Crisis Intervention 7 Stages (Pyramid)

Stage I: Psychosocial and Lethality Assessment

The crisis worker must conduct a swift but thorough biopsychosocial assessment. At a minimum, this assessment should cover the client's environmental supports and stressors, medical needs and medications, current use of drugs and alcohol, and internal and external coping methods and resources (Eaton & Ertl, 2000). One useful (and rapid) method for assessing the emotional, cognitive, and behavioral aspects of a crisis reaction is the triage assessment model (Myer, 2001; Myer, Williams, Ottens, & Schmidt, 1992, Roberts, 2002). Assessing lethality, first and foremost, involves ascertaining whether the client has actually initiated a suicide attempt, such as ingesting a poison or overdose of medication. If no suicide attempt is in progress, the crisis worker should inquire about the client's "potential" for self-harm. This assessment requires

- asking about suicidal thoughts and feelings (e.g., "When you say you can't take it anymore, is that an indication you are thinking of hurting yourself?");
- estimating the strength of the client's psychological intent to inflict deadly harm (e.g., a hotline caller who suffers from a fatal disease or painful condition may have strong intent);
- gauging the lethality of suicide plan (e.g., does the person in crisis have a plan? how feasible is the plan? does the person in crisis have a method in mind to carry out the plan? how lethal is the method? does the person have access to a means of self-harm, such as drugs or a firearm?);
- inquiring about suicide history;
- taking into consideration certain risk factors (e.g., is the client socially isolated or depressed, experiencing a significant loss such as divorce or layoff?).

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

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

Stage II: Rapidly Establish Rapport

Rapport is facilitated by the presence of counselor-offered conditions such as genuineness, respect, and acceptance of the client (Roberts, 2005). This is also the stage in which the traits, behaviors, or fundamental character strengths of the crisis worker come to fore in order to instill trust and confidence in the client. Although a host of such strengths have been identified, some of the most prominent include good eye contact, nonjudgmental attitude, 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) pointed out, the crisis worker is interested in elucidating just what in the client's life has led her or him to require help at the present time. Thus, the question asked from a variety of angles is "Why now?"

Roberts (2005) suggested not only inquiring about the precipitating event (the proverbial "last straw") but also prioritizing problems in terms of which to work on first, a concept referred to as "looking for leverage" (Egan, 2002). In the course of understanding how the event escalated into a crisis, the clinician gains an evolving conceptualization of the client's "modal coping style"—one that will likely require modification if the present crisis is to be resolved and future crises prevented. For example, Ottens and Pinson (2005) in their work with caregivers in crisis have identified a repetitive coping style—argue with care recipient-acquiesce to care recipient's demands-blame self when giving 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 strives to allow the client to express feelings, to vent and heal, and to explain her or his story about the current crisis situation. To do this, the crisis worker relies on the familiar "active listening" skills like paraphrasing, reflecting feelings, and probing (Egan, 2002). Very cautiously, the crisis worker must eventually work challenging responses into the crisis-counseling dialogue. Challenging responses can include giving information, reframing, interpretations, and playing "devil's advocate." Challenging responses, if appropriately applied, help to loosen clients' maladaptive beliefs and to consider other behavioral options. For example, in our earlier example of the young woman who found boyfriend and roommate locked in a cheating embrace, the counselor at Stage IV allows the woman to express her feelings of hurt and jealousy and to tell her story of trust betrayed. The counselor, at a judicious moment, will wonder out loud whether taking an overdose of acetaminophen will be the most effective way of getting her point across.

Stage V: Generate and Explore Alternatives

This stage can often be the most difficult to accomplish in crisis intervention. Clients in crisis, by definition, lack the equanimity to study the big picture and tend to doggedly cling to familiar ways of coping even when they are backfiring. However, if Stage IV has been achieved, the client in crisis has probably worked through enough feelings to re-establish some emotional balance. Now, clinician and client can begin to put options on the table, like a no-suicide contract or brief hospitalization, for ensuring the client's safety; or discuss alternatives for finding temporary housing; or consider the pros and cons of various programs for treating chemical dependency. It is important to keep in mind that these alternatives are better when they are generated collaboratively and when the alternatives selected are "owned" by the client.
The clinician certainly can inquire about what the client has found that works in similar situations. For example, it frequently happens that relatively recent immigrants or bicultural clients will experience crises that occur as a result of a cultural clash or "mismatch," as when values or customs of the traditional culture are ignored or violated in the United States. For example, in Mexico the custom is to accompany or be an escort when one's daughter starts dating. The United States has no such custom. It may help to consider how the client has coped with or negotiated other cultural mismatches. If this crisis precipitant is a unique experience, then clinician and client can brainstorm alternatives—sometimes the more outlandish, the better—that can be applied to the current event. Solution-focused therapy techniques, such as "Amplifying Solution Talk" (DeJong & Berg, 1998) can be integrated into Stage IV.

Stage VI: Implement an Action Plan

Here is where strategies become integrated into an empowering treatment plan or co-ordinated intervention. Jobes, Berman, and Martin (2005), who described crisis intervention with high-risk, suicidal youth, noted the shift that occurs at Stage VI from crisis to resolution. For these suicidal youth, an action plan can involve several elements:

- removing the means—involving parents or significant others in the removal of all lethal means and safeguarding the environment;

- negotiating safety—time-limited agreements during which the client will agree to maintain his or her safety;
- future linkage—scheduling phone calls, subsequent clinical contacts, events to look forward to;
- decreasing anxiety and sleep loss—if acutely anxious, medication may be indicated but carefully monitored;
- decreasing isolation—friends, family, neighbors need to be mobilized to keep ongoing contact with the youth in crisis;
- hospitalization—a necessary intervention if risk remains unabated and the patient is unable to contract for his or her own safety (see Jobes et al., 2005, 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 critical for restoring the client's equilibrium and psychological balance. However, there is another dimension that is essential to Stage VI, as Roberts (2005) indicated, and that is the cognitive dimension. Thus, recovering from a divorce or death of a child or drug overdose requires making some meaning out of the crisis event: why did it happen? What does it mean? What are alternative constructions that could have been placed on the event? Who was involved? How did actual events conflict with one's expectations? What responses (cognitive or behavioral) to the crisis actually made things worse? Working through the meaning of the event is important for gaining mastery over the situation and for being able to cope with similar situations in the future.

Stage VII: Follow-Up

Crisis workers should plan for a follow-up contact with the client after the initial intervention to ensure that the crisis is on its way to being resolved and to evaluate the postcrisis status of the client. This postcrisis evaluation of the client can include

- physical condition of the client (e.g., sleeping, nutrition, hygiene);
- cognitive mastery of the precipitating event (does the client have a better understanding of what happened and why it happened?);
- an assessment of overall functioning including, social, spiritual, employment, and academic;
- satisfaction and progress with ongoing treatment (e.g., financial counseling);
- any current stressors and how those are being handled;
- need for possible referrals (e.g., legal, housing, medical).

Follow-up can also include the scheduling of a "booster" session in about a month after the crisis intervention has been terminated. Treatment gains and potential problems can be discussed at the booster session. For those counselors working with grieving clients, it is recommended that a follow-up session be scheduled around the anniversary date of the deceased's death (Worden, 2002). Similarly, for those crisis counselors working with victims of violent crimes, it is recommended that a follow-up session be scheduled at the 1-month and 1-year anniversary of the victimization.