Assessment in Crisis Intervention

LO3

Assessment is a pervasive strategy throughout crisis intervention. This action-oriented, situation-based assessment is the basis for systematically applying our task model. Thus, the entire task process is carried out under an umbrella of assessment by the crisis worker. Because many of the assessments in crisis situations occur spontaneously, subjectively, and interactively in the heat of the moment, we are not dealing here with formal techniques such as DSM-5 diagnostic criteria or assessment instruments that are typically used in ongoing clinical evaluations. Kleespies and Richmond (2009) have a laundry list of mental status exam questions that cover everything from orientation/memory to visual/spatial organization. While these may be extremely useful in a set-piece intake assessment session at a hospital, lots of times there is neither the time nor the setting to engage in even a verbal comprehensive mental status examination.

Assessment is critically important because it enables the worker to determine (1) the severity of the crisis; (2) the client's current emotional, behavioral, and cognitive status—the client's level of mobility or immobility in these three areas; (3) the alternatives, coping mechanisms, support systems, and other resources available to the client; (4) the client's level of lethality (danger to self and others); (5) and how well the worker is doing in de-escalating and defusing the situation and returning the client to a state of equilibrium and mobility.

Assessing the Severity of Crisis

It is important for the crisis worker to evaluate the crisis severity as quickly as possible during the initial contact with the client. Crisis workers generally do not have time to perform complete diagnostic workups or obtain in-depth client histories. Therefore, a rapid assessment procedure, such as the Triage Assessment System (Myer, 2001; Myer et al., 1991, 1992) and its assessment siblings—the Triage Assessment Checklist for Law Enforcement (TACKLE; James, Myer, & Moore, 2006), the Triage Assessment System for Students in Learning Environments (TASSLE; Myer et al., 2007), and the Triage Assessment Form: Family Therapy (Myer, 2015)—are recommended as a quick and efficient way of obtaining information relevant to the specific crisis situation. These triage systems enable the worker to gauge the severity of the client's current functioning across affective, behavioral, and cognitive domains. The degree of severity of the crisis may affect the client's mobility, which in turn gives the worker a basis for judging how directive to be. The length of time the client has been in the present crisis will determine how much time the worker has in which to safely defuse the crisis.

The ABCs of Assessing in Crisis Intervention

Crisis is time limited; that is, most acute crises persist only a matter of days or weeks (the exception being large-scale disaster events) before some change—for better or worse—occurs. The severity of the crisis is assessed from the client's subjective viewpoint and from the worker's objective viewpoint. Objective assessment is based on an appraisal of the client's functioning in three areas that may be referred to as the ABCs of assessment: *affective* (feeling or emotional tone), *behavioral* (action or psychomotor activity), and *cognitive* (thinking patterns).

Affective State. Abnormal or impaired affect is often the first sign that the client is in a state of disequilibrium. The client may be overemotional and out of control or severely withdrawn and detached. Often the worker can assist the client to regain control and mobility by helping the client express feelings in appropriate and realistic ways. Some questions the worker may address are: Do the client's affective responses indicate that the client is denying the situation or attempting to avoid involvement in it? Is the emotional response normal or congruent with the situational crisis? To what extent, if any, is the client's emotional state driven, exacerbated, or otherwise influenced by other people? Do people typically show this kind of affect in situations such as this?

Behavioral Functioning. The crisis worker focuses much attention on *doing, acting out, taking active steps, behaving,* or any number of other psychomotor activities. In crisis intervention, the quickest (and often the best) way to get the client to become mobile is to facilitate positive actions that the client can take at once. People who cope with crisis successfully and later evaluate their experiences favorably report that the most helpful alternative during a crisis is to engage in some concrete and immediate activity. However, it is important for the worker to remember that it may be very difficult for immobilized people to take independent and autonomous action even though that is what they need to do most.

These are appropriate questions that the worker might ask to get the client to take constructive action: "In cases like this in the past, what actions did you take that helped you get back in control? What would you have to do now to get back on top of the situation? Is there anyone who, if you contacted them right now, would be supportive to you in this crisis?" The fundamental problem in immobility is loss of control. Once the client becomes involved in doing something concrete, which is a step in a positive direction, an element of control is restored, a degree of mobility is provided, and the climate for forward movement is established.

Cognitive State. The worker's assessment of the client's thinking patterns may provide answers to several important questions: How realistic and consistent is the client's thinking about the crisis? To what extent, if any, does the client appear to be rationalizing, exaggerating, or believing part-truths or rumors to exacerbate the crisis? How long has the client been engaged in crisis thinking? How open does the client seem to be toward changing beliefs about the crisis situation and reframing it in more positive terms of cooler, more rational thoughts, or is the client engaged in a downward spiral of catastrophic thinking with no hope of ameliorating the crisis?

The Triage Assessment System

Because rapid and adequate assessment of a client in crisis is one of the most critical components of intervention (Hersh, 1985), assessment has a preeminent place in the crisis intervention model, as an overarching and ongoing process. Constant and rapid assessment of the client's state of equilibrium dictates what the interventionist will do in the next seconds and minutes as the crisis unfolds (Aguilera, 1998). Unhappily, many assessment devices that can give the human services worker an adequate perspective on the client's problem are unwieldy and time consuming, and require that the client be enough in control to complete the assessment process or be physically present while undergoing evaluation. Although we might gain a great deal of helpful information with an extensive intake form, a background interview, or an in-depth personality test, events often occur so quickly that these are unaffordable and unrealistic luxuries.

What the interventionist needs in a crisis situation is a fast, efficient way of obtaining a real-time estimate of what is occurring with a client. Such a tool should also be simple enough that a worker who may have only rudimentary assessment skills can use the device in a reliable and valid manner. It should enable the assessment to be performed rapidly by a broad cross-section of crisis workers who have had little if any training in standardized testing or assessment procedures. What you are about to encounter (see Figure 3.2) is a composite of several forms of the Triage Assessment Form (TAF), which we believe admirably fits the foregoing criteria.

The Triage Assessment Form

Variations of the general TAF have been tested with police officer trainees, veteran crisis intervention team police officers who deal with the mentally ill, school counselors, community agency workers, secretaries, undergraduates, agency and crisis line supervisors, volunteer crisis line counselors, university professors, residence hall staff, and counselors-in-training (Blancett, 2008; Conte, 2005; Logan, Myer, & James, 2006; Myer, 2001; Myer et al., 1991, 1992; Pazar, 2005; Slagel, 2009; Watters, 1997). Before training, none of the groups had any familiarity with the TAF.

Ratings of these groups were compared with expert triage ratings on a variety of different crisis scenarios (Minimal Impairment, Moderate Impairment, and Severe Impairment). These researchers found that police officer trainees tended to overrate and label the Moderate Impairment scenario as Severe Impairment (probably because they were very sensitive to not underrating the severity for fear of criticism or making a mistake that could cause a fatality). Veteran crisis intervention team police officers' ratings almost replicated the expert ratings (Logan, Myer, & James, 2006; Pazar, 2005). The most problematic area of the scale appears to be the Moderate Impairment range (Watters, 1997). Veteran mental health workers either underrated or overrated Moderate Impairment scenarios. When queried, those veteran mental health workers who gave lower ratings than the experts indicated that they had seen, heard, and handled far more problematic behavior and felt Moderate was too high a rating. Conversely, other veteran mental health workers interpreted subtle responses in the Moderate scenarios to imply greater threat than what was being portrayed, and thus gave higher ratings than the experts. Overall, the ratings of all the other groups, such as the school counselors and volunteers, were deemed reliable and comparable with the ratings of the experts. All groups were congruent with the Minimal Impairment and Severe Impairment range (Blancett, 2008;

CRISIS EVENT *(continued)*

TRIAGE ASSESSMENT (X = Initial Assessment/O = Terminal Assessment)

Affective

___ Anger ___ Fear ___ Sadness

1 2 3 4 5 6 7 8 9 10

Behavioral

___ Approach ___ Avoidance ___ Immobile

1 2 3 4 5 6 7 8 9 10

Cognitive

___ Transgression ___ Threat ___ Loss

1 2 3 4 5 6 7 8 9 10

_____ Physical _____ Psychological _____ Relationship _____ Moral/Spiritual

Initial Total Score: _____ Terminal Total Score: _____ (if used)

Transgression_____ Threat_____ Loss_____

Describe the observations that led you to check the characteristics above:

_____

_____

FIGURE 3.2

Logan, Myer, & James, 2006; Pazar, 2005; Watters, 1997). What the research seems to imply is that the scales should be taken at face value, and the less interpretation made of what the affect, behavior, and cognition implies, the more congruent ratings will be. In other words, trying to read too much or too little into what is being observed appears to invalidate the instrument when clients are operating in the moderately impaired range.

Although simple to use, the TAF is also elegant in that it cuts across affective, behavioral, and cognitive domains, or dimensions, of the client; compartmentalizes each dimension as to its typical response mode; and assigns numeric values to these modes that allow the worker to determine the client's current level of functioning. These three severity scales represent mechanisms for operationally assigning numeric values to the crisis worker's action continuum in Figure 3.2. The numeric ratings provide an efficient and tangible guide to both the degree and the kind of intervention the worker needs to make in most crisis situations. Perhaps more important, they not only tell the worker how the client is doing, but also tell the worker how he or she is doing in attempting to de-escalate, defuse, and help the client regain control. The rationale and examples for each of the scales are discussed on the following pages. Because the original TAF scales were not parallel across numerical ratings with different numbers of anchors, workers reported having difficulty with assessment. As a result, Myer (2014) has developed a more efficient parallel set of ratings for each dimension.

The Affective Severity Scale. No crisis situation that we know of has positive emotions attached to it. Crow (1977) metaphorically names the usual emotional qualities found in a crisis as yellow (anxiety), red (anger), and black (depression). To those we would add orange (our students chose this color) for frustration, which invariably occurs as clients attempt to meet needs. These needs range all across Maslow's needs hierarchy, from inability to get food, water, and shelter (Hurricane Katrina) to interpersonal issues (attempts to regain boyfriend/girlfriend) to intrapersonal issues (get rid of the schizophrenic voices) to spiritual concerns (God can't let this happen). Frustration of needs is often the precursor of other negative emotions, thoughts, and behaviors that plunge the client

further into crisis. Even more problematic, some very famous psychologists have investigated the relationship between frustration and aggression and found that aggression is always a consequence of frustration (Dollard et al., 1939, p. 1). That outcome particularly does not bode well when the client is in crisis.

Undergirding these typical emotions may lie a constellation of other negative emotions such as shame, betrayal, humiliation, inadequacy, and horror (Collins & Collins, 2005, pp. 25–26). Clients may manifest these emotions both verbally and nonverbally, and the astute crisis worker needs to be highly aware of incongruencies between what the client is saying, how the client is saying it (voice tone, inflection, and decibel level), and what the client's body language says.

Invariably, these negative emotions appear singularly or in combination with each other when a crisis is present. In their model, Myer and associates (1992) have replaced the term *depression*, because of its diagnostic implications, with *sadness/melancholy*. When any of these core negative emotions becomes all-pervasive such that the client is consumed by them, the potential for these emotions to motivate destructive behavior becomes extremely high.

The Behavioral Severity Scale. While a client in crisis is more or less behaviorally immobile, immobility can take three different forms. Crow (1977) proposes that behavior in a crisis approaches, avoids, or is paralyzed in the client's attempts to act. Although Crow's proposal may seem contradictory, it is not. A client may seem highly motivated but be acting maladaptively toward a specific target or acting in a random, non-goal-directed manner with no specific target discernible. Alternatively, the client may attempt to flee the noxious event by the fastest means possible, even though the immediate threat to the client's well-being is gone. Whereas in many instances taking stock of the situation before acting is an excellent plan, clients transfixed in the face of immediate danger need to flee or fight. Although a great deal of energy may be expended and the client may look focused, once the crisis goes beyond the client's capacity to cope in a meaningful and purposeful manner, we would say that the client is immobilized, stuck in the particular approach, avoidance, or static behavior in a continuous loop no matter how proactive he or she may seem to be. At the severe impairment end of the continuum, maladaptive behavior often takes on a lethal aspect in regard to either the client or others.

The Cognitive Severity Scale. Ellis has written at length about the part that thinking plays in emotions and behavior (Ellis, 1971; Ellis & Abrahms, 1978; Ellis & Grieger, 1977; Ellis & Harper, 1975). In a crisis situation, the client's cognitive processes typically perceive the event in terms of transgression, threat, loss, or any combination of the three. These "hot" cognitions, as Dryden (1984) calls them, can take on catastrophic dimensions at the extreme end of the continuum.

Such highly focused irrational thinking can cause the client to obsess on the crisis to the extent that little, if any, logical thinking can occur within or beyond the boundaries of the crisis event. The event itself consumes all of the client's psychic energy as the client attempts to integrate it into his or her belief system. The client may generate maladaptive cognitions about intrapersonal, interpersonal, or environmental stimuli. Transgression, threat, or loss may be perceived in relation to physical needs such as food, shelter, and safety; psychological needs such as self-concept, emotional stability, and identity; relationship needs such as family, friends, coworkers, and community support; and moral and spiritual needs such as integrity and values.

To differentiate between transgression, threat, and loss, think of these dimensions in terms of time. *Transgression* is the cognition that something bad is happening in the present moment, *threat* is the cognition that something bad will occur, and *loss* is the cognition that something bad has occurred. When cognitions of the crisis move to the severe impairment end of the continuum, the perception of the event may be so extreme as to put the client or others at physical risk. Sometimes the client's thinking moves from "It's a pain in the neck that this is happening, but I'll get over it" to "It's absolutely intolerable, I will not stand for this, and I'll never get over it." This kind of shift, from cool to hot cognitions (Dryden, 1984), is setting the client up to make some bad decisions. Such decisions most probably will result in even worse behavioral consequences for the client and others.

Certainly the innate intellectual capacity of clients has much to do with how they respond cognitively to a crisis and how the crisis worker should respond to them. Given the same crisis, a client with borderline intelligence may perseverate on the need to obtain basic nurturance while an intellectually gifted person might brood on the existential issue of whether God had a hand in the crisis.

There are four basic areas of cognitive functioning that are likely to become involved in a crisis: physical,

psychological, social relationships, and moral/spiritual beliefs. These look a lot like Maslow's needs hierarchy, and in some ways they are and some ways they aren't. In a disaster, as you will see in Chapter 17, people are pretty much concerned with getting food in their bellies and a roof over their heads first and worrying about other things second. On the other hand, it is not uncommon for all of these dimensions to come into play at once. Physical: "I am hungry, cold, and don't know how much longer I can stand it on top of this roof." Psychological: "I screwed up by not listening and preparing for the hurricane." Social: "Where is my family? Have they survived?" Moral/Spiritual: "How could God have done this to us?"

Some of you who are reading this book may take issue with the moral/spiritual component if you are agnostic, atheist, or just think the supreme being is currently on vacation in an alternate universe. But whatever your spiritual persuasion and whether you believe deities are named the Great Spirit, Allah, God, Vishnu, a large Douglas fir tree, your personal fitness trainer, guru, or preacher, or Charlie Brown's Great Pumpkin, we believe as others do that spirituality is a key component in the crisis business. We like Pargament and Sweeney's definition (2011) of spirit in their work developing the spiritual fitness component of the new U.S. Army's Comprehensive Soldier Fitness Program (see Chapter 7, Posttraumatic Stress Disorder). They define *spirit* as "the essential core of the individual, the deepest part of the self, and one's involving human essence" and *spirituality* as "the continuous journey people take to discover and realize their essential selves." Pargament (2007) adds that it is looking for the *sacred* in one's life. If you think that people who are in crisis don't get down to the core of their being and at times try like crazy to figure out what is sacred, morally right, and how their spirit and spirituality tie into this business, and that this is not really worthy of your consideration, you would be dead wrong.

Comparison With Precrisis Functioning. Although it may not always be possible, the worker should seek to assess the client's precrisis functioning with the TAF as a guide to determine how effectively the client functioned prior to the event. Comparing precrisis ratings with current ratings lets the worker gauge the degree of deviation from the client's typical affective, behavioral, and cognitive operating levels. The worker can then tell how atypical the client's functioning is, whether there has been a radical shift in that functioning, and whether that functioning is transitory or chronic. For example, a very different approach would be used to counsel someone with chronic schizophrenia suffering auditory hallucinations compared to an individual experiencing similar hallucinations from a prescription drug. Such an assessment can be made in one or two questions without having to ferret out a great deal of background information.

Rating Clients. In rating clients on the TAF, we move from high to low. This backward rating process may seem confusing at first glance, but the idea is that we rule out more severe impairment first. So if we were rating affect, we would first look at whether the client fits any of the descriptors under Severe Impairment. If not, we would then consider the descriptors under Marked Impairment. If we were able to check off at least two of those descriptors, the client would receive a rating of 9. If we could identify fewer than two of the descriptors, the client would receive an 8. We would repeat this rating process across all three dimensions to obtain a total rating. Based on the total rating, which will range from 3 to 30, we generally group clients into three categories. A 3–10 rating means minimal impairment; these clients are generally self-directing and able to function effectively on their own. A rating of 11–19 means that clients are more impaired; they may have difficulty functioning on their own and need help and direction. This midscore range is the most problematic as far as disposition of clients is concerned. Low teen scores (11–15) call for at least some guidance and directiveness from the worker to get the client on course as opposed to a single-digit score where the client can be pretty much self-directed with minimal guidance and information. High teen scores (16–19) are indicative of clients who are losing more and more control of their ability to function effectively and call for a good deal more than passive and palliative responses from the worker so that they do not escalate into 20 territory. Clarity in setting boundaries and finding specific and continuous support systems for the immediate future is generally called for when scores fall into this range. Clients with a total score of 20 or above are moving deeper into harm's way; they are likely to need a great deal of direction and a secure and safe environment so they do not escalate into the lethal range. Scores in the high 20s almost always mean that some degree of lethality is involved, whether it is premeditated or clients are simply so out of control that they cannot stay out of harm's way.

Rating clients on the triage scale also means rating the crisis worker! How is this so? If the worker is

effective in stabilizing a client, the triage scale score should go down. If it does not, then the worker probably needs to shift gears and try another approach. While the TAF is not absolutely precise and is not intended to be, it does give a good numerical anchor that the crisis worker can use in making judgments about client disposition and the effectiveness of the intervention. Our students very quickly become skillful at making these ratings on sample cases, and so will you.

One rating issue that constantly arises is the question, "What do you mean by severe? Shouldn't a mother who just got news that her son was badly injured in a school bus accident be pretty hysterical and out of control?" That is certainly true. However, what puts the mother into a crisis category and allows us to rate her as "severely impaired" on the TAF is twofold. First, even though the feelings, thoughts, and behaviors may seem reasonable responses given the horrific situation, what kind of potential trouble does that get the mother into? Are her feelings, thoughts, and actions liable to exacerbate the situation further? Second, it is not just the intensity but also the duration of the feelings, thoughts, and actions. We might reasonably expect an initial response that is highly volatile, but if after 4 hours that same degree of emotional energy were still present, it would be obvious that the client is out of control, in crisis, and in need of assistance.

Alternate Forms of the TAF

The TAF has been modified for use with police departments (Logan, Myer, & James, 2006), higher education/student affairs personnel (Armitage et al., 2007), and disaster relief workers (James, Blancett, & Addy, 2007), and is currently being adapted to families (Myer, 2015) based on the increased interaction with and need to provide services or actions for mentally ill and emotionally disturbed individuals in each of these venues. All these alternate forms of the TAF have been developed because of the expanding needs of a variety of workers who do not have a mental health background yet who come in contact with emotionally disturbed individuals for whom they are expected to render service of some kind. All of the following variations of the TAF have been modified for ease and simplicity of use and have or are undergoing field testing.

TACKLE. The Triage Assessment Checklist for Law Enforcement (TACKLE; James, Davis, & Myer, 2014; James, Myer, & Moore, 2006) was developed in cooperation with a focus group of police officers and mental health workers from the Montgomery County, Maryland, police department. It is used by police officers to make on-the-scene assessments of how they are doing in defusing and de-escalating emotionally out-of-control recipients of service, to provide the officers with concrete behavioral assessments for placing recipients of service under legal confinement for psychiatric evaluation and/or commitment, and to provide behavioral assessments in legal proceedings to back up actions taken against recipients of service (see Chapter 14, Violent Behavior in Institutions).

The second section of the TAF form is titled "Observations" (see Figure 3.3). This section is divided into three columns listing some of the behaviors that may be seen with an individual in crisis. Several of the items have been identified as critical for either getting clients support or removing them to a place of safety. A general guideline is the more items you check, the more likely a person will either need support or should be removed. Most often checking numerous items means the individual's rating on the severity scales will also be high. High scores on the severity scales generally mean an increased need for support services and an increased potential for hospitalization.

The first column addresses psychological problems. Check appropriate descriptors in this section based on your observations and questioning of individuals. You may not be able to gather all this information because clients may be uncooperative or simply unable to respond to questions. A good source for some of this information is other people who may know the client. Asking them about the individual may give you the information needed to check the appropriate descriptors in this column. The second column focuses on clients that are dangerous to themselves or others. They may be only threatening harm or actually making suicidal or homicidal gestures. If they are simply threatening harm, you will need to make a judgment as to whether the person is an immediate danger to self or others. Simply making threats to harm oneself or others does not automatically mean the student needs support services or removal. A standard guideline is if a person has a plan formulated and if the means to carry out the plan are available, that person is a threat and needs to be monitored in a safe place by qualified mental health workers until the threat has abated.

The third column relates to the severity scales most directly. Listed in this column are feelings,

behaviors, and thoughts persons may experience when in a crisis. These correspond to characteristics on the severity scales. Generally, you can complete this section based on your observations and experience with students. Four of the descriptors have been identified as being critical: (1) hysterical, (2) confusion, (3) unable to follow simple directions, and (4) nonresponsive. Individuals who fit these descriptors are vulnerable, mentally fragile, and unable to care for themselves.

In summary, the TAF and its derivative alternate forms provide multiple three-dimensional combinations of the domains of assessment regarding the degree of impairment the crisis is causing, target specific areas of functioning, and let the crisis worker evaluate the client quickly and then construct specific interventions aimed directly at areas of greatest immediate concern.

Psychobiological Assessment

LO4

Although psychobiological assessment for psychopathology is beyond the scope of this book and most crisis situations, in terms of both immediacy of assessment and the assessment skills required of most human services workers, there is clear evidence that neurotransmitters, the receptors they land on and physical changes in brain structures play an exceedingly important role in the affective, behavioral, and cognitive functioning of individuals both during a crisis and, for some, long after a crisis (Briere & Scott, 2006; Elharrar, Warhaftig, Issier, Szainberg, Dikshtein et al., 2013; Lanius, Frewen, Nazarov, & McKinnnon, 2014; Nicholson, Bryant, & Felmingham, 2013; Strawn & Geracioti, 2008; van der Kolk, 1996a; Vermetten & Landius, 2012; Yehuda, 2006; Yehuda & LeDoux, 2007).

It is becoming pretty clear that the limbic system in the brain plays a part in "catching" and "carrying" PTSD. It also appears possible that the gene pool you jumped out of may have something to do with how susceptible you are to anxiety disorders, because there is substantive evidence that a lesser volume of certain limbic system components makes people more susceptible to PTSD (Gilbertson et al., 2002; Glat et al., 2013; Skelton et al., 2012). The good news is that certain drug therapies and psychotherapies can potentially increase the volume and change neurotransmitter conductivity that goes with symptomatic improvement in PTSD, depression, and other anxiety disorders (Chapman, 2014; Felmingham et al., 2007; Klavir, Genud-Gabai, & Paz, 2012; Lippy & Kelzenberg, 2012; Niv, 2013; Pietrzak et al., 2014; Tomko, 2012; Vermetten et al., 2003).

For at least three reasons, human psychobiology can be an important consideration in crisis intervention. First, evidence exists that when people are involved in traumatic events, dramatic changes occur in the discharge of neurotransmitters, such as endorphins, and in the central and peripheral sympathetic nervous systems and the hypothalamic-pituitary-adrenocortical axis (Bailey, Cordell, Sobin, & Neumeister, 2013). These two systems regulate one another. When PTSD enters the picture, the balance of these two systems is not maintained and the responses

Observations (Check all that apply)

___ off medication*
___ hallucinating† (___smells ___sights ___sounds ___touch)
___ bizarre behavior/appearance
___ poor hygiene
___ absurd, illogical, nonsensical speech
___ paranoid/suspicious thoughts
___ flashbacks, loss of reality contact*
___ intoxicated/drugged*
___ possible developmental disability
___ aggressive gestures
___ physically violent†
___ verbal threats to self or others
___ suicidal/homicidal thinking/verbalizing*
___ suicidal/homicidal gestures/behaviors†
___ suicidal/homicidal plan clear†
___ uncooperative
___ reckless behavior
___ impulsivity
___ hysterical*
___ confusion*
___ unable to follow simple directions*
___ unable to control emotions
___ cannot recall personal information* (phone, address)
___ situation perceived as unreal* (spectator)
___ nonresponsive*

*Support services recommended.
†Protective custody recommended.

FIGURE 3.3 Triage Assessment System for Students in Learning Environments (TASSLE): Observational Checklist.
SOURCE: Myer et al., 2007.

of both systems are affected (Raison & Miller, 2003). These neurological changes may become residual and long-term and have subtle and degrading effects on emotions, acting, and thinking (Antunes-Alves & Comeau, 2014; Bovin, Ratchford, & Marx, 2014; Burgess-Watson, Hoffman, & Wilson, 1988; Scaer, 2014; van der Kolk, 1996b). Client education about the psychobiological effects of trauma is important in letting clients know they are not going "nuts" and that the urges of their bodies to spring into physical action even though the original stressor is long past have a neurological basis (Halpern & Tramontin, 2007, p. 83).

Second, research indicates that abnormal changes in neurotransmitters such as dopamine, norepinephrine, and serotonin are involved in mental disorders that range from schizophrenia (Crow & Johnstone, 1987) to depression (Healy, 1987) and affective and anxiety disorders in general (Petrik, Lagace, & Eisch, 2012). Psychotropic drugs are routinely used for a host of mental disorders to counteract such neurological changes. A common problem faced by human services workers and police officers is the deranged or violent client who has gone off medication because of its unpleasant side effects or an inability to remember when to take it (Ammar & Burdin, 1991; Miller, 2006). Individuals with psychosis who have gone off their medication and taken their reactivated psychosis out onto the streets are legion and are the bane of crisis intervention team police officers.

Third, both legal and illegal drugs have a major effect on mental health. Although the way illegal drugs change brain chemistry and behavior has gained wide attention, legal drugs may promote adverse psychological side effects in just as dramatic a manner. In particular, combinations of nonpsychotropic drugs are routinely given to combat several degenerative diseases in the elderly. At times, these drugs may have interactive effects that generate unanticipated psychological disturbances. One has to read no further than the consumer trade books on prescribed drugs to obtain a rather frightening understanding of the psychological side effects prescription drugs can cause.

Therefore, the human services worker should attempt to assess prior trauma, psychopathology, and use, misuse, or abuse of legal and illegal drugs in an effort to determine whether they correlate with the current problem. "Talking" therapies do little good when neurobiological substrates are involved. If the human services worker has reason to suspect any of the foregoing problems, an immediate referral should be made for a neurological/drug evaluation. Officer Lewis's question about how much Leron had been drinking is almost a default question in regard to use or misuse of both prescription and nonprescription medications.

The following questions are practically mandatory during initial exploration activities with a person in crisis and should be asked in a nonaccusatory way.

Crisis worker: Lots of times people have a reaction to medication or changes in medication. Are you on any medication right now? Is it for emotional problems? Have you stopped taking it? Are you on any medications for other physical problems? Have you stopped taking or changed medications? Did you have any alcoholic beverages with your medication? Has there been any way you feel like you have changed or felt different since you went on or changed or went off a medication?

Assessing the Client's Current Emotional Functioning

LO5

Four major factors in assessing the client's emotional stability are (1) the duration of the crisis, (2) the degree of emotional stamina or coping at the client's disposal at the moment, (3) the ecosystem within which the client resides, and (4) the developmental stage of the client.

The duration factor concerns the time frame of the crisis. Is it a onetime crisis? Is it recurring? Has it been plaguing the client for a long time? A onetime crisis of relatively short duration is called *acute* or *situational.* A long-term pattern of recurring crisis is labeled *chronic, long-term,* or *transcrisis.*

The degree factor concerns the client's current reservoir of emotional coping stamina. During normal periods of the client's life the coping reservoir is relatively full, but during crisis the client's reservoir is relatively empty. Assessing the degree factor, then, involves the crisis worker's determining how much emotional coping strength is left in the client's reservoir. Has the client run out of gas, or can the client make it over a small hill?

The ecosystem is a very large extraneous variable that can dramatically influence client coping (Collins & Collins, 2005; Halpern & Tramontin, 2007; James, Cogdal, & Gilliland, 2003; Myer & Moore, 2006). Geographic region and accessibility, communication systems, language, cultural mores, religious beliefs, economic status, and social micro- and macrosystem

interactions are only some of the ecosystemic variables that may have subtle or profound effects on a client's emotional coping ability. No individual's crisis can be taken out of the ecosystemic context in which it occurs, and to believe it can be somehow treated separately without considering that context is to make a grave intervention error.

Developmental stages (Collins & Collins, 2005) certainly play a part in the client's emotional functioning during a crisis. Merely transitioning from life stage to life stage has its own potential for crises (Blocher, 2000; Erikson, 1963). Understanding the developmental tasks of different life stages, which may frame a client's view of a crisis and how the client responds to it, is critical for crisis workers. Further compounding the issue, developmental tasks are sometimes not accomplished at a particular life stage, and developmental crises occur (Levinson, 1986). It does not take much imagination to foresee that adding a situational crisis may have a tremendous impact on a "stuck-in-stage" individual's emotional coping skills.

The Client's Current Acute or Chronic State. In assessing the crisis client's emotional functioning, it is important that the crisis worker determine whether the client is a normal person who is in a *onetime* situational crisis or a person with a *chronic,* crisis-oriented life history. The onetime crisis is assessed and treated quite differently from the chronic crisis. The onetime crisis client usually requires direct intervention to facilitate getting over the specific event or situation that precipitated the crisis. Having reached a state of precrisis equilibrium, the client can usually draw on normal coping mechanisms and support people and manage independently.

The chronic crisis client usually requires a greater length of time in counseling. That individual typically needs the help of a crisis worker in examining available coping mechanisms, finding support people, rediscovering strategies that worked during previous crises, generating new coping strategies, and gaining affirmation and encouragement from the worker and others as sources of strength by which to move beyond the present crisis. The chronic case frequently requires referral for long-term professional help.

The Client's Reservoir of Emotional Strength. The client who lacks emotional strength needs more direct responses from the crisis worker than the client who retains a good deal of emotional strength. A feeling of hopelessness or helplessness is a clue to a low reservoir of emotional strength. In some cases, the assessment can be enhanced by asking open-ended questions for the specific purpose of measuring that reservoir. Typically, if the reservoir is low, the client will have a distorted view of the past and present and will not be able to envision a future. Such questions can reveal the degree of emotional stamina remaining: "Picture yourself after the current crisis has been solved. Tell me what you're seeing and how you're feeling. How do you wish you were feeling? How were you feeling about this before the crisis got so bad? Where do you see yourself headed with this problem?" In general, the lower the reservoir of emotional strength, the less the client can get hold of the future. The client with an empty reservoir might respond with a blank stare or by saying something like "There are no choices" or "No, I can't see anything. The future is blank. I can see no future." The worker's assessment of the client's current degree of emotional strength will have definite implications for the strategies and level of action the worker will employ during the remainder of the counseling.

Strategies for Assessing Emotional Status. The crisis worker who assesses the client's total emotional status may look at a wide array of social locations (Brown, 2008) that affect both the duration (chronic versus acute) and the degree (reservoir of strength) of emotional stability. Some factors to be considered are the client's age, educational level, family situation, marital status, vocational maturity and job stability, financial stability and obligations, drug and/or alcohol use, legal history (arrests, convictions, probations), social background, level of intelligence, lifestyle, religious orientation, ability to sustain close personal relationships, tolerance for ambiguity, physical health, medical history, and past history of dealing with crises. A candid look at such factors helps the crisis worker decide whether the client will require quick referral (for medical treatment or examination), brief counseling, long-term therapy, or referral to a specific agency.

Ordinarily, no one factor alone can be used to conclude that the client's reservoir of emotional coping ability is empty. However, some patterns can often be pieced together to form a general picture. A person in middle age who has experienced many disappointments related to undereducation and subsequent underemployment would be viewed differently from a

young person who has experienced a first career disappointment. A person who has experienced many serious medical problems and hospital stays would feel different from a person who is having a first encounter with a medical problem. The foregoing example is a *facilitative* affective assessment of the individual. By "facilitative assessment," we mean that data gleaned about the client are used as a part of the ongoing helping process, not simply filed away or kept in the worker's head.

Assessing Alternatives, Coping Mechanisms, and Support Systems

Throughout the helping process, the crisis worker keeps in mind and builds a repertory of options, evaluating their appropriateness for the client. In assessing alternatives available to the client, the worker must first consider the client's viewpoint, mobility, and capability of taking advantage of the alternatives. The worker's own objective view of available alternatives is an additional dimension.

Alternatives include a repository of appropriate referral resources available to the client. Even though the client may be looking for only one or two concrete action steps or options, the worker brainstorms, in collaboration with the client, to develop a list of possibilities that can be evaluated. Most will be discarded before the client can own and commit to a definite course of action. The worker ponders questions such as: What actions or choices does the client have now that would restore the person to a precrisis state of autonomy? What realistic actions (coping mechanisms) can the client take? What institutional, social, vocational, or personal (people) strengths or support systems are available? (Note that "support systems" refers to people!) Who would care about and be open to assisting the client? What are the financial, social, vocational, and personal impediments to client progress?

Assessing for Suicide/Homicide Potential

Not every crisis involves the client's contemplating suicide or homicide. However, in dealing with crisis clients, workers must always explore the possibility of harm to self or others, because destructive behavior takes many forms and wears many masks. Crisis workers need to be both wary of and competent in their appraisal of potential suicidal and homicidal clients. What may appear to the crisis worker as the main problem may camouflage the real issue: the intent of the client to take his or her life, or someone else's life. Contrary to popular belief, most suicidal and homicidal clients emit definite clues and believe they are calling out for help or signaling warnings. However, even the client's closest friends may ignore those clues and do nothing about them. For that reason, every crisis problem should be assessed as to its potential for suicide and homicide. The most important aspect of suicidal/homicidal evaluation is the crisis evaluator's realization that suicide and homicide are always possible in all types of clients.

SUMMARY

The hybrid model in this chapter has to do with tasks to be accomplished during a crisis that do not always move in a stepwise linear progression. Overarching all tasks is safety—not only for the client, but for others and the worker as well. Making initial contact in a crisis is not always easy. That's why we have designated predispositioning, engaging, and initiating contact as a new primary task that is critical in laying the groundwork for the intervention to follow. Problem exploration includes affective, behavioral, and cognitive dimensions of the current crisis; it involves finding out what got the immediate crisis going and generally does not delve into all the past issues of the client. Providing support means finding what human resources are available to help the client and what role the crisis worker will play in either finding or being part of the support system. Examining alternatives and options, making plans, obtaining commitments, and following up are neither extensive nor long-term. They are target-specific attempts to find short-term solutions to restore precrisis equilibrium.

A major difference between crisis intervention and other human services endeavors, such as counseling, social work, and psychotherapy, is that the crisis worker generally does not have time to gather or analyze all the background and other assessment data that might normally be available under less stressful conditions. A key component of a highly functioning crisis worker is the ability to take the data available and make some meaningful sense out of it. This

may be somewhat unsettling to those human services workers who are accustomed to having complete social and psychological workups available to them before they proceed with intervention. However, the ability to quickly evaluate the degree of client disequilibrium and immobility—and to be flexible enough to change your evaluation as changing conditions warrant—is a priority skill that students should seek to cultivate. That's why you have been introduced to the hybrid task model and the Triage Assessment Form.

From onset to resolution of the crisis, assessment is a central, continuous process. The crisis worker must not assume that because the crisis appears on the surface to have been resolved, assessment is no longer needed. The balance sheet of assessing the client's crisis in terms of severity, current emotional status, alternatives, situational supports, coping mechanisms, resources, and level of lethality is never complete until the client has achieved his or her precrisis level of mobility, equilibrium, and autonomy. Only then are the psychological debts of the client reconciled. The resumption of precrisis equilibrium does not imply that the client needs no developmental or long-term therapy or medical treatment. It does mean that the crisis worker's job is done, and the acute phase of the crisis is over.

Visit CengageBrain.com for a variety of study tools and useful resources such as video examples, case studies, interactive exercises, flashcards, and quizzes.