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ABSTRACT

A basic tenet of this paper is that the concept of crisis and crisis management has developed as a central issue within the fields of community psychiatry, psychology, and mental health, but that little systematic attention has been devoted to a particular subgroup at risk, i.e., older persons. Both theoretical background and clinical implications for crisis management, especially in long-term care settings, are discussed. Important differences for the elderly that warrant attention are examined, including the type, perception of, and number of stressful events which can precipitate crises, e.g., nursing home residents who are exposed to an alarming number of these events as a direct result of entry into the nursing home. Three levels and types of crisis intervention are proposed to help older persons in crisis situations, including preventive, clinical, and problem-solving approaches. (Author/JAC)

CRISIS INTERVENTION WITH OLDER PERSONS: STATE OF THE ART AND CLINICAL APPLICATIONS.

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Introduction

The concept of crisis has been systematically researched since the 1940's and the existence of crisis as a distinct psychological event has been well established. Crisis responses have been noted as reactions to both catastrophic and normal developmental events, in both severely disturbed and well-integrated individuals. In the central concept, as developed by Gerald Caplan (1), crisis represents the impasse an individual faces when confronted by a perceived stressful event which is not amenable to previously learned coping skills. The typically brief time-span and potential for personal growth as new skills are developed in crisis mastery has encouraged the utilization of crisis intervention as a formal procedure in mental health services.

While crisis theory has developed and research and treatment have been conducted with several special populations, little attention has been given to the special significance of crisis for older persons. It is a fact, however, that a wide array of particular stressful events tend to be associated with the process of aging, and that several of these events (e.g. death of spouse, retirement, loss of income, physical and sensory disability, illness) may coincide in one time period. It is also significant that despite these multiple and interacting stressors, personal, social and institutional resources may be less available in later life.

The Concept of Crisis

The term "crisis" is used so widely and with such different meanings that it is probably useful to specify and differentiate the use of the term as it is utilized here. For many persons, the word "crisis" is

synonymous with "emergency" with all its overtones of urgency, alarm and the need for immediate intervention. Another concept often used synonymously is the "stressful event" itself in its various forms. Most commonly, however, crisis is defined as a set of emotional reactions typical of the crisis situations.

In fact, while these various phenomena are often associated with the crisis experience, they are not synonymous with it. Not all emergencies are crises, not all stressful events will uniformly precipitate the crisis experience, and emotional reactions, such as panic, do not necessarily indicate a true crisis experience.

Most accurately, crisis is the experience of helplessness, inability to cope that a person experiences when faced with a stressful event that extends him/her beyond his/her current coping repertoire.

The following process model is offered in explanation of the crisis experience and the various accompanying factors mentioned above.

Figure 1 about here

The stressful event is, of course, the precipitating force in the etiology of a crisis, but it must be understood that it is the subjective experience of stress that is the critical factor. Many persons may experience the same stressful event, but not in all cases will it become a crisis. A typical listing of stressful events may be seen in the Holmes and Rahe stress scale (2) and it can be seen that these life events are generally understandable as either developmental/maturational or situational. Many stressful events, however, such as entering into

marriage, are both developmental and situational in nature.

The essence of the crisis experience is the way in which these events are experienced and perceived by the person. Depending on the person's past experience of this type of event, or the general level of their coping skills, a particular event may leave him/her immobilized and without any perceived ability to cope. This is variously experienced as a "threat," an "impasse" or even as a "breakdown." It might be suggested that in many cases where people are said to have had a "nervous breakdown," we might reasonably assume that in fact a crisis has taken place. And viewing the experience as a crisis rather than as a "nervous breakdown" would suggest a more remediable situation and a more hopeful prognosis.

Viewing a crisis from a systems perspective leads us to understand crisis as a disequilibrium in the customary coping mechanisms and as a challenge for homeostatic, or better, "homeodynamic" (3) readjustment within the person's life.

Caplan (1) contributed significantly to crisis theory when he pointed to the essentially subjective nature of the response to stressful events. It should be noted, however, that some hazardous environmental situations, such as a fire, are almost universally experienced subjectively as dangerous and difficult. Despite this, the more precise definition of crisis as the subjective experience of feeling helpless and out of control helps make important distinctions even among such universally traumatic events. By no means do all older persons experience retirement, death of spouse, institutionalization as crises, although they will usually be stressful events.

A person who is in crisis will frequently become symptomatic as the stress is expressed in various ways. Anxiety and panic-like reactions are common, with the person expressing their sense of impasse by "rushing in many directions" at the same time, with little useful outcome. Alternatively, a person's impasse may be (reasonably) expressed by immobility - an almost catatonic-like state - as they are overwhelmed by the stressful event and its perceived insolubility. These symptoms are often frightening, both to the person in crisis and to potential helpers. It should be realized, however, that such emotions might well be conceived as normal expressions of what the person is experiencing.

As might be expected, the crisis experience described above is acute, not chronic, by nature. In physiological terms, one would not anticipate that the human organism could tolerate such extreme arousal for extended periods and therefore there is a tendency to restore equilibrium and bring the dilemna to resolution. As indicated in Figure 1, there is a response phase in the resolution of the crisis. This response may be either effective or ineffective. These terms are defined functionally, rather than ideally. An effective response may not be ideal or optimal (there may be no ideal solutions to some problems!). Does the person's response/solution allow him/her to regain equilibrium and regain normal functioning? Further, having learned this new response, will the person be better able to confront this or other stressful events should they reoccur? If the answer to both questions is "yes," then the person has functionally made an effective response. If the answer is "no," then the response is ineffective - the person has not learned from the crisis.

This latter point is critical in understanding the role of crises in human development. This concept of the crisis presented here describes a process that is developmental rather than pathological. It can well be viewed as an adaptive process rather than a deficit in the personality. Crisis is an essentially normal experience, whether on a minor or catastrophic scale, allowing a person to gradually increase his/her sense of mastery over challenges that come with living, and concretely enlarging the repertoire of coping skills.

Finally, mention must be made of the time factor in the development and resolution of a crisis. Since crises are acute rather than chronic, early studies of crisis noted that crises will occur and be resolved within a finite time period. Lindemann (4) in his work with the survivors and families of victims found that they were functioning again after a period of 4-6 weeks. More recently, in a study with cancer patients, Lewis, et al (5) found that patients who experienced crisis as a result of their diagnosis were again functioning (not without distress, of course) in their daily lives within a period of 2-28 weeks. The time span seems to vary according to personal differences and the nature of the precipitating stress. Lewis was able to conclude, however, that the crisis experience is essentially time-limited by nature.

This has implications for diagnosis and intervention in crisis. The caregiver can have some assurance that his/her involvement with the person in crisis may be intense, but it will be time limited. The time factor also is useful in differentiating between persons undergoing a period of "psychological distress," which may last indefinitely, and persons in

in crisis, strictly defined. As the caregiver continues to provide help to a person beyond the time periods indicated above, it is reasonable to question whether the client ever was, or still is, in crisis. It may be that the caregiver, erroneously, assumed the presence of crisis on the basis of symptoms of panic and anxiety; some persons know how to cope, but do not choose to do so, using panic and anxiety as a "signal" to invoke help. Alternatively, the caregiver may be mistaking the symptoms of an ineffective response (eg. depression over bereavement) for the symptoms of ongoing crisis.

Levels of Intervention

The process of crisis has received most attention within the fields of community psychiatry and psychology and public health. This is particularly so since crises are amenable to relatively brief forms of intervention. These approaches have suggested that treatment might better be based on the concept of positive mental health rather than on more traditional and potentially negative concepts of psychopathology. A crisis, viewed as an oppportunity for growth becomes an opportunity for relatively brief, and inexpensive forms of intervention. Thus, the use of supportive social resources and focussed brief treatments, often by non-professionals, can produce a maximum of therapeutic effects.

Figure 2 illustrates three such levels of intervention, based on the concept of crisis prescribed here.

Figure 2 about here

Preventive approaches to crisis intervention are clearly the first-choice strategy where possible. While crises are essentially subjective and therefore often difficult to predict for the individual, it is possible that community educational approaches could head off potential crises in such frequent stressors as retirement, death of spouse, loss of income, etc. These are some events which are common enough and stressful enough to put large groups of older persons "at risk" of crisis. A well-advised nursing home administrator, for example, might avoid predictable crises (and general high levels of stress, of course) by devising administrative, educational and service policies which would minimize the risks to elderly residents.

When a crisis is unavoidable, a series of brief clinical interventions can be used to lower the level of perceived stress and guide the person through the crisis experience. These involve "taking over" for the person for a short period in a fairly directive, "authoritative" manner, using breathing control exercises and systematic muscle relaxation to decrease anxiety, and managing various other helping resources such as family and staff in a coordinated way. To offset the person's sense of loss of control in crisis, the caregiver must clearly provide a safe and predictable environment.

When control is reestablished there is the opportunity to focus on problem-solving strategies as the person examines the costs and benefits of various solutions to the perceived impasse. One challenging aspect of the problem solving phase is confronting the fact that no palatable solution may be at hand.

Stresses on Older Persons

While stressful events cannot be equated with crises, per se, it is highly possible that older persons may be more at risk than younger persons in the number of stresses they face. This is not precisely because of old age itself, but rather because of a series of stressful events that in fact often accompany later life in contemporary society.

This author has frequently utilized the Holmes and Rahe stress scale (2) to examine the configuration of stresses experienced by older persons as they enter a nursing home, for example. It is a presumption of the authors of this scale that a person would be "at risk" if they had experienced even a relatively small number of these events within a given year. This author has reviewed the stress scale with numerous nursing home residents and personnel, and finds that a typical resident is exposed to an alarming number of these events as a direct result of entry to a nursing home. Further, since the scale is designed for a general population, it by no means covers the full range of stressful events potentially experienced by older persons specifically.

Multiple and Interacting Crises

There are two implications which suggest that persons may be particularly at risk as they reach later life and particularly as they face institutionalization in a nursing home. The first is that the number of precipitating events is likely to increase; the second is that these events occur interactively in a relatively short life span. Consider the following confluence of stressful events that may coincide at about the time of entering a nursing home. A person may well experience the

following set of situations taken directly from the Holmes and Rahe scale

Detention in institution

Death of spouse

Major change in sleeping habits

Death of a close family member

Major change in eating habits

Revision of personal habits

Death of a close friend

Major change in health or behavior of a family member

In-law troubles

Major change in number of family get-togethers

Major change in financial state

Change in residence

Marital separation from mate

Major change in church activities

Major change in number of arguments with spouse (more, less)

Spouse ceasing work outside of home

Major change in usual type and/or amount of recreation

Obtaining psychological counseling or services

Major personal injury or illness

Major change in social activities

Major business readjustment

Major change in living conditions

Christmas (away from home)

Retirement from work.

To which might be added several specifically geriatric situations such as:

Loss of sensory acuity (hearing, sight)

Loss of drivers' license and personal automobile.

Such is the scale and number of these situations that it is hard to imagine any other phase of life when the potential losses are as numerous or acute, or a period in life when these events are as likely to interact within the same time period. In fact, the situation would seem well nigh unmanageable except for the fact that older people are "survivors." They have a history of coping with stresses and crises, and surmounting them. It is probably true that younger persons would be far less equipped to deal with such a situation.

Conclusion

The nature of crisis and the pattern of its occurrence among older persons suggests that renewed attention be given to crisis management within the various health services. Most critically there exists a need to prevent the most serious and predictable crises facing persons in later life. This will only be successful if relevant policies can be developed at the administrative level in health, education and community service agencies.

The mental health professions will also need to first develop a much clearer awareness of the mental health needs of older persons, soon (by 2020) to be 1 in 5 of the population. Specifically, an increasing sensitivity must develop to the range and type of stresses which threaten to precipitate crises among older persons.

Clearly, systematic research is needed to investigate these issues more thoroughly; because of definitional problems, the area of crisis has been notoriously under researched. Some indication of the seriousness of the problem may be seen in the high levels of even reported suicides and depression among the elderly (6). It is also seriously argued that organic deterioration among older persons may mark reactive depression in response to stressful life situations.

At best the position argued by this paper implies a need for serious future research. At worst it implies a need for immediate corrective action by policymakers and service providers.

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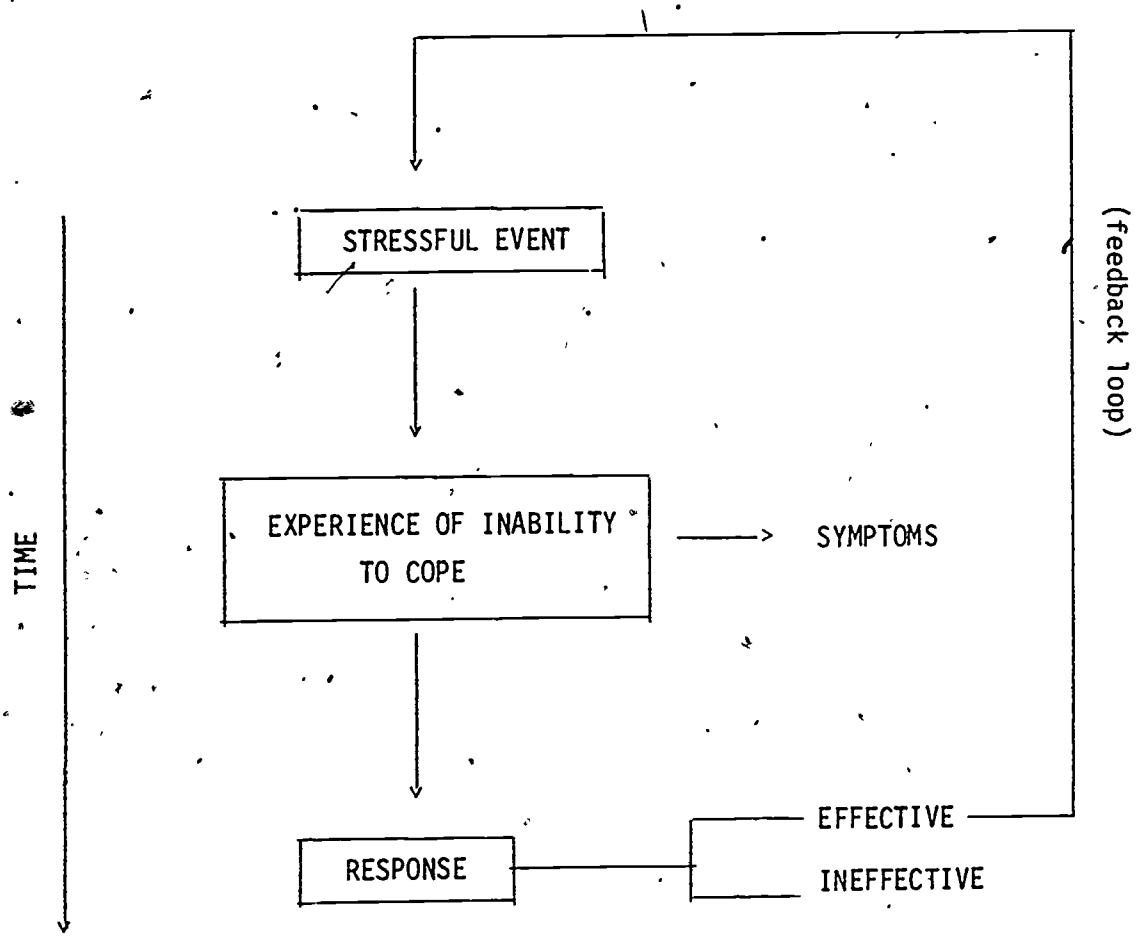

Figure 1 A Process Model of Crisis

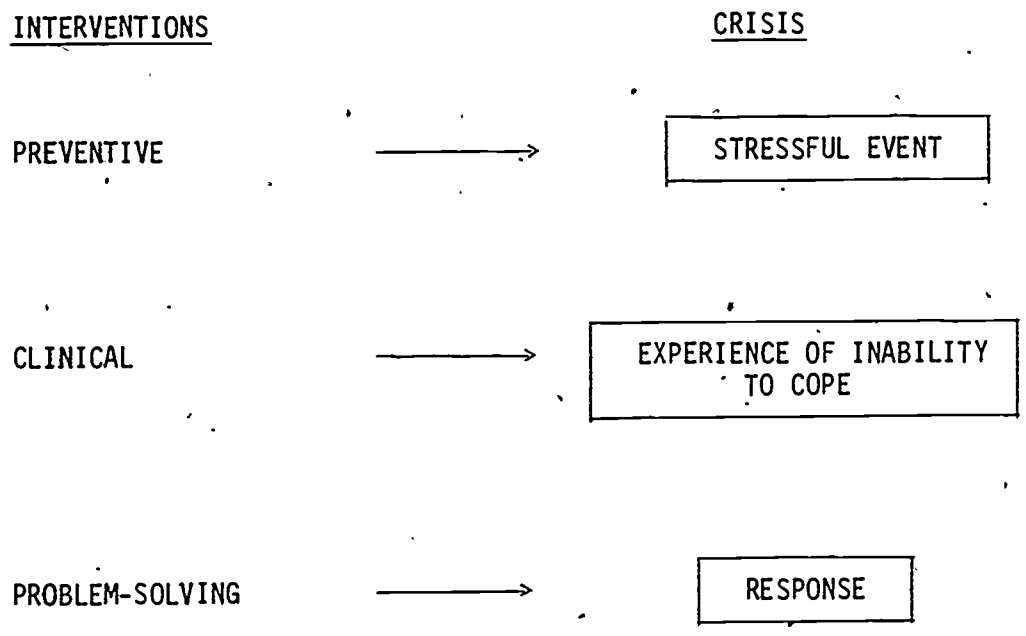

Figure 2 Levels and Types of Crisis Intervention