# Crisis Intervention

**WHAT IS CRISIS?**

We all experience a variety of stressful events in our lifetime. Each of us has unique ways of dealing with these events to maintain a comfortable emotional balance, and when the usual coping mechanisms fail, we seek new ways of coping. A crisis state comes into being when these new attempts fail to return us to the pre-crisis level of emotional balance.

Crisis is a state of feeling; an internal experience of confusion and anxiety to the degree that formerly successful coping mechanisms fail us and ineffective decisions and behaviors take their place. As a result, the person in crisis may feel confused, vulnerable, anxious, afraid, angry, guilty, hopeless and helpless. Perceptions often are altered and memory may be distorted.

Crisis is both a time of opportunity and danger. Crisis is useful when it causes one to go beyond familiar coping skills (both internal and external) and to develop new skills, therefore becoming more competent and autonomous. A crisis is dangerous when the person becomes overwhelmed with anxiety and pain and adapts in negative ways.

Good mental health has been described as the result of a life history of successful crisis resolutions.

A crisis state involves the breakdown of coping behavior that may have been adequate in the past, and as such it is a departure from the "status quo" of the client. A healthy, well-adjusted individual can experience a crisis as can someone who is mentally ill. In neither case do we pass judgment on how the person functions normally, but through crisis intervention assist the client in returning to whatever is normal for them, hopefully, armed with new, more effective coping skills.

**Development of a Crisis**

1. A precipitating event such as a perceived loss or traumatic experience produces intense anxiety and dependence on problem-solving skills.

2. Usual coping skills fail; the problem is still present and anxiety increases. The individual must look outside himself for help.

3. External resources may be tapped (religion, other people, alcohol, etc.) and fail to return the person to a comfortable emotional level. Anxiety continues to increase and the person may feel helpless. Perceptions are altered and the individual may think of nothing else but his situation.

4. All known internal and external resources fail; this tension and anxiety become unbearable. At this point, something must change.

**Possible Crisis Outcomes**

A person cannot stay in crisis. The body can't stand the physical and emotional strain indefinitely. Either the situation will change and the person will return to a pre-crisis state; the person will develop new coping skills and resources; or the person will avoid crisis by substance abuse, mental or physical illness, a suicide attempt, or other destructive behavior. Some precipitating events can never be undone (such as in the case of rape or death of a spouse) and so the option of returning to a pre-crisis emotional state is not possible. Even where the situational crisis may be resolved, the client's range of possible experiences and feelings has been altered and denial may play a big part in any resolution that does not include growth and development of new coping skills.

**Types of Crisis**

**Developmental Crisis** is a crisis resulting from a normal life change (i.e. puberty, leaving home, marriage, birth of children, retirement). These are changes that are normal parts of life and can only be successfully transitioned through as one learns to cope with her situation.

**Situational Crisis** is the result of the unexpected trauma such as losses, illness or displacement. Because of the unexpected shock, one typically experiences these events as more stressful.

At times these developmental or situational crises can occur simultaneously, and when that happens the crisis is usually more disruptive.

**The Person in Crisis**

There is not a clear-cut description of a person in crisis. Below are some feelings commonly experienced by someone in crisis:

1. Anxiety – Any substantial threat produces anxiety that can be helpful in mobilizing us to defend ourselves against the threat through change, action, etc. However, too great an amount of anxiety can lead to confusion, poor judgment, immobilization, and self-defeating behavior.

2. Helplessness – Being faced with an external or internal situation that we are not prepared to face can leave one feeling vulnerable. Intense emotions may contribute to the experience of helplessness.

3. Anger – Anger may be directed at another person, an event, or at the self.

4. Shame/guilt – The person in crisis often feels incompetent and out of control. S/he may experience feelings that are not acceptable or usual to her/him. The pain may be further complicated by being ashamed of one's plight.

5. Confusion – Crisis may interfere with one's ability to think straight, problem-solve, or event accurately perceive one's experience. This distortion in itself may be frightening and the persons in crisis may fear s/he is "losing his mind".

6. Fear – The fear may be of actual components and possible outcomes of the crisis situation, as well as of the powerful effects listed above.

**Helping the Person in Crisis**

We may begin to sense that a person is in crisis by the intense feelings of fear, anger, sadness, pain, etc. which s/he expresses. In addition to the feelings of the person in response to the painful event, there may be another group of feelings because of his reaction to being in crisis. For example, a client may say, "I'm so angry I never want to see her again…but I should not feel this way". Through empathic, reflective listening we accept the client and his/her feelings and identify and clarify the feelings. In a sense, we say, "But you do feel that way and that's ok". Help the client sort out what is going on, what the crisis is about.

If the client is talking loudly or wildly, the Life Guide may be swept up in his sense of urgency and react to the impulse to do something, to fix it before adequate information has been gathered or adequate relationship established. In such a case, the first step would be to get the person to slow down, to take his time, and to communicate our concern and willingness to help. It is also important to remember that options for the situation, if there are any, already exist. The Life Guide does not invent them and a thorough exploration is the initial step in discovering important feelings and information.

In a crisis, a here-and-now focus is helpful. It is highly unlikely that we can resolve a large or complex problem in one phone call, but we can help the person to reduce their level of anxiety to a more manageable level and to develop short-term plans aimed at beginning to work him/herself out of the crisis. The plan should be simple, concrete and behavioral (something he can do and see the results of quickly).

**Stages in helping a person in crisis or problem**

**STAGE I** **Establish rapport / Build a relationship**

- Unconditional Positive Regard, Genuineness, Empathy
- Establish trust. Engage in Active Listening
- Reflect, reflect, reflect. . .feelings or thoughts
- Open-ended questions
- Attending behaviors: "Ear contact," "mmm'mm," "I hear you."
- Tracking - responding to what he or she has just said.
- "Take your time". Give permission to ventilate
- Silence can be a powerful form of active listening.

**STAGE II** **Clarification / Define the Problem**

- Who is this person?
- Break it into smaller pieces. Gather information.
- What does this problem mean to him or her?
- Reflect, reflect, reflect . . .
- Open-ended questions or closed-ended questions.
- Assess the situation for risk, emergency, or danger.
- Bring up a difficult subject.

**STAGE III** **Explore Resources**

- Prior strains? Available resources? Perception of the problem?
- What has he/she tried before?
- What options does he/she see?
- Who can they turn to for support or help?
- What special considerations factor in to the resources?
- Facilitate his/her development of the solution or options.
- Refrain from giving advice! Let the client do the work.

**STAGE IV** **Plan of Action**

- Pace him/her *and* yourself . . . "Rome wasn't built in a day."
- Break plan into manageable steps - Summarize. Anticipate problems
- The call may be resolved before it gets to action planning.

**STAGE V** **Wrap up the call/session**

- How does he/she feel now?
- Commend him/her for making call - for risking.
- Offer other resources.
- If there is a special reason follow-up, plan and make clear.
- Give feedback.

**Crisis Assessment and Intervention**

A client in crisis may be experiencing some impairment of this usual level of functioning. It is important to assess the degree of that impairment of functioning and if the client is in immediate danger (emergency risk). This assessment will determine how directive and involved we need to be with this client. We do not want to further disable a client by taking over for him; thus increasing his dependency on others. Nor do we want a dysfunctional client to continue a downward, out of control spiral into a more serious crisis. In effect, we as Life Guides are trying to assess how much control we need to take with a client in order to help him. We make this assessment by gathering relevant information. The following questions are useful in making this determination.

- Is the person able to carry on normal responsibilities: are they paying bills, attending work, school, caring for kids?

- Are they eating/sleeping normally?

- Is the client catastrophizing? "No one cares"; "It's hopeless".

- Are there other behavioral indicators of distress: i.e. inappropriate laughter, hearing voices, can't stop crying, inability to concentrate, make decisions, distorted perceptions of people, places, or things?

Generally, the more "yes" answers the assessment reveals, the more dysfunctional the client, and the more directive the intervention should be.

Consider the following continuum when making your decision about intervention strategy.

**Assessment of Client's Emotional State**

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| Very Functional | Totally Dysfunctional |
|---|---|
| Client is in distress but it is at a manageable level. Normal activities are not affected | Client is over-whelmed by distress, which is seriously affecting their ability to make rational decisions, care for themselves or others. |

**Life Guide's Style of Intervention**

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| Non-Directive | Very Directive |
|---|---|
| Non-intrusive and respectful of client's ability to make decisions. Life Guide is reflective, provides support, encouragement, clarification, and information | Life Guide takes control. Tell client what to do. Very here and now orientation. |

The other level of assessment, which occurs simultaneously, is the assessment of "emergency risk". How likely is it that the client will harm themselves or a third party? When, during a call, we as Life Guides become concerned that the client might be at risk of harming themselves or someone else, we must ask very directly, "Are you thinking about hurting yourself or….?" If their answer indicates possible danger, then we must assess the "Emergency Risk". Let the client know that you are concerned for them and that you believe they are serious. The following questions are necessary in making an emergency risk assessment:

- Have you ever felt like this before? – Check history of assault. How did you handle it then? (Past behavior is good predictor of future behavior.)
- What is the plan? How is the client planning to kill himself or a third party? Generally, the more clear the plan, the more serious the threat.
- Are you using alcohol or drugs? An intoxicated person is more likely to act impulsively.
- What is the precipitating event? Has there been a recent disruption of the relationship? i.e. divorce, break up, just discovered spouse to be unfaithful.
- Is the person threatening to kill himself after the homicide?

- Does the person have access to the means to carry off the threat?

Notice that we use close-ended questions. These make good assessment questions because they elicit specific information necessary to determine risk. The more yes answers you get, the higher the emergency risk.

When a high emergency risk is assessed, the Life Guide should focus on reducing the risk. i.e. getting rid of the means, stop drinking, rally support system: family, friends, paramedics, police. If the life of a third party is threatened, we have a "duty to warn".

As mentioned earlier, crisis intervention should take place in very small steps, i.e. "I want you to take some deep breaths and let's make a plan". The plan should be short term and have a high probability for succeeding.

**CRISES & EMERGENCIES COMPARED**

| **PSYCHOLOGICAL CRISES** | **PSYCHOLOGICAL EMERGENCIES** |
|---|---|
| A crisis is a loss of psychological equilibrium. | Many emergencies can develop from or involve a crisis. |
| A crisis is longer lasting in duration than an emergency and does **not include the risk of danger.** | An emergency is an abrupt, sudden situation in which **there is an imminent risk of harm.** |
| In crisis, normal coping responses are insufficient to resolve the situation. | Emergencies can potentially result in harm to self or others in four possible ways: |
| Secondary attempts to cope are unsuccessful and the crisis is activated. | 1. Risk of suicide |
| There is a marked increase in anxiety, tension, agitation, depression or a sense of defeat. | 2. Risk of physical harm to another |
| Activities of daily living (eating, sleeping, grooming, daily habits, etc.) become impaired or are impossible to carry out. | 3. Being in a state of seriously impaired judgment in which an individual is endangered (delirium, dementia, acute psychotic episode, severe dissociation, etc.) |
| A person can not remain in crisis permanently. | 4. Risk to a defenseless victim (such as a child or elder) |
| The goal of crisis intervention is brief or short term Life Guiding designed to **stabilize and restore the individual's functioning at a normal and adaptive level as soon as possible.** | The goal of emergency intervention is to **remove lethality and reduce or eliminate danger.** |

**STEPS TO TAKE DURING**
**CRISIS INTERVENTION OR EMERGENCY**

| CRISIS INTERVENTION STEPS | EMERGENCY INTERVENTION STEPS |
|---|---|
| Crisis intervention done well may occur within the next 24 hours and over the next several weeks. Frequent use of Stage 1. Stay in Rapport Building for much of the call. | Emergencies demand an immediate, personal and flexible type of interview if a tragedy is to be averted. Go pretty quickly to Stage 4, Plan of Action after careful assessment. |
| 1. Engage the client in telling his or her story. Use open-ended questions. Learn how and why things have built up. | 1. Contain and define the emotional turmoil of the client. Use closed-ended questions, avoid reflection of feelings, and focus on facts. |
| 2. Obtain an understanding of the meaning of the crisis for the client, prior attempts at coping, and availability of support systems | 2. Determine the degree of risk: |
| 3. Assess for the presence of a psychological emergency. If yes, suspend crisis intervention and conduct an emergency intervention. | a. Assess lethality: ask about it in a direct and straightforward manner. |
| If no psychological emergency is present, resume crisis intervention. | b. What is the level of intent? For example, on a 1-10 scale….? |
| 4. Assess functional impairment (activities of daily living) and impulse control, ego strength, quality of relationships, etc. | c. What is the viability of the plan? For example, access to a method, etc. |
| 5. Take a personal history. Has this ever happened before? How did you cope with this before? How do other earlier difficulties spill over into this one? | d. What is the likelihood that the client will act impulsively? (fuse builds up, a prior history of explosive conduct, etc.) |
| 6. Normalize that feelings are normal for an abnormal buildup of strain and stress. Focus on coping strategies, support systems, referrals, etc. | 3. Direct him or her to appropriate care and treatment, such as inpatient or outpatient medical care. Resolve problem and allay crisis. |

**DIRECTIVE AND NON-DIRECTIVE RESPONDING**
**MINI-CASE STUDIES**

Remember, non-directive responding is very much like Stage 1-Rapport building, with active use of reflection, open-ended questions, ear contact, trust-building. Directive responding is used in emergency situations, with active use of emergency assessment, closed-ended questions, and a plan of action.
Decide how you would respond to the following situations. Try to anticipate any problems that might arise in dealing with such issues, including management of your own feelings.

1. A 17-year old male, angry with a teacher who he feels humiliated him in front of his classmates, clients to say he's planted a bomb in the high school gymnasium.
   Directive _____ or Non-directive_____
   What would you do? _____

2. A young girl whose presenting problem is a suspected unwanted pregnancy reveals the father of the baby may be her brother. She refused to give any identifying information.
   Directive _____ or Non-directive_____
   What would you do? _____

3. A woman clients to say she is certain that her neighbors are physically abusing their children. She is a widow living alone and is fearful of any repercussions if she attempts to intervene by herself or if she reports it to the police.
   Directive _____ or Non-directive_____
   What would you do? _____

4. The past two clients you have answered have been from the same person—an adult female named Mary who wants to talk about her divorce that happened five years ago. At least one other co-worker on your shift has taken a call today from the same woman. She seems totally uninterested in doing anything about her problems of loneliness and depression but readily agrees to free the line when confronted with the ("Oh, of course—I'm just wasting your time.") The phone rings again and it is Mary.
   Directive _____ or Non-directive_____
   What would you do? _____

5. You receive a call form an obviously angry woman who says a Crisis Center Life Guide has mistreated her the night before and she wants to file a complaint with the Executive Director. She demands his home phone number. When you say you will have to take a message and have him return the call in the morning, she becomes furious and is verbally abusive toward you. She says she will call the newspaper and tell them what a shoddy operation this is unless you comply.
   Directive _____ or Non-directive_____

What would you do? _____