

Approaching Crisis Intervention

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A Brief History of Crisis Intervention

We open the eighth edition of this book with **LO1** a brief history of crisis intervention. While crisis itself has probably been in existence ever since Eve ate the apple in the Garden of Eden, formal crisis theory, research, and intervention comprise one of the newest fields in psychotherapy. Probably most laypersons would think of formal crisis intervention as historically having to do with large-scale disasters, such as hurricanes or 9/11, and most typically performed by government agencies like the Federal Emergency Management Agency (FEMA) in the United States or by charitable organizations like the Red Cross. While the Red Cross and the Salvation Army have been involved in disaster relief for approximately the past century, FEMA has been in existence only for about 35 years, and until quite recently none of these organizations has had much to say or do about crisis intervention from a mental health perspective. Like Topsy in Harriet Beecher Stowe's classic, *Uncle Tom's Cabin*, "it just sorta grewed." Understanding just how much it has "grewed" in such a short time will help you understand why there's still a lot we don't know. But what we do know in 2015 is light-years ahead of what we knew when the first edition of this book appeared in 1987. If you could find a first edition in your library, it would look very little like this book does now.

The First Crisis Line. Suicide prevention is probably the longest running intervention program in which individual crisis is addressed from a mental health standpoint. The first identifiable crisis phone line was established in 1906 by the National Save-a-Life League (Bloom, 1984). Dr. Edwin Shneidman's (2001) landmark research into the causes of suicide, which

LEARNING OBJECTIVES

After studying this chapter, you should be able to:

1. Understand the origins and evolution of the practice of crisis intervention.
2. Learn the basic definitions of individual crisis.
3. Differentiate between the concepts of individual crisis, systemic crisis, transcrisis, and metastasizing crisis.
4. Know the different types of theories of crisis intervention.
5. Understand the different applied crisis intervention action models.
6. Know the specific action steps of psychological first aid.
7. Assess yourself against traits and attributes common to competent crisis interventionists.

started in the 1950s, has spanned six decades. Suicide has achieved such importance that it has become an "ology" and has a national association devoted to its study.

Cocoanut Grove Nightclub Fire. However, most people who study the field would probably say the benchmark for crisis intervention was the Cocoanut Grove nightclub fire in 1942, in which more than 400 people perished. Dr. Erich Lindemann (1944), who treated many of the survivors, found that they seemed to have common emotional responses and a need for psychological assistance and support. Out of Lindemann's work came the first notions of what may be called "normal" grief reactions to a disaster. Dr. Gerald Caplan (1961) was also involved in working with the Cocoanut Grove survivors. Sometimes referred to as the father of crisis intervention, his experiences led to some of the first attempts to explain what a crisis is and to build a theory of crisis. However, not until the

1960s did the first attempts occur to provide a structure for what would become crisis intervention.

The Community Mental Health Act of 1963. This federal act completely changed the way mental health services were delivered in the United States by mandating the development of community centers to deal with the mentally ill in the United States, who, prior to that act were generally housed in large state “insane asylums.” As the large state insane asylums were closed down and replaced by community mental health centers, one of the primary mandates of those centers was to provide emergency services and crisis intervention 24/7. While the community mental health concept was laudable, the idealistic notion that patients would be docile, medication compliant, and fully functional proved to be problematic and those problems would end up in homeless shelters and prisons.

The New Asylums—Prisons. Although the statistics are dated (James & Glaze, 2006), they are probably conservatively representative of where the mental health problems of the United States currently reside. In 2006 more than one million two hundred thousand inmates in federal and state prisons and local jails could be identified as having a diagnosable mental illness. James and Glaze’s (2006) grim statistical analysis of incarcerates portrays a sad legacy of the Community Mental Health Act and what this country has done about it. Three quarters of prisoners with mental illness also suffer from co-occurring substance abuse disorders. They are three times more likely to have been sexually or physically abused in their past than their fellow inmates. Women with mental illness make up an even higher proportion of incarcerates (approximately 70 %) than do men (approximately 56%). Prison is also not a safe place if you are mentally ill. Incarcerates with mental illness are twice as likely to be injured in fights as compared to fellow inmates who are not mentally ill. Finally, they also do not stay out of jail. Nearly 25% of those inmates with mental illness have served three or more prior incarcerations. In summary, if you were to go looking to find a fertile field to do crisis intervention with the mentally ill, you would need look no further than your local jail.

How could this happen with such good intentions of the Community Mental Health Act? One of the overarching tenets of crisis intervention that flows through every theoretical model is the concept

of support. When familial supports either wear down and out or were never there in the first place, when no medical professional is there to monitor medication, when mental health clinics are underfunded and overwhelmed with clients, and when little vocational opportunities or rehabilitation counselors are available, persons who are mentally ill become the “crazy” panhandler you are bothered by when you are on the streets of a big city. As a result of this evolution in mental health care (or the lack of it), it should not be surprising that a great deal of crisis intervention is now done on the streets and in the homes of local communities. What might surprise you is that a lot of it is being done by police officers.

Birth of the Police Crisis Intervention Team. Indeed, one of the major, serendipitous outcomes of the return of mentally ill to the community has been the birth of the police Crisis Intervention Team. Faced with continuous interactions with the mentally ill who were off their medication, many confrontations with the police ended violently with the mentally ill consumer forcibly being taken into custody. That interaction often resulted in the consumer or police officer being injured or being killed. These continuous confrontations culminated in the city of Memphis in 1987 with a man suffering a severe schizophrenic episode being shot to death by the police. The resulting hue and cry from the citizens of our city resulted in a radical shift in police thinking and the establishment of the first **police Crisis Intervention Team** specifically trained to de-escalate and defuse people who are mentally ill and demonstrating dangerous behavior to themselves or others (James & Crews, 2009).

Word about what we were doing in Memphis soon spread, and other law enforcement jurisdictions that were grappling with the same problems across the country began asking for help in training their officers. What started out as a small group of mental health professionals, government officials, and police officers attempting to deal with a critical local political problem has now spread across over 2,400 jurisdictions in the United States, Canada, Australia, Europe, and Africa and is now considered a “best practices” model for police departments (Watson & Fulambarker, 2012), which we will thoroughly explore in Chapter 5, Crisis Case Handling.

International Movement. The United States has not been alone in its endeavors to organize large-scale crisis intervention operations. Internationally, the

United Nations Inter-Agency Standing Committee (IASC, 2007) has published guidelines for mental health provision in emergency situations. Europe has established the **European Network of Traumatic Stress** to develop evidence-based responses to large-scale disasters and provide assistance to those parts of the European Union that suffer from a lack of psychological resources. The **International Federation of Red Cross and Red Crescent Societies** has entered into the psychosocial facet of disaster relief by helping individuals and communities heal the psychological wounds and rebuild social structures after an emergency or a critical event. Its mission is to change people into active survivors rather than passive victims (International Federation of Red Cross and Red Crescent Societies, 2014). Most notably, the Australians have been in the vanguard of dealing with the mental health issues of large-scale disasters particularly through the research and writing of Beverley Raphael (Raphael, 1977, 1986; Raphael & Wilson, 2000).

Grassroots Movements

To really understand the evolution of crisis intervention, though, is to understand that several social movements have been critical to its development, and these did not start fully formed as “crisis intervention” groups by any means. Three of the major movements that helped shape crisis intervention into an emerging specialty were Alcoholics Anonymous (AA), Vietnam veterans, and the women’s movement of the 1970s. Although their commissioned intentions and objectives had little to do with the advancement of crisis intervention as a clinical specialty, they had a lot to do with people who were desperate for help and weren’t getting any. These groups all started as grassroots movements.

The need for crisis intervention services remains unrecognized by the public and by existing institutions until a critical mass of victims comes together to exert enough legal, political, or economic pressure to cause the particular crisis category, malady, or social problem to become formalized. Until that time, it remains informal, nonprofessional, and unsubsidized. The problem is responded to or handled mainly through ad hoc, informal means by former victims, current victims, friends, or significant others who are affected by the problem. The free storefront clinics for Vietnam veterans that grew out of a refusal of the Veterans Administration to handle their problems and the attempt by Mothers Against Drunk Driving (MADD) to deal with the crisis of drunk driving in

the face of resistant state legislatures are excellent examples of grassroots responses to unmet needs.

Initiators of crisis intervention services are generally concerned with one particular crisis category that personally affects them in some way. Typically, the crisis gets far enough out of hand to cause noticeable problems before remedial responses are initiated. At first, the initiators are mavericks who are starting a victims’ revolt. The revolt is against an entrenched status quo or power structure that shows little awareness of or responsiveness to the problem. The victims’ revolt somehow manages to get a fledgling crisis agency started despite the benign neglect and reluctance of mainstream society. In the 1970s, Vietnam veterans’ efforts to get posttraumatic stress disorder (PTSD) categorized as a mental disease and get financial support for research and treatment are a classic example of this revolt. So are the efforts of the National Organization for Women and other women’s groups in the 1970s to raise the curtain on domestic violence and child abuse in the United States and to get state legislatures to deal with them as criminal acts.

The fledgling crisis agency is initially funded by private donations, as with the many telephone call-in lines for victims of domestic violence that were started at local YWCAs in the 1970s. The services are often provided by volunteers who are loosely organized. The crisis agency gains access to public funding only after the agency has attained validation and some recognition by a substantial portion of the power structure. If, after a time, the crisis agency does not attain credibility sufficient to garner substantial private support or a modicum of public support, the agency begins to falter and eventually folds and ceases to operate.

It is this grassroots influence that often captures the attention of the media, impels people to join as volunteers, and causes a greater number of clients and victims to seek the services of the agency. Initially, community leaders may deny that the crisis exists, minimize its seriousness, or express doubt that it represents a recurring problem. But when the crisis persists, they finally come to realize that someone must become proactive—someone must exert the leadership, energy, time, resources, and resolve to confront the crisis. Thus the formation of an agency is sanctioned or even encouraged. If the fledgling agency born from the need to contain the crisis succeeds and is publicly recognized as fulfilling a need, the quest to expand and mature begins.

As mainstream institutions, such as governmental structures, become aware of the problem and as

volunteer centers reach the saturation point at which needs are obviously going unmet, some governmental or institutional funding is provided. Pressure politics, public relations, and public image building affect the course and growth of an organization and the problem it seeks to solve. For example, the plight of the Vietnam veterans suffering from PTSD was largely ignored until the problem spilled over from the streets into the seats of power and authority—from personal crisis to politics. When the PTSD problem began to affect members of Congress, the power of the federal government and the resources of the Veterans Administration were brought to bear not only to create a network of veterans centers throughout the country, but also to slash bureaucratic red tape to ensure that services for Vietnam veterans were taken to the streets where PTSD sufferers were living rather than requiring veterans to report to regular VA hospitals.

The activism of those veterans in the 1970s can be seen today in the comprehensive frontline treatment and exit programs of the armed services and the extensive use of veterans outreach centers across the United States. Satellite outreach centers throughout the country have now been established by the VA to make it substantially easier for veterans of the Middle Eastern conflicts to access services that would otherwise require them to travel to mainstream VA hospitals.

The Importance of Volunteerism

Contrary to the popular misconception that paid veteran crisis workers descend on a large-scale disaster like smoke jumpers into a forest fire, most crisis intervention in the United States is done by volunteers. Volunteer workers perform all kinds of services in most crisis agencies—from menial chores to answering the phone to frontline crisis intervention with clients. Volunteerism is often the key to getting the fledgling crisis agency rolling. The use of trained volunteers as crisis workers has been a recognized component of many crisis centers and agencies for years (Clark & McKiernan, 1981; Roberts, 1991, p. 29; Slaikou & Leff-Simon, 1990, p. 321). Probably the greatest number of frontline volunteers are used in staffing 24-hour suicide hotlines in major cities. Such hotlines require an enormous number of crisis workers because the crisis service never ceases—it must be provided 7 days a week, 52 weeks a year. Roberts (1991, p. 29) reported that more than three quarters of all crisis centers in the United States indicate that they rely on volunteer crisis workers and

that such volunteers outnumber professional staff by more than 6 to 1. Typically, as the numbers and needs of the clientele increase, the agency reaches the point where compassion and volunteerism alone cannot handle all of the complex personal, social, economic, public relations, psychological, and political problems that assail it.

The Need for Institutionalism

As crisis agencies become well known and as their clientele are drawn from a wider segment of the community (to the point that the work cannot be handled by the communication system of grapevine, word of mouth, notepad, e-mail, and Twitter), the agency sees that if it is to continue to grow and serve its clients, it must institutionalize. The seeds of bureaucracy are thus born.

To manage all of its vital functions, the agency must centralize and formalize most aspects of its operation. It takes on a formal board of directors, establishes rigorous auditing and record-keeping functions, and requires more money, paid staff, and staff support. As crisis agencies become crisis organizations, they gain more power, prestige, and notoriety. They tend to attract the attention of the human services professions because they offer fertile fields for funded research, placement of practicum and internship students, and employment of graduates. Crisis agencies sometimes attain eminent success, to the point that it becomes a vested interest of the human services professions to formalize the competencies of the personnel of such successful agencies through certification, licensure, and accreditation. The progression from the humble origins of Alcoholics Anonymous as a support group formed by fellow alcoholics in the 1930s to the current classification of alcoholism as a disease, the proliferation of thousands of treatment centers around the world, huge government funding for research and prevention, university courses on the subject, and the state licensure or certification of substance abuse counselors provides an outstanding example of the evolution from self-help by a group of recovering alcoholics in crisis to the full institutionalization of the crisis of drug abuse.

As a specialty evolves, it develops its own empirical base, professional research, and writings. For example, for crisis intervention we have publications such as *Crisis Intervention*, *Journal of Interpersonal Violence*, *Victimology*, *Violence and Victims*, *Journal of Family Violence*, *Death Studies*, *Journal of Traumatic Stress*, *Suicide and Life Threatening Behavior*, *Child Abuse and*

Neglect, Journal of Child Sexual Abuse, Aggression and Violent Behavior, and Violence Against Women. The amount of data and information in the field has expanded so much that the *Encyclopedia of Psychological Trauma* (Reyes, Elhai, & Ford, 2008) includes 720 large pages covering everything from A (Abuse, child physical) to W (Workplace violence).

Specialty areas may also attain a distinct level of recognition by building a base of national or regional affiliates, as with various topic- or malady-centered hotlines, chat rooms, and websites; AA chapters; spouse abuse centers; and victim assistance programs. Local, state, regional, and national conferences are organized to provide for exchange of ideas and problem-solving strategies. These conferences range from specialty areas that bring together some of the greatest research minds in the field—such as the First Annual Conference on Trauma, Loss, and Dissociation in 1995—to “in the trenches” conferences such as the Crisis Intervention Team International (CITI) convention which provides practical, hands-on programs for crisis intervention police officers who deal with the mentally ill.

The emergence of hundreds of crisis-oriented organizations in the 1970s, 1980s, and 1990s (Maurer & Sheets, 1999) and the realization of the role that immediate intervention plays in alleviating traumatic stress (Mitchell & Everly, 1995) attest to the dramatic transformation and professional acceptance of crisis intervention from a psychological backwater field to a pervasive specialty. Probably the best testament to the center stage on which crisis intervention is now playing is the birth in 2006 of the American Psychological Association’s newest division, Division 56, Trauma Psychology, along with the provision of counseling (Council for Accreditation of Counseling & Educationally Related Programs, 2009) and school psychology (National Association of School Psychologists, 2010) professional accreditation standards for training graduates in crisis intervention. One of the major players in the field of trauma, Christine Courtois (Courtois & Gold, 2009), has eloquently stated the critical need for inclusion of psychological trauma training in all helping service curricula. Thus, like lots of other concepts in mental health that evolve and continue to grow to meet increased demands for crisis services, it is incumbent that beginners in the mental health field understand the processes and evidence-based practices associated with crisis intervention (Cutler, Yeager, & Nunley, 2013) that this book is about.

The Media and the Societal Impetus for Crisis Intervention

Why, from the 1970s to the present, has the crisis intervention movement experienced such extraordinary growth? Probably no single factor alone can explain why. In the United States, the bombing of the Murrah Federal Building in Oklahoma City, 9/11, the mega natural disaster of Hurricane Katrina, mass shootings at Virginia Tech, Northern Illinois University, Columbine High School, Sandy Hook elementary school, and a variety of public massacres have all given rise to the demand for crisis intervention. Yet such natural and human-made disasters have been with us since the city of Pompeii was buried by Mt. Vesuvius and Rome was sacked and burned. What has changed public perception to the extent that the acronym PTSD—which in the first edition of this book was a brand new term that lots of psychologists were unfamiliar with or didn’t believe was a valid diagnostic—is now common parlance?

The media’s role in creating awareness of crises and crisis intervention has probably generated the most profound change in public consciousness of what it means to be in crisis after a large-scale disaster. When Matthew Brady’s pictures of the windrows of dead from the American Civil War battle of Antietam were put on display in New York in 1863, this first use of photographic media changed forever how people would perceive wars and the psychological trauma that invariably comes with them. Public perception of war as glorious changed forever as its horror and carnage were brought to the American doorstep by Brady’s harrowing pictures. Since that time, the ability of the media has advanced from the still-life daguerreotypes of Brady to real-time sound and video of New Orleans citizens sitting on top of flooded buildings, of Baghdad residents running from a car bombing, of the jumpers from the Twin Towers. It is unclear exactly what impact such real-time media has on the public, but clearly it does have an impact and changes our perception of the world as ever smaller, more interconnected, and certainly more dangerous, unsafe, and crisis prone (Marshall et al., 2007).

There are valid reasons for the widespread acceptance of crisis intervention as a therapeutic specialty. People in general have become more positive in their acceptance of outreach strategies following a crisis and are more knowledgeable about its psychological ramifications such as PTSD. There is less “blaming the victim” as somehow psychologically inadequate. Probably most important from a pragmatic point of

view, it is cost effective (Roberts, 1991). People in human services and political leadership positions have discovered that when they either ignore crisis situations or leave solutions entirely to the experts who have little political clout, lasting solutions elude them, and the leaders themselves are blamed and held publicly responsible. Reactive responding has not worked very well. Leaders have discovered that endemic crises will not easily go away, that reaction or no action may result in problems' metastasizing out of control. In a sense, then, political expediency has dictated not only the widespread acceptance of effective crisis intervention strategies but also that crisis intervention become proactive, preventive, and integrated on the local, national, and international levels. One need go no further than the aftermath of Hurricane Katrina to understand the full impact of what this paragraph is about.

The Case Against Too Much "Helping"

With the rise of postintervention psychological assistance in the last 20 years, an interesting phenomenon has started to emerge. "Do-gooder" individuals and paternalistic bureaucracies appear on the scene and want to "straighten" things out and "help" people. Van den Eynde and Veno (1999) report the case of an Australian community that literally had to kick government "help" out of town after the discovery of a case of long-term mass pedophilia in their midst. Even though the community clearly had the situation under control, the government authorities kept insisting they did not. What they had to do to get the government out of their town is interesting reading indeed.

In a worst-case scenario, crass commercialization, pseudoscience, vicarious thrills, and outright fraud mark the traumatic wake of a crisis (Echterling & Wylie, 1999; Gist, Lubin, & Redburn, 1999; Gist, Woodall, & Magenheimer, 1999; Lohr et al., 1999). Gist, Lubin, and Redburn (1999) have coined the term "trauma tourism" to describe the burgeoning industry in postintervention psychological trauma replete with trade shows, trade publications, talk shows, and charitable giving and bus tours of trauma areas. Indeed, such tours have become so acrimonious in New Orleans that tour companies have been fined by city officials for bus tours through the devastated ninth ward of that city (Brown, 2012).

The assumption is that disaster invariably leads to psychopathology, and psychopathology sells. If people are seen as incapable of caring for themselves and are

traumatized and in a panic state after a disaster, it follows that they must be somehow infirm and unequal to the task and need assistance. A paternalistic government is then tasked with taking care of them. This view may be even more true with "noble savages," transients, indigenous people, or other marginalized and disenfranchised groups who are seen as socially or technically unsophisticated and in need of benevolent and well-intentioned guidance and protection (Gist, Lubin, & Redburn, 1999; Kaniasty & Norris, 1999; Ober et al., 2000). On the other hand, such groups of disenfranchised and dislocated persons, particularly if they are migrants or undocumented aliens, may be given short shrift from the authorities and may be persecuted if they come to the attention of bureaucracies that are dealing with a crisis (Brown, 2009, pp. 215–226). It is with good reason that activists in the counseling field have proposed that "Social Justice" is the new benchmark against which therapy should be measured (Ratts & Pedersen, 2014), and that is particularly true in the aftermath of disasters.

However, the fact is that in most instances victims of disaster do not panic. They organize themselves in a collective manner and go about the business of helping one another and restoring equilibrium (Kaniasty & Norris, 1999). Called the "altruistic or therapeutic community," the typical immediate collective response to a disaster is characterized by the disappearance of community conflicts, heightened internal solidarity, charity, sharing, communal public works, and a positive "can-do" attitude (Barton, 1969; Giel, 1990). So, as of 2015, crisis intervention has emerged from a psychological backwater 30 years ago when we started writing the first edition of this book to a veritable tidal wave of interest, although at times controversial and full of heated debate, and that includes defining exactly what a crisis is.

Definitions of Crisis

This book is mainly about doing crisis **LO2** intervention with individuals and the microsystems such as families and workplaces. To a lesser extent, it is also about macrosystems in crisis and how the crisis interventionist functions within those systems, whether in institutions such as hospitals, schools, and mental health centers or as service providers after large-scale disasters. To that end we start this book in a pretty boring way by giving you not only a history lesson but also a long list of definitions of crisis as

it applies to both individuals and systems. We apologize for that, but we do this because we want you to understand that this business is still so new that a definition of an individual or a system in crisis is by no means fixed or absolute. As a matter of fact, as you are going to find throughout this book, there is a whole lot about crisis and crisis intervention that is not fixed or absolute! Consider, then, the following definitions of individuals in crisis.

Individual Crisis Definitions

1. 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 (Caplan, 1961, p. 18).
2. A crisis arises from a traumatic event that is unpredictable and uncontrollable. There is an inability to influence it by one's actions. The nature of the event changes values and priorities, and indeed changes everything (Sarri, 2005, pp. 19–24).
3. Crisis is a crisis because the individual knows no response to deal with a situation (Carkhuff & Berenson, 1977, p. 165).
4. Crisis is a personal difficulty or situation that immobilizes people and prevents them from consciously controlling their lives (Belkin, 1984, p. 424).
5. Crisis is a state of disorganization in which people face frustration of important life goals or profound disruption of their life cycles and methods of coping with stressors. The term *crisis* usually refers to a person's feelings of fear, shock, and distress *about* the disruption, not to the disruption itself (Brammer, 1985, p. 94).
6. Crisis is a temporary breakdown of coping. Expectations are violated and waves of emotion such as anger, anxiety, guilt, and grief surface. Old problems and earlier losses may surface. The event's intensity, duration, and suddenness may affect the severity of response to the crisis (Poland & McCormick, 1999, p. 6).
7. Crisis is a loss of psychological equilibrium or a state of emotional instability that includes elements of depression and anxiety which is caused by an external event with which individuals are unable to cope with at their usual level of ability (Kleespies, 2009, p. 15).
8. Crisis in a clinical context refers to an acute emotional upset arising from situational, developmental, or sociocultural sources, and results in a temporary inability to cope by means of one's usual problem-solving devices (Hoff, Hallisey, & Hoff, 2009, p. 4).
9. A crisis may be a catastrophic event or a series of life stresses that build rapidly and accumulate such that the person's homeostatic balance is disturbed and creates a vulnerable state, which, if not resolved, avoided, or redefined will cause self-righting devices to no longer be effective and plunge the person into psychological disequilibrium (Golan, 1978, p. 8).

It should immediately become clear that the term *crisis* has different meanings to different people and is used to describe a variety of incidents, settings, situations, and the adaptations, albeit less than adequate, that people attempt to make in response to them. To summarize these definitions, for an individual, **crisis** is the perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms. Unless the person obtains relief, the crisis has the potential to cause severe affective, behavioral, and cognitive malfunctioning up to the point of instigating injurious or lethal behavior to oneself or others. At that point the crisis becomes a behavioral emergency (Kleespies, 2009).

Behavioral Emergencies

A **behavioral emergency** occurs when a crisis escalates to the point that the situation requires immediate intervention to avoid injury or death to oneself or others or the person is in imminent risk of serious injury or death by another. Direct or intentional behavioral emergencies fall into the general categories of engaging in self-injurious behavior, perpetrating violent interpersonal behavior, and being a victim of violence as opposed to a behavioral crisis which may not necessarily be potentially lethal (Kleespies, 2009, p. 13; Kleespies, 2014, pp. 11–12). Suicides/homicides resulting from broken romances provide a classic example of these categories.

We believe that **indirect and noncommissioned behavioral emergencies** can also occur. Indirect behavioral emergencies occur when people make bad decisions and wind up placing themselves in potentially lethal situations. Indirect and noncommissioned behavioral emergencies are crises that happen with no directed purpose or intentionality to do

something harmful to oneself or others. Drunk driving, boating, snow skiing, swimming, and project construction may all turn into behavioral emergencies that have the potential for injurious or lethal behavior and call for intervention. A parent who, after receiving a phone call informing her that her child has been seriously injured in a school bus accident, becomes hysterical, leaves her newborn at home with a pot of cooking oil boiling on the stove, and drives 90 miles an hour to the hospital is creating a behavioral emergency to put it mildly. Persons with borderline personality disorder are the archetype of people whose unstable lifestyles continuously set them up to fly into crisis after crisis and oftentimes move quickly into behavioral emergencies by impulsively deciding to commit suicide or committing **parasuicide** (accidentally doing something or going into a situation a reasonable person wouldn't and getting himself or herself killed).

More often than we would like to imagine, crisis interventionists will deal with people whose behavior has escalated to the point that they can be considered to be behavioral emergencies. For that reason, when you first make the acquaintance of the Triage Assessment Form in Chapter 3 you will note that scores of 10 (maximum) on the form's scales all have lethal feeling, behaving, and thinking as part of their assessment anchors.

Systemic Crisis Definitions

"Individual crisis" is really something of an **LO3** oxymoron, because as most crises unfold, they rarely remain confined to one person. They ripple out and affect numerous other people who interact with the person in crisis. To think that the crisis created by a date rape or an alcoholic mother affects only the young woman who was assaulted or the housewife who drinks is to have a very wrong notion indeed about what a crisis is and what you may have to do and with whom you may work. Therefore, when we consider a definition of crisis, we are bound to look at how that crisis affects the system within which the individual operates. For most individuals the first ripple effect of a crisis will be with the family system. Although you will meet numerous family members as they are affected by various kinds of crisis in this book, we have developed a new chapter that looks more closely at the family system itself as it is impacted as opposed to the individual originally targeted by the crisis.

Systemic crises may come in many forms. They may be economically based, perhaps affecting only the

families of a small produce chain that goes bankrupt when the refrigeration in their warehouse fails or as large as a worldwide recession that throws millions of people out of work. They may be natural disasters, as small as a tornado tearing up a small Kansas farming community or as large as a pandemic flu epidemic that kills millions. They may be human-made, ranging from a structural failure that causes a building to collapse to wars that kill and displace millions of people. They may be psychologically based, ranging from fear of a school bully to an entire nation rendered paranoid by the terrorist attacks of 9/11. As you will see in the last chapter of this book, large-scale disasters that become systemic crises most generally fit the public perception of what crisis intervention is about. Indeed, the role of crisis interventionists as mental health service providers in that setting is becoming larger and larger. Consider, then, the following definitions of a system in crisis, in which the term *system* ranges across families, churches, businesses, neighborhoods, communities, large cities, geographical flood plains, and nations:

1. A crisis that threatens the organization is unexpected, demands a rapid response in a short time frame, and threatens its basic values (Hermann, 1963, p. 63).
2. Communities in crisis have several characteristics in common with individuals. Within the group there is an atmosphere of tension and fear. Rumors run rampant. Normal functioning is at a standstill, schools and businesses are closed, and health and emergency resources may be in short supply (Hoff, Hallisey, & Hoff, 2009, p. 209).
3. Communities in crisis go through chronological stages following a disaster that are known as the impact, heroic/rescue, honeymoon, disillusionment, and reconstruction/recovery phase. Each phase has identifiable characteristics and sequential timelines, and depending on how the various systems in the community react, may move forward positively or not (Roberts, 2005, p. 205).
4. A systemic crisis is a negative event or outcome, which includes the element of surprise, disruption of operations, and is a threat to the property, financial and physical resources, well-being of individuals within the system, and the reputation of the system to provide for the well-being of its constituency (Zdziarski, Dunkel, & Rollo, 2007, p. 6).

To sum up what we believe generally defines a **systemic crisis**: When a traumatic event occurs such

that people, institutions, communities, and ecologies are overwhelmed and response systems are unable to effectively contain and control the event in regard to both physical and psychological reactions to it, the crisis has become systemic. The size of the system may range from a family, to a mental health clinic, to a nation, but the main identifying factor is that the system is in disequilibrium and previous response systems and coping mechanisms no longer work. If adequate intervention doesn't occur, the potential exists for irreparable damage or termination of the system. Sandwiched between individual and systemic crises is another type of crisis with which the interventionist is likely to be faced, which we have called a "*metastasizing crisis*."

Metastasizing Crisis

A **metastasizing crisis** occurs when a small, isolated incident is not contained and begins to spread. The analogy to the spread of cancer is apt because what may start out as a focal and localized problem that could have been easily cured with early, preemptive intervention is not diagnosed or remedied, but is allowed to grow through benign neglect and suddenly becomes endemic within the system. At that point it is anything but easy to excise or remedy. A school system's neglect in dealing with isolated cases of bullying can soon lead to a culture of bullying that moves out of the classroom and into cyberspace to pervade and wreak havoc on students' lives 24 hours a day. Predispositioning both personnel and resources can go a long way toward what is called *primary* intervention, which seeks to proactively handle problems before they metastasize and get out of control. From that standpoint many crisis interventionists are also engaged in **primary prevention**, stopping a problem before it starts, as well as **secondary intervention**, minimizing the harmful effects that have already occurred (Caplan, 1964).

Characteristics of Crisis

The following discussion of characteristics of crisis represents an expanded definition of what *crisis* means.

Presence of Both Danger and Opportunity. Crisis is a *danger* because it can overwhelm the individual to the extent that serious pathology, including homicide and suicide, may result. Crisis is also an *opportunity* because the pain it induces impels the person to seek help (Aguilera & Messick, 1982, p. 1). If the individual

takes advantage of the opportunity, the intervention can help plant the seeds of self-growth and self-realization (Brammer, 1985, p. 95). People can react in any one of three ways to crisis. Under ideal circumstances, many individuals can cope effectively with crisis by themselves and develop strength from the experience. They change and grow in a positive manner and come out of the crisis both stronger and more compassionate (Danish, 1977).

Others appear to survive the crisis but effectively block the hurtful affect from awareness, only to have it haunt them in innumerable ways throughout the rest of their lives. Yet others break down psychologically at the onset of the crisis and clearly demonstrate that they are incapable of going any further with their lives unless given immediate and intensive assistance (Rapoport, 1967).

Seeds of Growth and Change. In the disequilibrium that accompanies crisis, anxiety is always present, and its discomfort provides an impetus for change (Janosik, 1984, p. 39). Often anxiety must reach the boiling point before the person is ready to admit the problem is out of control. One need look no further than the substance abuser for affirmation of this assertion. By waiting too long, for example, the substance abuser may become so entrenched that he or she may need a therapeutic jackhammer to break the addiction down into manageable pieces. Even here, however, a threshold point for change may be reached, albeit in last-ditch desperation, when the abuser finally surrenders to the fact that something must be done.

No Panaceas or Quick Fixes. People in crisis are generally amenable to help through a variety of forms of intervention, some of which are described as *brief therapy* (Cormier & Hackney, 1987, p. 240). For problems of long duration, however, quick fixes are rarely available. Many problems of clients in severe crisis stem from the fact that the clients sought quick fixes in the first place, usually through a pill. Such a "fix" may dampen the dreadful responses but doesn't change the instigating stimulus, so the crisis deepens.

The Necessity of Choice. Life is a process of interrelated crises and challenges that we confront or not, deciding to live or not (Carkhuff & Berenson, 1977, p. 173). In the realm of crisis, *not to choose is a choice*, and this choice usually turns out to be negative and destructive. *Choosing to do something* at least contains

the seeds of growth and allows a person the chance to set goals and formulate a plan to begin to overcome the dilemma.

Universality and Idiosyncrasy. Disequilibrium or disorganization accompanies every crisis, whether universal or idiosyncratic (Janosik, 1984, p. 13). Crisis is universal because no one is immune to breakdown, given the right constellation of circumstances. It is idiosyncratic because what one person may successfully overcome, another may not, even though the circumstances are virtually the same. It is foolhardy to maintain a belief that one is immune to psychic assaults, that one can handle any crisis in a stable, poised, and masterful fashion. Thousands of “tough” veterans of the Vietnam, Afghanistan, and two Gulf Wars suffering from posttraumatic stress disorder (PTSD), who have turnstiled through VA hospitals, veterans’ centers, and other medical facilities, are convincing proof that when a crisis boils over, disorganization, disequilibrium, disorientation, and fragmentation of an individual’s coping mechanisms can occur no matter how conditioned against psychological trauma the person may be.

Resiliency. Yet the National Comorbidity Survey found that while their nationally representative sample had better than a 50% prevalence of traumatic events for both men and women, only about 5% of men and 10% of women contracted PTSD (Kessler et al., 1995). One of the key jobs of the crisis interventionist is finding the right combination of support systems and coping mechanisms, and forming them into action plans that will tap the reservoir of resiliency that most people have to move them through and beyond the crisis.

Perception. As paradoxical as it may seem, the precipitating event is not the major cause of the crisis. It is the *perception* of the event that plays a huge role in a crisis. How individuals interpret events has a great deal to do with how amenable the crisis will be to resolution (Callahan, 2009, p. 21). As the old adage states, “One man’s fruit may be another man’s poison.” It is no accident that the Cognitive scale in the Triage Assessment Form that you will encounter in Chapter 3 is the most complex of the three scales. How people appraise precipitating events and what the interventionist can do to reframe and temper catastrophic interpretations of the event will have a great deal to do with how well and how quickly the crisis is alleviated.

Complicated Symptomology. Crisis is *not* simple; it is complex and difficult to understand, and it defies cause-and-effect description (Brammer, 1985, p. 91; Kliman, 1978, p. xxi). The symptoms that overlie precipitating crisis events become tangled webs that crisscross all environments of an individual. When an event reaches a flash point, there may be so many compounding problems that crisis workers must intervene directly in a variety of areas. Furthermore, the environment of people in crisis strongly affects the ease or difficulty with which the crisis can be handled. Families, individuals, partners, institutions, and employees may all directly affect problem resolution and a return to stability. When large numbers of people are affected at the same time by a crisis, the entire ecological system of a neighborhood, community, geographical region, or country may need intervention. A stark but global example of such a nationwide ecological crisis occurred in the United States in the immediate aftermath of the September 11, 2001, terrorist attacks (Bass & Yep, 2002; Pyszczynski, Solomon, & Greenberg, 2003).

Transcrisis States

Crises have typically been seen as time limited, usually persisting a maximum of 6 to 8 weeks, at the end of which the subjective discomfort diminishes (Janosik, 1984, p. 9). That view is now changing, and the effects of the original crisis may extend a good bit beyond that time frame (Callahan, 1998; Salzer & Bickman, 1999). Indeed, the impact of a crisis may last a lifetime (van der Kolk & McFarlane, 1996). What occurs during the immediate aftermath of the crisis event determines whether or not the crisis will become a disease reservoir that will be transformed into a chronic and long-term state. Although the original crisis event may be submerged below awareness, and the individual may believe the problem has been resolved, the appearance of new stressors may bring the individual to the crisis state again. This emotional roller coaster may occur frequently and for extended periods of time, ranging from months to years. An adult who has unresolved anger toward a dead parent and transfers that anger to other authority figures, such as supervisors or employers, is in a **transcrisis state**.

The adult may have apparently attained functional and normal mental health. However, this appearance is gained at the cost of warding off and repressing the “unfinished business” of making peace with the lost parent. Later, during the stress related to getting

along with another authority figure, the person blames that authority figure and has no conscious awareness that the unfinished repressed material (submerged as a transcrisis state) is at the root of the problem. Although the person with the transcrisis state may come to identify the problem as poor relationship skills and enter counseling to improve those skills, this action is also a symptom of the psychological roller-coaster ride that started with the unfinished business. The relationship skills may be temporarily improved, but the source of the transcrisis state may not have been recognized or expunged. It has merely subsided, and a temporary state of equilibrium has been achieved, but the original trauma will usually reemerge and instigate a new crisis the moment new stressors are introduced. Dynamically, this pattern is defensive repression. Therapeutically, this transcrisis state calls for crisis intervention techniques.

Transcrisis Differentiated From Posttraumatic Stress Disorder

People familiar with posttraumatic stress disorder (PTSD) may ask, “So how is a transcrisis state different from PTSD?” First, PTSD is an identifiable anxiety disorder (American Psychiatric Association, 2013) caused by an extremely traumatic event, and very specific criteria must be present for a diagnosis of PTSD to be made. Although a person who is suffering from PTSD may be in a transcrisis state, not all people who are in a transcrisis state suffer from PTSD. Indeed, it would probably be more appropriate to look at all the different kinds of anxiety and personality disorders found in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) as representative of transcrisis states because of the chronic kinds of thinking, feeling, and acting that keep these individuals constantly in psychological hot, if not boiling, water.

But it is not just persons with anxiety and personality disorders who may be in a transcrisis state. A broad range of people, from so-called normal individuals who are constantly fired from jobs because of their uncontrollable tempers to those with psychoses who quit taking their medicine because it has unpleasant side effects, are also representative of individuals in transcrisis states. Armsworth and Holaday (1993), in their review of affective, behavioral, cognitive, and physiological-somatic effects of trauma, identified a number of factors that, although not found in PTSD descriptors, would probably be inherent in many

transcrisis states. The key differentiating element of a transcrisis state is that, whether it is due to trauma, personality traits, substance abuse, psychosis, or chronic environmental stressors, the state is residual and recurrent and always present to some degree. Although people in a transcrisis state are generally capable of functioning at some minimal level, they are always at risk, and any single small added stressor may tip the balance and send them into crisis. Therefore, when we assess individuals in crisis, our focus is not only on the current clinical/diagnostic state of the individual, but also, and as importantly, on the repetitious cycle of problems and the historical precursors that may have caused the crisis to arise. A medical analogy would be the person suffering from a chronic sinus condition who continually takes nasal decongestant and so can function, although at a less than optimum level. However, if the person is exposed to a virus, the sinus condition may progress to an infection and eventually pneumonia.

Being aware that someone is operating in a transcrisis state also gives us important information regarding the kind and degree of therapeutic intervention to provide, in both the short and the long term. We probably would deal far differently with the salesperson who just turned 45, lost her job with a company she had been with for 20 years, has been unemployed for 6 months, and is now clinically depressed and suicidal, than we would with the salesperson who just turned 45, lost her job for the 20th time, has been unemployed for 6 months, and is now clinically depressed and suicidal. Although immediate intervention in regard to the suicidal ideation of both women might be very similar, our view as to what caused the depression, how we would treat it, and what transcrisis issues we might expect would be very different.

Transcrisis Points

Transcrisis points occur frequently in transcrisis states within the therapeutic intervention. These points are generally marked by the client’s coming to grips with new developmental stages or other dimensions of the problem. Transcrisis points do not occur in regular, predictable, linear progression. For example, an abused spouse may go through transcrisis point after transcrisis point talking to a crisis worker over the telephone before making a decision to leave the battering relationship, often calling crisis workers a dozen times in the course of a few days. The abused spouse may then make a decision to leave

the battering relationship and go to a spouse abuse shelter, only to find that the necessity of making a geographic move or finding a job instigates a crisis almost as potent as the battering.

Human services workers who practice long-term therapy are often shocked, confused, and overwhelmed by the sudden disequilibrium their clients experience. Handling these transcrisis points can be the equivalent of standing in the middle of a Los Angeles freeway and attempting to stop traffic. Behaviorally, such clients may vacillate from a placid to an agitated state so fast that the worker puts out one brush fire only to be confronted by yet another. It is at these transcrisis points that standard therapeutic strategies and techniques are suspended and the therapist must operate in a crisis intervention mode.

Transcrisis points can be seen as benchmarks that are crucial to progressive stages of positive therapeutic growth. These points are characterized by approach-avoidance behavior in seeking help, taking risks, and initiating action steps toward forward movement. Encountering these transcrisis points, a person will experience the same kind of disorganization, disequilibrium, and fragmentation that surrounded the original crisis event. Leaping one hurdle does not necessarily mean that the entire crisis is successfully overcome. Survivors of a catastrophe may expunge the event from memory and then be faced with repairing gaping wounds in personal relationships that have been torn apart by their long-term pathological behavior. People who have spinal cord injuries may be successfully rehabilitated physically, but may retreat into substance addiction or become depressed and/or suicidal as they attempt to begin a new lifestyle from a wheelchair.

Therefore, it is not only the initial crisis with which the worker must contend but also each transcrisis point, as it occurs, if clients are not to slip back into the pathology that assailed them in the first place. Transcrisis points should not be confused with the jumps and starts that go with working through typical adjustment problems. Although these points may be forecast with some degree of reliability by workers who are expert in the particular field, their onset is sudden, dramatic, and extremely potent. In that regard, these psychological aftershocks can be just as damaging as the initial tremor and may require extraordinary effort on the part of the human services worker to help the client regain control. This book is also concerned with these transcrisis states and points; the cases portrayed represent both components.

Theories of Crisis and Crisis Intervention

LO4

No single theory or school of thought encompasses every view of human crisis or all the models or systems of crisis intervention. We present here a brief overview of theories relevant both to crisis (as a phenomenon) and to crisis intervention (as an intentional helping response). Janosik (1984) conceptualizes crisis theory on three different levels: basic crisis theory, expanded crisis theory, and applied crisis theory. The newly emerging ecosystem theory has been expanded into a comprehensive chapter (Chapter 17) in this text.

Basic Crisis Intervention Theory

The research, writings, and teachings of Erich Lindemann (1944, 1956) gave professionals and paraprofessionals a new understanding of crisis. Lindemann helped caregivers promote crisis intervention for many sufferers of loss who had no specific pathological diagnosis but who were exhibiting symptoms that appeared pathological. Lindemann's basic crisis theory and work made a substantive contribution to the understanding of behavior in clients whose grief crises were precipitated by loss. He helped professionals and paraprofessionals recognize that behavioral responses to crises associated with grief are normal, temporary, and amenable to alleviation through short-term intervention techniques. These "normal" grief behaviors include (1) preoccupation with the lost one, (2) identification with the lost one, (3) expressions of guilt and hostility, (4) some disorganization in daily routine, and (5) some evidence of somatic complaints (Janosik, 1984, p. 11). Lindemann negated the prevailing perception that clients manifesting crisis responses should necessarily be treated as abnormal or pathological.

Whereas Lindemann focused mainly on immediate resolution of grief after loss, Caplan (1964) expanded Lindemann's constructs to the total field of traumatic events. Caplan viewed crisis as a state resulting from impediments to life goals that cannot be overcome through customary behaviors. These impediments can arise from both developmental and situational events. Both Lindemann and Caplan dealt with crisis intervention following psychological trauma using an equilibrium/disequilibrium paradigm. The stages in Lindemann's paradigm are (1) disturbed equilibrium, (2) brief therapy or grief work, (3) client's working through

the problem or grief, and (4) restoration of equilibrium (Janosik, 1984, pp. 10–12). Caplan linked Lindemann's concepts and stages to all developmental and situational events and extended crisis intervention to eliminating the affective, behavioral, and cognitive distortions that precipitated the psychological trauma in the first place.

Differentiating Basic Crisis Theory From Brief Therapy.

The work of both Lindemann and Caplan gave impetus to the use of crisis intervention strategies in counseling and brief therapy with people manifesting universal human reactions to traumatic events. Whereas **brief therapy theory** typically attempts to remediate more or less ongoing emotional problems, **basic crisis theory**, following the lead of Lindemann and Caplan, focuses on helping people in crisis recognize and correct temporary affective, behavioral, and cognitive distortions brought on by traumatic events. Although brief or solution-focused therapy may be the equivalent of crisis intervention (in that it seeks to restore the person to a state of homeostasis or equilibrium), not all brief or solution-focused therapy is related to crisis intervention.

Perhaps the following example will clarify the difference between the two. A student fails one algebra test and concludes that he or she can never pass algebra, therefore cannot become an engineer (as the parents are perceived to expect/demand). The student progresses to a feeling of helplessness, then to hopelessness, and then contemplates suicide. Here, crisis intervention that focuses on suicide prevention is clearly indicated. Another student fails one algebra test and, feeling uncomfortable, disappointed, and confused, makes an appointment to see the school counselor. Here, the modality becomes a typical brief or solution-focused therapy situation wherein the emphasis is on how to improve study habits and test-taking skills.

Differentiating between brief or solution-focused therapy and crisis intervention depends on how intensely the client views the problem as intolerable or on how much emotional disequilibrium the client experiences. Severe emotional disequilibrium over the event may escalate the person into crisis and the therapist into a crisis intervention modality.

Expanded Crisis Theory

Expanded crisis theory was developed because basic theory, which depended on a psychoanalytic approach alone, did not adequately address the social,

environmental, and situational factors that make an event a crisis. As crisis theory and intervention have expanded, it has become clear that an approach that identifies predisposing factors as the main or only causal agent falls short of the mark. A prime example of this restrictive view was the erroneous diagnosis, by practitioners who first encountered PTSD victims, that pathology preceding the crisis event was the real cause of the trauma. While preceding factors can certainly create a fertile field for PTSD and other psychopathology, it has become apparent that given the right combination of developmental, sociological, psychological, environmental, and situational determinants, anyone can fall victim to transient pathological symptoms. Therefore, expanded crisis theory draws not only from psychoanalytic theory but also from general systems, ecosystems, adaptational, interpersonal, chaos, and developmental theory. The following are synopses of these major theoretical components of an expanded view.

Psychoanalytic Theory. Psychoanalytic theory (Fine, 1973), applied to expanded crisis theory, is based on the view that the disequilibrium that accompanies a person's crisis can be understood through gaining access to the individual's unconscious thoughts and past emotional experiences. Psychoanalytic theory presupposes that some early childhood fixation is the primary explanation of why an event becomes a crisis. This theory may be used to help clients develop insight into the dynamics and causes of their behavior as the crisis situation acts on them.

We have come almost completely full circle in our view of this approach. First thought to be the only valid way to view pathology resulting from trauma, then dismissed as patently false and an excuse for the government not to meet the medical needs of veterans suffering from PTSD, currently treatment approaches see predisposing factors as one of the many factors that can contribute to PTSD and other psychopathologies.

Systems Theory. Systems theory (Haley, 1973, 1976; Hardy, 1997) is based not so much on what happens within an individual in crisis as on the interrelationships and interdependence among people and between people and events. Belkin (1984) adds that this theory "refers to an emotional system, a system of communications, and a system of need fulfillment and request" in which all members within an intergenerational relationship bring something to bear on

the others, and each derives something from the others (pp. 350–351). Indeed, Slaikeu (1990, p. 6) defines crisis as “a helping process aimed at assisting a person or a *family* so that the probability of debilitating effects is minimized and the probability of growth is maximized.”

Systems theory represents a turning away from traditional approaches, which focus only on what is going on within the client. A standard systems approach to crisis may be thought of in interpersonal terms. Systems theory is contextual in that it suggests that we look at the environment within which the person lives and the dynamic interactions the person has within that environment, which can provide information into the predisposing factors, onset, length, intensity, and resolution (Slaikeu, 1990, p. 34). Normally the “environment” in basic systems theory can be thought of as the extended family unit, the neighborhood, school, job, social clubs, fraternal or civic organizations, beauty parlors, bars, church, and so on.

Ecosystems Theory. Ecosystems theory (Bronfenbrenner, 1995) broadens out the base of the system and looks at crisis in relation to the environmental context within which it occurs (James, Cogdal, & Gilliland, 2003; Myer & Moore, 2006). Systemic interactions may occur from the microsystem (family and community) out to the macrosystem (nation) or vice versa. There is great value in looking at crises in their total social and environmental settings—not simply as one individual being affected in a linear progression of cause-and-effect events (Hardy, 1997; James & Gilliland, 2003, pp. 336–368). Cook (2012, pp. 6–7) proposes that an ecological counseling perspective operates with three fundamental propositions: First, while behavior is personal (the individual) it also contextual (the physical environment and the culture within which the individual operates); second, behavior is interactional in the sense that individuals influence and are influenced by the environments within which they function; third, individuals attempt to control and make sense of what environments they are engaging that ranges from their romantic choices, their career preferences, the churches they decide to attend, or their recreational decisions to collect stamps as opposed to climbing mountains. Thus people continuously attempt to make meaning of the multiple contexts in the environment so they can operate effectively, and that is no small chore. These three propositions take on added importance during a crisis because all the previous meaning making and

sense of how one *has* operated effectively in a familiar environment may go flying out the window in a crisis environment where chaos calls for a whole new set of tactics and strategies.

The fundamental concept of ecosystems theory is analogous to “ecological systems in which all elements are interrelated, and in which change at any level of those interrelated parts will lead to alteration of the total system” (Cormier & Hackney, 1987, p. 217). Passage of time, proximity to the epicenter of the crisis, and what develops over time and the environment all contribute to the ultimate resolution of the crisis. Ecosystems theory comes into play most typically when large-scale disasters occur and affect very large **macrosystems (the total culture in which people live)**. The expanding role of communication systems and their ability or inability to link systems is a critical ingredient that will be explored in Chapter 17, Disaster Response.

Adaptational Theory. Adaptational theory, as we use the term, depicts a person’s crisis as being sustained through maladaptive behaviors, negative thoughts, and destructive defense mechanisms. Adaptational crisis theory is based on the premise that the person’s crisis will recede when these maladaptive coping behaviors are changed to adaptive behaviors.

Breaking the chain of maladjusted functioning means changing to adaptive behavior, promoting positive thoughts, and constructing defense mechanisms that will help the person overcome the immobility created by the crisis and move to a positive mode of functioning. As maladaptive behaviors are learned, so may adaptive behaviors be learned. Aided by the interventionist, the client may learn to replace old, debilitating behaviors with new, self-enhancing ones. Such new behaviors may be applied directly to the context of the crisis and ultimately result in either success or reinforcement for the client in overcoming the crisis (Cormier & Cormier, 1985, p. 148). People who have learned ineffective coping skills and continue to use them even though they continually wind up in psychological hot water best manifest this approach. Changing ingrained and entrenched behaviors and thoughts that create transcrisis invariably means changing adaptive mechanisms and coping skills—not an easy job!

Interpersonal Theory. Interpersonal theory (Rogers, 1977) is built on many of the dimensions Cormier and Hackney (1987) describe as enhancing personal

self-esteem: openness, trust, sharing, safety, unconditional positive regard, accurate empathy, and genuineness (pp. 35–64). The essence of interpersonal theory is that people cannot sustain a personal state of crisis for very long if they believe in themselves and in others and have confidence that they can become self-actualized and overcome the crisis. When people confer their locus of self-evaluation on others, they become dependent on others for validation of their being (Raskin & Rogers, 1995). Therefore, as long as a person maintains an external locus of control, the crisis will persist.

The outcome goal in interpersonal theory is returning the power of self-evaluation to the person. Doing so enables the person once again to control his or her own destiny and regain the ability to take whatever action is needed to cope with the crisis situation. In terms of crisis intervention, interpersonal theory is reflected in the initial tasks of Predispositioning, Problem Exploration, and Providing Support in our overall crisis intervention model to be introduced in Chapter 3.

Chaos Theory. Why is a meteorologist (Lorenz, 1993) who thinks a butterfly cruising along in a jungle path in the Amazon capable of starting a hurricane in the Atlantic getting a reference in a crisis intervention book? Furthermore, what in the world do words like *fractals*, *bifurcations*, *intermittences*, *folded towel diffeomorphisms*, and *smooth noodle maps* have to do with crisis? These are all concepts that seek to capture the structural complexity underlying chaos theory, and Edward Lorenz in his attempts to better predict weather patterns is seen as its founder. The primary reason we include chaos theory is, as you may well imagine, that in most crises there is a lot of chaos! But lo and behold, it turns out that chaos isn't random and that it has all kinds of ramifications for a range of other occupations, including crisis interventionists. Early conceptualizations of chaos theory by scientists in the fields of meteorology, mathematics, and physics viewed the theory as applying to systems or events that appeared random but, on closer inspection, revealed an underlying order (Gleick, 2008). Paradoxically, what happens in chaotic systems appears to be random and unpredictable so that there is no possibility of determining what future outcomes will be, but in fact there is (Lorenz, 1993, p. 9).

Chaos theory is really sort of a theory of evolution when applied to human functioning such as crisis intervention. It is evolutionary in that it is essentially an

open-ended, ever-changing, “self-organizing” system whereby a new system may emerge out of the crisis (Butz, 1995, 1997; Chamberlain, 1993, 1994). A chaotic (crisis) situation—which Postrel (1998, p. xv) calls “emergent complex messiness”—evolves into a “self-organizing” mode whenever a critical mass of people come to perceive that they have no way to identify patterns or preplan options to solve the dilemma at hand. Because the chaotic situation falls outside of known alternative solutions, both physicists and human services workers necessarily resort to spontaneous, trial-and-error experimentation to try to cope with the crisis. The “messiness” of the crisis lies not in disorder but in an order that is unknown, unpredictable, and spontaneous, an ever-shifting pattern driven by millions of uncoordinated, independent factors that necessitate experimentation, yet may finally result in a global clarification of the crisis. Such experimentation may lead to false starts, temporary failure, dead ends, spontaneous innovation, creativity, improvisation, brainstorming, cooperative enterprise, and other “evolutionary” attempts to make sense of and cope with the crisis (Gleick, 2008, pp. 33–42). Indeed, chaos theory has many parallels with another emerging field called evolutionary psychology which, as you can also well imagine, is not without its controversial aspects (Confer et al., 2010).

The crisis intervention attempts in the wake of British Petroleum's Deep Horizon well blowout provide a vivid example of chaos theory at work—in both a positive and a negative sense. So it is not just the “messiness” of an utterly new phenomenon like the blowout of the deep well in the Gulf of Mexico and attempts to look at and fix the disaster at one fixed point such as the wellhead. While that point is critical, it is also reductionistic in terms of chaos theory and doesn't look at the total gestalt, or “big picture,” of the economic, ecological, and psychological costs of the crisis. All the tangled threads and points on the fabric of the crisis don't portray the underlying and interlocking patterns that provide information about the big picture and the potential ramifications of these dynamic systems on one another and on the total system after the crisis erupts.

Okay, so you didn't sign up for a course in higher mathematics or physics, which is where chaos's roots are, and the foregoing paragraphs are making your hair hurt! But a basic understanding of this exotic and esoteric theory should give you two important pieces of information. First, big crises call for a lot of different people working from a lot of different

perspectives in a well-coordinated manner who can connect the myriad dots in a chaotic situation, see the underlying patterns, make sense of them, and change to meet changing conditions as new eddies and vortexes swirl out of the crisis. Myer and his associates have attempted to demonstrate what this theory looks and acts like when combined with ecosystemic theory after a disaster on a college campus (Myer, James, & Moulton, 2011).

Second, transcrises come close to manifesting chaos theory at work. Lots of times transcrises don't make sense and don't appear to have any discernable pattern, but much like the theoretical mathematician, just because you don't have an equation to solve the problem doesn't mean that one doesn't exist. There is an underlying pattern, and that's why all professional crisis interventionists use the right side of their brain a lot because dealing with crisis calls for a lot of creative thinking. No other writers at present are discussing chaos theory as it applies to crisis intervention, but our guess is that they will as we attempt to unravel and understand the genetics that make up this field.

Developmental Theory. Because many crises have their bases in developmental stages that humans pass through, developmental theory must play a part in crisis intervention. Developmental stage theorists such as Erikson (1963), Levinson (1986), Levinson and Levinson (1996), and Blocher (2000) clearly believe that movement through various developmental life stages is critical. Developmental tasks that are not met and accomplished during particular life stages tend to pile up and cause problems. As individual needs and wants butt heads with the demands and expectations of society, and the individual fails to move on to the next life stage, the potential for crisis arises. Neglected, abused, and bullied children; alienated and isolated adolescent drug abusers; people who lack education or lack vocational satisfaction or success; or those exposed to domestic violence, divorce, suicide, homicide, and a host of other problems may be unable to meet life stages effectively. When an external, environmental, or situational crisis feeds into preexisting developmental crises, intrapersonal and interpersonal problems may reach the breaking point.

Applied Crisis Theory

Brammer (1985, pp. 94–95) characterizes applied crisis theory as encompassing three domains: (1) normal *developmental crises*, (2) *situational crises*, and

(3) *existential crises*. Given the ecosystem theory perspective, we have added a fourth domain, (4) *ecosystemic crises*.

Developmental Crises. Developmental crises are events in the normal flow of human growth and evolution whereby a dramatic change or shift occurs that produces abnormal responses. For example, developmental crises may occur in response to the birth of a child, graduation from college, midlife career change, retirement, or even the aging process. Developmental crises are considered normal; however, all persons and all developmental crises are unique and must be assessed and handled in unique ways.

Situational Crises. A situational crisis emerges with the occurrence of uncommon and extraordinary events that an individual has no way of forecasting or controlling. Situational crises may follow such events as terrorist attacks, automobile accidents, kidnappings, rapes, job loss, or sudden illness and death. The key to differentiating a situational crisis from other crises is that a situational crisis is random, sudden, shocking, intense, and often catastrophic.

Existential Crises. An existential crisis includes the inner conflicts and anxieties that accompany important human issues of purpose, responsibility, independence, freedom, and commitment. An existential crisis might accompany the realization, at age 40, that one will never make a significant and distinct impact on a particular profession or organization; remorse, at age 50, that one chose never to marry or leave one's parents' home, never made a separate life, and now has lost forever the possibility of being a fully happy and worthwhile person; or a pervasive and persistent feeling, at age 60, that one's life is meaningless—that there is a void that can never be filled in a meaningful way.

Ecosystemic Crises. Ecosystemic crises typically occur when some *natural* or *human-caused* disaster overtakes a person or a (large or small) group of people who find themselves, through no fault or action of their own, inundated in the aftermath of an event that may adversely affect virtually every member of the environment in which they live. Such crises may be the result of natural phenomena such as hurricanes, floods, tsunamis, earthquakes, volcanic eruptions, tornadoes, blizzards, mudslides, drought, famine, and forest or grassland/brush fires. Other instances of ecosystemic

crises may be *biologically derived*, such as a disease epidemic like ebola, or the effects of a huge oil spill; *politically based*, as in war, a refugee crisis associated with war, or ethnic cleansing; or *severe economic depression*, such as the Great Depression of the early 20th century.

Crisis Intervention Models

Three basic crisis intervention models discussed by both Leitner (1974) and Belkin (1984) are the *equilibrium model*, the *cognitive model*, and the *psychosocial transition model*. These three generic models provide the groundwork for many different crisis intervention strategies and methodologies. Two new models that target ecological factors that contribute to crisis are the *developmental-ecological model* (Collins & Collins, 2005) and the *contextual-ecological model* (Myer & Moore, 2006). Two field-based practice models are *psychological first aid* (Raphael, 1977; U.S. Department of Veterans Affairs, 2011), which is used in the immediate aftermath of disasters and terrorist attacks, and Roberts' (2005) ACT model, which is more generic but primarily trauma based.

The Equilibrium Model

The equilibrium model is really an equilibrium/disequilibrium model. People in crisis are in a state of psychological or emotional disequilibrium in which their usual coping mechanisms and problem-solving methods fail to meet their needs. The goal of the equilibrium model is to help people recover a state of precrisis equilibrium (Caplan, 1961). The equilibrium model seems most appropriate for early intervention, when the person is out of control, disoriented, and unable to make appropriate choices. Until the person has regained some coping abilities, the main focus is on stabilizing the individual. Up to the time the person has reacquired some definite measure of stability, little else can or should be done. For example, it does little good to dig into the underlying factors that cause suicidal ideation until the person can be stabilized to the point of agreeing that life is worth living for at least another week. This is probably the purest model of crisis intervention and is most likely to be used at the onset of the crisis (Caplan, 1961; Leitner, 1974; Lindemann, 1944).

The Cognitive Model

The cognitive model of crisis intervention is based on the premise that crises are rooted in faulty thinking about the events or situations that surround the crisis—not in the events themselves or the facts

about the events or situations (Ellis, 1962). The goal of this model is to help people become aware of and change their views and beliefs about the crisis events or situations. The basic tenet of the cognitive model is that people can gain control of crises in their lives by changing their thinking, especially by recognizing and disputing the irrational and self-defeating parts of their cognitions, and by retaining and focusing on the rational and self-enhancing elements of their thinking.

The messages that people in crisis send themselves become very negative and twisted, in contrast to the reality of the situation. Dilemmas that are constant and grinding wear people out, pushing their internal state of perception more and more toward negative self-talk until their cognitive sets are so negative that no amount of preaching can convince them that anything positive will ever come from the situation. Their behavior soon follows this negative self-talk and begets a self-fulfilling prophecy that the situation is hopeless. At this juncture, crisis intervention becomes a job of rewiring the individual's thoughts to more positive feedback loops by practicing and rehearsing new self-statements about the situation until the old, negative, debilitating ones are expunged. The cognitive model seems most appropriate after the client has been stabilized and returned to an approximate state of precrisis equilibrium. Basic components of this approach are found in the rational-emotive work of Ellis (1982), the cognitive-behavioral approach of Meichenbaum (1977), and the cognitive system of Beck (1976).

The Psychosocial Transition Model

The psychosocial transition model assumes that people are products of their genes plus the learning they have absorbed from their particular social environments. Because people are continuously changing, developing, and growing, and their social environments and social influences (Dorn, 1986) are continuously evolving, crises may be related to internal or external (psychological, social, or environmental) difficulties. The goal of crisis intervention is to collaborate with clients in assessing the internal and external difficulties contributing to the crisis and then help them choose workable alternatives to their current behaviors, attitudes, and use of environmental resources. Clients may need to incorporate adequate internal coping mechanisms, social supports, and environmental resources in order to gain autonomous (non-crisis) control over their lives.

The psychosocial model does not perceive crisis as simply an internal state of affairs that resides totally within the individual. It reaches outside the individual and asks what systems need to be changed. Peers, family, occupation, religion, and the community are but a few of the external dimensions that promote or hinder psychological adaptiveness. With certain kinds of crisis problems, few lasting gains will be made unless the social systems that affect the individual are also changed, or the individual comes to terms with and understands the dynamics of those systems and how they affect adaptation to the crisis. Like the cognitive model, the psychosocial transition model seems to be most appropriate after the client has been stabilized. Theorists who have contributed to the psychosocial transition model include Adler (Ansbacher & Ansbacher, 1956), Erikson (1963), and Minuchin (1974).

The Developmental–Ecological Model

Collins and Collins (2005) have developed a developmental-ecological model of crisis intervention that integrates developmental stages and issues with the environment within which the individual operates. In this model, the crisis worker needs to assess both the individual and the environment as well as the interrelationship between the two and then factor in the developmental stage within which the person is operating. Any situational crisis must always be considered in relationship to the stage of development the person is in, and the potency of the crisis may depend on how well there has been stage mastery of the tasks affected by the crisis.

The Contextual–Ecological Model

Myer and Moore (2006) have developed an ecological model that focuses on contextual elements of the crisis. Their first premise is that contextual elements may be seen as layered. These layers are dependent on two elements: proximity to the crisis by physical distance, and reactions that are moderated by perception and the meaning attributed to the event.

The second premise of this model is that reciprocal impact occurs between the individual and systems affected by the event. Understanding the reciprocal effect of the crisis involves recognition of two elements: the interaction among the primary and secondary relationships, and the degree of change triggered by the event. Primary relationships are those in which no intervening component (other individuals or systems) interacts with or mediates the connection. An

example of a primary relationship would be between an employee and a company. If an accident occurred and the company immediately took a number of steps to support employees and assure them that safety measures had been increased so that such an accident would be unlikely to happen again, the employees might feel secure, safe, and satisfied with the company's efforts. A secondary relationship is mediated by at least one other individual or system. For example, if the employee's family members were so terrified for the safety of their loved one that no amount of assurances would satisfy them, then the primary relationship between the employee and the company would be affected.

The third premise is that time directly influences the impact of a crisis. The two major time elements are the amount of time that has passed and special occasions such as anniversaries and holidays following the event.

Myer and Moore (2006) propose a formula for gauging the impact of the crisis on the individual or system. The formula can be summarized as a function of proximity to the event, reaction to the event, relationship to the event, and amount of change caused by the event, which is then divided by the amount of time that has passed. What is critical in this formula is understanding that no single component can be considered separately. Close proximity alone may not have as much bearing on the impact of the crisis as the degree of change resulting from it. While this highly theoretical model as of yet has no empirical basis, nor does it yet have a great deal of utility for intervention, it poses questions and generates premises that can help us understand the impact of the crisis as it interacts between and within a variety of systems and individuals.

Psychological First Aid

Slaikeu (1990, p. 6) breaks crisis intervention **LO6** into two parts: First-order intervention, or **psychological first aid**, seeks to address the immediate crisis situation and provide immediate relief, possibly to a wide range of individuals. Second-order intervention, or **crisis therapy**, seeks to resolve the crisis and is generally provided by trained, licensed human services professionals. In this book, most of what would be seen as psychological first aid and initial crisis therapy is what we define as crisis intervention. To attend to the mental health needs of survivors of large-scale disasters, public health personnel are now being taught to use empirically grounded, best practice techniques

called psychological first aid that are designed to provide immediate, palliative mental health assistance to survivors (Parker, Barnett, Everly, & Links, 2006).

The National Institute of Mental Health (2002) defines psychological first aid as establishing the safety of the client, reducing stress-related symptoms, providing rest and physical recuperation, and linking clients to critical resources and social support systems. Raphael (1977) first coined the term *psychological first aid* in her discussion of crisis work with an Australian railway disaster. She described a variety of activities that provided caring support, empathic responding, concrete information and assistance, and reuniting of survivors with social support systems. Paramount in psychological first aid is attending to Maslow's needs hierarchy and taking care of survival needs first. Many counselors, social workers, and psychologists helped meet basic support needs of food, shelter, clothing, and other survival needs during the aftermath of Hurricane Katrina before they ever did any "counseling."

Controversy has arisen over who should get care, what kind of care should be provided, how it should be delivered, by whom, and under what circumstances immediately after a traumatic event—especially after a mass disaster. Much of this controversy has arisen in regard to critical incident stress debriefing (Mitchell & Everly, 1995) and the notion that everybody exposed to a traumatic event needs to talk about it as quickly after the event as possible to stave off PTSD. A huge controversy has erupted over this treatment approach (to be discussed in Chapter 17), to the point that the prevailing approach for immediate disaster intervention is now psychological first aid that is nonintrusive and does not promote discussion of the traumatic event (Young, 2006). The notion is that not all people will need psychological help and the initial paratraumatic symptoms that most people manifest will self-eradicate in a short period of time (National Institute of Mental Health, 2002).

The National Center for PTSD (U.S. Department of Veterans Affairs, 2011) has published a field manual, *Psychological First Aid: Field Operations Guide*, that offers an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism, to reduce initial distress and to foster short- and long-term adaptive functioning. The manual states that it is for use by first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief

organizations, Community Emergency Response Teams, Medical Reserve Corps, and the Citizens Corps in diverse settings. This approach to psychological first aid includes eight core actions (U.S. Department of Veterans Affairs, 2011, p. 18):

1. **Contact and Engagement**

Goal: To respond to contacts initiated by survivors, or to initiate contacts in a nonintrusive, compassionate, and helpful manner.

2. **Safety and Comfort**

Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.

3. **Stabilization** (if needed)

Goal: To calm and orient emotionally overwhelmed or disoriented survivors.

4. **Information Gathering: Current Needs and Concerns**

Goal: To identify immediate needs and concerns, gather additional information, and tailor psychological first aid interventions.

5. **Practical Assistance**

Goal: To offer practical help to survivors in addressing immediate needs and concerns.

6. **Connection with Social Supports**

Goal: To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community helping resources.

7. **Information on Coping**

Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.

8. **Linkage with Collaborative Services**

Goal: To link survivors with available services needed at the time or in the future.

Psychological first aid provides the bare-bones basics of crisis intervention. It is designed to be palliative. It is not designed to cure or fix anything, but rather to provide nonintrusive physical and psychological support. Social workers would be very comfortable with this model because a great deal of it resembles social work services. If we consider the first four tasks (Predispositioning, Problem Definition, Providing Support, Safety) of the model of crisis intervention you will meet in Chapter 3 as being close to what is meant by psychological first aid, then psychological first aid is clearly necessary. Whether it is also *sufficient* in providing immediate crisis intervention services is another matter. Certainly not all people need immediate psychological assistance, nor should they have it

forced on them, but the high adrenal moments of a lot of crisis intervention make us believe that something more than psychological first aid is needed to defuse emotional volatility, de-escalate life-threatening behavior, and reframe and cool the insane, irrational, hot cognitions that typify many crisis situations.

The ACT Model

The ACT model proposed by Roberts (2005) is an acronym:

- Assessment of the presenting problem, including emergency psychiatric and other medical needs and trauma assessment
- Connecting clients to support systems
- Traumatic reactions and posttraumatic stress disorders

The model has seven generally linear stages: crisis assessment, establishing rapport, identifying major problems, dealing with feelings, generating and exploring alternatives, developing plans, and providing follow-up (pp. 104–106). This model has been designed to deal with the onset of a traumatic event and, probably even more appropriately, with what Kleespies (2009) calls behavioral emergencies.

Playbook/Game Plan Model

As you will see in detail in this book, specially trained police officers called Crisis Intervention Team (CIT) officers are playing a larger and larger role as first line responders to the mentally ill and other emotional distraught individuals who come to the attention of law enforcement. Major Sam Cochran (retired former coordinator of the Memphis Police Department CIT) has developed a crisis intervention model based on coaching, which has a great deal of face validity given that most police officers have engaged in some kind of team sport so a playbook/game plan makes perfect sense and there is ready acceptance in trying to learn it. It is specifically tailored to diffuse and de-escalate angry, distraught, out-of-control potentially lethal individuals that are in the middle of a crisis and who come to police attention through 911 “mental illness” calls (Kirchberg, James, Cochran, & Dupont, 2013). It trains first line responders through a game plan strategy that teaches them how to assess individuals’ verbal and nonverbal behavior and develop a game plan that uses a combination of verbal de-escalation techniques (plays) to defuse individuals who may be manifesting lethal behavior toward themselves or others. We will visit some of these “plays” in Chapter 4, The Tools of the Trade.

Eclectic/Integrated Crisis Intervention Theory

In current psychotherapeutic theory the term “eclectic” has taken on a somewhat negative connotation as a sort of “anything goes, try and see if it works” approach and has generally been replaced with the term “integrated,” which critics of “eclecticism” believe implies a more purposeful and planful treatment methodology. As far as we’re concerned, it’s a “rose” by any name so call it what you will; we believe it’s a best bet on how to go about doing the business of crisis intervention. Eclectic/integrated crisis intervention involves intentionally and systematically selecting and integrating valid concepts and strategies from all available approaches to helping clients. Eclecticism/integrated theory is thus a hybrid of all available approaches. It operates from a task orientation, as opposed to concepts. Its major tasks (James & Gilliland, 2003, p. 374; Lazarus, 1989; Thorne, 1973, p. 451) are (1) to identify valid elements in all therapeutic systems and integrate them into an internally consistent whole that does justice to the behavioral data to be explained; (2) to consider all pertinent theories, methods, and standards for evaluating and manipulating clinical data according to the most advanced knowledge of time and place; and (3) to identify with no specific theory, keep an open mind, and continuously experiment with those formulations and strategies that produce successful results. This theoretical approach would find favor with current multicultural and social justice approaches to counseling because the workers enter into the relationship with no preconceived notion of the “right” therapeutic approach, but rather allows the social and cultural factors that contribute to the client’s problems to unfold before making a decision on what the “best bet” approach to take might be (Ratts & Pedersen, 2014, p. 7).

Throughout this book, you will find an eclectic/integrated approach to the interventions presented. Much of what happens will depend on the situation with which we find ourselves. “Situation” may be defined as including the type of crisis, the physical and ecological setting in which it occurs, individual characteristics, cultural background, and significant others who may be directly or indirectly involved. Probably more important than all the factors that affect clients are the knowledge, strength, and skills that interventionists bring to the crisis and meld these into the client’s world.

The eclectic/integrated approach fuses two pervasive themes: (1) all people and all crises are unique and distinctive, and (2) all people and all crises are

similar. We do not see these themes as mutually exclusive. All people and all crises are similar in that there are global elements to specific crisis types. The dynamics of bereavement are generic and provide us with general guidelines for intervention. However, treating individual cases of bereavement is anything but generic. How a family perceives the impact of the death of a member depends on a number of factors: the deceased member's place in the family, what each member of the family does in response to the death, and how the changed family system now operates. Treatment of surviving family members who have lost a child after rearing five others, as opposed to those who have lost their only child, born late in the parents' life, who had become the focus of existence for the couple, may call for far different intervention strategies even if bereavement is the generic issue.

An eclectic/integrated approach does not mean taking a therapeutic shotgun and aimlessly blasting away at the crisis. Using an eclectic approach means not being bound by and locked into any one theoretical approach in a dogmatic fashion. Rather, it means being well versed in a number of approaches and theories and being able to assess the client's needs so that appropriate techniques can be planned and fitted to them. Many human services workers avow an eclectic/integrated approach but actually use the word to rationalize not being able to do anything very well. Being a true eclectic/integrated interventionist means doing lots of hard work, reading, studying, experiencing, and being supervised and critiqued by other professionals. It also means taking risks and being willing to abandon an approach that on first inspection might seem reasonable and proper but, once entered, proves fruitless for the particular situation.

Eclectic/integrated therapy performed well is equal parts skill and intuition. Paying attention to your feelings as much as to your cognition about the situation is crucial. Changing to a more effective intervention is often based on nothing more scientific than a feeling that something is amiss. Although having a "gut" feeling is little justification, in the scientific sense, for doing something, it can nevertheless be a sound basis for action. There is no known formula for deciding when to move from a nondirective to a highly directive stance with a client in crisis; nor is there an equation that tells a therapist that mental imagery may be more effective than confrontation as an intervention technique. An eclectic approach done well is the zenith of the performing art of crisis intervention.

Characteristics of Effective Crisis Workers

LO7

Almost everyone can be taught the techniques in this book and with practice can employ them with some degree of skill. However, the crisis worker who can take intervention to the performing art level is more than the sum of techniques read about and skills mastered. A master of this art is going to have not only technical skill and theoretical knowledge but also a good deal of the following characteristics.

Life Experiences

The worker handles a crisis or not to the extent that he or she is a whole person or not (Carkhuff & Berenson, 1977, pp. 162–163). A whole person has a rich and varied background of life experiences. These life experiences serve as a resource for emotional maturity that, combined with training, enables workers to be stable, consistent, and well integrated not only within the crisis situation but also in their daily lives. However, life experiences alone are not sufficient to qualify one to be a crisis worker and can be debilitating if they continue to influence the worker in negative ways.

This issue is central to crisis intervention because many people who work as volunteers, support personnel, and professionals are products of their own crisis environments. They have chosen to work with people experiencing the same kind of crisis they themselves have suffered, and they use their experiential background as a resource in working with others. For example, recovering addicts may work in alcohol and drug units, battered women work in spouse abuse centers, and PTSD victims counsel in veterans' centers. These professionals have had firsthand experience with the trauma their clients have experienced. Does this background give them an edge over other workers who have not suffered the same pain?

The answer is a qualified yes—qualified in that the person who carries emotional baggage into the helping relationship may be even less effective than the person who has had few if any life experiences. One sees examples of emotional carryover into the intervention process in the proselytizing recovering alcoholic who vilifies others to assuage his own insecurities and fears about "falling off the wagon" and in the child abuse worker, herself a former victim of sexual abuse, who castigates mothers for their failure to confront abusing fathers.

Such human services workers may have tremendous difficulties because they mingle many of their own problems with those of their clients. The workers alternate among feeling states characterized by sympathy, anger, disappointment, and cynicism, which are detrimental both to themselves and to their clients. We do not believe crisis workers must have “lived in the crisis” to be able to understand and deal with it effectively. We do believe that interventionists who have successfully overcome some of life’s problems and have put those problems into perspective will have assets of maturity, optimism, tenacity, and tough-mindedness that will help them marshal their psychological resources to assist their clients.

You should also be cautioned that on-the-job training in this business is a very arduous way to win one’s spurs, particularly for a worker who has led a sheltered, constricted life and decides through misguided idealism to become a Florence Nightingale and fix the problems of the world. This rose-colored view does little for clients in general and may do considerable harm to workers as their good intentions pave the road to **burnout**. We hasten to add that chronological age has very little to do with having or not having self-enhancing life experiences and a broader, more resilient viewpoint. We know people ranging in age from 21 to 65 who are emotional adolescents. When threatened by face-to-face encounters with the real world, they may be characterized by rigidity, insularity, and insecurity. The ideal crisis worker is one who has experienced life, has learned and grown from those experiences, and supports those experiences in his or her work by thorough training, knowledge, and supervision. This individual constantly seeks to integrate all these aspects into his or her therapeutic intervention in particular and into living in general.

Personal Characteristics

Poise. The nature of crisis intervention is that the worker is often confronted with shocking and threatening material from clients who are completely out of control. Probably the most significant help the interventionist can provide at this juncture is to remain calm, poised, and in control (Belkin, 1984, p. 427). Creating a stable and rational atmosphere provides a model for the client that is conducive to restoring equilibrium to the situation. Effective crisis workers are as steady and well-anchored psychologically as the Rock of Gibraltar. This does not mean that effective crisis workers are made of stone and are not frightened, tense, anxious, and at times unsure

of themselves. However, in the very act of making self-disclosing owning statements of his or her own frailties and shortcomings, the worker models the assuredness, transparency, and congruency that are prized professional assets in any professional human service worker (Carkhuff, 1987; Rogers, 1961).

Creativity and Flexibility. Creativity and flexibility are major assets to those confronted with perplexing and seemingly unsolvable problems (Aguilera & Messick, 1982, p. 24). In our courses and training workshops, students and trainees often have difficulty conducting role plays with peers because they have no formula for getting the “right” answer. Although practice in tough role-play situations builds confidence, how creative individuals are in difficult situations depends in large measure on how well they have nurtured their own creativity over the course of their lives by taking risks and practicing divergent thinking.

Energy and Resiliency. Functioning in the unknown areas that are characteristic of crisis intervention requires energy, organization, direction, and systematic action (Carkhuff & Berenson, 1977, p. 194). Professional training can provide organizational guidelines and principles for systematic acting. What it cannot do is provide the energy requisite to perform this work. A crisis worker must also be resilient. By its very nature crisis work has many “downs” when, no matter how capable, no matter how committed, no matter what was tried or done, “success” was not achieved. Crisis workers must have “bounce back” potential. They take care of themselves physically and psychologically and make wise use of their available energy.

Quick Mental Reflexes. Crisis work differs from typical therapeutic intervention in that time is a critical factor. Crisis intervention requires more activity and directiveness than ordinary therapeutic endeavors usually do. Time to reflect and mull over problems is a rare commodity in crisis intervention. The worker must have fast mental reflexes to deal with the constantly emerging and changing issues that occur in the crisis. The worker who cannot think fast and accurately is going to find this business very frustrating indeed.

Assertiveness. One of the major problems that interventionists who have been trained in formal professional programs experience in attempting to apply the skills in this book is their reticence at times to be proactive, assertive, and directive. These therapeutic

stances run counter to what has been hammered into them with regard to not being judgmental, not breeding client dependence, not imposing their values on the client, being accepting, and unconditionally positively regarding their clients as human beings of worth. While we believe wholeheartedly in those dictums, and employ them whenever possible, crisis intervention has different rules.

Many clients who are in crisis do not talk or act nicely. For that reason you need to be able to assertively set limits to behavior, both in regard to maintaining your own integrity and keeping the client stabilized so that intervention can occur. Clients are likely to have exhausted their repertory of coping skills and drained their psychological resources to the point that their ability to take action, think constructively, or control feelings is gone. At such times crisis interventionists cannot be passive. You are the expert on the scene, you have the fund of knowledge needed, and you need to employ your skills, knowledge, and abilities in as clear and directive manner as you possibly can. The nine intentional helping strategies described in Chapter 4 are predominately interventionist driven and have little passivity or reactivity. Much like competitive athletics, if you are going to do this well, you need to get your game face on and get actively involved.

Other Attributes. Crisis workers have found the following attributes to be of utmost importance to themselves and their clients: tenacity, the ability to delay gratification, courage, optimism, a reality orientation, calmness under duress, objectivity, a strong and positive self-concept, and abiding faith that human beings are strong, resilient, and capable of overcoming seemingly insurmountable odds. They also have a spiritual sense in that they know when to seek nourishment from that spiritual source and when to let that higher power take over for them (Hardiman & Simmonds, 2013; Naz, Suri, & Parveen, 2012). Poll yourself: Do you have these attributes? We also want

you to understand that admission into the inner circle of the profession is not reserved solely for a few supermen and superwomen. Most interventionists we know, certainly including ourselves, are at times perplexed, frustrated, angry, afraid, threatened, incompetent, foolish, vain, troubled, and otherwise unequal to the task. We allow ourselves and our students and trainees at least one mistake per day and go on from there. We would very much like you to remember that cognitive billboard, “You get one free,” and place it squarely in the forefront of your mind. Few readers of a book ever look at the dedication. We’d like you to do that now and meet the two people to which the eighth edition of this book is dedicated. They represent the very best of what one aspires to be in this business, and you could do far worse than model your career after these two consummate professionals.

Rewards

Standing up to the intense heat of the crisis situation to help people through seemingly unsolvable problems is some of the most gratifying and positively reinforcing work you can do in the psychotherapy business. The intense personal rewards that accrue to crisis workers lead us to believe that this work would be high on Glasser’s (1976) list of positive addicting behaviors.

Now consider for a moment yourself as a client. Everyone is at times subject to the whims of a randomly cruel universe, and the kinds of crises that are dealt with in this book are apt to be visited on us all. Understanding how to navigate through these constellations of problems is a valuable resource. How well we live depends on our ability to handle the problems that confront us when we least expect them. As you read through the material, you may find yourself “living into” some of these problems and asking yourself, “I wonder how I’d fare if I were a client?” We believe that this too is a worthwhile perspective if you can look beyond the dilemmas to the coping techniques and bank them for future reference and use.

SUMMARY

Historically, crisis intervention has developed and evolved in about the last 60 years. Its origins have typically been in grassroots organizations, groups of people who came together to solve a specific crisis

that was assailing them. Through both natural and human-made crises and the influence of the media, crisis intervention has moved from a backwater psychological specialty into the mainstream of helping skills.

Our composite definition of *individual crisis*, derived from the sources given at the beginning of this chapter, is *a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms. Unless the person obtains relief, the crisis has the potential to cause severe affective, behavioral, and cognitive malfunctioning up to the point of instigating injurious or lethal behavior to oneself or others.* Because systems play an equally important part in the business of crisis intervention, we define *systemic crisis* as follows: *When a traumatic event occurs such that people, institutions, communities, and ecologies are overwhelmed and response systems are unable to effectively contain and control the event in regard to both physical and psychological reactions to it, the crisis has become systemic.* These general definitions are enhanced by considering several important principles and characteristics of crisis:

1. Crisis embodies both danger and opportunity for the person experiencing the crisis.
2. Crisis is usually time limited but may develop into a series of recurring transcrisis points.
3. Crisis is often complex and difficult to resolve.
4. The life experiences of crisis and other human services workers may greatly enhance their effectiveness in crisis intervention.
5. Crisis contains the seeds of growth and impetus for change.
6. Panaceas or quick fixes may not be applicable to many crisis situations.
7. Crisis confronts people with choices.
8. Emotional disequilibrium and disorganization accompany crisis.
9. The resolution of crisis and the personhood of crisis workers interrelate.

Understanding transcrisis states and transcrisis points helps in understanding many crises. Clients experiencing crises rooted in their transcrisis states or transcrisis points show recurring trauma-like symptoms derived from earlier traumatic events. Transcrisis states and points have parallels with and differences from PTSD.

Basic crisis theory views crisis as situational or developmental rather than pathological in nature. *Expanded crisis theory* adds to and enhances basic theory

by incorporating and adapting components from psychoanalytic, general systems, ecosystems, adaptational, interpersonal, chaos, and developmental theory.

Five fundamental crisis intervention models are equilibrium, cognitive, psychosocial transition, developmental-ecological, and contextual-ecological. The *equilibrium model*, probably the most widely known model of the five, defines equilibrium as an emotional state in which the person is stable, in control, or psychologically mobile. It defines disequilibrium as an emotional state that accompanies instability, loss of control, and psychological immobility. The *cognitive model* views the crisis state as resulting from faulty thinking and belief about life's dilemmas and traumas. The *psychosocial transition model* assumes that people are products of both hereditary endowment and environmental learning and that crisis may be caused by psychological, social, or environmental factors. The *developmental-ecological model* considers developmental stages in relation to the ecological system within which the individual develops. A *contextual-ecological model* looks at layers, relationships, and time when it examines a crisis. The *psychological first aid* and *ACT* models are both practice-based field models that deal with disasters and trauma-related crises. The *playbook/game plan* model is targeted toward police officers and other first line responders who deal with potentially lethal, out-of-control clients. An eclectic/integrated theoretical position incorporates and integrates all valid concepts of crisis intervention.

Effective crisis workers share a number of positive personal characteristics. They maintain poise, quick wittedness, creativity, tenacity, assertiveness, and resiliency, among a host of other attributes, while confronting the difficult issues of clients in crisis.

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