SIXTH EDITION

A GUIDE TO CRISIS INTERVENTION

KRISTI KANEL

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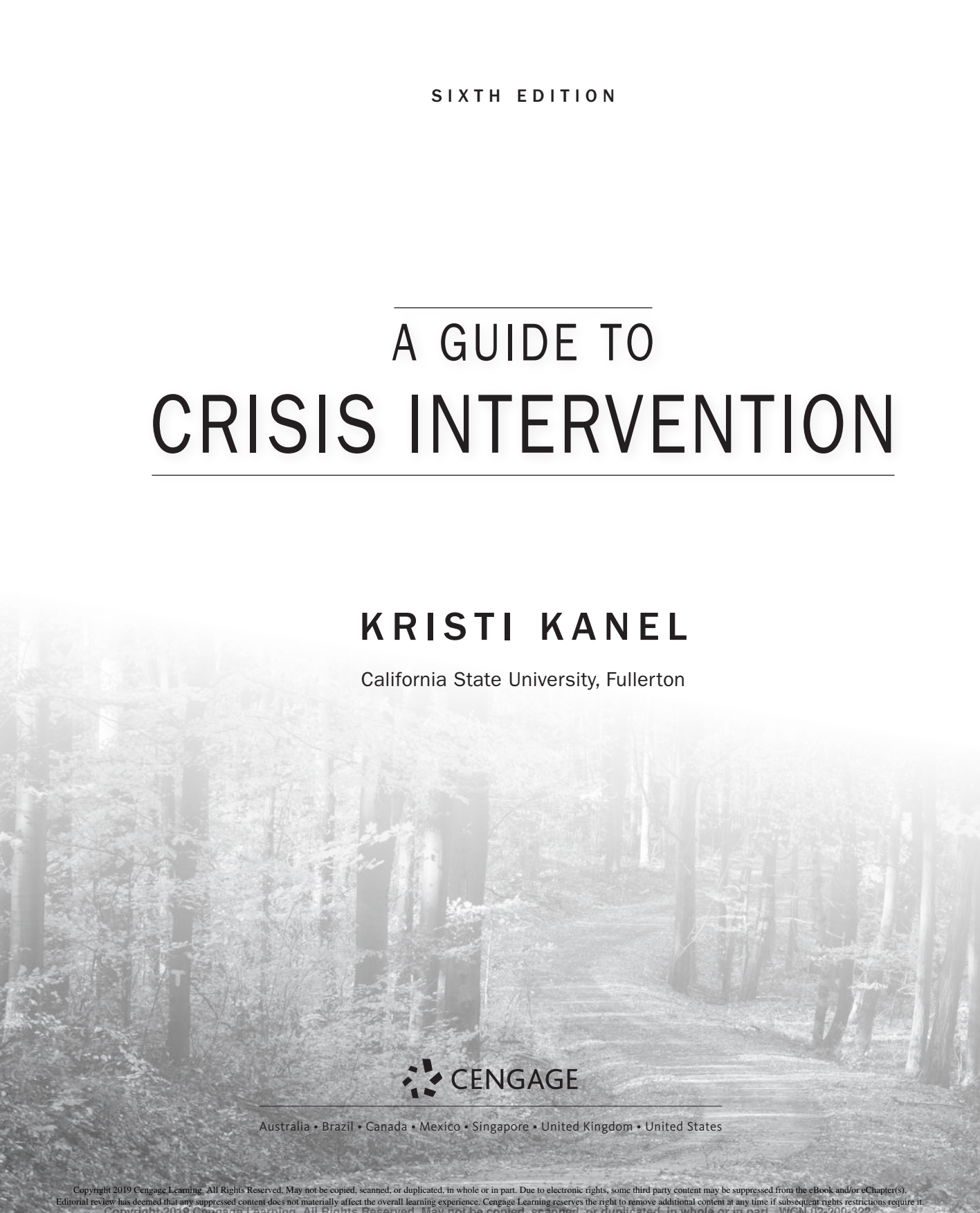
California State University, Fullerton



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This book is dedicated to the many human service students who have given me their feedback over the years and to all the brave individuals who have survived and grown through their crises.

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Preface

When I first wrote this book, my intent was to create a student-friendly text that would guide both new and more experienced counselors through specific procedures when conducting brief crisis intervention sessions with a variety of client populations. Although I have included much research and theory throughout the book, the focus has stayed the course—how to conduct interviews in a structured fashion.

In general, this book is written for college students and beginning mental health professionals who might benefit from a step-by-step practical guide on how to work effectively with clients in a variety of settings. There are many case examples and practice opportunities woven throughout the text. This text works great in courses in which students are given opportunities to practice what they are reading through role-plays with one another, or with actual clients, under the supervision of the instructor or other mental health counselors. It has been useful for professionals such as police, firefighters, military personnel, as well as mental health counselors.

Organizing Features

I have included many real-world examples and sample scripts for students throughout the text. Over the years, I have found that students benefit from seeing what others actually say during counseling sessions. They can then practice similar types of comments when they conduct role-play sessions.

I have also presented the major theory behind crises, and then how the theory is utilized when conducting crisis intervention. Connecting theory with practice helps students better understand both and systematically learn how theoretical constructs are put into practice. Once theory is presented, students are provided with a detailed description of the ABC Model of Crisis Intervention. In order to practice that model, students are then provided with various chapters that deal with specific client populations, their needs, and how to implement the ABC model with that type of client.

Pedagogical Aids

Boxes have been inserted through the book to highlight interesting new case examples and scripts. Tables, diagrams, boxes, and figures have also been inserted to keep students focused on essential theoretical and clinical material.

In chapters dealing with client populations, case vignettes to practice are placed at the end of the chapter. Included with these are specific ideas such as precipitating events, cognitions, emotional distress, impairments in functioning, suicidality, and therapeutic interaction statements so that the student can more easily practice the ABC model with other students. Chapter review questions are located at the end of all chapters along with key terms for study.

New to This Edition

As I have revised the text over the years, I have included new information as the world has changed, and as various traumas have been experienced by many of us. For example, my second edition included the issues surrounding the effects of 9/11, and the third edition included information about the Katrina disaster. In the fourth edition, I had included data based on my own research study related to the types of crisis experiences described by the returning military personnel who were stationed in Iraq and Afghanistan. In the fifth edition, an entire chapter was devoted to just veteran issues. In this sixth edition, I have included material related to gun violence, ISIS terrorism, Fear of Missing Out (FOMO) and the Quarter life crisis, transgender issues, Black Lives Matter, and have updated all statistics on various issues.

I have changed the names of some chapters, and have included a chapter on crises of sexuality, which includes issues surrounding abortion for both men and women. I have added a true case about a man transitioning to a woman.

Ancillaries to Accompany the Text

There is an instructor's manual that includes a section on how to teach the course I have taught for 31 years, test items for instructors to use (both multiple choice and essay style) and a description of the lectures for each chapter. Also available is a PowerPoint slide presentation and quiz items for students. These materials can be accessed through the instructor's companion site at login.cengage.com. For access, please contact your Cengage Learning sales representative.

New to the sixth edition is MindTap®, a digital teaching and learning solution, that helps students be more successful and confident in the course—and in their work with clients. MindTap guides students through the course by combining the complete textbook with interactive multimedia, activities, assessments, and learning tools. Readings and activities engage students in learning core concepts, practicing needed skills, reflecting on their attitudes and opinions, and applying what they learn. Videos of client sessions illustrate skills and concepts in action, while case studies ask students to make decisions and think critically about the types of situations they will encounter on the job. Helper Studio activities put students in the role of the helper, allowing them to build and practice skills in a nonthreatening environment by responding via video to a virtual client. Instructors can rearrange and add content to personalize their MindTap course, and easily track students' progress with real-time analytics. And, MindTap integrates seamlessly with any learning management system.

Acknowledgments

I so appreciate the energy and efforts of the many reviewers of this text over the years. For this edition I would like to thank Ann H. Barnes, Stephan Berry, Angela-Cammarata, Lisa Corbin, Valerie L. Dripchak, Amanda Faulk, Amy Frieary, Nichelle Gause, Mary S. Jackson, Jalonta Jackson, Steven Kashdan, Naynette Kennett, Cinda Konken, Jim Levicki, Ashley Luedke, Lisa Nelligan, Bob Parr, James Ruby, Lauren Shure, Cathy Sigmund, Bonnie Smith, Matt Smith, Rodney Valandra, Jennifer Waite, Jennifer Walston, Michelle Williams.

Lastly, I give much appreciation to my students who have provided me with invaluable feedback over the years about what aspects of the text help and hinder them. I have tried to eliminate any hindering aspects and strengthen the helping aspect.

About the Author

Dr. Kristi Kanel has been a teacher, practitioner, and scholar of human services for over 38 years. She has been a college professor for the past 34 years. She helped create the first crisis intervention course at California State University, Fullerton, in 1986 and has been teaching the course since then. She also teaches basic counseling theories, case analysis, human service delivery to Latinos, Group Leadership, and Serving Veterans and their families. She will be serving as the Chair of the Department of Human Services for the next three years.

Throughout her career as a human services practitioner, Dr. Kanel has worked at a free clinic as a counselor, interned with the Orange County Board of Supervisors as an executive assistant, worked as a mental health worker and specialist for the County Mental Health agency, worked as a clinical supervisor at a battered women's shelter, and provided psychotherapy for individuals, families, and groups in private practice and at a large health maintenance organization. She has worked extensively with victims of child abuse, partner violence, and sexual assault. Additionally, she has worked with Spanish-speaking Latinos and has conducted research related to the needs of this population. She specializes in crisis intervention and has conducted research on the most effective approach to working with people in crisis.

Dr. Kanel earned her Ph.D. in Counseling Psychology from the University of Southern California, her Master of Counseling degree from California State University, Fullerton, and her Bachelor of Science degree in Human Services from California State University, Fullerton.

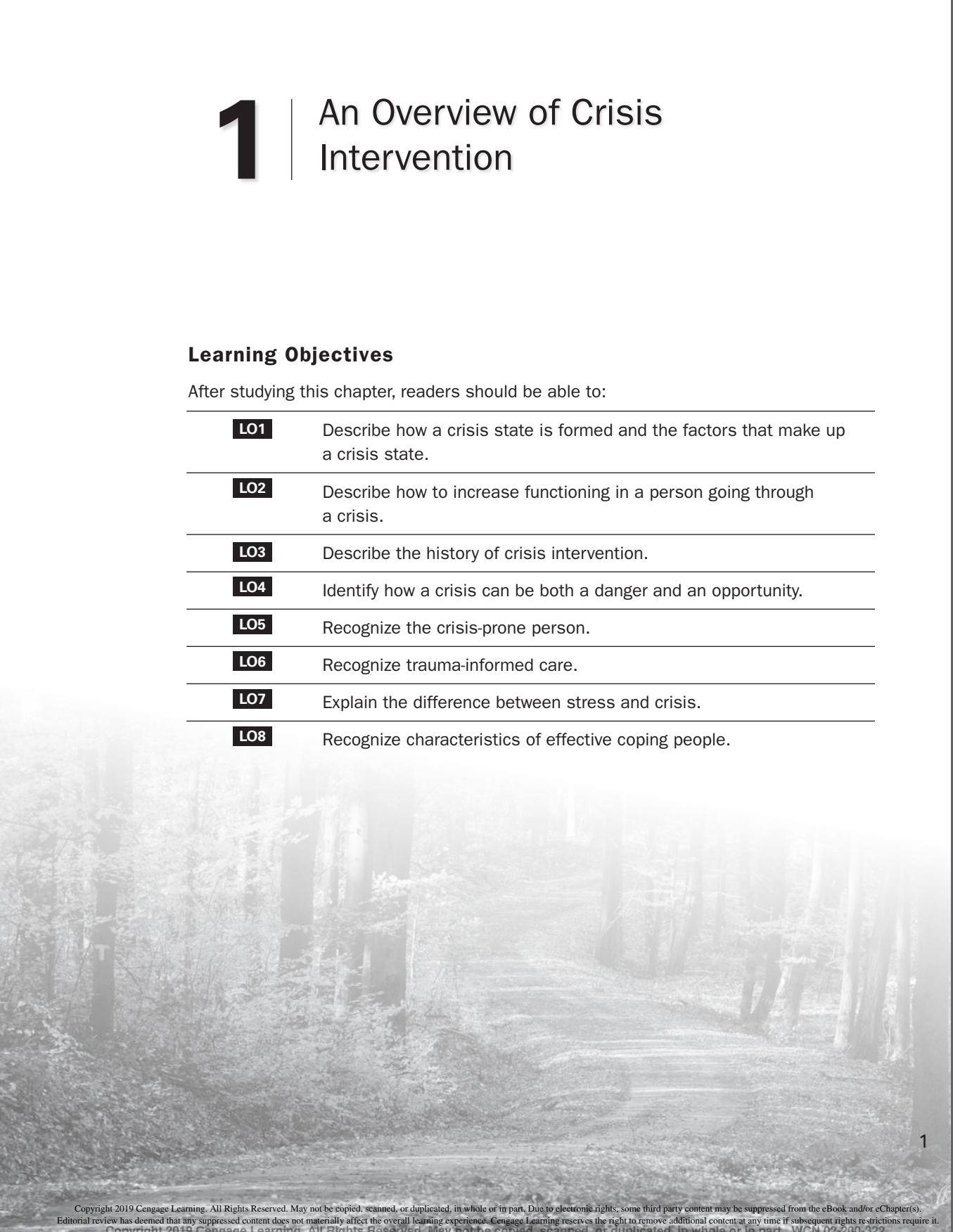
Her hobbies include teaching Zumba, indoor cycling, karaoke, beaching, and hiking.

1 An Overview of Crisis Intervention

Learning Objectives

After studying this chapter, readers should be able to:

LO1	Describe how a crisis state is formed and the factors that make up a crisis state.
LO2	Describe how to increase functioning in a person going through a crisis.
LO3	Describe the history of crisis intervention.
LO4	Identify how a crisis can be both a danger and an opportunity.
LO5	Recognize the crisis-prone person.
LO6	Recognize trauma-informed care.
LO7	Explain the difference between stress and crisis.
LO8	Recognize characteristics of effective coping people.



Crisis Defined

The term **crisis** can be defined in a variety of ways. **Gerald Caplan**, often referred to as the father of modern crisis intervention, described crisis as "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 a solution are made" (1961, p. 18). In its simplest form, according to Caplan, "it is an upset in the steady state of the individual" (p. 18). James and Gilliland (2013) offer nine definitions for an individual crisis. Most of these focus on a situation that an individual cannot respond to in an effective way, leaving the person in a state of emotional and psychological imbalance. The definition of a crisis referred to throughout this book contains four components based on Caplan's definition and on more modern cognitive-behavioral approaches such as Ellis's Rational Emotive Behavior Therapy (Ellis, 1994) and Beck's Cognitive Therapy (Beck, 1976). These aspects will be essential when conducting the ABC Model of Crisis Intervention to be described in detail in Chapter 3 and mentioned briefly in this chapter. The four parts of a crisis as used in this text are: (1) a precipitating event occurs, (2) a person has a perception of the event as threatening or damaging, (3) this perception leads to **emotional distress**, and (4) the emotional distress leads to impairment in functioning due to failure of an individual's usual **coping methods** that previously have prevented a crisis from occurring.

These components of a crisis must be recognized and understood because they are the elements the crisis counselor will be identifying and helping the client to overcome. The perception of the event is by far the most crucial part to identify, for it is the part that can be most easily and quickly altered by the counselor. It is the focus in this definition that differentiates crisis intervention from other forms of counseling.

By keeping this particular definition in mind, the crisis worker can perform the necessary services in a brief time. Whereas other forms of counseling may focus on building self-esteem, modifying personality, or even extinguishing maladaptive behaviors, in crisis intervention the focus is on increasing the client's functioning. Everly (2003) describes the goals of crisis intervention as including four aspects: stabilization of psychological functioning, mitigation of psychological dysfunction and distress, return of adaptive psychological functioning, and facilitation of access to more care if needed. A more thorough history of the development of crisis intervention as a proven approach to helping emotional crises will be addressed later in this chapter.

For now, two useful formulas for the crisis interventionist are provided: Figure 1.1 provides the essential definition of how a crisis state occurs, and Figure 1.2 presents the process for leading a client out of a crisis. It will be shown later in this

Figure 1.1 Formula for Understanding the Process of Crisis Formation

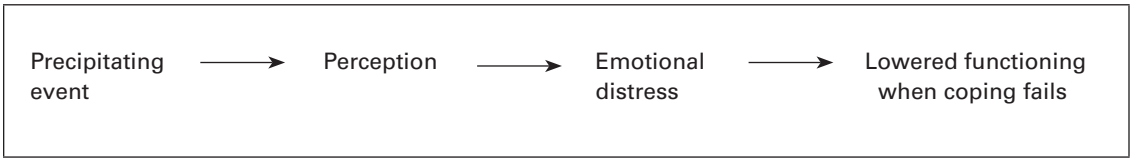
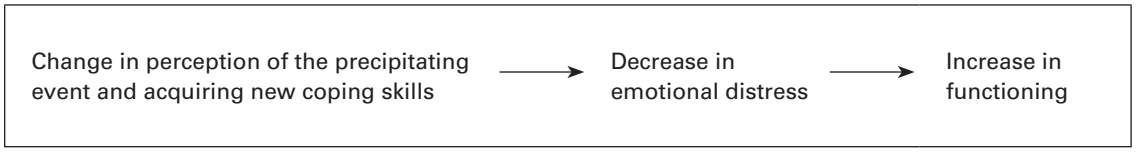


Figure 1.2 Formula for Increasing Functioning



(Both figures developed by the author.)

chapter how Caplan's characteristics of effective coping people corresponds with the formula in Figure 1.2.

Notice that this method involves changing the perception of the precipitating event. Since it is not possible to change the precipitating event, the best one can do is work at changing or altering the client's cognitions and perceptions of the event, offer referrals to supportive agencies, and suggest other coping strategies. These ideas are explored further in subsequent chapters.

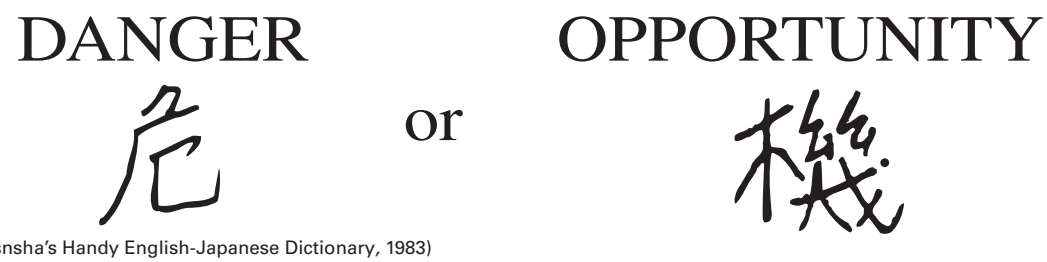
One additional thought about crises in general: The word *crisis* often conjures images of panic, emergency, and feeling out of control. Sometimes this is true as in the case of natural disasters, bombing, shootings, and personal attacks. When the precipitating events are experienced by entire communities or directed at specific groups, the terms *critical incident stress management* and *disaster mental health* are often used (Everly & Mitchell, 2000). Critical incident stress management will be discussed in more detail later in this chapter.

Crisis states may also be viewed as a normal part of life. Crises frequently occur in the lives of normal, average individuals who are just having difficulty coping with **stress**; therefore, they represent a state to which most of us can relate.

Crisis as Both Danger and Opportunity

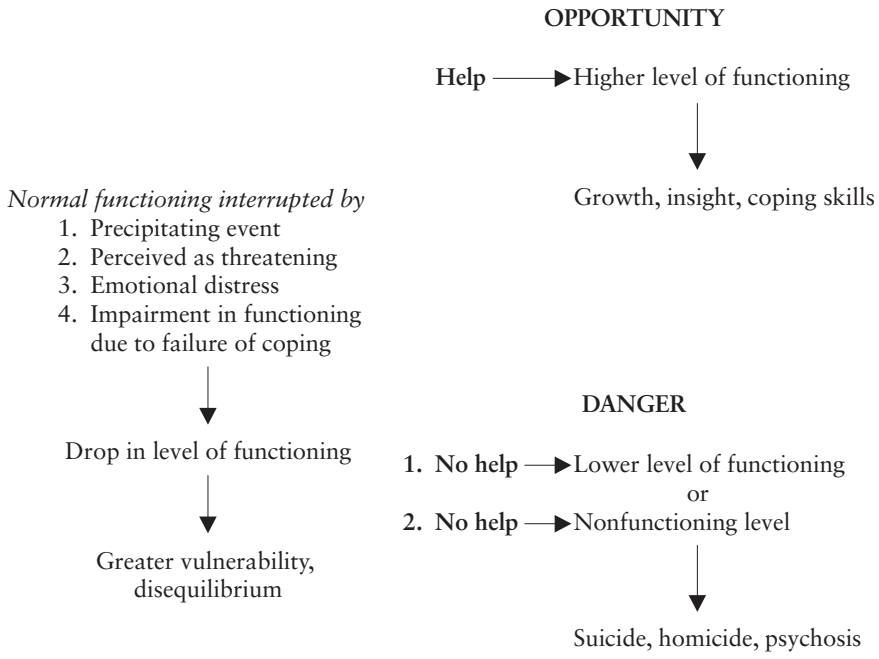
Some crisis states are seen by many as somewhat normal developments that occur episodically during "the normal life span of individuals" (Janosik, 1986, p. 3). Whether the individual comes out of any crisis state productively or unproductively depends on how he or she deals with it. In Chinese, crisis means both danger and opportunity (see Figure 1.3). This dichotomous meaning highlights the potentially beneficial as well as the potentially hazardous aspects of a crisis state. A person might face the challenge

Figure 1.3 Danger or Opportunity



(Obusnsha's Handy English-Japanese Dictionary, 1983)

Figure 1.4 Crisis as Both Opportunity and Danger



of the precipitating event adaptively, or might respond with a neurotic disturbance, psychotic illness, or even death.

According to Caplan (1961, p. 19), "Growth is preceded by a state of imbalance or crisis that serves as the basis for future development. Without crisis, development is not possible. As a person strives to achieve stability during a crisis, the coping process itself can help him or her reach a qualitatively different level of stability. This state of stability may be either a higher or lower **functioning level** than the person had before the crisis occurred" (see Figure 1.4).

Box 1.1 provides an example of how a rape victim's crisis might create a lowered level of functioning if she does not receive help. This lowered level of functioning is an example of the potential for danger addressed above.

Crisis as Opportunity

Even if a person receives no outside intervention or help, the crisis state will eventually cease, usually within four to six weeks. A crisis is by nature a time-limited event because a person cannot tolerate extreme tension and psychological disequilibrium for more than a few weeks (Caplan, 1964; Janosik, 1986, p. 9; Roberts, 1990; Slaikeu, 1990, p. 21). Although a person's character influences how he or she emerges from a crisis, that is, either stronger or weaker, seeking and receiving focused help during the crisis state have a big impact on the person. In the midst of a crisis, a person is more receptive to suggestions and help than he or she is in a steady state. A crisis worker can gain significant leverage at this time because of greater client vulnerability. Instead of

BOX 1.1

Example of Crisis as Danger

After having been raped, a woman might not seek help or even tell anyone about the trauma. About a month after the violation, she may slip into a state of denial, with reduced contact with the world, lowered trust levels, increased substance abuse, poor interpersonal relations, and a state of dissociation. However, she may continue to be able to work, go to school, put on a front with family and friends, and appear to function normally. In reality, however, she is functioning at a lower level than she did before the rape and will be somewhat impaired until she gets intervention. The longer she waits to get help, the more resistant she will be to it because of the amount of energy she will have invested in the denial process. She may exist in a chronic state of depression, lowered trust toward people, and anxiety, which would affect interpersonal functioning.

stabilizing at a lowered level of functioning, an individual who receives help is likely to stabilize at a higher, more adaptive level of functioning, learning coping skills that might prepare him or her for future stresses.

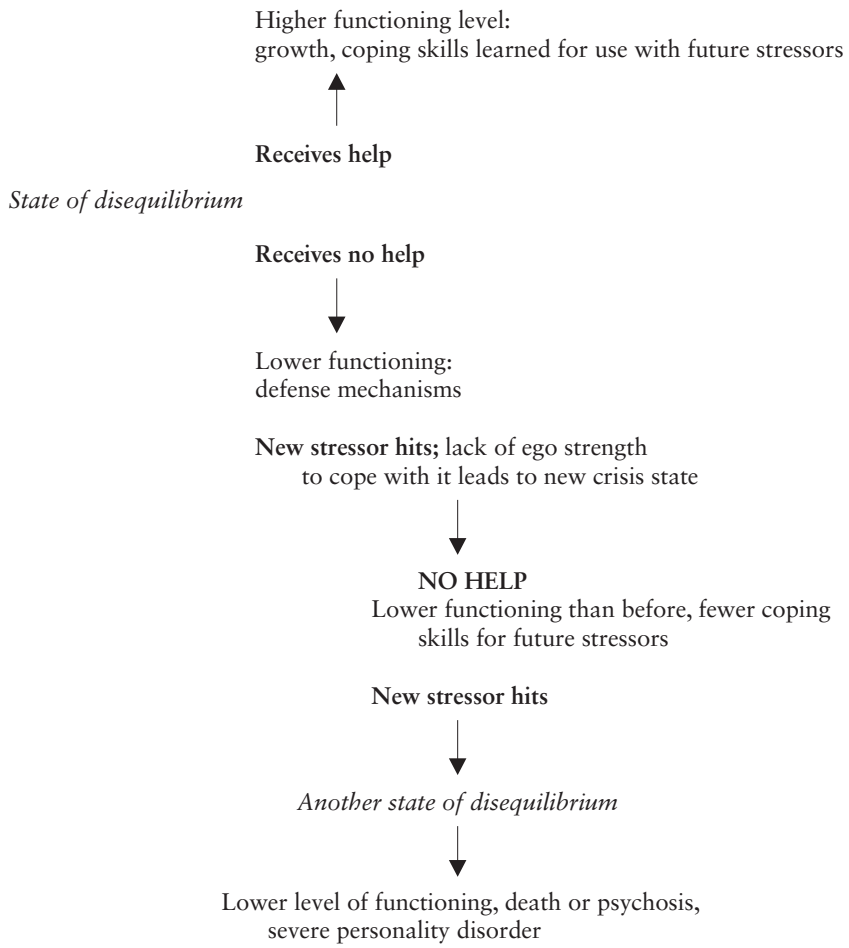
An example of how receiving help soon after a trauma would be more beneficial than waiting years or getting no help at all might be in the case of sexual abuse of a child. It seems fairly obvious that a 3-year-old girl brought in for counseling after being molested one time will respond better than a 30-year-old woman who was molested at age 3 and never talked about it, and then seeks help after 27 years.

Once a client has returned to a previous, or higher, level of functioning, he or she may opt to continue with therapy. Brief therapy is a reasonably cost-effective approach for dealing with aspects of life that have plagued a person regularly but have not necessarily caused a crisis state. A counselor may work with an individual for 6 to 20 sessions and obtain excellent results in behavioral and emotional changes. Once a person has benefited from crisis intervention, he or she is often more open to continuing work on additional in-depth personal issues because of increased trust in the therapeutic process and the therapist. The choice to continue in postcrisis counseling will of course depend on financial resources and time availability.

Crisis as Danger: Becoming a Crisis-Prone Person

Not everyone who experiences a stressor in life will succumb to a crisis state. No one is certain why some people cope with stress easily, whereas others deteriorate into disequilibrium. Several explanations seem plausible. Figure 1.5 expands on Figure 1.4 to include the crisis-prone person. If a person does not receive adequate crisis intervention during a crisis state but instead comes out of the crisis by using ego defense mechanisms such as repression, denial, or dissociation, the person is likely to function at a lower level than he or she did before the stressful event. The ego, which has been hypothesized to be the part of the mind that masters reality in order to function (Gabbard, 2014), must then use its strength to maintain the denial of the anxiety or pain associated with the precipitating event. Such effort takes away the individual's strength to deal with future stressors, so that another crisis state may develop the next

Figure 1.5 Crisis as Danger: The Development of the Crisis-Prone Person



time a stressor hits. This next crisis state may be resolved by more ego defense mechanisms after several weeks, leading to an even lower level of functioning if the person does not receive adequate crisis intervention.

This pattern may go on for many years until the person's ego is completely drained of its capacity to deal with reality. Such people often commit suicide, harm others, or have psychotic breakdowns. When people were exposed to trauma or toxic parenting in their early years when the neurological structures of the brain were forming, they usually do not seek crisis intervention due to their age. These developmental and situation crises sometimes lead to personality disorders. People with personality disorders are usually seen as suffering from emotional instability, an inability to master reality, poor interpersonal and occupational functioning, and chronic depression (Gabbard, 2014).

When trauma and other stressors occur after basic personality structures are in place, a person may not develop a personality disorder, but instead may use defense mechanisms and may misuse substances to cope with the traumas instead of seeking professional help.

Traditional psychotherapy has usually been the course of counseling implemented with people suffering from personality disorders. In today's economy and with health maintenance organizations (HMOs) dictating mental health treatment, clinicians often cannot take the traditional road with crisis-prone people. Because short-term treatment is the only service offered in most settings, it is essential to begin working with people as soon as possible after the crisis state sets in to prevent a chronic cycle of poor functioning from developing.

Other Factors Determining Danger or Opportunity

Other factors may also determine whether a crisis presents a danger or an opportunity. These factors are generally found in the client's own environment. In addition to receiving outside help, having access to (1) material resources, (2) personal resources, and (3) social resources seems to determine the level an individual reaches after a crisis. **Material resources** include things such as money, shelter, food, transportation, and clothing. Money may not buy love, but it does make life easier during a crisis. For example, a battered woman with minimal material resources (money, food, housing, and transportation) may suffer more in a crisis than a woman with her own income and transportation. A woman with material resources has the choice of staying at a hotel or moving into her own apartment. She can drive to work, to counseling sessions, and to court. The woman with no material resources will struggle to travel to sessions and will have to be dependent on others. Her freedom to choose wherever and whenever she goes will be largely decided by those on whom she depends. According to Maslow's (1970) hierarchy of needs, material needs must be met before other needs of personal integration and social contact can receive attention. Not until she is housed, fed, and safe can the battered woman begin to resolve the psychological aspect of the crisis.

It is important to remember that despite financial and other material resources, people with material resources are not immune to suffering. They may at times suffer more than those with fewer resources because of various psychological and social factors, the duration and severity of the victimization, or other precipitating events. After her material needs are met, the woman can begin to work through the crisis. Her **personal resources**, such as ego strength, previous history of coping with stressful situations, absence of personality problems, and physical well-being, will help determine how well she copes on her own and how she accepts and implements intervention.

If the ego is the part of our mind that carries the ability to understand the world realistically and act on that understanding to get one's needs and wishes met, then **ego strength** refers to how well one can do this on a regular basis and in times of stress. At times a crisis worker will serve as a client's ego strength (as when a person is psychotic or severely depressed) until the client can take over for himself or herself. Some clients can neither see reality clearly nor put into action realistic coping

behaviors. They need someone to structure their behavior until the crisis is managed successfully, often with medication, family intervention, and individual counseling. When someone has coped successfully in the past with various stressors, then usually his or her ego strength is high. However, when someone does not cope successfully with stressors, the person's ego strength is lowered (see Figure 1.5). A crisis worker must "tune into" a client's level of mastering reality in order to set up realistic goals and problem-solving strategies.

Certain personality traits may interfere with coping and also with accepting intervention. Some people have problems accepting help or being strong. Others are paranoid or avoid conflict. These people present challenges to counselors, in contrast to clients who are open and trusting.

A client's physical well-being also affects how well he or she deals with crises. Physically healthy people have more energy and greater ability to use personal and social resources. The ability to move about and exercise is essential in coping with stress. Clients with disabilities and suffering from illnesses must constantly cope with their conditions, and so when stress occurs, they simply do not have as much psychological energy to deal with it as physically healthy individuals do.

A person's level of intelligence and education also affect the outcome of a crisis state. Well-educated people are better able to use cognitive reframes and logical arguments to help them integrate traumas psychologically. People with lower IQs have more difficulty understanding events and their reactions to events, and may be less flexible when solving problems.

A person's **social resources** also affect the outcome of a crisis. A person with strong support from family, friends, church, work, and school has natural help available, provided these support systems are healthy. A lone individual struggles more during a crisis and tends to depend on outside support systems such as professional counselors, hotlines, emergency rooms, and physicians. Part of the crisis worker's responsibility is to link clients with their natural support systems so their dependency on mental health workers is reduced. Knowledge of support groups such as 12-step self-help groups is vital to a counselor's effective intervention. Clients without much natural support can participate in these groups indefinitely, and the 12-step group may become a natural support resource. The use of 12-step groups will be explored in Chapter 3.

Precipitating Events

Personal crises have identifiable beginnings or **precipitating events**. These can be new adjustments in the family, loss of a loved one, loss of one's health, contradictions and stresses involved in acculturation, normal psychosocial stages of development, or unexpected situational stressors. Previously, it has been proposed that the most important aspect of any crisis is how the person perceives the situation. The meaning given to the event or adjustment determines whether the person will experience emotional distress. This meaning has been termed the **cognitive key** (Slaikeu, 1990, p. 18). It is the key with which the counselor unlocks the door to understand the nature of the client's crisis. Once the helper identifies the cognitive meanings the client ascribes to the precipitating events, the helper can work actively to alter these cognitions.

This new way of perceiving the event aids the client in reducing emotional distress and increasing coping abilities, and ultimately increase functioning.

The way the precipitating event interacts with the person's life view is what makes a situation critical. If people cannot cope with new situations by using their usual mechanisms, a state of disequilibrium will occur. However, if their cognitive perspective of a potential hazard or precipitating event allows people to relieve the stress effectively and resolve the problem, the crisis will not occur in the first place.

Stress is different from crisis, though the two terms are often confused. When a person experiences a negative precipitating event, suffers from negative emotions, but does not experience impairment in functioning due to being able to cope with it, he or she is probably suffering from daily or normal stress. Stress is part of modern life; in fact, it is part of daily life. This does not mean that crises are part of daily life, however, because people typically cope with stress without falling apart emotionally. Even if people undergoing stress experience some emotional distress, if they have the coping skills to master the stress, their functioning level will not be impaired, and hence, a crisis state will not ensue.

For conceptual purposes, we can describe two types of crises: developmental and situational.

Developmental Crises

Developmental crises are normal, transitional phases that are expected as people move from one stage of life to another. They take years to develop and require adjustments from the family as members take on new roles. James and Gilliland (2013) suggest that developmental crises are part of the normal flow of human growth in which change occurs and people respond abnormally. Developmental crises will be explored in Chapter 5 along with crises related to cultural issues. Clients often seek counseling because of their inability to cope with the evolving needs of one or more family members. Effective crisis workers are sensitive to the special issues surrounding this type of precipitating event.

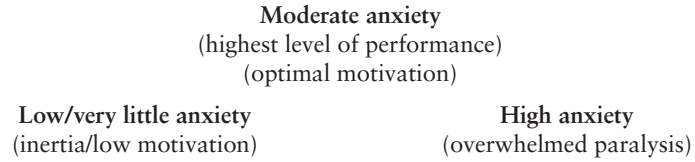
Situational Crises

Situational crises "emerge when uncommon and extraordinary events occur that an individual has no way of forecasting or controlling" (James & Gilliland, 2013, p. 16). Some examples of situational crises are crime, rape, death, divorce, illness, and community disaster. The chief characteristics that differentiate these from developmental crises are their (1) sudden onset, (2) unexpectedness, (3) emergency quality, and (4) potential impact on the community (Slaikeu, 1990, pp. 64–65).

Emotional Distress

A rise in anxiety is a typical reaction to the initial impact of a hazardous event. A person may experience shock, disbelief, distress, and panic (e.g., stage 1 of Kübler-Ross's stages of death and dying). If this initial anxiety is not resolved, the person may

Figure 1.6 Curvilinear Model of Anxiety as Motivator for Change



experience a period of disorganization. During this period of disorganization, a person often experiences feelings of guilt, anger, helplessness, hopelessness, dissociation, confusion, and fatigue, and often is unable to function at their previous level at work, school, or home. Ironically, in certain circumstances anxiety has the power to generate energy and increase coping abilities, as when a child is in danger and a parent has a surge of adrenaline that helps him or her rescue the child, or when a natural disaster hits and people have the increased physical strength and endurance to carry bodies and sandbags.

Anxiety, however, seems to fit the **curvilinear model** (see Figure 1.6) in that too much or too little leaves a person in a state of inertia or with undirected and disintegrative energy (Janosik, 1986, p. 30).

When the anxiety level is moderate and manageable, the crisis worker can use it to help motivate the client to make changes. In sum, anxiety is not always a bad thing; it is considered necessary, at moderate levels, to spur people to make changes in their lives.

Anxiety is an internal experience; therefore, interventions might first be aimed at alleviating the internal component of stress. This action makes sense because the external component of a crisis (the precipitating stressor) usually cannot be undone. The only remedy for emotional distress is to change the internal experience.

Changing the internal experience as a remedy for distress can be done in several ways. One way would be to medicate the person (e.g., inject a tranquilizer) to relieve the anxiety or grief. The benefit of this intervention is immediate reduction in emotional distress. Sometimes clients cannot benefit from cognitive crisis intervention because their anxiety or grief is too great; in these cases, medication can provide temporary relief until their cognitions can be altered. Crisis workers often work jointly with psychiatrists when medication is necessary. The crisis worker might call a psychiatrist or physician whom he or she has worked with in the past to create a bridge for the client with the psychiatrist. At other times, the crisis worker might consult over the phone with a physician and set up a relationship in which the psychiatrist and crisis worker feel comfortable having ongoing communication while both are working with the client. Some agencies employ both counselors and psychiatrists. In these cases, it is rather simple for the crisis worker to work jointly with the psychiatrist because both workers generally get together during regularly scheduled staff meetings. It is not uncommon for colleagues at agencies to "pop" into each other's offices from time to time to engage in "informal" communication about the progress of mutual clients. No matter which way crisis workers choose to engage with a psychiatrist or a client's primary care physician, it is wise to be knowledgeable about the medications being prescribed and to let the physician take the lead in medication management.

The crisis worker, however, would not want to rid clients of all emotional distress too soon without helping them change their perception of the precipitating event or without encouraging coping behaviors. Without discomfort, clients are not as motivated to change. The crisis counselor depends on clients to be in a state of disequilibrium and vulnerability if cognitive change and behavioral change are to occur. Clients with good ego strength and no history of mental illness can often work through a crisis without any medication. Some people, though, absolutely need medication, and knowing when the situation calls for more than just talk therapy is a helpful skill for crisis workers.

For clients who do not seem to need medication to relieve emotional distress, the internal experience is best changed through cognitive restructuring, discussed in subsequent chapters. Some clients may also be able to implement recommended behavioral changes, which can be done in a number of ways.

The essential idea to remember is to keep the focus not on changing precipitating events but rather the way in which clients experience them. Changing perceptions will lower clients' emotional distress and increase their functioning levels. Offering coping strategies also aids in lowering emotional distress and increases functioning.

Failure of Coping Methods and Impairment in Functioning

The final component of a crisis state refers to a person's inability to cope with the emotional distress leading to a decrease in functioning. When people in crisis are experiencing feelings of bewilderment, confusion, and conflict, they are in a vulnerable position. They lack skills to improve their situation. The ability to perform at work, at school, and in social situations may be impaired. Likewise, there may be a change in one's eating, sleeping, and everyday tasks, which are often referred to as "tasks of daily living." People sometimes try to fix these impairments on their own, but when they cannot, they may seek help, adapt through the use of ego defenses, dive into a deep depression, or, unfortunately, attempt or succeed at killing themselves. Thus, the urgency to get them intervention as soon as possible when they enter a crisis state is clear.

The Wellesley Project: The Development of Crisis Intervention

Eric Lindemann (1944) introduced the first major community mental health program that focused on crisis intervention. He studied the grief reactions experienced by relatives of victims injured or killed in the **Cocoanut Grove fire** in Boston, on November 28, 1942. On that night, 493 people perished as the Cocoanut Grove nightclub burned. It was the single largest building fire in U.S. history. As Lindemann joined others from Massachusetts General Hospital to help survivors who had lost loved ones, he came to believe that clergy and other community caretakers could help people with **grief work**. Before this time, only psychiatrists and psychologists had

provided services for those with anxiety and depression, symptoms that were thought to stem from personality disorders or biochemical illnesses.

After his study, Lindemann worked with **Gerald Caplan** to establish a communitywide mental health program in Cambridge, Massachusetts, that became known as the **Wellesley Project**. They worked at first with individuals who had suffered traumatic events such as surviving the fire, losing a loved one in the fire, sudden bereavement in other situations, or the birth of a premature child. This focus on working with women dealing with the grief of either the death of an infant or the birth of an infant with abnormalities was most likely influenced by the baby boom, which began during the late 1940s, after World War II had ended. Millions of women were pregnant, and some had complications with their pregnancies. Physicians were experimenting with a new drug, thalidomide, that prevented morning sickness. Unfortunately, the drug also led to birth defects and other complications. Women whose babies had birth defects because of the drug needed a way to deal with their trauma.

Caplan's focus on **preventive psychiatry**, in which early intervention was provided to promote positive growth and minimize the chance of psychological impairment, led to an emphasis on mental health consultation (Slaikeu, 1990, p. 7). It may seem hard to believe that the term *crisis intervention* had not even been thought of at that time in history. Caplan's approach began a trend toward short-term, directive, and focused crisis intervention. Interestingly, much of current-day crisis intervention theory has come from the Wellesley Project.

In his research at the Wellesley Project, Caplan (1964, p. 18) discovered certain people were able to cope with the situation better than others. He describes **seven characteristics of effective coping behavior** that were displayed by those who were able to climb out of their crisis state and of those who did not enter into a crisis (see Table 1.1).

Once a client's emotional distress has been lowered to a manageable level, the crisis worker may offer coping strategies. These range from referrals to agencies, groups, doctors, and lawyers to reading, journaling, and exercising. Caplan's seven characteristics of effective coping behavior can guide the counselor in creatively constructing a treatment plan that changes cognitions, lowers emotional distress, and increases functioning. Although the name of crisis intervention has gone through

TABLE 1.1 Caplan's Seven Characteristics of Effective Coping Behavior

1. Actively exploring reality issues and searching for information
2. Freely expressing both positive and negative feelings and tolerating frustration
3. Actively invoking help from others
4. Breaking problems into manageable bits and working through them one at a time
5. Being aware of fatigue and pacing coping efforts while maintaining control in as many areas of functioning as possible
6. Mastering feelings where possible; being flexible and willing to change
7. Trusting in oneself and others and having a basic optimism about the outcome

Source: Caplan (1964). *Principles of preventive psychiatry*. New York, NY: Basic Books.

changes (e.g., trauma response, critical incident and debriefing, and critical incident stress management), the ideas that Caplan proposed between late 1940s and the 1960s are still relevant and effective.

As Rapoport noted in 1965, "A little help, rationally directed and purposely focused at a strategic time is more effective than extensive help given at a period of less emotional accessibility, p. 30" (cited in Everly, 2003).

And by 1989, the American Psychiatric Association Task Force Report on the Treatment of Psychiatric Disorders stated that "Crisis Intervention is a proven approach to helping in the pain of an emotional crisis, p. 2520" (Swanson & Carbon cited in Everly, 2003).

This acceptance of crisis intervention over time is particularly important in understanding how mental health today is practiced in the community. It essentially moved from a focus on medication and long-term psychoanalytically focused approaches to short-term crisis management, ultimately leading to trauma response and critical incident stress management.

Crisis Intervention and Suicide Prevention Strengthen Nationwide

In the early 1960s, the crisis intervention trend gave rise to the suicide prevention movement. This movement grew rapidly, and many community centers offered 24-hour hotlines. These centers developed out of the social activist mentality of the 1960s and Caplan's theory. They relied on nonprofessional volunteers for their telephone counseling programs. Caplan's focus on critical life crises attracted nontraditionalists, who were dissatisfied with medical-model and psychoanalytic treatments. Many current nonprofit organizations specializing in the treatment of certain personal crises evolved from these nontraditional **grassroots programs** such as free clinics for abortion of unwanted pregnancies, battered women's shelters, rape centers, and AIDS centers. Nonprofit agencies still exist today dealing with these same issues and many more.

Parallel to the suicide prevention movement was the community mental health movement in the United States. In 1955, there were over 500,000 patients in mental hospitals, which was the highest in U.S. history. With the introduction and widespread use of psychiatric medications such as Thorazine and lithium in the 1950s, patients who suffered from chronic mental illness could be managed in the community, which fostered the deinstitutionalization of the mentally ill over the ensuing two decades. Consequently, this population of the mentally ill was reduced to about 200,000 in the decades that followed (Cutler, Bevilacqua, & McFarland, 2003). In 1955, Congress established the Joint Commission on Mental Illness and Health and found that three out of every four individuals treated for mental illness were in public mental hospitals, and by 1960, the joint commission recommended that the mentally ill be cared for in the community and that federal financial assistance would be provided to the states to accomplish this (Library of Congress, 1989–1990). President Kennedy was very interested in community mental health as there was someone in his own family with a mental disability, and in 1963, he proposed a new national mental health program.

Community Mental Health Act of 1963

The goal of **Community Mental Health Act of 1963** was that by 1980 there would be one community mental health center per 100,000 individuals, or 2,000 such centers nationwide. In 1967, Congress reaffirmed the goal of having 2,000 community mental health centers built, but by 1980, there were only 768 centers, which may have been the cause of the high homeless population among the mentally ill (Cutler et al., 2003). Subsequent to the federal legislation, many states have developed their own laws and ethical standards to implement community mental health programs, but not without controversy in some areas. Some of the specific natures of these controversies (including involuntary confinement and the definition of "dangerous") will be explored in Chapter 2, which deals with ethics, laws, and the mentally ill.

One aspect of the community mental health programs was the development of the 24-hour emergency service, which became known as **psychiatric emergency treatment (PET)** services. Most community mental health services are still based on this 1963 act. The original intent of these services was to deal with psychotic, suicidal, and homicidal crises, which had previously been dealt with in the mental hospitals. Many changes have come about in these agencies but the overall goal of evaluating and treating crises of this nature is still relevant today. Current intervention approaches related to these populations are addressed in Chapter 4.

In the late 1960s and early 1970s, journals such as *Crisis Intervention* and *Journal of Life-Threatening Behavior*, which dealt specifically with crisis topics, were published. Crisis intervention became more valued in the 1970s as economic conditions led to greater use of community resources (Slaiku, 1990, p. 8). In the 1970s, there was a growing anti-medical attitude in mental health centers. There was an increase in the number of psychologists, nurses, and master-level workers serving in mental health. Psychiatrists were leaving these centers and being replaced by other types of mental health workers (Cutler et al., 2003) who could be paid lower rates than psychiatrists and could efficiently provide crisis management and case management services.

During this time, the country also saw an increase in university and college programs in which curricula focused on psychology and counseling. Many **paraprofessionals** who had previously staffed community mental health centers went to college to become professional therapists. Soon, the profession of licensed therapy was big business. Insurance companies paid for counseling services offered by individuals with master's degrees; this led to a rise in the number of people seeking mental health counseling as well as to complaints by insurance companies about the financial burden.

The Rise of Managed Care

The complaints resulted in managed care by indemnity insurance companies. Insurance companies no longer paid for patients to stay in therapy as long as clinicians felt necessary.

The short-term crisis intervention model is cost-effective and, thus, the approach sought by most **HMOs**, preferred provider organizations, and other insurance carriers

in today's mental health treatment community. This type of payment for services became confusing as state-operated Medicaid programs began to emerge. Public funding and private funding became integrated and although many poor people were eligible for public welfare, an estimated 40 million people had no coverage at all, leaving them without any third-party payer for health services. By the 1990s, community mental health programs came under government scrutiny. Once the Clinton initiative for a single-payer system failed, finding fraud seemed to be the main purpose of the federal government in dealing with mental health services. In 1969, Gerald Caplan stated, "In a democratic capitalist country, individual psychiatrists have the freedom to decide how they will use their skills and make a living, but as corporate professionals, they must either be responsive to organized communal demands to deal with formally recognized population needs or they will incur sanctions and eventually be pushed aside in favor of some other profession, the development of which will be fostered in order to deal with the neglected problem" (Caplan & Caplan, 1969, p. 320). Currently, most managed care facilities, insurance companies, nonprofit agencies, and public mental health agencies (which have been relabeled as behavioral health agencies) focus on providing short-term, crisis, and emergency services. Understanding how to conduct crisis intervention is vital for modern-day counselors at all educational levels.

The Need for Nonprofessionals A continuing controversy in the field of crisis intervention centers on the use of paraprofessionals to provide services to clients. Some licensed professionals believe that these workers, who have traditionally provided crisis intervention, do not have enough training to do intervention. Some professionals have proposed that only those with at least a master's degree should be allowed to provide services to those in crisis. Beigel (1984) suggested we should re-medicalize community mental health centers, which has indeed happened in recent years because it is more cost-effective to medicate than offer ongoing psychotherapy. One can often hear terms like "treat 'em and street 'em," or "evaluate, medicate, evacuate" on television shows. It often sounds cold, uncaring, and negative.

If nonprofessionals are forbidden to provide crisis management, this might have a negative impact on poorer communities that cannot afford the costs of services provided by counselors of master level and above. Also, not everyone in crisis needs medication to heal. The use of paraprofessionals would be cost-effective, and with proper training and supervision, this level of worker can offer effective crisis management as has been shown for the past 60 years. Understandably, politics and perhaps professional jealousy and fear play a part in the opposition to paraprofessional counseling. But, it is without doubt that many clients in need would go untreated if these workers were prohibited from practicing crisis intervention.

Many professional therapists are not aware of the historical foundations of crisis intervention, which was based on paraprofessional services during the Wellesley Project period. Although crisis intervention is used in most mental health offices, not all mental health workers have received specific training in the field. It is often included in other courses in graduate schools and other counseling preparatory colleges. Hence, students must provide crisis intervention based on their interpretation of how to shorten the traditional therapy process. Because crisis intervention is not often emphasized in traditional counseling and psychology graduate schools, many

TABLE 1.2 Time Line in the Development of Crisis Intervention

Time Frame	Development
1942	Cocoanut Grove fire; use of nonprofessionals to provide counseling
1946–1964	Baby boom; increase in stillbirths, birth defects, and miscarriages caused by thalidomide; WWII Shell Shock Syndrome
1950s	Psychotropic medications introduced; deinstitutionalization of the mentally ill
1963	Community Mental Health Act
1960s	Publication of professional journals related to suicide prevention and crisis intervention; increase in professional studies in psychology and counseling
1960s–1970s	Civil rights movement; grassroots movements; rise in nonprofit agencies; use of paraprofessionals
1970s–1980s	Increase in college programs offering psychology and counseling courses; professionalization of mental health; proliferation of licensed counselors; movement away from crisis intervention and toward traditional longer-term mental health counseling
1980s–1990s	Managed-care takeover of medical field, including mental health; return to crisis intervention in private industry and in community mental health

nonprofit agencies provide specific training in crisis intervention to ensure that nonprofessional volunteers can work effectively with clients.

One cannot say that traditional models have had no influence on crisis work. In fact, each traditional counseling approach has contributed to the field of crisis intervention. This seems reasonable considering that the founders of crisis intervention were themselves trained in these models. Table 1.2 provides an historical outline of events leading up to modern day crisis intervention.

Contributions from Other Theoretical Modalities

No single discipline or school of thought can claim crisis theory as its own, for this theory has been derived from a variety of sources. The result, therefore, is an eclectic mixture drawn from psychoanalytic, existential, humanistic, and cognitive-behavioral theories.

Psychoanalytic Theory

Psychoanalytic theory has contributed to the treatment of people in crisis. Sigmund Freud postulated an idea that is applicable to crisis intervention and crisis theory in his assumption that psychic energy is finite and that only a limited amount exists for each person. This assumption helps explain the disequilibrium that develops when customary coping skills fail and a person's psychological energy is depleted. It also helps explain why people with personality disorders, neuroses, and psychoses react poorly in a crisis: Much of their psychic energy is being used to maintain their disorder; they do not have the "spare" energy to combat unforeseen emergencies (Brenner, 1974, pp. 31–80).

In crisis theory the counselor is advised to assess the client's ego strength and at times take over the function of the ego. The concept of ego strength is directly related to psychic energy. People with personality disorders or psychotic disorders usually cannot cope effectively with precipitating events because their psychic energy is being used to deal with previous stressors, losses, and traumas.

Existential Theory

Existential theory has contributed to crisis treatment. Although true existential psychotherapy is a long-term therapy with the goal of basic revision of life perspective (Bugental, 1978, p. 13), some ideas are also useful in a short-term adjustment model. Certainly, the existential proposition that anxiety is a normal part of existence which often serves as a catalyst for self-development and growth may be a useful concept when working with people in crisis. This idea coincides with the Chinese idea of **danger and opportunity**. Without anxieties caused by new life situations, people would never grow. Therefore, anxiety as a motivator for risk taking and growth is a key concept from existential theory that has contributed to crisis theory. The belief that all people will suffer in life at one time or another and that suffering can strengthen people can be used to reframe a crisis for the person experiencing it.

Another useful concept from existential theory relates to the acceptance of personal responsibility and realization that many problems are self-caused. Choice then becomes a major focus for the person in crisis. Empowering clients with choices and encouraging them to accept responsibility are useful strategies in many crisis situations. For example, a person who has recently been confronted about his or her cocaine abuse can be helped to accept responsibility for his or her addiction. The worker can offer alternative choices and be supportive while the client struggles with the anxiety of withdrawing from the cocaine habit.

Humanistic Approach

The **humanistic approach** and person-centered therapies have much to offer crisis intervention. This style of helping stresses the importance of trusting clients to realize their potential in the context of a therapeutic relationship. Having optimism and hope that clients will recognize and overcome blocks to growth are the foundations for trying to help someone work through a difficult situation (Bugental, 1978, pp. 35–36). If the crisis interventionist does not truly believe that his clients can work through their problems, why would he waste his efforts on them? True, clients may not resolve their difficulties his way, or in his time frame exactly, but he needs to respect clients at their level and work from there.

Carl Rogers, the founder of person-centered counseling (considered a humanistic therapy), has contributed to the field of crisis intervention by his focus on reflective and empathetic techniques. These techniques, shown to be effective in treatment outcome, help clients acknowledge and freely express their emotions (Corsini & Wedding, 1989, pp. 175–179). In addition to these outcomes, humanistic techniques create an environment that is special.

Practitioners of person-centered counseling believe that people can grow in a beneficial direction if they can experience a relationship of true acceptance, genuineness,

and empathetic understanding. Crises are seen as blocks to growth and the potential for growth. By their presence, counselors help clients begin to accept themselves, trust in themselves, and make new choices based on this self-acceptance and trust.

Cognitive-Behavioral Theories

Most crisis models are based on a **behavioral problem-solving model**, which involves the following steps:

1. Define the problem.
2. Review ways that you have already tried to correct the problem.
3. Decide what you want when the problem is solved.
4. Brainstorm alternatives.
5. Select alternatives and commit to following through with them.
6. Follow up.

The **cognitive approaches** that blossomed in the 1970s and 1980s are also important in crisis work. As has previously been stated, a person's cognitions, meanings, and perspectives about the precipitating event are important in the counselor's determining the key to the crisis state. Cognitive approaches are largely based on Albert Ellis's Rational Emotive Behavior Therapy (Ellis, 1994), Beck's Cognitive Therapy (Beck, 1976), and Meichenbaum's Self-Instructional Training and Stress Inoculation Training (Meichenbaum, 1985). These approaches are concerned with understanding the person's cognitive view of the problem and then restructuring and reframing any maladaptive cognitions (Peake, Borduin, & Archer, 1988, pp. 69–71). Cognitive approaches stress homework assignments and follow-up.

Table 1.3 offers a summary of the contributions from other models to crisis intervention.

Brief Therapy

Brief therapy may be confused with crisis intervention. It may be short term, but the focus is not only on increasing functioning. In this approach, clients explore past patterns of behavior and how the patterns have prevented them from succeeding in life in

TABLE 1.3 Contributions from Counseling Models to the ABC Model of Crisis

Intervention	
Theoretical Model Contribution	
Psychoanalytic	Finite psychic energy and ego strength
Existential	Responsibility; empowerment; choices; crisis as danger and opportunity for growth; anxiety as motivation
Humanistic	Rapport; safe climate; hope and optimism; basic attending skills
Cognitive-behavioral	Focus on perceptions; reframing; goal setting; problem solving; follow-up

the way they have wanted to succeed. They may explore interpersonal relationships, self-concept, and family patterns. The focus is on creative change and incorporating new styles of relating to the world. Sometimes the precipitating event is the best thing that could happen to a person because it leads him or her to a counselor's office, where some chronic debilitating patterns can be identified. If past ineffective patterns can be recognized, they can be eliminated and the client can learn more effective behaviors for dealing with current as well as future stressors.

Brief therapy seems to be as effective as long-term therapy. According to Garfield (1980, p. 282), "The evidence to date suggests that time-limited marital family therapy is not inferior to open-ended treatment." The average length reported in his research was seven sessions, a number that certainly fits with crisis intervention philosophy.

Critical Incident Stress Debriefing

Since posttraumatic stress disorder was officially recognized by the American Psychiatric Association as a psychiatric disorder in 1980, people suffering from traumatic events have been the focus of several interventions (Everly, 1999) including crisis intervention, critical incident stress debriefing, eye movement desensitization and reprocessing, trauma response, and disaster mental health. Throughout the 1980s and 1990s, there were a variety of traumatic events that instigated the Red Cross and other agencies to seek the services of clinicians trained in these models.

In 1994, a new category was added to the *Diagnostic and Statistical Manual of Mental Disorders* that highlighted exposure to trauma: acute stress disorder (Everly, 1999). Workers were called in to assist people who were traumatized by the Oklahoma City bombing, the workplace violence that occurred at a post office, and a variety of other situations. Of course, after the terrorist attacks on 9/11/2001, the Katrina floodings, the gun shootings, and ISIS threats that have occurred in the twenty-first century, critical incident stress debriefing and other forms of crisis work have become essential for many individuals throughout the world.

Critical incident stress management refers to an integrated, multicomponent crisis intervention system that includes a seven-phase structured group discussion, usually provided 1–14 days post crisis, designed to mitigate acute symptoms, assess the need for follow-up, and provide a sense of postcrisis psychological closure (Everly & Mitchell, 2000). This approach will be revisited in Chapter 7 when we address community disasters.

Trauma-Informed Care

One of the most recent developments being researched and utilized in many federal- and state-level agencies is referred to as **trauma-informed care**. This model focuses on three key elements:

1. Realizing the prevalence of trauma
2. Recognizing how trauma affects individuals
3. Responding by putting this knowledge into practice.

This model becomes valuable for the crisis worker who may be working with clients currently dealing with a trauma, who have a history of having already experienced trauma. This approach engages clients with histories of trauma and how trauma has played a role in their lives. According to Wisconsin Department of Health Services (2017), trauma refers to extreme stress that overwhelms a person's ability to cope. It can be a single event, a series of events, or a chronic condition. This new model complements our definition of a crisis state and the ABC Model of Crisis Intervention.

This will be explored more in Chapter 7.

The ABC Model of Crisis Intervention

The **ABC Model of Crisis Intervention** is useful in most nonprofit agencies, county agencies, hospitals, and HMOs and with most insurance plans. It is a convenient crisis interviewing technique that can be used either face-to-face or over the phone. It can be completed in a 10-minute phone conversation, in one session, or over six sessions.

The ABC model, developed by Kanel beginning in 1995 and revised repeatedly, is loosely based on Jones's (1968) ABC method of crisis management as well as on lecture notes from, and discussions with, Mary Moline at California State University, Fullerton, in the 1980s (prior to crisis intervention being a regular part of graduate level training). Chapter 3 explores in detail the different aspects of the model. In general, crisis intervention is an action-oriented effort between a helper and a person immobilized by an emergency situation; the purpose is to provide temporary, but immediate, relief. This treatment differs from psychotherapy, which is usually a more intensive, introspective analysis between a professional therapist and a client; psychotherapy's goal is to provide self-understanding and reconstruction of long-standing personality traits and behavior (Cormier, Cormier, & Weisser, 1986, p. 19).

The focus of the ABC model is to identify the precipitating event and the client's cognitions about the precipitating event, emotional distress, failed coping mechanisms, and impaired function. Remember that these are the aspects of a crisis. The goal is to help the client integrate the precipitating event into his or her daily functioning and return to precrisis levels of emotional, occupational, and interpersonal functioning.

Chapter Review Questions

1. What are the components that make up a crisis state?
2. What role does a person's perception play in creating and overcoming a crisis?
3. What is the goal of crisis intervention?
4. How can crisis be both an opportunity and a danger?
5. What are the characteristics of effective coping behaviors?
6. Who began the Wellesley Project and what types of crisis were they dealing with in the 1940s?
7. What was the focus of the Community Mental Health Act of 1963?
8. What contributions have been made by traditional approaches to counseling to the field of crisis intervention?
9. What is critical incident and debriefing?
10. How does stress differ from a crisis state?

Key Terms for Study

ABC Model of Crisis Intervention: One way to structure crisis intervention that includes (A) developing and maintaining contact, (B) identifying the problem, and (C) coping.

behavioral problem-solving model: Approach focusing on goal setting, problem solving, and brainstorming alternatives.

brief therapy: May be confused with crisis intervention, but focuses on changing longer-standing behavior patterns rather than on only the current precipitating event.

Caplan, Gerald: Known as the father of modern crisis intervention. Worked with Eric Lindemann on the Wellesley Project after the Cocoanut Grove fire.

Caplan's seven characteristics of effective coping behavior: Behaviors proposed by Gerald Caplan (1964) as essential for getting through a crisis state. They can be learned through formal crisis intervention, through experience, or while growing up. In any case, the crisis worker needs to acknowledge these characteristics and to transmit them to clients when possible.

Cocoanut Grove fire: Nightclub fire in 1942 in which over 400 people died, leaving many survivors in crisis; considered one of the major events leading to the development of crisis intervention as a form of mental health treatment.

cognitive approaches: Approaches focusing on a person's perceptions and thinking processes and how these lead to crisis states.

cognitive key: The perception a person has of the precipitating events that lead to emotional distress. The crisis worker must identify the perception if he or she is to help the client change it and thereby increase functioning.

Community Mental Health Act of 1963: Legislation enacted during the Kennedy administration directing all states to provide mental health treatment for people in crisis.

coping methods: The behaviors, thinking, and emotional processes that a person uses to handle stress and continue to function.

crisis: A state of disequilibrium that occurs after a stressor (precipitating event). The person is then unable to function in one or more areas of his or her life because customary coping mechanisms have failed.

curvilinear model of anxiety: Model showing that anxiety has the potential to be either a positive or a negative influence for someone in crisis. Too much anxiety may overwhelm the person and lead to lowered functioning. However, moderate anxiety may offer an opportunity for growth and transition from one stage of life to another or may motivate the person to grow from the experience of trauma. People who have no anxiety tend not to be motivated to make any changes at all.

danger and opportunity: Dichotomy associated with a crisis. A crisis can be an opportunity when the person grows by developing new coping skills and altering perceptions. It can be a danger when the person does not seek help and instead copes with the crisis state by using defense mechanisms, resulting in a lowered functioning level and possibly psychosis or even death.

developmental crises: Normal transitional stages that often trigger crisis states, which all people pass through while growing through the life span.

ego strength: The degree to which people can see reality clearly and meet their needs realistically. People with strong egos usually cope with stress better than people with weaker egos.

emotional distress: Painful and uncomfortable feelings experienced by a person in crisis.

existential theory: Theory from which crisis intervention took the ideas of choice and anxiety. The crisis worker believes that anxiety can be a motivator for change and encourages the client to master anxiety realistically by making choices and accepting responsibility for the choices.

functioning level: The way a person behaves socially, occupationally, academically, and emotionally. The functioning level is impaired when a person is in a crisis. The goal of crisis intervention is to increase functioning to precrisis levels or higher.

grassroots programs: Upward movement from local groups that led to the creation in the 1960s and 1970s of many agencies to meet the needs of various populations not being helped by traditional governmental agencies.

grief work: Crisis intervention largely based on working with survivors and family members of victims of the Cocoanut Grove fire. It was with this population that Caplan and Lindemann learned how to conduct short-term interventions.

health maintenance organizations (HMOs): The current trend in health insurance. These organizations focus on maintaining health rather than curing illness. The orientation of mental health care under this style of management is definitely crisis intervention.

humanistic approach: Model using a person-centered approach in developing rapport with clients; counselor uses basic attending skills to focus on the inherent growth potential in the client.

Lindemann, Eric: Worked with Gerald Caplan on the Wellesley Project and helped create crisis intervention as it is known today; recognized for his contributions to grief work.

material resources: Tangible things such as money, transportation, clothes, and food. They constitute one determinant of how well a person is able to deal with a crisis.

paraprofessionals: Originally community volunteers. Because of the tremendous number of clients needing help at the same time after the Cocoanut Grove fire, it was necessary to employ community volunteers, who were not professionally trained, to conduct crisis intervention sessions. These paraprofessionals became part of many agencies in later decades.

personal resources: Determinants of how well a person will deal with a crisis. They include intelligence, ego strength, and physical health.

precipitating event: An actual event in a person's life that triggers a crisis state that can be either situational or developmental.

preventive psychiatry: The term Caplan originally used to describe his work with the survivors of the Cocoanut Grove fire and others going through crises.

psychiatric emergency team (PET): The professionals designated by a county/hospital to assess whether someone should be involuntarily hospitalized due to a mental disorder.

psychoanalytic theory: An approach considered the opposite of crisis intervention but with certain ideas useful for the crisis worker. The notion that we have only a certain amount of psychic energy to deal with life stressors leads us to keep our clients proceeding at a slow pace so they do not deplete this energy. Also, ego strength is a useful concept.

Rogers, Carl: Founder of person-centered therapy and well-known contributor to the humanistic approaches to counseling.

situational crises: Unexpected traumas having a sudden onset that impair one's functioning level.

social resources: A person's friends, family, and coworkers. The more resources one has, the better will one weather a crisis.

stress: A natural, though trying, part of life. A reaction to difficult events usually involving feelings of anxiety. Stressful events do not become crises if a person can cope with them and functioning is not impaired.

trauma-Informed Care: An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

Wellesley Project: Developed by Caplan and Lindemann, it was the first organized attempt at introducing crisis intervention into a community.

References

Beck, A. T. (1976). *Cognitive therapy and emotional disorders*. New York, NY: International Universities Press.

Beigel, A. (1984). The re-medicalization of community mental health. *Hospital and Community Psychiatry*, *35*, 1114–1117.

Brenner, C. (1974). *An elementary textbook of psychoanalysis*. Garden City, NY: Anchor Books.

Bugental, J. F. T. (1978). *Psychotherapy and process: The fundamentals of an existential-humanistic approach*. New York, NY: Random House.

Caplan, G. (1961). *An approach to community mental health*. New York, NY: Grune & Stratton.

Caplan, G. (1964). *Principles of preventive psychiatry*. New York, NY: Basic Books.

Caplan, R., & Caplan, G. (1969). *History of psychiatry in the 19th century*. New York, NY: Basic Books.

Cormier, L. S., Cormier, W. H., &Weisser, R. J., Jr. (1986). *Interviewing and helping skills for health professionals*. Portola Valley, CA: Jones and Bartlett.

Corsini, R. J., & Wedding, D. (1989). *Current psychotherapies*. Itasca, IL: F. E. Peacock.

Cutler, D., Bevilacqua, J., & McFarland, B. (2003). Four decades of community mental health: A symphony in four movements. *Community Mental Health Journal*, *39*(5), 381–398.

Ellis, A. (1994). *Reason and emotion in psychotherapy revised*. New York, NY: Kensington.

Everly, G. S. (2003). Early psychological intervention: A word of caution. *International Journal of Emergency Mental Health*, *5*(4), 179–184.

Everly, G. S. (1999). Emergency mental health: An overview. *International Journal of Emergency Mental Health*, *1*, 3–7.

Everly, G. S., & Mitchell, J. T. (2000). The debriefing "controversy" and crisis intervention: A review of lexical and substantive issues. *International Journal of Emergency Mental Health*, *2*(4), 211–225.

Gabbard, G. O. (2014). *Psychodynamic psychiatry in clinical practice* (3rd ed.).Washington, DC: American Psychiatric Press, Inc.

Garfield, S. L. (1980). *Psychotherapy: An eclectic approach*. New York, NY: John Wiley.

James, R. K., & Gilliland, B. E. (2013). *Crisis intervention strategies* (7th ed.). Pacific Grove, CA: Brooks/Cole.

Janosik, E. H. (1986). *Crisis counseling: A contemporary approach*. Monterey, CA: Jones and Bartlett.

Jones, W. (1968). The A-B-C method of crisis management. *Mental Hygiene*, *52*, 87–89.

Library of Congress. (1989–1990). *Community mental health centers construction act of 1989*. Author.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, *101*, 141–148.

Maslow, H. A. (1970). *Motivation and personality* (rev. ed.). New York, NY: Harper & Row.

Meichenbaum, D. (1985). *Stress inoculation training*. New York, NY: Pergamon Press.

Obusnsha's Handy English-Japanese Dictionary. (1983).

Peake, T. H., Borduin, C. M., & Archer, R. P. (1988). *Brief psychotherapies: Changing frames of mind*. Newbury Park, CA: Sage.

Roberts, A. R. (1990). *Crisis intervention handbook: Assessment, treatment, and research*. Belmont, CA: Wadsworth.

Slaikeu, K. A. (1990). *Crisis intervention: A handbook for practice and research* (2nd ed.). Boston, MA: Allyn & Bacon.

Wisconsin Department of Health Services. (2017). *Trauma-informed care—Principles.* Retrieved February 6, 2017, from www.dhs.wisconsin.gov/tic/principles.htm

2 Ethical and Professional Issues

Learning Objectives

After studying this chapter, readers should be able to:

LO1	Describe the major ethical standards in most mental health professions.
LO2	Recognize the need for ethics in crisis intervention.
LO3	Identify the various controversies related to ethics.

Introduction

Basically, ethics assure the public that counselors operate with the best interests of their clients and by mindfully trying to do no harm (an idea that has its roots as far back as the ancient Greek physician Hippocrates and his "oath"). This concept of **nonmaleficence** guides most of the ethical standards to be presented in this chapter.

Even before this Hippocratic oath, standards of practice and the idea of accountability were seen in the ancient Egyptian code of Hammurabi around 2000 BC (American College of Physicians, 1984). This code contained a description of physician responsibilities and the consequences and punishments to the physician if the patient's health did not improve.

The Need for Ethics

Strong ethical practice is especially important in the field of crisis intervention, because clients in crisis come to a counselor in a vulnerable state of disequilibrium and instability. It would be easy to take advantage of someone in such an unsteady state. At the outset of counseling, clients often feel hopeless and scared. They may view a counselor who reaches out with empathy with seemingly all the answers as a hero or savior of some type. Crisis interventionists adhere to strong ethical behaviors to help clients see them and their abilities in a realistic light.

What Are Ethics?

The term *ethics* is derived from the Greek word *ethos*, meaning character, and the Latin word *mores*, meaning customs. They guide behaviors that are deemed good for society and each individual (Elite CME, 2012). When someone identifies himself or herself as a mental health professional, he or she should uphold the ethical standards put forth by the profession. In 1947, the social work profession adopted a code of ethics, and many revisions have been created over the ensuing years by the National Association of Social Work, which was formed in 1960 (Elite CME, 2012). This process of revising standards is common to most mental health associations such as the American Psychiatric Association, the American Psychological Association, the American Association of Marital and Family Therapists, and the American Counseling Association. The reader is invited to visit the many websites that describe the specific ethical standards for each association. It will be no surprise to see similarities among all of these groups.

Defining Law

Law is not exactly the same thing as ethics, though they sometimes overlap. Saltzman and Furman (1999) define *law* as "standards, principles, processes, and rules adopted, administered and enforced by governmental authority that regulate behaviors." Some laws regulate mental health practice by requiring certain education, experience, and

examination completion to receive government standing as a professional. Other laws impose mandatory reporting practices such as child abuse reporting (Elite CME, 2012). Some general laws such as the sexual harassment laws created by the Equal Employment Opportunity Commission and the laws put forth by the Americans with Disability Act apply to mental health practice as well. An important law created by Congress in 1996 established national standards for the protection of certain health information. This Health Insurance Portability and Accountability Act (HIPAA) addressed who can use, look at, and receive individuals' health information, including mental health providers. In 2009, the Department of Health and Human Services created penalties for violations of this privacy rule, making it imperative that all mental health providers adhere to the HIPAA law.

Since the inception of the Community Mental Health Act, various states have implemented laws and regulations about the rights of clients who utilize the mental health centers. This has led to controversies in the field.

Controversies

When mental health service centers were built in the community, they became places of specialty for psychiatry. The Community Mental Health Act was originally intended to serve individuals suffering from chronically mental illnesses, but soon mental health workers began seeing healthier, less dysfunctional patients suffering from emotional disorders who had typically been treated in private psychologists' offices. As a result, the chronically mentally ill were receiving less care than intended. The **Lanterman-Petris-Short Act**, passed in 1968 in California, established more specific requirements for the provision of mental health services in the community. It set up the conditions of involuntary detention by peace officers or an individual designated by the act. If an individual was determined to be gravely disabled or a danger to himself or herself or to others, that person could be taken into custody for 72 hours if this was a result of a mental disorder. These conditions have been reviewed and are not without controversy. Some see this act as vague and may lead to unfair consequences to the poor and minorities. Moore (2000) found that at least one-third of Blacks receiving psychiatric care in various California facilities were given twice the dosage of antipsychotic drugs compared to other races. He expresses concern about current pending legislation in the California legislature (Assembly Bill 1800 authored by Thomson and Peralta) that would expand forced treatment because it would lead to more racial bias and strengthen the mistrust of the mental health system by people of color. His studies suggest that African Americans are misdiagnosed and overrepresented as schizophrenic by many mental health providers.

Interestingly, "The primary motivations for this act (Lanterman-Petris Short Act) were the abolition of indeterminate commitment and the removal of legal disabilities suffered by individuals adjudged mentally disordered" (Lenell, 2010, p. 733).

Lenell suggests that the concept of preventive detention may raise constitutional questions. If it is to be allowed, the client being detained must be assessed

by psychiatrists as being at risk of causing serious harm. She reports about certain research studies that indicate that psychiatrists consistently error in their prediction of violence, and often individuals who are involuntarily detained may have lost their Fourteenth Amendment right to due process (2010). The Supreme Court stated in *Jackson v. Indiana* that "at the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed" (p. 751). This refers to the idea that patients have the right to effective treatment if they are to be detained. Another Supreme Court decision, *O'Connor v. Donaldson*, stated that states may not confine a nondangerous individual who is capable of surviving safely by himself or herself or with help of others. The "gravely disabled" condition does not apply if a person with a mental illness can properly survive even if others believe his or her clothing and food habits are not adequate. One last notable controversy is the case of *Humphrey v. Cady* in which the Supreme Court decided that evidence of an individual's harm to others must be high and the probability of danger must exist before confinement. Controversies like these are important to ensure that those suffering from mental illness and other forms of crises receive the effective treatment they need and that mental health practitioners operate in the most diligent and ethical manner possible.

Use of Paraprofessionals

Another controversy has to do with the use of nonprofessionals in the provision of crisis intervention. Some mental health professionals may think that crisis intervention should only be provided by counselors with at least a master's degree or a license. However, as discussed in Chapter 1, crisis intervention began with the use of community workers, sometimes referred to as nonprofessionals or paraprofessionals. These workers often functioned in multidisciplinary team settings such as county agencies and grassroots nonprofit organizations. Effective crisis intervention can be conducted by undergraduate student trainees or community volunteers as well as by graduate-level students and professional counselors if their training is appropriate and if they are properly supervised.

The use of paraprofessional crisis workers has continued to be especially important as the world has moved into the twenty-first century. The economic recession of the early 1990s plus a decided shift in governmental policies during the beginning of the twenty-first century, and more recently the increasing governmental debt and the Wall Street collapse that began soon after the wars in Iraq and Afghanistan, has led to cutbacks in government spending on human services programs. This has meant less money or no money to pay mental health workers. Under these circumstances, the use of volunteers and paraprofessionals makes excellent economic sense because most professional therapists will not provide crisis intervention consistently for the lowered fees often paid to many paraprofessionals. Also, many situations—including the wars in Iraq and Afghanistan, terrorism, continuing experiences of family deterioration, child and spousal abuse, and the inevitability of loss and

subsequent states of crises that follow—seem to lead to the ongoing need for crisis intervention services. When immediate low-cost help is needed, using paraprofessionals makes the community stronger by ensuring that its population is functioning and coping with stress.

Everly (2002) proposes that, for certain individuals who are unfamiliar with or resistant to mental health intervention, the use of peer psychological support may allow services for those who might otherwise avoid such support. He agrees with the tenets of the ABC model that suggest that rapport is a significant challenge for crisis workers in the development of the therapeutic relationship and that, with proper training and supervision, peer counselors are valuable.

Ethical Issues

Most professional associations have created ethical standards around similar issues. These usually include issues related to boundary violations, improper and incompetent practice and record keeping, lack of honesty, breach of confidentiality, financial fraud, and failure to report inappropriate violations by others. Kitchener (1984) has offered five guiding moral principles that make up ethical decision-making: (1) autonomy—freedom of choice for the client; (2) nonmalfeasance—do no harm; (3) beneficence—contributing to the welfare of the client and attempting to benefit the client; (4) justice—providing equal treatment for all clients; and (5) fidelity—honoring commitments and guarding trust.

By maintaining self-awareness and proactively monitoring ourselves, we will typically succeed in honoring ethical standards and engaging in minimal violations of ethical and legal codes.

Self-Awareness and Self-Monitoring

"In addition to external ethics guidelines, mental health professionals must also rely on their internal cues through personal character" (Elite CME, 2012, p. 1). Therapeutic self-awareness means being conscious of one's own emotions, values, opinions, and behavior. Understanding one's own psychological processes and dynamics can help one guide others through their processes (Corey, Corey, & Callanan, 2010). Students can learn therapeutic self-awareness in crisis intervention classes; such training can help students take an honest, in-depth look at themselves in relation to the crisis of interest. It can be a valuable learning experience, enhancing the crisis worker's skills in helping clients. If workers learn to deal with the most common and pressing issues surrounding death, for example, they have a better chance of helping a client deal with bereavement. It also helps counselors monitor reactions to situations that might trigger inappropriate reactions and lead to unethical behaviors. Additionally, without ongoing self-reflection and awareness, counselors may be prone to developing **countertransference** with clients. In these situations, the counselor intervenes inappropriately with the client because the client has triggered an emotional issue within the counselor based on the counselor's history with significant others.

Countertransference must often be addressed in the helping professions and has been formally defined as an "unconsciously determined attitudinal set held by the therapist which interferes with his work" (Singer, 1970, p. 290). It can be worked through effectively with personal therapy, lab sessions, and active self-exploration. Students new to crisis intervention have often experienced one or more of the situational crises practiced in coaching sessions. If students have not worked through the crisis completely, their feelings may interfere with their ability to remain calm, objective, and client-focused. However, once students' unresolved issues are discovered and processed, both in their own counseling and in lab group, they often are able to work quite effectively with clients going through that same type of crisis. Countertransference is not restricted to students in training. In actuality, this concept was first developed by Carl Jung in his training of analysts. Even the highly trained professional is liable to experience countertransference from time to time. This is the primary reason that personal analysis has been encouraged for psychoanalysts from the very beginning of the discipline.

Dual Relationships

Another ethical issue involves **dual relationships**—which occur when a counselor has more than one kind of relationship with a client. When counselors are providing crisis intervention to a client, they are prohibited from being involved with that client on a personal level of any kind. This includes prohibition of any relationship—sexual, social, employment, or financial—that is not directly related to the provision of crisis intervention. Such a separation is necessary because a person in crisis is often in a vulnerable state and could be taken advantage of quite easily by a counselor (who is viewed as an expert). Another reason to avoid a dual relationship is because of the possible emotional damage clients may sustain if they experience the counselor in a different role and then are disillusioned or disappointed. Also, the power differential between counselor and client is enormous. The counselor knows quite a bit about the client, and this knowledge can be a source of awkwardness for the client when he or she is out of the therapeutic situation. The most potent advice on the subject is this: *Do not make friends or lovers of your clients. It is unethical and in some cases illegal.*

Confidentiality

Confidentiality is one of the hallmarks of any trusting relationship. It is also an important part of the ethical code for mental health providers. A broad concept that refers to safeguarding clients from unauthorized disclosures of information made in the therapeutic relationship, confidentiality is an explicit promise by the counselor to reveal nothing unless the client has agreed to it. **Privileged communication**, which is sometimes confused with confidentiality, is the statutory right that protects clients from having their confidences revealed publicly (Corey et al., 2010).

Cullari (2001) conducted a study in which clients were questioned about the most important aspect of a therapeutic relationship. Feeling safe and secure and the chance

to talk to the therapist in a safe environment without fear of repercussion were the two most critical aspects mentioned. This certainly supports the idea that confidentiality is paramount.

However, some **exceptions to privilege and confidentiality** do exist, as they relate to crisis intervention. Privilege is waived if the client signs a document giving the helper permission to disclose the communications between the client and the counselor. Clients may be asked to waive privilege to ensure continuity of care among mental health professionals, to provide for appropriate supervision, when access to records is needed for court testimony, and when information is needed for submitting health insurance claims. Confidentiality must be broken in cases of child abuse or elder abuse, when clients are a **danger to others**, and it may be broken when clients are a danger to themselves or are **gravely disabled**. Sometimes, a client's mental condition will be the focus of a lawsuit, and in some of those cases, confidentiality can be ethically and legally broken. For example, a client who sues a therapist for malpractice and claims to have suffered emotional damage because of the therapist's incompetence gives up privileged communications from the therapy sessions. The therapist may use case notes to defend against the malpractice charge. A similar example in which a client would forfeit the protection of privilege is a case in which the client is attempting to prove emotional injury in a workers' compensation.

In order to remember these exceptions to confidentiality, the following philosophy offered by Justice Mathew O. Tobriner of the California Supreme Court, after the court heard *Tarasoff v. Regents of the University of California* and created the "duty to warn mandate," is often applied: "Privileged communication ends where public peril begins" (Buckner & Firestone, 2000). This includes peril to clients if they endanger themselves because of a mental disorder. If clients are considered suicidal or gravely disabled and unable to care for themselves, helpers may breach confidentiality to protect them. The spirit of this allowance is that sharing information is meant to be among professionals, family, and friends, and not for frivolous purposes. Gravely disabled clients are those who, because of a mental disorder, cannot take care of their daily needs for food, shelter, medical care, clothing, and so on. Clearly, it is more important to break confidentiality to save someone with Alzheimer's disease from starving because he is delusional about having food in the house than it is to maintain confidentiality.

The other situations in which privileged communications should be broken involve trying to prevent clients from harming others. These conditions include elder abuse, child abuse, and the possibility that clients might cause different kinds of danger to others. Specifics of mandatory reporting are presented next.

Elder Abuse Reporting Act

The department of social services in some states has an adult protective services program that responds to reports of abuse of the elderly (i.e., adults over 65 years old). **Elder abuse** refers to any of the following acts inflicted by other than accidental means on an elder by another person: physical abuse, fiduciary abuse (involves trust and money), and neglect or abandonment. In many states, knowledge of such abuse must be reported to social services, the police, or a nursing home ombudsman

(governmental investigator). Some agencies have also begun taking reports of abuse of the disabled adult population. This could cover any adult who suffers from a mental or physical disability such as mental retardation or blindness.

Child Abuse Reporting Act

Since passage by Congress of the National Child Abuse Prevention and Treatment Act in 1974, many states have enacted laws requiring professionals to report child abuse. This act provided federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities. It was amended several times and was most recently amended and reauthorized in 2003 by the Keeping Children and Families Safe Act (P.L. 108-36) (U.S. Department of Health and Human Services, 2010). States differ on the indicators for reporting and whether sanctions will be imposed on individuals for not reporting. **Child abuse reporting** is mandated when certain professionals that work with children and families suspect the child is a victim of physical abuse, sexual abuse, general neglect, and emotional abuse.

In many states, child abuse must be reported within 36 hours of its discovery to the department of social services or the police. The child protective services program will then investigate the suspicion. Remember that there is no requirement to have evidence of abuse before it can be reported; suspicion alone is enough evidence. If abuse is suspected that is later proved, and it is not reported, the person who is required to report may be fined by the state. On the other hand, more and more states are ensuring immunity from suit for false reports. Each crisis worker is encouraged to know the requirements of reporting in his or her state. Child abuse issues will be covered in chapter 9 and Elder Abuse issues and Disabled abuse issues will be covered in Chapter 12.

The *Tarasoff* Case The consequences of failing to warn an individual of possible danger to him or her by another are dramatically illustrated in the above-mentioned *Tarasoff* case. In 1969, Prosenjit Poddar was seeing a therapist at the campus counseling center of the University of California, Berkeley. Poddar confided to the therapist that he intended to kill Tatiana Tarasoff when she returned from Brazil. The therapist considered Poddar dangerous and called campus police, requesting that Poddar be confined. But he was not confined. To complicate matters, the therapist's supervisor ordered that all case notes be destroyed. Tarasoff was later killed by Poddar, and her parents filed suit against the University of California's Board of Regents. The decision from this case requires a therapist to notify the police and the intended victim when possible if the therapist has reasonable belief that a client is dangerous toward others (duty to warn) (California State Case Law, 2010).

Informed consent is a way of providing clients with information they need to become active participants in the therapeutic relationship (Corey et al., 2010). Although no specific rules exist governing how much information a therapist is to provide, three legal elements to informed consent do exist. First, clinicians must make sure clients have the ability to make rational decisions and, if not, must

ensure that a parent or guardian takes responsibility for giving consent. Second, therapists must give clients information in a clear way and check their understanding of the risks and benefits of treatment and alternate procedures available. Third, clients must consent freely to treatment. The exceptions to these elements occur when clients are dangerous to themselves and others or are gravely disabled. Electroconvulsive shock treatments and psychosurgery (lobotomies) cannot be done without consent; however, there are times when medication is given without client consent.

Competence

There is a growing model to ensure clients receive the most competent and effective service possible, often referred to as *evidence-based practice*. Evidence-based practice takes into account the current state of knowledge regarding a variety of clinical needs.

Another way in which competence is increased and monitored is the requiring of counselors to receive appropriate supervision and training. Unless paraprofessionals are supervised by a licensed professional, most agencies—county, state, and nonprofit—do not let them provide crisis intervention and counseling. Even seasoned therapists often consult with colleagues about cases for which they have minimal training or experience. Crisis workers sometimes refer a client to another helper because the worker's duties mainly involve assessment and brokering out clients—tasks requiring a sound knowledge of community resources for a variety of problems.

Knowing one's limitations is essential for ethical practice. When a helper is conducting a crisis interview, being able to make an assessment for organic illnesses and severe mental illness is especially important. Some cases require a multidisciplinary team approach with a medical doctor involved such as serious mental illness or neurological impairment. Even though making technical diagnoses is not usually considered appropriate for paraprofessionals, knowledge of the *Diagnostic and Statistical Manual of Mental Disorders*, *5th edition* (American Psychiatric Association, 2013), is helpful in ensuring that clients receive services from the type of professional appropriate to their needs. This manual provides information about very serious mental disorders that require intervention by physicians. Crisis workers should review this manual when possible to gain an understanding of the types of presenting complaints that usually necessitate physician involvement. Box 2.1 provides an example of necessary physician involvement due to a client suffering from an organic illness.

Client's Rights

In addition to rights for privacy, a client also has the right to give consent for treatment unless he or she is considered incompetent to refuse. Clients must also be given information about the service so he or she may weigh the benefits and risks of treatment. They must be informed of the fee structure, the counselors' qualifications, and termination rights.

BOX 2.1

Example of an Organic Illness Necessitating Physician Intervention

Suppose that a 45-year-old woman comes to a community center because her 70-year-old mother has been behaving strangely, does not recognize her family members, and leaves the gas stove burners on all day. Knowing that these symptoms are indicative of Alzheimer's disease or other organic brain disorders helps the crisis worker develop treatment strategies. Most important is having the mother examined neurologically to rule out any medical cause for her unusual behavior.

Virtual or e-Therapy

Since the development of certain technological advances such as Skype and Face time, many counselors have begun offering counseling services electronically. This may be done via email, the Internet, teleconferencing, or videoconferencing. Some support this practice saying it allows people to be served who otherwise could not, due to their living location or due to fears of stigma, or conditions such as agoraphobia (Kanani & Regehr, 2003). They also have some concerns such as risks to security and confidentiality, lack of legal recourse for malpractice, and inappropriate counseling due to lack of observation of facial expressions. This practice is certain to come under more scrutiny in the future due to the global trend to "cyber everything."

Multicultural Competence

The idea that counselors should be sensitive to various cultural norms and behaviors when helping clients work through crises is nearly universally accepted. Crisis workers are encouraged to be open and knowledgeable toward subgroups that may differ from mainstream culture. Counselors must not *impose* personal values on clients, but instead be aware of how the client's values may be a part of the problems that exist. Of course, one cannot help but sometimes *expose* one's values to others, but it is considered unethical to assume that everyone should believe and act the way counselors think they should.

This interest in the sensitivity of counselors and therapists to culturally diverse clients has been growing in the past few decades. It began in the 1960s when the civil rights and affirmative action movements emerged, and became a part of formal education in the late 1980s and 1990s. Arredondo and colleagues (1996, p. 43) describe specific behaviors and attitudes of counselors who are culturally aware: "Multicultural counseling refers to preparation and practices that integrate multicultural and culture-specific awareness, knowledge, and skills into counseling interactions." They suggest that multicultural refers to five major cultural groups in the United States: African Americans, Asian Americans, Caucasians, Latinos, and Native Americans. The reader is encouraged to obtain a copy of the article and keep it for reference. Although these groups have been the main