

Crisis Intervention

Crisis Intervention Theory

A crisis is said to occur when a person is faced with a situation that pushes him or her beyond his capacity to cope and still continue in a normal life style. In times of crisis, it is imperative to be able to provide an immediate response. Crisis intervention is a specific body of professional knowledge and skills. The aim of crisis intervention is to enable a person faced with a crisis to cope with the immediate acute and stressful demands being made by circumstances and to restore normal functioning so that the subject can take up the task of seeking a satisfactory resolution to his own crisis (Newberry, 1993).

The rationale for *school-based* postvention/crisis intervention is that a timely response to a suicide is likely to reduce subsequent morbidity and mortality in fellow students, including suicidality, the onset or exacerbation of psychiatric disorders (e.g., posttraumatic stress disorder, major depressive disorder), and other symptoms related to pathological bereavement. The major goals of postvention programs are to assist survivors in the grief process, identify and refer those individuals who may be at risk following the suicide, provide accurate information about suicide while attempting to minimize suicide contagion, and implement a structure for ongoing prevention efforts (Gould, Greenberg, Velting, & Shaffer, 2003).

Young (1989) argues that the process of "being in crisis" can be subdivided in two distinct phases:

1. The Impact Phase is when the crisis begins and initially impacts upon the subject. This is often experienced as overwhelming and quite frightening. During this phase, the role of the worker is to assist the client in (i) the management of heightened emotions, (ii) the restructuring of the crisis situation and (iii) the activation of coping responses. Interventions in this phase, which may last from a few days to a week, need to be intense and frequent.
2. The Integration Phase is concerned with accepting and assimilating the implications of the crisis into the individuals' life . Evaluation is done at the conclusion of the Impact Phase and the client and worker review how and to what extent the immediate demands of the crisis have been dealt with and what remains to be done. Interventions during this phase gradually become more infrequent as the client learns to live with the results of the crisis and is able to function independently.

In their analysis of youth focus group data related to suicide, Coggan, Patterson, and Fill (1997) identify several key issues related to prevention and crisis intervention:

- Many of the participants said that as educational institutions were the place where the majority of young people spent a large part of their lives, what they learn in a school setting has far-reaching effects. Schools are therefore significant avenues for young people to receive positive messages about themselves.
- All participants argued for an urgent need for educational institutions to introduce curriculum-based programs that deal with the issues surrounding conflict resolution, overcoming depression, dangers of excessive substance abuse, stress, being happy, being able to handle the emotional trauma of relationship breakups and coping with sexual orientation. Such programs were seen to be important as it was stated by most participants that having this type of broad focus would probably do more to help to reduce the numbers of young people contemplating self-harm than programs which concentrated only on suicide.
- Participants stated that providing teachers, caregivers, and peers with training in recognizing the warning signs of a depressed young person and information on where to turn for help was important.
- Participants identified the need for more health professionals who are specifically trained and have the resources to promote the health status of youth. Many of the participants favored a "one stop" concept for youth health which was friendly and provided "social support" as well as "medical treatment".
- For those who make a non-fatal suicide attempt, the emergency department in a general hospital is the setting where suicidal young people are most likely to present. Youth focus group participants were highly critical of current emergency department practice in New Zealand with regard to both acute management and follow-up care of young suicide attempters. This would suggest that resources need to be allocated to ensure that emergency department staff have the skills, time, and the availability of specialist referral staff to ensure that appropriate clinical care is provided. These authors suggest the need to further investigate emergency department procedures with an emphasis on the needs of young people.

Good Practice Findings

In a comprehensive evaluation of the Australian National Suicide Prevention Strategy (2000), five major themes emerged concerning principles of good practice in prevention of suicide among young people, including:

1. ***Multidimensional approach***- The value of the multidimensional approach used by the strategy has been affirmed strongly by the evaluation. The multidimensional approach includes attention to the full spectrum of interventions; whole populations as well as high risk sub-populations and individuals; a range of different settings and sectors; and multiple levels of action

including target populations, service agencies, service systems, local, State and Commonwealth government.

2. **Access-** Much has been learned about the characteristics of services and programs that are likely to make them more accessible to young people. Critical elements of accessible services and programs include: universal and selective (aggregated) targeting; flexibility in terms of selection criteria and source of referrals; delivery in multiple community-based settings; and having multiple 'soft' entry points.
3. **Engagement-** Problems of engagement go hand in hand with barriers to access as major reasons why service systems have failed to develop appropriate responses to young people's needs. Services and prevention programs have particularly failed to adequately engage young males and young people with complex psychosocial problems. Communication is the key to engagement both in therapeutic situations as well as for the purposes of engaging young people as partners in service and community development. The evaluation found that service providers need to develop better knowledge of adolescent developmental health issues and skills in challenging negative assumptions about young people's culture. Providing a relaxed youth-friendly environment and a holistic range of services within one location is also very important for engaging young people who may lack the resources, skills and motivation to engage with service that are widely dispersed in different locations and administrative systems. Assertive follow-up is particularly critical for ensuring that young people at high risk are provided with the encouragement and practical assistance to return to services once initial contact has been made.
4. **Effective intervention-** The Strategy has underscored the importance of interventions that address protective factors as well as risk factors. This is important across the full spectrum of interventions, not just primary prevention. The evaluation underscored the importance of striving to provide holistic, multisystemic interventions.
5. **Capacity building-** One-dimensional activities aimed at increasing the knowledge and skills of service providers such as provision of information and education and training are insufficient. Capacity building interventions need to be designed with an awareness of all the forces that operate within systems to facilitate or inhibit the changes that are desired, and address as many of these as possible in a comprehensive fashion. Individual agencies can achieve little working in isolation. Genuine collaboration between organizations is necessary. This requires active engagement beyond the activities of individual project staff or service providers. Real collaboration or partnership involves developing and working towards shared goals and usually demands a willingness to modify organizational structures and processes.

Roberts' (2002) Seven-Stage Crisis Intervention Model provides practitioners with a crisis intervention protocol and guidelines to follow in dealing with crises.

Roberts' Seven-Stage Crisis Intervention Model:

Stage 1: *Plan and Conduct a Crisis Assessment (Including Lethality Assessment).*

Stage 2: *Establish Rapport and Rapidly Establish Relationship.*

Stage 3: *Identify Major Problems (Including the "Last Straw," or Crisis, Precipitants).*

Stage 4: *Deal with Feelings and Emotions (Including Active Listening and Validation).*

Stage 5: *Generate and Explore Alternatives.*

Stage 6: *Develop and Formulate an Action Plan.*

Stage 7: *Follow-up*

It is useful for counselors, psychologists, nurses, and social workers to have a conceptual framework in order to improve the delivery of services for persons in a pre-crisis or traumatic state. Roberts' ACT Intervention Model of Crisis and Trauma Assessment and Treatment can help ascertain what to assess, and which methods should be used to conduct assessments.

Roberts' ACT Intervention Model of Crisis and Trauma Assessment and Treatment:

- **A**ssessment/Appraisal of immediate medical needs, threats to public safety and property damage
 - Triage Assessment, crisis assessment, trauma assessment and the biopsychosocial and cultural assessment protocols
- **C**onnecting to support groups, the delivery of disaster relief and social services, and Critical Incident Stress Debriefing (CISD) implemented
 - Crisis intervention (Roberts' Seven-Stage model) implemented
- **T**raumatic stress reactions, sequelae, and posttraumatic stress disorders (PTSD)
 - Ten-step acute trauma and stress management protocol (Lerner & Shelton), Trauma Treatment Plans and recovery strategies implemented

Evidence

- A number of studies have demonstrated that certain population groups benefit from crisis intervention programs. Female individuals in both the 15-24 and 55-64 age groups benefited the most from suicide prevention and crisis intervention programs. The research on the effectiveness of crisis intervention programs with people presenting psychiatric emergencies also show positive outcomes (Roberts, 2002).
- An encouraging study by Poijula et al. (2001) found that no new suicides took place during a 4-year follow-up period in schools where an adequate intervention took place, whereas the number of suicides significantly increased after suicides with no adequate subsequent crisis intervention. It is imperative for crisis interventions to be well planned and evaluated; otherwise, not only may they not help survivors, but they may potentially exacerbate problems through the induction of imitation (Gould, Greenberg, Velting, & Shaffer, 2003).
- Newberry's (1993) study of Hong Kong's "Youth Outreach" crisis intervention program provides evidence for the argument that early intervention with at-risk youth is most effective.

References

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Crisis Intervention Strategies

Brief Strategic Family Therapy (BSFT) is a short-term, problem-focused therapeutic intervention, targeting children and adolescents 6 to 17 years old, that improves youth behavior by eliminating or reducing drug use and its associated behavior problems and that changes the family members' behaviors that are linked to both risk and protective factors related to substance abuse. The therapeutic process uses techniques of:

- **Joining**—forming a therapeutic alliance with all family members
- **Diagnosis**—identifying interactional patterns that allow or encourage problematic youth behavior
- **Restructuring**—the process of changing the family interactions that are directly related to problem behaviors

Multidimensional Family Therapy (MDFT) is a comprehensive and flexible family-based program for substance-abusing adolescents or those at high risk for substance use and other problem behaviors. MDFT interventions target the research-derived risk factors and processes that have created and perpetuate substance use and related problems such as conduct disorder and delinquency. MDFT also intervenes systematically to help individuals and families develop empirically derived protective and healing factors and processes that offset substance use and behavioral problems. MDFT is a multicomponent and multilevel intervention system. It assesses and intervenes multisystemically with the adolescent and parent(s) individually; family as an interacting system; and individuals in the family relative to their interactions with influential social systems that impact the adolescent's development. Interventions are solution-focused and strive to obtain immediate and practical outcomes in the most important individual and transactional domains of the adolescent's everyday life—home and school. MDFT studies have demonstrated the capacity to significantly reduce substance abuse and behavior problems and improve school, peer, and family functioning in many different youth populations.

Trauma-Focused Cognitive Behavioral (TF-CBT) is a psychotherapeutic intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It was developed by integrating cognitive and behavioral interventions with traditional child abuse therapies that focus on enhancement of interpersonal trust and empowerment. The program can be provided to children 3 to 18 years of age and their parents by trained mental health professionals in individual, family, and group sessions in outpatient settings. It targets symptoms of posttraumatic stress disorder (PTSD), which often co-occurs with depression and behavior problems. The intervention also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use.

The Coping with Stress Course (CWS) targets adolescents at risk for depression who are experiencing elevated depressive symptoms, or "demoralization." The program involves cognitive-restructuring techniques in which participants learn to identify and challenge negative or irrational thoughts that may contribute to the development of future mood disorders, such as depression. CWS is an adaptation of the [Adolescent Coping with Depression Course](#), which targets adolescents already experiencing major depression or dysthymia.

The Cognitive Relaxation Coping Skills (CRCS) program targets heightened cognitive, emotional, and physiological sensations, with a goal of increasing children's ability to control their emotions. Students are taught methods for relaxation and for attitude change and how to use those skills to control their feelings of anger. The premise of the program is that as students apply these skills and learn how to relax, or if they avoid becoming angry in the first place, they are better able to deal effectively with frustrating situations.

The Coping Cat program is a cognitive-behavioral therapy intervention that helps children recognize and analyze anxious feelings and develop strategies to cope with anxiety-provoking situations. The program focuses on four related components: (1) recognizing anxious feelings and physical reactions to anxiety; (2) clarifying feelings in anxiety-provoking situations; (3) developing a coping plan (for example, modifying anxious self-talk into coping self-talk, or determining what coping actions might be effective); and (4) evaluating performance and administering self-reinforcement. By incorporating adaptive skills to prevent or reduce feelings of anxiety, the Coping Cat therapist uses a workbook to guide the child through consideration of previous behavior in situations in which the child felt anxious, as well as the development of expectations for future behavior in anxious situations. The Coping Cat workbook is used for children aged 8 to 13 years and the C.A.T. Project workbook is used for children aged 14 to 17 years. The C.A.T. Project differs from Coping Cat only in the use of developmentally appropriate pictures and examples for older ages.

Reality Therapy focuses on behavior rather than past attitudes or experiences. The worker functions both as a teacher and a model and helps the client evaluate whether his behavior is fulfilling his basic needs without harming himself or others. The basis of Reality Therapy is rationality and responsibility, with the worker focusing on what clients are able and willing to do to change their behavior and on practical ways of doing this. Problems are listed and plans drawn up to solve them. If the plan does not work, there are no recriminations but a redrawing of the plan. In this way, the client learns not only how to deal with a specific problem but also the whole process of rationally analyzing problems and planning solutions (Newberry, 1993).