Part I

Theories and Models of Crisis Management
1
Introduction

LIFE CRISIS: HELPING WHEN THE STAKES ARE HIGH

The intense personal cost—both physical and psychological—of tragedies such as the one reported above is all too familiar to mental health practitioners. The idea that the poor resolution of life crises (here the attack and its aftermath) can lead to long-range psychic damage has been one of the cornerstones of crisis theory (Caplan 1964).

In some cases, the possibility of any future adjustment is cut short, as these newspaper headlines indicate:

Distraught husband kills wife and self.
Student dies in plunge from tower.
Vietnam veteran holds family of four hostage.


For many people, insurmountable problems and life stresses build to such a point that something has to give. Physical harm—to self, family/friends, or even strangers—can be the tragic result.

Historically, however, the concept of crisis has been understood in a positive sense as well. The Chinese symbol for crisis indicates both danger and opportunity. Webster defines crisis as a “turning point,” suggesting that the turn can be for good or ill, better or worse. This view of crisis became especially apparent in the popular literature of the 1970s that created tremendous public interest in developmental crises or passages through expected life events (Sheehy 1976). Midlife crisis took its place alongside adolescent identity crisis as a stage which, if properly understood, would help explain seemingly unexplainable behavior, and help families to cope with difficult events.

What makes one crisis result in growth and another result in immediate harm or subsequent psychological problems? An initial consideration is the severity of the event touching off the crisis. Some occurrences, such as death of a loved one or physical attack, seem in and of themselves to have crisis potential. An individual’s personal resources make up a second set of key variables. Whether born that way, or seasoned through life experience, some people are better equipped than others to cope with life’s stresses.

A third set of variables includes the social resources present at the time of crisis. Who is available to help in the immediate aftermath of the crisis event, and what sort of assistance do these helpers provide? Since crises are characterized by a breakdown in problem-solving capabilities, outside help is critical in determining how individuals will negotiate these turning points.

Consider the case with which this chapter began—a teacher attempting to cope with the consequences of a physical attack. The first question to ask might be: “Who first knew of the crisis event, the assault?” With a few moments reflection, we might construct the following list of people who, within twenty-four hours of the attack, had some knowledge of its occurrence:

1. other students in the classroom;
2. fellow teachers/colleagues in the school;
3. the school nurse;
4. administrative superiors (principal, disciplinarian dean of the school);
5. spouse;
6. best friend(s);
7. family physician, nurse;
8. pastor/rabbi; and
9. attorney, legal assistant.

It is very likely that several of these people heard of the incident and even talked with Susan after the assault. According to the model presented in this book, each could have provided first-order crisis intervention. Whether these outsiders’ chief role was to provide medical attention, emotional support, administrative action, or legal advice, each was in a position to assist in negotiating the very critical first steps in handling the crisis and its eventual impact on Susan’s total life. What would these helpers have done? How much time would it have taken? What skills did they need?

There are a number of other questions we might ask about Susan. In the days immediately following the assault, what decisions did she face? For example, would she/could
she/should she return to the classroom? If so, when, and under what circumstances? What preparation or coaching might she need to face the class on the first day back? How would she have dealt with her administrative superiors who, the newspaper account later reported, did nothing to discipline the student involved? Later Susan might consider changing careers. How would this decision be made? How about the impact of this crisis on her family? What role would they play in the ultimate resolution of the crisis? All in all, how could she have dealt better with the psychological reaction that, left untreated, affected both her personal life and career?

In the weeks and months following a crisis event, some people need second-order crisis intervention, or crisis therapy. This involves short-term (several weeks to several months) psychotherapy aimed at assisting individuals in working through traumatic or unsettling events so that they emerge equipped to face the future instead of closed to the prospect.

In Susan’s case, helpers in several community systems could have helped her deal with her immediate reaction, and assisted her also in making decisions about the ultimate impact of this critical event on her life. The extreme disorganization that accompanies a crisis experience will soon lead to some form of reorganization, whether positive or negative, for the victim and his/her family. A wealth of clinical data suggests that even in a tragedy such as Susan’s, there is a possibility for eventual gain. This might take the form of a change in career, an adjustment in how she handles certain aspects of her current job, the development of new coping strategies, better use of social supports, or a change in significant attitudes about life. Many times these seemingly random events provide the occasion for a person in crisis to rework old conflicts so that psychological health is actually enhanced.

Some people, especially those whose social supports are readily apparent, and those whose ego strength is great, work through this process without formal outside help. Others, like Susan, do not. For these people, the assistance of a trained therapist or counselor can be very important. The list of possible community settings for such services might include:

1. community mental health centers;
2. hospitals;
3. pastoral counseling centers; and
4. private practitioners.

Susan might have been referred to one or more of these by any one of those who first had contact with her. She might eventually have received short-term therapy from a nurse practitioner working as part of a family-oriented health care team, or from a clinical psychologist, psychiatrist, social worker, pastoral counselor, or a paraprofessional trained to offer short-term therapy under supervision.

We can use the case of Susan Hudson to define crisis intervention a “a helping process aimed at assisting a person or family to survive an unsettling event so that the probability of debilitating effects (e.g., emotional scars, physical harm) is minimized, and the probability of growth (e.g., new skills, new outlook on life, more options in living) is maximized.”

This process can be broken down into two phases: first-order intervention, which is actually psychological first aid, and second-order intervention, which is best thought of as crisis therapy. Both are important in determining eventual crisis resolution. Psychological first aid needs to be offered immediately, much like physical first aid, by those who have
first contact with the victim. These procedures take only a short period of time (minutes or hours), and can be offered by a wide range of community helpers. Crisis therapy, on the other hand, is aimed at facilitating psychological resolution of the crisis. It takes more time (weeks to months), and is offered by therapists and counselors knowledgeable in specific assessment and treatment techniques. As we shall see later in this chapter, crisis intervention is something which takes place after an unsettling event has occurred, though before its ultimate resolution, whether positive or negative. We shall return to these concepts after looking first at a brief history of crisis intervention and its chief theoretical influences.

HISTORICAL BACKGROUND

The origin of modern crisis intervention dates back to the work of Eric Lindemann and his colleagues following the Coconut Grove fire in Boston on November 28, 1942. In what was at that time the largest single building fire in the country’s history, 493 people perished when flames swept through the crowded Coconut Grove nightclub. Lindemann and others from the Massachusetts General Hospital played an active role in helping survivors, those who had lost loved ones in the disaster. His clinical report (Lindemann 1944) on the psychological symptoms of the survivors became the cornerstone for subsequent theorizing on the grief process, a series of stages through which a mourner progresses on the way toward accepting and resolving loss. Lindemann came to believe that clergy and other community caretakers could play a critical role in helping bereaved people through the mourning process, thereby heading off psychological difficulties later in life. This concept was further operationalized with the establishment of the Wellesley Human Relations Service (Boston) in 1948, one of the first community mental health services noted for its focus on short-term therapy in the context of preventive psychiatry.

Building on the start given by Lindemann, Gerald Caplan, also associated with the Massachusetts General Hospital and the Harvard School of Public Health, first formulated the significance of life crises in adult psychopathology. He stated the matter quite succinctly: “An examination of the history of psychiatric patients shows that, during certain of these crisis periods, the individual seems to have dealt with his problems in a maladjusted manner and to have emerged less healthy than he had been before the crisis” (Caplan 1964, p. 35).

If an examination of adult psychiatric patients concluded that poorly handled crises or transitions led to subsequent disorganization and mental illness, then it follows that prevention should look closely at developmental transitions of childhood and early adulthood. Caplan’s crisis theory was therefore cast in the framework of Erikson’s (1963) developmental psychology in which human beings were understood to grow or develop through a series of eight key transitions. Caplan’s interest was on how people negotiated the various transitions from one stage to another. Early on, he identified the importance of both personal and social resources in determining whether developmental crises (and situational or unexpected crises as well) would be worked out for better or for worse.

Caplan’s preventive psychiatry, with its focus on early intervention to promote positive growth and minimize the chance of psychological impairment, led to an emphasis on mental health consultation. Since many of these early crises could be identified and even predicted, it became important to alert and train a wide range of community practitioners on how to help children and young adults manage this disorganization. The role of the men-
tal health professional became one of assisting teachers, nurses, clergy, guidance counselors, and others in learning how to detect and deal with life crises in community settings.

In the early sixties, the suicide prevention movement grew rapidly in the United States, resting in part on Caplan’s crisis theory. Centers such as Los Angeles Suicide Prevention and Crisis Service, and Erie County (Buffalo) Suicide Prevention and Crisis Service offered 24-hour, 365-day hotlines aimed at preventing suicide. Linked to the social activist mentality of the 1960s, the centers relied heavily upon the efforts of nonprofessional and paraprofessional volunteers in their telephone counseling programs (McGee 1974). While the centers’ early identification was with the prevention of suicides, most moved rather quickly toward an intervention approach aimed at providing assistance for a wide range of crises. The idea was to make supportive counseling immediately available by telephone, any time, day or night. This approach was further developed to include an outreach function where workers would, when necessary, travel to homes, bus stations, playgrounds, and the like, to provide onsite intervention (McGee 1974). Techniques uniquely suited to telephone crisis intervention had to be developed (Fowler and McGee 1973; Knickerbocker and McGee 1972; Slaikeu et al. 1973; Slaikeu et al. 1975). The chief theoretical framework for this work rested with the life crisis orientation of Caplan. Whether crises of suicide, divorce, unemployment, spouse abuse, or adolescent rebellion, the idea was to understand the severe disorganization and upset in terms of the crisis theory.

Running parallel to the growth of the suicide prevention centers was the formal emergence of the community mental health movement in the United States. As a means of implementing the recommendations of the U.S. Congress’ Joint Commission on Mental Illness and Health, 1961, and with the active support of the Kennedy Administration, Congress passed the Community Mental Health Centers Act in 1963. Congruent with the goal of providing mental health services in community settings (that is, not restricting them to hospitals) was an emphasis on early intervention aimed at keeping minor problems from developing into severe pathology. Crisis intervention and emergency services (24-hour) were considered to be an integral part of any comprehensive community mental health system, so much so that federal funding was impossible unless an emergency services component was included in any center’s programming. Though implementation of the community mental health concept faced obstacles early on (Bloom 1977), the immediacy of services component, built in a crisis framework, has endured. The balanced service system of the seventies identified five programming areas: service, administration, citizen participation, research and evaluation, and staff development. The service area was broken into eight subheadings, two of which (crisis stabilization and growth) include activities covered under the Caplanian notion of intervention during life crises (Joint Commission of Accreditation of Hospitals 1979).

As crisis intervention programs were developed in the sixties and seventies, intervention literature began to emerge. Numerous case reports on how to help individuals and families in crisis appeared in the psychiatry, psychology, nursing, and social work journals. Journals were published dealing specifically with crisis topics, such as Crisis Intervention and Journal of Life Threatening Behavior. A number of practical instructional books on “how to” do crisis intervention were published (Aguilera et al. 1974; Crow 1977; Hoff 1978; McMurrain 1975; Puryear 1979), accompanied by edited books of readings (Lester and Brockopp 1973; Specter and Clairborne 1973).
During this time researchers also turned attention to program evaluation in crisis centers (Fowler and McGee 1973; Heaton et al. 1972; Knickerbocker and McGee 1972; Slaikeu et al. 1975; Slaikeu et al. 1973). By the late 1970s, enough studies had been generated to merit several important reviews (Auerbach and Kilmann 1977; Baldwin 1979; Butcher and Koss 1978; Butcher and Maudal 1976; Smith 1977).

With its reliance on short-term treatment, crisis intervention became even more valued as economic constraints led to an emphasis on diligent use of scarce resources. For example, Cummings and his colleagues at Kaiser Permanente in California demonstrated the cost-effectiveness of short-term psychotherapy (average of 6.2 sessions) in a prepaid health plan (Cummings 1977). Innovative short-term therapy was found to be more effective than long-term psychotherapy, with the cost being offset by the savings from reduced future medical care. Crisis intervention therefore plays an important role in comprehensive health service packages.

Beyond the need to economize, however, the renewed interest in crisis intervention was sparked by the provocativeness of the crisis concept: Emotional pain and suffering is time-limited and holds potential for both positive and negative long-range outcomes. As Viney (1976) points out, the crisis concept...

... avoids much of the pessimistic, devaluing, even invalidating approach we...often make to patients, by viewing crises as part of normal development, by emphasizing positive coping rather than negative defensive maneuvers and by proposing crisis resolutions which allow for growth as well as regression (p. 393).

Similarly, Baldwin (1979) suggests that the crisis intervention model, by virtue of its strong interdisciplinary character in both theory and practice, may lend a unifying influence among health professionals. Its ideas are congruent with the increasing emphasis on the interconnectedness of health and mental health care in treating the whole person.

THEORETICAL INFLUENCES

Moos (1976) identifies four theoretical influences on crisis theory. The first is Charles Darwin’s theory on the evolution and adaptation of animals to their environment. Darwin’s notion of the survival of the fittest examines the struggle for existence of living organisms in relationship to their environments. Darwin’s ideas led to the development of human ecology whose distinctive hypothesis is that the human community is an essential adaptive mechanism in humanity’s relation to the environment (Moos 1976, p. 6).

A second theoretical influence stems from psychological theory regarding human fulfillment and growth. The basic questions concern motivation and drive: What keeps people going and to what end? Freud’s idea that motivation is an attempt to reduce tension, that motivation is grounded in sexual and aggressive drive, was challenged in later years by theorists such as Carl Rogers (1961) and Abraham Maslow (1954), who emphasized positive human growth and fulfillment. Both focused on human beings’ tendency toward self-actualization and urge to enrich experience and expand horizons. Maslow’s study of outstanding contemporary and historical figures (Abraham Lincoln, Albert Einstein, Jane Addams, and Eleanor Roosevelt) revealed life styles characterized by spontaneity, social interests and altruism, friendships, relative independence of extreme cultural influence,
ability to solve problems, and a broad frame of reference or outlook on life. The premise of human self-actualization is also congruent with the emphasis of Buhler (1962) and others that human behavior is intentional, and is constantly oriented toward seeking and restructuring goals. This latter concept is a critical cornerstone to theories that view crises as times when goals become blocked or seem suddenly unreachable.

Erikson’s (1963) developmental life cycle focus provided a third chief theoretical influence for crisis theory. Erikson’s view of eight stages, each presenting a new challenge, transition, or crisis, provided an alternative to early psychoanalytic theory that suggested that life was essentially based on events in infancy and very early childhood. Erikson’s stage theory assumed that, with each transition, subsequent development was “on the line” so to speak. An adolescent who could not resolve the crisis of identity versus role confusion by making choices about career, beliefs, and marriage partner ran the risk of clouding and confusing later adult decisions until the earlier struggle was resolved.

A fourth influence on crisis theory rose from empirical data on how human beings cope with extreme life stress. Studies in this area include coping with the trauma of concentration camps, sudden death of spouses and relatives, major surgery, slow death of a child, and disasters. Broadening this concept to include the impact of a series of smaller events, Holmes and his colleagues demonstrated a relationship between the stress associated with life events and physical health and disease (Holmes and Masuda 1973).

**THE UNIQUENESS OF CRISIS INTERVENTION**

From its earliest beginnings in the late forties, crisis intervention has had a preventive focus. Hotlines trained volunteer workers to prevent callers from committing suicide. Properly working through the grief process was assumed to prevent the possibility of maladjustment later in life. Virtually any intervention aimed at assisting people in managing life crises has been viewed as important since it might prevent psychopathology of some sort later on (Caplan 1964).

In the context of public health, prevention can take three forms (Bloom 1977; Caplan 1964). Primary prevention aims to reduce the incidence of disorders; secondary prevention aims to minimize the harmful effects of events that have already occurred; and tertiary prevention aims to repair damage long after its original onset. In this context, crisis intervention is secondary prevention, since it is a process which takes place after critical life events have occurred.

Is secondary prevention “second best”? Rather than intervening after crises have already taken place, should we not direct energy toward primary prevention which seeks to keep crises from occurring in the first place? Tyhurst (1958) answers that there will always be a critical need for crisis intervention as secondary prevention:

In such transitions as disaster, migration, or retirement, we have not been impressed by the value of preparation and planning. Unpredictability in disaster, unfamiliarity in migration and denial in retirement have, for example, all interfered with realistic preparation. Instead, as already described, we have been much more impressed by the importance of preventive measures during the period of recoil in disaster, and during analogous periods in migration and retirement. During these phases of turmoil, the individual has tried to act, his assumptions have been in question, and developments at this time will have a crucial bearing upon subsequent psychological events and upon his future health or illness . . ./
To repeat, then, with regard to the optimum time of intervention, it is our belief that increasing emphasis will have to be placed upon attempts to intervene during the period of turmoil that is so characteristic of transition states (p. 163).

To state this another way, for many people things have to get worse before they will get better. Growth can only occur after previous patterns have been destroyed and the rebuilding process takes place.

Danish and D’Augelli (1980) contend that the very concept of prevention should be replaced by enhancement and growth during crisis. They suggest that prevention language actually implies that we should keep people from experiencing crises in the first place in the hope of reducing the chance of psychological debilitation later on. As an alternative, they offer an enhancement model of human development:

... growth is preceded by a state of imbalance or crisis which serves as the basis for future development. In fact, without crises, development is not possible. Caplan (1964) recognized this quality of crisis in arguing that the way crises are resolved has a major impact on their ultimate role in mental health. In striving to achieve stability during crises, the coping process itself can result in the achievement of a qualitatively different “stability.” Thus, contrary to the view that crises are destructive, we contend that they may initiate a restructuring process toward further growth (Danish, 1977). If crises can result in either negative or positive outcomes, the goal of intervention is not to prevent crises, but rather to enhance or enrich individuals’ abilities to deal constructively with these events (p. 61).

As Table 1.1 indicates, crisis intervention can be understood as a strategy bounded on the one side by enhancement strategies (primary prevention) before critical life events occur, and on the other side by treatment strategies (tertiary prevention) administered well after the crisis events and their consequences have taken place. Crisis intervention is the strategy that takes place at the time of the severe disorganization, resulting from a crisis. As such, according to Tyhurst, it comes at the time when breakdown has occurred, and reorganization will take place, for good or ill. In developmental models it is viewed as the supreme opportunity for growth, since old patterns have been found wanting, and new ones must re-emerge. How people conceptualize the events, that is, interpret them in light of life’s expectancies and long-range goals, is critical to future development. As Table 1.1 indicates, crisis intervention is intended to reduce the probability of debilitating effects, and to maximize the probability of growth or mastery for the individual. Target populations are crisis victims and their immediate families and friends. (See Felner et al. 1981 for a description of a prevention program for young children experiencing crisis.) The chief instruments of change are front-line community caretakers, as well as counselors and therapists. This is not to suggest that many crises are not worked out naturally in community settings. Indeed, we know that this is often the case. However, for many the assistance of outside helpers will be critical in determining the ultimate resolution of the crisis. Finally, the strategies of crisis intervention are twofold: immediate psychological first aid (offered by those closest to the event) and short-term crisis therapy (offered by trained counselors and therapists).

By contrast, primary prevention takes place well before crisis events actually occur. True prevention literally means keeping some events from happening in the first place through public policy changes (e.g., reducing unemployment), and other interventions at
When the external stimulus cannot be affected, enhancement strategies aim at teaching individuals problem-solving and coping skills so that they will be better prepared to weather critical life events. Whether referred to as prevention or enhancement, these strategies take place before events occur. They are the mainstay of such fields as community psychology and community psychiatry (Danish and D’Augelli 1980; Rappaport 1977; Reiff 1975).

Treatment or tertiary prevention includes strategies whose aim is to reduce impairment and emotional disorders that result from poor resolution of life crises. Its goal is to repair damage already done to patients who are psychiatric casualties of life stress. It draws on a wide range of psychotherapeutic and pharmaceutical techniques, and is primarily the

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<th>Primary Prevention</th>
<th>Secondary Prevention</th>
<th>Tertiary Prevention</th>
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<tr>
<td><strong>Goal</strong></td>
<td>Reduce incidence of mental disorders; Enhance human growth and development through the life cycle.</td>
<td>Reduce debilitating effects of life crises; Facilitate growth through crisis experience.</td>
<td>Repair damage done by unresolved life crises, that is, treat mental/ emotional disorders.</td>
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<tr>
<td><strong>Techniques/strategies</strong></td>
<td>Public education, public policy changes re: environmental stressors; Teaching problem-solving skills to children.</td>
<td>Crisis Intervention: Psychological First Aid; Crisis Therapy.</td>
<td>Long-term psychotherapy, retraining, medication, rehabilitation.</td>
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<td><strong>Target population</strong></td>
<td>All human beings, with special attention to high risk groups.</td>
<td>Victims of crisis experiences and their families.</td>
<td>Patients, psychiatric casualties.</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td>Before crisis events occur.</td>
<td>Immediately after crisis event.</td>
<td>Years after crisis event.</td>
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<td>** Helpers/community systems**</td>
<td>Government (legislative, judicial, executive branches); schools; churches/synagogue; mass media.</td>
<td>Frontline practitioners (attorneys, clergy, teachers, physicians, nurses, police, etc.); Families/social networks; Psychotherapists and counselors.</td>
<td>Health and mental health practitioners in hospitals and outpatient clinics.</td>
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purview of mental health practitioners, whereas enhancement/prevention falls to planners and educators.

Susan Hudson’s case, as noted earlier in this chapter, illustrates the various interactions in Table 1.1. Prevention strategies would have aimed at keeping the assault from taking place in the first place. This would include efforts to reduce class size or to increase educational and staff resources in the school. Although it is possible to say that Susan herself might have taken steps to prevent this occurrence, a true primary prevention focus would have been on the school system itself. Crisis intervention would have aimed at working with Susan in the immediate aftermath of the tragedy. Its concern would have been with what occurred, the impact on Susan and her family, the relative absence or presence of strengths and resources available to her, and with helping her work through the entire episode. Its focus would be to prevent the outcome that actually occurred in her case—bitterness and debilitation two years after the fact. While it might seem naïve to talk about growth through such a tragic episode, there were possible new directions in Susan’s life after this crisis (such as new career, new approach to teaching, greater assertiveness in dealing with students and administrators). Treatment or rehabilitation would involve helping Susan years after the incident, at which time she was so closed to living (unable to return to school) that she was not fully functioning. Crisis intervention could have helped Susan to cope more effectively with the situation, and to become more open to future life experiences.

PLAN OF THIS BOOK

A review of the main topics covered in this chapter gives a clue to the approach to crisis intervention taken throughout the rest of this volume. The next chapter describes crisis theory, casting it into a general systems framework. The emphasis will be on considering any individual’s crisis in the context of family and social group, community systems, and cultural values. This will be followed by chapters devoted to analysis of both developmental and situational types of life crises. Important findings will be reviewed, with particular emphasis given to intervention implications. In Part Two, a comprehensive model for crisis intervention will be described, followed by descriptions of both first-order (psychological first aid) and second-order (crisis therapy) interventions, including an analysis of sample cases for each.

Part Three includes concrete applications of the crisis model by key practitioners in various community systems, followed by chapters on training and research on crisis intervention (Part Three).

Throughout the rest of the book, our primary concern will be with the practice of crisis intervention. Material presented will be offered with a view to its eventual application by practitioners such as those listed in Part Three. At the same time, by reference to a general systems framework for crisis theory and the intervention process (chapters 2 and 3), we will attempt to delineate directions for future research. Selected chapters will contain a research section intended primarily to summarize trends, expose gaps, and offer suggestions for further work in this area.