A Practical Guide to Crisis Management

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Family physicians often treat patients who are experiencing psychological or medical crises. Any event perceived as overwhelming by the patient may trigger a crisis reaction consisting of psychological and physiological symptoms. Physicians are encouraged to assist patients who are experiencing a crisis by: (1) providing reassurance and support; (2) evaluating the nature of the problem and determining the patient's mental, psychiatric, suicidal or homicidal, and medical statuses; (3) ensuring the safety of the patient and others; (4) assisting the patient in developing an action plan that minimizes distress, and obtaining patient commitment to the plan; and (5) following up with the patient and other relevant persons to ensure follow-through, assess progress, and provide additional assistance and support. Medication or referral for psychiatric or psychological counseling may be necessary for patients with continuing problems. (Am Fam Physician 2006;74:1159-64, 1165-66. Copyright © 2006 American Academy of Family Physicians.)

Patient information: A handout on crisis management, written by the authors of this article, is provided on page 1165.

Physicians often are required to assist patients in crisis. An estimated 4 percent of visits to primary care physicians involve psychiatric or social crises.[1,2] Numerous additional visits and telephone calls involve persons who are experiencing medical crises or are presenting with physical symptoms caused by acute stressful events. Although crisis management is not a major part of a physician's routine, when it does occur it requires time and resources. Proper assessment and intervention are essential to ensure the safety of the patient and others, to assist the patient in coping effectively with the problem, and to empower the patient to confront future life events successfully.

Definition of a Crisis

A crisis occurs when a person is confronted with a critical incident or stressful event that is perceived as overwhelming despite the use of traditional problem-solving and coping strategies.[1] Often it is not the event itself that causes the crisis; rather, it is the appraisal of the event as serious, uncontrollable, and beyond the patient's resources for coping that triggers a crisis response.[3,4] Persons who are unable to cope using traditional strategies can develop affective, behavioral, cognitive, or physical difficulties[3] that may cause them to seek physician assistance. Patients may present to the physician in a variety of settings (e.g., the physician's office, the hospital, via telephone) with problems ranging from minor setbacks to acute, highly stressful events, psychiatric problems, or medical crises. Examples of critical incidents that may precipitate a crisis are listed in *Table 1*.[1,3]

The Physician's Role in Crisis Management

Patients experiencing a crisis often rely on their physician for support and advice. Although each patient and situation is different, there are several general steps that physicians can follow to respond effectively to a patient's crisis[3,5] *(Table 2)*. These include providing reassurance and support to the patient, assessing the situation, ensuring the safety of the patient and others, and teaching the patient strategies that will assist him or her to cope more effectively with the current incident and related symptomatology as well as with future critical incidents. An algorithm for effective crisis management is provided in *Figure 1*.

STEP 1: REASSURE AND SUPPORT THE PATIENT

The first step in communicating with a patient experiencing a crisis is to reassure the patient that it is safe to discuss the presenting concern and that the physician will be available to assist the patient through this crisis. If the patient is distressed, he or she should be encouraged to use deep breathing techniques and refocus on the problem. The physician

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SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	*Evidence rating*	*References*
Patients who are experiencing a crisis should be assessed for suicidal and homicidal ideations.	C	7, 10
Patients who are suicidal and have co-morbid psychiatric or medical problems, a history of violent or near-lethal suicide attempts, a poor response to outpatient treatment, or limited family or social support should be considered for inpatient hospital admission.	C	10, 14
Physicians must warn and protect intended victims of a patient.	C	17
Physicians should help patients experiencing a crisis to stabilize acute distress, to explore options, to make a specific plan, and to commit to the plan.	C	3
Selective serotonin reuptake inhibitors and other antidepressants are reasonable clinical interventions for patients with acute stress disorder or post-traumatic stress disorder.	C	10, 14

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, see page 1079 or http://www.aafp.org/afpsort.xml.

should then commend the patient for seeking help and validate the patient's experience. Validation in this context does not necessarily mean that the physician agrees with the patient's view and response to the crisis; instead, the physician uses reflective listening to demonstrate understanding and to clarify and amplify the patient's situation without imposing his or her opinions.[6]

The physician also should establish rapport with the patient by using active listening skills (e.g., open-ended questions, encouraging statements) and, if applicable, nonverbal techniques (e.g., speaking at eye level, leaning forward). This will facilitate open and honest communication and will help establish a working alliance with the patient.[3]

STEP 2: EVALUATE THE CRISIS SEVERITY AND ASSESS THE PATIENT'S STATUS

As rapport builds, the physician should evaluate the severity of the crisis and assess the patient's mental, psychiatric, suicidal or homicidal, and medical statuses. It is essential to define the triggering situation precisely and to understand the problem from the patient's point of view.[3] The physician should determine the nature of

TABLE 1
Critical Incidents That May Precipitate a Crisis

Developmental (i.e., life-transition events):
Birth of child, graduation from college, midlife career change, retirement

Existential (i.e., inner conflicts and anxieties related to purpose, responsibility, independence, freedom, or commitment):
Realization that one will never make a significant impact on one's profession, remorse that one has never married or had children, despair that one's life has been meaningless

Environmental (i.e., natural or man-made disasters):
Tornado, earthquake, floods, hurricanes, forest or grass fires

Medical (i.e., a newly diagnosed medical condition or an exacerbation of a current medical problem):
Multiple sclerosis, human immunodeficiency virus infection, infertility, myocardial infarction, cancer, medical problems that result in partial or total disability

Psychiatric (i.e., actual syndromes and those that affect coping):
Depression or suicidal thoughts, events precipitating acute or post-traumatic stress disorder

Situational (i.e., uncommon, situation-specific events):
Loss of job, motor-vehicle collision, divorce, rape

Information from references 1 and 3.

TABLE 2
Principles of Crisis Management

STEP 1. Provide reassurance and develop rapport through validation of the problem and use of active listening skills.

STEP 2. Evaluate the severity of the crisis and assess the patient's mental, psychiatric, suicidal or homicidal, and medical statuses.

STEP 3. Ensure the safety of the patient and others through voluntary hospitalization, involuntary commitment, securing close monitoring by family and friends, or helping to remove the patient from a dangerous situation.

STEP 4. Stabilize the patient's emotional status, explore options for dealing with the crisis, develop a specific action plan, and obtain commitment from the patient to follow through.

Counteract the patient's use of inappropriate coping mechanisms such as denial, withdrawal, and reliance on harmful behaviors and substances.

Help the patient focus on his or her strengths and how these and other coping mechanisms were used successfully in the past.

STEP 5. Follow up with the patient to provide ongoing support and to reinforce appropriate action.

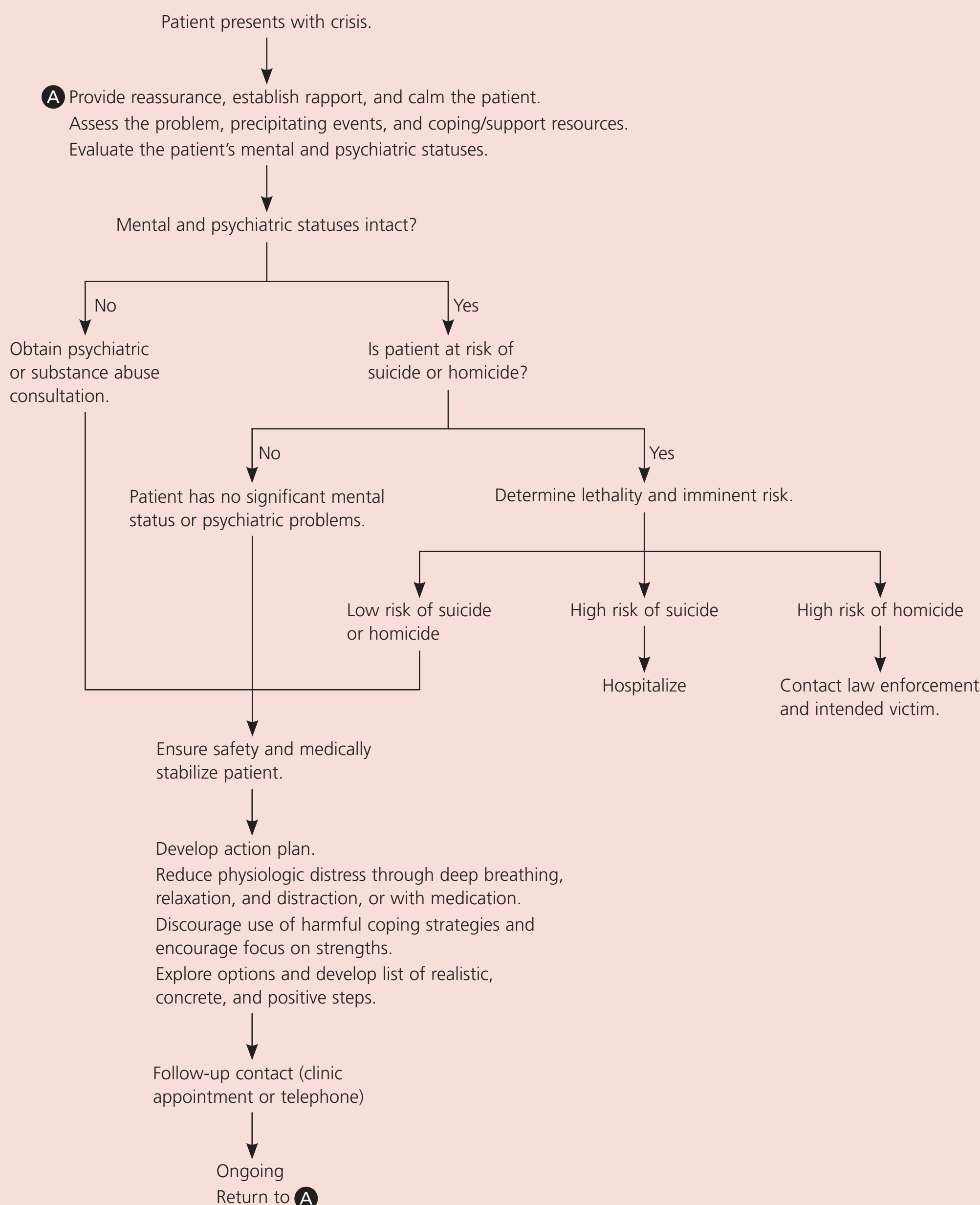

Figure 1. Algorithm for effective crisis management.

the crisis, its precipitating events, how the patient has attempted to cope, and what resources may be available to assist with the problem.

In conjunction with this process, the physician should carefully evaluate the patient's general appearance, behavior, speech, thoughts, judgment, and affect, and assess whether the patient has recently used substances that could impair his or her judgment. Assessing psychiatric status is important because depression, schizophrenia, bipolar disorder, borderline personality disorder, and substance abuse or dependency greatly increase suicide risk.[7-10] The patient's mental and psychiatric statuses can affect the reliability of information given by the patient and the physician's confidence that any plan will be carried out. If the patient's mental status is not stable, it may be necessary to contact a family member or close friend to gather additional information and to ensure the patient's safety and appropriate follow-through; psychiatric referral also may be necessary.

The patient should be evaluated for suicide and homicide risk; this can be achieved by asking the patient directly whether he or she has thoughts or intentions

TABLE 3
Factors Associated with Suicide Risk

Factor	Examples
Increased risk	
Childhood traumas	Sexual or physical abuse
Cognitive features	Loss of executive function, thought constriction, polarized thinking, closed-mindedness
Demographic features	Male sex; widowed, divorced, or single; older age, adolescent, or young adult; white race; gay, lesbian, or bisexual
Genetic and familial effects	Family history of mental illness, substance use disorders, or suicide
Physical illnesses	Diseases of the nervous system, malignant neoplasms, human immunodeficiency virus, acquired immunodeficiency syndrome, pain syndromes
Psychiatric diagnoses	Depression, bipolar disorder, schizophrenia, anorexia nervosa, alcohol and substance use disorders, cluster B personality disorders (e.g., borderline personality disorder)
Psychological features	Hopelessness, severe anxiety, panic attacks, shame, decreased self-esteem, impulsiveness, aggression, agitation
Psychosocial features	Lack of support, unemployment, drop in socioeconomic status, domestic violence, recent stressful events
Suicidal thoughts or behaviors	Suicidal ideas, plans, or attempts
Other factors	Access to firearms, substance intoxication, unstable or poor therapeutic relationship
Lowered risk	
Children in home	
Life satisfaction	
Positive coping skills	
Positive problem-solving skills	
Positive social support	
Positive therapeutic relationship	
Pregnancy	
Reality testing ability	
Religious faith	
Sense of responsibility to family	

Adapted with permission from Practice guideline for the assessment and treatment of patients with suicidal behaviors. Arlington, Va.: American Psychiatric Association, 2003:12.

of hurting him- or herself or others.[7,10] Although little evidence exists to guide the accurate assessment of suicide risk in primary care patients,[11,12] physicians should consider factors that have been associated with an increased risk of suicide *(Table 3)*.[10] Risk factors for homicide include a history of aggressive behavior to self or others, a history of criminal behavior, a history of experiencing child abuse or witnessing domestic violence, low intelligence, neurologic impairment, hostility, substance abuse or dependency, and perceptions of threat or of someone else controlling one's thoughts. The latter often is associated with paranoid disorders, schizophrenia, or other thought disorders.[13]

STEP 3: ENSURE THE SAFETY OF THE PATIENT AND OTHERS

After obtaining information regarding the crisis and assessing the patient's mental, psychiatric, and medical statuses and risk for causing harm, the physician may need to ensure the safety of the patient and others.[14] Patients who are suicidal and have comorbid psychiatric or medical problems, a history of violent or near-lethal suicide attempts, a poor response to outpatient treatment, or limited family or social support should be considered for inpatient hospital admission.[10] A family member or close friend may transport the patient; if the patient refuses, local law enforcement should be contacted.[10,15,16]

Patients who have chronic suicidal ideations without a history of medically serious suicide attempts and who are not judged to be in immediate danger may be managed as outpatients if they have a stable and supportive living situation and are able to cooperate with an action plan.[10] These patients should be encouraged to make an appointment immediately with a physician (their own, if possible), a psychiatrist, and/or a psychologist for medication review and counseling. Family members and friends should be encouraged to remove any firearms and potentially dangerous medications from the patient's environment and to safeguard the patient from other lethal means. Ongoing monitoring of the patient is essential, with appropriate modifications made to the action plan as necessary.

If the patient is homicidal, the physician must ensure the safety of the patient and of potential victims. Again, hospitalization of the patient may be necessary. The case

of *Tarasoff v. Board of Regents of the University of California* mandates that physicians have a duty to warn and protect intended victims of a patient.[17]

Patients experiencing a crisis in which they are at risk of bodily harm must be encouraged to remove themselves from the situation immediately. Victims of abuse may be directed to quickly gather their children and necessary personal belongings and go immediately to a shelter or other safe place. The National Center for Victims of Crime has published safety plan guidelines for victims of domestic violence[18]; these guidelines are available from its Web site at http://www.ncvc.org/ncvc/main.aspx?dbName=DocumentViewer&DocumentID=32452.

Patients experiencing agitation may be at risk of harming the physician and staff. Clinics should establish policies and procedures for handling agitated or dangerous patients and should provide training to all personnel.

STEP 4: DEVELOP AN ACTION PLAN

When safety issues have been addressed, the physician can assist the patient in developing a constructive response to the crisis. Throughout this process, the physician must emphasize that although the patient may be unable to control the event that precipitates a crisis, he or she can control the response to it. Physicians can help the patient stabilize acute distress, explore options, make a plan, and commit to the plan.[3]

First, although some emotional arousal can promote crisis resolution, the physician should help the patient stabilize distress by providing reassurance and support and encouraging the patient to use self-calming methods. Techniques such as deep breathing and muscle relaxation will facilitate self-control over physiology and emotions and will allow the patient to focus on taking active steps to cope successfully with the crisis incident.

Highly distressed patients experiencing acute anxiety, sleep difficulties, and significant impairment of daily functioning may benefit from short-term or intermittent pharmacologic therapy directed toward specific symptoms,[14,19] such as anxiolytics for anxiety or hypnotics for insomnia. Patients presenting with acute psychosis, aggression, agitation, or extreme anger should be considered for intramuscular antipsychotic medication.[20] Some patients who experience a crisis develop depression,[5] acute stress disorder, or post-traumatic stress disorder; these patients may be treated with selective serotonin reuptake inhibitors or other antidepressants.[14] Benzodiazepines are not recommended as monotherapy for patients with post-traumatic stress disorder because discontinuation has been associated with profound exacerbation of symptoms.[14,21]

Second, the physician can assist the patient in exploring options for dealing with the crisis. These may include obtaining additional information, gathering situational support (e.g., family, friends), employing coping mechanisms (e.g., exercise, hobbies), and using positive and constructive thinking patterns (i.e., those that change the patient's view of the problem). The use of specific "homework" assignments that involve gathering additional information on the topic of concern; self-monitoring of symptoms, thoughts, or activities; identification of strengths; and experimentation with new coping behaviors can empower the patient to take action rather than feel helpless and remain inert.[1]

Third, the physician and patient should develop a specific action plan that includes a short list of realistic, concrete, and positive steps that the patient can begin to implement immediately. The goals of any action plan are to restore emotional stability, increase patient control over the problem, and promote independent functioning. The patient thus becomes an active problem solver and begins to return to a normal routine and lifestyle.

Finally, the physician should ask the patient to summarize the plan and to commit to carrying out one or more steps. This allows the patient and the physician to clarify any misunderstandings regarding the plan, and it motivates the patient to take initial action.

As part of any action plan, the physician should advise the patient against using negative or harmful coping strategies such as denial, avoidance, withdrawal, or dependency on substances. Harmful coping strategies also include the use of negative cognitive processes such as catastrophizing (i.e., overemphasizing the probability of a catastrophic outcome and the possible consequences of such an outcome),[22] which may increase the patient's anxiety and forestall productive problem-solving efforts. Patients should be encouraged to recognize such thought processes, stop them, and replace them with more rational and solution-focused thinking.

Physicians also may help patients to recognize and use their strengths instead of negative coping strategies. The patient may be asked to recall coping strategies that have worked successfully in the past and to apply these or similar methods to the current problem. The physician can encourage the patient to identify family, friends, and other mechanisms of support, as well as internal strengths and resources that may have been overlooked.[5]

STEP 5: FOLLOW UP

Supportive follow-up is recommended to check on the patient's status and to reinforce his or her positive efforts.[3] The immediacy of the contact should be determined

by the seriousness of the problem and the trust that the physician has in the patient and the plan. Follow-up provides patients with a lifeline and improves the likelihood that they will follow through with the action plan.

During follow-up, the physician should assess progress regarding the specific plan of action and reinforce even small therapeutic gains.[1] Reinforcing success increases patients' resilience, which should allow them to handle future crisis situations more successfully. The physician also may assist the patient to focus on potentially positive outcomes related to the crisis, including improved self-discipline, a feeling of competence, an appreciation of life, and a sense of future ability to cope with adversity.

Patients who have experienced significant trauma, who have a history of crisis, or who continue to experience significant distress despite these efforts may need to be referred to a professional individual or agency that can provide a higher and more intense level of care. The physician should maintain a list of services of this kind that are available in the local community.

Depending on the nature of a patient's crisis, the physician and office staff may be adversely affected by the surrounding circumstances. Therefore, appropriate follow-up may include meetings to debrief staff and providing counseling as necessary.[3]

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