THE PSYCHOLOGICAL INTERVENTION IN CRISIS SITUATIONS

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Abstract: *The society we live in is full of crisis-generating events. People face daily events that they cannot cope with on their own, such as wars, pandemics, natural disasters, famine, drought, financial problems, unemployment, political uncertainties, social upheavals, personal crises, divorces, deaths, or involvement in critical incidents. A professional category that goes through crises and is frequently exposed to critical incidents is the firefighter rescuers. (Vancu 2013) The role of the psychologist working in emergency situations is to provide psychological first aid in the initial phase of the crisis so that symptoms do not worsen and the firefighter can function at normal psychological parameters.*

Keywords: *crisis; traumatic events; firefighter rescuer; emergency; crisis intervention; psychological first aid.*

1. Theoretical foundation

People describe negative life events using words such as stress, distress, emergency, or crisis. However, stress is not a crisis; it is an event that triggers a non-specific defense reaction of the body to a threatening situation. Distress is an unpleasant situation perceived as dangerous or embarrassing, and emergency is a combination of circumstances that require immediate action. Distress or emergency leads to stress, and stress itself has the potential to become a "crisis." Whether distress or stress turns into a crisis depends on each individual's ability to deal with such life circumstances (Hoff, 1995).

Over time, various definitions have been given to the concept of crisis. A complex definition is provided by James and Gilliland (2005): "A crisis is a perception or experiencing of an event or situation as an intolerably difficult challenge that exceeds the person's current resources and coping mechanisms."

Crisis involves a rapid change in an individual's functional state, resulting from a contextual situation that is unusual and to which the individual reacts subjectively and emotionally, with the triggering event compromising the individual's emotional stability and coping ability (Yeager and Roberts, 2003).

"Crisis is not a mental or emotional disorder. Crisis can be defined as a serious situation or a turning point generated by danger or opportunity" (Hoff, 1995).

"A crisis is a perception or experiencing of an event or situation as an intolerably difficult challenge that exceeds the person's current resources and coping mechanisms" (James and Gilliland, 2005).

The word "crisis" derives from the Greek word "crisis," which means decision or turning point, and was introduced to the field of mental health in 1944 by Erik Lindemann. He studied the reactions of 101 individuals who experienced a crisis and found that "adequate management of grief reactions can prevent prolonged and severe disturbances of social adaptation and subsequent mental disorders" and highlighted the importance of caregivers in overcoming the suffering caused by a crisis (Lindemann, 1944).

Later, Gerald Caplan and a team at Harvard studied the reaction of families after World War II. He conceptualized a crisis as a short-term response to severe stress, which produces a disruption of individual "homeostatic" mechanisms. Following this disruption, the individual engages in activities aimed at restoring balance. Additionally, Caplan considers that a crisis occurs when the individual does not have an immediate solution to the problem at hand, feeling that it is insurmountable: "A crisis occurs when a person faces an important life obstacle that appears for a time insurmountable through the use of usual problem-solving methods" (Caplan, 1964).

In the 1960s, the first crisis intervention centers appeared, including phone lines for individuals in crisis and prevention centers in schools (Slaikeu, 1990).

It should be noted that there are no symptoms of crisis, as all manifestations are expressions of hyper-alertness of the autonomic nervous system, emotional imbalance, and the manifestation of pre-existing psychopathological disorders before the crisis occurs (Howarth, R.A., 2011). Each individual manifests differently in limit situations, which they cannot manage physically, mentally, emotionally, or spiritually.

However, analyzing all definitions and characteristics of researchers, there are several common reactions: sleep disturbances, eating disorders, fatigue,

abdominal cramps, digestion problems, diarrhea, nausea, headaches, difficulty making decisions, difficulty concentrating, difficulty solving problems, dizziness, loss of balance, irritability, emotional instability, muscle tension, fear, panic, nightmares, social withdrawal, isolation, feelings of guilt, feelings of hopelessness, emotional confusion, memory disorders, anxiety, hyper vigilance, suspicion, sadness and suicidal thoughts, aggression, blaming others, extreme sensitivity, and manic episodes (Doka, K., 2002).

Roberts and Yeager (2009) developed a classification that emphasizes the nature of the critical incident, which is the most commonly used in crisis intervention programs. Thus, we distinguish:

crisis is a danger but also an opportunity - it is a danger because it exceeds the individual's coping capacity; it is an opportunity because it makes them seek solutions and learn new coping methods for future crises.

crisis has a complex clinical aspect - characterized by unstable affective and behavioral elements

crisis contains the kernel of development and change - personal development is imminent because the individual mobilizes their existing resources and discovers new ones while resolving the situation that caused the crisis. A person who has overcome a crisis will never be the same again, and change is inevitable.

- crisis does not have standardized interventions - there is no recipe for overcoming a crisis. Each individual responds in their own way to a unique and unrepeatable situation.
- a crisis represents a necessity for change - it arises as a result of stagnation, inflexibility in the face of life situations.
- a crisis is universal - it is part of human existence, being present in all cultures. (France, K., 1982):

Whether they become crisis situations or not depends on how the person interprets the stressful events and crisis situation in their own way, based on cognitive schemas, previous experience, coping abilities, individual resources, and proximal support.

2. Research design

The present study is a qualitative one, based on the reality that firefighters attribute certain meanings to the world they live in, and these meanings are to some extent different from person to person (Myers, 2000). Investigating how

firefighters experience life, in this case, their experience of participating in a rescue operation involving a victim in agony, offers the possibility of describing different subjective realities.

Qualitative research provides the opportunity for a deeper understanding of the research subject, by analyzing the whole and the dynamics of the relationships between phenomena, capturing the human experience in all its richness. It investigates a small number of cases, sometimes under the conditions of a close interaction between the researcher, psychologist, and the cases themselves.

2.1. Objectives and hypotheses

The objective is to observe the stages of psychological crisis among rescue firefighters, provide psychological first aid, and prevent psychiatric problems.

Hypotheses:

1. Identifying normal reactions versus atypical reactions in firefighters at the intervention site;

2.Providing psychological first aid to rescuers at the intervention site;

3.post-session psychological evaluation of debriefing and defusing;

4.Psychological intervention to reduce psychological reactions in firefighters.

2.2 Research method

Instruments used:

1. Direct observation on site
2. Clinical interview;
3. Observation grid;
4. Beck Depression Inventory (21 items);
5. Somatization scale;
6. Quality of Life questionnaire;
7. Coping scale;
8. STAI X2 (trait).

Subjects investigated:

- 6 firefighter rescuers, one of whom was on his first rescue mission.

2.3. Description of the crisis situation:

Through a call to 112, an accident with three trapped victims is reported. A rescue team consisting of 4 firefighters and a Mobile Emergency Service, Resuscitation and Extrication Service (SMURD=MESRES) team consisting of a doctor, a nurse and 2 firefighters heads towards the accident site. The 6

male firefighter rescuers, aged between 23-48, from the emergency services participated in the extrication of three victims, one of whom was in agony, trapped in the car involved in the road accident. Of the 6 firefighters, one was on his first intervention, having just joined the team. A psychologist from the emergency services was also present at the scene.

2.4. Psychological aspects observed by the psychologist during the rescue intervention:

-the 5 firefighters act promptly, carrying out their activities according to specific procedures and protocols. They demonstrate emotional control, self-control, decisiveness, teamwork, effective communication, speed, and safety under time pressure, and resilience to stress.

-1 firefighter shows disorientation, total lack of action, difficulty concentrating, emotional imbalance, crying, fixed gaze, psychomotor agitation, and cannot communicate.

3. CRISIS INTERVENTION AND EVALUATION:

The role of the psychologist in a crisis is "to be present alongside the person in crisis, more of a companion than a guide, more of a friend than a teacher" (Welshons, 2002).

In order to carry out the crisis intervention plan, the model proposed by Roberts (Vrasti, 2006) was used and personalized.

Stage 1 - Early identification of the rescuer in crisis - immediate action, at the intervention site

In this stage, we analyzed the emotional, cognitive, and behavioral characteristics that all 6 firefighters directly manifested, and identified the specific symptomatology of the psychological crisis. This stage involves direct observation and data collection at the crisis site, in order to evaluate all firefighters and identify the firefighter in crisis and implicit danger to oneself and others, as well as the immediate psychological needs of the firefighter (Marineanu, V. Voicu, I. 2016).

Stage 2 - Rapidly establishing contact with the firefighter in psychological crisis due to exposure to the psychotraumatic event - immediate action at the intervention site.

In this stage, it is important to immediately remove the firefighter in crisis from the intervention site due to the risk of mission failure, defocusing from the intervention, distraction with other activities (including music, videos, VR

techniques based on relaxation), physical relaxation exercises, active and attentive listening, or providing the person with the opportunity to communicate in the way they can and want to. Focusing on both verbal and non-verbal content is also an essential aspect to consider, while maintaining a focused, open, honest, and sincere attitude.

Stage 3 - Debriefing and defusing sessions with the entire intervention team - at 24, 72 hours after the mission

Debriefing and defusing psychological sessions are carried out with all 6 firefighters, even if the other 5 did not show symptoms, with the aim of prevention and positive influence on the sixth firefighter who manifested acute stress reactions. Due to the fact that the symptoms persisted in one firefighter, we moved on to stage 4 only with him. (Mitchell, J.T. Everly, G.S. 2000).

Stage 4 -Psychological evaluation of the firefighter and identification of the triggering factor - this stage is carried out at the psychological office.

In this stage, a psychological evaluation of the rescue firefighter is conducted using the psychological instruments mentioned in this article (questionnaires, tests, interviews). The firefighter is asked to describe the event they participated in and all the symptoms they experienced.

Test results:

Beck Inventory: score 22, indicates **mild depression**, with the highest scores obtained for feelings of sadness, guilt, sleep disturbance, and loss of sexual appetite.

Somatization Scale: score 33, indicates **a moderate degree of somatization**. On a scale from 1 to 7, where 1=never and 7=very often, the client marked 6 items: "difficulty falling asleep"; "restless sleep".

Coping Scale: active: score 12; planning: score 13; disengagement from current activities: score 12; restraint coping: score 13; **seeking social support**: **score 16;** seeking emotional social support: score 12; positive reinterpretation: score 14; **acceptance: score** 15; denial: score 6; emotional discharge: score 7; religious coping: score 4; mental disengagement: score 7; behavioral disengagement: score 10; use of alcohol/illicit drugs: score 2.

The highest score was obtained in "seeking social support", which is an active coping mechanism. It is observed that predominantly active coping mechanisms are used.

Quality of Life Satisfaction Evaluation Questionnaire: Final Score 4, with the lowest score obtained in the category of leisure time.

Observation grid during intervention: confused. Person has become stuck and unable to intervene, emotional instability.

Description of psychological components:

- on a subjective/emotional level, there is a mild depressive mood.
- from a cognitive perspective: unaffected, no irrational thoughts, unimpaired reasoning.
- frequently exhibits behaviors of withdrawal, isolation, lack of interest in recreational activities, and low psychological energy.
- sleep-wake rhythm is disturbed.
- in terms of defensive/adaptive mechanisms, active coping mechanisms are utilized.

However, there are some suggestions for those who come into contact with a person in crisis that should be taken into account during an intervention. These were formulated by Wheeler-Roy and Amyot in 2004:

Conclusions:

Following the psychological evaluation, the following psychological conclusions can be drawn:

- the presence of a mild state of depression characterized by disturbed sleep, lack of psychological energy, fatigue, lack of interest in others, loss of joy and pleasure in normally enjoyable activities, decreased appetite and libido.

It meets only 4 of the 9 DSM V criteria for Major Depressive Disorder:

-depressed mood almost every day (feelings of sadness and emptiness);

-markedly diminished interest or pleasure in almost all activities most of the day, nearly every day;

-insomnia almost every day;

-fatigue or loss of energy almost every day.

Subclinical case

Recommendations:

-family and social support;

-counseling sessions during crisis situations.

Stage 5 - Management of the person's dysfunctional negative emotions in crisis - at the Psychological Office

In this stage, the intervention focuses on identifying and expressing emotions and thoughts in an empathetic and compassionate manner towards the emotional state of the firefighter, helping him to accept his emotions and thoughts without judging himself. (Boelen, P.A., Hout, M.A., Bout, J., 2006). In this stage can be very useful the breathing exercises, muscle relaxation, distraction techniques, engaging in various relaxation activities, VR techniques. (Marineanu, V. 2015).

The correction of cognitive distortions regarding the crisis takes place to reduce dysfunctional maladaptive reactions ("all or nothing" thinking,

catastrophic thinking, mental filtering) to prevent the onset of PTSD. (Yeager. K.R., Roberts, A.R., 2003).

Stage 6 - Generating and exploring coping alternatives

Intervention in this stage focuses on establishing a relationship of unconditional acceptance, followed by the firefighter identifying what he believes has triggered the crisis, clarifying the issues they must face, identifying the source of the problem, encouraging exploration of the emotions and thoughts that generate them, as well as exploring appropriate coping alternatives through a problem-solving process oriented towards a positive direction. Additionally, it is important to cultivate optimism, understanding that the problem is external, temporary, specific, and that it does not represent an inevitable expression of personal failure. Selecting alternative coping strategies, identifying social support, identifying familiar coping strategies or new ones, as well as developing and using coping statements for each of the mentioned problems represent other specific directions of intervention for a psychological crisis.

Stage 7 – Implementation of an action plan

The action plan for exiting the crisis aims to restore psychological balance and proper functioning of the person based on their pre-existing adaptive coping resources; their vision of the crisis, and the accessible social support network. The firefighter has benefited from systematic and progressive desensitization through participation in other missions with less emotionally charged critical incidents.

The crisis action plan focuses on competence, potential, change, and possible solutions, not on deficits, limitations, problems, stagnation, and causes. The firefighter must be functional in their professional activity, not professionally isolated or excluded from activity.

Stage 8 – Psychological reassessment of the firefighter

Following the psychological reassessment at a 6-week interval, in which the firefighter participated in 10 counseling sessions and had a new call with a non-life-threatening victim while being observed by the psychologist, no acute stress reactions were observed. The firefighter displayed emotional stability, self-control, and acted professionally according to procedures and protocols during the call.

Two days after the call, the firefighter underwent a psychological evaluation and the following results were obtained:

Test results:

Beck Inventory: score 4, no psychological problems

Somatization scale: score 3, indicating a **minimal degree of somatization**. He no longer has insomnia

The coping scale: active: score 14; planning - score 10; disengagement from current activity - score 6; restraint coping - score 10; **seeking social support - score 18**; seeking social emotional support - score 18; positive reinterpretation - score 20; **acceptance - score 18**; denial - score 0; emotional discharge - score 4; religious coping - score 4; mental passivity - score 7; behavioral passivity - score 10; alcohol/substance use - score 0.

The highest score was obtained for "seeking social support" and "acceptance", which are both active coping mechanisms. It can be observed that the individual has developed active coping mechanisms.

Quality of Life Satisfaction Assessment Questionnaire: final score 8, much improved score

Observation grid at a second intervention: balanced, without psycho-behavioral manifestations

Description of psychological components:

-does not show obvious psychological problems

4. Study results and conclusions

Based on the analysis presented in this paper, the hypotheses we started with are confirmed. We can say that whether an event becomes a crisis situation or not depends on how the individual interprets stressful events and crisis situations in their own way, based on their cognitive schemas, previous experience, coping abilities, individual resources, and proximal support, and most importantly, psychological intervention in crisis situations.

No one can go through a crisis alone, nor should they. We need family, friends, community energy, and psychologists to manage the repercussions of a crisis (Gaspar, 2021).

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