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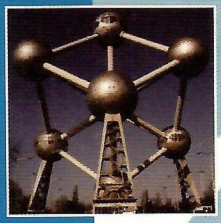

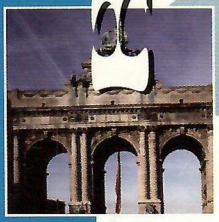

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CRISIS INTERVENTION IN PSYCHIATRIC EMERGENCIES: A SELECTION FOR ADMISSION TO PSYCHIATRIC SERVICES

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ABSTRACT

Background: The Emergency Psychiatric Unit has been established since several years at the Psychiatric Clinic of Milan University, with the aim of obtaining a complete diagnostic picture and providing specific and immediate treatment for all patients facing an acute psychological crisis. Objective of the present report is the analysis of the 12 month follow-up study carried out with patients after termination of Crisis Intervention. Methods: The cases examined regard subjects who came to the Psychiatric Emergency Service, followed a Crisis Intervention (61 subjects) and who were assessed in a one-year follow-up study. Results: The follow-up data indicate that 54 patients (87%) no longer present symptoms, whereas 7 subject (11,5%) still do. The latter 7 patients are still on the medication prescribed during the initial phase of treatment, whereas the others are no longer on drug therapy. In the absence of symptoms, these subjects present a positive social and work functioning, as likewise a positive relational functioning. Conclusions: from the results of the follow-up study it is possible to appreciate the Crisis Intervention's efficacy: more than 80% of patients have maintained a satisfactory psychic equilibrium at one-year follow-up, presenting a complete symptoms' control and a good social and relational functioning.

Key words: Psychotherapy follow-up, Core Conflictual Relationship Theme (CCRT),

INTRODUCTION

The Psychiatric Emergency Unit was established at the Psychiatric Clinic of Milan University with the aim of diagnosing and rapidly providing specific treatment for all patients undergoing an acute psychological crisis [1]. The term "crisis" defines a time of psychical suffering in which the patients express a subjective feeling that their emotional equilibrium has been totally upset. Acute symptoms are accompanied by the subject's impression that he has insufficient resources to regain his emotional stability, while his normal defence mechanisms and capacity for psychosocial adjustment are overwhelmed [2]. The Emergency Psychiatric Unit is composed of those patients who are sent to the Psychiatric Emergency Room of our hospital due to symptoms connected with psychological distress of recent onset. At the end of the first assessment phase, intervention proceeds as for Crisis Intervention, characterised by clarification and support, or along the lines of analytically-oriented Brief Psychotherapy, for patients who satisfy certain selection criteria. It is important to define the conceptual frame within which we focus our crisis intervention. We can see the crisis as a crucial moment in the life of an individual, that may lead - through the experience of change - to a psychological transformation and maturation which allows the person concerned to develop more adaptive modes of reaction to conflictual situations. So the crisis is interpreted as an opportunity to recognise those seeds of maturation that are always contained within it. The suitability of Crisis Intervention, which has the features of a brief supportive psychotherapy, is decided after a phenomenological and psychodynamic assessment of the patient. The subject does not need to have advanced intellectual or introspective capacities, but he must be aware of the

crisis and want to overcome it through the intervention [3]. Sessions are held weekly and 8-12 sessions are envisaged, so the overall duration of the intervention is from 2 to 3 months. One of our prime aims is clearly to stop the escalation of the crisis and, therefore, to prevent hospitalisation and the chronicization of the pathological condition. By the end of the crisis intervention, the individual has reacquired his feelings of control and mastery over what is happening to him, thanks partly to the new strategies acquired and interiorized during the process he has established with the therapist. If the subject has interiorized the strategies he has learned during the course of the therapy, even if we are dealing with a short-term intervention, he will then be able to apply them to life situations, which will consequently be faced in new ways. The therapeutic process thus continues without any time-limit: in other words, it is not conditioned by the end of the therapy.

OBJECTIVES

The aim of this study was to analyse the results of the follow-up studies conducted at twelve months from the end of the Crisis intervention, investigating the stability of results and the variables predictive of the outcome of treatment.

MATERIALS

Patients included in the study had been referred by the Psychiatric Emergency Room. Selection criteria includes patients aged between 18 to 65 undergoing a psychological crisis, while were excluded patients already receiving specialist treatment or suffering from psycho-organic syndromes. The data analysed in the study refer to 61 patients who completed the Crisis Intervention and who were evaluated in the one-year follow-up.

Sociodemographic Variables: The sample group was composed of 16 males (26.2%) and 45 females (73.8%), with an average age of 33.4 (range 18-56) and schooling lasting on average 12.6 years (range 5-20). 27 patients (44.2%) had a "lower school leaving certificate", 26 (42.6%) had a "higher school leaving certificate" and 8 patients (13.1%) had a university degree. 55.8% of patients were employees, 27.2% were not in a working category (students, housewives, invalids), 9.5% were unemployed or worked irregularly, 7.4% were free-lance workers. Only 38.9% of patients were married; the rest were single (54.7%), divorced or widowed (6.3%). **Clinical variables:** The following Diagnoses, formulated according to the DSM-IV criteria [4] were obtained on axis I: Anxiety Disorder (34.7%), Mood Disorder (31.1%), Adjustment Disorder (9.8%), Somatoform Disorder (9.8%), NAS Psychotic Disorder (6.5%). 5 patients (8.1%) had symptoms not diagnosable on axis I. As far as axis II was concerned, most patients (51.6%) received no diagnosis, while for the remaining patients, the most frequent diagnoses were: Cluster C (Avoidance, Dependence and Obsessive-compulsive disorders) (20%) and Cluster B Personality Disorders (Histrionic, Narcissistic, Borderline and Antisocial Disorders) (18.9%). Social and affective functioning was assessed on arrival by means of a structured clinical interview we have developed. For statistical purpouses we have transformed the clinical variables into dichotomic values. The respective evaluations were: 65% of patients had good or satisfactory social relationships, 45% good sentimental relationships; whereas sexual relationships were good only for 25%

METHODS

Basal Evaluation at time 0 (T 0): During the first three sessions, anamnestic records are compiled and psychodiagnostic tests are also administered. These comprise:

- Minnesota Multiphasic Personality Inventory, for the assessment of the personality profile [5];
- Interpersonal Inventory of Personality, for the assessment of the patient's main interpersonal relational problems (IIP) [6];

Starting out from transcriptions of the first sessions, the Core Conflict Relationship Theme (CCRT) [7] is also analysed. This expresses the patient's relational modes based

on the analysis of the conflictual situations he has lived through, and then reported during the sessions. The purpose of this tool is to measure the "Core Conflict Theme" in the narrative produced by the patient, which is identified as the "Central Relational Pattern" of the patient in psychotherapy. The definition of the CCRT is standardized and is carried out by breaking down the text of a session into sections defined as Relational Episodes (E.R.), within which the most frequent Wishes (W), Responses of the Object (R.O.) and Responses of the self (R.S.) are identified. The CCRT method was applied to the first and the last audiotaped sessions of the psychotherapy. Detailed analyses were carried out both as regards the presence of positive and negative responses - in other words, coherent with or frustrating to the patients' wishes.The percentage of pervasiveness of each CCRT component was also analysed, according to the eight standard categories relating to the forms of Wish (W), the eight types of Response of Others (RO) and the eight responses of the self (RS). The most frequent CCRT was: "I want to assert myself and be independent; I feel others to be rejecting and opposing; I feel anxious and ashamed". As regards the results of the CCRT, negative responses from others (NRO) were predominant at the beginning of the therapy, NRO: 68.26%. As regards the negative responses of the self were also predominant, NRS: 61.94%. The predominance of Negative Responses of Others and the Self was expected, and was in accordance with the recent onset of psychological crisis in the patients and with the reconstruction of the events that had triggered the crisis.

Follow-up assessment (T1): Follow-up on the sample of patients who had Crisis Intervention (IDC) consisted in clinical and psychological test evaluations to assess maintenance of the clinical improvement made. These were carried out at one, three, six and twelve months. In this study, the variables relating to the twelve months follow-up will be used. For the analysis of clinical effectiveness, we have considered parameters such as the evolution of symptoms, functioning in the social, relational and work spheres, the interruption or continuance of drug therapy and, finally, any further request for psychiatric visits in the follow-up time. As regards test assessment, the same psychometric tests and Luborsky's CCRT analysis adminestered at the recruitement phase were administered. All patients signed the informed consent for the evaluation procedures and the therapeutic intervention.

RESULTS

Analysis of the results of the follow-up study, provided by a structured clinical interview, showed that symptoms improved in 88.5% of the patients who completed the Crisis Intervention, or at least remained stable, maintaining the improvement achieved by the end of the crisis intervention. However, 11.5% of the patients still presented symptoms at follow-up. The relational and social functioning of these patients at one year follow up was also analysed, and in both contexts, satisfactory progress was found in 88.5% of patients. A statistically significant improvement on the social level proved to be associated with this progress ($p<0.05$) and, moreover, the improvement in the closest interpersonal relationships was significantly correlated with the symptomatological improvement at 12 month follow-up ($p<0.01$). At one year from Crisis Intervention only 11.5% of the subjects were still on drug treatment. We subsequently carried out a comparative analysis to see whether differences existed in the individual sociodemographic, clinical and psychological variables between the two sub-groups of patients, i.e. those with a positive evolution in the symptoms and good functioning at follow up, as compared with patients for whom the intervention had proved less effective. The following results were obtained: patients who still presented symptoms at follow up had significantly higher scores on the Depression ($p=0.04$), Hypochondria ($p=0.03$) and Hysteria scales ($p=0.01$) of the MMPI administered at the initial evaluation.

The neurotic triad seems to have a bad prognostic value for the effectiveness of crisis intervention. No statistically significant differences emerged between the two groups as concerns sociodemographic and clinical variables. Another analysis showed that there were no significant differences in evolution of the symptom between patients with and without Personality Disorders, either as regards social and relational functioning or as concerns the continuation of drug treatment. Patients also showed improvement in psychometric indices of distress. This was evident from the scores obtained on the psychological tests, which are always associated with the clinical assessments. Statistically significant decreases emerged in ratings on the Hysteria, Paranoia, Psycasthenia and Social Introversion scales of the MMPI ($p<0.05$). A statistically significant decrease in scores was also found on the IIP scales for Fragility due to over-sensitivity, Fragility due to refusal to take responsibility, Intimacy, and Egocentricity ($p<0.05$). As regards the CCRT in the follow-up study a significant reduction in negative responses of the self and others emerged, testifying to the validity of the elaborations of conflictual relational aspects (due particularly to the relationship established with the therapist), although the same range of wishes was maintained, as these are not easily changed in such a brief lapse of time.

DISCUSSION

The satisfactory results in terms of stability in symptom control and improvement in social and relational functioning show that it is appropriate to provide the patient undergoing an acute psychological crisis with a therapy that integrates the functional relationship and the more empathetic relationship that can perceive the more private and personal distress of each patient. In conclusion from the results of the follow-up assessment of patients treated by the Emergency Psychiatric Unit, the efficacy of the intervention can be appreciated. This helps to resolve the acute psychological crisis situation, and thus to prevent hospitalization - which may turn an acute event into a chronic clinical situation, - and also to maintain control of the symptom and improvement of social and affective relationships over the course of time. Indeed, due to the effectiveness of the intervention, the subject will have introjected those psychological tools that will, in future, allow him to cope with conflictual situations in a more mature manner, by referring to a new way of relating and communicating he has acquired that will finally be able to prevent the occurrence of further states of crisis.

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