

Approaching complex cases with a crisis intervention model and teamwork: A commentary

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Crisis Theory

- ◆ Crisis: a period of disequilibrium and decreased functioning as a result of an event or situation that creates a significant problem which cannot be resolved by using familiar coping strategies (Roberts, 2000).
- ◆ The crisis is not the event itself, but rather the individual's perception of and response to the situation (Parad, 1971).
- ◆ Acute responses: helplessness, confusion, anxiety, shock, and anger (Golan, 1978)

Case Study: SA

(O'Daniel & Wells)

- ◆ SA: individual case study of a woman plagued by the news of a potentially aneuploid fetus and the challenge of having to make decisions regarding amniocentesis as well as self and fetal testing for Huntington's Disease (HD)
- ◆ Additional stressors include: the limited time frame for decision-making (dictated by the pregnancy), lack of social support, limited financial resources, and potential compromised cognitive functioning (a result of early HD symptoms).
- ◆ Crisis response: anxiety, confusion, scattered/erratic thought processes, and forgetfulness
- ◆ Issues raised: pregnancy termination, employment and insurance discrimination, and the long-term emotional and psychological impact regarding the knowledge of her own and child's incurable, fatal illness.

Crisis Intervention

(Payne, 1991; Roberts 2000)

- ◆ Beginning Phase: 1) build relationship and joining; 2) define and assess the crisis situation; and 3) develop goals and an action plan to meet these goals.
- ◆ Action Phase: 1) collect any additional information to guide actions; 2) address potential barriers to implementation; 3) draw on all strengths which can help the patient implement the plan; and 4) implement the plan.
- ◆ Termination Phase: 1) review the actions taken and evaluation of their success; 2) counselor anticipatory guidance (Hepworth et al., 2002); and 3) process the patient's feelings regarding termination of counseling relationship.

The Beginning Phase

- ◆ Focus specifically on the crisis situation, but expand beyond the factual information to include the patient's current emotions.
- ◆ Explore the meaning and importance of the crisis situation from the patient's perspective, and identify the emotional and affective responses.
- ◆ Partialize the crisis – break it down into manageable smaller issues which can be addressed individually (Ragg, 2001).
- ◆ SA's experience: easily established rapport and trust; partialized crisis into 2 issues that resulted in decreasing her anxiety and helping her to make decisions one at a time; and was able to define her goals and develop an action plan.

The Action Phase

- ◆ Counselor and patient operationalize the strategies developed during the beginning phase.
- ◆ Counselor and patient obtain all additional information, including the individual's barriers and strengths
- ◆ Implementation of the plan
- ◆ SA's experience: counselors obtained more detailed medical and psychological data; identified barriers (isolation, finances, and cognitive limitations); acknowledged strengths (resilience in past difficulties). SA was able to meet her goals and make her own decisions, while addressing the lack of social support and financial resources.

The Termination Phase

- ◆ Counselor and client review the actions taken and evaluate their success (but allow return to the action phase if crisis is not fully resolved).
- ◆ Anticipatory guidance: helping the patient think about potential future crises, how they might be addressed, and where future support may be found (Hepworth et al., 2002).
- ◆ Process patient's feeling around ending the therapeutic relationship.
- ◆ SA's experience: successful completion, with the counselors providing local HD testing site for SA's self testing, if desired in the future.

Non-directiveness

- ◆ Key principle in genetics counseling
- ◆ Defined: value-neutral communication where the genetic counselor provides information for patient's decision-making, without imposing personal values (Anderson, 1999; Bartels et al., 1997).
- ◆ Balancing directiveness & non-directiveness is difficult: Survey of genetic counselors by Bartels et al. (1997): 96% reported non-directiveness to be important or extremely important; however, 72% reported occasionally using directives in their work in "an apologetic tone."
- ◆ Kessler (1997): "there is a gray area between directiveness, with its techniques of coercion, and non-directiveness" (p. 165).

Non-directiveness and Decision-making

- ◆ Concept of non-directiveness is based on autonomy (Witmer et al., 1986).
- ◆ Truly autonomous decision-making requires informed choice
- ◆ Elements of informed choice: 1) understanding; 2) voluntariness; and 3) disclosure (Applebaum et al., 1987).
- ◆ The counselor explores feeling and meaning so the patient can fully understand the issue and the impact of possible actions, addresses and attempts to minimize paralyzing patient emotions, and provides useful ways for the patient to frame and tackle the problem.
- ◆ The counselor does NOT define the meaning or feelings for the patient, inject personal values or opinions, or choose the patient's course of action.

Non-directiveness and Decision-making

- ◆ Therefore, non-directiveness around *content*, but directiveness around *process*, may be appropriate.

Activity: Role Play

References

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