

# Situational Crisis

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# Question??

- Have you ever received a referral in the ED from Mental Health stating that a Pt is not mentally ill but experiencing a situational crisis?





# Outline and Outcomes

- The issue of *Acute Mental Health vs Situational Stress* is becoming a hot topic in Emergency Department settings.
- Today we will be looking at:
  - Definitions of Situational Crisis
  - Assessment Skills
  - Intervention skills
- Outcomes:
  - to obtain knowledge and skills to manage these presentations in the Emergency Department, and use with clients throughout the hospital setting.





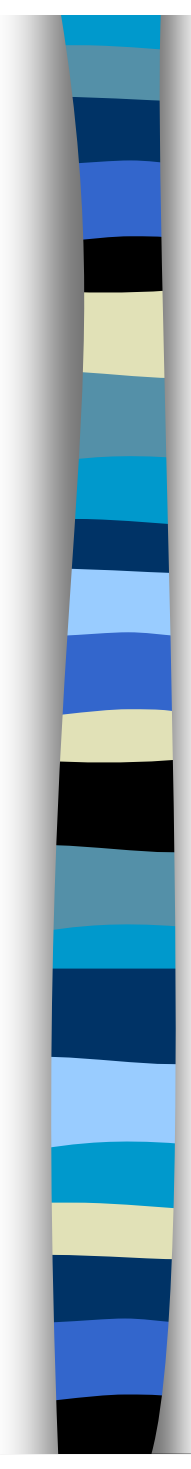
# Situational Crisis

## ■ Definitions

Crises are experienced by people of all ages, cultures, and socioeconomic conditions, and may not be related to a specific mental disorder.

Crises begin with a precipitating event and intensify into feelings of fear and emotional disequilibrium. (Hamilton 2007)

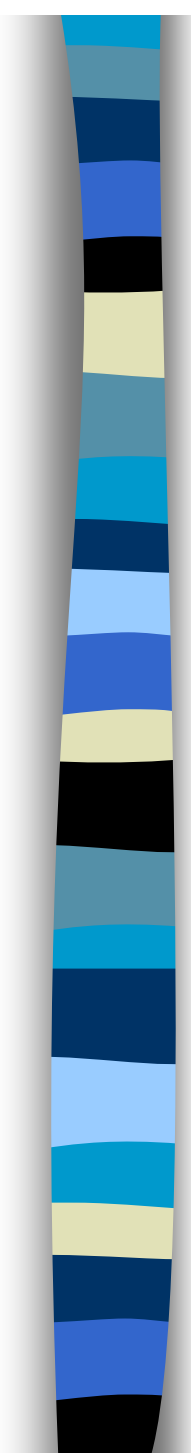




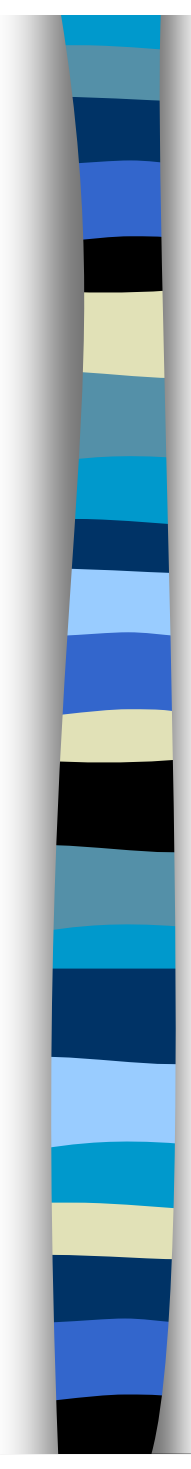
In 1965, Caplan noticed that crises develop in four predictable phases:

- **Initial threat.** People are faced with a problem or conflict. In an effort to lower their anxiety, they employ various defence mechanisms, such as compensation (using extra effort), rationalization (reasoning), and denial. If the problem is resolved, the threat disappears, and there is no crisis.
- **Continuing threat becomes a crisis.** If the problem persists, people in crisis become increasingly distraught and their anxiety grows to serious levels. In crisis now, they become disorganized and have difficulty thinking, sleeping, and functioning. They initiate trial-and-error efforts to solve the problem and restore emotional equilibrium.



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- **Crisis intensifies to panic.** When trial-and-error attempts fail, their anxiety intensifies to severe and panic levels and the person is immobilized with fear. Some people in crisis redefine the problem, attack it from a new angle, and try again to find a solution.
  - **Serious disorganization and assault.** If the problem is not resolved and new coping skills are ineffective, anxiety may overwhelm the person and lead to serious disorganization, depression, confusion, violence against others, or suicidal behaviour. (Varcarolis et al., 2006)





**A Situational Crisis** is not a diagnostic term.

It is a phrase given to a person whose coping mechanisms are affected due to their circumstances - in the absence of a mental illness.

**Common Stressors precipitating psychological distress**

- **Losses-** Bereavement, separation, divorce, financial losses, loss of status, reduced physical capacity.
- **Life Changes-** New job, moving house, entering university, marriage, retirement, developmental stage eg. adolescence .
- **Problems with-** Relationships including DV, accommodation, work, finances, legal system.





# How does a person in situational crisis present in the ED?

Presenting symptoms may be a combination of Behaviour, emotions, thoughts and physical:

- Self Harm and aggression
- Hysterical, Screaming, agitated, highly distressed and crying
- Under police section
- Self presenting due to psychosomatic symptoms
- Withdrawn, flat, teary, exhausted
- Comments about suicide
- Discharged from MH service, not found to have acute depression, psychosis, low risk of suicidality/homicidality.







# Normal Reactions in a crisis

## Acute responses:

- Helplessness
- Confusion
- Anxiety
- Shock
- Anger
- Scattered/erratic thought processes
- forgetfulness
- Distressed/crying
- Screaming/agitated
- Hyperventilation
- Dizzy/shortness of breath
- Abdominal pain
- Headaches
- Shaking/trembling





# Assessment - role of MH

The role of the mental health clinician is to assess if a persons presentation is affected by a mental illness. The following model is used:

- **Mental State Examination-** This includes appearance, behaviour, affect/mood, speech, thought form/content, perception, cognition, memory, orientation, insight, judgement.
- **Risk Assessment**
- **Physical examination-** AOD issues, blood tests, CT scans etc
- **Corroborative history-** History from family, friends, old records, police etc

## Risk assessments include;

- General risk factors - psychiatric background, drug & alcohol abuse
- Suicide - suicide and self harm history, significant life events, hopelessness/despair, isolation, family history of suicide
- Violence/Aggression - history of violence, childhood abuse, paranoia, command hallucinations, agitation/frustration, reduced ability to control behaviour
- Other Vulnerabilities - sexual/ financial vulnerability, harm to children, delusional beliefs, self neglect

Based on this risk assessment, the mental health clinician will deem if the patient is safe to be discharged from mental health/the hospital.





# Role of MH cont..

- Mental health clinicians are cautious not to pathologise a situation - just because your having a bad day, doesn't mean your mad
- The absence of a current diagnosed mental illness does not mean a mental health problem wont evolve down the track eg depression - but the assessment shows the current presentation is directly related to situation
- People can present with symptoms or traits of a mental illness without meeting the diagnostic criteria e.g low mood, poor sleep, suicidal ideation etc Passive suicidal thoughts e.g. 'What's the point in living', with nil plan/intent

Mental health clinicians can also be utilised in a advisory capacity.





# SW intervention strategies and Skills

## Skills

- Remain calm and in control despite Pt distress.
- Allow ventilation and debriefing
- Listen and explore meaning of the crisis for the pt.
- Normalise the feelings expressed by Pt.
- Partialise the overwhelming nature of the crisis
- Prioritise and problem solve one issue at a time
- Explore support systems and ways in which they have problem solved in the past.

## Skills

- Write a plan of action with the Pt. starting with the most immediate issue and what they need to do.
- Encourage keeping a journal or using a diary to record important information, appointments etc
- Provide information on relevant issues eg. Gambling resources, adolescent development etc
- Encourage and discuss self care
- Make referrals to relevant agencies.





# Managing Risk

## Skills

- Safety of the Pt and staff must be the focus constantly throughout the intervention.
- The main types of risk in the ED are risk of absconding, aggression and self harm. De-escalation is preferred approach to managing risk.
- Asking if someone has thought about committing suicide does not make them do it! Provide patients with a safe, unbiased and non-judgemental space to express their fears and feelings.
- Direct questions to ask of people who are at risk for suicide are:
  - Have you ever felt that life was not worth living?
  - Have you been thinking about death recently?
  - Do you ever think about suicide?
  - Have you ever attempted suicide?
  - Do you have a plan for committing suicide?
  - If so, what is that plan? (APA, 2003)





# Managing Risk

## Resources

- Help patients identify their own strengths and resources e.g. staying with a friend, talking to family. Safety plan.
- Identify protective factors e.g. children, religious beliefs
- Culturally specific supports e.g. Migrant Resource Centre - Nepalese Support Project
- Counselling, psychology, Lifeline
- Acute Care Team - Community Mental Health Crisis Service for St George catchment area. Provides short term intensive intervention, operating a 24/7 service Ph: 9553 2595
- Websites: Reachout, Headspace, SANE



# Case examples

- Miss N aged 27, walked in to ED saying she had been hit by a car in Kogarah while crossing the road. Pt was well dressed in business suit and heels.
- History given to medical staff was patchy and incoherent, Miss N crying and sobbing, but was found to have nil injuries. Referral made to SW as Pt refusing to speak to male MH Nurse.
- Pt initially reluctant to engage with SW but with gentle persistence she started disclosing the following.
- Miss N came to Kogarah from work in a finance company in the city. She came to visit her “boyfriend”, but states he was not home.
- Miss N states her BF recently returned from China and she had found out from a friend that he had been having an affair with a girl there. This had been going on for several months whenever he visited his family in China.
- The girl in China was pregnant, baby born during BF’s last visit to China.
- Miss N describes feelings of utter betrayal and anger. States BF had “forced” her to have 3 abortions over last 18 months refusing to marry her despite 8 years in a relationship.
- Miss N stated BF was now deliberately avoiding her. Reports she has wasted her life waiting for him to marry her, described not wanting to live any longer.
- SW asked directly about the incident with the car- Pt stated she became upset when he wasn’t home and run onto the road/traffic with intent to harm herself. A car narrowly missed hitting her, just caused her to tip over. The driver offered to help her so she asked for his mobile phone to call her BF. She told BF she had been hit by a car however he said he didn’t care what happened to her.



# Case examples

- Ms J self presents to ED with injury to the head, bleeding from a significant laceration, which she reported was self inflicted.
- Ms J was was agitated and loud, alternatively crying and screaming. She was accompanied by a friend.
- Mrs J was referred to MH due to the self harm presentation.
- She disclosed head butting a wall until she bled after receiving bad news. MH risk assessment found no evidence of depression, suicidal ideation or psychosis. Pt referred to SW.
- Assessment conducted with Pt who was still agitated and distressed. She reported finding out her 14 yr old Dtr had been sexually assaulted the night before by a 35 yr old family friend. Dtr was currently with a teacher from school at Westmead hosp having an examination.
- Pt reports she was so overwhelmed and hysterical when the school called her that she became unable to cope, head butting a wall in her distress. Pt still describing thoughts of wanting to die due to feeling she had failed as a parent to protect her dtr.





# Case examples

- Mr B self presents to ED with thoughts of suicide. Referral to MH who are not able to diagnose acute depression, suicidality etc. Pt found to have significant social stressors which are impacting of his ability to cope. Pt referred to SW
- Mr B is a young man aged 28. He has an above knee amputation from an MVA in his teens. Pt has been high achieving, highly functioning and independent despite this disability.
- Mr B has travelled around the world completing challenging mountain climbs for the past 6 years. His goal was to climb Mount Everest.
- He lived alone, but had many friends. He worked as a TAFE teacher.
- Recently Mr B had lost a significant sum of money after an investment in a film making opportunity of his climbing achievements did not eventuate. He had resigned from his job to focus on this.
- Mr B also recently failed to complete a climb that was a prelude to travelling to Nepal to climb Mount Everest
- Mr B reported a huge loss in confidence and ability to trust in his own decision making.
- He reported not being able to pay rent, pay his car loan and computer repayments.
- Reported the world would be a better place without him in it.

