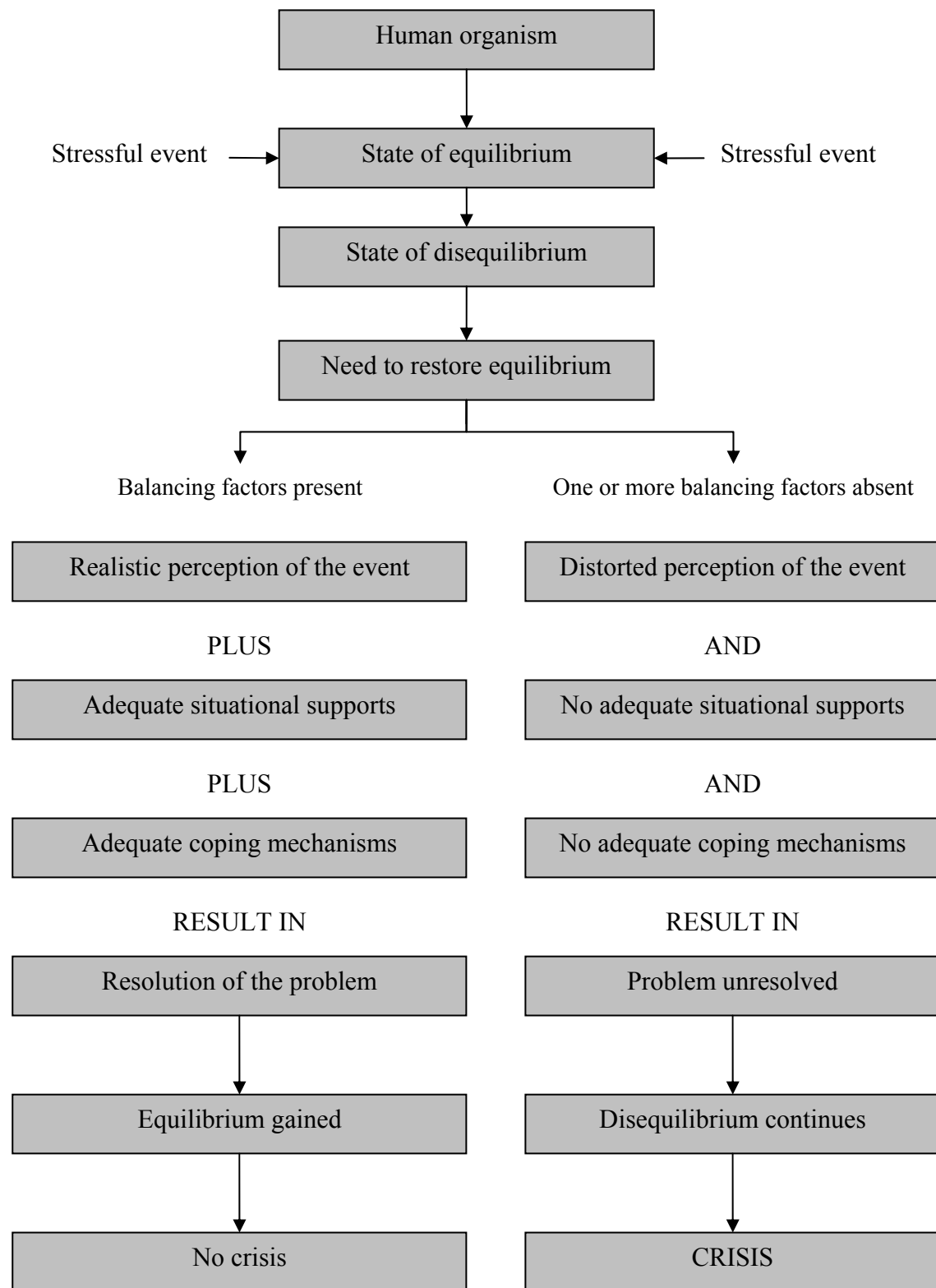
Key questions asked by the therapist might be:

- "Why did you come for help today?"
- "What happened in your life that is different these last days?"
- "How many days have passed since the incident?"
- "Did the stressful event occur the day before or the night before?"

Stressful events may vary a lot, for example:

- The loss of a loved person;
- Threat of divorce or separation;
- Discovery of extramarital relations;
- Finding out that a son or a daughter is taking drugs;
- Loss of job;
- An unwanted pregnancy.

An important role in precipitating the crisis is played by the individual's perception of the event. The therapist will ask a series of questions in assessing the event, for example: "What does this event mean to you?", "How do you see the event?" – does he see the event realistically, or does he distort its meaning?, "How do you see its effect on your future?", "Do you have available situational supports (friends, work colleagues, family members)?".



[Fig. 1] From Donna Aguilera – CRISIS INTERVENTION Theory and Methodology, 1998

2. Planning therapeutic intervention. It is designed to restore the person to the precrisis level of psychic and somatic equilibrium and to hinder major changes in the personality structure. The precipitating event usually occurs from 1 to 2 weeks before the individual seeks help. It is important to assess the length of time since onset of the crisis, to determine how much the crisis has disrupted the person's functionality and quality of life and the effects of this disruption on others in his home or professional environment. Another important objective in crisis intervention is to determine the way in which the coping skills have worked, whether these coping skills were the same as the ones used in the past, or if the patient developed new ones.

3. Intervention. It is based on using intervention techniques that are highly dependent on preexisting skills of the therapist, such as: creativity, flexibility and empathy. Morley, Messick, and Aguilera suggest some of the following techniques, which have been useful: [3].

- Helping the individual to gain an intellectual understanding of his crisis. Often the individual sees no relationship between a hazardous situation occurring in life and the discomfort that he is experiencing. The therapist should use a direct approach, describing to the patient the relationship between crisis and the event in his life.

- The therapist should help the individual become aware of his present feelings. Some persons may have suppressed real feelings such as anger or other inadmissible emotions. Others may also deny the crisis situations (loss of a loved person), although they experience guilt and reprehensibility. The therapist will provide means for the individual to recognize these feelings, which will be discussed during the psychotherapy sessions. In many cases it is necessary to produce emotional catharsis that will reduce the immobilizing tension.

- Exploring coping mechanisms. In order to reduce the anxiety, there can be used coping skills that may have been used successfully in the past. If those coping skills are unsuccessful in the present situation, new methods are sought, and the individual devises some highly original methods that he has never tried before.

- Reopening the social world. If the crisis has been precipitated by the loss of someone significant to the individual's life, it is necessary that the therapist alongside the patient should identify new people to fill the void.

4. Resolution of the crisis and anticipatory planning. In this last phase, the therapist reinforces those adaptive coping mechanisms that the individual has used successfully in the past to reduce tension and anxiety. As coping abilities increase and positive changes occur, they have to be summarized to allow the person to reconfirm the progress made. The therapist alongside the patient will participate in making realistic plans for the future, and there will be discussion of ways in which the present experience may help in future crises.

The main purpose of the crisis approach is to provide the consultation services of a therapist who is skilled in problem-solving techniques. The therapist will be expected to answer and to clarify the problems that occurred, to guide and to support his client toward crisis resolution.

Depending on past experience related to the immediate problem, some people are more adept at finding solutions than others. Problem solving requires that a logical sequence of reasoning should be applied to a crisis situation, even when there is no immediate source of reliable information.

Problem solving involves a logical sequence of reasoning.

Anxiety represents an adaptative response to a dangerous situation that is felt like a discomfort. Anxiety depends on the ease with which an individual finds an answer to a crisis situation. If the person doesn't succeed in finding a solution to the problem, his anxiety will increase in proportion, but if it is kept within tolerable limits, it can be an effective stimulant to action. If a solution is still not found, anxiety raises, becomes more and more severe, feelings of discomfort intensify, and the individual becomes unable to recognize his own feelings, the problem, the evidence, and the situation in which he finds himself.

Although problem-solving involves a logical sequence of reasoning, it doesn't always succeed in finding well adapted and effective solutions or ideas. We distinguish two major modalities to solve the problems:

- Reproductive solving problems which depends on past successes in finding solutions
- Productive problem solving in which the person counting on insufficient data and information from the past, is faced with the need to resort to external, efficient sources and to construct new ideas from more or less raw data.

Crisis intervention counselling is based on the premise that psychological intervention during or in the proximal aftermath of a traumatic experience can help not only to stabilize the client and improve the client's present level of functioning but also to reduce or prevent future psychological distress. [4]

Intervention methods frequently include a structured procedure or guided process called psychological debriefing, whereby trauma survivors express their thoughts and feelings about the traumatic [5]. However, meta-analyses [6] and an extensive review of the literature on the effectiveness of psychological debriefing [7] have found very little evidence to suggest that early intervention prevents or attenuates the development of later symptoms of posttraumatic stress.

There isn't a consensus about the number of psycho-therapy sessions needed to obtain the resolution of the crisis; some authors suggesting 1 to 2 sessions, while others 4 to 5 sessions.

Also, it's important to know that crisis intervention leads to a shift from hospitalization to outpatient psychotherapeutic management in emergency psychiatric services which has a significant economic impact [8].

REFERENCES:

1. Caplan G.: Principles of preventive psychiatry, New York, 1964, Basic Books.
2. Robinson L.: Stress and anxiety, *Nurse Clin North Am* 25: (4)935, 1990.
3. Morley W.E., Messick J.M., Aguilera D.C. Crisis: paradigms of intervention. *J Psychiatry Nurs* 5:537, 1967.
4. Seely, Mark R. Psychological debriefing may not be clinically effective: implications for a humanistic approach to trauma intervention. *Journal of Humanistic Counselling, Education and Development*, September 22, 2007.
5. Richard J. McNally, Richard A. Bryant, and Anke Ehlers. Early Psychological Intervention. *Psychological Science in the Public Interest*, Vol. 4, No. 2, November 2003
6. Van Emmerik A.A., Kamphuis J.H., Hulsbosch A.M., Emmelkamp P.M. Single session debriefing after psychological trauma: a meta-analysis. *Lancet* 2002 Sep 7;360(9335): 766-71.
7. Richard J. McNally. Psychological Debriefing Does Not Prevent Posttraumatic Stress Disorder. *Psychiatric Times*. Vol. 21, No. 4, 2004.
8. Damsa C., Hummel C., Sar V. et al. Economic impact of crisis intervention in emergency psychiatry: a naturalistic study. *European Psychiatry* 2005, vol. 20, no. 8, 562-566.

Lidia NICA UDANGIU, MD, PhD, Professor, Department of Psychiatry
University of Medicine and Dental Medicine "Titu Maiorescu" Bucharest,
Head of Department, Psychiatric Hospital "Al. Obregia", Bucharest

Costin Emilian ROVENȚA, MD, Junior psychiatrist,
Psychiatric Hospital "Al. Obregia", Bucharest

Dan TEODORESCU, MD, Junior psychiatrist,
Psychiatric Hospital "Al. Obregia", Bucharest