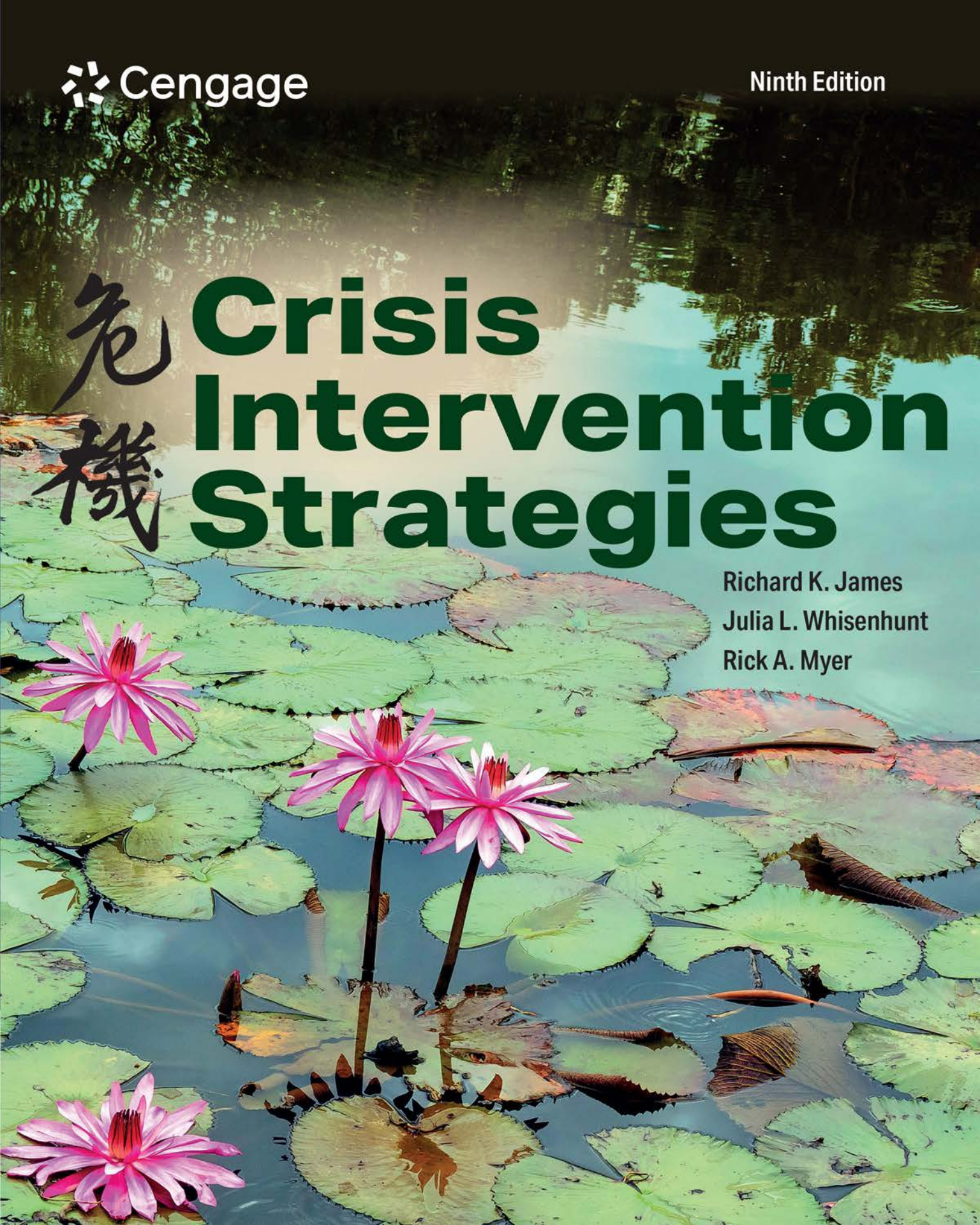
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Ninth Edition
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Crisis Intervention Strategies
Richard K. James
Julia L. Whisenhunt
Rick A. Myer

# Crisis Intervention Strategies

**Ninth Edition**


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# Dedication

Through the timeline of 37 years and nine editions of this book, we have never experienced an ecosystemic crisis that has affected people and first responders worldwide the way the COVID-19 pandemic has. The pandemic is an example of chaos theory in action, with a titanic struggle to find innovative ways to deal with the countless emergencies and challenges therein. But that is how we remain resilient and how we survive—by evolving to meet such horrific challenges. Accordingly, we would like to dedicate this ninth edition to the first responders who went directly into harm's way to provide services for a world in desperate need of support and assistance. From EMT's and fire personnel who transported sick people, to law enforcement officers and social workers who made wellness checks, to doctors and nurses who risked their lives and health during double and triple shifts, and to the grandparents, parents, brothers and sisters, and dear friends who stood vigil and cared for their loved one, this ninth edition of the crisis book is dedicated to you. This edition is also dedicated to my beloved daughter, Samantha Whitehawk, Nurse Practitioner at St. David's Hospital ICU in Austin, Texas, who was in the middle of that crisis tsunami and worried her dad every night she went to work. Thank you all for being there for us.

Dr. Dick James

# Brief Contents

# Contents

# Preface

## Rationale for the Book

### The Primacy of Crisis Intervention

The Chinese characters embedded in the front of this book symbolize both "danger" and "opportunity!" Further, the lotus flower pictured on the cover roots in mud and grows out of murky water to blossom into a stunning symbol of purity and rebirth. This symbolism encapsulates the focus of this book while capturing the essence of **crisis**—the human dilemma that is common to all cultures. We believe that practically all counseling is initiated as crisis intervention. As much as the helping professions would prefer otherwise, people tend either to avoid presenting their problems to a helper until those problems have grown to crisis proportions or become ensconced in situational dilemmas that wind up in unforeseen crises. Our ideal objective, as human services workers, is to establish primary prevention programs so effective that crisis intervention will seldom be needed. Although recently a shift has occurred, still many people are not as quick to adopt preventive measures for their psychological health as for their physical health.

### The Case for an Applied Viewpoint

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

Where controversies exist in regard to treatment modalities, this text attempts to present as many perspectives as possible. The authors have endeavored to incorporate, synthesize, and integrate the case-handling strategies of these resource people in a comprehensive, fluid, and dynamic way that will provide crisis workers with a basic set of tenets about effective crisis intervention. This book is not about long-term therapy or theory, nor is it a volume dealing with crisis from only one theoretical perspective, such as a psychoanalytic approach or a cognitive-behavior system. The book incorporates a wide diversity of therapeutic modalities and reflects our eclectic and integrated approach to crisis intervention.

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

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

than science and is not prescriptive. Therefore, we would caution you that there are no clear-cut prescriptions or simple cause-and-effect answers in this book. We encourage you not to fall into the trap that since you have heard something before and the strategy you used worked to perfection, to simply use the same strategy again. Each crisis and person is unique, meaning the intervention strategy must be tailored for that situation.

## The Case for an Experiential Viewpoint

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

**Moral Dilemmas.** Another issue that permeates many of the topics covered in this book is the emotions they generate and the beliefs about what is morally "right" and what is morally "wrong" that pervades them. People have been willing to go to prison or die because of the strong beliefs they held about many of these topics. Where such moral issues and beliefs abound, we have attempted to deal with them in as even-handed a manner as possible. Although many of you will deal with crises in an office setting or possibly responding to a disaster, understand that not all crisis intervention takes place in those settings. A classic current example is the role law enforcement plays in crisis intervention. We spend a fair amount of time detailing how crisis intervention team officers play an important role in responding to crisis individually and as members of a crisis response team. This book is not about the morality of the issues covered, but rather about what seems to work best for the people who are experiencing the dilemma. We ask you to read the book with that view in mind, and for at least a while, suspend your moral view of the situation or problem as you read about crisis workers attempting to grapple with these heart- and gut-wrenching problems.

At times, we have been questioned and criticized for our use of regional cultural dialects and the use of profanity in our dialogues. That is not done to disparage or demean anyone or any group of people. We do this to portray, as realistically as we can, the way people in crises talk. Know that people in crisis are not necessarily politically correct and, even more important, they may use colorful language. When individuals experience crisis, their emotions are raw, behavior is uncharacteristic, and thought processes are altered. Crises create such disequilibrium that social and political filters may not be used. As such, to help prepare readers for the experience of crisis intervention, we attempt to present case vignettes that depict a relatively realistic crisis and the emotions, behaviors, and thoughts that most often are experienced with the crisis state.

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

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

Our experience has shown us over and over that students and trainees who scoff at and dismiss these basic relationship skills are the ones who invariably have the most trouble meeting the experiential requirements of our courses and workshop training sessions. We feel very strongly about this particular point and thus ask you to read Chapter 3 with an open mind. Much the same can be said about Chapter 4, The Tools of

the Trade. Students and veteran human service workers who operate out of a client-centered mode may find what we are proposing pretty close to heresy because a lot of these tools are directive and judgmental as to the action to be taken, particularly when client safety is concerned. Again, we ask you to suspend judgment and give these tools a good tryout in this new venture.

The learning objectives for each chapter are based on Bloom's Taxonomy but tend to focus on lower order skills. This is because reading a book cannot, in and of itself, prepare individuals for crisis work. In addition to gaining the knowledge of crisis intervention, one of two things needs to happen to move readers into higher order learning. First, the MindTap supplement that goes with this book will do that admirably with the supplementary materials it provides. Second, instructors can put the knowledge, theories, and techniques to work in live classroom exercises that include critical demonstrations, role play, and discussion, to apply the knowledge to produce skill and technique in crisis intervention.

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

A major problem in role playing is the perception of standing up in a class or workshop and risking making a complete fool of oneself. We want to assure you that in our classes and training sessions, we don't expect perfection. If our students and trainees were perfect at crisis intervention, they wouldn't be taking instruction from us in the first place! Therefore, put your inhibitions on the shelf for a while and become engaged in role plays as if the situations were real, live, and happening right now. Further, be willing and able to accept critical comments from your peers, supervisors, or instructors. Your ego may be bruised a bit in the process, but that's far better than waiting until you are confronted with an out-of-control client before you think about what you are going to do. The bottom line is that the classroom is the safest place to do this, and as you will soon discern, safety is our most important product. Over and over, our students report that this component of instruction was the most profitable to them and was also the most fun!

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

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

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

## Organization of the Book

### Part One, Basic Training

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

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

**Chapter 2, Culturally Effective Helping in Crisis.** Chapter 2 is concerned with how crisis and culture interact. Effectively helping people from diverse backgrounds who are undergoing a crisis or have survived a disaster mandates an understanding and sensitivity to culturally diverse issues. What are called "social locations" for both worker and client play a major role in crisis intervention work. A derivation of those social locations, called SAFETY locations, has been formulated to specifically to help a person in crisis. We have also introduced Relational Cultural Theory into this edition as a key operating system for integrating crisis with multicultural practice.

**Chapter 3, The Intervention and Assessment Models.** Chapter 3 introduces the task model for crisis intervention as well as the triage assessment system for rapidly assessing the severity of the crisis in a multidimensional way in real time. We have also introduced the LASER model as an ethical decision making model for crisis intervention.

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

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

**Chapter 6, Telephone and Behavioral Telehealth Crisis Counseling.** The majority of crisis intervention is still done on the telephone by trained volunteers. However, with the advent of the Internet, social media, and the social exclusion brought on by COVID-19, more and more crisis intervention is being done online in behavioral telehealth formats. Chapter 6 explores the issues and techniques that are involved in these two mediums of crisis communication.

## Part 2, Handling Specific Crises: Going into the Trenches

Part 2 (Chapters 7 through 13) addresses a variety of important types of crises. For each chapter in Part 2, the background and dynamics of the particular crisis type are detailed to provide a basic grasp of the driving forces behind the dilemma. Although some theory is present to highlight the therapeutic modalities used, comprehensive theoretical systems are beyond the scope of this book. For the sources of that information, turn to the reference section at the end of each chapter.

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

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

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

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

**Chapter 10, Partner Violence.** Chapter 10 deals with a crisis that many people in an intimate relationship face: being treated violently by their partner. This chapter provides strategies to help people who are suffering abuse in *any kind of intimate partner relationship.*

**Chapter 11, Family Crisis Intervention.** Chapter 11 deals with the whole family as they seek to navigate the family system through a crisis. The chapter describes the types or crises families experience as well as their path to resolution,

**Chapter 12, Personal Loss: Bereavement and Grief.** Chapter 12 presents a type of crisis that every person will sooner or later face: personal loss. Even though the phenomenon of loss has been with us as long as the human species has existed, many people in our contemporary culture are poorly prepared and ill-equipped to deal with it. This chapter examines a variety of loss models and looks at different types of losses. This chapter also provides models and strategies for coping with unresolved or complicated grief. We have woven into the chapter a discussion of the effects of the COVID-19 pandemic, particularly related to the altered grief experience.

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

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

Part 3 (Chapters 14 and 15) concentrates on the problems of crisis workers themselves and their employing institutions.

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

**Chapter 15, Human Services Workers in Crisis: Burnout, Vicarious Traumatization, and Compassion Fatigue.** Chapter 15 is about you and all human services workers who are in the helping professions. No worker is immune to stress, burnout, and the crises that go with human services work. This fact is particularly true in crisis work. This chapter should prove invaluable information for any worker anywhere whose work environment is frenetic and filled with crisis intervention or whose personality tends to generate compulsive behavior, perfectionism, or other stressors that may lead to burnout.

### Part 4, No Man's Land: Facing Disaster

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

**Chapter 16, Disaster Response.** Chapter 16 explores the theoretical basis and operating paradigm for large-scale disasters through an ecosystemic viewpoint. This chapter introduces the concept of a mega-crisis by describing the way these disasters change functioning on a day-to-day basis. The chapter details a family as they experience a natural disaster and how they interact with a variety of crisis workers and the services the workers provide for the family as they move through post-disaster events over the course of a year. Finally, the chapter highlights the personal impact of large-scale disasters and the experiences of crisis workers who were involved with them at the scene of the disaster.

## Supplementary Materials

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

### MindTap

MindTap for *Crisis Intervention Strategies*, 9th ed., engages and empowers students to produce their best work—consistently. By seamlessly integrating course material with videos, activities, apps, and much more, MindTap creates a unique learning path that fosters increased comprehension and efficiency.

For students:

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

Additionally, for instructors, MindTap allows you to:

- Control what content students have access to and when they access it with a learning path that can be used as-is or matched to your syllabus exactly.
- Create a unique learning path of relevant readings and multimedia and activities that move students up the learning taxonomy from basic knowledge and comprehension to analysis, application, and critical thinking.
- Integrate your own content into the MindTap Reader using your own documents or pulling from sources like RSS feeds, YouTube videos, websites, Google Docs, and more.
- Use powerful analytics and reports that provide a snapshot of class progress, time in course, engagement, and completion.

## Ancillary Package

Additional instructor resources for this product are available online. Instructor assets include an Instructor's Manual, Educator's Guide, PowerPoint® slides, and a test bank powered by Cognero®. Sign up or sign in at http://faculty.cengage.com to search for and access this product and its online resources.

The Cengage Instructor Center is an all-in-one resource for class preparation, presentation, and testing. The instructor resources available for download include:

- **Instructor's Manual** Includes key terms with definitions, a chapter outline, and additional activities and discussion questions that may be conducted in an on-ground, hybrid, or online modality.
- **PowerPoint Slides** Helping to make lectures more engaging, these handy Microsoft PowerPoint slides outline the chapters of the main text in a classroom-ready presentation. The PowerPoint slides reflect the content and organization of the text and provide ample opportunities for generating classroom discussion and interaction.
- **Test Bank** A comprehensive test bank, offered in Blackboard, Moodle, Desire2Learn, and Canvas formats, contains learning objective-specific multiple-choice and essay questions for each chapter. Import the test bank into your LMS to edit and manage questions and to create tests.
- **Cengage Learning Testing, Powered by Cognero** This assessment software is a flexible, online system that allows you to import, edit, and manipulate test bank content from the *Crisis Intevention* test bank, or elsewhere, including your own favorite test questions; create multiple test versions in an instant; and deliver tests from your LMS, your classroom, or wherever you want.

# Acknowledgements

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

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

Finally, we extend our grateful appreciation to the Cengage team members who provided support throughout this process.

PART 1

# Basic Training
## Crisis Intervention Theory and Application

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

# Approaching Crisis Intervention 1

### Learning Objectives

After studying this chapter, you should be able to:

1. Explain the origins and continuing evolution of the practice of crisis intervention and how it applies to your professional development through class discussion.
2. Explain the basic definitions of individual crises and how they apply in practice.
3. Differentiate between the concepts of individual crisis, systemic crisis, mega crisis, transcrisis, and metastasizing crisis and how they dynamically operate.
4. Explain the different types of theories of crisis intervention in building your own intervention theory and its application to intervention through discussion, role play, and feedback.
5. Explain the different applied crisis intervention action models and use them in simulation activities and crisis scenarios.
6. Apply the specific action steps of psychological first aid and practice them in simulation activities.
7. Assess yourself against traits and attributes common to competent crisis interventionists and analyze your degree of fit for this kind of work.

## A Brief History of Crisis Intervention

LO1 We open the ninth edition of this book with a brief history of crisis intervention. While crisis itself has probably been in existence since the dawn of humankind, formal crisis theory, research, and intervention comprise one of the newest fields in psychotherapy. Most laypersons probably would think of formal crisis intervention as historically having to do with large-scale disasters, such as hurricanes or 9/11, and most typically performed by government agencies like the Federal Emergency Management Agency (FEMA) in the United States or by charitable organizations like the Red Cross. While the Red Cross and the Salvation Army have been involved in disaster relief for approximately the past century, FEMA has been in existence only for about 40 years, and until quite recently, none of these organizations has had much to say or do about crisis intervention from a mental health perspective. But what we do know in 2023 is light-years ahead of what we knew when the first edition of this book appeared in 1987. If you could find the first edition in your library, it would look very little like this book does now.

**The First Crisis Line.** Suicide prevention is probably the longest-running intervention program in which an individual crisis is addressed from a mental health standpoint. The first identifiable crisis phone line

was established in 1906 by the National Save-a-Life League (Bloom, 1984). Dr. Edwin Shneidman's (2001) landmark research into the causes of suicide, which started in the 1950s, has now spanned seven decades. Suicide has achieved such importance as a mental health problem that it has become an "ology" and has a national association devoted to its study and a national suicide and crisis hotline number, 988.

**Cocoanut Grove Nightclub Fire.** Most people who study the field would probably say the benchmark for crisis intervention was the Cocoanut Grove nightclub fire in 1942, in which more than 400 people perished. Dr. Erich Lindemann (1944), who treated many of the survivors, found that they seemed to have common emotional responses and a need for psychological assistance and support. Out of Lindemann's work came the first notions of what may be called "common" grief reactions to a disaster. Dr. Gerald Caplan (1961) was also involved in working with the Cocoanut Grove survivors. Sometimes referred to as the father of crisis intervention, his experiences led to some of the first attempts to explain what a crisis is and to build a theory of crisis. However, not until the 1960s did the first attempts occur to provide a structure for what would become crisis intervention.

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

**The New Asylums—Prisons.** Although the following statistics are dated, they are probably conservatively representative of the mental health problems of the United States. There are more individuals with serious and persistently serious mental illnesses in the Los Angeles County Jail, Chicago's Cook County Jail, or New York's Riker's Island Jail than any psychiatric facility in the United States (Torrey et al., 2010). In 2006, more than one million two hundred thousand inmates in federal and state prisons and local jails could be identified as having a diagnosable mental illness. (James & Glaze, 2006). This grim statistical analysis of incarcerated people portrays a sad legacy of the Community Mental Health Act and what this country has done about it.

A follow up by the Department of Justice in 2012 into incarcerated people with mental illness found that 1 in 7 people imprisoned in state and federal institutions (14 percent) and local jail inmates (26 percent) met the criteria for serious psychological distress of some kind (Bronson & Berzosfsky, 2017). In 2014, about 10 times more individuals with serious mental illness were in prisons than mental health hospitals (Torrey et al., 2014). In a compiled report of policies and practices of prison mental health, the Prison Policy Initiative (2022) found that the number of prisoners had skyrocketed to 44 percent in local jails and 43 percent in prisons. Our own experience working in a prison mental health unit from 2012–2017 subjectively confirms that this is a fairly accurate estimate.

How could this happen with such good intentions of the Community Mental Health Act? One of the overarching tenets of crisis intervention that flows through every theoretical model is the concept of support. When familial supports either wear down and out or were never there in the first place, when no medical professional is there to monitor medication, when mental health clinics are underfunded and overwhelmed with clients, and when little vocational opportunities or rehabilitation counselors are available.

As a result of this evolution in mental health care (or the lack of it), it should not be surprising that a great deal of crisis intervention is now done on the streets and in the homes of local communities. What might surprise you is that a lot of it is being done by police officers.

**Birth of the Police Crisis Intervention Team.** Indeed, one of the major, serendipitous outcomes of deinstitutionalization has been the birth of the police Crisis Intervention Team. Faced with continuous interactions with individuals who experience psychological disorders and were off their medication, many confrontations with the police ended violently, with individuals with mental health issues forcibly being taken into custody. That interaction often resulted in the consumer or police officer being injured or being

killed. These continuous confrontations culminated in the city of Memphis in 1987 when a man who was experiencing a mental health crisis related to his diagnosed schizophrenia was shot to death by the police. The resulting hue and cry from the citizens of Memphis resulted in a radical shift in police thinking and the establishment of the first **police Crisis Intervention Team** specifically trained to de-escalate and defuse people with mental health issues and who demonstrate dangerous behavior to themselves or others (James & Crews, 2009).

Word about what we were doing in Memphis soon spread, and other law enforcement jurisdictions that were grappling with the same problems across the country began asking for help in training their officers. What started out as a small group of mental health professionals, government officials, and police officers attempting to deal with a critical local political problem has now spread across over 2700 jurisdictions in the United States, Canada, Australia, Europe, and Africa and is now considered a "best practices" model for police departments (Rogers, et. al., 2019; Watson & Fulambarker, 2012), which we will thoroughly explore in Chapter 5, "Crisis Case Handling."

**International Movement.** The United States has not been alone in its endeavors to organize large-scale crisis intervention operations. Internationally, the United Nations Inter-Agency Standing Committee (IASC, 2007) has published guidelines for mental health provision in emergency situations. Europe has established the European Society of Traumatic Stress Studies (ESTSS, 2022) and their Traumatic Stress Network to develop evidence-based responses to large-scale disasters and provide assistance to those parts of the European Union that suffer from a lack of psychological resources. The **International Federation of Red Cross and Red Crescent Societies** has entered into the psychosocial facet of disaster relief by helping individuals and communities heal psychological wounds and rebuild social structures after an emergency or critical event. Its mission is to change people into active survivors rather than passive victims (International Federation of Red Cross and Red Crescent Societies, 2022).

Most notably, the Australians have been in the vanguard of dealing with the mental health issues of large-scale disasters particularly through the research and writing of Beverley Raphael (Raphael, 1977, 1986; Raphael & Wilson, 2000), determining early on whether crisis intervention procedures were effective (Bordow & Porritt, 1979), and staying on the cutting edge technologically in providing services to hard-to-reach populations ( Williams et al., 2020).

## Grassroots Movements

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

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

Initiators of crisis intervention services are generally concerned with one particular crisis category that personally affects them in some way. Typically, the crisis gets far enough out of hand to cause noticeable community problems before remedial responses are initiated. At first, the initiators are mavericks who are starting a victims' revolt. The revolt is against an entrenched status quo or power structure that shows little awareness of or responsiveness to the problem. The victims' revolt somehow manages to get a fledgling crisis agency started despite the benign neglect and reluctance of mainstream society.

The fledgling crisis agency is initially funded by private donations, as with the many telephone call-in lines for victims of domestic violence that were

started at local YWCAs in the 1970s. The services are often provided by volunteers who are loosely organized. The crisis agency gains access to public funding only after the agency has attained validation and some recognition by a substantial portion of the power structure. If, after a time, the crisis agency does not attain credibility sufficient to garner substantial private support or a modicum of public support, the agency begins to falter and eventually folds and ceases to operate. However, if it attains enough critical mass through consumer support, it can grow and become institutionalized as a legitimate entity.

In the 1970s, Vietnam veterans' efforts to get posttraumatic stress disorder (PTSD) categorized as a mental disease and get financial support for research and treatment were a classic example of this revolt and grudging acceptance by the mainstream. So were the efforts of the National Organization for Women and other women's groups in the 1970s to raise the curtain on domestic violence and child abuse in the United States and to get state legislatures to deal with them as criminal acts.

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

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

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

## The Importance of Volunteerism

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

## The Need for Institutionalism

As crisis agencies become well known and as their clientele are drawn from a wider segment of the community (to the point that the work cannot be handled

by the communication system of grapevine, word of mouth, notepad, e-mail, and social media X (formerly know as Twitter)), the agency sees that if it is to continue to grow and serve its clients, it must institutionalize. The seeds of bureaucracy are thus born.

To manage all of its vital functions, the agency must centralize and formalize most aspects of its operation. It takes on a formal board of directors, establishes rigorous auditing and record-keeping functions, and requires more money, paid staff, and staff support. As crisis agencies become crisis organizations, they gain more power, prestige, and notoriety. They tend to attract the attention of the human services professions because they offer fertile fields for funded research, placement of practicum and internship students, and employment of graduates. Crisis agencies sometimes attain eminent success to the point that it becomes a vested interest of the human services professions to formalize the competencies of the personnel of such successful agencies through certification, licensure, and accreditation.

The progression from the humble origins of Alcoholics Anonymous as a support group formed by fellow individuals with alcoholism in the 1930s to the current classification of alcohol use disorder to the proliferation of thousands of treatment centers around the world, huge government funding for research and prevention, university courses on the subject, and the state licensure or certification of substance misuse counselors provides an outstanding example of the evolution from self-help by a group of people recovering from alcohol use disorder in crisis to the full institutionalization of the crisis of drug misuse.

As a specialty evolves, it develops its own empirical base, professional research, and writings. For example, for crisis intervention, we have publications such as *Crisis Intervention; Journal of Interpersonal Violence; Victimology, Violence and Victims,; Journal of Family Violence; Death Studies; Journal of Traumatic Stress; Suicide and Life Threatening Behavior; Child Abuse and Neglect; Journal of Child Sexual Abuse; Aggression and Violent Behavior;* and *Violence Against Women*. The amount of data and information in the field has expanded so much that the *Encyclopedia of Psychological Trauma* (Reyes et al., 2008) includes 720 large pages covering everything from A (Abuse, child physical) to W (Workplace violence).

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

The emergence of hundreds of crisis-oriented organizations in the 1970s, 1980s, and 1990s (Maurer & Sheets, 1999) and the realization of the role that immediate intervention plays in alleviating traumatic stress (Mitchell & Everly, 1995) attest to the dramatic transformation and professional acceptance of crisis intervention from a psychological backwater field to a pervasive specialty. It is worth noting that the main literacy magazine of the American Counseling Association ran as its featured article in the August 2021 edition of *Counseling Today* that crisis counseling had become every counselor's job (Bray, 2021). Probably the best testament to the center stage on which crisis intervention is now playing is the birth in 2006 of the American Psychological Association's newest division, Division 56, Trauma Psychology, along with the provision of counseling (Council for Accreditation of Counseling & Educationally Related Programs, 2009) and school psychology (National Association of School Psychologists, 2010) professional accreditation standards for training graduates in crisis intervention. One of the major players in the field of trauma, Christine Courtois (Courtois & Gold, 2009), has eloquently stated the critical need for the inclusion of psychological trauma training in all helping service curricula. Thus, like lots of other concepts in mental health that evolve and continue to grow to meet increased demands for crisis services, it is incumbent that beginners in the mental health field understand the processes and evidence-based practices associated with crisis intervention (Cutler et al., 2013) that this book is about.

## The Media and the Societal Impetus for Crisis Intervention

Why, from the 1970s to the present, has the crisis intervention movement experienced such extraordinary growth? Probably no single factor alone can explain why. In the United States, the bombing of the

Murrah Federal Building in Oklahoma City, 9/11, the mega natural disaster of Hurricane Katrina, the mass shootings at Virginia Tech, Northern Illinois University, Columbine High School, the Sandy Hook and Uvalde elementary schools, and a variety of public massacres such as Las Vegas and El Paso have all given rise to the demand for crisis intervention. Yet, such natural and human-made disasters have been with us since the city of Pompeii was buried by Mt. Vesuvius and Rome was sacked and burned. What has changed public perception to the extent that the acronym PTSD—which in the first edition of this book was a brand-new term that lots of psychologists were unfamiliar with or didn't believe was a valid diagnostic—is now common parlance?

The media's role in creating awareness of crises and crisis intervention has probably generated the most profound change in public consciousness of what it means to be in crisis after a large-scale disaster. When Matthew Brady's pictures of the windrows of dead from the American Civil War Battle of Antietam were put on display in New York in 1863, this first use of photographic media changed forever how people would perceive wars and the psychological trauma that invariably comes with them. Public perception of war as glorious changed forever as its horror and carnage were brought to the American doorstep by Brady's harrowing pictures. Since that time, the ability of the media has advanced from the still-life daguerreotypes of Brady to real-time sound and video of the jumpers from the 9/11 Twin Towers, New Orleans citizens sitting on top of flooded buildings from Katrina, and of Kiev residents running from a drone bombing, all of which come into your living room in real time in graphic detail.

Charlotte Huff's article on the stress of media overload in negative news coverage in the November (2022) issue of *Monitor on Psychology* raises some interesting questions about how the mainstream media and social media affect the perception of viewers and readers and potentially contributes to negative mental health outcomes from negative news overload. It raises the question of how potent the media is in the creation of vicarious crisis associations and whether that has metastatic effects in the spread of it. She reports on the phenomena of "*doomscrolling*" or feeling impending doom when scrolling excessively through negative news.

Probably even more profound is the emerging role of social media with the good and ill it can bring into a crisis milieu and the questions it brings with it: How well are individuals able to separate fact from fiction and override misinformation transmitted through social media (Wang et al., 2022)? How does collective memory sway users' thinking and acting during a crisis? Does time spent involved in a crisis-related social medium lead to mental health impairment (El Frenn et al., 2022 ) and panic behavior (Dia et al., 2022)? There is some evidence that it does have deleterious effects on mental health (El Frenn et al., 2022; Price et al., 2022). Or is it, in fact, a positive outlet of personal catharsis and emotional and cognitive problem solving (Goode, 2022). It is still unclear exactly what impact such real-time media has on the public, but clearly, it does have an impact and changes our perception of the world as ever smaller, more interconnected, and certainly more dangerous, unsafe, and crisis prone (Marshall et al., 2007). At its best, it has brought acceptance of trauma and crisis intervention procedures into the public mainstream and raised consciousness that failure to navigate through them without help is not some character defect. An outstanding example is the following farm publication's outreach to its readers.

One would be hard pressed to find a publication more unlike the Illinois Farm Bureau weekly newspaper to be in the business of promoting good mental health for its readership, but as of this writing in April 2023, that is exactly the case (Sloup, 2023). American farmers day in and day out are besieged with multiple stressors in producing a crop. This often results in severe stress and opens a Pandora's box of mental health issues that are exacerbated by embarrassment, an unwillingness to obtain help, and particularly the lack of accessibility to mental health help in rural areas.

A very positive approach to this problem in Illinois has been launched by the University of Illinois Agricultural Extension service in conjunction with the Illinois Farm Bureau by coordinating and publicizing a United States Department of Agriculture (USDA) funded voucher program. It is designed to broaden access for agricultural producers and their families to mental health services and provides vouchers for up to three free mental health sessions. Conjointly, the Southern Illinois University School of Medicine Center for Rural Health and Social Service Development is offering free telehealth counseling sessions with up to six free sessions. No insurance backup is required for either program (Sloup, 2023). There are valid reasons for the widespread acceptance

of crisis intervention as a therapeutic specialty, and media examples such as this has certainly played a part in that shift.

## COVID-19 and the Rise of Telebehavioral Health

The COVID-19 pandemic changed the way the world operated, and it certainly changed the way a great deal of the format of psychotherapy and crisis intervention and how it had been provided (Myers, 2021). A historic shift from face-to-face to telebehavioral therapy occurred and reshaped the clinical skills therapy used to fit an online environment (Rhodes, 2023). Along with the legal ramifications of the provision of those services (Wheeler, 2023), practitioners had to be mindful and adhere to the new ACA (2014) internet usage standards. Further on the horizon but looming quickly is the role that technology (Phillips, 2019) and artificial intelligence will have in therapy (Giovannetti, 2023). This evolution of therapeutic provision will be discussed at length in Chapter 6, "Telephone and Online Crisis Counseling."

### A Positive Shift in Attitude

As a result of such programs and publicity, people in general have become more positive in their acceptance of outreach strategies following a crisis and are more knowledgeable about its psychological ramifications, such as PTSD. There is less "blaming the victim" as somehow psychologically inadequate. Probably most important from a pragmatic point of view, it is cost effective (Roberts, 1991). People in human services and political leadership positions have discovered that when they either ignore crisis situations or leave solutions entirely to the experts who have little political clout, lasting solutions elude them, and the leaders themselves are blamed and held publicly responsible. Reactive responding has not worked very well.

Leaders have discovered that endemic crises will not easily go away and that reaction or no action may result in problems metastasizing out of control. In a sense, then, political expediency has dictated not only the widespread acceptance of effective crisis intervention strategies but also that crisis intervention become proactive, preventive, and integrated on the local, national, and international levels. One need go no further than the aftermath of Hurricane Katrina to understand the full impact of what this paragraph is about.

### The Case Against Too Much "Helping"

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

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

The assumption is that disaster invariably leads to psychopathology, and psychopathology sells. If people are perceived as incapable of caring for themselves and are traumatized and in a panic state after a disaster, it follows that they must be somehow infirm and unequal to the task and need assistance. A paternalistic government is then tasked with taking care of them. This view may be even more true with marginalized and disenfranchised groups who are seen as socially or technically unsophisticated and in need of benevolent and well-intentioned guidance and protection (Gist, Lubin et al., 1999a; Kaniasty & Norris, 1999; Ober et al., 2000). On the other hand, such groups of disenfranchised and dislocated persons, particularly if they are migrants or undocumented persons, may be given short shrift from the authorities and may be persecuted if they come to the attention of bureaucracies that are dealing with a crisis (Brown, 2009, pp. 215–226). It is with good reason that activists in the counseling field have proposed that social justice is the new benchmark against which crisis intervention and training should be measured (Espelage, 2022; Mamarosh, 2022; Rector, 2021;

Smith et al., 2022), and that is particularly true in the aftermath of disasters.

However, the fact is that in most instances, victims of disaster do not panic. They organize themselves in a collective manner and go about the business of helping one another and restoring equilibrium (Kaniasty & Norris, 1999). Called the "altruistic or therapeutic community," the typical immediate collective response to a disaster is characterized by the disappearance of community conflicts, heightened internal solidarity, charity, sharing, communal public works, and a positive "can-do" attitude (Barton, 1969; Giel, 1990). So, as of 2023, crisis intervention has emerged from a psychological backwater 40 years ago when we started writing the first edition of this book to a veritable tidal wave of interest, although at times controversial and full of heated debate, and that includes defining exactly what a crisis is.

## Definitions of Crisis

LO2 This book is mainly about doing crisis intervention with individuals and microsystems such as families and workplaces. To a lesser extent, it is also about macrosystems in crisis and how the crisis interventionist functions within those systems, whether in institutions such as hospitals, schools, and mental health centers or as service providers after large-scale disasters. To that end, we start this book in a pretty boring way by giving you not only a history lesson but also a long list of definitions of crisis as it applies to both individuals and systems. We apologize for that, but we do this because we want you to understand that this business is still so new that the definition of an individual or a system in crisis is by no means fixed or absolute. As a matter of fact, as you are going to find throughout this book, there is a whole lot about crisis and crisis intervention that is not fixed or absolute! Consider, then, the following definitions of individuals in crisis.

### Individual Crisis Definitions

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

It should immediately become clear that the term *crisis* has different meanings to different people and is used to describe a variety of incidents, settings, and situations and the adaptations, albeit less than adequate, that people attempt to make in response to them. To summarize these definitions,