The Merrill Counseling Series

4TH EDITION

CRISIS ASSESSMENT, INTERVENTION, AND PREVENTION

LISA R. JACKSON-CHERRY BRADLEY T. ERFORD

Fourth Edition

Crisis Assessment, Intervention, and Prevention

Lisa R. Jackson-Cherry
Marymount University

Bradley T. Erford
Peabody College at Vanderbilt University

Pearson

Content Development: Shannon LeMay-Finn
Content Management: Rebecca Fox-Gieg
Content Production: Purnima Narayanan
Product Management: Drew Bennett
Product Marketing: Krista Clark
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To all crisis workers who give selflessly to alleviate the pain of others. To my family, Jim, Gabrielle, and Alexandra. In memory of my parents, Barbara Japzon-Jackson and Francisco Japzon, MD, whose sacrifices throughout my life are too numerable to list. Your love continues to be felt even without your physical presence. I am ever-mindful that all my blessings are attributed to God.

LJC

This effort is dedicated to The One: the Giver of energy, passion, and understanding; Who makes life worth living and endeavors worth pursuing and accomplishing; the Teacher of love and forgiveness.

BTE

PREFACE

The purpose for writing this text was to convey the practical implications of and applications for dealing with crisis situations. Prior to September 11, 2001, crisis counselors' and university faculty members' conceptualization of crisis was generally limited to individual clients, primarily addressing suicidal client needs. But recent events (e.g., terrorism, school shootings, natural disasters), coupled with renewed societal concerns over continuing violence (e.g., homicide, intimate partner violence, rape, sexual abuse), have expanded our conceptualization of crisis and the needs of the new generation of counselors. This text addresses this expanded concept of crisis in today's world and includes the practical applications that will help crisis counselors serve diverse clients immediately in a changing world. Crisis intervention and crisis roles differ from traditional counseling. Understanding these differences is imperative to assisting individuals in a variety of crises. Crisis counselors, when able to assess and intervene effectively, may also assist individuals in responding to future crises—a preventive, resiliency-based approach.

Preservice students and mental health professionals in the field need crisis intervention training to effectively intervene in the various crisis situations they will encounter in their roles as counselors with diverse populations and across settings. This short text provides vital information on assessing and reacting to various crises involving suicide, homicide, intimate partner violence, sexual assault/abuse, bereavement/grief, substance use, natural disasters, war, and terrorism. The text provides practical applications for various crisis situations experienced by crisis workers. The text allows students to become familiar with various crisis issues and situations and to practice necessary skills before encountering the problem for the first time in the field. The text features numerous crisis situations not found in other crisis texts and is of benefit to various counseling specialties (e.g., school counseling, university counseling, mental health counseling, and pastoral clinical mental health counseling). Students see the process as a whole and are exposed to crucial information, clinical considerations, and practical experiences on every crisis topic.

NEW TO THIS EDITION

The fourth edition of *Crisis Assessment, Intervention, and Prevention* has been purposefully revised with new and expanded content to address the needs of a diverse group of counselors in the field and counselors-in-training. The following features are new to this edition:

- Application of the task model for assessment and intervention was integrated into cases throughout the book.
- Technological and distance counseling applications of crisis intervention during a pandemic were added to chapters, as applicable.
- Counselor safety, self-care, and wellness issues were added to each chapter, as applicable.
- The schools/universities chapter has been expanded.

- Updated references and citations connect practitioners with the latest information.
- Updated and standardized chapter features include Case Studies, Voices from the Field, Activities, Think About It features, and resource lists.

ORGANIZATION OF THIS TEXT

The text is divided into two parts. Part I: *Elements of Crisis Intervention*, which includes Chapters 1 through 5, reviews the fundamental information related to crises and crisis intervention.

In Chapter 1: *Basic Concepts of Crisis Intervention*, Lisa R. Jackson-Cherry, Jason M. McGlothlin, and Bradley T. Erford acknowledge that crises occur in a variety of settings for a variety of reasons. Responses to crises are equally variable. Chapter 1 also provides basic frameworks for assessing and conceptualizing crises, along with a discussion of how crisis intervention may differ from traditional counseling. A task model of crisis assessment and intervention is introduced in Chapter 1 and integrated into all chapters. The model is a more comprehensive approach to assessing the whole person for a more accurate intervention.

Chapter 2: *Safety Concerns in Crisis Situations* was written by James Jackson, Lisa R. Jackson-Cherry, Latofia Parker, and Bradley T. Erford. When responding to a crisis, counselors need to be able to act promptly, meaning that crisis preparedness is essential to best practice during emergency situations. A brief overview of crisis planning guidelines and crisis counselor safety procedures is presented.

In Chapter 3: *Ethical and Legal Considerations in Crisis Counseling*, Paul F. Hard, Laura L. Talbott-Forbes, Lisa R. Jackson-Cherry, and Bradley T. Erford propose that crisis counselors well versed in crisis procedures and processes will be able to provide ethical, skilled help in all types of crisis conditions. The goal of this chapter is to provide information on ethical and legal considerations related to preventive measures, federal legislations, sentinel court findings, and best practices regarding privacy matters in crisis counseling.

Chapter 4: *Essential Crisis Intervention Skills*, by Bradley T. Erford and Lisa R. Jackson-Cherry, provides an overview of the fundamental skills needed to engage in effective crisis intervention work. The skills covered in this chapter focus on Ivey et al.'s (2022) microskills hierarchy. At the heart of this hierarchy is the basic listening sequence, an interrelated set of skills that not only fosters the development of rapport with clients but also aids in the identification of interventions to help achieve a successful resolution to the client's crisis state. Examples of the skills in use, as well as practice exercises to foster individual skill development, are provided.

Part I concludes with Chapter 5: *Loss, Grief, and Bereavement*, by Lisa R. Jackson-Cherry and Bradley T. Erford, which covers approaches to crisis counseling with mourners, theories of grieving, and the variables that affect how a bereaved person mourns. The chapter also addresses how timing, cause of death, and the role the relationship played in a person's life all mediate the mourning process, as well as an attempt to distinguish between "normal" grief and complicated bereavement. Chapter 5 concludes with an outline of components that should be implemented when preparing for and providing effective death notifications. Effective death notifications decrease the need

for intense debriefings and a complicated grief process, reduce counselor burnout, and may open the door for individuals to seek counseling when they are ready.

Part II: *Special Issues in Crisis Intervention* comprises the remaining chapters of the text. Chapter 6: *Risk Assessment and Intervention: Suicide, Nonsuicidal Self-Injury, and Homicide,* by Judith Harrington, Lisa R. Jackson-Cherry, and Bradley T. Erford, recognizes that suicide and homicide continue to play increasingly important roles in American society and on the world stage and that they affect us personally as we, family members, friends, and those in extended social networks struggle with the ever-increasing challenges of modern life. As personal liberty has increased, the chance for violent responses to stressful situations has increased. The effectiveness of the care given by professional emergency first responders, as well as the effectiveness of ordinary people in responding to their own crises and the crises of those about whom they care, is improved by background knowledge involving current trends in and treatments for suicide and homicide impulses.

Chapter 7: *Understanding and Treating Substance Use Disorders with Clients in Crisis*, by Bradley T. Erford and Lisa R. Jackson-Cherry, reviews substance use disorders and the disease of addiction, including causes, manifestations, and treatment. There are numerous models and theories about the causes of alcoholism and drug addiction, and this chapter introduces the medical and moral/legal models as well as important genetic, sociocultural, and psychological theories.

Chapter 8: *Intimate Partner Violence and Domestic Violence* is by Lisa R. Jackson-Cherry and Bradley T. Erford. This chapter provides an overview of DV/IPV, discusses the cycle of violence commonly experienced in abusive relationships, and explores perspectives on survivors who stay in relationships with abusive partners. Common crisis issues experienced by survivors of DV/IPV are also highlighted. In addition, this chapter explores special considerations regarding DV/IPV in lesbian, gay, bisexual, transgender, questioning, and other (LGBTQ+) relationships, relationships characterized by female-to-male violence, abusive relationships in various racial-ethnic populations, and abusive dating relationships among adolescents and young adults. Guidelines for crisis counselors conducting DV/IPV assessments, responding to DV/IPV disclosure, planning for client safety, and addressing the emotional impact of DV/IPV are provided. Finally, the goals, theories, and challenges associated with DV/IPV offender intervention are discussed.

Chapter 9: *Sexual Violence*, by Robin Lee and Jennifer Jordan, reveals that sexual violence is one of the most underreported crimes, with survivors facing a number of potential physical, psychological, cognitive-behavioral, and emotional consequences. Crisis counselors who work with individuals who have survived sexual violence need to be aware of the multitude of challenges these individuals face, best practices for treatment, and support services available in the local community.

In Chapter 10: *Child Sexual Abuse*, by Carrie Wachter Morris, child sexual abuse is defined, signs and symptoms described, treatment interventions discussed, and guidelines for working with law enforcement and child protective services personnel provided. In addition, this chapter addresses sexual offenders, their patterns of behavior, and common treatment options.

Chapter 11: *Military and First Responder Populations*, by Seth C. W. Hayden and Lisa R. Jackson-Cherry, acknowledges that serving the needs of military personnel and families

presents unique challenges for counselors working in a variety of settings. This chapter provides an in-depth discussion of the military experience and offers various approaches to assist military service members and their families. The chapter also addresses the unique issues encountered by first responders. Occupational stressors, medical emergencies, threats to personal safety, acts of violence, deaths, and crimes are common daily occurrences. Understanding the roles of first responders, their limitations based on departmental policies, and how to work as a team with first responders is important for crisis counselors. Common intervention programs with first responders are discussed to meet their unique needs.

In Chapter 12: *Emergency Preparedness and Response in the Community and Workplace*, by Jason M. McGlothlin, the information and interventions from the preceding chapters are integrated into an overview of the various disasters and crises that crisis counselors may need to address. Crisis intervention models and clinical implications for disasters and terrorist situations are explored.

In Chapter 13: *Emergency Preparedness and Response in Schools and Universities*, by Bradley T. Erford and Lisa R. Jackson-Cherry, crisis management in the school and university is explored, including the components of a crisis plan and the role of counselors and other officials. Mitigation and prevention strategies are emphasized as critical elements in the educational environment. Crisis preparedness, response, recovery, and debriefing procedures are applied to school and university settings. Special emphasis is given to strategies for how to help students and parents during and after a crisis event. Like Chapter 12, the content of this chapter infuses information found in previous chapters to allow readers to synthesize what they have previously read.

Finally, Chapter 14: *Counselor Self-Care in Crisis Situations*, written by James Jackson, Lisa R. Jackson-Cherry, and Bradley T. Erford, provides a brief overview of counselor self-care concerns and wellness.

KEY CONTENT UPDATES BY CHAPTER

All chapters include updated references/sources and compliance with the 2024 CACREP curricular standards. Application of the task model for assessment and intervention was integrated into cases throughout the book. Technological and distance counseling applications of crisis intervention during a pandemic were added to chapters, as applicable. Counselor safety, self-care, and wellness issues were added to chapters, as applicable. Chapter features including Case Studies, Voices from the Field, Activities, Think About It features, and resource lists were updated and standardized. In addition, specific content updates follow.

Chapter 1: Basic Concepts of Crisis Intervention incorporated learning objectives, reorganized content order for clarity, and added a new case study so that two cases are used to exemplify the task model of crisis assessment and intervention.

Chapter 2: Safety Concerns in Crisis Situations incorporated learning objectives and expanded several subsections to reflect current workplace safety protocols.

Chapter 3: Ethical and Legal Considerations in Crisis Counseling incorporated learning objectives and bolstered several sections to included electronic health record updates, technology, and spiritual and multicultural considerations.

Chapter 4: Essential Crisis Intervention Skills incorporated learning objectives, SOLER content, and revised examples to be more diverse, inclusive, and crisis focused.

Chapter 5: Loss, Grief, and Bereavement incorporated learning objectives and added content related to delayed or masked grief reactions and the importance of culture in understanding grief reactions.

Chapter 6: Risk Assessment and Intervention: Suicide, Nonsuicidal Self-Injury, and Homicide incorporated learning objectives, reorganized the chapter content order for clarity, added a new section on nonsuicidal self-injury, introduced Q-trees and additional assessment strategies, updated prevalence statistics, and expanded the discussion of violence risk factors.

Chapter 7: Understanding and Treating Substance Use Disorders with Clients in Crisis incorporated learning objectives, updated statistics, resources, and content and revised cases to use more inclusive language.

Chapter 8: Intimate Partner Violence and Domestic Violence incorporated learning objectives, updated statistics, resources, and content and added a Q-tree assessment for DV/IPV.

Chapter 9: Sexual Violence incorporated learning objectives, restructured order of content for flow and clarity, clarified terminology, expanded the section on treatment of juvenile offenders, and added a Q-tree.

Chapter 10: Child Sexual Abuse incorporated learning objectives and bolstered the prevention of CSA section.

Chapter 11: Military and First Responder Populations incorporated learning objectives and updated resources.

Chapter 12: Emergency Preparedness and Response in the Community and Workplace incorporated learning objectives, updated standards, expanded coverage of the response to natural disasters and use of telehealth, and updated resources.

Chapter 13: Emergency Preparedness and Response in Schools and Universities incorporated learning objectives and updated statistics and was expanded to include crime prevention through environmental design, the PREPaRE model, trauma-informed approaches, soft and hard lockdown protocols, evacuation and reverse evacuation protocols, contingency planning, psychological safety, new resources, and university response teams.

Chapter 14: Counselor Self-Care in Crisis Situations incorporated learning objectives, the importance of ongoing counselor self-assessment, and new self-assessments for wellness and resiliency.

PEDAGOGICAL FEATURES

Voices from the Field includes interviews with teachers, administrators, and curriculum specialists related to instructional practices and policies. These Voices features take the reader to the counseling frontlines for a real-life glimpse of what it is like to live the life of a professional counselor.

Think About It includes thought-provoking questions and examples that challenge the reader to dig deeper into the content and apply the learning to real-world contexts.

Activities provide applied learning, practice, and skill-building opportunities by encouraging readers to act upon and apply what they are learning. It is oft said, "You won't really learn it until you do it." Activities encourage readers to do just that!

In-chapter **Case Studies** with discussion questions and **Skill Practice** provide additional opportunities for students to apply what they learn to real-life case studies and

skill applications. Each case study is accompanied by processing questions that challenge the reader to think more deeply and apply what they learn to benefit clients.

LEARNING MANAGEMENT (LMS)–COMPATIBLE ASSESSMENT BANK, AND OTHER INSTRUCTOR RESOURCES

Assessment Bank

With this new edition, all assessment types—quizzes, application exercises, and chapter tests—are included in LMS-compatible banks for the following learning management systems: Blackboard, Canvas, D2L, and Moodle. These packaged files allow maximum flexibility to instructors when it comes to importing, assigning, and grading. Assessment types include:

- **Chapter Quizzes** Each chapter learning objective is the focus of a *Chapter Review Quiz*. Learning objectives identify chapter content that is most important for learners and serve as the organizational framework for each chapter. The multiple-choice questions in each quiz will measure your understanding of chapter content, guide the expectations for your learning, and inform the accountability and the applications of your new knowledge. Each multiple-choice question includes feedback for the correct answer and for each distractor to help guide students' learning.
- **Application Exercises** Each chapter provides opportunities to apply what you have learned through *Application Exercises*.

- **Chapter Tests** Suggested test items are provided for each chapter and include questions in multiple choice and short answer/essay formats.

Instructor's Manual

The Instructor's Manual is provided as a Word document and includes resources to assist professors in planning their course.

PowerPoint® Slides

PowerPoint slides are provided for each chapter and highlight key concepts and summarize the content of the text to make it more meaningful for students.

Note: All instructor resources—LMS-compatible assessment bank, instructor's manual, and PowerPoint slides—are available for instructor download at www.pearson.com. After searching for your title, be sure you have selected "I'm an educator," then select the "Instructor resources" tab.

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BRIEF CONTENTS

CONTENTS

ABOUT THE EDITORS

Lisa R. Jackson-Cherry, PhD, LCPC, NCC, ACS, NCSC, PCE, is a professor and director in the School of Counseling at Marymount University. She received a PhD in counselor education and supervision, an EdS in counseling, a Master's of Criminal Justice from the University of South Carolina, and a BA in Psychology and Sociology from the University of Notre Dame of Maryland. She is a Fellow with the American Counseling Association (ACA) and served two terms on the ACA Governing Council. Dr. Jackson-Cherry is the recipient of the ACA Carl Perkins Government Relations Award; the Lifetime Service Award from the Military and Government Counseling Association (MGCA) for her contributions with Law Enforcement and families; the Outstanding Service Award, Leadership Award, and Meritorious Service Award by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC); the Outstanding Leadership recipient of the European Branch of the American Counseling Association; the Outstanding Professor recipient of the Mediterranean Region Counselors Association; and the Outstanding Service and Leadership Awards from the Licensed Clinical Professional Counselors of Maryland. Dr. Jackson-Cherry is a licensed clinical professional counselor in Maryland, national certified counselor, approved clinical supervisor, and national certified school counselor. She is approved as a pastoral counselor educator by the American Association of Pastoral Counselors. She is trained as a disaster mental health counselor by the American Red Cross and in Critical Incident Stress Management/Debriefing by the International Critical Incident Stress Foundation. Dr. Jackson-Cherry is past president of ASERVIC, a division of ACA, and served on the Executive Board of the American Association of State Counseling Boards. She was appointed as the Task Force Committee Chair by MGCA to develop Best Practices for Counseling First Responder Populations. She was appointed to the Board of Professional Counselors and Therapists in Maryland, serving as chairperson for 4 years, chair of the Ethics, Credentials, and Legislative/Regulations Committees; and interim Executive Director. Dr. Jackson-Cherry's research focuses mainly on the areas of crisis intervention, ethical and legal issues in counseling and supervision, stressors with military and first responders, risk assessment, and religious and spiritual integration. She is the primary investigator and project director for a $1.2 million grant to increase clinical mental health counselors working with medically underserved populations and communities. She teaches courses primarily in the areas of crisis assessment and intervention, pastoral counseling integration, ethical and legal issues in counseling, and clinical mental health counseling internship. She coordinates an international class annually on global mental health issues and responses. Dr. Jackson-Cherry has been in private practice in Maryland for more than 20 years, the majority in an interdisciplinary and primary care setting where she worked with children, adults, and families focusing on anxiety, depression, substance use, autism, and behavioral issues. She served for many years as lead counselor with COPS-Kids (Concerns of Police Survivors-Kids) during National Law Enforcement Officers Week, providing group counseling to children who experienced the death of a law enforcement officer-parent in the line of duty. Prior to her faculty appointment in 2000, her previous clinical experiences consisted of clinical director for a mobile crisis team in Baltimore City, behavioral specialist (Grades K–5), conflict resolution coordinator/counselor (Grades 9–12), and group co-facilitator for a women's maximum-security correctional facility. She also worked with the dual-diagnosed population, in a police department youth counseling services division, and as a crisis intervention training facilitator for law enforcement basic trainees and hostage negotiators. Dr. Jackson-Cherry has written numerous articles, book reviews,

and book chapters and participated extensively at state, national, and international conferences over the past 25 years.

Bradley T. Erford, PhD, LCPC, NCC, LPC, LP, LSP, is professor and director of the human development counseling program of the Department of Human and Organizational Development in Peabody College at Vanderbilt University and Human Development Counseling Program Director. He was the 61st President of the American Counseling Association (ACA) for 2012–2013 and ACA Treasurer for 2017–2018. He is a Fulbright Specialist and is the recipient of the ACA Research Award, ACA Extended Research Award, ACA Arthur A. Hitchcock Distinguished Professional Service Award, ACA Professional Development Award, Thomas J. Sweeney Award for Visionary Leadership and Advocacy, and ACA Carl D. Perkins Government Relations Award. Dr. Erford was also inducted as an ACA Fellow. In addition, he has received the Association for Assessment in Counseling and Education (AACE) AACE/MECD Research Award, AACE Exemplary Practices Award, AACE President's Merit Award, the Association for Counselor Education and Supervision's Robert O. Stripling Award for Excellence in Standards, Maryland Association for Counseling and Development (MACD) Maryland Counselor of the Year, MACD Counselor Advocacy Award, MACD Professional Development Award, and MACD Counselor Visibility Award. He is the editor of numerous texts including *Orientation to the Counseling Profession*, *Crisis Intervention and Prevention*, *Group Work in the Schools*, *Internship and Practicum Experiences in Counseling*, *Group Work: Process and Applications*, *Transforming the School Counseling Profession*, *Professional School Counseling: A Handbook of Principles, Programs and Practices*, *Assessment for Counselors*, *Research and Evaluation in Counseling*, and *The Counselor's Guide to Clinical, Personality, and Behavioral Assessment* and coauthor of several more books: *Mastering the NCE and CPCE*, *45 Techniques Every Counselor Should Know*, *Free Access Assessment Instruments for Common Mental Health and Addiction Issues*, *Educational Applications of the WISC-IV*, and *Group Activities: Firing Up for Performance*. Dr. Erford is also the General Editor of *The American Counseling Association Encyclopedia of Counseling*. His research specialization falls primarily in development and technical analysis of psychoeducational tests and has resulted in the publication of more than 90 refereed journal articles, 1,500 book chapters, and 20 published tests. He is editor emeritus of *Measurement and Evaluation in Counseling and Development* (MECD) and Senior Associate Editor of *Journal of Counseling & Development*. Dr. Erford was a representative to the ACA Governing Council and the ACA 20/20 Visioning Committee. He is a past president and past treasurer of the Association for Assessment and Research in Counseling, past chair and parliamentarian of the American Counseling Association - Southern (U.S.) Region; past chair of ACA's Task Force on High Stakes Testing; past chair of ACA's Standards for Test Users Task Force; past chair of ACA's Interprofessional Committee; past chair of the ACA Public Awareness and Support Committee (co-chair of the National Awards Sub-committee); chair of the Convention and past chair of the Screening Assessment Instruments Committees for AACE; past president of MACD; past president of Maryland Association for Measurement and Evaluation; past president of Maryland Association for Counselor Education and Supervision; and past president of the Maryland Association for Mental Health Counselors. He was an associate editor of the *Journal of Counseling & Development*. Dr. Erford is a Licensed Clinical Professional Counselor, Licensed Professional Counselor, National Certified Counselor, Licensed Psychologist and Licensed School Psychologist. A graduate of The University of Virginia (PhD), Bucknell University (MA), and Grove City College (BS), he teaches courses in assessment, research and evaluation in counseling, and stress management (not that he needs it, of course).

ABOUT THE CONTRIBUTING AUTHORS

Paul F. Hard, PhD, LPC-S, NCC, is Chair of the Department of Counselor, Leadership, and Special Education at Auburn University at Montgomery, where his concentrations are in clinical mental health and marriage and family counseling. He has over 26 years of agency counseling and private practice experience. Dr. Hard's clinical foci have been in the areas of addictions, relationship counseling, individuals with LGBTQ+ sexual identities, and trauma. His research interests have been in the areas of ethics, counselor/professional impairment and wellness, complicated grieving in pre- and postnatal loss, professional credentialing and advocacy, sexual minority issues in counseling, and ministerial termination.

Judith Harrington, PhD, LPC-S, LMFT, is an associate professor and program coordinator at the University of Montevallo in Alabama, and also maintained a private practice for over 30 years in Birmingham, providing counseling and consultation to individuals, couples, families, groups, and agencies. She is an approved trainer for the *Assessing and Managing Suicidal Risk* curriculum for mental health professionals on behalf of the Suicide Prevention Resource Center at the Substance Abuse and Mental Health Services Administration (SAMHSA). Since 2008, Dr. Harrington has instructed the graduate counselor education curriculum on suicide for the University of Alabama at Birmingham and the University of Montevallo. She served for 5 years on the Standards, Training, and Practices Committee for the National Suicide Prevention Lifeline at SAMHSA. She has served the suicidally bereaved community by facilitating the SOS Bereavement Group for 14 years and was the first- and twice-elected president of the nonprofit Alabama Suicide Prevention and Resources Coalition (ASPARC). Dr. Harrington's state and ASPARC were twice awarded a 3-year Garrett Lee Smith Youth Suicide Prevention grant for which, among its many initiatives, she developed the Comprehensive Suicide Prevention Resource Directory for mental health professionals and concerned citizens, found at *www.asparc.org*.

Seth C. W. Hayden, PhD, NCC, is an associate professor of counseling and coordinator of the clinical mental health program at Wake Forest University. His research focuses on the connection between career development and mental health. In addition, he examines the career and personal development needs of military service members, veterans, and their families. Dr. Hayden is a licensed clinical mental health counselor in North Carolina, a licensed professional counselor in Virginia, a national certified counselor, a certified clinical mental health counselor, a certified career counselor educator, and an approved clinical supervisor. In addition, he is past president of the Military and Government Counseling Association and National Career Development Association, both divisions of the American Counseling Association.

James Jackson, PhD, LPC-S, NCC, is a professor and coordinator of the Clinical Mental Health Counseling track at the University of Montevallo in Alabama. His clinical specialties include play therapy, trauma-focused cognitive-behavioral therapy, and advocacy services with abused children and adolescents in schools, foster homes and group homes, as well as serving adults and families through private practice, in-home, and community mental health agencies.

Jennifer Jordan, PhD, LPCS, NCC, is a professor in the Counseling and Development program at Winthrop University. She is president of the South Carolina Board of Examiners for licensed professional counselors, marriage and family therapists, addictions counselors, and psychoeducational specialists and Executive Director of the South Carolina Counseling Association.

Robin Lee, PhD, is a professor in the Professional Counseling program in the Womack Educational Leadership Department at Middle Tennessee State University, specializing in mental health counseling. She earned a PhD in counselor education and supervision from Mississippi State University and an MEd in community counseling and a BA in psychology from Delta State University in Cleveland, Mississippi. Dr. Lee is a licensed professional counselor with Mental Health Service Provider status in Tennessee, a national certified counselor, and an approved clinical supervisor.

Jason M. McGlothlin, PhD, LPCC-S, is an associate professor in the Counselor Education and Supervision program at Kent State University. He earned his PhD in counselor education from Ohio University and is a licensed professional clinical counselor with supervisory endorsement in Ohio. For nearly 30 years, he has specifically worked with suicidal clients in a variety of settings including his private practice (McGlothlin Counseling & Consultation, LLC). Through his practice and research, Dr. McGlothlin developed the SIMPLE STEPS model of suicide lethality assessment and presents and consults nationally and internationally on suicide assessment practices. He has served as president of the Ohio Counseling Association (2000–2001) and in 2022 began serving as chair of the American Counseling Association Midwest Region.

Latofia P. Parker, PhD, LPC, NCC, BC-TMH, completed her doctoral study at the University of Alabama and is an associate professor in the Counselor Education program at the University of Montevallo, with primary teaching responsibilities in grief and loss, ethical and legal issues in counseling, and clinical supervision. Her research interests include crisis intervention, counselor education pedagogy, and ethical and legal issues in counselor education.

Laura L. Talbott-Forbes, PhD, MCHES, is an associate professor in the Department of Human Studies at the University of Alabama at Birmingham. She has served as a prevention specialist with general college student health issues and director of substance abuse prevention programs at a large university. Her research interests include the prevention of substance abuse, education and early intervention with potentially suicidal persons, and other public health issues that impact young adult health.

Carrie Wachter Morris, PhD, NCC, ACS, is an associate professor of Counseling and Educational Development at the University of North Carolina at Greensboro, where she coordinates the school counseling track. She served as president (2015–2016) of the Association for Assessment and Research in Counseling. She has nearly two dozen articles in national peer-refereed journals, one book, and an additional 10 chapters in different works. She presents regularly at state, regional, and national conferences on topics related to the scholarship of teaching and learning in counselor education, crisis, and school counselor education.

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CHAPTER

1 Basic Concepts of Crisis Intervention

Lisa R. Jackson-Cherry, Jason M. McGlothlin, and Bradley T. Erford

PREVIEW

Crises occur in a variety of settings for a variety of reasons. Responses to crises can come in various forms and can include multiple levels of complexities. In this chapter, we discuss how crisis intervention may differ from traditional counseling, describe the roles of various professionals and paraprofessionals who work in crisis teams, describe actions crisis workers can take depending on the crisis affecting the client, describe basic historical and contemporary crisis theories, and describe models of crisis assessment and intervention. We start our exploration of crisis intervention by discussing key terms and concepts related to crisis.

LEARNING OBJECTIVES

Upon completion of this chapter, the reader will be able to:

1.1 Describe the key terms and concepts in the field of crisis intervention.
1.2 Compare crisis intervention and traditional counseling.
1.3 Describe the roles of various professionals and paraprofessionals who work in crisis teams.
1.4 Describe approaches crisis workers can take depending on the crisis affecting the client.
1.5 Describe historical and contemporary crisis theories.
1.6 Apply the task model of crisis assessment and intervention to crisis situations.
1.7 Apply other models of crisis assessment and intervention to crisis situations.

KEY TERMS AND CONCEPTS RELATED TO CRISIS

Learning Objective 1.1 Describe the key terms and concepts in the field of crisis intervention.

To help plan effective crisis response strategies, it is important to keep a few key concepts in mind and to be aware that many of the terms used in stress and crisis literature are used inconsistently, interchangeably, or without specificity. While the definitions of many terms seem obvious, some have unique connotations within the context of crisis intervention. In this section, we define key phrases and concepts used to describe crisis intervention theories and models.

What Is a Crisis?

If asked to think about a crisis, what comes to mind? Natural disasters? School shootings? Suicide? Domestic violence? How do some people survive crisis events adaptively and with resilience, while others endure mental health issues for months, years, or a lifetime?

To begin, situations such as tornadoes, earthquakes, acts of terror, and suicide do not in and of themselves constitute crises. A crisis is an event that may or may not be perceived as a disruption in life. A crisis does not necessarily lead to trauma. Typically, a crisis is described using a trilogy definition; that is, there are three essential elements that must be present for an event to be considered a crisis: (1) a precipitating event, (2) a perception of the event that leads to subjective distress, and (3) diminished functioning when the distress is not alleviated by customary coping mechanisms or other resources. Using the trilogy definition, some experience diminished functioning following a crisis event experience, while others, however affected or horrified, usually continue to function as normal. For these individuals, the crisis event was not perceived as traumatic, and it did not disrupt their everyday lives.

James and Gilliland (2017) reviewed numerous definitions of crisis that exist in the literature and summarized crisis as "a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms" (p. 3). When a crisis is perceived as disruptive to one's life, the crisis may be experienced as a traumatic event. Fortunately, most individuals can work through crisis events. For many who experience a crisis, the experience can assist in preventing or working through future crises, therefore decreasing trauma in the future.

No formula exists that explains why some individuals can work through a crisis, while others who experience the same crisis find it traumatic and disruptive to daily functioning. Therefore, the idea that an individual's perception of an event determines whether the event will become traumatic is paramount to understanding an individual and making a plan of action. However, an individual's perception of an event can be influenced by various determinants, such as the individual's level of resilience, resources, coping mechanisms, and support system.

Often a crisis can lead to additional crises that can be debilitating and affect not only the person but also the entire family or community system. When a person encounters multiple crises, or when past crises the person was exposed to were not resolved effectively, the person or system could experience trauma. When a person experiences trauma, they may need assistance from a crisis counselor to assess the situation, evaluate options for adjusting to the crisis, explore resources currently available to the client, work through the current crisis, and connect with new resources and referrals. As a first exposure to the potential characteristics of a crisis, see Case Study 1.1 and answer the discussion questions that follow. Also read Voices from the Field 1.1.

CASE STUDY 1.1

The Nguyens: A Natural Disaster Affects a Family System

Vin and Li Nguyen are recent immigrants to the United States. They reside in a small town along the Gulf Coast of Mississippi, where many other Vietnamese immigrants have settled. Like many new members of the community, the Nguyens are learning

to speak, read, and write English and are hoping to become naturalized citizens of the United States someday. After arriving in the United States, the Nguyens invested all their money in an old shrimp boat to support themselves by selling their daily catch to local seafood processing facilities.

Recently, the shrimp boat was heavily damaged, and the seafood processing facilities were destroyed by a hurricane. Subsequently, the Nguyens had no income for quite a while. With that and no health insurance, they relied on the county department of public health for prenatal care when Li became pregnant. Li's pregnancy progressed normally; however, her daughter was born with spina bifida. As you read this chapter, try to conceptualize the Nguyens' situation according to the crisis models presented.

Discussion Questions

1. What incidents have occurred in the Nguyens' lives that could be considered provoking stressor events?
2. Beyond these events, are there additional stressors that the Nguyens must address?
3. What resources are the Nguyens using?
4. What additional information do you need to determine whether the Nguyens are in crisis?
5. What factors will predict the outcome for this family?

VOICES FROM THE FIELD 1.1

My First Day

Beth Graney

I spent the summer planning all the classroom lessons and groups I would offer students in my first position as the only school counselor in a K–12 school in rural Iowa. After the principal shared with me that the previous counselor never really connected with many of the kids, I knew I needed to be especially creative to win their trust. The principal told me the town had a saying, "If you aren't born here, you're not from here!" How would a big-city girl from Chicago ever fit in?

All these thoughts raced through my head, drowning out the din of my radio as I drove the 20 miles to school. The newscaster's report that a couple died in a motorcycle accident the previous night barely registered. When I arrived early that morning, the principal greeted me at the door and pulled me into her office. "The parents of two of our students died last night, and other students have arrived at school crying. You have to do something," she blurted as she hurried off to take care of notifying the rest of the staff. My mouth went dry and my thoughts started to race. What should I say? What should I do? What strategies would be most effective? More importantly, I thought, I don't know a single student in this building!

As I entered the large classroom that was now my office, I saw 20 kids ranging in age from early elementary to high school. As I put down my bag on the desk, I looked at the crying kids, pulled up a chair, and said, "Who wants to start?" Someone began with, "They are my friends, my neighbors, and our classmates!" I listened. Soon another child said, "My grandma is sick," and then others said, "My dad lost his job" and "My parents are getting divorced." I listened. As the morning progressed, some kids went on to class, others went home, and more came from class or home to share their grief and fears with the group. I listened some more. When the long day finally ended, I did not know everyone's name that I had written on the sign-in sheet by memory, but I had a growing sense of community.

Two days later, after listening to many students and teachers explain how this tragedy had affected them, the principal told me the funeral service would be held in the gym because the gathering would be so large. She thought it would be important for me to

(*continued*)

be there to support the kids in case anyone needed immediate assistance. I listened as the minister and other family members eulogized the parents. After the service, I met many of the parents and community members, and again I listened to their grief and pain. When a person dies, the family and friends grieve. But in a small town, when someone dies, the whole town grieves.

As I drove home that day, I felt drained and wondered whether I had been helpful because I had no great insights or strategies to offer the students or parents as to why something so difficult and tragic had happened. All I really did was listen. It was then that it struck me that it was the first skill ever taught in my graduate counseling program: Listen! And so began one of my most memorable years in counseling. My phone did not stop ringing and my sign-up sheet was never empty. I made the transition from city girl to rural school counselor simply by listening.

Stress

In Western culture, the word *stress* is widely used to describe emotional phenomena ranging from feeling mild irritation and frustration to being frozen with fear. As the word relates to crises, however, it applies more to the ability to function than it does to affect. The term *stress* was introduced into medical literature by Hans Selye (1978), to describe nonspecific responses of the human body to demands that are placed on it. Stress activates what Selye called the "general adaptation syndrome," which is associated with biological responses. Changes in hormonal patterns, such as increased production of adrenaline and cortisol, over time, may deplete the body's energy resources, impair the immune system, and lead to illness. Selye distinguished between two types of stress: (1) distress (i.e., changes that are perceived negatively) and (2) eustress (i.e., changes that are perceived positively). He noted that distress tends to cause more biological damage than eustress, the latter seeming to contribute to well-being. Thus, how stress is perceived influences adaptation.

The terms *stress* and *crisis* often have been used interchangeably in the literature, thus creating a bit of confusion. Boss (2006) has attempted to distinguish between the two concepts, stating that *stress* is a continuous variable (i.e., stress may be measured by degree), whereas *crisis* is a dichotomous variable (i.e., there either is or is not a crisis). In other words, it is helpful to think of a crisis as simply an event. There either is a crisis or there is not a crisis. Stress may be thought of as a process that exists over time, such as the stress of having a loved one serving in the military in a hostile environment. In contrast, crisis may be thought of as a temporary period during which typical coping ceases and there is intense disorganization and disequilibrium. For example, a family accustomed to coping with the stress of having a loved one serving in the military and stationed in a combat zone may experience crisis when that individual returns home. The family's boundaries, structure, and coping mechanisms may have changed during the loved one's absence, leaving the family inadequately equipped to function with that loved one's homecoming.

Stress is the pressure or tension on an individual or family system. It is a response to demands brought about by a stressor event and represents a change in the equilibrium or steady state of an individual or family system (Boss, 2006; Bush & Price, 2020). The degree of stress experienced hinges on perceptions of, and meanings attributed to, the stressor event. While anything with the potential to change some aspect of the individual or family (e.g., boundaries, roles, beliefs) might produce stress, increased stress levels do not necessarily always lead to crises. Often, stress can be managed, and the family or individual can arrive at a new steady state.

Since stress can be measured by degree, a common and effective technique used in assessing stress levels and changes to stress is *scaling* (Erford, 2020). This simple technique can be used to monitor increases and decreases in stress (as well as just about any other symptom or variable such as depression, sadness, anger, etc.) and then to compare present distress to a baseline prior to the crisis event. This may occur, for example, when asking a client in crisis, "On a scale of 0 to 10 (with 0 being none and 10 being the highest you ever experienced), what would you rate the level of anxiety you are feeling right now?" If you have worked with the client previously, you can use the number as a comparison in the next contact, "Last time we met, you said your anxiety was an 8. Where would you rate it today?" Then the same scaling can be used to understand possible helpful or hindering coping resources, changes in symptoms, or new events. For example, in this dialogue, if the client says they are now at a 2, you could inquire; "The last time we met, you rated your stress at an 8 and now you report a 2. What has made the number lower today?" For a crisis worker, this simple assessment can help better understand whether coping tools or resources are helpful and allow for adjustments. We suggest using a scale from 0 to 10 and identifying the end points so there is no confusion or misinterpretation of rating levels.

Trauma

Stressor events that involve trauma are powerful and overwhelming, and they threaten perceptions of safety and security. Some may be single incidents of relatively short-term duration, whereas others may occur over longer periods of time, resulting in prolonged exposure to the threatening stressor.

Just as the terms *stress* and *crisis* have been incorrectly used interchangeably, so too have the terms *crisis* and *trauma*. A crisis is the event that, by itself, does not result in trauma. The crisis event cannot be controlled. If a person perceives the crisis event in a way that affects daily functioning, the crisis event may become a traumatic experience. Likewise, stress may or may not be experienced because of an event. Rather, it depends on the individual's perception of the crisis.

According to the fifth edition, text revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022), a traumatic event involves threatened or actual death or serious injury, or a threat to the well-being of oneself or another person. Traumatic events may be human-caused accidents or catastrophes. Other traumatic events include acts of deliberate cruelty, such as acts of terrorism, school and workplace shootings, and homicides and sexual assaults. Note that these crisis events created trauma in some people but not in all people. The crisis was an event; trauma was a reaction to that event.

Responses to Trauma

In general, people experiencing traumatic events respond with intense feelings of fear and helplessness (American Psychiatric Association, 2022). Most people respond to trauma within a normal range of reactions to abnormal events, whereby the individual's baseline is not disrupted to the point that it causes impairment or dysfunction. Others become significantly distressed and impaired, and a few develop illnesses such as acute stress disorder (ASD) and posttraumatic stress disorder (PTSD). The risk for psychological disturbance tends to increase with the magnitude or intensity of the traumatic stressor and with the degree to which the event was human caused and intended to harm.

Reactions to traumatic events typically include physical, behavioral, cognitive, emotional, and spiritual responses, which tend to occur in stages but ultimately are temporary. These transient reactions are often referred to as reactions to posttraumatic stress. Physical responses involve the autonomic nervous system as the person prepares to "fight, flee, or freeze" and may be experienced through symptoms such as palpitations, shortness of breath, nausea, muscle tension, headaches, and fatigue. Behaviorally, individuals may experience sleep and dietary changes, social withdrawal, purposeful avoidance of or attention to reminders of the trauma, changes in relationships, and increased use of alcohol or other mood-altering substances. Cognitive responses include rumination, preoccupation, forgetfulness, and difficulty concentrating. Emotional responses include distress, anxiety, impatience, irritability, anger, and symptoms of depression. Finally, spiritual responses are centered on existential questions and attempts to find meaning in the traumatic event. These reactions may transpire over a period of up to 2 years but are not considered pathological.

While most people return to a level of equilibrium and healthy functioning following a reaction to traumatic stress, some may experience consequences that impair their ability to function. Many of these people experience one or two of the trauma- and stressor-related disorders described in the DSM-5-TR: ASD or PTSD. These two disorders are similar in their symptomology and differ mainly in their temporal association with exposure to the traumatic event. According to the DSM-5-TR, the diagnostic criteria for ASD and PTSD include hyperarousal (e.g., hypervigilance, difficulty concentrating, exaggerated startle responses, sleep disturbance), reexperiencing (e.g., flashbacks, nightmares, intrusive thoughts), negative cognitions and mood (e.g., memory lapse, exaggerated negative beliefs, distorted cognitions, lessened interest in activities), and avoidance (e.g., attempts to avoid reminders of the traumatic event, inability to recall components of the event, detachment, dissociation, restricted affect)—symptoms that lead to distress and impairment in key areas of functioning such as work and interpersonal relationships. If these symptoms appear within 1 month of exposure to the trauma, ASD is diagnosed. If exposure to the traumatic event occurred more than a month prior to the development of these symptoms, PTSD is diagnosed. If symptoms persist for more than 3 months, PTSD is considered chronic. For the most part, the role of the crisis counselor would be to gather this information, indicate what the client reported about these events, and list with which symptoms the client presented.

Coping

A crisis event may be perceived as traumatic due to a lack of resources or failed coping strategies. *Coping* is defined as any behavioral or cognitive action that is taken to manage stress. In general, coping is considered a process (Erford, 2023). The process begins with an appraisal of a stressor and its potential for harm. If the situation is perceived as challenging or threatening (as opposed to irrelevant), further assessment takes place to determine what responses are possible and what the potential outcomes might be. Responses to stress fall into three broad categories: problem-focused coping, emotion-focused coping, and avoidance-focused coping (Linley & Joseph, 2004).

Problem-focused coping involves taking direct behavioral actions to change or modify aspects of the environment that are thought to be the causes of stress. When this type of coping strategy is employed, efforts are made to define the problem, generate

possible solutions, weigh alternatives in terms of their costs and benefits, choose an alternative plan, and act. *Emotion-focused coping*, on the other hand, is more likely to be used in situations deemed unlikely to change. The aim of such coping is to reduce affective arousal so that the stressful situation may be tolerated, and it generally involves cognitive processes that change the meaning of a stressor or create emotional distance from it. *Avoidance-focused coping*, the third type of response to stress, may be viewed as a subset of emotion-focused coping, in which responses such as distraction or diversion are employed to avoid the stressor and the emotions that would be associated with it.

Coping may lead to successful or unsuccessful and adaptive or maladaptive outcomes. Following the experience of a traumatic stress event, for example, some individuals may choose to increase their alcohol consumption. While this behavior does little to address the needs brought about by the stressor, it may be an effective (albeit unhealthy) way to keep unwanted emotions at bay (Bush & Price, 2020). Whether coping averts crisis and leads to adaptation depends on the person experiencing stress, the specific type of stress encountered, and the features of the stressful encounter that the person attempts to manage.

Although problem-focused, emotion-focused, and avoidance-focused coping have all been linked to adaptation or posttraumatic growth (Linley & Joseph, 2004), none of these approaches to coping guarantees a positive outcome. Problem-focused coping seems to be most valued in Western culture (Hays & Erford, 2023), yet it can be counterproductive if the situation causing stress is unalterable. If the stressor is unalterable, problem-focused efforts fail and distress is likely to persist. In such times, emotion-focused coping might be the better option. Avoidance-focused coping is least likely to result in adaptation or growth and most likely to lead to impaired well-being (Linley & Joseph, 2004). Complete Think About It 1.1 to assess how you cope with stress.

THINK ABOUT IT 1.1

Think about how you cope with stress (and possibly trauma). What material factors and cognitions help you cope? What people help you cope? How could these material factors, cognitions, and people be considered protective factors in your life?

Adaptation

Adaptation—an outcome of stress or crisis—is the degree to which functioning has changed over an extended period and may be measured by the fit between the individual or family system and the environment. Some individuals and families benefit from the challenges of adversity. Successfully dealing with adversity often results in an outcome that is better than one that might have been reached without the adversity. Many individuals and families change to the point where they have the resources to meet the demands of stressors while continuing to grow. Quite often, changes have occurred in functional behaviors such as rules, roles, boundaries, and interpersonal communication patterns, resulting in families being better equipped to meet the challenges of future stressors. Conversely, for some individuals and families, an imbalance continues between stress demands and the capability to meet those demands. Many families may adopt unhealthy and unproductive responses to stress. Unhealthy coping behaviors, such as

addictions or domestic violence, result in additional stress. Furthermore, it is often the case that coping behaviors that appear to be healthy contribute to stress. A parent, for example, might take a second job to increase the family's financial resources. Working extra hours, however, removes that parent from the home and may contribute to strained family relationships and a decrease in other nontangible resources.

Resilience

Individuals or families that bounce back from adversity are considered to have *resilience*. Numerous studies have attempted to identify factors that determine resiliency in individuals. Although there has been some confusion in the literature about whether to conceptualize resilience as a personal trait or as a dynamic process (Luthar, 2006), the prevailing viewpoint favors process. Thus, resilience may be defined as the dynamics that contribute to positive adaptation following exposure to experiences that have the potential to disrupt functioning (Masten & Obradovic, 2008).

Early studies of resilience focused on individuals with schizophrenia and factors that would predict the course of the illness for them, but most research on resilience has focused on children experiencing adversity. Among the multiple adverse conditions studied have been parental mental illness, chronic illness, poverty, community violence, abuse, and catastrophic events (Luthar, 2006). Through these studies, a variety of concepts were identified as protective factors that operate to ensure resilience. For the most part, these factors involve relationships.

Masten and Obradovic (2008) summarized several fundamental adaptive systems that seem to make a difference in human resilience. Beginning in early childhood, adaptation and the likelihood of resilience seem to depend on the quality of relationships with attachment figures. Attachments that are described as "secure" seem to moderate anxiety by allowing children to feel confident, connected, and reassured. As secure, confident children mature, they develop competence, self-efficacy, and mastery. Mastery develops as individuals learn they can interact successfully with their environments. In times of adversity, those with mastery motivation are likely to persist in their efforts to manage the environment.

Related to mastery is the ability to apply cognitive skills to solve problems. People who are resilient seem to be better at applying cognitive skills during times of adversity than those who are less well adapted. During times of high stress or threat of harm, it is important to be able to continue to think and plan effective responses. Thinking and problem solving during stressful situations are enhanced when emotions, arousal, and attention are self-regulated (Masten & Obradovic, 2008).

Being a part of larger social systems also seems to play a role in resilience. Social groups and networks provide resources such as information and support that are important in dealing with adversity. For children, attending school provides opportunities to acquire knowledge, develop social skills, and practice self-regulation, all resources that might be called for in times of stress. For older children, adolescents, and adults, being part of friendship networks, clubs, work groups, or civic organizations also has the potential to contribute to resilience.

Among the larger systems most studied are religion and spirituality. Religious and spiritual connections provide attachment-like relationships and social support, as well

as opportunities to practice self-regulation through prayer and meditation (Masten & Obradovic, 2008). In addition, religious and spiritual beliefs influence the way people attribute meaning to stressful situations and events and contribute to posttraumatic growth (Gerber et al., 2011).

Whether individuals experiencing adverse conditions demonstrate resilience depends on the operation of protective systems that have evolved through biology and culture (Masten & Obradovic, 2008). If the systems are operating normally, the capacity for resilience is optimal; if they are damaged, the potential for resilience is compromised. Read Voices from the Field 1.2, which discusses resilience within the context of a hurricane.

VOICES FROM THE FIELD 1.2

Human Resilience in the Aftermath of Katrina

Beth Graney

We landed in the New Orleans airport 6 weeks after Hurricane Katrina devastated the coastal areas and encountered the first of many eerie and unsettling sights we would experience over the next 2 weeks. Six school counselors from our county were given permission to volunteer with the Red Cross disaster relief effort to provide counseling to victims of the hurricane. Our mission, or so we thought, was to aid school-age children. However, upon arriving, we quickly found that the Red Cross had different ideas. Due to the devastation caused by the hurricane, most children were still with parents in shelters throughout Louisiana and other states.

As a licensed professional counselor, I was able to function as a counselor/therapist; however, "my office" was outside, at a drive-through Red Cross site handing out food and cleaning supplies to folks who had lost their homes or were beginning the clean-up process. As cars came through, we offered people advice on safety issues for cleaning up mold, pamphlets on medical concerns typical after a devastating event, and warning signs of depression and other mental health concerns. The days were long and hot with a steady stream of cars from 7:00 a.m. to 6:00 p.m. or later. From the beginning, I was talking and listening to people and their experiences, sharing their pain.

At first, I was not clear about how I was offering counseling or mental health assistance. Yet as the days passed, I noticed that many people came again and again, and each time I heard a little more of their story. Some days a person seemed upbeat, only to come back later in the day with tears, anger, or frustration at the bureaucracy involved in getting anything meaningful accomplished. I heard stories of amazing escapes from the hurricane or the flooding when the levees burst. People told me how they witnessed great acts of selflessness and heroism—stories that never made the papers. Others talked of all they lost: "I don't even have one picture of my three kids," "I not only lost my house, my possessions, my car, but my job too," "All of my important medical papers are gone as well as all of my insurance information." Most heartbreaking were the loss of friends and relatives: "I still can't reach my daughter," "My mother died because she wouldn't leave her house." One woman was trying to find a place to continue her chemotherapy treatment from breast cancer, while another talked about leaving with her son who was a quadriplegic and trying to replace important medical equipment she could not bring when she left.

Yet, each day, there was laughter and happiness despite the hurricane, because people had survived and so they could begin again. At times, people pulled their car out of the line so we could talk in-depth about their situation—not for answers necessarily, just for a few brief moments to allow themselves to grieve before they got back in line to pick up yet another bottle of bleach and a new mop to continue their clean-up.

I learned many things about people and how they come to terms with hardship, loss, and devastation. Firsthand, I learned that Maslow was right: People's primary needs such as food, clothing, shelter, and safety must first be met before they can deal with higher-level emotional needs. I learned that people can and do survive against overwhelming odds and the most difficult of circumstances. Often, they do so with great resolve, courage, and even optimism. Quickly I noted that most people were able to deal with the loss of their possessions because they realized they could have

(*continued*)