METHODS OF PSYCHOLOGICAL INTERVENTION IN ANXIETY*

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Abstract: *Goal:* The present study investigates the efficiency of a psychological intervention for students who show symptoms of anxiety. What motivates this study is the fact that the psychologist must not only evaluate and monitor students psychological evolution, but also to intervene in a preventive or therapeutic way.
Methods and instruments: Out of the students we evaluated periodically, we selected 19 individuals who showed higher level of anxiety symptoms, in order to include them in a psychological intervention program. The intervention targeted cognitive aspects: positive reformulation of experiences, emotional aspects: awareness and acceptance of intense emotions and a behavioral aspect: development of new or improved coping strategies. The intervention comprised of six meeting. Pre-intervention and post-intervention psychological assessment was done with Hamilton Anxiety Scale.
Results: The scores for anxiety symptoms, for the entire lot, were significantly lower post-intervention than those pre-intervention, showing a decrease in the intensity of symptoms. Yet, 4 of the 19 subjects showed stagnation or an increase of scores, indicating no improvement of symptoms.
Conclusions: The short intervention we proposed had positive outcomes in most cases, 79% of participants showed significant decrease in symptoms. In the cases

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were the intervention showed no improvements we intend to continue it with the consent of participants.

Key words: students, anxiety, psychological intervention, Hamilton Anxiety Scale

Introduction

The students are frequently and constantly exposed to stressful life events. A critical incident represents a highly stressing event which can significantly disturb the physical and psychological function and wellbeing. The critical incident is a stimulus which can trigger a physical and psychological crisis (Burns, Rosenberg, 2001).

The response to critical incidents and to any other stressful situation is determined by objective features of the situation, by individual's subjective perception and interpretation of the situation, by the state of physical health and psychological wellbeing, by the coping mechanisms, by as series of psycho-individual factors such as emotional stability and responsiveness, self esteem, perceived self-efficacy, sense of coherence, locus of control, but also by several psycho-social factors (Baba, 1998; Iamandescu, 2002; Maier, 2011).

The stress generated by critical incidents induces changes both at a physiological and somatic level, as well as at a psychological and behavioral level. At physiological level, one can show cardiac dysfunctions, neurological and endocrine dysfunctions, myalgia, somato-visceral dysfunctions (Iamandescu, 2002). At psychological level one can show sensorial and perceptive dysfunctions, cognitive, emotional and affective dysfunctions and, in some severe cases, even psychotic decompensations. These dysfunctions can be reversible or irreversible (Maier, 2011).

Physical symptoms include: shivers, thirst, fatigue, nausea, feint or tendency to feint, vertigo, vomiting, headaches, myalgia, spurts of high blood pressure, chest pains, accelerated heartbeat rhythm, muscular tremor. Generally they can be described as high physiological responsiveness. At cognitive level one can show: confusion, uncertainty, denial, hyper-vigilance, concentration problems, time and space disorientation, decrease in decision making. At a emotional and affective level, the most frequent symptoms refer to: anxiety, self blaming, panic, agitation, irritability, impulsivity, depression, anger, fear, suicidal thoughts, inadequate emotional responses (either regarding the intensity

or the nature of expressed emotions), hyper or hypo-emotionality. And at behavioral level one can find: social withdrawal, antisocial behaviors, abuse of alcohol and substances, psychogenic flight, impairment in family (Maier, 2011).

Methods and instruments

The study was run on a lot of 19 students that showed some anxiety symptoms. All subjects are males, aged between 16 and 18. The age average is 17 years while the standard deviation is 3.77 years. Subjects were selected from the entire students periodically assessed on the basis of higher scores on Hamilton Anxiety Scale. The selection of subjects took in account the scores that could be consider of clinical significance at least at one of the two scales used.

The 19 subjects' lot has undergone a psychological intervention which aimed to reduce the intensity of anxiety symptoms. The intervention focused on following aspect: a) awareness of one's own intense emotions and feelings experienced after a critical incident; b) emotional unblocking and confronting with the intense experiences triggered by the critical incident; c) investigating and acknowledging the negative consequences of one's own inadequate response and coping strategy to stressful events in the professional and personal life (family, social relationships); d) positive reformulation of highly stressful experiences; e) replacing the less functional coping strategies, focused on emotion relief, with more functional ones, focused on problems and solutions. The intervention comprised of six meetings with each of the 19 subjects, respecting each subject's privacy. Five of the six meetings focused on one of the five aspect mentioned above and the sixth one consisted of a summarization, a feedback and a chance to re-evaluate the subject's anxiety symptoms.

The Hamilton Anxiety Scale consists of 14 items, scored on a five steps scale, from 0 to 4. Maximum score is 56. Scores above 20 show the presence of clinical intensity anxiety.

Data were centralized and processed with SPSS for Windows 10. In order to investigate the differences between pre-intervention and post-intervention anxiety and depression scores, we used the paired sample t test due to the fact that the research design is a two factor within group. All 19 subjects assessed pre-intervention were subjects to the final assessment.

Results

Initial assessment

The scores on the anxiety rating scale, pre-intervention, subject scored between 9 and 17 with an average score of 11 and a standard deviation of 2. The intensity of the anxiety symptoms is not of clinical level, but as they are associated with the mild depression symptoms, taken together it could represent a risk factor for developing more severe emotional, cognitive and behavioral dysfunctions later.

Post-intervention assessment

At the end of the intervention another psychological assessment of anxiety symptoms was done. Results on the anxiety scale show an average score of 9.26 with a standard deviation of 1.97 and individual scores ranging between 6 and 13. We notice a drop in the average scores both for anxiety

Comparing scores at pre-intervention and post-interventions, with the paired sample t test, turned the following results. We must mention that for both rating scales as well as for both assessments, the distribution was a normal one. For the anxiety scale, we obtained $t(18) = 3.511$ at $p = 0.002$. The magnitude of the differences in scores revealed by the r coefficient shows the following figures: 0.637 for anxiety.

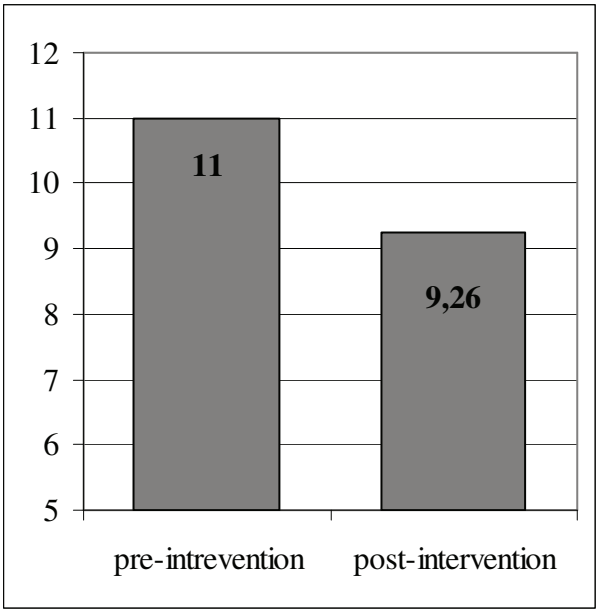

Figure 1. Average scores at the anxiety scale

Discussions

We notice that the t values, for anxiety are statistically significant at p values lower than 0.05 thus allowing us to state that anxiety levels dropped significantly as a result of the psychological intervention. Therefore we can say that our intervention achieved its goals, that of improving the students' emotional wellbeing as shown by the decrease of anxiety and depression symptoms. In the case of anxiety, the intervention explains 64% of the score variance from pre-intervention to post-intervention. Thus, the five step intervention we proposed seems to yield positive outcomes at an emotional and psychological wellbeing.

Analyzing the post-interventions scores, as for anxiety, 15 subjects show lower scores post-intervention, 1 subject scored identically post and pre-intervention while 3 subjects show an increase in scores post-intervention.

Also, in order to identify new strategies of intervention we consider necessary to investigate some other psychological variables which could influence students responses to stress as a consequence of frequent and constant exposure to critical incidents. Such variables are: self-esteem, perceived stress, post-traumatic stress growth, perceived self-efficacy, robustness, optimism, sense of coherence, tendency towards developing somatic symptoms as well as rational versus irrational beliefs (Băban, 1998).

The defusing represents a volunteer, short, individual meeting, in complete privacy that aims mainly to defuse the psychological and physical tension of the students. It has to take place short time after the incident, recommended at 4 hours but not later than 12 hours and does not have to be to formal, actually it is recommended to be as least formal as possible (Maier, 2011).The defusing is focused on the awareness and acceptance of one's own feeling as normal and on the adaptive or non-adaptive role of action taken post-event.

The debriefing is a more formal meeting, run within the group that took part in the incident, at an interval of about 24 – 72 hours and it focuses on different coping ways (Maier, 2011).

Research in the field of clinical and health psychology show that most recommended types of psychological interventions regarding the students are the short-term ones, focused on problems and solutions (Maier, 2011; Holdevici, 2002).

Conclusions

Our study shows that a short-term psychological intervention, centered on explicit goals, on problems and solutions, on positive reformulation of experiences without neglecting awareness and

acceptance of the students intense emotional responses in highly stressing situations and also these reactions' consequences on individual's, his family and peers' physical and psychological wellbeing can lead to a significantly improvement of anxiety and depression symptoms. Yet, there are individuals for which our intervention does not work. Therefore we must strive to improve our approach by looking for the causes of the intervention failure as well as trying to find other psychological variables that could enable us to improve the psychological intervention process. The diversity of therapeutic approaches and that of therapeutic methods available at the present allow us to develop improved therapeutic interventions.

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