RESCUE
August 17, 1976

Jeffrey T. Mitchell, M.S.
Marge Epperson, M.S.W.

Psychiatric Emergencies and Crisis Intervention

Although we don't often think of them that way, psychiatric emergencies can often be classed right alongside severe bleeding, poisonings, and cardiac emergencies in terms of their severity and threat to life and limb. That's right, a severe psychiatric emergency can be as death producing as a cardiac arrest.

If you would like to confirm thatlast statement, just take a brief look at the national statistics on suicide or consider the number of people who are injured or killed while wandering around a fire ground or an accident scene in a state of bewilderment and emotional shock.

Psychiatric emergencies occur much more frequently than we realize. In fact, most psychiatric emergencies do not involve "crazy" people. Psychiatric emergencies, for the most part, involve the average victim of a sudden illness or injury. They also involve that victim's family and friends who are suddenly thrown into a stressful situation which taxes their ability to function normally and make appropriate decisions.

Although few police, fire and rescue personnel are adequately trained to handle severe psychiatric emergencies, they should not underestimate the impact they may have upon the victims of psychiatric crisis. Their actions and comments during the initial moments of the crisis may determine the long range ability of crisis victims to adapt to the strains of the situation and continue to live emotionally healthy lives.

Most of the available literature on the subject today expresses the importance of the first responder in psychiatric crisis situations. Immediately after the crisis event the victim, and often his family, enters into a state of emotional disequilibrium. Crisis workers have the opportunity to provide a helping intervention during this period. Therefore, it is important that crisis intervention begin as soon as possible after the crisis event.

Although EMT's and other first responders usually deal with psychiatric crisis patients and their families during the stage of disequilibrium which immediately follows the crisis event, it is important for them to realize that victims of crisis and their families usually pass through six basic stages or phrases of the crisis. Many patients pass rapidly through these phases and some have several phases which overlap with each other.

The Family Services Division of the Maryland Institute for Emergency Medicine has identified the six phases as follows:

1) The High Anxiety Phase (more will be said on this later)
2) Denial
3) Anger
4) Remorse
5) Grief
6) Reconcilliation

During the first phase or the high anxiety phase of the crisis, the victim and his family experiences a period of confusion, time and space disorientation, reduced ability to

discriminate the dangerous from the trivial, disorientation of visual-motor coordination, and high anxiety.

The victim or his family may be in danger during this period. Consider, for example, the woman who returns into a burning house to recover some trivial household items. In another example family members in one recent incident interferred with the rescuers and busied themselves in a search for a pair of eyeglasses while another family member lay critically injured on the roadside awaiting treatment and transportation to a medical facility.

Steps to Crisis Intervention in the Field

1) Crisis intervention begins when the EMT's or other first responders calmly take control of the situation and remove the victim and his family from the hostile environment or protect them adequately from harmful situations.

2) The second step in crisis intervention is data gathering. The EMT-A or first responder needs to know a brief but accurate history of the situation. Actively involving the family in the data gathering process also actively involves them in the helping process and enables them to keep a fairly balanced view of the situation.

3) Next the EMT or other first responder should allow the victim and the victim's family to ventilate their feelings. This step in crisis intervention demands an unrushed period of careful listening on the part of the crisis worker.

4) Crisis workers should supply the victim and family members with accurate information concerning the victim's

condition, initial treatment, destination and other important factors. The information given should be brief but factual and should be balanced with good common sense. Sincere human concern should be the mark of all communications with the victim and the family members.

5) Effectively complete the transfer of the patient to appropriate medical or psychiatric facilities.

Helpful Hints:

1) Most people experiencing a crisis are not dangerous to anyone.

2) Restraints should be used as a last resort (they should be used as sparingly as a tourniquet since, like tourniquets, they almost always do some damage; in this case the damage is usually emotional).

3) Do not rush a person undergoing a crisis. Remain calm and think ahead.

4) Avoid arguing with a person undergoing crisis.

5) Never lie to victims of crisis or the family members.

6) Remove the patient from disturbing persons or things.

7) Utilize family members or friends who have positive influence on the patient.

8) Be aware of your own limitations.

9) Intervene only to the extent that you feel competent.

10) If you feel you have reached your limits, seek additional help or consultation.

It is not necessary, as some may think, to train fire, rescue and police personnel to the level of practicing psychologists in order to be able to deal effectively with the majority of psychiatric emergencies. The ability to diagnose behavior in the field is of little or no value during the crisis. It makes little difference that the first responder classify one as psychotic or neurotic, or as suffering from schizophrenia, paranoia or a transient situational personality disorder. What is important, above all else, is that people are treated carefully as valuable people regardless of whether their unusual behavior is caused by an emotional or physical hurt.

CRISIS INTERVENTION FOR FAMILIES BY EMERGENCY MEDICAL TECHNICIANS AND OTHER FIRST RESPONDERS

by

Jeffrey T. Mitchell, M.S.

Dr. A. Plotkin
Loyola College
Spring, 1976

CRISIS INTERVENTION FOR FAMILIES BY EMERGENCY MEDICAL TECHNICIANS AND OTHER FIRST RESPONDERS

A family is routed from its home in a late night fire; another stands anxiously by as paramedics attempt to resuscitate a sixteen year old family member who has fallen victim to a drug overdose; and still another family must be informed that they have called for the ambulance too late to be effective. In each case and in multiple thousands similar to them each day in this nation, families call for help for inumerable situations over which they have little or no control. Police and ambulance crews respond to these emergencies. Their actions and comments during the initial moments of the crisis may determine the ability of the family to adapt to the strains of the crisis or to suffer the long lasting pain of maladjustment to the family crisis.

Few police personnel, firefighters and emergency medical technicians are sufficiently aware of the impact

they have upon family units during a crisis. In addition, few are even minimally trained to adequately assist a family experiencing a psycho/social crisis as a result of individual or family trauma. At the present time, emergency medical technicians average approximately one hour of psychiatric emergencies training during their standard eighty one hour basic training program.

A review of the literature shows that one of the most fundamental principles of crisis intervention calls for an almost immediate intervention on the part of the helper. While the family is involved in a state of disequilibrium which usually occurs immediately after the crisis event, crisis workers have the best opportunity to provide some therapeutic intervention.[1]

Ole R. Holsti in his article "Crisis, stress and decision-making", points out how most individuals, and, we can assume, families react under the stress of sudden, unforeseen crisis. He reports that immediately following the crisis event the individual enters a period of time in which his initiating behaviors decrease substantially. The individual and family as a unit expresses an inability to distinguish sense from nonsense. Holsti also reports "increased random behaviour; deterioation of verbal performance; increased rate of error; regression to simpler and more primitive modes of response; problem solving rigidity; diminished

tolerance for ambiguity; reduction in focus of attention, both across time and space; reduced ability to discriminate the dangerous from the trivial; diminished scope of complex perceptual activity; loss of abstract ability; and disorientation of visual-motor coordination."[2]

Almost any experienced ambulance crew will be able to verify the reported effects of crisis. Consider for example, the mother who returns to a burning building to recover some trivial household items while her house is still dangerously burning. During a recent critical emergency to which the author responded, family members busied themselves in a search for a pair of eye glasses while a family member lay critically injured on the roadside awaiting evacuation to the Maryland Institute for Emergency Medicine.

Ambulance crews, police officials and other first responders, understanding the dynamics of the crisis situation and the reactions described above, will be less likely to ignore the distraught family members or, even worse, become annoyed at the seemingly aimless and occasionly disruptive behavior of disoriented family.

Emergency Medical Technicians, as well as other first responders, are often distressed by a seemingly inordinate quantity of angry expressions provided by the family of the traumatized victim. This is often due to distorted perspective of time victims of crisis usually experience.[3] Time seems to move rapidly to those in

distress and the short two or three minute response to the scene may be exaggerated in their minds to fifteen or twenty minutes.

The emergency medical technicians usually see the families of the victims of trauma in the first of six phases of crisis which Ms. Marge Epperson, director of the family services section of the Maryland Institute for Emergency Medicine, has carefully defined over the past few years in her work with the families of hundreds of trauma victims.[4] Ms. Epperson calls the first stage the "Initial high anxiety phase". Family members react in it as described earlier in this paper.

In addition to their medical tasks, the emergency medical technicians can be most helpful during this stage of crisis by carefully handling the victim's family. If time allows and the crisis is not immediatlely life threatening, the EMT's should attempt to gather an adequate history of the events which may have led to accident or sudden illness. This is not only important from a medical standpoint. It actively involves the family in the process of helping and enables them to keep in mind the reality of the situation.[5] Epperson reports that allowing family members to ventilate their feelings may help to identify a family member who might be utilized by the EMT's as an ally in

their efforts to assist the trauma victim and the entire family.

The emergency medical technicians should become more acutely aware of the feelings of helplessness experienced by families. These feelings can be alleviated by the EMT's if they are willing and able to supply brief, accurate discriptions of the situation and facts regarding the patient's condition, destination, type of care to be administered, and procedures to be followed by the family once they have arrived at the medical facility.[6] Holsti suggests strongly that communications is a key factor in dealing with crisis situations.[7] It is therefore vitally important that communications with the family as a whole and between family members begin at the earliest possible time. The EMT's can be instrumental in this area as described above.

Although this paper simply deals with the crisis intervention which can be performed by the EMT's in the field, and therefore only covers the first phase of crisis, it is important, for the understanding of the overall crisis process, that the EMT's have an adequate knowledge of the other phases of crisis. Many of the phases overlap with each other and are difficult to distinguish. Perhaps this brief summary will prove to be helpful. After the first or high anxiety phase, the family experiencing a crisis will usually go through a phase of denial which eventually gives way to anger. Anger is often followed by a strong sense

of remorse or sorrow. Grief usually appears after the remorse stage and may lead to reconcilliation or reintergration.[8]

In dealing with distraught families, EMT's should be discrete. They should realize that crisis intervention is simply that. There should be no attempt to pry into the private lives of the families in distress, who are particularly susceptible to invasions of privacy in their weakened state. Crisis intervention is short in duration. Any attempt at in depth psychoanalysis would certainly be out of place. As members of a health care team, EMT's, trained to assist families in crisis situations, should be aware of the right of every patient and family to confidentiallity.

Communications to members of a distressed family should always be factual, non-judgemental, realistic and be adequately supported with caring, empathy and warmth.

Although additional training for crisis workers is a must today, no one need become a masters level or PhD. psychologist to deal effectively with families in need of crisis intervention. Most EMT's and other first responders, aware of the needs of the family as a whole, are quite capable of dealing with a hurting family in the initial stages of the crisis and can be considered an important adjunct to the behavioral scientists who will take over the task of aiding the family once that family arrives at the medical facility.

NOTES

1. Howard J. Parad and Libbie G. Parad, "A Study of Crisis-Oriented Planned Short-Term Treatment," Social Casework, vol. XLIX, no. 6, June, 1968, p. 420.

2. Ole R. Holsti, "Crisis, Stress and Decision-Making", International Social Science Journal, vol. 23, '71, p. 58.

3. Ole R. Holsti, "Crisis, Stress and Decision-Making," International Social Science Journal, vol. 23, '71, p. 59.

4. Marge Epperson, M.S.W., "Families in Crisis", presented to the International Emergency Medical Services Symposium, Baltimore, Md. May 10-12, 1976.

5. Peter G. Bourne, M.D., "Treatment of the Drug Abuser in An Emergency Medical Services System," System Response to Behavioral Emergencies, William C. Huddleston, ed., to be printed by the Department of Health, Education And Welfare in 1976-77, p. 71 (of the Draft).

6. Marge Epperson, M.S.W., "Families in Crisis," from a taped presentation to the Emergency Medical Technician - Ambulance Instructors' Association of Maryland, Oct. 1975.

7. Ole R. Holsti, "Crisis, Stress and Decision-Making," International Social Science Journal, vol. 23, '71, p. 63.

8. Marge Epperson, M.S.W., "Families in Crisis", presented to the International Emergency Medical Services Symposium, Baltimore, Md., May 10-12, 1976.

BIBLIOGRAPHY

Bourne, Peter G., "Treatment of the Drug Abuser in an Emergency Medical Services System," System Response to Behavioral Emergencies, William C. Huddleston, ed., presented to the National Symposium on Emergency Medical Services Patient Care Systems Design and Implementation, Grand Rapids, Michigan, Nov. 11-13, 1975. (to be printed by Dept. HEW 1976-77.)

Cavan, R.S. and Ranck, K.H., The Family and The Depression, University of Chicago, 1938.

Eliot, Thomas D., "handling Family Strains and Shocks," Family, Marriage and Parenthood, Howard Becker and Reuben Hill, eds., Heath and Co., Boston, 1955.

Epperson, Marge, "Families in Crisis," Presentation to the Emergency Medical Technician - Ambulance Instructors' Association of Maryland, taped Oct., 1975.

Epperson, Marge, "Families in Crisis," Presented to the International Emergency Medical Services Symposium, Baltimore, Md., May 10-12, 1976. (tobe published 1976-77.)

Erikson, Kait, "Lossof Communality at Buffalo Creek," American Journal of Psychiatry, vol. 133, no. 3, March, 1976.

Goldberg, "Family Tasks and Reactions in the Crisis of Death," Social Casework, vol. 54, June '73.

Hamovitch, Maurice B., The Parent and the Fatally Ill Child, Delmar Publishing Co., Los Angeles, 1964.

Hill, Reuben, Families Under Stress, Harper and Bros., New York, 1949.

Holstic, O. R., "Crisis, Stress and Decision-Making," International Social Science Journal, vol. 23, '71.

Koos, Earl L., Families in Trouble, Kings Crown Press, New York, 1946.

Koos, Earl L., "Class Differences in Family Reactions to Crisis," Marriage and Family Living, vol. 12, no.3, 1950.

Lynch, James J., "The Effects of Tactile Stimulation on Acutely Ill Patients" presented to the International Emergency Medical Services Symposium, Baltimore, Md. May 10-12, 1976.

Newman, Janet, "Children of Disaster: Clinical Observations At Buffalo Creek," American Journal of Psychiatry, vol. 133, no. 3, March, 1976.

Parad, H.J., Crisis Intervention: Selected Readings, Family Service Association of America, New York, 1966.

Parad and Parad, " A Study of Crisis-Oriented Planned Short Term Treatment," Social Casework, June and July, 1968.

Rangeli, Leo, "Discussion of the Buffalo Creek Disaster: The Course of Psychic Trauma," American Journal of Psychiatry, vol. 133, no. 3, March, 1976.

Resnik, H.L.P. and Ruben, Harvey, eds. Emergency Psychiatric Care: The Management of Mental Health Crises, Charles Press Publications, Bowie, Md. 1972.

Robinson, "Family Reaction to Stress," Medical Social Work, vol. 22, June, 1969.

Spiegel, John, "The Resolution of Role Conflict Within the Family," Psychiatry, vol.20, no. 1, 1957.

Titchener, James L. and Kapp, Frederick T., "Family and Character Change at Buffalo Creek," American Journal of Psychiatry, vol. 133, no. 3, March, 1976.