CHAPTER ONE

Introduction/Overview

LEARNING OBJECTIVES

1. To learn an overview of the philosophy of crisis counseling.
2. To understand the history of crisis counseling.
3. To develop awareness of areas related to crisis counseling, such as helpful characteristics of counselors and interagency collaboration.

PERSONAL REFLECTIONS ON THE OVERALL BOOK

Whoever can see through all fear will always be safe.

—Tao Te Ching

A few comments regarding this book’s philosophy and approach toward crisis counseling need to be presented in this opening chapter. While sometimes this type of information is provided in the preface of a book, it is included in the introductory chapter of this text because of how significantly the underlying philosophy of this book influences each chapter and the general framework of the book.

The motivation for this book stems from my experiences with crisis counseling during 35 years of clinical work. These professional crisis counseling experiences have been augmented recently by my work as a disaster mental health worker with the American Red Cross. This work began in response to the 9/11 attacks in New York and has expanded over the past 10 years to local and state disasters. These combined clinical experiences have resulted in the guiding question used to write
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this book: “What information is essential to assist mental health professionals in doing crisis work?” This book has evolved from that question and focuses on the goal of the crisis counseling captured in the Tao Te Ching quote at the start of the chapter: to help the client see through the fears of the crisis and feel safe enough in counseling to make the best life-enhancing decisions possible.

In order to assist the client in seeing through the crisis and feeling safe enough to make life-enhancing decisions, the counselor is metaphorically acting as a lighthouse for the client; the client can focus on the guidance of the counselor as the tumultuous waters of the crisis are navigated. As we each think of personal or professional crises we have navigated, we know the power of a caring person simply staying with us through the journey. There is a deep, abiding, sustaining connection offered by the counselor to the client in a crisis situation when the counselor is able to be present with the client and reach out with compassion in response to the client’s suffering. The counselor also needs to: (a) help clients proactively respond to the crisis situation, in order to give them a sense of self-control (empowerment); (b) assist clients in getting back into some aspects of their daily routines (activities, rituals), in order to be reassured that the world is a safe place; and (c) provide them with a safe place to vent, where the counselor is listening to the client’s storyline (the crisis) but not becoming lost in it to the point of feeling helpless him- or herself or of being drawn to rescue the client and thereby encourage unnecessary dependency of the client on the counselor.

This book, then, is an attempt to provide the reader with practical, hands-on crisis counseling information that will assist clients in crisis and help them heal in their recovery from the crisis. The book can be used as a primer, a handbook presenting an overview of crisis counseling that can be used in clinical work. This can be particularly useful to the reader, because while all clinicians need to be ready to do effective crisis counseling, many of us do not do this work full time. Instead, we have a tendency to integrate this approach into our clinical work when situations arise with clients that require us to have a crisis counseling mindset and crisis counseling skills. Different factors, such as internal client factors (e.g., specific mental health diagnoses that result in the client going in and out of crisis states) or external factors (e.g., life situations such as divorce or natural disasters) may influence the necessary shift to a crisis counseling emphasis in clinical work. To apply effective, timely interventions that operate in the best interests of the client, the reader needs to be prepared to quickly shift to a crisis counseling perspective, often relying solely on his/her clinical judgment under the adage of “the buck stops here.”

Because crisis situations require thoughtful clinical decisions that need to be made quickly, the book is designed to expose the reader to an overview of aspects of crisis counseling that one might use infrequently, at best, in clinical work. This approach is intended to help hone the reader’s assessment and treatment approach and to enhance the skills that might be required in the crisis counseling situation. The self-reflective aspect of the book (questions, case studies, exercises, etc.) is designed to assist the reader in developing or enhancing his/her crisis counseling mindset by creating an interactive experience between the book and the reader.
This interactive approach is meant to help the reader understand his/her own crisis counseling strengths and weaknesses with the goal of enhancing his/her effectiveness. This self-assessment involves knowledge of critical components, such as: (a) current evidence-based, practical crisis counseling approaches and techniques; (b) operation as an “environmental stress manager” for the client; (c) development of internal and external resources that facilitate client resilience; and (d) self-care approaches that result in the reduction or elimination of burnout.

Finally, the term “counselor” is used throughout the text to describe the mental health professional reader. Readers may identify with different mental health professions and use different labels to describe their work. The term counselor has been chosen by the author as a term that represents the application of crisis counseling skills. While it is true that there are emphasis differences in crisis counseling among professionals (due to orientation and training), there are also similar themes and approaches that bridge these differences. While I have attempted to be sensitive to these variances, the reader is asked to acknowledge any limitations of the terminology used in this book and to not allow these limitations to block the potential usefulness of the text.

DEFINITIONS OF CRISIS, CRISIS COUNSELING, AND CRISIS INTERVENTION

There are numerous definitions for crisis (James, 2008). Typically, the crisis is made up of an event that occurs before the crisis, the client’s perception of the event, and the client’s previous coping strategies not being enough in the situation (Roberts, 2005). It is a state of upset-disorganization that is temporary and has the potential for either a “radically positive or negative outcome” (Slaikeu, 1990, p. 15). Essentially, the various definitions state the same components of a crisis: the client’s perception or experience of an event/situation as being intolerable and going beyond their resources and coping abilities. There are three components of the crisis: an event, the client’s perception, and the failure of the client’s typical coping methods (Kanel, 2007). As human beings we are, at least temporarily, unable to find relief in the crisis situation (Hoff, Hallisey, & Hoff, 2009).

When the individual does reach out for assistance, the reaching out can, obviously, include counseling. There are two main components to crisis counseling: first-order intervention (psychological first aid) and second-order intervention (crisis therapy) (Slaikeu, 1990). The first-order intervention of crisis counseling (psychological first aid) has been defined by the National Institute of Mental Health (2002) as making sure clients are safe, stress-related symptoms are reduced, clients have opportunities to rest and recover physically, and clients are connected to the resources and social supports they need to survive and recover from the crisis. The term “psychological first aid” originated in a description of crisis work in response to an Australian railway disaster (Raphael, 1977). It is considered the basic component of crisis intervention (James, 2008).
The goal at this stage of psychological first aid is to break up the behavior cycle that is dysfunctional and help the person return to their previous functioning level. Slaikeu (1990) breaks this stage into five components: psychological contact, problem exploration, solution exploration, concrete action taken, and follow-up. Overall assessment of the client can be done through the BASIC personality profile (Slaikeu, 1990) as described by Miller (2010, p. 100):

1. **Behavioral.** This area focuses on the client’s behavior in terms of strengths and weaknesses as well as behavioral antecedents and consequences.
2. **Affective.** The counselor assesses the client’s feelings about these behaviors.
3. **Somatic.** The counselor assesses the client’s physical health through sensations experienced.
4. **Interpersonal.** This area focuses on examining the quality of various relationships in the client’s life.
5. **Cognitive.** The counselor assesses the client’s thoughts and self-talk.

When counselors respond, they are intervening in the crisis. In this intervention, counselors are basically assessing the crisis situation at that moment, stabilizing the person, and assisting in the development of a plan to help them move out of the crisis mode. In crisis intervention, the counselor tries to reduce the crisis impact by immersing him- or herself into the client’s life and assisting in the development of resources. This involves crisis therapy along a continuum that includes assessment, planning, implementation, and follow-up; the crisis intervention is woven into the context of therapy (Hoff et al., 2009).

Counseling interventions in therapy need to be sensitively timed for the client, because the crisis is both a danger and an opportunity. It is dangerous in that the client may resort to destructive behavior (suicide, homicide), but it is an opportunity because the client may reorganize him/herself and his/her life by reaching out for assistance and thereby developing new knowledge and skills. It is in this development of new knowledge and skills that the counselor can be immeasurably significant in the client’s life; this is where therapy can have a long-lasting impact. A well-designed, sensitively timed intervention that is idiosyncratically matched to the individual client and his/her situation can change a life forever.

**History of Crisis Intervention**

Crisis intervention work has been around since 1942, when the staff of Massachusetts General Hospital responded to the Cocoanut Grove nightclub fire in Boston, where 493 people died (Lindemann, 1944). In their work with survivors and families of the victims, the hospital staff studied their acute and delayed reactions and clinically addressed psychological symptoms (survivors) and the prevention of unresolved grief (family members) (Roberts, 2005). In addition
to Lindemann, Gerald Caplan (1961) also worked with these survivors and was a pioneer in defining and developing theory related to crisis (stages). Rapoport (1967) added to Lindemann’s and Caplan’s work by showing that an event led to a crisis and by describing the nature of the event more precisely, as well as emphasizing the importance of the intervention—particularly in assessment (Roberts, 2005).

This work continued into the 1960s, when suicide prevention (e.g., 24-hour hotlines) and community mental health (e.g., mental health clinics, managing psychiatric patients on medication on an outpatient basis) became popular concerns in the United States. Crisis intervention strategies and research grew out of these concerns (Kanel, 2007). Three major grassroots movements impacted crisis intervention: Alcoholics Anonymous (AA), activism by veterans from the Vietnam War, and the women’s movement (James, 2008). The impact came because these three groups of people needed help and were not receiving it. Crisis intervention strategies and research, then, became even more widespread, as there were increased concerns about money and limited resources that could not meet the demands of the population. Since the 1960s, additional crisis management has focused on specific areas, such as domestic violence (hotlines, shelters), child abuse (hotlines, referral networks), and rape crisis programs (Roberts, 2005).

In recent years, crisis intervention has become even more of a core component of the helping professions due to the impact of violent incidents on helping professionals in all areas of the United States because of (a) increased access to information, and (b) violence expressed in terrorist acts in public settings (e.g., the attacks on the Twin Towers, school shootings, etc.). A crisis in one part of the United States can easily set off a secondary trauma in another part of the United States. For example, although the 9/11 terrorist activity took place in New York, Pennsylvania, and Washington, DC, and Hurricane Katrina was physically localized to the southern part of the United States, the impact of these traumas throughout the United States was widespread because of the visual images and information spread through television and the Internet. Additionally, the impact of disasters such as 9/11 and Hurricane Katrina does not remain localized to one specific area, since many individuals needed to relocate themselves in response to the disasters. Finally, shootings such as the ones that occurred at Virginia Tech show that helping professionals are increasingly working with individuals impacted by crises in their communities; the helping professionals need to be prepared to do crisis intervention work at a moment’s notice.

The history of crisis intervention work and the current context of this work (increased opportunities for exposure to crisis work) speak again to the focus of this book. This book has an overall goal of providing mental health professionals and students in training in the mental health professions with readily applicable theoretical and practical research-based crisis intervention approaches. Ready access to the essentials of crisis counseling work can assist these individuals in their very important work with the clients in their communities. All counselors will do crisis counseling work, whether it is brief work of a few sessions, working with
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clients who are in continual crises, and/or working with clients on an ongoing basis who experience a crisis during their therapy.

HELPFUL CHARACTERISTICS OF COUNSELORS

While there may be numerable counselor characteristics that can be helpful in a crisis situation, this section will elaborate on five: life experiences, poise, creativity and flexibility, energy and resiliency, and quick mental reflexes. These are drawn from James’s (2008) list of helpful counselor characteristics.

Life experiences means the crisis counselor has emotional maturity that stems from life experiences. Our training as mental health professionals teaches us how to work with clients, whether we have personally experienced their specific crisis or not. Emotional maturity developed through learning from our life experiences can enhance the depth and sensitivity with which we treat our crisis clients. Those of us who have experienced the same type of crisis as our client need to be aware of our countertransference issues that stem from personal and professional biases and “wounds” and work with those issues through consultation with colleagues, mentors, supervisors, and/or personal therapy.

In terms of poise, it is important to stay calm, stable, poised, rational, and in control, because in a crisis the client can be out of control and/or might present material that can be shocking and threatening. Here the counselor is acting as the rudder for the client in the storm of the crisis; the client can pick up on the emotional state as well as the physical presence of the counselor. Therefore, the counselor needs to find ways to reassure him/herself in the crisis in order to remain stable for the client. Specific suggestions to the counselor are made in Chapters 3 and 9 of this text with regard to disaster mental health work and self-care. In the overall practice of self-care, the counselor will have the balance and internal resources to be of maximum benefit to the client in the crisis. Or, in terms of the metaphor stated previously, the counselor will be a stable rudder for the client’s boat in the storm. Such stability makes an impressive impact on reducing the crisis. In a 9/11 crisis situation, I saw a counselor calmly approach a hostile, belligerent client. In a steady, calming voice and manner, the counselor said, “Friend, I do not think this approach is going to take you far in this situation.” Immediately the client calmed down in the situation, making the crisis more manageable.

Creativity and flexibility are major assets and encourage divergent thinking. The more creative and flexible counselors can be in a crisis situation, the more effectively they can meet the needs of the client. If the counselor becomes caught in a formula approach to a crisis situation, then the counselor’s response can be an automatic, rigid one that does not meet the unique needs of the client or the possibly changing dynamics of the crisis situation. Rather, if the counselor can approach the crisis with a tentative plan for how to address it, combined with a readiness to let go of that approach if it does not work, then the counselor can be more effective, because a more comfortable intervention fit can evolve for the client through
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a natural process. For example, a counselor may approach a crisis situation in which the client has been given a terminal illness diagnosis. The counselor may assume the client will want to discuss issues related to death. However, the client may be in a place of denial and may be interested only in discussing how to fight the illness; he or she is unwilling to discuss death at all. The counselor may need to shift the focus of the session to discussing the “battle” first, and then gently but quickly explore the underlying fears related to death.

In terms of energy and resiliency, we need to have energy and be organized, direct, and systemic in the actions we take, which means we need to practice self-care to promote our own resiliency. Energy, self-care, and resiliency are discussed more extensively in Chapter 9. To have physical and emotional energy, we need to care for ourselves. The practice of self-care can provide us with resiliency, which is required in the intensity of addressing crises. Clients in crisis will sense when a counselor is balanced, resulting in a helpful contagion effect that may calm the client. When we care for ourselves as mental health professionals, the result is that we are calm and steady in facing the crisis situation, providing the sense that “someone is in charge here.” I was told by a mental health worker in a crisis situation where other workers had been having “meltdowns,” “Oh, no, you won’t have a meltdown—you take care of yourself too well on an ongoing basis.”

Quick mental reflexes are critical because the issues in a crisis are steadily emerging and changing. This is very similar to creativity, flexibility, energy, and resiliency. We need to be able to think divergently and be resilient in order to have quick mental reflexes. The nature of the crisis situation calls for us to be able to make quick decisions. This is why I advocate that my students and trainees interested in crisis work have licensure and experience as counselors before doing this type of work, because it is truly work where “the buck stops here.” One needs to be comfortable making decisions quickly and often alone in the context of the crisis. There may be time and opportunity for consultation with colleagues, mentors, and supervisors, but we cannot count on it.

This section on characteristics of the counselor is not meant to be discouraging to the reader. No crisis counselor is perfect all the time, nor do any of us handle the crisis perfectly throughout. Rather, we act in the best interest of the client and continually assess the client and the situation for what appears to be the approach that reflects caring for the client’s welfare. Rather than focusing on avoiding making a mistake or being flawless, it is more important for us, if and when we make a mistake, to recognize it and recover from it. Most importantly, we need to be human beings with our clients in a crisis situation, for whom everything feels tumultuous. Such humanity can be an umbilical cord of hope for our clients.

INTERAGENCY COLLABORATION

We need to discuss briefly the subject of collaboration with other agencies, because client crises often mean that other agencies will need to be involved somewhere
in the process of the intervention—whether it be in terms of referral, assessment, treatment, or follow-up. The same characteristics described above as being helpful with clients are also helpful in working with other agencies: life experiences, poise, creativity and flexibility, energy and resiliency, and quick mental reflexes. Other agency personnel may be almost, or sometimes more, out of balance than the client in the crisis, and through their behavior they may exacerbate the crisis. Or the counselor may approach or interact with the other agency personnel during the crisis in a manner that fuels the crisis.

In crisis situations, emotions tend to run high and just one comment, behavior, intervention, or the like can inflame a crisis through deterioration of a professional relationship. That is why the counselor needs to learn how to remain calm when others are not calm. In Chapter 3, this approach is titled “environmental stress manager.” This means that the counselor needs to be able to read his/her own stress levels, those of the client, and those of the surrounding crisis situation, and then intervene on these stressors present in each area—that is, manage the stress. Counselors should not assume that others will pick up on stress indicators and respond to them. Rather, the counselor needs to be cognizant of the skills developed through his/her training to recognize, address, and minimize these indicators. For example, a supervisor at a disaster mental health site had not been caring for herself on a regular basis, but had focused almost exclusively on others. As a result, after a few days on the site, she was very critical and sharp in her dealings with other agencies. Her fellow counselor team members successfully encouraged her to take more breaks, which ended up in her approaching other agencies in a more collaborative manner and reducing the stress in the environment.

SUMMARY

This chapter presented an overview of crisis counseling: philosophy, definition, and history. Finally, it addressed the importance of helpful counselor characteristics and interagency collaboration.

QUESTIONS

1. What is the philosophy of crisis counseling as presented in this book?
2. Describe the history of crisis counseling.
3. What are typical reactions (professional, client) to crisis situations, and what makes interagency collaboration so critical to crisis counseling?

EXERCISE

Write out your philosophy of crisis counseling work in a few sentences. Make sure to address these questions: What is your main focus? How does your current
Case Study 1.1
You have a client who requires the assistance of a number of agencies (social services, church, health department, etc.) in dealing with a crisis situation. Your client is very distraught, but is willing to contact these agencies to obtain assistance and willing to have you talk with them regarding her situation (she has signed consent forms). You have a history of working with helping professionals at the local health department; you are aware that they do not like to work with clients in crisis mental health situations, and generally, they have not been cooperative with you in the past.

1. How would you approach this situation with the health department?
2. What would you tell your client, if anything, about the history of your experiences in working with the health department?
3. Would you warn your client about some of the barriers she may face in approaching them? If so, what would be your general strategy?

(or anticipated) job/clientele impact your philosophy of crisis counseling? What do you see as your main strengths and weaknesses in this type of work?

SUGGESTED READINGS


This book has ten chapters that address a mindfulness approach in counseling clients in general.


This book is divided into two sections: trauma effects and assessment and clinical interventions.


This short book has 11 chapters that briefly cover basic approaches and strategies in crisis work with focused chapters on children, families, hotline workers, loss, legal implications, and disasters.


This book is an overview of crisis work. It is divided into three sections: understanding crisis intervention, specific crises, and suicide/homicide/catastrophic events.

This book provides an overview of crisis intervention. It has four sections: theory and application, handling specific crises, workplace, and disaster. There is a specific chapter related to addiction.


This book has 12 chapters that cover general crisis information (definition, history, ethical/professional issues) as well as chapters on multicultural concerns, the ABC model, and addressing issues related to crisis, such as danger, developmental crises, loss, illness and disabilities, substance abuse, PTSD/community disasters/trauma, and abuse (child, spousal, sexual assault).


This brief book has 33 chapters, each of which, in a few pages, covers major topics of crisis work. It may be thought of as a type of CliffsNotes or a primer of crisis work.


This book has three sections: an overview, suicidal ideation, and assessment. It has helpful appendices on assessment documentation, safety contracts, and suicide prevention Web sites.

**WEB SITES**

Mental health professionals can contact the following Web sites for information on mental health counseling in a crisis context with regard to their professional organizational affiliation.

American Association for Marital and Family Therapy: www.aamft.org
American Counseling Association: www.counseling.org
American Psychiatric Association: www.psych.org
American Psychological Association: www.apa.org
National Association of Social Workers: www.nasw.org

**Co-occurring Disorders**

Substance Abuse and Mental Health Services Administration (SAMHSA): www.mentalhealth.samhsa.gov

This Web site provides a variety of information and resources on substance abuse and mental health.

**Crísis**

Crisis Prevention Institute: www.crisisprevention.com

This Web site provides information on training professionals working with potentially violent people.
Web Sites

National Organization for Victim Assistance: www.trynova.org
This Web site offers information on the rights of victims and services available to them.

General

Department of Health and Human Services (DHHS): www.hhs.gov
This Web site provides information on various aspects of American health concerns. A connecting Web site, www.phe.gov/preparedness, provides information specifically focused on public health emergencies, including crises such as disasters and trauma.

National Institute of Mental Health: www.nimh.nih.gov
This Web site provides information on understanding and treating mental illness and offers helpful publications for the mental health professional.

Suicide

American Association of Suicidology (AAS): www.suicidology.org
One can join this organization. The Web site has facts, warning signs, support groups, crisis centers, a bulletin board (members only), and a bookstore.

American Foundation for Suicide Prevention (AFSP): www.afsp.org
This Web site has statistics and suicide survivor information.

SA/VE: Suicide Awareness Voices of Education: www.save.org
This Web site has suicide prevention education, advocates for suicide survivors, and information on developing a group for suicide survivors.

Suicide Prevention Action Network (SPAN) USA: www.spanusa.org
If You Are Thinking About Suicide . . . Read This First: www.metanoia.org/suicide
This Web site attempts to reduce the stigma around having suicidal thoughts so that the reader is open to receiving help.