

The Intervention and Assessment Models

Introduction

The purpose of this chapter is to present an **LO1** applied crisis intervention model that describes in detail the major tasks involved in dealing with a crisis. The Triage Assessment System is introduced as a rapid but systematic technique for the crisis worker to use to adjudicate the severity of a client's presenting crisis situation and gain some sense of direction in helping the client cope with the dilemma. Finally, this chapter shares some ideas on using referrals and gives some suggestions regarding counseling difficult clients. This chapter and Chapter 4, *The Tools of the Trade*, are a prerequisite for succeeding chapters, and we urge you to consider this foundation material carefully.

The model of crisis intervention you are about to encounter emphasizes an immediacy mode of actively, assertively, intentionally, and continuously assessing, listening, and acting to systematically help the client regain as much precrisis equilibrium, mobility, and autonomy as possible. Two of those terms, **equilibrium** and **mobility**, and their antonyms, **disequilibrium** and **immobility**, are commonly used by crisis workers to identify client states of being and coping. Because we will be using these terms often, we would like to first provide their dictionary definitions and then give a common analogy, so their meaning becomes thoroughly understood.

Equilibrium. A state of mental or emotional stability, balance, or poise in the organism.

Disequilibrium. Lack or destruction of emotional stability, balance, or poise in the organism.

Mobility. A state of physical being in which the person can autonomously change or cope in response to different moods, feelings, emotions, needs, conditions,

LEARNING OBJECTIVES

After studying this chapter, you should be able to:

1. Understand the concepts of equilibrium/disequilibrium and mobility/immobility as they apply to stabilizing an individual in crisis.
2. Understand how the hybrid model of crisis intervention is used, what its component parts are, and how they are applied.
3. Understand and use the Triage Assessment System and its affective, behavioral, and cognitive components in doing real-time assessment of an individual in crisis.
4. Understand the role that psychobiology plays in assessing crisis.
5. Understand the role that the duration of time, the degree of emotional stamina, the developmental stage of the client, and the ecosystem contribute to the crisis.

influences; being flexible or adaptable to the physical and social world.

Immobility. A state of physical being in which the person is not immediately capable of autonomously changing or coping in response to different moods, feelings, emotions, needs, conditions, influences; inability to adapt to the immediate physical and social world.

A healthy person is in a state of approximate psychological and behavioral equilibrium, like a motorist driving, with some starts and stops, down the road of life—for both the short and the long haul. The person may hit some potholes but does not break any axles. Aside from needing to give the car an occasional tune-up, the person remains more or less equal to the task of making the drive. In contrast, the person in crisis, whether it be acute or chronic, is experiencing serious difficulty in steering and successfully

navigating life's highway. The individual is at least temporarily out of control, unable to command personal resources or those of others in order to stay on safe psychological pavement.

A healthy person is capable of negotiating hills, curves, ice, fog, stray animals, wrecks, and most other obstacles that impede progress. No matter what roadblocks may appear, such a person adapts to changing conditions, applying brakes, putting on fog lights, and estimating passing time. This person may have fender benders from time to time but avoids head-on collisions. The person in a dysfunctional state of equilibrium and mobility has failed to pass inspection. Careening down hills and around dangerous curves, knowing the brakes have failed, the person is frozen with panic and despair and has little hope of handling the perilous situation. The result is that the person has become a victim of the situation, has forgotten all about emergency brakes, downshifting, or even easing the car into guardrails. He or she flies headlong into catastrophe and watches transfixed as it happens. The analogy of equilibrium and mobility applies to most crisis situations. Thus, it becomes every crisis worker's job to figuratively get the client back into the driver's seat of the psychological vehicle. As we shall see, sometimes this means the client must temporarily leave the driving to us, sometimes it means sitting alongside the client and pointing out the rules of the road, and sometimes it means just pretty much going along for the ride!

All of that being said, the crisis worker will meet a number of individuals who were not poster children for psychological equilibrium before the crisis. Many people who were displaced by Hurricane Katrina, for example, were physically and psychologically fragile before the hurricane. We will have more to say about such people, who are more typically in a state of transcrisis, in Chapter 5, Crisis Case Handling.

A Hybrid Model of Crisis Intervention

There are numerous models for crisis inter-
vention (Aguilera, 1998; Kanel, 1999; Kleespies, 2009; Lester, 2002; Roberts, 2005; Slaikeu, 1990). All of these models depict crisis intervention in some linear, stage, or stepwise fashion. Indeed, through 25 years of publishing this book we did much the same, with the admonition that changing conditions might well mean that the interventionist would have to recycle and move back to earlier steps. We no longer believe

that a stage or purely step model captures the way crisis intervention works, and here's why.

The problem that we have struggled with as we try to teach students like you about crisis intervention is that at times crisis is anything but linear. A lot of the times crisis intervention absolutely epitomizes chaos theory—with starts, stops, do-overs, and U-turns. At times doing crisis work is a lot like being a smoke jumper, controlling a psychological brush fire on this side of the mountain only to be faced with a new one on the other side of the valley. Fighting those psychological fires according to a neat, progressive, linear plan is easily said but not so easily done. Therefore, we have combined our former linear model with a systems model we helped develop (Myer, James, & Moulton, 2011), resulting in what could more appropriately be called a hybrid model for individual crisis intervention that is generally linear in its progression but can also be seen in terms of tasks that need to be accomplished. While certainly some of these tasks would usually be done in the beginning, middle, or end of a crisis, changing conditions may mean you have to accomplish some task you would normally do later, first. Or indeed, a task you thought was already accomplished comes apart and has to be done over not once, but multiple times.

A further problem with a strict linear model is that each step should be discrete, following from step one to step two and so on, with particular techniques to employ in each of those steps. In crisis intervention, issues suddenly erupt that defy discrete, stepwise techniques. Focus on getting a commitment from a person to do something, which would normally come at the end of a crisis session, may need to happen immediately if that person is standing out in the middle of a busy intersection at rush hour! Likewise, gaining that commitment to get out of the street may call for assertion techniques that are anything but what we might normally do when making initial contact with a client. Consider the following analogy.

Picture yourself as a linesperson on the cross arm of a power pole, hard hat on, heavy insulated clothing, leather over insulated gloves, dug in with your climbing spikes, attempting to repair a high-voltage (crisis) transmission line in North Dakota in January with the wind blowing sleet in your face at 20 miles an hour. On your utility belt are a variety of tools. You know the steps required to get the transformer hooked back up and the sequential manner in which you will employ the tools on your belt to get the job done. The problem is, Mother Nature is not happy and the wind picks up and a coupling breaks loose or a new fuse you just put in blows

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and you have to start all over again! If you can picture this analogy in your mind's eye, you are well on the way to understanding how crisis intervention works. As we describe the model, we will give you some examples of when you have to change tools to meet the changing conditions up on that pole.

The model you are about to examine is the hub around which the crisis intervention strategies in this book revolve, and the tasks/steps are designed to operate as an integrated problem-solving process (Myer, Lewis, & James, 2013). It is not complex, but rather is designed to be simple to implement, easy to use, and adaptable to just about any crisis we can think of you would likely encounter.

Task 1. Predispositioning/Engaging/Initiating Contact

Predispositioning may be seen as first and foremost getting ready to do something. It is usually the first step in a crisis model: placing oneself, or something, in a position to be of use in some future occurrence. Typically, systems such as the armed forces and government agencies such as FEMA use **predispositioning** to get supplies, equipment, and personnel ready to meet some future emergency. Indeed, in Chapter 17, Disaster Response, you will see predispositioning in operation on a very large scale. In the counseling literature, predisposition was originally studied by Prochaska, DiClemente, and Norcross (1992) in regard to what motivated people who were suffering from addiction to decide to change. Since their seminal work, the concept of predisposing clients to get them ready for counseling has become widespread.

In crisis intervention, predisposition is somewhat different. It means predisposing individuals to be receptive to our intervention when, in many instances, they may not be at all enthused about our presence or be so out-of-control that they are only vaguely aware of us. Therefore, predisposition has a lot to do with the attitudinal set and predisposition of how the crisis worker enters the situation. A number of clients the crisis worker will meet do not act, talk, look, or even smell nice! The ability to convey empathy and be authentic as to who and what you are doing without pretense is critical (Kleespies & Richmond, 2009).

Particularly with a first contact, predispositioning the client as to what to expect is critical. Along with letting the client know what is going to occur, it is important to make contact in such a way that the client can see the interventionist as an immediate ally and support, and not another in a long line of people,

representative of bureaucracies and institutional authorities, who have been anything but helpful in resolving their problems. One of the most critical initiating components of crisis intervention is how the worker introduces himself or herself to a client who has never met the crisis interventionist—which is a fairly common occurrence in this business. It is not just to fill time that our practicum training with aspiring crisis intervention team police officers now devotes an initial session specifically to how the officer introduces himself or herself to a recipient of services (Memphis Police Department, 2010). Our primary objectives in predisposing an individual to accept crisis intervention are twofold: (1) to establish a psychological connection and create a line of communication and (2) to clarify intentions with regard as to what is going to happen.

Establishing Psychological Connection. First and foremost, you need to introduce yourself in a way that is nonthreatening, helpful, and assumes a problem-solving as opposed to an adversarial approach.

Leron: (standing in the middle of a main city street in five o'clock rush hour waving two broken whiskey bottles) The God damned house authority. NO place to live. Kicked me out, the rotten bastards. Everybody needs to know them for the crooks they are.

CIT officer: (slowly approaching the subject from a distance with hands visible, empty, and open) Man! You really are angry with them to make this kind of statement out in the middle of Union Avenue during rush hour. My name's Scott Lewis, a CIT officer with the Memphis Police Department. I didn't catch your name. Mind telling me?

One of the most important elements in making **first contact** is getting the client's name and introducing yourself in a nonthreatening manner. Note that Scott approaches the subject slowly, not only because he is armed with two whiskey bottles (which has to do with another task that is pretty important here, providing for the client's safety and your own), and responds to his current affective and behavioral state of being. Before he ever asks a question about why this has happened, he immediately states his name and asks for the client's. Also note that his full name, not his rank or the police department, comes first.

Another advantage with the approach used by Scott is that he allows Leron to maintain some control over the situation. The housing authority has already taken his home and barred him from his belongings. Imagine if Scott rolled onto the scene and

immediately began demanding Leron to get out of the street and put down the whiskey bottles. Scott would likely get the response “screw you, cop.” Scott would be seen as just another authority figure who doesn’t listen. By establishing a problem-solving, helpful connection, Scott allows Leron to maintain momentary control of the situation. By reflecting Leron’s anger, the crisis worker immediately attempts to convey empathic understanding of the extreme measures the client has taken in attempting to problem-solve.

Clarifying Intentions. Clarifying intentions means informing the client about what the crisis intervention process is and what the client can expect to happen. For many clients who are in crisis, this will be their first contact with a crisis interventionist, and they will have little if any idea of what is going to happen or how it is going to happen. Leron most likely has had experiences with the police that will lead him to believe that nothing positive is going to happen with Officer Lewis. Thus, the CIT officer needs to quickly apprise him of what will happen.

CIT officer: Okay I can see right off you clearly have some issues with the housing authority. Right now I am going to listen very closely to what got you out here. I may ask you some questions so I get a clearer notion of the problem. We’ve got some time and I am going to take the time to hear you out. I’ll also probably kinda sum up what you’re saying so I’m sure I heard you right. So I wonder if we could move this over underneath that shade tree cause it’s hot and not very safe out here.

Leron: (*weaving unsteadily and sweating profusely*) No! As soon as I do that, those other cops will bum rush me. Long as I’m out here they got to pay attention and that News 5 chopper stays up there. Lost my job through no fault of my own and now kicked out.

CIT officer: Okay. I hear what you’re saying about keeping the evil stuff the housing authority has done to you in the public’s eye. However, sooner or later we’re going to need to get out of the street. I’d like that to be sooner since it is 98 degrees out here and my guess is you’re getting thirsty and would like to get it settled and get out of the sun. Nobody’s going to bum rush you. It’s between you and me right now. That’s the way I’d like to keep it.

Officer Lewis uses basic listening and responding statements that own what is going to happen in the next few minutes. He also states the immediate end

goal of the crisis resolution for him as “getting out of the middle of the street.” He clearly states his intention to listen, get the client’s perspective, and do no harm to him while this is going on. While the client’s end goal may be completely different—bringing the housing authority to justice in some manner—the interventionist states from the outset in pretty clear terms what he is going to do. In clear, concise statements, the interventionist creates a line of communication by using open-ended questions, reflection of feelings, and owning statements (all of which you will learn about in the next chapter) that reinforce and encourage the client to tell his story. The major intentional strategy here is allowing the client to cathart but also keeping the client in real time and not allowing the interaction to degenerate into all the perceiving injustices ever perpetrated on him.

This introduction “stuff” may sound pretty simplistic, but in the heat of the moment it is surprising how that can go by the wayside. It may also seem like a “once and done” deal, but even for a client who has known the interventionist for a long time and is currently out of touch with reality, anchoring the client by stating who the interventionist is, clarifying intentions, and stating what needs to happen is a critical ingredient for a successful intervention.

Task 2. Problem Exploration: Defining the Crisis

A major initial task in crisis intervention is to define and understand the problem from the client’s point of view. This is particularly difficult in the middle of a chaotic situation where there are complex biopsychosocial contributors interacting with one another (Kleespies & Richmond, 2009). Unless the worker perceives the crisis situation as the client perceives it, all the intervention strategies and procedures the helper might use may miss the mark and be of no value to the client. Intervention sessions begin with crisis workers practicing what are called the **core listening skills**: empathy, genuineness, and acceptance or positive regard (Cormier & Cormier, 1991, pp. 21–39).

Problem definition of a crisis does not mean going on a psychological archaeological dig to dredge up and sift every artifact of the client’s past. Defining the crisis does mean attempting to identify the precipitating event across the affective, behavioral, and cognitive components of the crisis. This task serves two purposes. First, the interventionist sees the crisis from the client’s perspective. Second, defining the crisis gives the interventionist information on the

immediate conditions, parties, and issues that led to eruption of the problem into a crisis.

CIT officer: I understand that the housing authority screwed you over somehow. So tell me what got you so mad and frustrated you needed to get everybody's attention.

As Leron angrily expounds on the housing authority's injustices toward people and himself, Officer Lewis uses an expansion strategy to broaden the client's view of the problem without letting the problem escalate. He restates the client's complaint and follows with an open lead.

Inevitably other issues will surface as the interventionist attempts to define the crisis. In the case of Leron, Officer Lewis may suspect that Leron is dependent on alcohol, given the fact that he has two empty whiskey bottles in his hands and is having trouble keeping his balance. He also is now aware that Leron has recently been laid off from his job. While these issues need attention, at the moment the interventionist needs to remain focused on the crisis—getting Leron out of the street and assisting him to access the resources needed to address the eviction from his apartment. The other issues should be placed on the back burner and may well be discussed after the crisis has been resolved.

CIT officer: So they lost your application for delayed payment while you wait for unemployment to kick in, then said you hadn't filed and kicked you out. I understand how that could make you so mad. So how about putting those bottles down and stepping over to that shade tree. I see you're sweating pretty hard out here in the hot sun and bet you could use some water. I just happen to have some bottles in my lunch cooler. I've got a couple of ideas about how to get you out of this predicament.

Task 3. Providing Support

The third task in crisis intervention emphasizes communicating to the client that the worker is a person who cares about the client. Workers cannot assume that a client experiences feeling valued, prized, or cared for. In many crisis situations, the exact opposite will be true. The support step provides an opportunity for the worker to assure the client that "here is one person who really cares about you." We believe that providing support occurs in three ways.

Psychological Support. First and most immediate is providing psychological and physical support. Deep,

empathic responding using reflection of feelings and owning statements about the client's present condition serves as a bonding agent that says emphatically, "I am with you right here." In Task 3, the person providing the support is the crisis worker. This means that workers must be able to accept, in an unconditional and positive way, all their clients, whether the clients can reciprocate or not. The worker who can truly provide support for clients in crisis is able to accept and value the person no one else is willing to accept. While Officer Lewis is attempting to get Leron out of the street, he also offers genuine support and help in getting the client out of his predicament with the housing authority.

Logistical Support. In a more general sense, support may be not only emotional but also instrumental and informational (Cohen, 2004). At times the client may not have money, food, clothing, or shelter. Little psychological support will be desired or progress made until the basic necessities of living and surviving are met. Physical support means giving clients concrete assistance to help weather the crisis. This support comes in many forms, ranging from providing pamphlets to arranging transportation of clients to organizations that have the resources needed to help them to simply giving them a drink of water.

CIT officer: I can't imagine what it's like not to have a job or a roof over your head. Where's your family in all this?

Leron: Tormeda and the kids done went to her momma's in Arkansas. Nothin' to eat and no place to live ceptin' the street. Momma took her back cause I ain't no account and cain't feed 'em or put a roof over dere heads.

CIT officer: The words "terrifying" and "hopeless" come to mind. I can see why this might come down to the only solution you can think of. I really do want to help you out with this and get you back on your feet, and I do maybe have an idea or two about how to do that. But I don't want to see you arrested and if we don't move this out of the middle of the street so I can share some of my ideas with you, nothing will happen except you going to jail. So you have a choice. What's your wish? Help getting this resolved or jail?

Leron: Jail don't sound good . . . been there, done that.

CIT officer: I hear that. I don't want to see you in jail either, so come on over here and let's look at some options.

Leron: (walks slowly over to the curb and sets the bottles down) Okay, I be done. I be givin' you a shot at dis. I guess I be needin' some hep.

In this exchange, Officer Lewis forms a bond with Leron. Officer Lewis does not judge Leron, instead he encourages him to stay out of jail. This encouragement helps Leron regain a belief that the situation is not as dire as it seems and maybe with help a solution can be found. Encouragement is a critical component in crisis intervention because, for most clients, what they are going through is anything but encouraging. Catching clients' even feeble attempts to problem-solve gives them a chance to regain some hope, validates that they still have capabilities, and starts reframing thinking toward a proactive, problem-solving mode (Courtois & Ford, 2009, pp. 86–87).

Social Support. Third, providing support means activating clients' primary support system: family, friends, coworkers, church members, and so forth. For many people in crisis, this primary support system may be absent (a car accident 600 miles from home), fed up with their behavior (lying and stealing from them to subsidize an addiction), or unequal to the task of providing support as a result of the crisis (symptoms of posttraumatic stress disorder). Conversely, clients may feel too embarrassed or guilty to ask for help from their immediate support system such as Sunday school members (loss of job and inability to contribute to their church financially). At such times, the interventionist is not only the initial point of contact and immediate psychological and physical anchor, but also the “expert” who provides information, guidance, and primary support in the first minutes and hours after the initiating event (Aguilera, 1998; Cohen, 2004).

Informational Support. At other times, clients do not have adequate information to make good decisions. The need for informational support is particularly critical in the next step, examining alternatives. One of the best techniques a crisis interventionist can be in command of is the ability to provide information on where, how, who, and what resources clients can access to get out of the predicament they are in. That is particularly true of people who after a disaster are trying to access the basic necessities of living (Ruzek, 2006).

Default Task: Safety

Safety is a default task that is *always* operational. Safety is a primary consideration throughout crisis intervention for a variety of reasons that are both physically

and psychologically based. The task of assessing and ensuring the client's and others' safety is always part of the process, whether it is overtly stated or not. When we speak of safety, we are concerned about the physical safety not only of the client but also of those who may interact with him or her and, just as important, about keeping ourselves safe. Whether by commission or omission, clients often put themselves in hazardous situations as a result of their affective, behavioral, and cognitive reactions to the crisis. Leron's attempt to publicize his plight clearly puts him, the general public, and the officer at risk. While Leron's crisis is with the housing authority, the immediate crisis of Leron in the middle of a main street with two broken whiskey bottles in his hands is a safety issue. Nothing is more paramount in a crisis than ensuring safety.

We have personally known three human services workers who have been killed at the hands of clients in crisis. One of your authors could very easily have been added to that list early in his career when he talked a violent juvenile into handing over a gun pointed a foot from his face. He didn't think the weapon would work. After the youth was taken into custody, blanks were loaded in the gun and it fired very well, to the shock of a shaken 24-year-old junior high school counselor who thought he was immortal! There are no dead heroes in this business, only dead interventionists. We will have a great deal more to say on the subject of the interventionist's safety in Chapter 14, *Violent Behavior in Institutions*.

Generally, when we think about safety in a crisis, we assume that someone is engaging in lethal behavior toward self or others. But limiting the task of ensuring safety to issues of life and death overlooks many clients whose safety is in jeopardy. The fact is that in much crisis intervention people do not intend to cause harm to themselves or others but engage in activities that have a high potential for that to happen. You can extend the task of ensuring safety to include meeting the daily needs of clients such as finding shelter and food.

CIT officer: Leron, I want to keep you safe, man, and the middle of Union Avenue at rush hour is anything but that. I can get you some help not only as far as the housing authority is concerned but also in regard to getting some food in your belly and a roof over your head, but that has to start happening over in my squad car. Otherwise the TAC team will come and take you in to custody and none of that will happen. When did you eat last?

Leron: Don't remember . . . yesterday maybe . . . no, a couple of days ago I think. Got some stuff out of the back of one of them restaurants on Beale Street.

Officer Lewis is working to protect Leron from inadvertently being injured. Food and the offer of shelter are used to entice Leron off the street. This offer makes a clear point that all crisis interventionists need to heed: If a person's basic physical needs are not being met, it is unlikely that the crisis will diminish until those needs are met.

Safety also includes assuring clients that they are psychologically safe. As we shall see in Chapter 9, Sexual Assault, many clients who have been subject to vicious assaults by sexual perpetrators have suffered secondary victimization, being revictimized by authority figures, government bureaucracies, religious entities, social service agencies, and, yes, incompetent therapists (Ochberg, 1988). Making it safe for a client in crisis to trust the interventionist comes before everything else and is a critical part of creating the trust and bond necessary to move forward (Courtois & Ford, 2009). Safety is a default task that is merged and subsumed in all the other tasks in the model, from predispositioning to follow-up.

Tasks 1, 2, 3, and the safety task involve a lot of listening activities, although they are not necessarily passive or devoid of action, particularly when safety issues are involved. Taken together, these four steps most nearly represent what has become known in the field as *psychological first aid* (see Chapter 1).

Task 4. Examining Alternatives

Examining alternatives addresses an area that both clients and workers in crisis intervention often neglect—exploring a wide array of appropriate choices available to the client. In their immobile state, clients often do not adequately examine their best options. Some clients in crisis actually believe there are no options. Clients may develop tunnel vision and become stuck in an endless merry-go-round of attempting to engage in the same futile behavior.

Alternatives can be viewed from three perspectives: (1) **Situational supports** are people known to the client in the present or past who might care about what happens to the client. (2) **Coping mechanisms** are actions, behaviors, or environmental resources the client might use to help get through the present crisis. (3) **Positive and constructive thinking patterns** on the part of the client are ways of reframing that might substantially alter the client's view of the problem and lessen the client's level of stress and

anxiety. The effective crisis worker may think about an infinite number of alternatives pertaining to the client's crisis but discuss only a few of them with the client. Clients experiencing crisis do not need a lot of choices; they need appropriate choices that are realistic for their situation. Some of these coping skills may be already present in the client but under the stress of the crisis may be forgotten or dismissed as ineffective because they were used "back when" or "back there" and are no longer workable in the here and now.

Leron: Used to have money in ma pocket. Had me a car 'n' a house 'n' food on de table. Fok lift op . . . e . . . ray . . . tore and damn good. Could figger stuff out. Fo'man on ma crew. Lotsa ideas 'bout movin' on up, din da compnee go bust. No mo'! Ain't got no job, no skills, no family, no nuthin' ceptin' damn housin' a-tho-it-tee.

CIT officer: Leron, it sounds like right now you're out there all alone against this big monster called MHA. I've got an idea. Okay, so your application for rent reduction got lost in the bureaucracy when you got laid off and they made it sound like it was your fault and blamed you for not submitting it when in fact you did. Your gripes to them haven't gotten you anywhere, and now you want everybody to know that they are trying to weasel out of their mistake. I've got one idea that might help, and that's the pro bono law advocacy student association of the Memphis University Law School. They take on stuff like this. I can take you down there and introduce you to somebody I know there, but I've got another concern. I wonder when was the last time you had something to eat and a place to lay your head down where you felt safe, could get some sleep and get some energy back?

By offering to physically transport Leron to the law school, Officer Lewis indicates that he is involved with Leron beyond his being a nuisance to get off the street. He also makes a hunch about Leron's physical condition, and that hunch segues into one of the most important tasks of crisis intervention, which is safety.

Examining alternatives is literally a "right here, right now" activity. Rapidly changing conditions may mean discarding old options that worked a half hour ago for completely new ones. One of the hallmarks of a world-class crisis worker is the ability to be resilient and rapidly brainstorm new ideas and implement them in a hurry.

CIT officer: (*noticing Leron's unsteady gate*) Leron, how much have you had to drink today?

Leron: 'Bout most of them two bottles.

CIT officer: I can understand why you'd need all that liquid courage to do this. Okay! Maybe we need to think about getting you sober before you talk to anybody down there. What about me taking you out to the Bartlett Salvation Army halfway house, getting some food in your stomach, cleaned up, some sleep so you got it all together and can talk real straight to the folks at the advocacy center.

Task 5. Planning in Order to Reestablish Control

A hallmark of people in crisis is the feeling of the loss of control. Chaos reigns and every effort to manage the situation has failed. Reestablishing control means helping clients create a plan to guide them in the resolution of the crisis. Such a plan needs to consider what options are available to the client and what choices need to be made in regard to those options. One of the primary strategies in planning to reestablish control is mobilizing the client.

The fifth step in crisis intervention, making plans, flows logically and directly from Task 4 alternatives. Much of the material throughout this book focuses either directly or indirectly on the crisis worker's involvement with clients in planning action steps that have a good chance of restoring the client's emotional, behavioral, and cognitive equilibrium. A plan should (1) identify additional persons, groups, and other referral resources that can be contacted for immediate support, and (2) provide coping mechanisms—something concrete and positive for the client to do now, definite action steps that the client can own and comprehend. The plan should focus on systematic problem solving for the client and be realistic in terms of the client's coping ability.

While it may be that crisis workers have to be very directive at times, as much as possible it is important that planning be done in collaboration with clients so that clients feel a sense of ownership of the plan. At the very least, explaining thoroughly what is about to occur and gaining client acquiescence is extremely important. The critical element in developing a plan is that clients do not feel robbed of their power, independence, and self-respect. The central issues in planning are clients' *control* and *autonomy*. The reasons for clients to carry out plans are to restore their sense of control and to ensure that they do not become dependent on support persons such as the worker. It should be emphasized that planning is not what clients are going to do for the rest of their lives. Planning is about

getting through the short term and getting some semblance of equilibrium and stability restored. Most plans in crisis intervention are measured in minutes, hours, and days, not weeks, months, or years.

CIT officer: I can't give you much more time. I gave you a choice. Those alternatives are to do something about the issue rather than going to jail. What do you want to do? I need for you to put those bottles down and walk over here and get in the car. Are you willing to do that and get some help for your problem and some food in your stomach?

Leron: (*hesitates and shrugs; puts bottles down and walks over to the car*) Okay . . . maybe you can get me some help.

(*Next afternoon at the legal aid office.*)

Legal aid worker: Mr. Brown, I believe we can exert some leverage on the housing authority and can make a case for you. This will take at least a couple of weeks, though, and I understand you have nowhere to stay.

(*Officer Lewis before dropping Leron off at the Salvation Army has made a promise to pick him up and take him to the legal aid office.*)

Officer Lewis: Leron, have you thought perhaps you might go over to Arkansas?

Leron: Man, I don't want to be beholden to my mother-in-law. She don't care much for me no how.

Officer Lewis: Well, you don't have a job, so you could go back out to the Salvation Army new halfway house. You'd qualify to get in it based on being out of work and the fact that your use of alcohol helped get you into that predicament.

Leron: Man, I ain't no charity case.

Officer Lewis: I hear that and understand you got your pride, but what about using their job counseling program out there to help you get back to work? I mean it's not like you're going there forever, and you'd be right there if anything comes in. They'd also do some job counseling.

Leron: Well, when you put it that way, could be okay.

Many times in crisis the alternatives are not what the client wants but what is necessary. When Officer Lewis reframes the stay at the Salvation Army as not charity but a way of getting Leron back to work, it becomes much more palatable and makes the alternative a much more positive and desirable one. Being able to reframe the alternative is empowering and one of the key ingredients in getting clients involved and energizing them to move forward.

Psychoeducation. At the time of the first edition of this book in 1987, there was not a great deal of information about many of the maladies in this book. Thus, interventionists didn't have a lot of information to give clients about the psychological course of the aftermath of a crisis. However, in the intervening 28 years, a tremendous amount of reliable and valid information has been discovered about the course of the crises discussed in this book. Giving clients this information, called *psychoeducation*, can be of tremendous benefit in helping them understand what is going on with them psychologically.

Psychoeducation means providing information to victims and survivors about what is happening and is probably going to happen to them psychologically in the aftermath of a traumatic event. Psychoeducation has become an extremely important treatment component in helping people in crisis get control back in their lives, not only in preemptive work such as educating people about suicide, domestic violence, and sexual assault, but also in understanding what happens in the traumatic wake of a crisis such as the terrifying flashbacks and nightmares of PTSD (Briere & Scott, 2006; Courtois, Ford, & Cloitre, 2009; Kleespies, 2009). Psychoeducation is a task in and of itself. However, for the present we have put it under planning because of the critical part it plays in helping to mobilize the client. Psychoeducation means providing clients with information about their condition, what they can expect in the way of affective, behavioral, and cognitive dimensions of it, and how they can develop coping skills to alleviate it.

We would not expect a first grader to have much knowledge or many psychological resources to deal with bullying, so we would be pretty directive in providing the child with information and strategies to deal with it. Likewise, for a person who knew nothing about how to deal with housing bureaucracies, options to get out of an unemployment line, and the common depressive symptoms that might exacerbate those problems into a full-blown crisis, the crisis worker's best treatment option is to start providing information and instructing the client about what needs to be done and how to take care of oneself psychologically while doing it.

Rehabilitation counselor: (at Salvation Army Treatment Center a week later) Leron, we have a lot of information that I believe will help you as far as getting employable is concerned. We also found out that you are most likely clinically depressed. That's important information because it goes a lot toward answering why you have been in such a rut, unable to do much about your problems, and why you wound up in the

middle of the street a frustrated and angry man. We're going to set you up with an appointment to get some medication for that and also to get some counseling. I am going to give you a lot of information on why we think this is a good plan, so if you have any questions, stop me and I'll try and answer them.

Task 6. Obtaining Commitment

The sixth task, obtaining commitment, flows directly from Task 5, and the issues of control and autonomy apply equally to the process of obtaining an appropriate commitment. It may seem like overkill to devote a specific task/step to commitment as opposed to just making it a part of planning. However, getting a specific commitment from a client in crisis to do something differently than what has not been working is a big deal. The commitment step is clear, concise, and behaviorally specific. As a result, it is clear to the client what he or she is going to do and what the worker will do.

CIT officer: So tell me what we're going to do.

Leron: We gonna get out to the Salvation Armee and get me sobered up, din two' morro you gonna come git me 'n' tak me dow to legal aid 'bout 4:30, if'n I git in de polelesse car now and don't be givin' you no mo' trouble.

If the planning step is done effectively, the commitment step is apt to be easy. Many times the commitment step is brief and simple, consisting of asking the client to verbally summarize the plan. Sometimes a handshake may be used to seal the commitment. In some incidents where lethality is involved, the commitment may be written down and signed by both parties. The objective is to enable the client to commit to taking one or more definite, positive, intentional action steps designed to move that person toward restoring precrisis equilibrium. The worker is careful to obtain an honest, direct, and appropriate commitment from the client before terminating the crisis intervention session. No commitment should be imposed by the worker. Commitments should be free, voluntary, and believed to be doable. The core listening skills are as important to the commitment step as they are to the problem definition or any other step. Any hesitation on the part of the client to commit to the plan of action should be reflected and queried by the worker. A worker-imposed plan or commitment will not work.

Task 7. Follow-up

When we speak of follow-up in crisis, we are not talking about days, weeks, or months. Long-term follow-up

after a disaster is a special condition we will deal with in Chapter 17, Disaster Response. We are generally speaking of following up in a time frame of minutes, hours, and days. Follow-up in crisis intervention has to do with keeping track of clients' success in maintaining precrisis equilibrium, not whether they are maintaining long-term goals or changing deep-seated personality traits.

CIT officer: (stopping by Salvation Army halfway house the next day) Leron, glad to see you. You look lots better today. Clean and sober. I checked with the coordinator and they have you set up for some vocational evaluation. While I'm not your social

worker, I did stop by the U of M law students' pro bono advocacy service and they are willing to look into your problem with MHA. I think you can get a voucher here to get a bus down there. You've got my card, let me know if I can do anything for you.

Short-term follow-up is also important as a reinforcing event that tells clients you are still in this with them. Engaging in follow-up is extremely important when clients have little other social support system.

The model of crisis intervention we have been describing in some detail is summarized briefly in Figure 3.1.

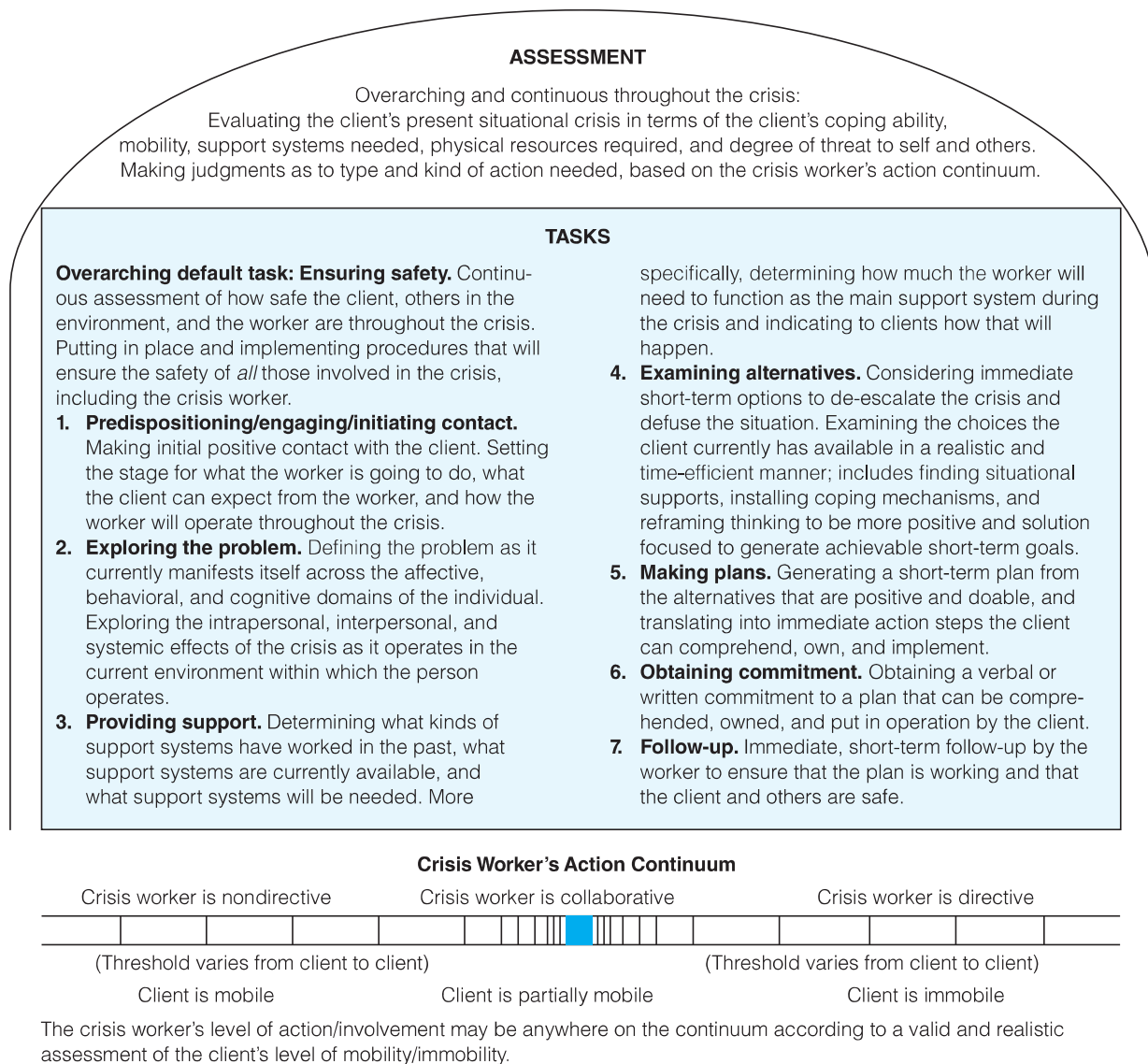


FIGURE 3.1 Model of Triage Assessment Form for Crisis Intervention

CIP-Solutions, June, 2009

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;

Client Name: _____ Time/Date: _____
Crisis Worker: _____ Contact Type: _____ Phone: _____ Office: _____
Field _____
Crisis Event: _____ _____ _____ _____
Disposition: _____ _____ _____ _____

Observations (Check as many that apply)		
☐ off medication* ☐ medication not effective*** ☐ hallucinating*** (___smells___ sights___sounds___touch) ☐ bizarre behavior/appearance ☐ poor hygiene ☐ absurd, illogical speech *** ☐ paranoid/suspicious thoughts *** ☐ flashbacks, loss of reality contact ☐ intoxicated/drugged* ☐ under the influence of mood altering substance ☐ other (explain)	☐ oppositional defiant to verbal suggestions ☐ coercion/intimidation ☐ aggressive gestures * ☐ reckless behavior ☐ self injurious behavior ☐ physically violent * ☐ verbal threats to self or others ☐ suicidal/homicidal thinking/verbalizing ☐ suicidal/homicidal gestures/behaviors * ☐ suicidal/homicidal plan clear *	☐ uncooperative ☐ flat affect ☐ impulsivity ☐ hysterical ☐ confusion ☐ unable to follow simple directions ☐ unable to control emotions ☐ cannot recall personal information (phone, address) ☐ situation perceived as unreal (spectator) ☐ nonresponsive ***
Notes: _____ _____ _____		
*** psychiatric evaluation recommended * hold for law enforcement officers or EMTs		

FIGURE 3.2 Triage Assessment Form for Crisis Intervention.

SOURCE: Compiled from Triage Assessment Form (TAF), Triage Assessment System for Students in Learning Environments (TASSLE), Triage Assessment Checklist for Law Enforcement (TACKLE). Crisis Intervention & Prevention Solutions Inc. Pittsburgh, PA.

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SEVERITY SCALES
Check those that apply

	1 No Impairment	2/3 Minimal Impairment	4/5 Low Impairment	6/7 Moderate Impairment	8/9 Marked Impairment	10 Severe Impairment
A F F E C T I V E	☐ Stable mood, control of feelings. ☐ Feelings are appropriate. ☐ Emotions are under control. ☐ Responses to questions/requests are calm and composed.	☐ Affect elevated but generally appropriate. ☐ Brief periods of slightly elevated negative mood. ☐ Emotions are substantially under control. ☐ Responses to questions/requests are emotional but composed.	☐ Evidence of negative feelings pronounced and increasingly inappropriate. ☐ Duration of feeling intensity longer than situation warrants. ☐ Emotions are controlled but focused on crisis event. ☐ Responses to questions/requests vary from rapid and agitated to slow and subdued.	☐ Feelings are primarily negative and are exaggerated or increasingly diminished. ☐ Efforts to control emotions are not always successful. ☐ Emotions not under control but remain focused on crisis. ☐ Responses to questions/requests are emotionally volatile or beginning to shut down.	☐ Feelings are negative and highly volatile or may be nonexistent. ☐ Extremely limited control of emotions. ☐ Emotions start to generalize from crisis event to other people and situations. ☐ Responses to questions/requests non-compliant due to interference of emotions.	☐ Feelings are extremely pronounced to being devoid of feeling. ☐ No ability to control feelings regardless of potential danger to self or others. ☐ Emotions of the crisis are generalized to other people and situations. ☐ Cannot respond to questions/requests because of interference of emotions.
B E H A V I O R S	☐ Behaviors are socially appropriate. ☐ Daily functioning unimpeded. ☐ Threat or danger nonexistent. ☐ Behavior is stable and non-offensive.	☐ Behaviors mostly effective, outbursts if present are inconsequential. ☐ Can perform tasks needed for daily functioning with minimal effort. ☐ Behavior demonstrates frustration, but is nonthreatening. ☐ Behaviors mostly stable and non-offensive.	☐ Behaviors are somewhat ineffective, yet not dangerous. ☐ Performing tasks needed for daily living minimally compromised. ☐ Behaviors minimal threat to self or others. ☐ Behavior becoming unstable and offensive.	☐ Behaviors are maladaptive but not immediately destructive. ☐ Performance of tasks needed for daily living is noticeably compromised. ☐ Behavior is a potential threat to self or others. ☐ Upon request, behaviors can be controlled with effort.	☐ Behaviors are likely to intensify crisis situation. ☐ Ability to perform tasks needed for daily functioning seriously impaired. ☐ Impulsivity has the potential to be harmful to self or others. ☐ Behaviors are very difficult to control even with repeated requests.	☐ Behaviors are totally ineffective and accelerate the crisis. ☐ Unable to perform even simple tasks needed for daily functioning. ☐ Behaviors are highly destructive possibly to cause injury/death to self or others. ☐ Behavior is out of control and nonresponsive to requests.

FIGURE 3.2 (continued)

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SEVERITY SCALES (continued)

	1 No Impairment	2/3 Minimal Impairment	4/5 Low Impairment	6/7 Moderate Impairment	8/9 Marked Impairment	10 Severe Impairment
C O G N I T I V E	○ Decisions are considerate of others. ○ Decisions are logical and reasonable. ○ Perception of crisis event substantially matches reality. ○ Able to carry on reasonable dialog and understand and acknowledge views of others. ○ Problem solving intact.	○ Decisions may not be considerate of others. ○ Decisions becoming indecisive but only with respect to crisis. ○ Thinking influenced by crisis, but under control. ○ Able to carry on reasonable dialog, understand and acknowledge views of others. ○ Problem solving minimally compromised	○ Decisions are inconsiderate of others. ○ Decisions becoming illogical, unreasonable, and generalized beyond crisis. ○ Thinking focused on crisis but not all consuming. ○ Ability to carry on reasonable dialog restricted and problems in understanding and acknowledging views of others. ○ Problem solving limited.	○ Decisions are offensive and antagonistic of others. ○ Decisions about crisis beginning to interfere with general functioning. ○ Thoughts are limited to crisis situation and are becoming all consuming. ○ Responses to questions and requests are restricted or inappropriate and denies understanding views of others. ○ Problem solving blocked.	○ Decisions have the potential to be harmful to self or others. ○ Decisions are illogical, have little basis in reality, and general functioning is compromised. ○ Thoughts about crisis have become pervasive. ○ Defiant to requests and questions and/or inappropriate with and antagonistic of others. ○ Problem solving ability absent.	○ Decisions are a clear and present danger to self and others. ○ Decision making frenetic or frozen and not based in reality and shuts down general functioning. ○ Thoughts are chaotic and completely controlled by crisis. ○ Requests and questions are believed as threat and responded to aggressively. ○ Problem solving not observable with no ability to concentrate.

CRISIS EVENT

Identify and describe briefly the crisis situation: _____

AFFECTIVE DOMAIN

Identify and describe briefly the affect that is present.

(If more than one affect is experienced, rate with #1 being primary, #2 secondary, #3 tertiary.)

ANGER/HOSTILITY: _____

ANXIETY/FEAR: _____

FIGURE 3.2 (continued)

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CRISIS EVENT (continued)

SADNESS/MELANCHOLY: _____

FRUSTRATION: _____

BEHAVIORAL DOMAIN

Identify and describe briefly which behavior is currently being used.

(If more than one behavior is utilized, rate with #1 being primary, #2 secondary, #3 tertiary.)

APPROACH: _____

AVOIDANCE: _____

IMMOBILITY: _____

COGNITIVE DOMAIN

Identify if a transgression, threat, or loss has occurred in the following areas and describe briefly.

(If more than one cognitive response occurs, rate with #1 being primary, #2 secondary, #3 tertiary.)

PHYSICAL (food, water, safety, shelter, etc.): _____

Transgression_____ Threat_____ Loss_____

PSYCHOLOGICAL (self-concept, sense of emotional well-being, ego integrity, self-identity, etc.): _____

Transgression_____ Threat_____ Loss_____

SOCIAL RELATIONSHIPS (positive interaction and support, family, friends, coworkers, church, clubs, etc.): _____

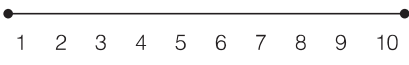
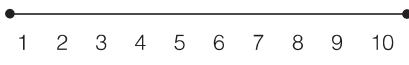
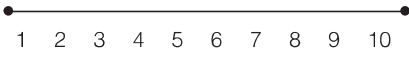
Transgression_____ Threat_____ Loss_____

MORAL/SPIRITUAL (personal integrity, values, belief system, spiritual reconciliation): _____

FIGURE 3.2 (continued)**Digital Download** [Download at CengageBrain.com](https://www.cengagebrain.com)

CRISIS EVENT (continued)

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

Affective ___ Anger ___ Fear ___ Sadness 	Behavioral ___ Approach ___ Avoidance ___ Immobile 
Cognitive ___ Transgression ___ Threat ___ Loss 	
_____ 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

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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 persevere 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

Although psychobiological assessment for **104** 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*	☐ aggressive gestures	☐ hysterical*
☐ hallucinating† (☐ smells	☐ physically violent†	☐ confusion*
☐ sights ☐ sounds ☐ touch)	☐ verbal threats to self or others	☐ unable to follow simple directions*
☐ bizarre behavior/appearance	☐ suicidal/homicidal thinking/ verbalizing*	☐ unable to control emotions
☐ poor hygiene	☐ suicidal/homicidal gestures/ behaviors†	☐ cannot recall personal information* (phone, address)
☐ absurd, illogical, nonsensical speech	☐ suicidal/homicidal plan clear†	☐ situation perceived as unreal* (spectator)
☐ paranoid/suspicious thoughts	☐ uncooperative	☐ nonresponsive*
☐ flashbacks, loss of reality contact*	☐ reckless behavior	
☐ intoxicated/drugged*	☐ impulsivity	
☐ possible developmental disability		

*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.

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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 & Co-meau, 2014; Bovin, Ratchford, & Marx, 2014; Burgess-Watson, Hoffman, & Wilson, 1988; Scaer, 2014; van der Kolk, 1996b). Client education about the psychological 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

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

LO5

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.

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Crisis of Lethality

Background

In crisis work the possibility of dealing with suicidal and/or homicidal clients is always present. Thus, in Chapter 3 the importance of the crisis worker's continuous awareness and assessment of risk level for all clients in crisis was emphasized. In this chapter strategies are presented to help crisis workers strengthen their skills in assessing, counseling for, intervening in, and preventing lethal behavior, with the major emphasis on suicide. While this chapter's focus on lethal behavior is mainly concerned with the intent to harm oneself, others may not be exempt from harm. Sometimes an individual in crisis may be homicidal and target a specific victim or random victims. These homicides are not about the criminal who murders a shopkeeper in a holdup or the wife who kills her husband for insurance or to be able to marry another person; those are **instrumental acts of homicide** that occur for some financial or other concrete gain. Rather, a suicidal/homicidal person in this chapter is one who is engaged in an **expressive act of homicide** designed to reduce psychological pain. Such suicidal/homicidal people are likely to be emotionally distraught, may feel gravely wronged, depressed, helpless, disempowered, and hopeless, and may attempt to solve their own dilemmas through harm to others and then to themselves.

According to Edwin Shneidman, the founder of suicidology, "Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution" (Shneidman, 1999a, p. 155) and who falls into a category of intense and unendurable psychological pain that is caused by unfulfilled psychological needs (Shneidman, 2001, p. 203). To Shneidman's definition should be added "or the murder of significant others."

LEARNING OBJECTIVES

After studying this chapter, you should be able to:

1. Understand the scope of suicide.
2. Understand the moral issues surrounding suicide.
3. Know and understand different theories and models of why people commit suicide.
4. Know the common characteristics of people who commit suicide.
5. Know the common characteristics of people who commit suicide/homicide.
6. Know the myths that surround suicide.
7. Know clues and factors that predispose suicide.
8. Know and understand suicide intervention strategies.
9. Know and understand how crisis management for suicide works.
10. Be familiar with the dos and don'ts of suicide case management.
11. Understand what a psychological autopsy is and why it is used.
12. Understand the reasons for postvention after a completed suicide.
13. Understand the crisis worker's own issues after losing a person to suicide.

The Scope of the Suicide Crisis

As with other maladies discussed in this **LO1** book, suicide has its own mind-numbing statistics. On a worldwide basis, about 1 million people kill themselves each year, or about one every 40 seconds. Worldwide suicide rates have increased about 60% in the last 45 years. Eastern European countries, particularly in the Baltic Sea area, are the leaders along with Hungary (World Health Organization, 2011). In the United States, 30,000 to 35,000 people kill themselves every year (Centers for Disease Control and Prevention, 2008; U.S. Department of Health and