**The Seven-Stage Crisis Intervention Model: A Road Map to Goal Attainment, Problem Solving, and Crisis Resolution**

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This article explicates a systematic and structured conceptualmodel for crisis assessment and intervention that facilitatesplanning for effective brief treatment in outpatient psychiatricclinics, community mental health centers, counseling centers,or crisis intervention settings. Application of Roberts' seven-stagecrisis intervention model can facilitate the clinician's effectiveintervening by emphasizing rapid assessment of the client'sproblem and resources, collaborating on goal selection and attainment,finding alternative coping methods, developing a working alliance,and building upon the client's strengths. Limitations on treatmenttime by insurance companies and managed care organizations havemade evidence-based crisis intervention a critical necessityfor millions of persons presenting to mental health clinicsand hospital-based programs in the midst of acute crisis episodes.Having a crisis intervention protocol facilitates treatmentplanning and intervention. The authors clarify the distinctdifferences between disaster management and crisis interventionand when each is critically needed. Also, noted is the importanceof built-in evaluations, outcome measures, and performance indicatorsfor all crisis intervention services and programs. We are recommendingthat the Roberts' crisis intervention tool be used for time-limitedresponse to persons in acute crisis.

KEY WORDS: crisis intervention, lethality assessment, establish rapport, coping, performance indicators, precipitating event, disaster management

We live in an era in which crisis-inducing events and acutecrisis episodes are prevalent. Each year, millions of peopleare confronted with crisis-inducing events that they cannotresolve on their own, and they often turn for help to crisisunits of community mental health centers, psychiatric screeningunits, outpatient clinics, hospital emergency rooms, collegecounseling centers, family counseling agencies, and domesticviolence programs ([Roberts, 2005](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB24)).

Imagine the following scenarios:

* You are a community social workeror psychologist working withthe Houston Police Department todeliver crisis interventionservices to police, emergency responders,and survivors of HurricaneKatrina who just arrived at the HoustonAstrodome disaster shelter.It is midnight and one of the survivors(who was brutally raped1 week prior to Hurricane Katrina) wakesup screaming and throwingthings at the young man in the cotnext to hers. You were walkingout the door to drive home andget a few hours sleep, but insteadyou are called on the loudspeakerto defuse the acute crisisepisode and provide crisis interventionservices.
* You are a crisis consultant to a large Fortune 500corporation,and a volatile domestic violence-related shootingtook placelast week at the corporate headquarters. The employeeassistancecounselor, the director of training, the directorof strategicplanning, and the director of disaster planningwant you toprovide crisis intervention training to all employeeassistancecounselors and all corporate security officers.
* Youare the new psychiatrist in an inpatient psychiatric unitwith50 patients diagnosed with co-occurring disorders; overtheweekend a patient assaulted the psychiatric resident youaresupervising. The resident wants to be transferred to anotherunit of the hospital because he had a nightmare and cold sweatslast night. What do you do now? What types of training shouldbe provided to all psychiatric residents and mental health cliniciansin order to prevent patient–staff conflict from reachinga crisis point?
* You are the counseling psychologist at a stateuniversity assignedto see walk-in emergency clients. An 18-year-oldfreshman appearsone afternoon and tells you she just came fromher residencehall room and found her boyfriend in bed withher "best friend"roommate. Now she tells you she is seriouslyconsidering takingan overdose of nonaspirin pain capsules intheir presence to"teach them a lesson." How can crisis interventionhelp herto find adaptive coping skills and a more effectiveproblem-solvingapproach to her predicament?

This article delineates and discusses a systematic and structuredconceptual model for crisis intervention useful with personscalling or walking into an outpatient psychiatric clinic, psychiatricscreening center, counseling center, or crisis interventionprogram. A model is a prototype of the real-life clinical processthe crisis clinician/counselor would like to implement. A systematiccrisis intervention model is analogous to establishing a roadmap as a model of the actual roads, highways, and directionsone will be taking on a trip. Thus, the clinician can visualizethe implications of each proposed crisis intervention guidepostand technique in the model's process and sequence of eventsand make any necessary adjustments before the program is fullyoperational. The model is a series of guideposts that makesit easier to remember alternative methods and techniques, thusfacilitating the counseling process. By learning about eachcomponent or stage of a model, the clinician will better understandhow each component relates to one another and should facilitategoal attainment, problem solving, and crisis resolution.

The focus of this article is on the clinical application ofRoberts' seven-stage crisis intervention model (R-SSCIM) tothose clients who present in a crisis state as a consequenceof an interpersonal conflict (e.g., broken romance or divorce),a crisis-inducing event (e.g., dating violence and sexual assault),or a preexisting mental health problem that flares-up. Crisisstates can be precipitated by natural disasters, such as HurricaneKatrina, which took place as this article went to press. However,there is a functional difference between crisis interventionand disaster management. A large-scale community disaster suchas a major hurricane first requires disaster management, thenemergency rescue services. The first two phases address theevent itself, rather than the psychological needs and responsesof those who experienced the disaster. For some, the event willoverwhelm their ability to cope; it is those people for whomR-SSCIM is invaluable. We will discuss the differences betweendisaster management and crisis intervention later in this article.

Crisis clinicians must respond quickly to the challenges posedby clients presenting in a crisis state. Critical decisionsneed to be made on behalf of the client. Clinicians need tobe aware that some clients in crisis are making one last heroiceffort to seek help and hence may be highly motivated to trysomething different. Thus, a time of crisis seems to be an opportunityto maximize the crisis clinician's ability to intervene effectivelyas long as he or she is focused in the here and now, willingto rapidly assess the client's problem and resources, suggestgoals and alternative coping methods, develop a working alliance,and build upon the client's strengths. At the start it is criticallyimportant to establish rapport while assessing lethality anddetermining the precipitating events/situations. It is thenimportant to identify the primary presenting problem and mutuallyagree on short-term goals and tasks. By its nature, crisis interventioninvolves identifying failed coping skills and then helping theclient to replace them with adaptive coping skills.

It is imperative that all mental health clinicians—counselingpsychologists, mental health counselors, clinical psychologists,psychiatrists, psychiatric nurses, social workers, and crisishotline workers—be well versed and knowledgeable in theprinciples and practices of crisis intervention. Several millionindividuals encounter crisis-inducing events annually, and crisisintervention seems to be the emerging therapeutic method ofchoice for most individuals.

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|  | **Crisis Intervention: The Need for a Model**  |

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A "crisis" has been defined as

An acute disruption of psychologicalhomeostasis in which one's usual coping mechanisms fail andthere exists evidence of distress and functional impairment.The subjective reaction to a stressful life experience thatcompromises the individual's stability and ability to cope orfunction. The main cause of a crisis is an intensely stressful,traumatic, or hazardous event, but two other conditions arealso necessary: (1) the individual's perception of the eventas the cause of considerable upset and/or disruption; and (2)the individual's inability to resolve the disruption by previouslyused coping mechanisms. Crisis also refers to "an upset in thesteady state." It often has five components: a hazardous ortraumatic event, a vulnerable or unbalanced state, a precipitatingfactor, an active crisis state based on the person's perception,and the resolution of the crisis. ([Roberts, 2005](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB24), p. 778)

Given such a definition, it is imperative that crisis workershave in mind a framework or blueprint to guide them in responding.In short, a crisis intervention model is needed, and one isneeded for a host of reasons, such as the ones given as follows.

When confronted by a person in crisis, clinicians need to addressthat person's distress, impairment, and instability by operatingin a logical and orderly process ([Greenstone & Leviton, 2002](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB11)).The crisis worker, often with limited clinical experience,is less likely to exacerbate the crisis with well-intentionedbut haphazard responding when trained to work within the frameworkof a systematic crisis intervention model. A comprehensive modelallows the novice as well as the experienced clinician to bemindful of maintaining the fine line that allows for a responsethat is active and directive enough but does not take problemownership away from the client. Finally, a model should suggeststeps for how the crisis worker can intentionally meet the clientwhere he or she is at, assess level of risk, mobilize clientresources, and move strategically to stabilize the crisis andimprove functioning.

Crisis intervention is no longer regarded as a passing fad oras an emerging discipline. It has now evolved into a specialtymental health field that stands on its own. Based on a solidtheoretical foundation and a praxis that is born out of over50 years of empirical and experiential grounding, crisis interventionhas become a multidimensional and flexible intervention method.The roots of crisis intervention come from the pioneering workof two community psychiatrists—Erich Lindemann and GeraldCaplan in the mid-1940s, 1950s, and 1960s. We have come a farcry from its inception in the 1950s and 1960s. Specifically,in 1943 and 1944 community psychiatrist, Dr. Erich Lindemannat Massachusetts General Hospital conceptualized crisis theorybased on his work with many acute and grief stricken survivorsand relatives of the 493 dead victims of Boston's worst nightclubfire at the Coconut Grove. Gerald Caplan, a psychiatry professorat Massachusetts General Hospital and the Harvard School ofPublic Health, expanded [Lindemann's (1944)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB14) pioneering work.[Caplan (1961](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB1), [1964](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB2)) was the first clinician to describe anddocument the four stages of a crisis reaction: initial riseof tension from the emotionally hazardous crisis precipitatingevent, increased disruption of daily living because the individualis stuck and cannot resolve the crisis quickly, tension rapidlyincreases as the individual fails to resolve the crisis throughemergency problem-solving methods, and the person goes intoa depression or mental collapse or may partially resolve thecrisis by using new coping methods.

A number of crisis intervention practice models have been promulgatedover the years (e.g., [Collins & Collins, 2005](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB3); [Greenstone & Leviton, 2002](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB11);[Jones, 1968](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB13); [Roberts & Grau, 1970](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB26)).However, there is one crisis intervention model that buildsupon and expands the seminal thinking of the founders of crisistheory, [Caplan (1964)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB2), [Golan (1978)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB10), and [Lindemann (1944)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB14): theR-SSCIM ([Roberts, 1991](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB19), [1995](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB20), [1998](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB21), [2005](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB24)). It represents a practicalexample of a stepwise blueprint for crisis responding that hasapplicability across a broad spectrum of crisis situations.What follows is an explication of that model.

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|  | **Roberts' Seven-Stage Crisis Intervention Model**  |

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In conceptualizing the process of crisis intervention, [Roberts (1991](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB19),[2000](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB22), [2005](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB24)) has identified seven critical stages throughwhich clients typically pass on the road to crisis stabilization,resolution, and mastery ([Figure 1](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#FIG1)). These stages, listed below,are essential, sequential, and sometimes overlapping in theprocess of crisis intervention:

1. plan and conduct a thorough biopsychosocialand lethality/imminentdanger assessment;
2. make psychologicalcontact and rapidly establish the collaborativerelationship;
3. identify the major problems, including crisis precipitants;
4. encourage an exploration of feelings and emotions;
5. generateand explore alternatives and new coping strategies;
6. restorefunctioning through implementation of an action plan;
7. planfollow-up and booster sessions.

What follows is an explicationof that model.

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| **View larger version** (23K):[[in this window]](http://btci.edina.clockss.org/cgi/content/full/5/4/329/FIG1)[[in a new window]](http://btci.edina.clockss.org/cgi/content-nw/full/5/4/329/FIG1)   | **FIGURE 1** Roberts' Seven Stage Crisis Intervention ModelSource: Copyright © Albert R. Roberts, 1991. Reprinted by permission of the author. |

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**Stage I: Psychosocial and Lethality Assessment**
The crisis worker must conduct a swift but thorough biopsychosocialassessment. At a minimum, this assessment should cover the client'senvironmental supports and stressors, medical needs and medications,current use of drugs and alcohol, and internal and externalcoping methods and resources ([Eaton & Ertl, 2000](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB7)). One useful(and rapid) method for assessing the emotional, cognitive, andbehavioral aspects of a crisis reaction is the triage assessmentmodel ([Myer, 2001](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB15); [Myer, Williams, Ottens, & Schmidt, 1992](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB16),[Roberts, 2002](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB23)).

Assessing lethality, first and foremost, involves ascertainingwhether the client has actually initiated a suicide attempt,such as ingesting a poison or overdose of medication. If nosuicide attempt is in progress, the crisis worker should inquireabout the client's "potential" for self-harm. This assessmentrequires

* asking about suicidal thoughts and feelings (e.g., "Whenyousay you can't take it anymore, is that an indication youarethinking of hurting yourself?");
* estimating the strengthof the client's psychological intentto inflict deadly harm(e.g., a hotline caller who suffers froma fatal disease orpainful condition may have strong intent);
* gauging the lethalityof suicide plan (e.g., does the personin crisis have a plan?how feasible is the plan? does the personin crisis have a methodin mind to carry out the plan? how lethalis the method? doesthe person have access to a means of self-harm,such as drugsor a firearm?);
* inquiring about suicide history;
* takinginto consideration certain risk factors (e.g., is theclientsocially isolated or depressed, experiencing a significantlosssuch as divorce or layoff?).

With regard to imminent danger,the crisis worker must establish, for example, if the calleron the hotline is now a target of domestic violence, a violentstalker, or sexual abuse.

Rather than grilling the client for assessment information,the sensitive clinician or counselor uses an artful interviewingstyle that allows this information to emerge as the client'sstory unfolds. A good assessment is likely to have occurredif the clinician has a solid understanding of the client's situation,and the client, in this process, feels as though he or she hasbeen heard and understood. Thus, it is quite understandablethat in the Roberts model, Stage I—Assessment and StageII—Rapidly Establish Rapport are very much intertwined.

**Stage II: Rapidly Establish Rapport**
Rapport is facilitated by the presence of counselor-offeredconditions such as genuineness, respect, and acceptance of theclient ([Roberts, 2005](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB24)). This is also the stage in which thetraits, behaviors, or fundamental character strengths of thecrisis worker come to fore in order to instill trust and confidencein the client. Although a host of such strengths have been identified,some of the most prominent include good eye contact, nonjudgmentalattitude, creativity, flexibility, positive mental attitude,reinforcing small gains, and resiliency.

**Stage III: Identify the Major Problems or Crisis Precipitants**
Crisis intervention focuses on the client's current problems,which are often the ones that precipitated the crisis. As [Ewing (1978)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB9)pointed out, the crisis worker is interested in elucidatingjust what in the client's life has led her or him to requirehelp at the present time. Thus, the question asked from a varietyof angles is "Why now?"

[Roberts (2005)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB24) suggested not only inquiring about the precipitatingevent (the proverbial "last straw") but also prioritizing problemsin terms of which to work on first, a concept referred to as"looking for leverage" ([Egan, 2002](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB8)). In the course of understandinghow the event escalated into a crisis, the clinician gains anevolving conceptualization of the client's "modal coping style"—onethat will likely require modification if the present crisisis to be resolved and future crises prevented. For example,[Ottens and Pinson (2005)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB18) in their work with caregivers in crisishave identified a repetitive coping style—argue with carerecipient-acquiesce to care recipient's demands-blame self whengiving in fails—that can eventually escalate into a crisis.

**Stage IV: Deal With Feelings and Emotions**
There are two aspects to Stage IV. The crisis worker strivesto allow the client to express feelings, to vent and heal, andto explain her or his story about the current crisis situation.To do this, the crisis worker relies on the familiar "activelistening" skills like paraphrasing, reflecting feelings, andprobing ([Egan, 2002](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB8)). Very cautiously, the crisis worker musteventually work challenging responses into the crisis-counselingdialogue. Challenging responses can include giving information,reframing, interpretations, and playing "devil's advocate."Challenging responses, if appropriately applied, help to loosenclients' maladaptive beliefs and to consider other behavioraloptions. For example, in our earlier example of the young womanwho found boyfriend and roommate locked in a cheating embrace,the counselor at Stage IV allows the woman to express her feelingsof hurt and jealousy and to tell her story of trust betrayed.The counselor, at a judicious moment, will wonder out loud whethertaking an overdose of acetaminophen will be the most effectiveway of getting her point across.

**Stage V: Generate and Explore Alternatives**
This stage can often be the most difficult to accomplish incrisis intervention. Clients in crisis, by definition, lackthe equanimity to study the big picture and tend to doggedlycling to familiar ways of coping even when they are backfiring.However, if Stage IV has been achieved, the client in crisishas probably worked through enough feelings to re-establishsome emotional balance. Now, clinician and client can beginto put options on the table, like a no-suicide contract or briefhospitalization, for ensuring the client's safety; or discussalternatives for finding temporary housing; or consider thepros and cons of various programs for treating chemical dependency.It is important to keep in mind that these alternatives arebetter when they are generated collaboratively and when thealternatives selected are "owned" by the client.

The clinician certainly can inquire about what the client hasfound that works in similar situations. For example, it frequentlyhappens that relatively recent immigrants or bicultural clientswill experience crises that occur as a result of a culturalclash or "mismatch," as when values or customs of the traditionalculture are ignored or violated in the United States. For example,in Mexico the custom is to accompany or be an escort when one'sdaughter starts dating. The United States has no such custom.It may help to consider how the client has coped with or negotiatedother cultural mismatches. If this crisis precipitant is a uniqueexperience, then clinician and client can brainstorm alternatives—sometimesthe more outlandish, the better—that can be applied tothe current event. Solution-focused therapy techniques, suchas "Amplifying Solution Talk" ([DeJong & Berg, 1998](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB6)) canbe integrated into Stage IV.

**Stage VI: Implement an Action Plan**
Here is where strategies become integrated into an empoweringtreatment plan or co-ordinated intervention. [Jobes, Berman, and Martin (2005)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB12),who described crisis intervention with high-risk,suicidal youth, noted the shift that occurs at Stage VI fromcrisis to resolution. For these suicidal youth, an action plancan involve several elements:

* removing the means—involvingparents or significant othersin the removal of all lethal meansand safeguarding the environment;
* negotiating safety—time-limitedagreements during whichthe client will agree to maintain hisor her safety;
* future linkage—scheduling phone calls,subsequent clinicalcontacts, events to look forward to;
* decreasinganxiety and sleep loss—if acutely anxious,medicationmay be indicated but carefully monitored;
* decreasing isolation—friends,family, neighbors need tobe mobilized to keep ongoing contactwith the youth in crisis;
* hospitalization—a necessaryintervention if risk remainsunabated and the patient is unableto contract for his or herown safety (see [Jobes et al., 2005](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB12),p. 411).

Obviously, the concrete action plans taken at this stage (e.g.,entering a 12-step treatment program, joining a support group,seeking temporary residence in a women's shelter) are criticalfor restoring the client's equilibrium and psychological balance.However, there is another dimension that is essential to StageVI, as [Roberts (2005)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB24) indicated, and that is the cognitive dimension.Thus, recovering from a divorce or death of a child or drugoverdose requires making some meaning out of the crisis event:why did it happen? What does it mean? What are alternative constructionsthat could have been placed on the event? Who was involved?How did actual events conflict with one's expectations? Whatresponses (cognitive or behavioral) to the crisis actually madethings worse? Working through the meaning of the event is importantfor gaining mastery over the situation and for being able tocope with similar situations in the future.

**Stage VII: Follow-Up**
Crisis workers should plan for a follow-up contact with theclient after the initial intervention to ensure that the crisisis on its way to being resolved and to evaluate the postcrisisstatus of the client. This postcrisis evaluation of the clientcan include

* physical condition of the client (e.g., sleeping,nutrition,hygiene);
* cognitive mastery of the precipitatingevent (does the clienthave a better understanding of what happenedand why it happened?);
* an assessment of overall functioningincluding, social, spiritual,employment, and academic;
* satisfactionand progress with ongoing treatment (e.g., financialcounseling);
* any current stressors and how those are being handled;
* needfor possible referrals (e.g., legal, housing, medical).

Follow-upcan also include the scheduling of a "booster" session in abouta month after the crisis intervention has been terminated. Treatmentgains and potential problems can be discussed at the boostersession. For those counselors working with grieving clients,it is recommended that a follow-up session be scheduled aroundthe anniversary date of the deceased's death ([Worden, 2002](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB29)).Similarly, for those crisis counselors working with victimsof violent crimes, it is recommended that a follow-up sessionbe scheduled at the 1-month and 1-year anniversary of the victimization.

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|  | **Differentiating Crisis Intervention From Disaster Management**  |

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For those in need, the third phase of disaster response—crisisintervention—usually begins 1–4 weeks after thedisaster unfolds. Phase I is generally known as "Impact" andPhase II is known as the "Heroic or Rescue" phase. Phases Iand II involve the disaster management and emergency reliefefforts of local and state police, firefighters and rescue squads,emergency medical technicians, the American Red Cross volunteers,the Salvation Army, and the Federal Emergency Management Agency.The disaster and emergency management agencies focus on publicsafety; on locating disaster shelters, temporary housing units,and host homes; and on providing food, clean water, clothing,transportation, and medical care for survivors and their families.After the survivors and their families are rescued and transportedto dry land and safe shelter, the goal is to provide them withwell-balanced meals, continued medical care, sleep, and rest.It is also critically important to help survivors to reconnectand reunite with family members and close friends. Then, 1–4weeks after surviving the loss of their home, neighbors, and/orcommunity, Phase III—crisis intervention can begin—ifit is requested.

Crisis intervention must be voluntary, delivered quickly, andprovided on an as-needed basis. A crisis is personal and isdependent on the individual's perception of the potentiallycrisis-inducing event, their personality and temperament, lifeexperiences, and varying degrees of coping skills ([Roberts, 2005](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB24)).A crisis event can provide an opportunity, a challengeto life goals, a rapid deterioration of functioning, or a positiveturning point in the quality of one's life ([Roberts & Dziegielewski, 1995](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB25)).One person with inner strengths and resiliency may bounceback quickly after an earthquake, tornado or hurricane, whereasanother person of the same age with a preexisting mental disordermay completely fall apart and go into an acute crisis state.A young emergency room physician might adapt well upon reachingAtlanta or Houston, whereas a young social worker sufferingfrom major depression may completely go to pieces upon arrivalat her cousin's house in Dallas, TX. R-SSCIM is the same forsurvivors of community disaster. But we suggest that extra carebe taken in applying R-SSCIM so that the mental health professionalunderstands and distinguishes an acute stress reaction fromthe intense impact of the disaster from which most people rapidlyrecover. This takes skill on the surface because both reactionsoften look the same. Normal and specific reactions frequentlyinclude shock, numbness, exhaustion, disbelief, sadness, indecisiveness,frustration, anxiety, anger, impulsiveness, and fear.

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|  | **Evaluation Research and Outcome Measures**  |

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The current approach in healthcare and mental health settingsis to apply best practices based on evidence-based systematicreviews such as the R-SSCIM in order to assist clinicians byproviding a stable sequential framework for quickly addressingacute crisis episodes in a continuously changing care environment.A growing number of studies have provided evidence of the effectivenessof time-limited crisis intervention ([Corcoran & Roberts, 2000](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB4);[Davis & Taylor, 1997](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB5); [Neimeyer & Pfeiffer, 1994](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB17);[Roberts & Grau, 1970](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB26); [Rudd, Joiner, & Rajab, 1995](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB27)).The research literature on quasi-experimental studies of theeffectiveness of crisis intervention compared to other treatmentssupports the use of time-limited and intensive crisis intervention.However, despite promising crisis treatment effects, we cannotyet determine the long-term impact of evidence-based crisisintervention until longitudinal studies are completed. First,crisis intervention applications need to be refined so thatbooster sessions after 1, 6, and 12 months are implemented.Otherwise, we will probably continue to see positive outcomeswash out after 12 months postcrisis intervention completion.As a growing number of clinicians move into crisis interventionwork, it is imperative that they become familiar with best practicesbased on evidence-based reviews and the need for built-in evaluations.

In order to measure effectiveness and crisis resolution, aswell as facilitate accountability and quality improvement, itis critical that outcome measures are clearly explicated inbehavioral and quantifiable terms. Common performance indicatorsand measures should eventually lead to quality mental healthand effective crisis intervention services. [Teague, Trabin, and Ray (2004)](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB28)in their chapter in the book *Evidence-Based PracticeManual: Research and Outcome Measures in Health and Human Services*identified and discussed key concepts and common performanceindicators and measures. We have applied four of these performanceindicators to a crisis intervention program:

1. *Treatment duration:*mean length of crisis service during thereporting period forpersons receiving services in each of threelevels of care:24-hr crisis intervention hotline, crisis interventionat outpatientclinic, and inpatient psychiatry crisis services.
2. *Follow-upafter hospitalization*: percentage of persons dischargedfrom24-hr inpatient psychiatric care who receive follow-upambulatory,day treatment, or outpatient crisis interventionwithin 30 daysof discharge.
3. *Initiation of crisis intervention for personswith mental healthproblems*: the percentage of persons identifiedduring the yearwith a new crisis episode related to major depression,schizophrenia,schizoaffective disorder, or bipolar disorderwho have had eitheran inpatient encounter for treatment ofthat disorder or a subsequenttreatment encounter within 14days after a first crisis interventionsession.
4. *Engagementin treatment for mental health problems:* the percentageof personsidentified during the year with a new episode ofmajor depression,social phobia, panic disorder, schizophrenia,schizoaffectivedisorder, or bipolar disorder who have had eithera single inpatientencounter or two outpatient treatment encounterswithin 30 daysafter the initiation of crisis intervention ([Teague et al., 2004](http://btci.edina.clockss.org/cgi/content/full/5/4/329/#BIB28),p. 59.).

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|  | **Conclusion**  |

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The R-SSCIM has applicability for the wide range of crisis workers—counselors,paraprofessionals, clinical social workers, clergy, or psychologists—whoare called upon to make rapid assessments and clinical decisionswhen faced with a client who is in the midst of a crisis-inducingor traumatic event. If done properly, crisis intervention canfacilitate an earlier resolution of acute stress disorders orcrisis episodes. Not only does this model give the crisis workeran overarching plan for how to proceed, but the components ofthe model take into consideration what the persons in crisisbring with themselves to every crisis-counseling encounter—theirinner strengths and resiliency.