CRISIS INTERVENTION IN A GENERAL HOSPITAL

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ABSTRACT

This paper presents the data of 90 patients admitted consecutively for crisis intervention in the psychiatric ward of the National University Hospital, Singapore. There were 48 men and 42 women; their mean age was 31.4 years (SD ±12.9). More women (73%) had relationship problems than men but more men (52%) had work related problems - the difference is significant (p<0.01). The commonest diagnoses were depression (45%) and adjustment reaction (24%).

The mean duration of hospitalisation was 4.3 days (SD ± 2.3). The majority of patients (63%) were managed by supportive psychotherapy and the remaining 37% by supportive psychotherapy and medication.

On follow up after one month, 20% of the sample were well, 62% improved and 18% were not better. About 85% of the sample could be contacted after 3 months, and of these, 51% were well, 39% improved but 10% were still not better. The efficacy of crisis intervention is briefly discussed.

Keywords: *crisis intervention, general hospital*

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INTRODUCTION

The original theories and practices of crisis intervention were proposed by Lindemann[1] and Caplan[2]. A crisis is seen as a disruption in the individual's steady state due to a sudden or threatened loss which overwhelms the individual's capacity to cope. It produces a predictable sequence of psychological numbness, increasing tension and ineffective behaviour; followed by the mobilisation of internal and external resources to try new methods of problem solving. The final reorganisation hinges on the healthiness and appropriateness of the new methods of coping. Two main types of crises are developmental and situational. Developmental crises are those expected changes in life, eg adolescence, marriage, parenthood and retirement. Situational crises are unpredictable and include bereavement, serious illness and relationship conflict.

Crisis intervention provides intensive short-term here-and-now therapy, directing at specific goals with emphasis on exploration of all possible options open to the individual. The objective is the psychological resolution of the immediate crisis and restoration to at least the level of functioning that existed prior to the crises[3].

Much has been written about the evolution, structure and evaluation of crisis intervention centres in the West[4-8], but there is a paucity of information in this region. It is expected that in eastern societies, the family has a pivotal role in helping to resolve any crisis in the home and seeking outside help is usually eschewed because of embarrassment. It is only when the family fails or the crisis is too overwhelming, that professional assistance is sought, eg in attempted suicide.

The Crisis Intervention Unit at the National University Hospital receives referrals from the Accident and Emergency Department and the acute admission wards of the Departments of Medicine and Surgery. The crisis team includes psychiatrists, social workers and nurses. This paper presents the characteristics of those patients who were referred and their outcome after 3 months' follow-up.

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METHODS

The sample in this study included all patients admitted for crisis intervention in the psychiatric ward of the National University Hospital from May to July 1994. There were 90 patients – 59 were referred from the medical wards, 20 from the Accident and Emergency Department, 6 from the surgical and orthopaedic wards, and 5 from the outpatient clinic. In the assessment, the following demographic information were noted: age, sex, marital status, main complaint, precipitating stressor, any suicidal attempt, family support, confidante, diagnosis, method of treatment, duration of hospitalisation and outcome after one and three months. The criteria of diagnosis used were according to the ICD9[9].

The strategies used in crisis intervention are discussed by Bancroft[10]. In crisis counselling, the objectives are to facilitate communication, expression of affect and problem-solving behaviour to help the patient understand his problems and feeling. Removal of the patient from a stressful environment and explicit transfer of responsibility will help to lower arousal and distress. The patients were seen daily and on discharge, were reviewed weekly for one month and fortnightly for 2 months. Some patients with depressive illness or insomnia were also prescribed antidepressants and hypnotics.

The outcome measures were divided into 3 categories: (i) well or fully recovered, (ii) improved with amelioration of symptoms, (iii) not better or worse.

All data were processed through SPSS in IBM 3081 KX2 main frame. For statistical analysis, chi-squared test was used with significance level at $p < 0.05$.

RESULTS

Of the 90 patients admitted, there were 48 men and 42 women; their mean age was 31.4 years (SD ± 12.9). Forty-three percent were married, 47% single and 10% divorced or widowed. There was no significant difference between men and women in age and marital status. Comparing the type of stressors, more women (73%) complained about conflicts in relationship with husband or boyfriend, but more men (52%) had work stress, eg work overload, problems with employer or employees and national

service - the difference is significant ($p < 0.01$).

About 37% of patients were admitted after a suicide attempt; and of these, 68% were from drug overdosage, 10%, self-poisoning (eg detergents or weed-killers) and 7%, self-laceration.

Although the commonest presenting symptom was depression (60%), anger was the main complaint (58%) of young people below 20 years of age. The common diagnoses were depression (45%) and adjustment reaction (24%); there was no significant difference between men or women (Table I). In the ICD9 code, depression includes reactive depression and neurotic depression.

The mean duration of hospitalisation was 4.3 days (SD ± 2.3). About 70% of the patients said that they had good family support but only 31% had a confidante. Most of the patients (63%) were managed by counselling and 37% by both counselling and medication (antidepressant and anti-anxiety compounds). On follow-up after one month, 20% recovered, 62% improved and 18% were not better. About 85% of the sample were contacted after 3 months; and of these, 51% remained well, 39% improved but 10% were still not better (Table II).

Table I – Diagnoses of sample (in percentage)

Diagnosis	Men (n=48)	Women (n=42)
Depression	47	43
Adjustment reaction	27	19
Personality disorder	8	7
Schizophrenia	6	5
Others*	12	26
Total	100	100

*include mania, alcohol dependence, anxiety states
p = ns

Table II – Outcome of crisis intervention (in percentage)

	1 month (n=90)	3 months (n=77)
Recovered	20	50
Improved	62	40
Not better	18	10
Total	100	100

DISCUSSION

The study yielded interesting results albeit the sample was small and follow-up was short. The number of men and women was almost similar and there was a wide range of the ages of the patients - the mean age of 31.4 years indicated that patients admitted for crisis intervention were not predominantly young people. The preponderance of men with work problems could be explained by the fact that a third of the women in the sample were not working; but comparing working men and women, there was no significant difference in work stress. However, relationship conflict as a stressor was more common in women and this was mainly with the husband or boyfriend.

Only a third of the sample had made a suicide attempt. On follow-up, there was no repeated attempt in the first 3 months. Tsoi and Kua[11] reported a low suicide risk following a suicide attempt in Singapore and those with high risk were mainly Chinese men with schizophrenia. In the present study, none of the schizophrenic patients committed suicide on follow-up. As in other studies[12,13] on crisis intervention, the commonest diagnosis was depression; but more of those below 20 years were admitted for adjustment reaction after enlistment into national service. Most patients stayed less than 5 days (87%) and usually by then, the crisis would have been resolved. Although all the patients lived with their family and said they had good support, only a third had someone to confide in.

Techniques of crisis counselling vary but most therapists tend to adopt a behavioural approach that is brief and goal-oriented. The strategy is to facilitate the expression of affect, communication, patient's insight of the conflict and problem-solving behaviour. Helping the patient gain mastery of the situation and dealing with excessive use of the defence of denial are also important goals in treatment[10]. Besides individual therapy, some may need family or marital therapy.

The prescription of psychotropic medication is sometimes controversial in crisis counselling. But in the acute phase, the patient may have sleep problem, severe anxiety or depression, and medication is necessary. Anti-anxiety drugs help to lower arousal for effective coping behaviour to resume, antidepressants are prescribed for those with depressive disorder and patients with sleep difficulty may need a hypnotic for a few nights. Prolonged prescription of benzodiazepines is to be avoided. Psychotropic medication is merely an adjunct in crisis counselling.

The outcome of the sample is generally good; after the third month the majority (90%) had either recovered fully or had improvement of symptoms. The remaining 10% were those who had intractable family, marital or work problems; some of them had personality disorders (usually hysterical or explosive) or recurrent depression and would need long-term therapy. A 2-year follow-up study by Andreoli et al[13] also showed that patients with personality disorders had a poor outcome in crisis intervention; but within this subgroup, those with better compliance in treatment predicted a better outcome. A follow-up study of crisis intervention by Bronish[7] also showed a favourable outcome of 82% of 76 patients after 5 years; all the patients had adjustment reaction or depression and only 17% developed chronic depression.

In recent years because of escalating medical expenditure, the cost effectiveness of crisis intervention was evaluated by Bengelsdorf[8], who found a mobile crisis intervention service could effect cost savings by diverting patients from expensive hospital admission into community-based treatment. The mobile service could include a doctor, a nurse and a social worker operating from a day centre. This innovative community psychiatric service would also be beneficial in many developing countries where resources and facilities are scarce.

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