CHAPTER

1 Overview of Crisis Intervention

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PREVIEW

Crises occur in a variety of settings for a variety of reasons. Responses to crises are equally variable. In this chapter, basic frameworks for assessing and conceptualizing crises are presented, along with a discussion of how crisis intervention may differ from traditional counseling.

A BRIEF INTRODUCTION TO CRISIS INTERVENTION

If asked to think about a crisis, what comes to mind? Hurricane Katrina? September 11, 2001? Suicide? Homicide? Domestic violence? How do some people survive such apparent trauma adaptively and with resilience, while others endure mental health issues for months or years afterward?

To begin, situations such as Hurricane Katrina, the terrorist attack of September 11, suicide, and domestic violence, although sharing traumatic characteristics, in and of themselves do not constitute crises. These are, instead, events that trigger crises. Typically, a crisis is described using a trilogy definition; that is, there are three essential elements that must be present for a situation to be considered a crisis: (1) a precipitating event, (2) a perception of the event that leads to subjective distress, and (3) diminished functioning when the distress is not alleviated by customary coping resources.

When terrorists bombed the World Trade Center in New York City in 1993, crises ensued for some individuals and families. Six families lost loved ones, approximately 1,000 individuals were injured, and the jobs, careers, and work of countless people were interrupted. Using the trilogy definition, it is obvious that all of those who experienced diminished functioning following the event were in crisis. People throughout the rest of the world, however horrified, continued to function as normal and therefore were not in crisis.

The trilogy definition is reflected in the work of several notable contributors to the crisis intervention literature and applies both to individuals and to families (Boss, 1987, 1988, 2002; McKenry & Price, 2005). Recently, James (2008) reviewed a number of definitions that

CASE STUDY 1.1

The Nguyens

Vin and Li Nguyen are recent immigrants to the United States. They reside in a small town along the Gulf Coast of Mississippi, where a number of other Vietnamese immigrants have settled. Like many members of the community, the Nguyens are learning to speak, read, and write English and are hoping to become naturalized citizens of the United States some day. After arriving in the United States, the Nguyens invested all of their money in an old shrimp boat in order to support themselves by selling their daily catch to local seafood processing facilities.

In 2005, the shrimp boat was heavily damaged, and the seafood processing facilities were destroyed by Hurricane Katrina. Subsequently, the Nguyens had no income for quite awhile. With limited income and no health insurance, they relied on the county department of public health for prenatal care when Li became pregnant. Li's pregnancy progressed normally; however, her daughter was born with Spina Bifida.

As you read this chapter, try to conceptualize the Nguyens' situation according to the crisis models presented.

Discussion Questions

- What incidents have occurred in the Nguyens' lives that could be considered provoking stressor events?
- Beyond the provoking stressor events, are there additional stressors that the Nguyens must address?
- What resources are the Nguyens utilizing? What further information do you need to determine if the Nguyens are in crisis?
- What factors will predict the outcome for this family?

exist in the literature and summarized crisis as "a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms" (p. 3).

According to Slaikeu (1990), a crisis is "a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem-solving, and by the potential for a radically positive or negative outcome" (p. 15). While it is always hoped that a positive outcome (McCubbin & Patterson, 1982) would occur, there are occasions when a radically negative outcome such as suicide happens, thereby precipitating further upset.

FOUNDATIONS OF CRISIS INTERVENTION THEORY

The study of crisis intervention began in earnest during the 1940s in response to several stressor events. During World War II, numerous families experienced distress and changes in functioning after individual family members left home to participate in the war effort. Families that seemed to experience the greatest degree of distress were those that had the most difficulty adapting to the absence of family members. Similarly, many families were forced to deal with losses brought about by a more acute stressor event, a

nightclub fire that claimed nearly 500 lives in Boston, Massachusetts. These events led to Hill's proposal of a model through which family stress and crisis could be conceptualized and to Caplan and Lindemann's proposed recommendations for responding to crises at the community level. In the decades following the 1940s, these original models have been expanded, with more attention to contextual variables and to outcomes.

Basic Crisis Intervention Theory

Caplan and Lindemann often are credited as pioneers in the field of crisis intervention. Their work began after a tragic event in Boston in 1942, the Cocoanut Grove nightclub fire, in which 493 people died. Lindemann treated many of the survivors of the nightclub fire and noted that they shared similar emotional responses, along with the need for psychological assistance and support (Lindemann, 1944). His work created awareness that many individuals who suffer loss experience pathological symptoms but have no specific psychiatric diagnosis. It was his contention that responses to sudden grief are normal and transient and need not be considered pathological. Lindemann theorized that "normal" responses to grief include preoccupation and identification with the deceased, feelings of guilt and expressions of hostility, disorganization in daily functioning, and somatic complaints (Janosik, 1984). In essence, his paradigm for crisis intervention included an individual who was in a state of disorganization, brief therapy to assist the individual in working through grief, and ultimately restoration of equilibrium.

As Lindemann worked with others from Massachusetts General Hospital to assist survivors who had lost loved ones in the Cocoanut Grove fire, he began to realize that helpers other than psychiatrists could assist people in coping with their sudden grief. Lindemann's report describing common grief reactions to disaster, as well as the benefits of including clergy and other community helpers in intervention efforts, became a cornerstone in the conceptualization of community mental health.

Following the Cocoanut Grove fire, Lindemann worked with Caplan to establish a communitywide mental health program in Cambridge, Massachusetts, known as the Wellesley Project (Caplan, 1964). The aim of this project was to study and provide support to individuals experiencing traumatic events. The outcome of this project supported Caplan's notion of preventive psychiatry—that is, early intervention in an effort to promote positive growth and well-being.

Caplan (1961, 1964) expanded Lindemann's concepts by expanding their application to a wider field of traumatic events. According to Caplan (1961), "People are in a state of crisis when they face an obstacle to important life goals—an obstacle that is, for a time, insurmountable by the use of customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made" (p. 18). What is important to note in Caplan's description is that the concept of crisis refers to an outcome of a precipitating event, not to the precipitating event itself. Similar to Lindemann, Caplan described the outcome, or the crisis, as the state of disequilibrium that the individual experiences.

The ABC–X Model of Crisis

Hill (1949, 1958) was among the first to conceptualize a crisis theory that applied to families. From his studies of families experiencing separation and reunion as a result of World War II, Hill postulated the ABC–X Model of Crisis (see Figure 1.1). According to

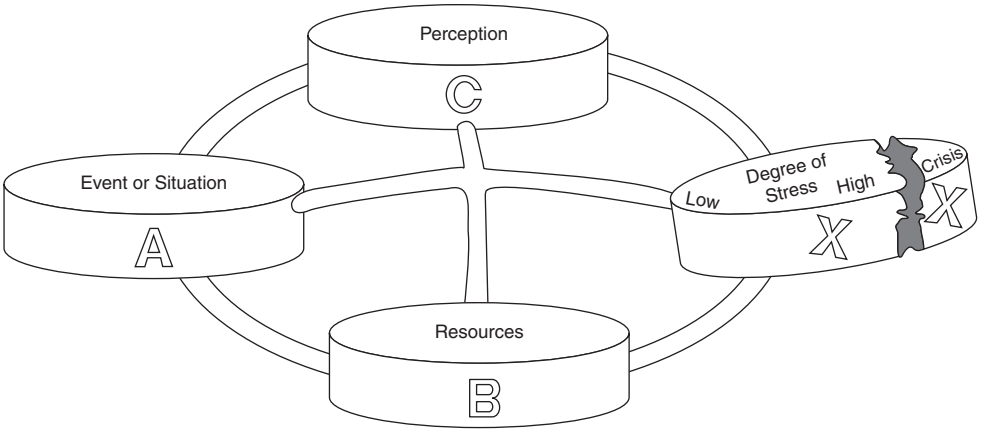

FIGURE 1.1 The ABC–X Model of Family Crisis.

this model, there is an interaction among (A) a provoking stressor event, (B) the family's resources, and (C) the meaning that the family attaches to the stressor event. The crisis (X), a state of acute disequilibrium and immobilization of the family system (Boss, 1988), is an outcome of this interaction. Although Hill's original research pertained to families, the concepts he proposed may be applied to individuals.

The Double ABC–X Model of Crisis

Hill's original ABC–X model continues to provide a framework for much research in the area of family stress and crisis; however, a few scholars (Boss, 1988, 2002; McCubbin & Patterson, 1982) have chosen to expand upon the model. Among the better-known variations of Hill's work is the Double ABC–X Model of Crisis proposed by McCubbin and Patterson (1982). Writing from a systems orientation, which assumes that systems naturally evolve and become more complex over time, McCubbin and Patterson considered recovery and growth following crisis. The concept of adaptation was introduced to describe lasting functional changes that occur in order to meet the demands of a crisis or stressful event. According to these scholars, Hill's original model was somewhat incomplete in that it outlined only those factors that contribute to a crisis or breakdown in functioning. Following a state of disequilibrium or incapacitation, additional stressors may accrue, and additional resources may be identified and acquired. Subsequently, new perceptions that take into account the original event and related hardships or stressors, along with the application of resources and coping strategies to meet the needs of those stressors, are formulated.

According to McCubbin and Patterson (1982), there is a "double A" factor that includes Hill's original concept of a provoking stressor plus the buildup of further stressors that must be addressed. These stressors may include unresolved issues related to the crisis-provoking event, changes that occur unrelated to the event, and any consequences of attempts to cope (McKenry & Price, 2005). The "double B" factor refers to resources available at the time of the provoking stressor, as noted by Hill, along with tangible and intangible resources that have been acquired or strengthened. Fortified coping resources would be included in this concept. The "double C" factor

refers not only to perceptions and meanings assigned to the original provoking stressor but also to accumulated stressors, resources, coping, and the entire situation. Perceptions are influenced by religious beliefs, family and cultural values, and how the situation may have been reframed. In the model proposed by McCubbin and Patterson, the original crisis (Hill's X factor) constitutes a beginning point, while adaptation ("double X") occurs later in time. Adaptation is an outcome variable involving changes in functioning and perception. More than the simple reduction of stress, adaptation is the degree to which long-term change has occurred in response to the demands of stressor and crisis events.

Ecological and Contextual Considerations

In addition to considering the accumulation of stressors and resources, Boss (1987, 1988, 2002) and others (Collins & Collins, 2005) have suggested that stress and crisis are affected by contextual factors. Collins and Collins (2005) have advocated a "developmental-ecological" perspective to conceptualizing crises. According to these authors, some crises are triggered by stressor events that are developmental in nature; that is, these developmental crises are expected events in the life span of the individual or family. However, regardless of whether the stressor event is developmental or situational, life span variables must be considered to determine their meaning and impact on the stress or crisis situation. In addition to considering developmental factors, Collins and Collins have maintained that the context provided by environmental factors such as interpersonal relationships, community resources, and society at large must be recognized. This approach suggests that each crisis is unique, since the ecological determinants for each person will be unique. Therefore, crisis counselors need to be aware that even though many of the clinical considerations and approaches may be similar for a specific crisis and for many individuals experiencing that crisis (e.g., sexual assault), the person in crisis will experience the crisis differently than someone else due to the unique and personal ecological determinants. In essence, do not simply generalize and implement a generic approach to a particular crisis without first assessing the client's unique ecological factors.

Boss (1987, 1988, 2002) similarly proposed a contextual approach to the study of stress and crisis, stating that "factors in addition to the stressful event influence family vulnerability or breakdown" (2002, p. 28). According to Boss, stress is mediated by contextual dimensions, which may be either internal or external. The internal context includes three dimensions that may be controlled or changed: the structure of the family, psychological elements such as perception and assessment, and philosophical elements such as values and beliefs. The external context is composed of environmental or ecosystemic dimensions over which there is no control. External influences on stress and crisis include historical, economic, developmental, hereditary, and cultural contexts.

Elements of Stress and Crisis Theory

PROVOKING STRESSOR EVENTS Stressor events are those occurrences that provoke change in the functioning of a system. Stressor events may be positive or negative, and while some are normal and predictable, others are unforeseen. In general, stressor events may be categorized as either normative stressor events (i.e., those stressors that occur at points of normal developmental transitions) or nonnormative stressor events

(i.e., products of distinctive, unexpected situations). Many families anticipate normative stressor events such as children graduating from high school and beginning college, while few anticipate nonnormative stressor events such as the school shootings at Columbine High School and Virginia Tech.

Boss (1988) categorized stressor events and situations by source, type, and severity. Sources are either internal, originating within the family, or external, attributable to someone or something outside the family. Examples of internal stressors include partner violence and chemical dependency. These stressors begin within the family and are accompanied by changes in the way the family functions. Partners and family members often adopt various roles, behaviors, and communication styles in attempts to cope with and survive the actions of the abusive or addicted person. As familiar coping strategies become increasingly inadequate, families cease to function effectively and healthily. "Crises" in these families are rarely a one-time occurrence (James, 2008).

Another example of an internal stressor is infertility. Within the context of the family life cycle, most couples expect to be able to conceive and carry a pregnancy to term. Infertility is considered an internal stressor because the inability to achieve a successful pregnancy originates with one (sometimes both) of the partners as opposed to something outside of the family. It becomes a crisis situation because the partners face psychological and relationship changes that affect the way they function. Each menses is encountered as a crisis situation. In response to this crisis situation, many couples are able to redefine their relationships and reframe their meanings of pregnancy and parenting; unfortunately, however, many couples do not respond well and ultimately separate (Puleo & Wilcoxon, 1995).

External stressors originate outside the family but affect family functioning nonetheless. Examples of external stressors include natural disasters, terrorism, financial decline due to the stock market, and the rising cost of oil. Some external stressors are attributable to forces of nature (e.g., hurricanes, tornadoes, earthquakes), some to humans (e.g., violent crimes, job termination), and some to a combination of the two (e.g., global warming). Individuals and families typically have less control over external stressors than they do over internal stressors. For example, families have little control over the stock market. However, the ramifications of a declining stock market could have a substantial impact on a family's future.

As with internal stressors, however, the degree to which crises caused by external stressors are experienced is contingent on available resources and the meaning attached to the stressor event. In the United States, Hurricane Katrina, an external stressor, interrupted the normal functioning and triggered crises for thousands of families along the Gulf Coast of Louisiana, Mississippi, and Alabama. Families who seemed to be the most resilient and who seemed to have the least difficulty recovering from this crisis were those with available resources such as social support, housing, and financial assets.

Many stressors are normal, predictable, and developmental in nature. Stressor events of this type generally are an expected part of everyday life and of the family life cycle. Typical normative stressor events include "birth, puberty, adolescence, marriage, aging, menopause, retirement, and death" (Boss, 2002, p. 51). Although these events are expected, they have the potential to disturb the equilibrium of an individual or family and result in crisis.

The type of crisis-inducing stressor that initially comes to mind for many people is the catastrophic, situational, unexpected event. Such a situation tends to be unique, is not predicted, and is not likely to be repeated. Examples of catastrophic stressors include those that may be attributable to human behavior, such as the bombing of the Alfred P. Murrah Federal Building in Oklahoma City in 1995, or to natural disasters, such as the 2008 earthquake in China. Other nonnormative stressors may not be catastrophic at all, and may actually be positive, but nonetheless may still have the potential to disrupt equilibrium. Examples are finding a lost relative (Boss, 2002) and winning the lottery. Unexpected stressor events such as these also may be categorized as nonvolitional stressors. Volitional stressors, on the other hand, are recognized by the amount of choice and control the individual or family has over them. Examples include wanted changes in jobs or residences and planned pregnancies. Although volitional stressors are wanted and initiated, pursued, or orchestrated by the individual or family, they still have the potential to trigger a crisis if resources and meaning do not match needs and requirements. Changing jobs for the sake of career advancement, for instance, may require a move to a geographic location where housing is unavailable or unaffordable. Even if everything goes according to plan (i.e., no medical complications, a single birth, and a healthy baby), financial and social support for a planned pregnancy may be inadequate.

Beyond classifying stressors by their source and type, Boss (2002) described stressor situations according to their duration and severity. Some stressors are one-time events, happen suddenly, and resolve quickly; these are considered acute stressors. An automobile accident, for example, might disrupt a family's equilibrium as broken bones heal and alternate transportation is used, but ultimately, the family's balance is restored. Other stressors, such as lifelong illnesses, infertility, and poverty, persist over long periods of time and are considered chronic. Families caring for aging family members may experience chronic stress and may face disequilibrium and crisis each time the elderly family member's health takes a turn for the worse. The crisis is triggered by changes in health but is the result of additional demands for financial, social, and other resources as well as the perception and meaning the family attaches to the elderly person's decline. Finally, Boss (2002) suggested that it is important to consider whether a stressor situation is an isolated event or part of an accumulation of stressor events. It is often the case that any one stressor event may not be enough to trigger a crisis, but the cumulative effect of the pileup of stressors taxes resources, disrupts equilibrium and functioning, and results in crisis.

RESOURCES Resources may be defined as traits, characteristics, or abilities that can be used to meet the demands of a stressor event (McCubbin & Patterson, 1982) and that can be available at the individual, family, or community level (McKenry & Price, 2005). They may be tangible (e.g., food, clothing, shelter) or intangible (e.g., social support, self-esteem). When resources are adequate to meet the demands created by a stressor situation, the situation is less likely to be perceived as problematic—and less likely to lead to crisis. Two types of resources are important: those that are available and used to mediate the initial stressor and those that are acquired, developed, or strengthened subsequent to a crisis situation (McCubbin & Patterson, 1982). Individual resources may include finances, education, health, and psychological qualities, whereas family resources include the internal, systemic attributes of cohesion and adaptability, along

with resources such as financial management, communication skills, compatibility, and shared interests (Olsen, 1988). Community resources include external supports, such as social networks, on which the individual or family can draw.

MEANING OR PERCEPTION Whether a stressor event results in crisis depends not only on available resources but also on the meaning attached to the event. The meaning attributed to a stressor event is subjective and comes from the way it is appraised through both cognitive and affective processes. Factors contributing to this qualitative variable include the ambiguity associated with the stressor situation, denial, and the belief and value orientation of the individual or family. Ambiguity occurs when facts cannot be obtained. It is often the case that specific information about the onset, development, duration, and conclusion of an unpredictable stressor event is unavailable. When information is unavailable, individuals may be uncertain in their perception of who is included in their families or social support systems. With limited understanding about who is in and who is out, it becomes difficult to ascertain how various roles, rules, and functions will be carried out. Whereas sometimes stressors themselves are ambiguous because data are not available, at other times facts are available but are ignored or distorted. The resulting denial may be a useful coping strategy in the short term but may be damaging if it prevents further action during a crisis situation (Boss, 1988, 2002; McKenry & Price, 2005).

COPING In his original ABC–X model, Hill (1949, 1958) considered coping behaviors as part of the family's resources (represented by "B" in the ABC–X model) to be utilized in response to demands of a stressor event ("A"). While many researchers agree that coping behaviors are a subset of available resources, coping itself is a separate construct, often interacting with both resources ("B") and perception ("C"). According to Pearlin and Schooler (1978), any effort taken to deal with stress may be considered coping. Thus, coping is a process and requires cognitive as well as behavioral activities (McKenry & Price, 2005; Pearlin & Schooler, 1978). Cognitively, people experiencing stressor events must appraise what is happening and assess any potential for harm. They also must evaluate the consequences of possible response actions. According to Lazarus (1966, 1976), these appraisals occur before any coping mechanisms are employed. Following appraisal, there are three types of coping responses that may be used: direct actions, intrapsychic mechanisms, and efforts to manage emotions. Direct actions are those behaviors that typically are thought of as "fight or flight" responses. Examples include acquiring resources, asking for help, and learning new skills (McKenry & Price, 2005). These actions are used in relation to the environment in order to master stressors and are thought of as problem-focused coping strategies.

Emotion-focused coping strategies, conversely, involve mechanisms used to change feelings or perceptions when there is little that can be done to change a stressor. Intrapsychic responses are those responses that often are thought of as defense mechanisms (e.g., denial, detachment) and allow people to alter their interpretations of the stress-provoking situation (Boss, 2002; McKenry & Price, 2005). Additional emotion-focused strategies are used to manage emotions generated by the stressor. Examples include the use of resources such as social support or of alcohol and drugs. Obviously, specific coping responses are neither adaptive nor maladaptive; they are simply efforts to manage.

CASE STUDY 1.1 (continued)

The Nguyens

Stressor events are those occurrences—positive or negative, predictable or unforeseen—that provoke change in the functioning of a system. They may be categorized as normative or nonnormative. The Nguyen family has experienced a number of provoking stressors, some of which they chose, others of which they did not.

Stressors may be categorized by source, type, and severity and should be considered within context (Boss, 1988). There are many variables, such as culture, history, education, and heredity, over which the Nguyen family has no control. These compose the external context. Crisis counselors who work with the Nguyens need to take into account their Vietnamese culture as well as additional cultural issues related to being part of an immigrant community along the Gulf Coast of the United States. Imbedded in these considerations is the fact that the Nguyens chose to leave Vietnam for the United States some thirty years after the Vietnam War. What kinds of social prejudices and biases does this couple face simply by being Vietnamese? Are there additional biases that they endure by virtue of being immigrants in a post-9/11 U.S. society?

The Nguyens' situation is complicated by their economic status, another component of their external context. Prior to Hurricane Katrina, they were making a living in the shrimp industry. They had few bills and no debt; however, they had no medical insurance. On those rare occasions when they required medical attention, they were able to use community public health resources. In the aftermath of Hurricane Katrina and the tough economic times that followed, numerous public, nonprofit health agencies were forced to close their doors, making it difficult for the Nguyens to access prenatal care. When their daughter was born with a birth defect, they found it necessary to travel to a larger city to receive care for her needs. Thus, they incurred transportation and lodging expenses, further affecting their delicate economic status.

Having lost their livelihood as shrimpers to Hurricane Katrina, the Nguyens were forced to look for work elsewhere. They were fortunate in that they had a rather large social support network and that acquaintances helped them find employment once retail outlets began to reopen in the months after the hurricane. Unfortunately, the retail jobs they found paid little more than minimum wages and did not include medical insurance. The Nguyens' educational background and minimal fluency in English made it difficult for them to pursue higher-paying jobs.

Internal contextual factors are those that originate within the family and are accompanied by changes in the way the family functions. The Nguyens chose to leave their family and friends in Vietnam in order to move to the United States. In doing so, the structure and definition of their family became less clear, particularly given the limited opportunities they had to return for visits. They also were forced to wrestle with issues related to caring for their aging parents. Once living in the United States, the Nguyens' family structure changed further when they became parents themselves.

For the Nguyens, a relatively young couple, becoming parents could be considered a "normative" stressor. Normative stressors are normal, predictable, and developmental in nature. This stressor of becoming parents also could be considered volitional, as a degree of choice was involved. Conversely, nonnormative stressors are those that are unexpected. A catastrophic event such as Hurricane Katrina and all of its ramifications certainly should

be classified as nonnormative. For the Nguyens, having a child with Spina Bifida also is a nonnormative and nonvolitional stressor, and its lasting implications will make its presence chronic.

To ameliorate their situation, the Nguyens have several resources, derived from both internal and external contexts, on which they may rely. Although they left friends and family behind in order to move to the United States, they are members of a fairly large immigrant community in Mississippi. From this community, they receive a tremendous amount of social support. In addition, the Nguyens have been able to utilize public community resources for health care and for other basic survival needs in the weeks and months after Hurricane Katrina. The Nguyens possess strengths such as initiative, resourcefulness, and a strong work ethic that help them to be resilient in the face of their stressors.

KEY TERMS RELATED TO CRISIS

To help plan effective crisis response strategies, it is important to keep a number of concepts in mind. A problem, however, is that many of the terms used in the stress and crisis literature are used inconsistently or without specificity (Boss, 2002). For example, in Western culture, the word *stress* is widely used to describe emotional phenomena ranging from feeling mild irritation and frustration to being frozen with fear. As the word relates to crises, however, it applies more to the ability to function than it does to affect. While the definitions of many terms seem intuitively obvious, some have unique connotations within the context of crisis intervention. In this section, key phrases and concepts used to describe crisis intervention theories and models are defined.

Stress

The terms *stress* and *crisis* often have been used interchangeably in the literature, thus creating a bit of confusion. Boss (1988, 2002), has attempted to distinguish between the two concepts, stating that stress is a continuous variable (i.e., stress may be measured by degree), whereas crisis is a dichotomous variable (i.e., there either is or isn't a crisis). Stress may be thought of as a process that exists over time, as, for example, the stress of having a loved one serving in the military in a hostile environment. Crisis, on the other hand, may be thought of as that temporary period of time during which typical coping ceases and there is intense disorganization and disequilibrium. A family accustomed to coping with the stress of having a loved one serving in the military overseas may experience crisis when that individual returns home. The family's boundaries, structure, and coping mechanisms may have changed during the loved one's absence, leaving the family inadequately equipped to function with that loved one's homecoming.

Stress is defined as pressure or tension on an individual or family system. It is a response to demands brought about by a stressor event and represents a change in the equilibrium or steady state of an individual or family system (Boss, 1988, 2002; McKenry & Price, 2005; Selye, 1978). The degree of stress experienced hinges on perceptions of, and meanings attributed to, the stressor event. While anything with the potential to change some aspect of the individual or family (e.g., boundaries, roles, beliefs) might produce

stress, increased stress levels do not necessarily always lead to crises. Often, stress can be managed, and the family or individual can arrive at a new steady state.

Trauma

Traumatic events are one type of stressor event. Traumatic events are powerful and overwhelming, and they threaten perceptions of safety and security. Some may be single incidents of relatively short-term duration, whereas others may occur over longer periods of time, resulting in prolonged exposure to the threatening stressor (Collins & Collins, 2005). According to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV–TR*; American Psychiatric Association, 2000), a traumatic event involves "actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (p. 218). Traumatic events may be human-caused accidents or catastrophes, such as the 2003 ferry disaster in New York City. The ferry reportedly had not been running a straight course and struck a concrete pier while attempting to dock at the Staten Island end of its run. The crash killed 11 people and injured dozens of others. Other traumatic events include acts of deliberate cruelty. The terrorist attacks on the World Trade Center and Pentagon on September 11, 2001; the bombing of the Alfred P. Murrah Federal Building in Oklahoma City in 1995; and school shootings such as those at Westside Middle School in Jonesboro Arkansas, at Columbine High School in Littleton, Colorado, and at Virginia Tech all are examples of acts of deliberate human cruelty, as are the numerous homicides and sexual assaults that occur in the United States each year. Additional traumatic events include natural disasters—events such as Hurricane Floyd, which struck the Carolina coast in 1999 and resulted in 56 deaths; the F-5 tornado that left a trail of death and destruction in Oak Grove, Alabama in 1998; the flood that occurred in Cedar Rapids, Iowa in 2008; and the earthquake that resulted in tens of thousands of deaths in China in 2008.

Responses to Trauma

In general, people experiencing traumatic events respond with feelings of "intense fear, helplessness, or horror" (American Psychiatric Association, 2000, p. 219). Many of these individuals become significantly distressed and impaired, and a few develop illnesses such as Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD). The risk for psychological disturbance tends to increase with the magnitude or intensity of the traumatic stressor and with the degree to which the event was human caused and intended to harm (Norris et al., 2002).

Following the Cocoanut Grove fire in 1942, practitioners began to become aware of "common reactions to abnormal events" that do not necessarily constitute psychiatric illnesses. Reactions to traumatic events typically include physical, behavioral, cognitive, emotional, and spiritual responses, which tend to occur in stages, but ultimately are temporary. These transient reactions often are referred to as reactions to posttraumatic stress (PTS). Physical responses involve the autonomic nervous system as the person prepares to "fight or flee" and may be experienced through symptoms such as palpitations, shortness of breath, nausea, muscle tension, headaches, and fatigue. Behaviorally, individuals may experience sleep and dietary changes, social withdrawal, purposeful avoidance of or attention to reminders of the trauma, changes in relationships, and increased use of alcohol or other mood-altering substances. Cognitive responses include rumination, preoccupation, forgetfulness, and difficulty concentrating.

Emotional responses include distress, anxiety, impatience, irritability, anger, and symptoms of depression. Finally, spiritual responses are centered on existential questions and attempts to find meaning in the traumatic event. These reactions may transpire over a period as long as two years, but they are not considered pathological.

While most people return to a level of equilibrium and healthy functioning following a reaction to traumatic stress, some may experience consequences that impair their ability to function. Many of these individuals experience traumatic stress–related anxiety disorders. Two such disorders are described in the *DSM–IV–TR* (American Psychiatric Association, 2000): ASD and PTSD. These two disorders are similar in their symptomology and differ mainly in their temporal association with exposure to the traumatic event. According to the *DSM–IV–TR*, the diagnostic criteria for ASD and PTSD include hyperarousal (hypervigilance, difficulty concentrating, exaggerated startle responses, sleep disturbance), reexperiencing (flashbacks, nightmares, intrusive thoughts), and avoidance (attempts to avoid reminders of the traumatic event, inability to recall components of the event, detachment, dissociation, restricted affect)—symptoms that lead to distress and impairment in key areas of functioning such as work and interpersonal relationships. If these symptoms appear within one month of exposure to the trauma, ASD is diagnosed. If exposure to the traumatic event occurred more than a month prior to the development of these symptoms, PTSD is diagnosed. If symptoms persist for more than three months, PTSD is considered chronic.

Coping

All actions taken in an effort to manage stress, regardless of whether they are successful, are referred to as coping. Coping involves cognitive and behavioral components and is considered a process, not an outcome. Coping requires an assessment of the stressor event and its potential for harm as well as an assessment of the possible outcome of any response strategy chosen. Coping responses may be problem focused or emotion focused and may employ direct action behaviors that are used in relation to the physical or social environment or intrapsychic tactics that allow for the reduction of emotional arousal. Specific coping behaviors are chosen either to deal directly with the problem associated with stress (e.g., fight or flight) or to control emotions, in some cases by covering them up. Coping strategies are neither adaptive nor maladaptive, as adaptation is considered an outcome variable. Instead, coping behaviors should be considered in relation to the specific purpose for which they were chosen. Following the experience of a traumatic stress event, for example, some individuals may choose to increase their alcohol consumption. While this behavior does little to address the needs brought about by the stressor, it may be effective (albeit unhealthy) in keeping unwanted emotions at bay (Boss, 1988; Lazarus, 1966, 1976; McKenry & Price, 2005; Pearlin & Schooler, 1978).

Adaptation

Adaptation is an outcome of stress or crisis. It is the degree to which functioning has changed over an extended period of time and may be measured by the fit between the individual or family system and the environment. According to McCubbin & Patterson (1982), some families benefit from the challenges of adversity. Successfully dealing with adversity results in an outcome that is better than one that might have been reached

without the adversity. These families have changed to the point where they have the resources to meet the demands of stressors while continuing to grow. Quite often, changes have occurred in functional behaviors such as rules, roles, boundaries, and interpersonal communication patterns, resulting in families being better equipped to meet the challenges of future stressors. Conversely, for some families an imbalance continues between stress demands and the capability to meet those demands. Many families may adopt unhealthy and unproductive responses to stress. Unhealthy coping behaviors, such as addictions or domestic violence, result in additional stress. Furthermore, it is often the case that coping behaviors that appear to be healthy contribute to stress. A parent, for example, might take a second job in order to increase the family's financial resources. Working extra hours, however, removes that parent from the home and may contribute to strained family relationships and a decrease in other nontangible resources.

Resiliency

How well an individual or family system bounces back from adversity is considered resiliency. Based on physiological strengths, psychological resourcefulness, and interpersonal skills (Cowan, Cowan, & Schultz, 1996), resiliency is that group of coping strengths that allows some people to benefit from having successfully dealt with stress. In addition to being considered an outcome of stress and crisis, resilience may be considered protective in that hardy individuals and families seem to be less vulnerable to stress. People who are resilient tend to be protected by their attribution, response, and cognitive styles as well as by their social and problem-solving skills (Boss, 2002). Very often, these protective factors have been acquired through the successful resolution of a crisis.

CRISIS INTERVENTION VERSUS TRADITIONAL COUNSELING

There are many differences between traditional counseling and crisis intervention. However, the overall differences rest in purpose, setting, time, and intervention plan. It is crucial for professionals to understand the purpose of crisis counseling, as it differs from that of traditional counseling, in order to intervene appropriately. Simply, the goal of traditional counseling is to increase functioning, whereas the goal of crisis counseling is to decrease suffering and increase stabilization in order to refer the client on for longer-term counseling. Imagine a car accident in which an individual may have experienced a severe medical trauma. It is essential for the EMT to stabilize the patient to prevent further injuries prior to transferring (referring) the patient to a surgeon at the hospital.

Traditional counseling is typically a scheduled event that lasts for a specific period of time (e.g., a 50-minute session), and it is expected to consist of more than one such session over a period of time. Traditional counseling sessions take place in mental health agencies, private practices, hospitals, correctional facilities, residential facilities, and other locations related to mental health services (Gladding, 1997).

Crisis intervention is quite different from traditional counseling. Crisis intervention happens at the spur of the moment and is not a scheduled event. Clients can present with symptoms of a crisis in traditional counseling, but typically crises are not planned. Crisis intervention can take place in all of the settings that traditional counseling takes place but has much broader borders. Crisis intervention can take place in

one's home (e.g., after a child becomes missing), a makeshift shelter (e.g., after a hurricane), an emergency room (e.g., after a rape), or any one of numerous other contexts.

Treatment Planning

A treatment plan is a formal document that has the primary purpose of focusing the treatment of clients, setting realistic expectations of counseling, developing a tool for measuring progress in treatment, and establishing a measure of quality control (Maruish, 2002). A formal treatment plan typically consists of the referral source and reason for referral, the presenting problem and a prioritized list of all problems, a working diagnosis, goals and objectives, treatment strategies and interventions, client strengths, possible barriers to treatment, referral for evaluation, criteria for ending treatment, responsible staff, risk assessment, and treatment plan review date.

Clinicians conducting traditional counseling will use these treatment planning components to focus the progress of counseling. Counselors who work with clients experiencing crises will also use treatment plans but may modify a treatment plan to specifically address the crisis issues (Johngma & Peterson, 1999). When dealing with clients who are in a crisis situation or who are in a continual state of crisis, considerable time should be spent in developing a strength-based treatment plan highlighting protective factors and the positive aspects of the client's life (Greene, Lee, Trask, & Rheinscheld, 2005). In addition, treatment planning in crisis intervention may use a team approach involving multiple professionals to address the various needs of the person in crisis. For example, counselors, psychiatrists, case workers, clergy/pastoral counselors, first responders, and law enforcement and medical professionals may all be involved to address specific issues for one person or family unit in crisis. Table 1.1 illustrates additional differences in treatment planning between traditional counseling and crisis intervention.

ROLES OF AND COLLABORATION BETWEEN HELPING PROFESSIONALS DURING CRISIS

The roles of mental health providers are not clearly defined in the scholarly literature. However, one could assume that all of those who work in the mental health profession have been exposed to crisis intervention training or at least basic counseling skills that can help clients reduce crisis or stressful situations. Following are brief descriptions of how different mental health professionals—including professional school counselors, professional counselors, psychologists, social workers, psychiatrists, hotline workers, and paraprofessionals—can be helpful in crisis situations.

Professional School Counselors

Professional school counselors play a vital role in a comprehensive crisis leadership team (Kerr, 2009) and are key figures in a school building who provide leadership to the school through advocacy and collaboration. They work to maximize student achievement and also to "promote equity and access to opportunities and rigorous educational experiences for all students" as well as helping to facilitate "a safe learning environment and work[ing] to safeguard the human rights of all members of the school community" (American School Counselor Association, 2008, p. 2). School counselors

TABLE 1.1 Treatment Planning Differences Between Traditional Counseling and Crisis Intervention

Treatment Plan Component	Traditional Counseling	Crisis Intervention
Purpose	Increase functioning.	Decrease suffering; increase stabilization.
Referral Source and Reason	Indicate who sent the client to therapy and why the client is in counseling.	Same as traditional counseling, but indicate if such reason for referral is due to a crisis or is a temporary situation.
Presenting Problem and Prioritized List of All Problems	Define the main problem that the client is experiencing.	Typically, the presenting problem is the crisis, although it is important to determine what issues may have led up to the crisis. The clinician must also contextualize and triage client problems even though the client may not see them as significant. For example, if the client is depressed but becomes suicidal when the depression increases, the clinician would view suicide as more pressing than the depression.
Working Diagnosis	The clinician will develop a five-axis diagnosis.	Same as traditional counseling but more of a rapid crisis assessment that may require symptomology to be triaged. Specific attention will also be brought to those diagnoses that contribute to suicide, crisis, and spontaneity (e.g., Substance Abuse, Borderline Personality Disorder, Anxiety Disorders, Mood Disorders).
Goals and Objectives	The clinician and the client will develop short-term and long-term goals and objectives to make progress in therapy. These goals and objectives must be stated in realistic and measurable terms.	Same as traditional counseling, but more short-term goals and objectives will typically be indicated when a crisis occurs.
Treatment Strategies and Interventions	The clinician will indicate specific theory-driven strategies and interventions to progress toward positive outcomes in treatment. Such strategies and interventions should correspond to the established goals and objectives.	Same as traditional counseling, but include issues of crisis assessments, issues of safety and possible supervision, and the client's readiness to change his/her ability to handle crisis.
	Nondirective or collaborative approaches are ideal.	May employ a directive, nondirective, or collaborative approach.
Client Strengths	The clinician and the client will develop a list of the client's strengths.	Same as traditional counseling, but specifically include client protective factors and strengths that will facilitate coping with crisis circumstances.

(*continued*)

TABLE 1.1 Treatment Planning Differences Between Traditional Counseling and Crisis Intervention (*continued*)

Treatment Plan Component	Traditional Counseling	Crisis Intervention
Possible Barriers to Treatment	The clinician and the client will develop a list of general events, situations, people, etc., that may negatively interfere with treatment.	Same as traditional counseling, but specifically indicate events, situations, people, etc., that are not to be initiated when a crisis occurs. For example, typically cousin Sally is a good resource and listens to problems, but she does not provide the client with what is needed when upset.
Referral for Evaluation	The clinician will indicate what assessments are needed to assist the progression of treatment and what outside resources need to be consulted.	Same as traditional counseling, but also provide specific assessments for crisis, protective factors, and other resources that may relieve crisis situations. For example, if a client is in crisis because he or she lost his or her job, a career counselor may be warranted. Referrals are used more often, since the crisis symptoms may mask the actual presenting issue, which may warrant a person with specialized training.
Criteria for Ending Treatment	Typically, termination criteria will involve a significant decrease in the presenting problem symptoms.	Priority is to decrease the symptoms associated with the presenting problem and then refer the client to long-term counseling. Termination often occurs due to referring the client to another professional.
	Often, a formal termination process is the protocol and is explained during the initial visit. Termination is completed after issues have been resolved or after a referral is made that allows for closure.	Appropriate termination and closure are often missing in crisis counseling, since the problem may not be reconciled at this point.
Responsible Staff	Indicate what staff are involved in treatment and include their responsibilities.	Same as traditional counseling, but include specific individuals and agencies to contact in crisis situations.
	Often, an individual counselor.	Team approach utilizes numerous professionals to address the symptoms and issues related to the crisis.
Treatment Plan Review Date	Typically in an agency setting this occurs every three months.	If the client is in a serious crisis or is continually in crisis, review of the treatment plan should be more frequent; in some settings, this is done daily or multiple times throughout the same day.

frequently accomplish these goals by providing preventative and substantive programs that are imbedded in a comprehensive school counseling program.

Given their unique role, school counselors can be helpful in school crisis situations by using individual counseling, group counseling, and classroom guidance activities

and by collaborating with key stakeholders. Individual counseling can be helpful to those who are directly affected by crises (e.g., by working with a student on expressing feelings after his or her house caught on fire). Providing group counseling to those who have been exposed to crises (e.g., by establishing a support group for students who have divorced parents) could ease the pain of the initial impact of the crisis and create a support network among the group members. School counselors could also provide classroom guidance activities such as these:

- Preventative programs via classroom guidance activities on crisis, suicide, handling stress, communication skills, expressing frustration, and the like, which are seen as ways to prevent crises from occurring.
- Classroom guidance activities in the aftermath of a crisis (e.g., providing students with resources after the town has been devastated by a flood).

Lastly, connecting with the community and collaborating with key stakeholders are a vital role for school counselors in the wake of a crisis. Such connective efforts could include the following:

- Collaborating with teachers, staff, principals, superintendents, and other school personnel on preventing and responding to crisis (e.g., by providing school staff with materials and training on recognizing suicidal behavior).
- Working with families and individuals in the Parent Teacher Organization on ways to prevent, respond to, intervene in, and manage crisis. This will help parents provide supportive care that is congruent with what their children are learning in school.

Professional Counselors, Psychologists, and Social Workers

For the purpose of this book, professional counselors, psychologists, and social workers are grouped in one category because each profession can provide short-term or long-term therapy and individual or group therapy. Each state may allow for a differing scope of practice, and it is beyond the purpose of this book to discuss each of the subtle differences. For example, some states may allow professional counselors to diagnose and treat mental and emotional disorders, while others may not allow this. Overall, this group of mental health professionals will need a minimum of a master's degree to become licensed and practice (Gladding, 1997) and must possess specific training in providing mental health services. These professionals can be helpful in crisis situations by

- Assisting clients in gaining insight into the ways crisis affects their life in a cognitive, behavioral, and emotional manner over a lengthy period of time.
- Providing specific treatment goals and objectives related to crisis.
- Monitoring and assessing the magnitude of severity of a crisis situation.
- Providing insight into co-occurring mental and emotional disorders and crisis (e.g., showing a client diagnosed with Bipolar Disorder how to cope with and monitor crisis).
- Providing specific crisis intervention strategies during a crisis and over a period of time.
- Providing clients in crisis with resources and preventative measures.
- Assisting in alleviating symptoms associated with the crisis.
- Preparing clients to handle future crises.

Some professional counselors, psychologists, and social workers may specialize in a particular area that would contribute to helping individuals in crisis. For example:

- Marriage and family therapists provide support for couples and families and may involve the family in the resolution of the crisis on a short- and long-term basis.
- Pastoral counselors provide religious or spiritual integration in times of a crisis. Often, a crisis involves a spiritual or religious disconnect or dimension that must be explored. It is also important to understand any religious or spiritual coping mechanisms that were effective in the past that could be applied to the present crisis. This is important for all counselors to explore and should not be limited to the pastoral counseling profession.
- Chemical dependency counselors specifically address the use of drugs and alcohol as a coping mechanism during crisis.
- Counselors or psychologists who specialize in treating children, adolescents, adults, or geriatric populations could specifically address the crisis needs of individuals at a specific age.

Psychiatrists

According to the American Psychiatric Association (2008), psychiatrists are physicians who have obtained specific training and experience in treating mental and emotional disorders. The key difference between the scope of practice of psychiatrists and that of other mental health practitioners is that psychiatrists can prescribe medication to clients. "Psychiatrists are especially suited to triaging direct and indirect victims in various settings, such as on consultation in hospitals' emergency rooms, intensive care and burn units, general medical floors or inpatient psychiatry units. Or psychiatrists may volunteer for agencies such as the American Red Cross, where they may be part of a mental health team providing grief support, notification of death to family members, or crisis intervention" (American Psychiatric Association, 2004, p. 21).

Hotline Workers

Hotline workers are often the first point of contact for many individuals experiencing a crisis and may handle any number of crises resulting from suicidal and homicidal ideation, domestic violence, substance abuse, and sexual assault. There are hotlines that specialize in specific crisis situations such as those mentioned previously. There are even crisis hotlines for specific age groups (e.g., a hotline dedicated to teen callers). Typically, hotline workers are not mental health professionals but volunteers who have undergone specific training in responding to crises. No matter what their focus, crisis hotlines play a vital role in assessing, intervening in, and preventing the occurrence of crises (Seeley, 1995). Crisis hotline workers are essential during a crisis situation to

- Assess the severity of the crisis situation and the lethality of the caller.
- Provide immediate crisis intervention to the caller in an attempt to deescalate the crisis. This is critical in a crisis situation because the caller does not have to make an appointment with a professional or wait to get help. Most hotlines are 24-hour services open 365 days a year.
- Provide resources to the caller that may help resolve the crisis (see Table 1.2 for a sample of national toll-free hotlines that serve those in crisis).

TABLE 1.2 Sample Toll-free Hotlines

General Crisis Intervention Hotlines for Youth (dealing with conflicts, family stressors, suicide, runaway youth, drugs and alcohol, homelessness, and so on)

- Boys Town Suicide and Crisis Line: 800-448-3000 (voice) / 800-448-1833 (TDD)
- Covenant House Hotline: 800-999-9999
- National Youth Crisis Hotline: 800-442-HOPE

Child Abuse Hotlines

- ChildHelp USA National Child Abuse Hotline: 800-4-A-CHILD (voice) / 800-2-A-CHILD (TDD)
- National Child Abuse Hotline: 800-25-ABUSE

Domestic Violence Hotlines

- National Domestic Violence/Child Abuse/Sexual Abuse Hotline: 800-799-SAFE (voice) / 800-787-3224 (TDD) / 800-942-6908 (Spanish speaking)
- Domestic Violence Hotline: 800-829-1122

Substance Abuse/Alcoholism Hotlines

- Al-ateen: 800-352-9996
- National Cocaine Hotline: 800-COCAINE
- National Drug Information Treatment and Referral Hotline: 800-662-HELP

Poison Control Hotline

- Poison Control: 800-362-9922

Rape Hotline

- National Rape Crisis Hotline: 800-656-4673

Suicide Prevention Hotlines

- National Suicide Hotline: 800-SUICIDE (voice) / 800-799-4TTY (TDD)
- National Suicide Prevention Lifeline: 800-273-TALK / 888-628-9454 (Spanish speaking)

Paraprofessionals

Some individuals within the mental health community have little professional mental health training but perform essential tasks (e.g., case management duties, residential care) for individuals in crisis. Paraprofessionals can

- Manage resources that help facilitate stabilization (e.g., make sure clients keep all medical, financial, emotional, environmental, and social service appointments).
- Ensure clients are aware of appropriate resources that could be seen as preventative actions to crisis (e.g., ensure a client has appropriate resources to pay a natural gas bill to have heat in the winter).
- Provide an outlet for a client to decrease isolation and talk to others (e.g., talk with individuals in crisis and provide assurance that someone cares for them and their situation).
- Participate in executing the modality and frequency aspects of the treatment plan—in other words, make the connections set out in the treatment plan. For

example, the professional counselor may develop a treatment plan for someone in a residential program that involves attending Alcoholics Anonymous groups daily, attending a group on a specified psychosocial issue three times per week, and addressing a medical issue. The paraprofessional case worker may be responsible for following through with the treatment plan by assisting the client in making the appointments and setting up transportation to the appointments or groups.

To be effective, a crisis worker, whether a professional or a paraprofessional, must be able to (a) rely on life experiences and emotional maturity to remain stable and consistent, (b) remain calm and poised in order to deescalate the situation, (c) use creativity and flexibility to adapt to rapidly changing situations, (d) maintain an energetic and resilient self to keep up with the rigor of working in a crisis situation, and (e) use effective clinical skills in a timely fashion in order to create a trusting and safe environment and suspend one's values just for the crisis time in order to stabilize the client and refer him or her on to another professional (James, 2008). Keep these characteristics in mind when doing Activity 1.1.

ACTIVITY 1.1
Who Does What and Why?

In the following crisis situations, what might be some activities, interventions, responsibilities, and considerations for each of the mental health professionals addressed above?

Crisis Situation 1

Alan and Mary have been married for three years. Alan has been cheating on Mary for the past six months, and Mary has been cheating on Alan for the past year. Each is unaware of the other's infidelity, but the stress in their house is severe. They yell constantly, and Mary throws objects during arguments. In the past month, Alan has begun to slap Mary during these arguments. Last night Alan hit her so hard that he knocked her unconscious. Mary is now in the hospital talking to a social worker. Mary states to the social worker, "I am afraid of my husband, but I don't have anywhere else to go; I feel so alone."

Crisis Situation 2

John F. Kennedy High School, located in a primarily low- to middle-class rural community, comprises approximately 1,000 students, most of whom know one another. Within the past four months, the school has been evacuated five times as a result of a call indicating that there is a bomb in the building and that "everyone should get out." As a result of these threats and evacuations, students are scared, parents do not want to send their children to school, and teachers and other school personnel are frightened to go to work. Students also have begun to accuse other students of calling in the bomb threats, and several students have been ostracized and bullied. The Parent Teacher Organization has called a meeting tonight to address this issue.

Crisis Situation 3

Walter Taylor is a 74-year-old African-American male who has worked all of his life as a plumber. Walter has been married to Martha for 52 years and has four children and six grandchildren. Due to intense flash floods within the past week from melting snow, the Taylor household is seven feet under water. When the water came, Walter, his 40-year-old daughter June, and his 13-year-old granddaughter Beverly had to be rescued from their house by boat. Walter's house is destroyed, Beverly is having nightmares and not wanting to leave her family, and June is recovering from a head trauma caused while being evacuated.

ASSESSMENT AND INTERVENTION

Attempts to intervene in crisis situations must begin with assessment. At a minimum, crisis counselors need to assess clients for disturbances in their equilibrium or mobility by evaluating their functioning in the areas of affect, behavior, and cognition. Through appropriate assessment, responders are able to gauge the severity of the crisis situation, the extent to which clients have been immobilized, available resources, lethality, and the effectiveness of the crisis workers' own efforts (James, 2008).

A Developmental-Ecological Model of Assessment

A number of models have been suggested for use in assessing crises, including the multidimensional model proposed by Slaikeu (1990) and the triage assessment model proposed by Myer, Williams, Ottens, and Schmidt (1992). The multidimensional model proposed by Slaikeu (1990) was based on Arnold Lazarus's multimodal approach to counseling. According to Slaikeu, it is important to approach crisis intervention from a systemic, contextual point of view. In addition, it is important to attend to behavior, affect, somatic responses, interpersonal interactions, cognitions, and spirituality. Similar to the multidimensional model, the triage assessment model (Myer et al., 1992) addresses affect, behavior, and cognition in response to crisis events. According to the triage assessment model, affective responses tend to be negative and centered around anxiety and fear, anger, or sadness. Behavioral reaction, in general, may be classified as approach, avoidance, or immobility. Cognitive perceptions, which often impact affective and behavioral responses, tend to emphasize the idea of transgression; that is, there is a sense of victimization or of rights being violated, threats to safety and security, and loss.

These models have strengths in that they stress assessment from a holistic perspective, but according to Collins and Collins (2005), neither has the collective qualities of being user-friendly, adaptable, comprehensive, and culturally sensitive. Thus, Collins and Collins have proposed a developmental-ecological paradigm for assessment as well as intervention. This model addresses the individual, the environment, and the interaction between the two.

The developmental-ecological model presented by Collins and Collins (2005) provides a framework for assessing clients, along with their environmental contexts. The framework includes five dimensions: affect, behavior, cognition, development, and the ecosystem or ABCDE. Common affective responses during crises include anxiety, anger, depression, sadness, fear, shame, and confusion. Behavioral responses range from inaction and immobility to lethal actions and are representative of how well clients are coping. Consideration of cognitions provides additional clues to coping, as clients engage in cognitive appraisal as one aspect of the coping process. Attention to cognitions also allows the crisis counselor to assess perceptions and the meaning that clients assign to the crisis situation.

In agreement with Boss (1987, 1988, 2002), Collins and Collins (2005) maintained that it is important to consider contextual variables in order to understand fully the crisis experience. As many crises are triggered by stressors that arise at transitional points during the life span, it is essential for crisis counselors to be familiar with theories of human and family development. Phenomena associated with various stages of development may contribute to the pileup of stressors but may present additional resources as well (McCubbin & Patterson, 1982).

CASE STUDY 1.1 (continued)

The Nguyens

If you were to work with the Nguyen family as a crisis counselor, you would need to assess Vin and Li and their environment from a contextual point of view. The ABCDE assessment model (Collins & Collins, 2005) is suggested for assessing the Nguyens' essential areas of function:

A (affect): Given the birth of a daughter with a disability in the context of the other hardships that the Nguyens have been dealing with, what feelings might this couple be experiencing?

B (behavior): What actions have Vin and Li taken to deal with their provoking stressors? Are any of these behaviors dangerous?

C (cognition): How do Vin and Li explain what has happened to them? Do their cultural and religious beliefs affect the meaning they have attributed to their situation? Since the Nguyens lost their livelihood to Hurricane Katrina, are they focused on loss, or has the birth of their daughter brought them new hope for the future?

D (development): Vin and Li are young adults and, in terms of the family life cycle, are at the developmental stage of becoming first-time parents. What additional stressors and resources come with this stage of development?

E (ecosystem): What is happening in the community in which Vin and Li live? Are the Nguyens supported in this community? Do they have friends and family? Are there other Vietnamese families in the community? Are social services available to them?

An additional contextual factor proposed by Collins and Collins (2005) is the ecosystem. From an ecosystemic perspective, clients should be considered within the context of their culture and ethnicity; family and extended family; friends; community affiliations such as church, school, workplace, and neighborhood; and formal social services at the institutional or society level.

FUNDAMENTALS OF WORKING WITH CRISIS CLIENTS

The underpinnings of working with clients in crisis begin with determining, based on assessment efforts, how best to approach them to deescalate the crisis. In other words, we need to assess whether the situation calls for us to be directive, nondirective, or collaborative (James, 2008).

Directive approaches call for us to "direct" or lead the person in crisis in a specific direction. Clients in crisis are typically scattered and unable to plan beyond their current situation. Therefore, providing some form of direction may help. For example, if someone is highly uncertain, spontaneous, or ambiguous and, at the same time, unable to get out of a crisis state, providing direction could provide immediate, though temporary, relief to feelings surrounding the crisis situation.

Nondirective approaches allow the person in crisis to come up with the directives while the crisis counselor facilitates that process. If the client is at a place where he or she can make rational decisions, even though he or she is still in a state of crisis, a nondirective approach may empower the client to make progress toward deescalation. For example, asking clients who were recently victimized by a flood "What might be of most help to you now?" allows them to respond with specifics, rather than having you guess what was needed. The thought process and response of such clients may also empower them to feel like they are regaining some control over their own lives.

A collaborative approach focuses on showing the person in crisis that you are there, with them, on the journey toward stabilization and normalcy. People in crisis need to know that there are others not only to provide help but also to decrease isolation and increase resource allocation. Collaborative approaches are considered a blending of directive and nondirective approaches—but with a flavor of togetherness. In other words, a collaborative approach provides support and a sense of working together toward a common goal.

Examples of directive, nondirective, and collaborative approaches in crisis situations follow. Discuss how each could be an appropriate statement in specific circumstances.

EXAMPLE 1

- I want you to put the gun down. (directive)
- Let's chat about how you feel about putting the gun down. (nondirective)
- I want to help, but knowing you have that gun in your hand scares me. Can you put the gun down for me so I can help you more? (collaborative)

EXAMPLE 2

- Calm down. (directive)
- How might you calm yourself down? (nondirective)
- Boy, I'm really upset. Let's try and calm down for a bit. (collaborative)

EXAMPLE 3

- I am calling the police. (directive)
- Would calling the police help? (nondirective)
- If I bring you the phone, would you call the police? (collaborative)

COMPLICATIONS OF INDIVIDUALS RESPONDING TO CRISIS

There is an old saying that exists in mental health treatment: "If you haven't had a client in crisis, then you haven't worked with clients long." Complications of working in crisis situations and with clients in crisis can take a physical, emotional, and professional toll on crisis counselors. It is important when reading the remainder of this text to consider how you might take care of yourself while helping others manage a crisis. Consider proactive ways to avoid burnout, manage your own emotional state during highly emotional crisis situations (e.g., when working with suicidal clients), and ensure that your physical, cognitive, and psychological self is up to working with clients in crisis. Working with others in a state of crisis is not easy. Crisis counselors need to stay abreast of their own well-being in order to help others.

Summary

A crisis is a situation in which there is a precipitating stressor event, a perception of that event that leads to distress, and diminished functioning when the distress is not relieved by familiar coping resources. Many individuals and families are resilient and benefit from having met the challenges of a crisis situation. How well an individual or family adapts following a crisis often is determined not only by the nature of the stressor event itself but also by the presence or absence of other stressors, the availability of tangible and intangible resources, and how the entire situation is perceived. Crises may be provoked by predictable events that occur during normal, developmental transitions during the lives of individuals and families or by situational events that often are sudden and unexpected.

Crisis intervention begins with assessment of the provoking event, reactions and responses to the provoking event, and other contextual variables that impact the situation. While there are times when a crisis counselor's response to a crisis appears indistinguishable from traditional counseling, crisis intervention generally is thought to be quite different from traditional counseling. Paraprofessionals and professionals from a variety of helping disciplines provide crisis intervention services, often working in teams where each helper may focus on a particular area of expertise. Working with clients in crisis places helpers at risk for vicarious trauma and burnout. The work is difficult, but the rewards are immeasurable.