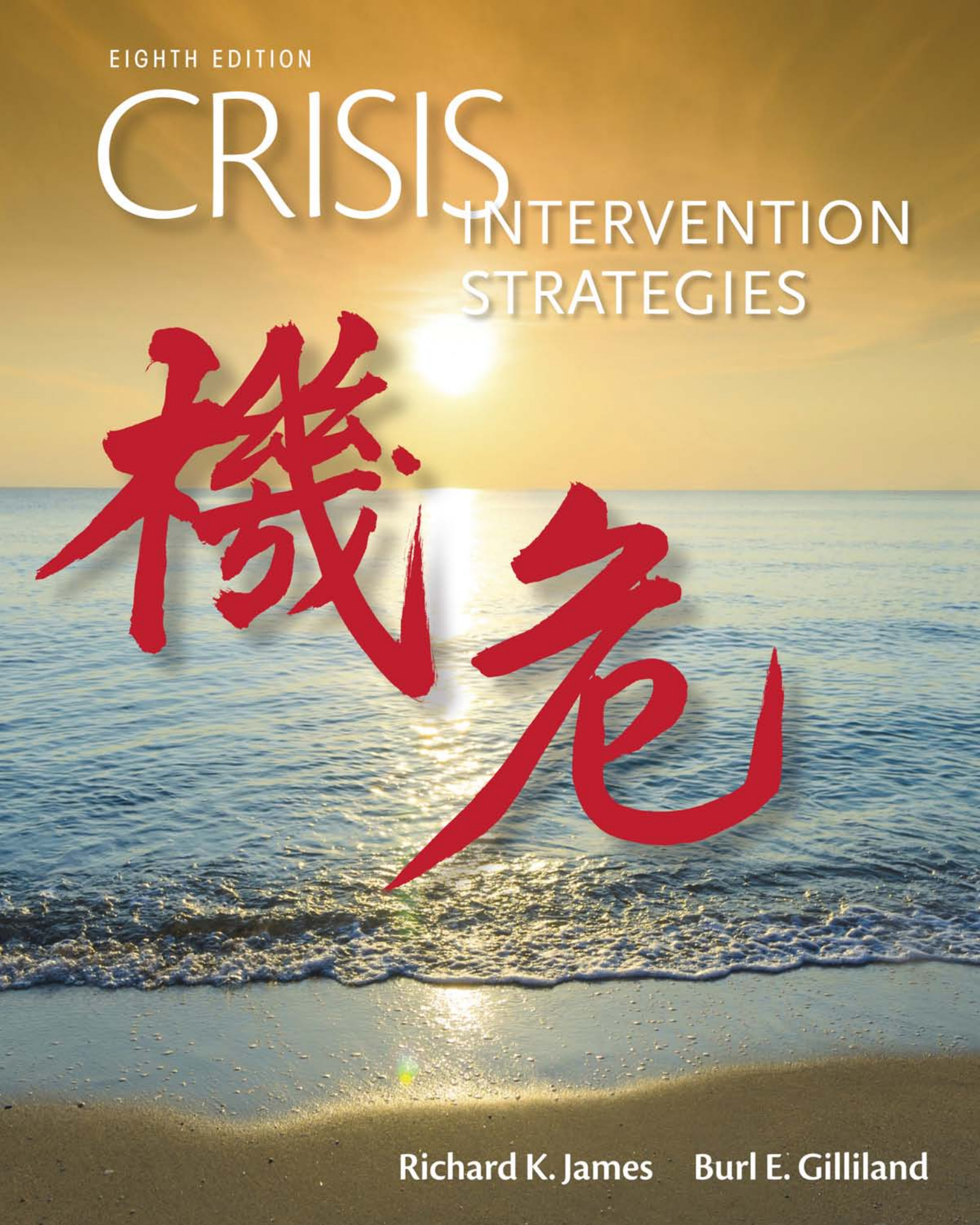
EIGHTH EDITION
CRISIS
INTERVENTION
STRATEGIES
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Richard K. James
Burl E. Gilliland

Crisis Intervention Strategies Eighth Edition

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In the spring of 2015, I was honored by my undergraduate and master's degree alma mater, Eastern Illinois University, with a lifetime achievement award. In my acceptance speech, I spoke to the writing, research, and service paths that led to that award. But I also spoke to something much more important than those "things" I did. Indeed, it is what I believe has been my greatest achievement in 50 years of doing counseling and teaching and is best represented by two people who attended that ceremony. I would like to introduce them to you now and say why this book is dedicated to them.

First is Steve Allen, Ed.S., who was an intern of mine in 1973–74 in the Title III ESEA Intensive Care Unit innovative education program for socially and emotionally maladjusted children in Mattoon, Illinois. Of the roughly hundred interns I have supervised, Steve was the best. Steve went on to become a world class K–12 school counselor in rural east-central Newman, Illinois. He garnered enough well deserved honors and recognition over the course of his career to also be recognized by Eastern Illinois University as a lifetime achievement recipient for the work he has done in innovative teaching, counseling, and educational practices.

The second person is Kay Dorner, Ph.D., who was a junior high school student I counseled in Mattoon, Illinois, in 1968. Kay has had a distinguished career as a psychologist in private practice and as an administrator in high schools in California and Oregon. Among her noteworthy achievements has been the principalship of a Bill and Melinda Gates small school grant to establish Technology High School in Rohnert Park, California. She is presently working as a school psychologist in Central Point, Oregon.

But those are not the reasons this eighth edition is dedicated to these two outstanding therapists and educators. The real reason is that both of these individuals have fought through many of the crises' snares and traps in this book that could have easily defeated them. Put in life's furnace and fired, they came out tempered steel. Many in their place would have turned to cinders and burned up. Neither Steve nor Kay did and, in fact, they grew stronger from the adversity they have faced.

I am honored and humbled that both of these fine people believe that I have had some influence on their lives by counseling and teaching them. Both of them have felt indebted to me, but it is really I who am indebted to them for what they have become and I have become with them. They have repaid the debt they felt they owned me for that counseling and teaching back in the 1960s and 1970s over and over with the many lives they have touched and changed for the better. They are my legacy and best epitaph. They have, indeed, paid it forward.

My fervent hope for any of you neophytes starting out in this business is that you can also manifest the sterling character, strength, compassion, skills, resiliency, and empathy that these two professional human services workers possess and continue to pay forward in 2015. If this book helps you in some way to do that, then I have done my job.

Dick James
Professor of Counselor Education
University of Memphis

Brief Contents

Contents

Preface

Rationale for the Book

The Primacy of Crisis Intervention

The Chinese characters embedded in the front of the book and the beginning of each chapter symbolize both "danger" and "opportunity!" That is the essence of *crisis*—the human dilemma that is common to all cultures. We believe that practically all counseling is initiated as crisis intervention. As much as the helping professions would prefer otherwise, people tend either to avoid presenting their problems to a helper until those problems have grown to crisis proportions, or become ensconced in situational dilemmas that wind up in unforeseen crises. Our ideal objective, as human services workers, is to establish primary prevention programs so effective that crisis intervention will seldom be needed. However, it appears that people will not be as quick to adopt preventive measures for their psychological health as for their physical health.

The Case for an Applied Viewpoint

The materials and techniques we promote in this book come from two sources: first, the authors' own experiences in teaching and counseling in crisis situations; second, interviews with people who are currently in the trenches, successfully performing counseling and crisis intervention. We have obtained input from many different individuals in the helping professions, whose daily and nightly work is dealing directly with human dilemmas, and related their views to the best of current theory and practice from the professional literature. Through many hours of dialogue, these experts have provided the most contemporary strategies and techniques in use in their particular fields. They have also reviewed the content on each crisis category and have provided much helpful commentary and critique of the ecology and etiology, tactics and procedures, terminology, and developmental stages of the specific crises with which they work. Therefore, what you read in the case-handling strategies comes directly from the horse's mouth.

Where controversies exist in regard to treatment modalities this text attempts to present as many perspectives as possible. Dr. Gilliland has been dead for 13 years, so if you encounter problems with the tactics and techniques presented in the current edition, the fault is undoubtedly in Dr. James's rendition of the current research and therapeutic modalities.

The authors have endeavored to incorporate, synthesize, and integrate the case-handling strategies of these resource people in a comprehensive, fluid, and dynamic way that will provide crisis workers with a basic set of tenets about effective crisis intervention. This book is not about long-term therapy or theory. Neither is it a volume dealing with crisis from only one theoretical perspective, such as a psychoanalytic approach or a behavioral system. The book incorporates a wide diversity of therapeutic modalities and reflects our eclectic and integrated approach to crisis intervention.

Specific crises demand specific interventions that span the whole continuum of therapeutic strategies. The strategies present in this book shouldn't be construed as the only ones available for a particular crisis. They are presented as "best bets" based on what current research and practice indicate to be appropriate and applicable. Yet these strategies may not be appropriate for all practitioners with all clients in all situations.

Good crisis intervention, as well as good therapy of any other kind, is a serious professional activity that calls for creativity and the ability to adapt to changing conditions of the therapeutic moment. To that extent,

crisis intervention at times is more art than science and is not always prescriptive. Therefore, we would caution you that there are no clear-cut prescriptions or simple cause-and-effect answers in this book.

The Case for an Experiential Viewpoint

The fact that no single theory or strategy applies to every crisis situation is particularly problematic to those who are looking for simple, concrete answers to resolve the client problems they will face. If you are just beginning your career in the human services, we hope that while reading and trying out activities in this book you will suspend your judgment for a while and be open to the experience as you read about crisis workers attempting to implement theory into practice.

Moral Dilemmas. Another issue that permeates many of the topics covered in this book is the emotions they generate and the beliefs about what is morally "right" and what is morally "wrong" that pervades them. People have been willing to go to prison or die because of the strong beliefs they held about many of these topics. Where such moral issues and beliefs abound, we have attempted to deal with them in as even-handed a manner as possible. This book is not about the morality of the issues covered, but rather about what seems to work best for the people who are experiencing the dilemma. We ask you to read the book with that view in mind, and for at least a while, suspend your moral view of the situation or problem as you read about crisis workers attempting to grapple with these heart- and gut-wrenching problems.

Finally, because of a virtually unlimited supply of different crises situations, we have had to make tough decisions about what kinds of problems to illustrate in the most *generic and comprehensive way possible* so as to reach the broadest possible audience. We understand and empathize very deeply with readers who may have suffered terrible crises that are not mentioned in this book and are puzzled, chagrined, and angry that we have not given space and time to the particular crisis that they have suffered through. For that we apologize. The space available means that we simply cannot include all situations. However, what we the authors would like you to do rather than rail at our callous treatment in ignoring your particular dilemma, is to imagine how the strategies and techniques you are reading about might apply to the particular crisis you have experienced. Hopefully, what we say about those crises may help you come to understand the dynamics of your own a bit better.

Basic Relationship Skills. The listening and responding skills described in Chapter 3 are critical to everything else the worker does in crisis intervention. Yet on cursory inspection these techniques and concepts may seem at best simplistic and at worst inane. They do not appear to fix anything because they are not "fixing" skills. What they do is give the crisis worker a firm basis of operation to explore clearly the dilemma the client is facing. Basic listening and responding skills are the prerequisites for all other therapeutic modalities.

Our experience has shown us over and over that students and trainees who scoff at and dismiss these basic relationship skills are the ones who invariably have the most trouble meeting the experiential requirements of our courses and workshop training sessions. We feel very strongly about this particular point and thus ask you to read Chapter 3 with an open mind. Much the same can be said about Chapter 4, The Tools of the Trade. Students and veterans who operate out of a client-centered mode may find what we are proposing pretty close to heresy because a lot of these tools are directive and judgmental as to the action to be taken, particularly when client safety is concerned. Again we ask you to suspend judgment and give these tools a good tryout in this new venture.

Role Play. If this volume is used as a structured learning experience, the case studies in each chapter are a valuable resource for experiential learning. So are the exercises your instructor will give you as well as the videos. It is essential that you observe effective crisis intervention models at work and then follow up by actually practicing and enacting the procedures you have observed. Intensive and extensive role play is an excellent skill builder. A critical component of training is not just talking about problems but practicing the skills of handling them as well. Talking about a problem is fine, but attempting to handle a live situation enables the trainee to get involved in the business of calming, defusing, managing, controlling, and motivating clients. Role play is one of the best ways of practicing what is preached, and it prepares human services workers for developing creative ways to deal with the variety of contingencies they may face. Role play gives human services workers the chance to find out what works and doesn't work for them in the safety of a training situation and affords their fellow students and trainees an opportunity to give them valuable feedback.

A major problem in role playing is the perception of standing up in a class or workshop and risking making a complete fool of oneself. We want to assure

you that in our classes and training sessions we don't expect perfection. If our students and trainees were perfect at crisis intervention, they wouldn't be taking instruction from us in the first place! Therefore, put your inhibitions on the shelf for a while and become engaged in the role plays as if the situations were real, live, and happening right now. Further, be willing and able to accept critical comments from your peers, supervisors, or instructors. Your ego may be bruised a bit in the process, but that's far better than waiting until you are confronted with an out-of-control client before you think about what you are going to do. Over and over, our students report that this component of instruction was the most profitable to them and was also the most fun!

Give the exercises that go with each chapter your best effort, process them with fellow students or trainees, and see what fits best with your own feelings, thoughts, and behaviors. Many times our students and trainees attempt to imitate us. Although it is gratifying to see students or trainees attempting to be "Dr. J.," it is generally an exercise in futility for them. What they need to do is view us critically as we model the procedures and then incorporate their own style and personhood into the procedures. We would urge you to do the same.

Some of these chapters are REALLY long. We didn't put all that "stuff" in there to beat you to death with verbiage. We did it because the field of crisis keeps expanding rapidly as does the knowledge base. Therefore you need to know "the stuff" to do your job effectively. If you just watch the PowerPoint presentations, you might get enough knowledge to pass your instructor's tests. However, you won't know enough though to help your client or yourself when you get in a tight spot. So read, read, read.

Finally, if you are never, ever going to be a crisis interventionist, but a "consumer," this book still can be very useful. Sad to say, but just through living, you are going to encounter a lot of crises in this book that are going to afflict you, your loved ones, your friends, your workplace and the ecosystem in which you live. To that end, this book can give you the basic knowledge to deal with the crisis or know when it's time to get help.

Organization of the Book

Part One, Basic Training

Part 1 of the book introduces the basic concepts of crisis intervention as well as telephone and online crisis counseling. It comprises Chapters 1 through 6.

Chapter 1, Approaching Crisis Intervention. Chapter 1 contains the historical background, basic definitions, and the theoretical and conceptual information needed for understanding applied crisis intervention.

Chapter 2, Culturally Effective Helping in Crisis. Chapter 2 is concerned with how crisis and culture interact. Dealing effectively with people from diverse backgrounds who are undergoing a crisis or have survived a disaster mandates an understanding and sensitivity to multicultural issues. What are called "social locations" for both worker and client play a major role in crisis intervention work. A new derivation of those social locations, called SAFETY locations, has been formulated to specifically deal with a person in crisis.

Chapter 3, The Intervention and Assessment Models. Chapter 3 introduces the task model for crisis intervention as well as the triage assessment system for rapidly assessing the severity of the crisis in a multidimensional way in real time.

Chapter 4, The Tools of the Trade. Chapter 4 introduces the basic communication techniques and skills applied to crisis intervention. It also details the strategies used to attack various kinds of problems that hinder individuals as they attempt to resolve the crisis and details how crisis workers operate on the directive–nondirective action continuum.

Chapter 5, Crisis Case Handling. Chapter 5 is an overview of how crises are handled. Long-term therapy is compared with crisis intervention. Different venues where crisis intervention operates are explored to give an overview of the general tactics and strategies that are used.

Chapter 6, Telephone and Online Crisis Counseling. The majority of crisis intervention is still done on the telephone by trained volunteers. However, with the advent of the Internet and social media, more and more crisis intervention is being done online. Chapter 6 explores the issues and techniques that are involved in these two mediums of crisis communication.

Part 2, Handling Specific Crises: Going into the Trenches

Part 2 (Chapters 7 through 13) addresses a variety of important types of crises. For each chapter in Part 2 the background and dynamics of the particular crisis type are detailed to provide a basic grasp of the driving forces behind the dilemma. Although some theory is present to highlight the therapeutic modalities

used, comprehensive theoretical systems are beyond the scope of this book. For sources of that information, turn to the reference section at the end of each chapter.

In Part 2 we provide scripts from real interventions, highlighted by explanations why the crisis workers did what they did. Throughout this section techniques and cases are used to support live tryout, experiencing, and processing of the cases and issues in each chapter.

Chapter 7, Posttraumatic Stress Disorder. Chapter 7, Posttraumatic Stress Disorder (PTSD), is the linchpin chapter of this section. Many of the following chapters will have problems that may be the precursors of PTSD, or alternatively, represent the manifestation of it. This chapter examines both adults and children who have suffered traumatic experiences and are in crisis because of them.

Chapter 8, Crisis of Lethality. Chapter 8 focuses on strategies that crisis workers need in working with people who are manifesting lethal behavior. Suicidal and homicidal ideation flows through many other problems that assail people the human services worker is likely to confront and is a consideration for all providers of crisis intervention services both in regard to the safety of those clients and keeping the interventionists safe.

Chapter 9, Sexual Assault. Chapter 9 addresses another societal crisis that practical every human services worker will eventually encounter—clients who have either experienced or been affected by sexual assault. Sexually assaulted clientele are a special population because of the negative moral and social connotations associated with the dehumanizing acts perpetrated on them. This chapter is in three parts. First, it details crisis intervention techniques in the immediate aftermath of sexual assault on adults. Second, the chapter examines the long-term traumatic wake adult survivors of sexual abuse experienced in childhood. Third, the chapter details intervention techniques with children who have suffered sexual abuse and the family systems they live in.

Chapter 10, Partner Violence. Chapter 10 deals with a crisis that many people in a domestic relationship face: being treated violently by their partners. This chapter provides strategies to help people who are suffering abuse in *any kind of domestic relationship*. The chapter also deals with emerging treatment techniques for the batterers themselves.

Chapter 11, Family Crisis Intervention. Chapter 11 is a new chapter that deals with the whole family as they seek to navigate the family system through a crisis. This chapter also introduces spiritual and religious components in the intervention process and the part they play in it.

Chapter 12, Personal loss: Bereavement and Grief. Chapter 12 presents a type of crisis that every person will sooner or later face: personal loss. Even though the phenomenon of loss has been with us as long as the human species has existed, many people in our contemporary culture are poorly prepared and ill-equipped to deal with it. This chapter examines a variety of loss models and looks at different types of losses. This chapter also provides models and strategies for coping with unresolved or complicated grief.

Chapter 13, Crises in Schools. Schools have become a focal point for the violence perpetrated by gangs and disenfranchised and socially isolated children and adolescents. This chapter will examine crises as it impacts schools from preschool through higher education. It will examine what crisis workers need to do in assessing, screening, and working with the potentially violent individual student who is estranged from the social mainstream of the school. It will also deal with what the crisis worker needs to know in dealing with suicide, a problem that has become endemic in youth. This chapter will detail how and what goes into making up a crisis response team for a school building and system and how and what they respond to when a crisis occurs.

Part 3, On the Homefront: Crisis in the Human Services Workplace

Part 3 (Chapters 14 through 16) concentrates on the problems of crisis workers themselves and their employing institutions.

Chapter 14, Violent Behavior in Institutions. Chapter 14 tackles the little publicized, and badly neglected, type of crisis that workers in many institutions face daily: violent behavior within the walls of the institution. Regardless of the organizational settings where they are employed, workers will find in this chapter useful concepts and practical strategies that they and the institution can put to immediate use with agitated and potentially assaultive clients.

Chapter 15, Legal and Ethical Issues on Crisis of Trauma. Legal and professional ethical standards for the practice of psychotherapy have been in existence for

over 50 years. Those laws and standards were intended for in-house, stabile, therapeutic settings. With the advent, growth, and maturation of crisis intervention services, these laws and standards are not always amenable to crisis situations. Another complicating factor in the ethical dilemmas that abound in crisis situations are the moral and political dilemmas that often go hand in hand with them. Those two issues are rarely mentioned in standard legal and ethical texts, but they almost always exist in some degree and form in crisis.

Chapter 16, Human Services Workers in Crisis: Burnout, Vicarious Traumatization, and Compassion Fatigue. Chapter 16 is about you and all human services workers who are in the helping professions. No worker is immune to stress, burnout, and the crises that go with human services work. This fact is particularly true in crisis work. This chapter should prove invaluable information for any worker anywhere whose work environment is frenetic and filled with crisis intervention or whose personality tends to generate compulsive behavior, perfectionism, or other stressors that may lead to burnout.

Part 4, No Man's Land: Facing Disaster

Part 4 focuses on an ecosystem view of crisis and crisis intervention in large-scale disasters.

Chapter 17, Disaster Response. Chapter 17 explores the theoretical basis and operating paradigm for large-scale disasters through an ecosystemic viewpoint. It details a family as they experience a natural disaster and how they interact with a variety of crisis workers, and the services the workers provide for the family as they move through postdisaster events over a course of a year. Finally, the chapter highlights the personal impact of large-scale disasters and the experiences of crisis workers who were involved with them at the scene of the disaster.

Online Chapters

Chapters 18 and 19 are available through MindTap; see the section below for more information.

Online Chapter 18, Chemical Dependency: The Crisis of Addiction. Addiction to substances is one of the most pressing issues of our time. Because chemical addiction is such a pervasive scourge in our society, no human services worker in the public arena can escape dealing with its effects. Crises of codependency and the long-term effects of substance abuse that create crises in the lives of adult children of addicts are also examined in this chapter.

Online Chapter 19, Crisis/Hostage Negotiation. This chapter presents another issue that human services workers pay little attention to, until it happens to them. The taking of hostages has become well publicized through terrorism and other acts violence. However, many hostage takings occur within the confines of human services work settings. This chapter provides basic crisis negotiation strategies and survival techniques that may enable a human services worker to contain and survive a hostage situation.

In summary, we have not been as concerned with intellectualizing, philosophizing, or using theoretical interpretations as with simply focusing on practical matters of how to respond in crisis situations as a way of giving you an understanding of some of the general types of crises you will face and the basic skills you will need to do something about them.

Supplementary Materials

This text is accompanied by several supporting products for both instructors and students.

MindTap

MindTap for *Crisis Intervention Strategies*, 8th ed., engages and empowers students to produce their best work—consistently. By seamlessly integrating course material with videos, activities, apps, and much more, MindTap creates a unique learning path that fosters increased comprehension and efficiency.

For students:

- MindTap delivers real-world relevance with activities and assignments that help students build critical thinking and analytic skills that will transfer to other courses and their professional lives.
- MindTap helps students stay organized and efficient with a single destination that reflects what's important to the instructor, along with the tools students need to master the content.
- MindTap empowers and motivates students with information that shows where they stand at all times—both individually and compared to the highest performers in class.

Additionally, for instructors, MindTap allows you to:

- Control what content students see and when they see it with a learning path that can be used as is or matched to your syllabus exactly.
- Create a unique learning path of relevant readings and multimedia and activities that move students up the learning taxonomy from

basic knowledge and comprehension to analysis, application, and critical thinking.
- Integrate your own content into the MindTap Reader using your own documents or pulling from sources like RSS feeds, YouTube videos, websites, Googledocs, and more.
- Use powerful analytics and reports that provide a snapshot of class progress, time in course, engagement, and completion.

Online Instructor's Manual

The Instructor's Manual (IM) contains a variety of resources to aid instructors in preparing and presenting text material in a manner that meets their personal preferences and course needs. It presents chapter-by-chapter suggestions and resources to enhance and facilitate learning.

Online Test Bank

For assessment support, the updated test bank includes true/false, multiple-choice, matching, short answer, and essay questions for each chapter.

Cengage Learning Testing Powered by Cognero

Cognero is a flexible, online system that allows you to author, edit, and manage test bank content as well as create multiple test versions in an instant. You can deliver tests from your school's learning management system, your classroom, or wherever you want.

Online PowerPoint

These vibrant Microsoft® PowerPoint® lecture slides for each chapter assist you with your lecture by providing concept coverage using images, figures, and tables directly from the textbook.

Acknowledgments

In writing a book that covers so many diverse areas of the human condition, it would be extremely presumptuous of us to rely solely on our own expertise and theories of truth, beauty, and goodness to propose crisis intervention techniques as the one true path of enlightenment to dealing with crises. We decided that the only realistic way to present the most current, reliable, and practical techniques to crisis intervention would be to go straight to the people who do this work day in and day out. They are not "big names," but rather people who go methodically about the business of crisis intervention daily in their respective venues. They work in such diverse occupational roles as ministers, police officers, psychologists, social workers, psychiatrists, nurses, marriage and family counselors, correction counselors, and school counselors. They work in every kind of agency and institution that deals with people and their dilemmas. They range geographically from across the United States to across the world. They are an encyclopedia of practical knowledge, and we are deeply in their debt for the help, advice, time, interviews, and critique they have given us. This book would not be possible without their assistance and we thank them one and all.

We would also like to thank the students in our crisis intervention classes at the University of Memphis. If you watch the videos that accompany this text, you are going to meet some of them up close and personal—both as crisis interventionists and wild and crazy clients! You will see that they are not perfect as rookies, but they are pretty darn good. They had fun doing the videos and hope you will have as much fun practicing these skills as they did. Thus, we want you to know we appreciate you deeply and have stood in awe and admiration in regard to how many of you have gone on to excel in this field.

Finally, we extend our grateful appreciation to the following professionals who have served as our editors and other gophers: Julie Martinez, Product Manager; Elizabeth Momb, Content Developer; Mary Noel, Content Development Manager; Stephen Lagos, Product Assistant; Vernon Boes, Sr., Art Director; and Rita Jaramillo, Sr. Content Project Manager. They practiced their own crisis intervention skills when we have become oppositionally defiant to written comments and suggestions.

PART 1

Basic Training
Crisis Intervention Theory and Application

Part 1 introduces you to the fundamental concepts, theories, strategies, and skills needed to understand and conduct effective crisis intervention. Chapter 1 presents a brief historical overview of the field and introduces the conceptual dimensions of crisis work. Chapter 2 deals with the ecosystemic and multicultural considerations involved in providing crisis intervention. Chapter 3 serves as a key to the application of assessment and intervention strategies in crisis intervention. Chapter 4 describes the basic skills and techniques crisis interventionists use. Chapter 5 explains the major components of effective case management in crisis intervention. Chapter 6 discusses two of the main ways that crisis intervention is delivered—by telephone and Internet.

Approaching Crisis Intervention 1

LEARNING OBJECTIVES

After studying this chapter, you should be able to:

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

A Brief History of Crisis Intervention

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

The First Crisis Line. Suicide prevention is probably the longest running intervention program in which individual crisis is addressed from a mental health standpoint. The first identifiable crisis phone line was established in 1906 by the National Save-a-Life League (Bloom, 1984). Dr. Edwin Shneidman's (2001) landmark research into the causes of suicide, which started in the 1950s, has spanned six decades. Suicide has achieved such importance that it has become an "ology" and has a national association devoted to its study.

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

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

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

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

How could this happen with such good intentions of the Community Mental Health Act? One of the overarching tenets of crisis intervention that flows through every theoretical model is the concept of support. When familial supports either wear down and out or were never there in the first place, when no medical professional is there to monitor medication, when mental health clinics are underfunded and overwhelmed with clients, and when little vocational opportunities or rehabilitation counselors are available, persons who are mentally ill become the "crazy" panhandler you are bothered by when you are on the streets of a big city. As a result of this evolution in mental health care (or the lack of it), it should not be surprising that a great deal of crisis intervention is now done on the streets and in the homes of local communities. What might surprise you is that a lot of it is being done by police officers.

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

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

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

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

Grassroots Movements

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

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

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

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

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

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

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

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

The Importance of Volunteerism

Contrary to the popular misconception that paid veteran crisis workers descend on a large-scale disaster like smoke jumpers into a forest fire, most crisis intervention in the United States is done by volunteers. Volunteer workers perform all kinds of services in most crisis agencies—from menial chores to answering the phone to frontline crisis intervention with clients. Volunteerism is often the key to getting the fledgling crisis agency rolling. The use of trained volunteers as crisis workers has been a recognized component of many crisis centers and agencies for years (Clark & McKiernan, 1981; Roberts, 1991, p. 29; Slaikeu & Leff-Simon, 1990, p. 321). Probably the greatest number of frontline volunteers are used in staffing 24-hour suicide hotlines in major cities. Such hotlines require an enormous number of crisis workers because the crisis service never ceases—it must be provided 7 days a week, 52 weeks a year. Roberts (1991, p. 29) reported that more than three quarters of all crisis centers in the United States indicate that they rely on volunteer crisis workers and that such volunteers outnumber professional staff by more than 6 to 1. Typically, as the numbers and needs of the clientele increase, the agency reaches the point where compassion and volunteerism alone cannot handle all of the complex personal, social, economic, public relations, psychological, and political problems that assail it.

The Need for Institutionalism

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

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

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

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

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

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

The Media and the Societal Impetus for Crisis Intervention

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

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

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

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

The Case Against Too Much "Helping"

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

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

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

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

Definitions of Crisis

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

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

Individual Crisis Definitions

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

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

Behavioral Emergencies

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

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