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

LO5

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 (noncrisis) 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

LO6

Slaikeu (1990, p. 6) breaks crisis intervention 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:

***A***ssessment of the presenting problem, including emergency psychiatric and other medical needs and trauma assessment
***C***onnecting clients to support systems
***T***raumatic 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

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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.

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