

Definition: **crisis intervention** from *Dictionary of Psychological Testing, Assessment and Treatment*
Nebulous term for treatment of a patient's reaction to a sudden catastrophic event, which the patient cannot adequately deal with on his/her own.

VICTIM

Image from: [Within every victim there is a... in 21st Century Psychology: A Reference Handbook](#)

Summary Article: **Crisis Intervention**

From *The Corsini Encyclopedia of Psychology and Behavioral Science*

A crisis is a collapse in one's ability to solve problems or cope with a situation in which the person's existing strategies for coping do not work. Whether a crisis is situational or developmental, the person in crisis is not able to regain homeostasis or balance by the usual means of coping typically employed. The term crisis is easily misunderstood if one views it in terms of an event or situation. In mental health terms, a crisis is not the traumatic event, but rather a person's reaction to it. The same event could be devastating for one individual and not affect another.

The less psychologically stable a person is at the time of a precipitating crisis event, the more apt the person is to exhibit a crisis reaction. Minor stressors have a low probability of triggering a crisis response, unless the person is already experiencing a high level of turmoil. Major stressors have a higher probability of eliciting a crisis response than minor stressors. A person with strong resources is less likely to be in crisis than a person with poor coping abilities. A person is most apt to experience a crisis response when he or she is currently nearing a state of disequilibrium.

A crisis differs from a problem by its level of severity. People who experience a crisis are in an emergency situation in which they may be dangerous to themselves or others or are gravely disabled (Parad & Parad, 1999). Someone in crisis usually can wait no longer than 24 to 72 hours for assistance that calls for specialized crisis-counseling techniques.

Many texts in crisis intervention refer to the Chinese word for the word crisis, which is formed with the characters for the word "danger" and the word for "opportunity." A person coming out of a crisis situation is changed by the event and will either grow or decline in a number of ways as a result of the crisis. Kanel (2003, p. 1) provides a good overall synopsis of other definitions of a crisis. Kanel states that a crisis has three parts: (1) a precipitating event occurs, (2) the perception of the event leads to subjective distress, and (3) usual coping methods fail. Thus, the person functions at a lower than usual level psychologically, emotionally, or behaviorally.

Risk Factors

Given the right circumstances, anyone can show crisis behavior. No one has unlimited resources that can prevent a state of disequilibrium from ever occurring. Individuals' resilience to stress varies, depending on a number of situational factors at a particular time in their life. People may be able to handle a given crisis situation or level of stress at one point in time, but not in another. Myers (1989) describes 12 types of risk factors for crisis reactions: (1) age and developmental phase, (2) health, (3) disability, (4) preexisting stresses, (5) previous traumatic life events, (6) strength of social supports, (7) coping skills, (8) expectation of self and others, (9) status of family members, (10) ethnic and cultural milieu, (11) interaction between the individual's occupation and event, and (12) perception and

interpretation of the event. Disruptions in one or any combination of these factors decrease one's ability to cope with a crisis event, because these events can in themselves lower one's defenses.

Basis Assumptions of Crisis Intervention

Wiger and Harowski (2003) describe the following basic assumptions of crisis interventions:

1. Most crises are sudden and unpredictable. One of the reasons why crises affect a person so dramatically is that they are neither prepared for nor expected. A sudden crisis significantly disrupts any of a number of aspects of an individual's life. However, some predictable events, such as retirement, marriage, and graduation, still lead to a crisis response. Other crises may be the cumulative result of several built-up stressors or events.
2. Crises are temporary. Most crises last no more than a few weeks and average about 36 hours in duration. Humans cannot sustain the level of stress caused by a crisis. The level of stress can be so overwhelming that irrational decisions such as suicide might be viewed as the only option. Crisis interventions help in presenting immediate alternative behaviors.
3. A crisis results in a loss of psychological equilibrium in which a person's normal coping mechanisms are not sufficient to return to a homeostatic state. During this time, the person in crisis is atypically vulnerable to coping strategies (Puryear, 1979). This vulnerability may be adaptive (e.g., uncharacteristic openness to listening to others for help), or dysfunctional (e.g., suicidality or abuse of substances).
4. People in crisis are not necessarily mentally ill. Both people with and without mental illness can go through times of crisis. The related anxiety and depression resulting from a crisis are not, in themselves, indicators of mental illness. Diagnosing someone who is going through a situational crisis with a diagnosis of a chronic mental health disorder may be a significant error. Although the symptoms may appear identical to a mental health disorder, they could subside in a brief time period, unlike a chronic mental health disorder.
5. Knowledge of the cultural, ethnic, spiritual, and other biopsychosocial aspects of a person will help understand the specific effects a crisis will have on the person. Without such information, errors in assessment are bound to occur.
6. Crisis intervention is a crucial aspect of treatment. It has its place in mental health treatment. In fact, it has been referred to as the third of three revolutionary phases in the mental health field since 1900 (Hoff, 2001). These include discoveries of the unconscious by Freud, of psychotropic drugs in the 1950s, and of crisis interventions in the 1960s. However, crisis intervention does not take the place of psychotherapy. Not all people in crisis will need follow-up psychotherapy. If crisis intervention adequately helps a distressed person to cope with the crisis situation and return to premorbid functioning, psychotherapy may not be necessary.

History of Crisis Intervention

Soldiers in WWI and WWII receiving early interventions for severe distress fared better than those without early interventions. Holmes (1985) notes that soldiers who demonstrated significant stress reactions were often viewed as weak, insane, or even traitors. Soldiers treated immediately for what was early on called "shell shock" had a much better chance of returning to combat. In the 1930s, New York's Mayor LaGuardia requested a study of police officers due to their proportionately high suicide

rate. Hospital emergency personnel have historically suffered a high turnover rate due to job stressors. Stress management procedures developed by Marge Epperson-Sebour at the Shock Trauma Center in Baltimore in the mid-1970s have influenced crisis management problems today.

Erich Lindemann's (1944) classic study of a fire in Boston's Coconut Grove Melody Lounge, in which 493 people died, is often cited as the first significant study of crisis intervention. Lindemann and others from Massachusetts General Hospital, helping in the disaster, discovered that nonmedical personnel and clergy were effective in helping survivors who had lost loved ones. Their results identified five common reactions to acute trauma as somatic distress, preoccupation with images of the deceased, guilt for having survived, hostile reactions, and loss of patterns of conduct. Prognosis improves when people can go through a period of grieving and deal with the loss. Lindemann and his colleagues also found that those who later developed significant psychological symptoms had not gone through a normal grieving process.

Lindemann and Gerard Caplan subsequently developed the Wellesley Project in Cambridge, Massachusetts, which focused on individuals reacting to traumatic events. This community mental health center became one of the first to emphasize preventive psychiatry within a short-term therapy model. Lindemann and Caplan are generally credited for initially developing contemporary crisis theory. Caplan continued his work in preventive psychiatry for the next few decades, focusing on early intervention and proposing theoretical concepts that are the foundations of modern crisis intervention theory. Virtually all writers in the field rely on or adapt Caplan's concepts of preventive psychiatry, which emphasized early interventions and incorporating community practitioners such as clergy, nurses, and teachers into efforts to help prepare people for predictable developmental crises like those defined by Erikson (1963) as requiring successful resolution for normal developmental growth to occur.

Throughout the 1960s the use of nonprofessionals and paraprofessionals in such contexts as suicide hotlines, walk-in centers, and community mental health centers (CMHC) expanded, and Caplan's model remained in the forefront. The community mental health movement was significantly aided by funding stemming from the Community Mental Health Centers Act of 1963. Rapoport (1967, p. 38) emphasized the need for immediate intervention for people in crisis, declaring "A little help, rationally directed and purposefully focused at a strategic time, is more effective than more extensive help given at a period of less emotional accessibility."

During the 1970s the research and knowledge base of crisis intervention techniques increased significantly. The rise in short-term therapy, and its lesser cost compared to long-term therapy, further increased the usage of crisis intervention services.

The 1980s led to a large increase in professional training of mental health workers. However, the combination of less public funds available and the requirement by insurance companies that mental health services be conducted by professionals with at least a master's degree led to a decrease in the crisis intervention models and an increase in long-term therapy (Kanel, 2003). Nevertheless, health maintenance organizations (HMOs) have demanded a short-term therapy mode of treatment, which once again turned the pendulum toward a crisis intervention model.

The 1990s and 2000s have seen widespread development of organized crisis intervention programs. The American Red Cross and critical incidents stress management (CISM) teams have developed national and training programs for group crisis interventions. Disasters such as the Oklahoma City Federal Building bombing, the 9/11 World Trade Center disaster, and other airline disasters have led to

increased services for victims, families, and communities.

The field of community psychology has gradually developed to meet modern needs related to changes in family structure, an increasing geriatric population, and the integration of the mentally ill into society. Community health centers offer primary and secondary prevention services provided by multidisciplinary teams. Due to economic restraints, there has been an increase in the number of paraprofessionals who work in these centers under the supervision of professionals. Many people who would otherwise not obtain any mental health treatment receive crisis-counseling services over the telephone through 24-hour hotlines staffed by volunteers. The Internet also contains numerous sites offering free or paid mental health services.

Crisis Counseling

A team of crisis workers, who may include first-responders, family members, medical personnel, crisis counselors, mental health professionals, and after-care treatment providers, can affect the path a person in crisis takes to either grow or decline. When immediate and effective support is provided, the victim can learn the tools necessary to cope with the experience and be better prepared for future crises. Some people who do not receive timely help develop significant mental health problems. The primary purpose and goal of crisis intervention (also called psychological first-aid or emotional first-aid; see Neil, Oney, Difonso, Thacker, & Reichart, 1974) is to aid victims by helping them secure safety, obtain needed resources for stabilization, and return to normal functioning.

The first responders in crisis intervention are trained in specific techniques of psychological first aid. Greenstone and Leviton (2002) comment that, early in their careers, crisis workers learn established procedures in a logical and orderly process. They further note that actions are thoughtful, measured, and purposeful. Workers must learn specific and proven intervention methods, instead of using a hit and miss approach. Crisis workers providing psychological first aid should in particular take the necessary steps to offer immediate intervention, establish rapport, do an assessment, take action, utilize available resources, and see to aftercare.

Each goal of crisis intervention focuses on the current situation, not long-term planning or the pre-crisis situation. Like psychotherapy, crisis intervention involves assessment, treatment planning, and treatment. However, the specific interventions in a crisis situation involve different skills and treatment methods from those applied in traditional psychotherapy. Assessment in typical psychotherapy requires obtaining multiple details about a client's strengths, needs, abilities, and preferences ("SNAP's"); inquiring about past, present, and, often, future goals; and formulating a diagnosis (Wiger & Huntley, 2002). Crisis intervention assessment involves a brief assessment of the client's safety, immediate needs, and need for immediate services.

Crisis intervention planning is short-term and designed to restore people to a level equal to or above their functioning prior to the crisis. A primary focus of immediate crisis intervention is resources. Crisis intervention is narrowly focused and usually a few weeks or less in duration. It focuses on understanding, coping, and restoration. It is not designed to restructure the client's personality, as in traditional, long-term psychotherapy. Interventions in psychotherapy may involve a variety of therapeutic techniques, ranging from short-term to long-term therapy, and might focus on the past, present, or future.

Crisis workers can be categorized into three groups: frontline workers, paraprofessionals, and

professionals. Frontline workers include such occupations as police officers, emergency medical personnel, and fire fighters. Frontline workers are present in emergency situations in which immediate help has been requested. In mental health situations, their primary purpose is to immediately assess the situation and deal with immediate concerns. Paraprofessionals are typically trained volunteers, undergraduate or graduate students in mental health, or others who receive specific, narrowly focused training in short-term crisis intervention. They usually work on hotlines or in centers for domestic violence, sexual assault, or crime. Professional mental health workers have at least an advanced degree in areas such as psychology, social work, counseling, psychiatric nursing, or psychiatry. Other professionals such as teachers and nurses might fit into more than one role. A large-scale situation, such as a trauma within a community, may require a multidisciplinary crisis intervention team.

See also

Disaster Psychology; Posttraumatic Growth; Posttraumatic Stress Disorder; Trauma Psychology.

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