CHAPTER 1

Crisis Intervention
An Overview

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Crisis has been no stranger to civilization since the time humans first roamed the earth. Some of the most intense crises have involved situations from natural disasters, pandemics, and wars, to illicit drug and alcohol abuse, physical and mental illness, suicides, and homicides. While the magnitude and frequency of crisis situations may vary, their occurrence in general remains consistent. If anything has changed over time, it is the perception of crises and with how they are dealt. Because of the soaring number of crisis situations, our world is in need of more effective interventions than ever before.

The term *crisis* generally evokes an image of any one of a number of extreme negative life events. Catastrophic disasters, terrorist attacks, overwhelming lack or manipulation of resources, rapes and other sexual violence, illness, and devastating loss, all by their very nature involve situations of life-threatening proportions. The images and stories of the victims of these terrible crises strike to the core of all of us. Nowhere does this ring truer than when watching the global events involving storms, fires, war-torn nations, abuses of human rights, and recent to the publication of this volume, the effects of a global pandemic, which knocked our world on its side with a worldwide death toll exceeding 15 million and counting (Associated Press, 2022). However, a crisis may also relate to circumstances or experiences that threaten one's home, family, property, health, or sense of well-being. A psychological crisis may involve a loss or threat of a loss or a radical change in one's relationship with oneself or with some significant other (Goldenberg, 1983). For a child, it may involve a sudden relocation of their home to another state and saying goodbye to friends. For an adolescent, it may be the breakup of a romantic relationship or being ostracized by one's peers, cyberbullying, or even an unrelenting condition of acne. What generates, or fuels, a crisis is not simply defined by a particular situation or set of circumstances but rather by the individual's perception of the event and their ability (or inability) to effectively cope with that circumstance. In the same situation, different individuals deal with the potential crisis with varying

degrees of competence or success. Simply stated, crisis results when stress and tension in an individual or family's life mount to unusual proportions and take a significantly negative toll on them (Greenstone & Leviton, 1993). Losing one's footing while trying to cope with a major setback leads to a crisis situation. What's more, crises can strike anyone without warning, which makes them all the more emotional.

History of Crisis Intervention

Historically, the concept of crisis intervention for individuals dates to the Lemberger Freiwillige Rettungsgesellschaft (Lemberg Rescue Society) organized in Vienna in the latter part of the 19th century (1883–1906). In 1906, the Anti-Suicide Department of the Salvation Army was organized in London, and the National Save-a-Life League was set up in New York City (Farberow & Schneidman, 1961). Crisis counseling was developed during World War II, when psychologists and psychiatrists, who were working near the battlefield, saw cases of extreme "battle fatigue" (*shell shock* in World War I; *posttraumatic stress disorder* [PTSD] in subsequent wars and conflicts). They found that dealing with the crisis close to the front line rather than being sent back to a rear-area hospital was helpful for some of the war personnel. The intervention that was used at that time took a focused approach. The goal was to return the soldier who suffered stress to active duty as quickly as possible. In fact, this is where group treatment became popular. Because there was such a large number of distressed soldiers, they had to be treated in groups (Dattilio, 1984).

With the opening of the Suicide Prevention Center in Los Angeles in the early 1950s, an intrinsic model for modern-day crisis centers was established and, soon after, similar suicide prevention centers and general crisis intervention hotlines began to emerge around the United States. In large part, these avenues spawned in answer to the general demand of social concern and awareness of the late 1950s and 1960s. This movement became particularly pronounced with the enactment of then-President John F. Kennedy's Community Mental Health Centers Act of 1963, in which crisis units played a major role (Dattilio, 1984). With the innovation of the suicide prevention hotline, crisis intervention hotlines began to diversify and specify their focus. This came about because suicide intervention centers were asked to help people deal with all types of crisis. Out of this need developed hotlines for teens, drug abusers, sexual assault victims, and older adults. The telephone began to be used as a means of maintaining contact and following up with patients discharged from psychiatric facilities. Poison control hotlines were developed, as well as for community rumor control, and general community services. These resources appeared to help callers with problems, such as garbage removal or pest control, low-income housing, voter registration, pollution, and many other types of issues.

Mirroring or serving as a model for similar growth around the world, currently in the United States there are more than 1,400 grassroots crisis centers and crisis units affiliated with the American Association of Suicidology or local community mental health centers. There are also more than 11,000 victim assistance, rape crisis, and child sexual abuse intervention programs, as well as more than 1,000 domestic abuse shelters and hotlines (Yeager & Roberts, 2015). In modern times, Roberts and Camasso (1994) estimated that each year as many as 4.3 million documented calls come into crisis hotlines. Roberts (2005) further projected that if we were to take this figure and broaden it to include all natural and local 24-hour crisis lines, including those for crime victims, survivors of

terrorist attacks, victims of domestic violence, sexual assault victims, troubled employees, adolescent runaways, and child abuse victims, as well as the crisis intervention units at mental health centers, the total estimate would be approximately 35–45 million crisis callers per year (p. 11). This does not include the thousands of crisis services available through community hospital emergency rooms or psychiatric emergency service centers.

In 2005, the United States Substance Abuse and Mental Health Services Administration (SAMHSA) and Vibrant Emotional Health (formerly the Mental Health Association of New York City) teamed up to launch the 988 Suicide and Crisis Lifeline (formerly the National Suicide Prevention Lifeline) with over 200 accredited crisis centers responding to callers dialing 988, and since July 2022, all landlines and cell phones in the United States have been able to access this service. Other countries (e.g., England, Australia, and Canada) have followed suit. In its first 5 months, the 988 Lifeline received over 1.7 million calls, texts, and chats, and since its inception, over 2.1 million individuals have used the 988 Lifeline, with the number of users increasing steadily each year. Specific data on usage and outcomes are limited but can be accessed through the 988 Lifeline website (*988lifeline.org*).

These numbers have increased since the first global health crisis of the 21st century and the first pandemic in generations to affect all countries in the world with the onset of COVID-19 in 2020. Like other recent epidemics (e.g., SARS, AIDS), this major physical health threat also fueled a widespread mental and behavioral health crisis, but this time causing a significant impact on the well-being of people, systems, and resources in every nation. Droves of frontline health workers became so physically and emotionally overwhelmed that they flooded crisis centers and mental health professionals (Nelson & Kaminsky, 2020). Supply chains were disrupted, and public health practices led to loss of livelihoods throughout the world, disproportionately affecting the already disadvantaged. As a result, on October 5, 2020, President Donald Trump signed Executive Order 13594, saving lives through increased support for mental and behavioral health needs. This support was designed to prevent the tragedy of suicide, to help end the opioid crisis in the United States, and to improve mental and behavioral health systems in general (Substance Abuse and Mental Health Service Administration, 2020).

Crisis Theory

Crisis intervention, based on crisis theory, is one of the most widely used types of brief treatment employed by mental health professionals working in community settings (Ell, 1996). Burgess and Roberts (2005) and Burgess and Holstrom (1974) posit that crisis results when homeostasis is disrupted—that is, when the individual's balance, however precarious or firm it might be, is thrown off, and the individual is no longer able to cope with the situation effectively. The result would be that the individual would then manifest a number of symptoms that become the clinical markers for the crisis response, often warranting crisis intervention. In general, crisis intervention is aimed at a psychological resolution of an immediate crisis in an individual's life and restoring them to at least the precrisis level of functioning (Aguilera, 1990). Rosenbaum and Calhoun (1977) regard a crisis as involving some precipitating event that is time limited and that disrupts the individual's usual coping and problem-solving capabilities. Slaiku (1990) offers a definition that synthesizes the definitions of crisis as "a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation

using customary methods of problem solving, and by the potential for a radically positive or negative outcome" (p. 15). This definition focuses on several specific areas. The first part of the definition addresses the "temporary" nature of crisis situations. For most individuals, crises are immediate, transient, and temporary. For other individuals, however, the temporary nature of crisis may lead to years of upset. Their life crises may become part of a posttraumatic stress that is long-term and chronic. Other individuals have a predisposition to view certain stimuli as dangerous and thereby damaging. They may see many circumstances as crisis laden. For these individuals, there is no one crisis but a series of "brush fires" that continue to strain their coping ability throughout life.

The second part of the definition addresses the individual's response of feeling upset. The term *upset* can be broadened to include the most common responses to crisis: those of anxiety and depression. In more severe reactions, the individual may also be disorganized. This disorganization may involve confusion and decreased problem-solving ability. In its severest form, it might include brief reactive psychoses or delirium. The disorganization may be cognitive (e.g., mental confusion), behavioral (e.g., acting in random or uncharacteristic ways), or emotional (e.g., being emotionally labile). The individual's inability to cope, the focus of the next part of the definition, revolves more specifically around the issue of problem-solving ability. If an individual's balance is disrupted and some form of anxiety results, the individual's cognitive flexibility decreases, problem-solving ability suffers, and avoidance or denial may be used as a coping strategy. By using the common or traditional techniques for personal coping, many individuals find themselves overwhelmed. Their customary methods of problem solving are not adequate to the present task requirements (Roberts, 2000).

The final part of the definition involves the potential for rather weighty consequences. Loss of health, property, or loved ones and death are well within the definition of weighty consequences that could lead to radically positive or negative outcomes. Negative outcomes would include loss of self-esteem, loss of esteem of others, or, in cultural contexts, loss of "face." Slaiku (1990) suggests the possibility that the crisis situation could also lead to powerful positive outcomes, including the opportunity for new experiences, starting over, or gaining new skills, behaviors, and even insights, including the appreciation of our human vulnerability to life's perils.

While the concept of crisis may be viewed in various ways, Yeager and Roberts (2015, p. 13) nicely emphasize it as a turning point in a person's life.

A classic example is evident in some recent crises in the years prior to publication of this volume: civil war in Syria, school and mass shootings in the United States, the invasion of Ukraine by the Russian Federation, and the AIDS epidemic, as well as the COVID-19 global pandemic. In the United States, the events of 9/11 and Hurricane Katrina also serve as exemplars. All of these events produced weighty consequences, including loss of life, health, and property, not to mention an increased vulnerability to life's perils. In fact, the events of 9/11 alone represented the largest loss of life of U.S. citizens in 1 day in its nation's history (Roberts, 2005). Untold lives have been lost in Syria and Ukraine, and by the worldwide pandemic that began in 2020.

Those responding to crisis learned a powerful lesson from all of these events, particularly those involved in large-scale crises: that one must be prepared for life-threatening events at any time, and that, as human beings, we are, by nature, always vulnerable to unanticipated crisis.

Usually, when individuals are in a crisis situation and their present resources are not adequate to the task, they call on little-used reserves of personal fortitude and spirit

to carry them through. They may also call on infrequently practiced skills to help them prevail. Or, if they have the added advantage of a family or social/community network on which they might rely for assistance, support, or encouragement, they use that network as an expanded resource. In addition, they may search for or create temporary systems of support to assist them through the crisis period. With an extensive repertoire of coping strategies and the techniques to implement the strategies, a supportive family system, an active cultural or religious community, good friends, or a therapist on whom to call, potential life crises can be more easily weathered.

Why a particular situation or event is moved to a level of a crisis at one time and not another is a central issue underlying the treatment of the individual who ends up in crisis. The strategies and techniques for intervening in crisis situations are the focus of this volume. Our goal in this chapter is to provide a theoretical and conceptual basis, as well as a rationale for a cognitive-behavioral format for the delivery of crisis intervention services.

Erikson's (1950) psychosocial theory of development was formulated as a "crisis theory" based on the concept that crises are not necessarily negative life occurrences that injure or destroy the individual but rather serve as points of growth. This growth can add to individuals' strength, provide them with a coping repertoire, and help them to succeed in every area of life. Erikson further believed that the lack of resolution of these crises could lead to a poor coping style. This theory would obviously be opposed by some victims of crisis in the short term. Most individuals who are the victims of disaster or violent attacks fail to see Erikson's crisis concept. It is a concept that is likely to be accepted only years after the crisis event has occurred.

Erikson's (1950) model states that throughout their lifetime, an individual encounters a number of predictable life crises (Erikson identified eight). By the nature and degree of resolution or nonresolution of these crises, the individual grows and develops in a particular direction. This growth and development lead to the conceptualization of an idiosyncratic life view and its attendant behaviors, cognitions, and emotions. Individually, and in combination, the eight crises subsume virtually every possible life schema. Overall, the resolution or nonresolution of the life crises determines the development of the individual's personal, family, cultural, gender, and age-related schema (Freeman, 1993). This schema then becomes a template for that individual's behavior. Erikson viewed the initial resolution of these crises as amenable to change throughout life, inasmuch as all eight crises are concurrent rather than sequential (aging, death, illness, etc.). A particular crisis may be more prevalent at a particular point in life (i.e., crises do not start and end during a particular developmental period). This fact then presents a much more optimistic view for ongoing crisis resolution. If an individual has not managed to successfully cope with a particular crisis or resolve it in a positive manner, they have other opportunities to resolve it throughout life.

To put this model in terms of cognitive-behavioral therapy (CBT), by understanding the particular types of behaviors that emerge from the resolution or nonresolution of these life crises, the therapist can understand the individual's coping style and strategies. Understanding of the individual's schemata sets the stage for tailoring interventions more effectively to help individuals and families resolve or cope with present life crises. The first major therapeutic task is discerning and manifesting a particular schema that then allows therapists to work with their patients to examine (1) the schema, (2) the advantages and disadvantages of maintaining it, and (3) methods for disputing and/or altering it. This schematic focus is central to the cognitive-behavioral approach to crisis intervention.

Schemata

Schemata are hypothesized structures that guide and organize the processing of information and the understanding of life experience. Beck (1967, 1976) has suggested that schemata are the cognitive substrate that generates the various cognitive distortions often observed in patients. These schemata serve to increase or decrease the individual's vulnerability to various situations. These schemata or basic rules of life begin to form as a force in cognition and behavior from the earliest points in life and are well ingrained by the middle childhood years. They involve the accumulation of the individual's learning and experience within the family group; religious group; ethnic, gender, or regional subgroup; and broader society. The particular extent or effect that a given schema has on an individual's life depends on (1) how strongly that schema is held; (2) how essential the individual sees that schema to their safety, well-being, or existence; (3) the individual's previous learning vis-à-vis the importance and essential nature of a particular schema; (4) how early a particular schema was internalized; and (5) how powerfully, and by whom, the schema was reinforced.

Schemata can be active or dormant, with the more active schemata serving as the rules that govern day-to-day behavior. The dormant schemata are called into play to control behavior in times of stress. The schemata may be either compelling or noncompelling. The more compelling the schemata, the more likely it is that the individual or family will respond to the schemata. A good example of this is the work of social psychologist Paul Slovic, who has studied "psychic numbing" in people with regard to observing the plight of others with mass murder and/or genocide (Slovic et al., 2013). Much of this boils down to the schema that people maintain regarding moral judgment.

Schemata are in a constant state of change and evolution. Environmental data and experience are taken in by individuals only as they are able to fit them into their already-learned structures, which have been built by their own subjective experience. If new learning doesn't fit into the existing structure, an individual may be able to build a new structure in order to assimilate the new view or information. And, some individuals may be better at this than others. The self-schemata then become selective as the individual may ignore environmental stimuli that doesn't fit into their preconceived notions. There is an active and evolutionary process by which all perceptions and cognitive structures are applied to new functions (*assimilation*) while revised cognitive structures are developed to serve old functions in new situations (*accommodation*). Some individuals persist in utilizing old structures without assimilating them to the new circumstances in which they are involved—they use them in toto without measuring fit or appropriateness. They may further fail to accommodate or build new structures.

Schemata are cognitive structures that can be described in great detail. We can also deduce them from behavior or automatic thoughts. The behavioral component involves the manner in which the belief system governs the individual's responses to a particular stimulus or set of stimuli. In seeking to alter a particular schema that has endured for a long time, the professional must help the individual deal with the belief from as many different perspectives as possible. A pure cognitive strategy would leave the behavioral and affective untouched. The pure affective strategy is similarly limited, and, of course, the strict behavioral approach is limited by its disregard for cognitive-affective elements. In many cases, we find that an individual's particular schemata are consensually validated.

The cognitive-behavioral approach initially involves an intrapsychic focus on the individual's automatic thoughts and schemata. This part of the therapeutic work deals

with the individual's belief systems; assumptions about self, world, experience, and the future; and general perceptions. A second focus of the therapy is interpersonal and deals with the individual's style of relating to others.

The third focus of the therapy is external, and it involves understanding how different ways of responding associate with changes in emotions and thoughts. With this assessment and, ideally awareness, then changing behaviors may affect a more productive coping style. This external focus involves learning new behaviors/responses, trying the new behaviors, evaluating the result of the new behaviors, and developing and using available resources. People typically do the best they can to cope but might use coping strategies that inadvertently maintain their distress or rely on strategies that do not actually lead to better outcomes for them.

The particular attributes of cognitive therapy make it ideal for crisis intervention work. The eight specific attributes involve the *activity* of the model. This part of the model invites the patient to become an active player in their therapy, helping to restore a sense of control over their life.

The *directiveness* of the model is important because it encourages the therapist to be an active guide, directing the therapy. The therapist's job is more than restatement and reformulation. The therapist shares hypotheses; utilizes guided discovery; encourages the patient; serves as a resource person; acts as a case manager, and in certain cases, advocates for the patient. The therapist helps the client become more aware of each element of the model, when possible, and points out when they think additional strategies seem warranted.

The *structure of the therapy* calls for the establishment of a discrete problem list that helps both patient and therapist clarify where the therapy is going and evaluate how the therapy is progressing. This structure is essential for the patient in crisis and commensurate with most models of crisis intervention (Greenstone & Leviton, 1993; Yeager & Roberts, 2015).

The content and the direction of the therapy are established early in the collaboration. Having established and agreed on a problem list and focus for therapy, the therapist and patient structure the individual sessions through agenda setting and homework.

Agenda setting provides for maximum success in the limited time available during a typical therapy session. Rather than having the therapy session wander and meander, the therapist can work with the patient to set an agenda for the session, which helps to focus the therapy work and makes better use of time, energy, and available skills. Agenda setting at the beginning of the session allows both patient and therapist to place issues of concern on the agenda for the day. Accomplishing the items on the agenda requires that the therapist be skilled at setting priorities and pacing the session, taking into account the needs of the patient. This is a skill refined through practice and experience. However, even seasoned therapists may feel tense and anxious and exhibit a loss of effectiveness when they are first learning how to pace a session that is built around a collaborative agenda. This is a natural part of adjusting to the patients' needs and establishing a footing in treatment.

The *short-term nature of the therapy* is a fourth element in crisis intervention. Research protocols for testing the efficacy of cognitive therapy generally involve 12–20 sessions over a period of no more than 20 weeks, whereas the treatment of a crisis situation may need to be more rapid but not necessarily limited to 20 weeks. For certain patients the length of therapy may be six sessions; for other patients, 50 sessions. The length of the therapy and the frequency and length of the sessions are all negotiable.

There is also some discussion in the professional literature about the pros and cons of early intervention techniques (Brom & Kleber, 1989; Foa et al., 1995; Schützwohl, 2000; Dattilio & Freeman, 2007). This aspect is something that therapists need to consider seriously in regard to the effectiveness of any intervention.

In addition to the aforementioned, the problems being addressed, the skills of the patient and the therapist, the time available for therapy, and financial resources all have the potential to dictate the parameters of treatment.

Another salient aspect, which has long been the backbone of CBT, is the development of *collaboration* (Beck et al., 1979). The therapist and patient must work together as a team. The collaboration is not always 50:50 but may, with the crisis patient, be 70:30 or 90:10, with the therapist providing most of the energy or work within the session or in the therapy more generally. The more stressed the patient is, the less energy they may have available to use during the course of therapy. The therapeutic focus would be to help such patients make maximum use of their energy and build greater energy resources and then to shift the ratio into a better proportion later in therapy to support maintenance and independence.

A sixth issue is that the cognitive therapy model is a *dynamic* model of therapy. The dynamic cognitive approach to therapy promotes rapid self-disclosure of individual cognitions in order to increase understanding through enhanced knowledge and an understanding of thoughts, beliefs, and attitudes. Early schemata develop and are modified within the family group, and cognitive therapy with families can provide a context for observing these schemata in operation (see Dattilio, 2010).

Also, cognitive therapy is a *psychoeducational* model of therapy. It is a skill-building or coping, model of therapy as opposed to a cure model. Patients in cognitive therapy ideally gain skills to cope more effectively with their own thoughts and behaviors that may be dysfunctional. Rather than cure, the cognitive therapist helps the patient to acquire a range of coping strategies for present and future exigencies of life.

Finally, the cognitive therapy model is a *social/interpersonal* model. We do not exist in social vacuums. The relationships of the individual to their significant others, friends, and work colleagues are all schematically based and are essential foci for the therapy. If the individual is isolated, there may be great gaps in their resource network.

Clearly, if one does not have external resources and few internal resources on which to rely, a crisis will result. In some cases, individuals have what objectively appears to be a wealth of support, but the support is not accepted by the individual or is perceived by the hopeless individual as not sufficient or available. In Edwin Arlington Robinson's (1897) poem "Richard Cory," Cory was seen to have everything. He was wealthy, handsome, well dressed, and sophisticated. Despite all these apparent resources, however, "one calm summer night, [Richard Cory] went home and put a bullet through his head" (as cited in Scheick, 2007).

Highlighting the importance of understanding the individual's schemata, available resources, and belief in those resources, we can look at the Social Readjustment Rating Scale (Holmes & Rahe, 1967). In this scale, the death of a spouse is rated number 1. It is seen as the most powerful stressor and the standard against which all other life stressors are measured. The death of a close family member is rated as 5 on the scale, and the death of a friend as 7. If the spouse was much loved, it is easily understandable as to why it is perceived as a situation of the highest stress. In the case of an embittered and estranged couple, the death of a spouse may be a solution to long-term stress, bringing with it relief

and even financial security. Or, in the case of a loved spouse with a terminal illness and intractable pain, the eventual death of that spouse, family member, or friend may be prayed for out of love and caring. The eventual death may be a great relief because of the peace and surcease the death will bring to the terminally ill individual. In such cases, then, the rating level on the Social Readjustment Rating Scale would be lower.

Slaiku (1990) states, "Short-term, time-limited therapy is the treatment of choice in crisis situations" (p. 98). In this respect, the active, directive, goal-oriented, structured, collaborative, and problem-solving nature of cognitive therapy makes it the ideal crisis intervention treatment model. The immediate goals of cognitive-behavioral strategies in crisis intervention are threefold: (1) evaluating and assessing the immediacy of the crisis situation; (2) assessing the individual's coping repertoire to deal with the crisis; and (3) generating options of thought/perception, emotion, and behavior. Some individuals have a skill deficit in problem solving. This requires the direct teaching of better problem-solving skills. Other individuals have the problem-solving strategies and techniques available but see their ability as far less than it is. A more behavioral approach is necessary in the former situation, whereas a more cognitive approach is called for in the latter.

Using Slaiku's (1990) definition, described earlier, there are several possible points of intervention. The initial point of intervention is the recognition that the situation that brings on the upset and disorganization is *temporary*. This implies that by seeing the situation with a long-term focus it may be possible to "wait it out"—for example, patients with panic have difficulty seeing the long view because the immediacy of the physiological symptoms and the misinterpretation of danger draws their focus to the "here and now" (see Dattilio & Kendall, 2007). The idea of waiting out the bodily response and not responding by running is somehow viewed by the patient with panic as impossible. Working with the patient to develop the long-term view may help to decrease the crisis perception. The perception of immediate danger and the need to avoid it cause patients with panic to act in self-defeating ways in the ideal interest of saving their life.

A second point of intervention involves the *upset*. Clearly, if the situation were not as upsetting, there would be no crisis. The upset is caused by a perception that can be questioned or challenged—for example, a businessman reported being in crisis over the economic downturn and the possible loss of his business. He reported that every time he thought of losing his business he would then extend the thought to losing everything. He would picture losing his home, his car, his wife, his children, his self-respect, and the respect of others. He would, in his view, be living on a hot-air vent in the street, housed in a large cardboard carton. His upset came not simply from the reality of his business difficulties but rather from his catastrophic style of thinking.

The third point of intervention relates to the *disorganization*. If the individual's thoughts, actions, and emotions are confused and disorganized, the clear therapeutic strategy is to offer some structure and a format for problem solving. The therapist must recognize that confusion and disorganization are common themes for virtually all psychological problems. Patients' complaints that they "need to get their life/head/marriage together" are quite common. For patients seeing themselves in crisis, this collection of parts or pieces may be more emergent. The cognitive therapy model is especially helpful with the patient who is disorganized—for example, a woman who was sexually assaulted while on a date saw her only avenue of action being to flee her job and school program. She was overwhelmed by the thoughts, images, and feelings related to the rape. She was further confused by the contradictory advice and information offered by

others, which was compounded by legal issues and threats. She described her reaction as running off in 10 directions simultaneously. No direction gave her answers or peace.

Each of us uses a fairly limited repertoire of techniques for coping with life. Our day-to-day life is rather familiar and comfortable. We can expect certain consequences when we act in particular ways. If, for example, an individual begins her morning commute at 6:30 A.M., she will likely experience little traffic. If, however, she leaves at 8:00 A.M., she may be in the middle of a traffic jam. She then knows that she has to leave earlier to avoid the "crisis" of the morning rush. If she lives in an area that experiences heavy winter snow, she considers driving in snow to be part of the risk or price to pay for living in that area. Ideally, she has coped by having snow tires, sand in the trunk, a shovel, cold-weather gear, a blanket, and flares. If there is snow in an area, and the people living there are not prepared for it, even a coating of snow becomes a crisis of major proportions.

A final point of intervention is to help the individual *reduce the potential for a radical outcome*. If the outcome were uncomfortable rather than catastrophic, the crisis potential would be significantly reduced.

Assessment

As in any other circumstance, assessment is crucial during crisis situations, particularly because the given situation may be critical at the time and require an almost immediate response. What makes assessment difficult is that it must be conducted almost three times as quickly as in the normal course of treatment and, in some cases, under difficult circumstances. When a crisis situation presents itself with little or no opportunity to implement formal assessment inventories or questionnaires, a paradigm is recommended for quick structured interviewing. Greenstone and Leviton (1993) recommend adhering to the following steps:

1. *Immediacy*. Intervention usually begins at the moment the intervener encounters the individual in crisis. The intervener must immediately attempt to size up the situation, alleviate anxiety, prevent further disorientation, and ensure that sufferers do not harm themselves or cause harm to others.

2. *Taking control*. Here it is important for the therapist to be clear about what and whom they are attempting to control. The purpose of assuming control is not to conquer or overwhelm the victim but to help reorder the chaos that exists in the sufferer's world at the moment of the crisis. The one conducting the crisis intervention provides the needed structure until the victim(s) is (are) able to regain control. Consequently, it is important to enter the crisis scene cautiously.

Approaching the crisis situation slowly and carefully can prevent unnecessary grief and give the professional time to mentally absorb what they are encountering. It is important for the professional intervening to make every attempt to remain stable, supportive, and able to establish a structured environment. This may involve using personal presence, including strength control, and making every effort to have a calming effect on the crisis situation and exercising some emotional control over the victim. Research usually indicates that victims respond to structure and those who represent it, if they sense genuineness and sincerity by the professional conducting the interview.

3. *Assessment.* Intervening usually involves making a quick, on-the-spot evaluation. This means attempting to understand how and why the individual got into a crisis situation at this particular time and which specific problem is of immediate concern. Assessment also involves the use of management and identifying any variables that would hinder the problem management process. This is particularly true of those individuals who have experienced multiple crisis situations or traumas. For this reason, a new diagnosis, "complex posttraumatic stress disorder," has been adopted in *International Classifications of Diseases, 11th Edition* (ICD-11; Maercker et al., 2022). Individuals with complex PTSD typically have sustained multiple exposures to traumas, such as childhood abuse and other traumatic incidences that may lead to their condition being more refractory and resistant to treatment interventions.

The bottom line consists of how the intervener can be most effective in the least amount of time. Consequently, lengthy histories are forfeited in favor of focusing on the assessment of the present crisis and the events that occurred within the immediate hours surrounding the crisis—more specifically, pinpointing the precipitating events.

A number of inventories have been designed for use in crisis situations, although, unfortunately, there is a surprising lack of standardized instruments with strong psychometric properties available to mental health practitioners engaged in crisis work.

One assessment measure that has been designed to provide a rapid assessment for measuring perceived psychological trauma and perceived problems in coping efficacy is the Crisis State Assessment Scale (Lewis, 2002). This scale is still in the process of validation but it offers constructs mentioned earlier and is used to predict or indicate the magnitude of a crisis state. This assessment measure may be helpful initially in order to aid in the direction of future treatment.

Another inventory is the modified version of the Structured Clinical Interview Schedule for DSM-5 (QuickSCID-5). This is an abridged version of the Structured Clinical Interview Schedule that allows the intervener to provide a more expedient method of assessment in crisis situations (First & Williams, 2021). In addition, there are other scales, such as the American Academy of Crisis Interveners Lethality Scale (Greenstone & Leviton, 1993, pp. 19–20). This scale allows an individual to quickly assess criteria in a crisis situation by summing up the scores and matching the total with the criteria.

4. *Decide how to handle the situation after the assessment.* This essentially involves using the material that was gathered during the assessment stage and deciding on an avenue for intervention. It may also involve exploring the possible options available to the individual in crisis and either handling the situation at the moment or referring it out as needed.

We suggest two additional steps, as follows:

5. *Develop a crisis implementation plan.* Once you have chosen an action, you will need a plan for real-time implementation. Often a crisis or safety plan is written out in a step-by-step manner or key steps and reminders are put on a coping card. These are then shared with important support people so that what is developed in the ideal setting of the therapy room can be put into action in the not-so-ideal crisis situation.

6. *Evaluate and follow up.* Discuss how the plan did and make changes to make it better or more flexible for future crises. Ideally you have a measurable outcome in

mind, planned before implementing your plan, like reduction of anxiety or completion of a task.

The reader is referred to the individual chapters of this book for more detail on various assessment tools for particular crisis situations.

Treatment

Obviously, models of brief psychotherapy have been the treatment of choice in crisis settings. There are several models of brief psychotherapy—however, they all have the common goal of removing and alleviating specific symptoms in a timely fashion. The intervention may lead to some personality reconstruction but this is not considered a primary goal (Aguilera, 1990).

The focused cognitive therapy approach to crisis intervention has five stages: The first stage is the development of a relationship with the patient and a building of rapport. This also follows in line with the cognitive model's notion of collaboration (Kazantzis et al., 2017). The patient must feel comfortable enough to allow a free flow of information about the crisis in which they are currently involved. The therapist's behavior is instrumental in developing this rapport. The therapist has to be able to convey a nonjudgmental attitude to the patient and a feeling of interest and concern in the patient's problem. In a more serious crisis, levels of trust tend to develop more easily—thus, the patient may have already assumed a certain level of trust in meeting with the therapist. Therefore, to some degree rapport will not be as difficult to develop; however, in a less serious crisis, deliberate attempts on the therapist's part to build rapport is especially important because it may be more difficult to develop.

The second stage is the initial evaluation of the severity of the crisis situation. Such an evaluation allows the therapist to get some idea of the immediate physical danger to the patient. It might also offer some idea as to the type of schemata held by the person with whom the therapist is dealing. The therapist must determine which course of action to take. Finally, the therapist must assist the patient in identifying the specific problem they are experiencing. Often the patients' confusion and disorganization render them unable to define their problem. The therapist must make every effort to help individuals focus on the specific areas creating problems as opposed to attempting to deal with the vagaries of "depression," "anxiety," or "communication problems." It is important, however, not to focus on one specific problem too early in the contact because there is a chance the therapist could be overlooking other significant problems. Developing a problem list ensures a more specific focus within the broader context.

Once the problems are identified, the third stage involves helping the patient assess and mobilize their strengths and resources. This may be in the form of identifying friends in the immediate vicinity who could help, as well as various internal strengths and resources the person in crisis is likely to overlook. It is extremely useful to have the cognitive and behavioral resources menu handy and available.

In the fourth stage, the therapist and patient must work jointly to develop a positive plan of action (collaboration and problem solving). An essential aspect of this collaboration includes eliciting the patient's commitment to the plan of action. At this point, the technique of problem solving is especially applicable. If the nature of the crisis is such that problem solving is not an appropriate mechanism, the last stage becomes necessary.

A resource that may be called into play at this point is the therapist as advocate for the patient. In such cases, the therapist may need to become more demonstrative in aiding the patient in making a decision.

The fifth stage involves testing ideas and new behaviors. How well the new coping techniques work can be evaluated and the strategies revised accordingly.

Patients in Crisis

The therapist who deals with patients in crisis is under a special pressure. Burnout occurs rather frequently. There is often no place for therapists to vent their own frustrations and upset, which may create a perception of crisis for the therapist. The notion of "therapist heal thyself" is easier said than done. Crisis workers may need peer supervision or some outlet for the pressure of working with patients in crisis. The reader is referred to Dattilio (Chapter 21, this volume) for a more elaborate discussion of this topic.

The crisis intervention work often represents the only link that individuals in crisis believe they have. Even when there is not a life-or-death outcome, the patient's perception is often that in some vague way their very existence is being threatened. When the individual is experiencing a peak in their emotional distress, the therapeutic environment can be seen as the only tie, however tenuous, to survival. For the patient accustomed to the idea of receiving help, the decision to seek professional help is less frightening. Too often, patients do not seek help until the problems have reached crisis proportions. For the more dependent patient, help seeking may in fact be overdeveloped as a coping strategy (Beck et al., 1990). Such patients see every problem as a potential crisis—therefore, they frequently seek help and need support. Conversely, the more autonomous patient may avoid seeking help, believing that they have all the answers themself, viewing the patient role as something to be ashamed of, or even fearing ridicule or criticism from the therapist.

Given the need for rather rapid conceptualization and intervention, we divide patients in crisis into the following five general categories:

1. *The adolescent style.* Such patients may or may not be chronologically adolescent. They are generally experiencing some major life changes having to do with self-image. They are extremely reluctant to show any signs that might suggest dependency, vulnerability, weakness, or lack of self-confidence. For this reason, any request for help may be perceived by these patients as threatening to their self-image. Typical schemata for these individuals revolve around issues of loss, dependence, and fear.

2. *The isolate.* Such individuals are typically distressed to the point of lacking all motivation to make social contact. Their crises revolve around social interactions or the lack of social involvement. Their main problems include their frequent lack of social skills, fear of rejection, passivity, and apathy. Their schemata often dictate that unless they receive absolute guarantees of recognition or support, they refuse to become socially involved.

3. *The desperate individual.* Such patients exemplify for many what crisis intervention is all about. They experience some sudden psychological shock and are in desperate

need of some type of immediate help. This shock may come from an environmental disaster or a psychological loss. As a result of this shock, desperate individuals most likely have lost contact with reality or this contact is extremely shaky. The therapist may represent their final link to reality. Often, the mere sound of a caring, concerned voice is enough to begin bringing these patients back from a state of despair—for example, a therapist reported meeting with a woman patient who was in crisis. He extended the session to double its time to help her move away from her determination of suicide. At some point in the session the patient asked for a cigarette. The therapist did not smoke but offered to use some of their session time to go for a walk together and continue their work while examining whether this healthy coping strategy might take her thoughts of suicide from a 10/10 in severity to something lower. Following a walk through a nice area near the therapist's office the client reported a significant drop to 5/10. When he believed that the patient was able to weather the crisis, he ended the session and set another appointment time for the following day. When the patient came in the next day, she was calmer and less confused. When the therapist asked her about her reaction to the previous day's session, she replied, "I don't remember anything that we talked about. All I remember is that you took the time to go for a walk with me."

4. *The one-shot crisis contact*. Such individuals are typically relatively normal and emotionally stable. Although the crises experienced by such people vary, there are specific reasons they call for therapy. They come to therapy to get help to deal with the specific crisis situation. They perceive themselves as mainly seeking someone to help them through some current situation. For this reason, a brief cognitive approach is especially well suited. This individual is simply looking for some immediate advice or someone to act as a sounding board to advise them on alternatives to the plans of action the individual may have already developed.

5. *The chronic patient*. Such patients seek therapy for one thing or another in a long history of brush fires, sometimes termed the *crisis of the week* [COW]. Therapy means that they will be able to call at any time, and that whenever they call they will be able to find someone to listen to them and help them through the COW. COWs are also effective strategies for avoiding deeper work or tackling bigger projects. We are reminded of the Confucian idea that if we give a person a fish, he can eat for a day but if we teach him to fish, he can feed himself for life. For this type of patient, long histories of therapeutic contact have taught them that they do not need to learn to cope. They can come to therapy and have the therapist do their coping for them.

The use of cognitive therapy techniques in crisis intervention offers advantages both to patients in their ability to receive help and to therapists in their ability to offer help. The patient often feels powerless to change their circumstances or is unmotivated to problem solve and reason through a solution. By working collaboratively and actively to identify cognitive distortions and automatic thoughts and to suggest alternatives, the therapist can provide such patients with some hope for resolving their seemingly insoluble difficulties.

CBT is attractive "because most of the concepts of cognitive and behavior therapy are consistent with commonly shared notions of human nature, the neophyte therapist can readily assimilate them" (Beck, 1976, p. 318). The theories of CBT are easily delineated, and, most important, the link between theory and practice is clear. By virtue of its

ease of learning, cognitive and behavior therapy techniques also make crisis intervention work much more satisfying for the therapist.

Issues in Crisis Intervention

Confidentiality

The issue of confidentiality is a sensitive one: knowing when to maintain confidentiality and when it is essential to break confidentiality are very important issues (see Barnett, Chapter 2, this volume, for an expanded discussion). Although confidentiality relies in large part on clinical judgment and accurate assessment of the severity of the situation, there is a general set of ethical standards. A life-threatening situation is one in which the patient is in danger of bodily injury or death. Once the therapist has established that there is a life-threatening situation, the therapist is no longer ethically bound to confidentiality and may have to exercise certain options—for example, if there is a crisis or emergency (e.g., homicide or suicide), the therapist may need to involve the police or insist that the patient offer the name of the spouse, friend, roommate, parent, or significant other who can be an available resource if assistance is necessary. The individual in crisis can enlist the support of these resources throughout the treatment process.

Cognitive Functioning

We use the term *cognitive functioning* to include intelligence; ability to comprehend and process information; and ability to understand both practical and abstract concepts of crisis, illness, injury, and health. The disorganization of the patient at the point of crisis may thus alter the therapeutic approach.

If, for example, patients or family members do not have a sufficient fund of knowledge to understand the nature of the present trauma, care must be taken to ensure that explanations are made in the simplest terms. Jargon, complex medical explanations, shorthand descriptions, or abstract concepts may be acknowledged as understood while actually leaving the patient and family puzzled by the events, treatment, and sequelae of the trauma (or treatment).

If the family is non-English speaking, it is essential that explanations be offered in their primary language. Regardless of language, care must be taken to work with the crisis within the context of a family's cultural values. Trauma service interpreters must be trained in addressing the practical and emotional needs of the patients and families and be able to translate the psychological concepts of the therapist into clear and digestible ideas that the patient can understand (Dattilio, 1999).

Mourning

Any loss has the effect of reducing one's ability to cope. The sequelae of an emergency may be the permanent loss of a family member through death or the temporary loss of a family member who is hospitalized. In addition, the result of the crisis might be the loss of a cognitive faculty, physical skill or ability, body parts, or intellectual or physical prowess.

The therapist must recognize and deal directly with losses, both real and imagined. In some cases, family members may refuse to recognize the loss. The therapist must walk the line between maintaining hope and facing reality, encouraging the search for

treatment options while evaluating the potential for success, and preparing for the worst while hoping for the best.

The mourning process must be identified for the patient. Patients must be helped to accept that any loss must be mourned and that the mourning process is normal, natural, and necessary. Often, follow-up treatment is especially important because the initial loss and mourning will be followed by another mourning process that might begin long after the immediate crisis. There is, in many cases, a "sleeper effect" in which the full effect of the loss does not become clear until the patient or significant other is gone.

Premorbid Personality, Lifestyle, and Interests

The particular interpersonal style, life choices, or intrapsychic conflicts can often provide a context for understanding the patient's or spouse's reaction to the crisis. In many cases, the dependent individual reacts to the trauma by seeking help, reassurance, or comfort. The more autonomous individual may be resistant to help, refuse treatment, and generally avoid therapy with statements such as "I'll be OK," "Just leave me (us) alone," and "I (we) can do it myself (ourselves)." In other cases, the premorbid personality style may not be a good predictor of the emotional reaction to the trauma—for example, under stress the "strong, silent type" becomes helpless and dependent, whereas the weak and helpless individual shows an internal strength and fortitude that may carry an entire family throughout the crisis. This can be explained by the existence of dormant schemata (Freeman, 1993; Freeman & Leaf, 1989) that become active under the stress of the trauma. When the stress of the trauma is removed, however, the individual may return to their previous style of functioning.

Discrepancy between Actual and Perceived Difficulty in Coping

As much as possible, it is important to make clear the discrepancy between actual and predicted ability to cope with problems effectively. It is essential for the patient to be realistic in terms of expectations for coping, recovery, and survival.

Reinforce Even Small Therapeutic Gains

A frequent concomitant of crisis is depression. The negative view of self ("I am unable to cope"), the world, and experience ("It's unfair; why has this happened to me?"), and the negative view of the future ("I will always be this way; I will die alone and unwanted") are the progenitors of depressive affect (Beck et al., 1979; Freeman et al., 1990). The patient's awareness of depressive symptomatology moderates the therapeutic strategy to identify the areas of greatest difficulty and focus rather quickly on these issues. Any small gain or improvement in dealing with the crisis must be identified and reinforced. Such reinforcement can lift the patient's mood. It is necessary to socialize patients to the cognitive model and help them to begin identifying automatic thoughts and schemata.

Emphasize the Collaborative Therapeutic Relationship

The therapist must be seen as a warm, supportive, competent, reasonable individual and must work toward building and maintaining the working alliance. Given the nature

of crises, the relationship must be built immediately. Empathy is the most important element; when a patient is in crisis, sympathy is likely to have a negative effect on the overall therapeutic work. There are probably many other people in the patient's world who offer sympathy. The patient needs someone who can enter their internal reality and then offer support and strategies for effective coping.

Barriers to Patient Empowerment

Empowerment is essential in treating patients in crisis. Patients must be helped to recognize their right and ability to be empowered. The goal of empowerment may be limited by the manner in which it is presented, by its implementation, or by misunderstanding the idea or model.

By definition, empowerment implies that one person or agency gives, offers, provides, or allows another person or agency to have or assume power. This definition assumes that the power giver has it within their purview to give or allow power. It further implies that the receiver is willing to assume the proffered power. The power may be related to work or taking charge of one's life or one's surroundings. Given the admirable goal, demonstrated potential, and egalitarian focus, empowerment may be doomed to fail for a variety of reasons. The ability to facilitate change in oneself and/or one's family group is critical to the development of empowerment. Too often self-change is impeded by repetitive, stylistic errors in personal information processing. Simply put, we can make errors in judgment, computation, reasoning, or perception. There are many examples of individuals who are smart, educated, talented, perceptive, and competent but who continue to repeat the same mistakes and find themselves in subsequent crises. Their mistake-making style becomes idiosyncratic and may cause them difficulties at work, at home, in relationships, or within themselves. It is important to help individuals to identify their particular schematic style and then to develop strategies to overcome impediments to change. Impediments to change include lack of practice in new behavior, environmental stressors interfering with change, personal ideas about ability to change oneself or family, personal ideas about consequence of change to self or group, group or family ideas about the need to avoid change, secondary gain from maintaining the status quo in spite of cost, lack of motivation, rigidity, some types of compensatory strategies (e.g., avoidance, "fear of fear," dependent interpersonal style), and vague or unrealistic goals. In therapy, if the goals are not agreed on, patient frustration will result.

Threshold and Vulnerability

The ability to cope with a stressor and whether the same stressors precipitate a crisis depend on the individual's threshold for response. In different situations, the individual's threshold will be very different. A surgeon working in a critical care setting is able to deal with medical emergencies with competence and skill. Once past the doors of the operating room, they may be unable to cope with the normal exigencies of life.

If we picture coping ability on a scale of 0–100, we can literally map an individual's normal threshold for coping. If, for example, the normal stress of life is 60 and one's threshold is 75, there is a cushion of 15 to accommodate extraordinary stress. If, due to higher than normal stress, the stress of life increases to 80, the individual would be

overwhelmed and have difficulty coping. If, however, the stressors of life remain the same but one's threshold decreases, the individual will likewise be overwhelmed.

Vulnerability factors lower one's threshold. These are circumstances, situations, or deficits that have the effect of decreasing the patient's ability to cope effectively with life stressors or to see available options.

The following list gives examples of such factors (Freeman & Simon, 1989):

1. *Acute illness*. This may span the range from a severe and debilitating illness to more transient illnesses, such as headaches, viral infections, and so on.
2. *Chronic illness*. When the health problem is chronic, there can be an acute exacerbation of suicidal thinking.
3. *Deterioration of health*. There may be a loss of activity due to aging.
4. *Hunger*. During times of food deprivation, the individual is often more vulnerable to a variety of stimuli. Recent studies have linked a depressive diagnosis to those with an eating disorder.
5. *Anger*. When individuals are angry, they can lose appropriate problem-solving ability. They may also lose impulse control or overrespond to stimuli that they are usually able to ignore.
6. *Fatigue*. In a similar fashion, fatigue decreases both problem-solving ability and impulse control.
7. *Loneliness*. Positive social connections and feeling like we belong are high on the list of human needs to maintain a sense of well-being. When individuals see themselves as isolated, leaving this unhappy world may seem to be a reasonable option.
8. *Major life loss*. Following the loss of a significant other through death, divorce, or separation, individuals often see themselves as having reduced options. They lose interest in what happens to them.
9. *Poor problem-solving ability*. Certain individuals may have impaired problem-solving ability. This deficit may not be obvious until the individual is placed in situations of great stress. The ability to deal with minor problems is a poor indicator of the individual's ability to deal with a crisis.
10. *Substance abuse*. The abuse of many substances can cause two types of problems: acute, in which the patient's judgment is compromised during periods of intoxication, and more chronic, in which judgment may be impaired more generally. Such problems increase suicidality.
11. *Chronic pain*. Chronic pain may cause the individual to view suicide as a method for ending the pain.
12. *Poor impulse control*. Certain patients have poor impulse control because of organic (hyperactivity) or functional problems. Patients with bipolar illness; psychosis; attention-deficit/hyperactivity disorder (ADHD); autism spectrum disorder; or borderline, antisocial, or histrionic personality disorders may all have impulse control deficits.
13. *New life circumstances*. Changing jobs, marital status, homes, or family status are all stressors that are considered vulnerability factors.

These factors can, alone or in combination, increase the patient's suicidal thinking or actions, lower threshold for anxiety stimuli, or increase the patient's vulnerability

to depressogenic thoughts and situations (Freeman & Simon, 1989). The vulnerability factors can have a summation effect—that is, when several vulnerability factors operate at the same time, they may continue to lower one's threshold—for example, if an individual who has a history of effective coping (threshold = 90, life stress = 60) suddenly loses the ability to cope and ends up in crisis, the family is often surprised. They may disregard the fact that the individual has had a stroke (–10), his wife has a broken leg (–7), his son is getting divorced (–6), his daughter has lost her job (–5), his oldest grandchild is having difficulty in school (–5), and his pet dog has been hit by a car (–4). His threshold is now 54, low enough to have him respond to normal life stress as if it were a crisis. Rather than thinking in terms of the sequence of losses, families may respond by thinking that the patient has dealt with similar problems in the past, so it is unclear why at this point he is having such a negative response.

Assessment of vulnerability factors may help to explain the ability to deal with crises and to predict the possibility of withdrawal, suicidal ideation, depression, or anxiety.

In the following chapters, the authors present situations and disorders that commonly lead patients into crisis. Each chapter presents a case example and provides related statistical information and prevalence rates, as well as common theories and models that apply to each scenario. The authors then lay out relevant and up-to-date cognitive-behavioral strategies that have been supported by the body of research in the respective areas. It is hoped that readers will use this information as an invaluable resource when taking on patients in crisis, and that they will feel more confident in helping their patients recover from the crises in which they find themselves.

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