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3RD EDITION

CRISIS ASSESSMENT, INTERVENTION, AND PREVENTION

LISA R. JACKSON-CHERRY | BRADLEY T. ERFORD

Third Edition

Crisis Assessment, Intervention, and Prevention

Lisa R. Jackson-Cherry
Marymount University

Bradley T. Erford
Loyola University Maryland

Pearson

330 Hudson Street, NY, NY 10013

Director, Teacher Education & the Helping Professions: Kevin M. Davis
Portfolio Manager: Rebecca Fox-Gieg
Content Producer: Janelle Rogers
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Cover Designer: Melissa Welch
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To all crisis workers who give selflessly to alleviate the pain of others. This work is also dedicated to my family, who has sacrificed and continues to be my source of support: my husband, Jim; my daughters, Gabrielle and Alexandra; and my parents, Barbara Jackson and Francisco Japzon, M.D. I am ever-mindful that all my fortunes and blessings are gifts from God.

LRJC

This effort is dedicated to The One: the Giver of energy, passion, and understanding; Who makes life worth living and endeavors worth pursuing and accomplishing; the Teacher of love and forgiveness.

BTE

PREFACE

The purpose for writing this text was to convey the practical implications of and applications for dealing with crisis situations. Prior to September 11, 2001, crisis counselors' and university faculty members' conceptualization of crisis was generally limited to individual clients, primarily addressing suicidal client needs. But recent events (e.g., terrorism, school shootings, natural disasters), coupled with renewed societal concerns over continuing violence (e.g., homicide, intimate partner violence, rape, sexual abuse), have expanded our conceptualization of crisis and the needs of the new generation of counselors. This text addresses this expanded concept of crisis in today's world and includes the practical applications that will help crisis counselors to be able to serve diverse clients immediately in a changing world. Crisis intervention and crisis roles differ from traditional counseling. Understanding these differences is imperative to assisting individuals in a variety of crises. Crisis counselors, when able to assess and intervene effectively, may also assist individuals in responding to future crises—a preventive approach.

Preservice students and mental health professionals in the field need crisis intervention training to effectively intervene in the various crisis situations they will encounter in their roles as counselors with diverse populations and across settings. This short text provides vital information on assessing and reacting to various crises involving suicide, homicide, intimate partner violence, sexual assault/abuse, bereavement/grief, substance use, natural disasters, war, and terrorism. The text provides practical applications for various crisis situations experienced by crisis workers. The text allows students to become familiar with various crisis issues and situations and to practice necessary skills before encountering the problem for the first time in the field. The text features numerous crisis situations not found in other crisis texts and is of benefit to various counseling specialties (e.g., school counseling, university counseling, mental health counseling, and pastoral clinical mental health counseling). Students see the process as a whole and are exposed to crucial information, clinical considerations, and practical experiences on every crisis topic.

NEW TO THIS EDITION

The third edition of *Crisis Assessment, Intervention, and Prevention* has been purposefully revised with new and expanded content to address the needs of a diverse group of counselors in the field and counselors in training. The following features are new to this edition:

- Introduction of a new Task Model for Assessment and Intervention developed and integrated throughout the book.
- A new chapter addresses counselor safety issues.
- A new chapter addresses counselor self-care and wellness issues.
- A new chapter addresses needs and interventions with first responders in crisis situations.
- New and expanded chapters address crisis counseling in the community and schools/universities.
- Updated references and citations connect practitioners with the latest information.
- Standardized chapter features including case studies, Voices from the Field, Activities, Think About It features, and resource lists.

ORGANIZATION OF THIS TEXT

The text is divided into two parts. Part I: *Elements of Crisis Intervention,* which includes Chapters 1 through 5, reviews the fundamental information related to crises and crisis intervention.

In Chapter 1: *Basic Concepts of Crisis Intervention*, Lisa R. Jackson-Cherry, Jason M. McGlothlin, and Bradley T. Erford acknowledge that crises occur in a variety of settings for a variety of reasons. Responses to crises are equally variable. Chapter 1 also provides basic frameworks for assessing and conceptualizing crises, along with a discussion of how crisis intervention may differ from traditional counseling. A new task model of crisis assessment and intervention is introduced in Chapter 1 and integrated into all of the chapters. The model is a more comprehensive approach to assessing the whole person for a more accurate intervention.

Chapter 2: *Safety Concerns in Crisis Situations*, was written by Charlotte Daughhetee, James Jackson, and Latofia Parker. When responding to a crisis, counselors need to be able to act promptly, meaning that crisis preparedness is essential to best practice during emergency situations. A brief overview of crisis planning guidelines and crisis counselor safety procedures is presented.

In Chapter 3: *Ethical and Legal Considerations in Crisis Counseling*, Paul F. Hard, Laura L. Talbott-Forbes, and Mary L. Bartlett propose that crisis counselors well versed in crisis procedures and processes will be able to provide ethical, skilled help in all types of crisis conditions. The goal of this chapter is to provide information on ethical and legal considerations related to preventive measures, federal legislations, sentinel court findings, and best practices regarding privacy matters in crisis counseling.

Chapter 4: *Essential Crisis Intervention Skills*, by Bradley T. Erford and Lisa R. Jackson-Cherry, provides an overview of the fundamental skills needed to engage in effective crisis intervention work. The skills covered in this chapter focus on Ivey, Ivey and Zalaquett's (2012) microskills hierarchy. At the heart of this hierarchy is the basic listening sequence, an interrelated set of skills that will not only foster the development of rapport with clients but also aid in the identification of interventions to help achieve a successful resolution to the client's crisis state. Examples of the skills in use, as well as practice exercises to foster individual skill development, are provided.

Part I concludes with Chapter 5: *Loss Grief, and Bereavement*, by Lisa R. Jackson-Cherry and Bradley T. Erford, which covers approaches to crisis counseling with mourners, theories of grieving, and the variables that affect how a bereaved person mourns. A common element in most crisis events is the experience of grief, loss, and bereavement. The loss and grief can be connected to a person, things, role, occupations, sense of purpose, and meaning, etc. The chapter also addresses how timing, cause of death, and the role the relationship played in a person's life all mediate the mourning process, followed by an attempt to distinguish between "normal" grief and complicated bereavement. Chapter 5 concludes with an outline of the components that should be implemented when preparing for and providing effective death notifications. A death notification given with empathy, calmness, and accuracy of information can assist loved ones gain a sense of control. The information in this chapter has been included to assist crisis counselors in being prepared and equipped when called upon to either give or assist with a death notification. Effective death notifications decrease the need for intense debriefings and a complicated grief process, reduce counselor burnout, and may open the door for individuals to seek counseling when they are ready.

Part II: *Special Issues in Crisis Intervention* comprises the remaining chapters of the text.

Chapter 6: *Risk Assessment and Intervention: Suicide and Homicide*, by Judith Harrington and Charlotte Daughhetee, recognizes that suicide and homicide continue to play increasingly important roles in American society and on the world stage and that they affect us personally as we, family members, friends, and those in extended social networks struggle with the ever-increasing challenges

of modern life. As personal liberty has increased, the chance for violent responses to stressful situations has increased. The effectiveness of the care given by professional emergency first responders, as well as the effectiveness of ordinary people in responding to their own crises and the crises of those about whom they care, is improved by background knowledge involving current trends in and treatments for suicide and homicide impulses.

Chapter 7: *Understanding and Treating Substance Use Disorders with Clients in Crisis*, by William R. Sterner, reviews substance use disorders and the disease of addiction, including causes, manifestations, and treatment. There are numerous models and theories about the causes of alcoholism and drug addiction, and this chapter introduces the medical and moral/legal models as well as important genetic, sociocultural, and psychological theories.

Chapter 8: *Intimate Partner Violence* is by Amy L. McLeod, John Muldoon, and Lisa R. Jackson-Cherry. Intimate partner violence (IPV) involves the infliction of physical, sexual, and/or emotional harm to a person by a current or former partner or spouse with the intent of establishing power and control over the abused partner. IPV is a major public health concern, and it is imperative that crisis counselors be able to recognize and respond to IPV survivors competently. This chapter provides an overview of the facts and figures associated with IPV, discusses the cycle of violence commonly experienced in abusive relationships, and explores various perspectives on survivors who stay in relationships with abusive partners. Common crisis issues experienced by IPV survivors, including dealing with physical injury, establishing immediate safety, and reporting IPV to the police, are also highlighted. In addition, this chapter explores special considerations regarding IPV in lesbian, gay, bisexual, and transgender (LGBT) relationships, relationships characterized by female-to-male violence, abusive relationships in racial and ethnic minority populations, and abusive dating relationships among adolescents and young adults. Guidelines for crisis counselors who are conducting IPV assessments, responding to IPV disclosure, planning for client safety, and addressing the emotional impact of IPV are provided. Finally, the goals, theories, and challenges associated with IPV offender intervention are discussed.

Chapter 9: *Sexual Violence*, by Robin Lee, Jennifer Jordan, and Elizabeth Schuler, reveals that sexual violence is one of the most underreported crimes, with survivors facing a number of potential physical, psychological, cognitive, behavioral, and emotional consequences. Crisis counselors who work with survivors of sexual violence need to be aware of the multitude of challenges these individuals face, best practices for treatment, and support services available in the local community.

In Chapter 10: *Child Sexual Abuse*, by Carrie Wachter Morris and Elizabeth Graves, child sexual abuse is defined, signs and symptoms described, treatment interventions discussed, and guidelines for working with law enforcement and child protective services personnel provided. In addition, this chapter addresses sexual offenders, their patterns of behavior, and common treatment options.

Chapter 11: *Military and First Responders*, by Seth C. W. Hayden and Lisa R. Jackson-Cherry, acknowledges that serving the needs of military personnel and families presents unique challenges for counselors working in a variety of settings. Military families are a significant part of our communities, with more than two-thirds residing in the larger civilian community and the remainder on military bases. While this population has long benefited from the work of skilled counselors, the current and anticipated needs of military and their family members requires an understanding of military culture in addition to effective methods to support this population. This chapter provides an in-depth discussion of the military experience and offers various approaches to assist military service members and their families. A new section to this chapter addresses the unique issues encountered by first responders. Law enforcement officers, emergency medical service professionals, and firefighters respond to various crisis situations daily and are exposed to various traumatic events that could impact their lives and their families. First responders are the first to arrive at a scene and

to intervene in horrific and traumatic situations. Occupational stressors, medical emergencies, threats to personal safety, acts of violence, deaths, and crimes are common daily occurrences. Understanding the roles of first responders, their limitations based on departmental policies, and how to work as a team with first responders is important for crisis counselors. Common intervention programs with first responders are discussed to meet their unique needs.

In Chapter 12: *Emergency Preparedness and Response in the Community and Workplace*, by Jason M. McGlothlin, the information and interventions from the preceding chapters are integrated into an overview of the various disasters and crises that crisis counselors may need to address. Crisis intervention models and clinical implications for disasters and terrorist situations are explored.

In Chapter 13: *Emergency Preparedness and Response in Schools and Universities*, by Bradley T. Erford, crisis management in the school and university is explored, including the components of a crisis plan and the role of counselors and other officials. Mitigation and prevention strategies are emphasized as critical elements in the educational environment. Crisis preparedness, response, recovery, and debriefing procedures are applied to school and university settings. Special emphasis is given to strategies for how to help students and parents during and after a crisis event. Like Chapter 12, the content of this chapter infuses information found in previous chapters to allow readers to synthesize what they have previously read.

Finally, Chapter 14: *Counselor Self-Care in Crisis Situations*, written by James Jackson, Latofia Parker, and Judith Harrington, provides a brief overview of counselor self-care concerns and wellness.

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BRIEF CONTENTS

CONTENTS

ABOUT THE EDITORS

Lisa R. Jackson-Cherry, Ph.D., LCPC, NCC, ACS, NCSC, PCE, is a professor in the Department of Counseling at Marymount University. She is the coordinator of program accreditation and assessment and program director for pastoral clinical mental health counseling. She received her Ph.D. in Counselor Education and Supervision, an Ed.S. in Counseling, a Masters of Criminal Justice from the University of South Carolina, and her B.A. in Psychology and Sociology from the University of Notre Dame of Maryland. She is the recipient of the American Counseling Association's (ACA) Carl Perkins Government Relations Award for her initiatives in psychological testing; the recipient of the Outstanding Service Award, Leadership Award, and Meritorious Service Award given by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC); Outstanding Leadership recipient of the European Branch of the American Counseling Association; and Outstanding Service and Leadership Awards from the Licensed Clinical Professional Counselors of Maryland. Dr. Jackson-Cherry is a licensed clinical professional counselor in Maryland, National Certified Counselor, approved clinical supervisor, and national certified school counselor. She is approved as a pastoral counselor educator by the American Association of Pastoral Counselors and is certified as a disaster mental health counselor by the American Red Cross. She is a Fellow with the American Counseling Association and is currently serving her second elected term on the Governing Council for ACA. She served on the Executive Board of the American Association of State Counseling Boards and is past-president of ASERVIC. She is the past membership co-chair and southern regional representative for the Counseling Association for Humanistic Education and Development and has served as past Secretary and Legislative Representative for the Licensed Clinical Professional Counselors of Maryland. She was appointed as a board member of the Board of Professional Counselors and Therapists in Maryland (BOPCT), serving as chairperson for 4 years, chair of the Ethics Committee, and Legislative/Regulations Committee. She was presented with citations from the Governor and Secretary of Maryland for her service and leadership on the BOPCT. Her research focuses mainly on the areas of ethical and legal issues in counseling and supervision, issues in military and first responders, risk assessment, and religious and spiritual integration. She teaches courses primarily in the areas of crisis assessment and intervention, pastoral counseling integration, and clinical mental health counseling internship. She is currently in private practice in Maryland, where she works with children, adults, and families focusing on anxiety, depression, substance use, autism, and behavioral issues. She served for many years as lead counselor with COPS-Kids (Concerns of Police Survivors-Kids) during National Law Enforcement Officers Week, providing group counseling to children who experienced the death of a law enforcement officer-parent in the line of duty. Prior to her faculty appointment in 2000, her previous clinical experiences consisted of clinical director for a mobile crisis team in Baltimore City, behavioral specialist (Grades K–5), conflict resolution coordinator/counselor (Grades 9–12), group co-facilitator for a women's maximum security correctional facility, dual diagnosed population, police department youth counseling services division, and crisis intervention training facilitator for law enforcement basic trainees and hostage negotiators. She has written numerous articles, book reviews, book chapters, and participated extensively at state, national, and international conferences over the past 20 years.

Bradley T. Erford, Ph.D., LCPC, NCC, LPC, LP, LSP, is the 2012–2013 president of the American Counseling Association (ACA) and a professor in the school counseling program of the Education Specialties Department in the School of Education at Loyola University Maryland. He is the recipient

of the American Counseling Association (ACA) Research Award, ACA Extended Research Award, Thomas J. Sweeney Award for Visionary Leadership and Advocacy, ACA Arthur A. Hitchcock Distinguished Professional Service Award, ACA Professional Development Award, and ACA Carl D. Perkins Government Relations Award. He was also inducted as an ACA Fellow. In addition, he has received the Association for Assessment and Research in Counseling (AARC) AARC/MECD Research Award; AARC Exemplary Practices Award; AARC President's Merit Award; the Association for Counselor Education and Supervision (ACES) Robert O. Stripling Award for Excellence in Standards; Maryland Association for Counseling and Development (MACD) Counselor of the Year; MACD Counselor Advocacy Award; MACD Professional Development Award; and MACD Counselor Visibility Award. He is the editor/coeditor of numerous texts, including *Orientation to the Counseling Profession* (Pearson Merrill, 2010, 2014, 2018), *Group Work in the Schools* (Pearson Merrill, 2010), *Group Work in the Schools* (2nd ed., Routledge, 2016), *Transforming the School Counseling Profession* (Pearson Merrill, 2003, 2007, 2011, 2015), *Group Work: Processes and Applications* (Pearson Merrill, 2010), *Developing Multicultural Counseling Competence* (Pearson Merrill, 2010, 2014, 2018), *Crisis Assessment, Intervention and Prevention* (Pearson Merrill, 2010, 2014, 2018), *Professional School Counseling: A Handbook of Principles, Programs and Practices (*pro-ed, 2004, 2010, 2016), and *The Counselor's Guide to Clinical, Personality and Behavioral Assessment* (Cengage, 2006). He is also an author/coauthor of *Forty Techniques Every Counselor Should Know* (Merrill/Prentice-Hall, 2010, 2015); *Assessment for Counselors* (Cengage, 2007, 2013), *Research and Evaluation in Counseling* (Cengage, 2008, 2014); *Educational Applications of the WISC-IV* (Western Psychological Services, 2006); and *Group Activities: Firing Up for Performance* (Pearson/Merrill/Prentice-Hall, 2007). He is the general editor of *The American Counseling Association Encyclopedia of Counseling* (ACA, 2009). His research specialization falls primarily in development and technical analysis of psychoeducational tests and has resulted in the publication of more than 70 refereed journal articles, 130 book chapters, and a dozen published tests. He was a member of the ACA Governing Council and the 20/20 Committee: A Vision for the Future of Counseling. He is past president of AARC, past chair and parliamentarian of the American Counseling Association–Southern (US) Region; past-chair of ACA's Task Force on High Stakes Testing; past chair of ACA's Standards for Test Users Task Force; past chair of ACA's Interprofessional Committee; past chair of the ACA Public Awareness and Support Committee (co-chair of the National Awards Sub-committee); chair of the Convention and past-chair of the Screening Assessment Instruments Committees for AARC; past president of the Maryland Association for Counseling and Development (MACD); past-president of Maryland Association for Measurement and Evaluation (MAME); past-president of the Maryland Association for Counselor Education and Supervision (MACES); and past-president of the Maryland Association for Mental Health Counselors (MAMHC). He was also a senior associate editor and board member of the *Journal of Counseling & Development*. Dr. Erford has been a faculty member at Loyola since 1993 and is a licensed clinical professional counselor, licensed professional counselor, nationally certified counselor, licensed psychologist, and licensed school psychologist. Prior to arriving at Loyola, Dr. Erford was a school psychologist/counselor in the Chesterfield County (VA) Public Schools. He maintains a private practice specializing in assessment and treatment of children and adolescents. A graduate of the University of Virginia (Ph.D.), Bucknell University (MA), and Grove City College (BS), he has taught courses in testing and measurement, psychoeducational assessment, life-span development, research and evaluation in counseling, school counseling, counseling techniques, practicum and internship student supervision, and stress management (not that he needs it, of course).

ABOUT THE CONTRIBUTING AUTHORS

Mary L. Bartlett, Ph.D., LPC-CS, NCC, CFLE, is a licensed professional counselor, a national board certified counselor, a certified family life educator and mental health consultant, a researcher, and a trainer. She earned her doctorate in counselor education from Auburn University and holds the position of Professor of Leadership and Ethics with the United States Air Force at Air University in Montgomery, Alabama. Dr. Bartlett is an experienced clinical counselor, and her primary areas of research are suicide and resilience. She is a master trainer for the Suicide Prevention Resource Center, an Army National Guard-qualified Master Resilience Trainer, has completed the Air Force Resilience Training program, and is well published in the field of suicide prevention, intervention, and postvention. She speaks internationally and trains leadership and mental health professionals on suicide- and resilience-related matters.

Charlotte Daughhetee, Ph.D., NCC, LPC, LMFT NCC, LPC, LMFT, is a professor in the graduate program in counseling at the University of Montevallo with counseling experience in K–12, university, and private practice settings. She earned her M.Ed. in school counseling and Ph.D. in counselor education from the University of South Carolina. She has experience in crisis intervention in school and university settings and has presented and published on crisis intervention and counselor trainee evaluation. She also serves as the chair of the Department of Counseling, Family & Consumer Sciences and Kinesiology.

Elizabeth Graves, Ph.D., LPCS, NCC, is an assistant professor in the Human Development and Psychological Counseling Department in the College of Education at Appalachian State University in Boone, North Carolina, where she serves as the program director for the Professional School Counseling Program. Her research focus is the study of resilience development in survivors of child sexual abuse, a passion sparked from her decade's work in both the professions of school counseling and clinical mental health counseling. As a result of her work in the counseling field, she earned MINT (Motivational Interviewing Network of Trainers) membership and a certificate in Spiritual Guidance and Formation; she leads trainings and groups in both.

Paul F. Hard, Ph.D., LPC-S, NCC, is an associate professor of counselor education at Auburn University at Montgomery. He has provided individual and group counseling in both private practice and community agency settings, focusing on addictions, relationship counseling, sexual minorities, and trauma. His research interests have been in the areas of ethics, counselor/professional impairment and wellness, complicated grieving in prenatal and postnatal loss, professional credentialing and advocacy, sexual minority issues in counseling, and ministerial termination.

Judith Harrington, Ph.D., LPC, LMFT, is a counselor educator at the University of Montevallo, and is an approved trainer for the *Assessing and Managing Suicidal Risk* curriculum for mental health professionals on behalf of the Suicide Prevention Resource Center. She designed and has taught an annual three-credit hour graduate counseling course in suicide prevention, intervention, and postvention for two universities for 9 years and frequently trains mental health professionals via workshops and seminars. In addition, she served on the Standards, Training, & Practices Committee for the National Suicide Prevention Lifeline for 5 years. She facilitated a Survivors of Suicide loss bereavement group for 14 years, and was the first- and twice-elected president of the Alabama Suicide Prevention and Resources Coalition (ASPARC). With assistance from the federal Garrett Lee Smith Youth Suicide Prevention grant, she developed the Comprehensive Suicide Prevention and Resources Directory, found at www.legacy.montevallo.edu/asparc.

Seth C. W. Hayden, Ph.D., NCC, is an assistant professor of counseling at Wake Forest University. Dr. Hayden has provided career and personal counseling in community agencies and secondary

school and university settings. Dr. Hayden's research focuses on the career and personal development of military service members, veterans, and their families. In addition, he explores the connection between career and mental health issues and integrated models of clinical supervision designed to facilitate growth in counselors' ability to formulate interventions. Dr. Hayden is a licensed professional counselor in North Carolina and Virginia as well as a national certified counselor, a certified clinical mental health counselor, and an approved clinical supervisor.

James Jackson, Ph.D., LPC-S, NCC, is an assistant professor and graduate counseling program coordinator at the University of Montevallo. He has experience as a school counselor, outpatient therapist, and group and foster home therapist, and he continues to provide services through his private practice in Montevallo, Alabama. James's interests include diversity, identity development, social justice, and self-care. Moreover, as a former professional touring musician, James enjoys integrating creative activities in his work with those he serves in clinical and educational settings.

Jennifer Jordan, Ph.D., is an associate professor and director of the counseling and development program at Winthrop University. She is also the director of the Winthrop Community Counseling Clinic. She serves as executive director of the South Carolina Counseling Association and is vice president of the South Carolina Board of Examiners for Licensure of Professional Counselors, a marriage and family therapist, and a psycho-educational specialist.

Robin Lee, Ph.D., is a professor in the professional counseling program of the Womack Educational Leadership Department at Middle Tennessee State University, specializing in mental health counseling. Dr. Lee earned a Ph.D. in counselor education and supervision from Mississippi State University, and an M.Ed. in community counseling and B.A. in psychology from Delta State University in Cleveland, Mississippi. Dr. Lee is a licensed professional counselor with Mental Health Service Provider status in Tennessee, a national certified counselor, and an approved clinical supervisor.

Jason M. McGlothlin, Ph.D., PCC-S, is an associate professor in the counselor education and supervision program at Kent State University (KSU). He earned his doctorate in counselor education from Ohio University and is currently a Professional Clinical Counselor with Supervisory endorsement (PCC-S) in Ohio. Prior to joining the KSU faculty, he practiced in community mental health, private practice, and suicide prevention/hostage negotiation facilities. His areas of teaching, service, publication, and research include the assessment, prevention, and treatment of suicide. He is the author of *Developing Clinical Skills in Suicide Assessment, Prevention and Treatment* (American Counseling Association, 2008) and the founder of the SIMPLE STEPS model for suicide assessment.

Amy L. McLeod, Ph.D., is the Counseling Department chair and an associate professor at Argosy University Atlanta. Dr. McLeod's research interests include counselor education and supervision, multicultural issues, women's issues, assessment, and crisis intervention.

John Muldoon, Ph.D., LPC, CAAP, is a specialist professor at Monmouth University. Dr. Muldoon has a doctorate in counselor education from the University of South Carolina. He is also a co-occurring and substance abuse counselor. Previously, Dr. Muldoon was the director of a batterer intervention program for domestic violence and worked at multiple levels of care with people who had substance abuse issues. Dr. Muldoon is licensed as a professional counselor in New Jersey, South Carolina, and Pennsylvania. He is also a Certified Addictions Professional in Florida. Dr. Muldoon's teaching interests include substance abuse treatment, group counseling, and counseling theory and techniques. His major areas of research are in domestic violence, substance use, aging issues, and trauma.

Latofia Parker, Ph.D., NCC, CRC, is an assistant professor in the graduate program in counseling at the University of Montevallo. She has counseling experience working with individuals and families in rehabilitation counseling. She earned her M.S. in rehabilitation counseling from Troy University and her Ph.D. in counselor education from the University of Alabama. She has experience

in helping individuals and families deal with the onset of disability and other health-related crises. As a professor, she integrates concepts of self-awareness, counselor's wellness, and crisis prevention/intervention throughout all her courses.

Elizabeth Schuler is a master's level graduate student in clinical mental health counseling at Middle Tennessee State University. She received her B.Sc. at Middle Tennessee State University. Her interests include relationship dynamics, adolescence, and family issues.

William R. Sterner, Ph.D., LCPC, ACS, NCC, is an associate professor in the Department of Counseling at Marymount University. He worked for a number of years as a clinical mental health counselor and drug and alcohol counselor in various community counseling settings. He is in private practice in Maryland and is an approved clinical supervisor. He also has experience in conducting drug and alcohol assessments, case management, and treatment placement with clients in the criminal justice system. His research interests include supervision, quantitative methodology, spirituality issues in counseling, substance abuse, incivility issues in higher education, and counselor competencies in assessing and managing suicidality.

Laura L. Talbott-Forbes, Ph.D., MCHES, is an associate professor in the Department of Human Studies at the University of Alabama at Birmingham. She has served as a prevention specialist with general college student health issues and director of substance abuse prevention programs at a large university. Her research interests include the prevention of substance abuse, education and early intervention with potentially suicidal persons, and other public health issues that impact young adult health.

Carrie Wachter Morris, Ph.D., NCC, ACS, is an associate professor of Counseling and Educational Development at the University of North Carolina at Greensboro, where she coordinates the school counseling track. She served as president (2015–2016) of the Association for Assessment and Research in Counseling (AARC). She has nearly two dozen articles in national peer-refereed journals, one book, and an additional 10 chapters in different works. She presents regularly at state, regional, and national conferences on topics related to the scholarship of teaching and learning in counselor education, crisis, and school counselor education.

CHAPTER

1 Basic Concepts of Crisis Intervention

Lisa R. Jackson-Cherry, Jason M. McGlothlin, and Bradley T. Erford*

PREVIEW

Crises occur in a variety of settings for a variety of reasons. Responses to crises can come in various forms and can include multiple levels of complexities. In this chapter, basic frameworks for assessing and conceptualizing crises are presented, along with a discussion of how crisis intervention may differ from traditional counseling.

A BRIEF INTRODUCTION TO CRISIS INTERVENTION

If asked to think about a crisis, what comes to mind? Natural disasters? School shootings? Suicide? Domestic violence? How do some people survive crisis events adaptively and with resilience, while others endure mental health issues for months, years, or a lifetime? To begin, situations such as tornadoes, earthquakes, acts of terror, and suicide do not in and of themselves constitute crises. A crisis is an event that may or may not be perceived as a disruption in life. A crisis does not necessarily lead to trauma. Typically, a crisis is described using a trilogy definition; that is, there are three essential elements that must be present for an event to be considered a crisis: (1) a precipitating event, (2) a perception of the event that leads to subjective distress, and (3) diminished functioning when the distress is not alleviated by customary coping mechanisms or other resources.

When terrorists bombed the World Trade Center in New York City in 1993, the crisis was experienced by many individuals and families. Six families lost loved ones, approximately 1,000 individuals were injured, and the jobs, careers, and work of countless people were interrupted. Using the trilogy definition, it is obvious that all of those who experienced diminished functioning following the crisis event experienced trauma. People throughout the rest of the world, however horrified, continued to function as normal. For these individuals, the crisis event was not perceived as traumatic and it did not disrupt their everyday lives.

James and Gilliland (2017) reviewed a number of definitions of crisis that exist in the literature and summarized crisis as "a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms" (p. 3). When a crisis is perceived as disruptive to one's life, the

*The authors wish to acknowledge Dr. Stephanie Puleo for her outstanding contributions to the first two editions of this chapter.

crisis may be experienced as a traumatic event. Fortunately, most individuals can work through crisis events. For many who experience a crisis, the experience can assist in preventing or working through future crises, therefore decreasing trauma in the future. No formula exists that explains why some individuals can work through a crisis, while others who experience the same crisis find it traumatic and disruptive to daily functioning. Therefore, the idea that an individual's perception of an event determines whether the event will become traumatic is paramount to understanding an individual and making a plan of action for him or her. However, an individual's perception of an event can be influenced by various determinants, such as the individual's level of resilience, resources, coping mechanisms, and support system.

Often a crisis can lead to additional crises that can be debilitating and impact not only the person affected but also the entire family or community system. When a person encounters multiple crises, or when past crises the person was exposed to were not resolved effectively, the person or system could experience trauma. When a person experiences trauma, he or she may need assistance from a crisis counselor to assess the situation, evaluate options for adjusting to the crisis, explore resources currently available to the client, work through the current crisis, and connect with new resources and referrals. As a first exposure to the potential characteristics of a crisis, see Case Study 1.1 and answer the discussion questions that follow. Also read Voices from the Field 1.1.

CASE STUDY 1.1

The Nguyens: A Natural Disaster Affects a Family System

Vin and Li Nguyen are recent immigrants to the United States. They reside in a small town along the Gulf Coast of Mississippi, where a number of other Vietnamese immigrants have settled. Like many new members of the community, the Nguyens are learning to speak, read, and write English and are hoping to become naturalized citizens of the United States someday. After arriving in the United States, the Nguyens invested all of their money in an old shrimp boat in order to support themselves by selling their daily catch to local seafood processing facilities.

Recently, the shrimp boat was heavily damaged, and the seafood processing facilities were destroyed by a hurricane. Subsequently, the Nguyens had no income for quite a while. With limited income and no health insurance, they relied on the county department of public health for prenatal care when Li became pregnant. Li's pregnancy progressed normally; however, her daughter was born with spina bifida. As you read this chapter, try to conceptualize the Nguyens' situation according to the crisis models presented.

Discussion Questions

1. What incidents have occurred in the Nguyens' lives that could be considered provoking stressor events?
2. Beyond the provoking stressor events, are there additional stressors that the Nguyens must address?
3. What resources are the Nguyens using?
4. What additional information do you need to determine whether the Nguyens are in crisis?
5. What factors will predict the outcome for this family?

VOICES FROM THE FIELD 1.1

My First Day

Beth Graney

I spent the summer planning all the classroom lessons and groups I would offer students in my first position as the only school counselor in a K–12 school in rural Iowa. After the principal shared with me that the previous counselor never really connected with many of the kids, I knew I needed to be especially creative to win their trust. The principal told me the town had a saying, "If you aren't born here, you're not from here!" How would a big city girl from Chicago ever fit in?

All of these thoughts raced through my head, drowning out the din of my radio as I drove the 20 miles to school. The newscaster's report that a couple died in a motorcycle accident the previous night barely registered. When I arrived early that morning, the principal greeted me at the door and pulled me into her office. "The parents of two of our students died last night, and other students have arrived at school crying. You have to do something," she blurted as she hurried off to take care of notifying the rest of the staff. My mouth went dry and my thoughts started to race. What should I say? What should I do? What strategies would be most effective? More importantly, I thought, I don't know a single student in this building!

As I entered the large classroom that was now my office, I saw 20 kids ranging in age from early elementary to high school. As I put down my bag on the desk, I looked at all of the crying kids, pulled up a chair, and said, "Who wants to start?" Someone began with, "They are my friends, my neighbors, and our classmates!" I listened. Soon another child said, "My grandma is sick," and then another said, "My dad lost his job," and "My parents are getting divorced." I listened. As the morning progressed, some kids went on to class, others went home, and more came from class or home to share their grief and fears with the group. I listened some more. When the long day finally ended, I didn't know everyone's name that I had written on the sign-in sheet by memory, but I had a growing sense of community.

Two days later, after listening to many students and teachers explain how this tragedy had affected them, the principal told me the funeral service would be held in the gym because the gathering would be so large. She thought it would be important for me to be there to support the kids in case anyone needed immediate assistance. I listened as the minister and other family members eulogized the parents. After the service, I met many of the parents and community members, and again I listened to their grief and pain. When a person dies, the family and friends grieve. But in a small town, when someone dies, the whole town grieves.

As I drove home that day, I felt drained and wondered whether I had been helpful because I had no great insights or strategies to offer the students or parents as to why something so difficult and tragic had happened. All I really did was listen. It was then that it struck me that it was the first skill ever taught in my graduate counseling program: Listen! And so began one of my most memorable years in counseling. My phone didn't stop ringing and my sign-up sheet was never empty. I made the transition from big city girl to rural school counselor simply by listening.

CRISIS INTERVENTION THEORY

The study of crisis intervention began and has been documented in earnest since the 1940s in response to several stressor events. During World War II, numerous families experienced disorganization and changes in functioning after individual family members left home to participate in the war effort. In most cases, disorganization was only temporary and families found ways to adjust. Families that had the most difficulty reorganizing and adapting to the absence of their loved ones seemed to experience the greatest degree of distress. Studies of families in crisis following war separation led Reuben Hill (1949) to propose a model through which family stress and crisis could be conceptualized by taking into account the family's resources, perception, and previous experience with crises. Additional research on families and crisis events was launched

following a more acute stressor event, the Cocoanut Grove nightclub fire that claimed nearly 500 lives in Boston, Massachusetts. Studies of the responses of the survivors of the fire, family members of those who died, and the community illuminated some common reactions to such a traumatic event and led Gerald Caplan and Erich Lindemann to propose recommendations for responding to community crises. In the decades following the 1940s, the original models proposed by Hill, Caplan, and Lindemann were expanded, with more attention to contextual variables and outcomes.

Caplan and Lindemann are often credited as pioneers in the field of crisis intervention. Their work began after the Cocoanut Grove nightclub fire, in which so many people died in Boston in 1942. Lindemann, a professor of psychiatry at Harvard Medical School and Massachusetts General Hospital, worked with patients dealing with grief following traumatic loss. Although many people died as a result of the fire, hundreds who were at the nightclub on that fateful night survived. The survivors and the grieving relatives of those who perished provided Lindemann with an opportunity to study psychological and emotional reactions to disaster. Based on his interviews with those who survived the fire as well as relatives of the deceased, Lindemann (1944) outlined a number of common clinical features, including somatic distress, feelings of guilt, hostility, disorganization, behavioral changes, and preoccupation with images of the deceased. Lindemann referred to these symptoms as "acute grief," which was not a psychiatric diagnosis but was a call for intervention nonetheless. Today, many of the symptoms of acute stress disorder identified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association [APA], 2013) seem to parallel Lindemann's description of acute grief.

In addition to describing clinical features of acute grief, Lindemann outlined intervention strategies for dealing with the symptoms. Because acute grief was not considered a psychiatric diagnosis per se, Lindemann suggested that helpers other than psychiatrists could be of assistance. This idea was further fueled by the large number of people in need of intervention following the Cocoanut Grove fire, and became a cornerstone in the conceptualization of community mental health.

In response to the needs of the number of people experiencing acute grief following the nightclub fire, Lindemann worked with his colleague Gerald Caplan to establish a community-wide mental health program in Cambridge, Massachusetts, known as the Wellesley Project. By studying and working with individuals who had experienced loss through the fire or similar traumatic events, Caplan developed the concept of "preventive psychiatry" (Caplan, 1964), which proposed that early intervention following a disaster or traumatic event can promote positive growth and well-being. Lindemann's "basic crisis theory" introduced the field to focus on crisis intervention as a distinct area in the helping field requiring specific interventions. His theory allowed others to build upon and develop alternative perspectives. Crisis intervention is not the same as brief therapy. Brief therapy attempts to decrease symptoms associated with ongoing mental health problems. Crisis intervention attempts to assist individuals who are experiencing temporary affective, behavioral, and/or cognitive symptoms associated with a crisis event.

Building on Caplan's model, Beverley Raphael (2000) coined the term "psychological first aid." Following a train accident in Australia in 1977 in which many people died, Raphael worked with bereaved families and injured survivors of the train disaster. She advocated for attention that included comfort and consolation, immediate

physical assistance, reunification with loved ones, an opportunity to express feelings, and support during the initial period of time following a traumatic event. In particular, she described the need to consider Maslow's hierarchy of needs, and the importance of attending first to basic survival needs before attempting more traditional forms of counseling (James & Gilliland, 2017). In describing crisis reactions, Raphael noted that the full impact of trauma may be experienced a considerable time following the initial crisis event, thereby leading an individual to undergo a period of "disillusionment." Much of her work subsequent to the 1977 train accident focused on the prevention of post-traumatic stress disorder (PTSD).

In his classic work, Caplan (1961) offered this explanation:

> People are in a state of crisis when they face an obstacle to important life goals—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 solution are made. (p. 18)

What is important to note in Caplan's description is that the concept of crisis refers to an outcome of a precipitating event, not to the precipitating event itself. Similar to more recent definitions of *crisis*, Caplan described the outcome, or the crisis, as the state of disequilibrium that is experienced.

There are several schools of thought pertaining to crisis theory, and the concept of disequilibrium following a stressful event seems to be common to all of them. Some theories focus on the disequilibrium experiences of individuals, while others take a more contextual, systemic stance. Many researchers and theorists take the point of view that the disequilibrium that constitutes a crisis can be understood by examining an individual's past experiences, cognitive structures, behaviors, and competencies. In their studies on hysteria, Freud and Breuer (2004) concluded that many of the neurotic symptoms that contributed to clients' states of equilibrium were repressed memories of past traumatic events. Their disequilibrium was sustained by destructive defense mechanisms.

Other crisis theorists contend that the disequilibrium is the result of ineffective psychological tools, such as negative or faulty thinking, poor self-esteem, and maladaptive behavior. According to "adaptational" theory (James & Gilliland, 2017), individuals who become incapacitated or dysfunctional following stressful events are those who perceive and interpret stressful events negatively. Negative thoughts, irrational beliefs, and defeating self-talk lead to paralyzing rather than helpful behaviors. From a cognitive-behavioral perspective, crises may be ameliorated when individuals replace their faulty thinking and ineffective behaviors with more positive thoughts and adaptive behaviors. From an interpersonal perspective, self-confidence and self-esteem also counter the disequilibrium of crises as individuals become more focused and reliant on their own abilities.

Applied crisis theory comprises four crisis domains: developmental, situational, existential, and ecosystemic crises (James & Gilliland, 2017). *Developmental crises* are events that are expected to be experienced by the majority of individuals during normal development. However, for some, the developmental crisis event could cause considerable trauma. Examples of developmental crises include pregnancy, graduation, retirement, career transition, and aging. *Situational crises* are events that are often unexpected

and involve some degree of a catastrophic, shocking, or random act. Examples of situational crises include a terrorist attack, a sexual assault, job loss, an accident, and a sudden illness. *Existential crises* may or may not involve religious faith or spirituality but are events that affect one's sense of meaning, purpose, freedom, independence, forgiveness, shame, or other core beliefs. *Ecosystemic crises*, which include natural or human-caused events, impact not only the individual but also any of the systems (families, schools, communities) connected with the crisis event.

It is important for the crisis counselor to understand the individual's perception of a crisis before categorizing the crisis into one or more of the four crisis domains. The reason is that the crisis domain acts as a framework for understanding the individual's perception of the event and its effect on his or her life. For example, consider the case of a woman who enters a crisis center pregnant. Initial observation may lead a crisis counselor to assume that the woman is experiencing a developmental crisis. However, upon learning that the pregnancy is the result of a rape, the crisis counselor may categorize the pregnancy as a situational crisis. It is also possible that the woman is thinking of terminating the pregnancy, which may have forced her into an existential crisis because following through would conflict with her religious beliefs. As this example indicates, a crisis must be understood by how it is perceived by the individual affected by it.

Regardless of the theory adopted, crisis intervention requires that a crisis counselor undertake a series of tasks to understand the client's circumstances, ameliorate the most harmful aspects of the crisis, and help return the client to precrisis or baseline functioning as safely, quickly, and efficiently as possible. Theories are assumptions about *why* an individual may experience a crisis and perceive it as traumatic. Theories provide a rationale or explanation that informs a crisis counselor's guiding practice, or *how* a crisis counselor works through the crisis with a client. This guiding practice is one's model of practicing in crisis intervention.

THE TASK MODEL OF CRISIS ASSESSMENT AND INTERVENTION

The task model of crisis assessment and intervention, developed by Jackson-Cherry (2018) for this third edition (see Table 1.1), focuses on four important areas of crisis assessment that lead to an effective four-task intervention plan for individuals in virtually every type of crisis, regardless of setting. Assessment of safety and stabilization; bio-psycho-social-spiritual elements; clarification of the problem(s); and coping skills, resources, and supports are essential first steps toward more accurately defining the actual crisis situation. Only when a thorough assessment is completed can an effective crisis plan be developed to address the actual problem(s). In traditional counseling, the definition of the problem may be very clear and the plan may follow a prescribed sequence. However, due to the complex nature of individuals in crisis, a reliable and valid definition of the problem can only be clarified after appropriate and comprehensive assessment tasks are completed and followed by an appropriate crisis plan.

Four Essential Crisis Assessment Tasks

ASSESSMENT TASK 1: ADDRESS SAFETY, STABILIZATION, AND RISK A crisis counselor should always maintain a sense of safety for self and others (see Chapter 2). Safety should be the main priority for the client, community, and counselor. Therefore, a thorough risk

TABLE 1.1 The Task Model of Crisis Assessment and Intervention (Jackson-Cherry, 2018)

Level I: Four Essential Crisis Assessment Tasks
Assessment Task 1: Address Safety, Stabilization, and Risk
Assessment Task 2: Follow a Holistic Bio-Psycho-Social-Spiritual Approach
Assessment Task 3: Clarify the Problem(s)
Assessment Task 4: Explore Coping Skills, Resources, and Supports
Level II: Four Essential Crisis Intervention Tasks
Intervention Task 1: Normalize and Educate
Intervention Task 2: Explore Options
Intervention Task 3: Develop a Plan and Obtain a Commitment
Intervention Task 4: Prepare Documentation, Follow Up, and Provide Referrals

assessment should be the first step in the assessment and the main goal for the counselor. Due to the nature of a crisis, risk should be assessed at varying times throughout crisis intervention. A client may be referred (or self-referred) for a perceived presenting problem that is not the primary problem causing the difficulties, and the client could present with varying degrees of lethality (i.e., none, low, moderate, or high) and types of risk (i.e., homicidal, suicidal). Lethality must always be assessed at the beginning of the relationship. If any degree of lethality is present, a comprehensive plan must be discussed with the client and documented. Not assessing for risk in a crisis situation, or waiting until the end of a session to conduct such an assessment that is not thorough, is negligent. If a person were to leave a session and follow through with suicidal or homicidal ideation or behavior that was not thoroughly assessed, the standard of care could be questioned. Adhering to the standard of care is a primary focus of Assessment Task 1, and if lethality is present, it should continue to be a focus in subsequent steps.

Often a person who is at risk may not initially report ideation or intentions of suicidal or homicidal behavior. Clients need to know that the crisis counselor is willing to explore the delicate issues that are leading to thoughts or behaviors of suicide or homicide, can provide an emotionally safe environment, and is competent to assist with an appropriate plan. Allowing for an open and thorough assessment helps clients understand that the counselor is fully present, cares, and is competent to assist with lethal thoughts. An assessment of safety and lethality actually enhances the rapport between the client and counselor. Importantly, if a client is experiencing intense crisis circumstances that affect the client's baseline functioning, then it is unlikely that the counselor and client can collaboratively progress through the essential intervention tasks that follow. A client has to be stabilized enough to progress through the intervention tasks of this model and collaborate in the intervention plan. Thus, client stabilization is the main focus before moving forward with additional tasks. If the client is unable to work collaboratively toward the additional tasks and unable to implement life-saving plans, the main goal for the counselor should be for the immediate safety of the client or others, and options for intensive care, including hospitalization, should be pursued.

ASSESSMENT TASK 2: FOLLOW A HOLISTIC BIO-PSYCHO-SOCIAL-SPIRITUAL APPROACH

Next, crisis counselors should thoroughly assess a client for physical, medical, substance, psychological, social, spiritual, and other concerns. Often, individuals experience a crisis because of medical issues such as pain associated with a physical condition or noncompliance with medical practices (including medication noncompliance); religious/spiritual and/or other existential conflicts; and other reasons. These medical issues often present with symptoms consistent with mental health issues during a crisis. If medical and other issues the client faces are not assessed, the diagnosis of the client may be incorrect, leading to an ineffective and inappropriate treatment plan or referral. Without this kind of assessment, the root problem will never be addressed and symptoms may actually increase over time, making the situation worse for the client. A comprehensive assessment of all of these considerations must be conducted in order to determine the cause of or connection to the perceived or actual crisis event.

A medical assessment may include questions such as the following:

- When was your last medical examination?
- Have you presented to the emergency room or another physician with an acute or chronic medical complaint? How often? When was the last visit?
- Have you been diagnosed with any medical condition(s)? Have you been prescribed any medications for the medical condition(s)? Have you been compliant with the recommended medication regimen? If not, what has prevented you from continuing to take the medications as prescribed? Has the medication affected your thoughts, mood, or behaviors? What was your life like prior to the medical condition(s)?
- Have you had medical complaints that are not being addressed by a medical doctor?
- Have you had any recent injuries? When was the injury? Did you receive medical attention? What was the treatment plan set by the physician? Have you been compliant with the treatment plan? Has there been a follow-up? Have you felt your mood change since the injury? If so, in what ways? What was life like prior to the medical condition(s)?

These questions begin the process of the ABCDE assessment and a described baseline.

It is essential to assess the baseline functioning of the client during the present crisis situation and prior to the crisis. Later, the goal may be to formulate a plan that moves the person back to precrisis functioning or to develop a new baseline. Most crisis models follows an ABC (affect, behaviors, cognitions) assessment approach. However, this task model follows an ABCDE assessment approach (*A*ffect, *B*ehaviors, *C*ognitions, *D*evelopment, and *E*nvironment). Keep in mind that while some assessment measures may fall into more than one category, all impact the overall assessment.

Affect consists of how a person presents during the assessment and may include nonverbal communication. Is the client withdrawn, distant, restrictive in speech or space, agitated, incongruent in presentation, and so on?

Behaviors are assessed to determine a person's response to and potential to move through the crisis. For example, since the precipitating crisis, what has the client done (or not done) in response to the crisis event? What resources has the person accessed or not accessed? How have the person's eating habits, sleep, work, and normal activities

and behaviors changed from before the crisis? What is preventing the person from moving toward the behaviors that were evident in precrisis daily living?

Cognitions, or thoughts, include thinking patterns, distortions, and deficiencies. In most situations, cognitions affect behaviors and how a person presents emotionally (i.e., affect). Are cognitive distortions present that are preventing the person from moving personal behaviors toward the precrisis or new baseline functioning? Are cognitions restrictive? For example, does the client believe no actions will improve the situation? For risk assessment, does a person believe that there is only one way to "fix" the problem (e.g., suicide, homicide), and is the person not willing to evaluate other options in the development of a plan?

In addition to the ABC assessment commonly used as the main criteria in the field, crisis counselors should understand the appropriate development and environment factors that may affect a person's response to a crisis. A person's response and functioning should be assessed based on normal levels of *development*, and plans should be made based on the developmental functioning level of a client. How does a client's current functioning abilities affect how he or she perceives the crisis? Are there limitations in the cognitive processing domain (e.g., how clients frame and perceive problems)? How do physical or emotional limitations affect the client's ability to use resources or follow through with a plan? For example, a young adult with autism spectrum disorder may need a plan established with goals appropriate for his functional level and ability to process the situation, which may be far different from a person not diagnosed with autism spectrum disorder. A person with a lower intellectual ability attempting to process the impact of the death of a parent will need to be given information in a very different way, with more concrete and simplified information than a person of normal intellectual ability.

The *environment*, which includes common multicultural components (e.g., socioeconomic status, religious or spiritual influences, racial and ethnic identification with groups, sex, resilience, physical disabilities, sexual orientation, educational level), must also be assessed and considered. In addition, personality characteristics formed by these components may promote or hinder moving past the crisis. For example, if a client is experiencing a spiritual crisis and in the past relied on a religious or spiritual leader to cope, a referral to the person's religious or spiritual leader may be crucial for intervention. However, this client, feeling guilty and intimidated by the perceptions and judgment of others, may not act (behavior) on this past coping skill in contacting a spiritual leader if the person believes (irrational cognitions) that a Higher Power will never forgive the action that is causing such emotional and spiritual pain.

A thorough ABCDE assessment allows the counselor to obtain information that is useful in developing a plan to get the person back to precrisis baseline functioning or to develop a plan to create a more stable new baseline.

ASSESSMENT TASK 3: CLARIFY THE PROBLEM(S) Although a client may present initially with a particular problem (which should be taken into consideration), the actual problem may not be known until a complete history is taken. For example, a person may have lost a life partner 5 years ago, but the death of the partner's pet may be the actual crisis due to the meaning placed both on the pet and the significant other relationship. Counselors should be aware that a client may be facing multiple crises, since an event may affect many parts of the client's life and cause multiple traumas or retraumatization.