

2

History and Theoretical Foundations of Crisis and Crisis Counseling

Most humans are confronted by crisis at some point in their existence and, as a result, experience powerful emotions, cognitions, distress, and dislocation. The universal and historic nature of crisis led individuals and societies to create and promote cultural narratives of crisis (Campbell, 1970). These powerful stories, passed from generation to generation, provide a contextual frame of reference for the world around us and communicate the meaning of language, norms, and beliefs. In a typical account, one unexpectedly encounters a dangerous or threatening event that warrants a larger-than-life decision at a critical moment. Enduring stress and hardship, the protagonist confronts danger, is transformed, and returns to a triumphant or renewed state. Echterling, Presbury, and McKee (2005) note the term crisis originates from early 17th century Greek word *krisis* and refers to a judgment or a decision point. Historic narratives like the *Odyssey* or Joan of Arc's victory at the Siege of Orleans and more recent ones like Nelson Mandela, Cesar Chavez and Delores Huerta represent the complexities and extent of crisis events—a decision (or evaluation) made at a critical junction that results in transformation. Cultural crisis narratives almost always end on a positive or aspirational note allowing others to learn what it takes to overcome a crisis. Hopefully, most of your clients will never face crises of similar magnitudes, yet lessons about the overwhelming nature of crisis, the restorative power of relationships, perseverance, and recovery are individually and collectively instructive. In this chapter, we define crisis counseling within a mental health context; discuss the history and theoretical foundation of crisis and crisis counseling; distinguish the types, categories, and nature of crises; identify models of crisis counseling; and distinguish the unique and common elements of crisis events.

Learning Objectives

After reading this chapter and completing the reflective exercises, you will be able to

1. Define crisis in a mental health context
2. Contextualize the history and theoretical foundations of crisis counseling
3. Articulate and understand the relationships between and among the types, categories, and nature of crises
4. Describe crises how affects individuals; and groups and subsystems
5. Distinguish acute and chronic crisis events
6. Discuss and apply the various approaches/models of crisis counseling

Crisis Counseling Within a Mental Health Context

Most clinicians will respond to a client's crisis during their career. A common definition of crisis counseling promotes shared understanding, consistent terminology, and more effective treatments and accurate research. However, many behavioral health professional societies distinguish their profession and membership by laying claim to greater expertise, a specific approach or intervention or service despite their clients receiving similar services from a variety of professionals. While pride in one's profession is admirable, unnecessary competition fragments clinical knowledge and services, limits quality research, results in a proliferation of terms and definitions, and most importantly, is tone deaf and irrelevant to clients.

With respect to crisis counseling we also see different definitions. For example, the American Counseling Association (ACA) defines individual crisis counseling as a discrete intervention with

limited goals to ensure safety and promote overall stability. The goal is to provide emotional support and concrete feedback/assistance for the individual. Crisis counseling helps problem-solve and assists individuals in obtaining available resources. . . . [C]risis counseling can range from 15 minutes to 2 hours, whereas the frequency of 1:1 crisis counseling with the same person ranges from 1 to 3 times. (2010)

The American Psychological Association defines crisis counseling as "immediate drop-in, phone-in, or on-site professional counseling provided following a trauma or sudden stressful event, often for emergency situations or in the aftermath of a disaster" (APA Dictionary, 2018). And social workers seem to focus on crisis intervention rather than counseling. Some social workers provide clients support as part of a crisis intervention team (CIT) in hospitals and or schools and support to clients in acute phase of a crisis. Many professional publications and social work websites identify Robert's Seven-Stage Crisis Intervention Model

(Roberts, 2005) as the preferred model of intervention. Thus, despite desires to distinguish ourselves by profession, paraphrasing Maya Angelou, “We are more alike my friends, than we are unlike” (Angelou, 1994, p. 224).

Another area of likeness in crisis counseling is Levers’s (2012) definition. She describes crisis counseling as

short-term interventions focused on assisting disaster survivors in understanding their current situation and reactions, mitigating additional stress, assisting those individuals in reviewing their options, promoting the use or development of additional coping strategies, providing emotional support, and encouraging linkage with other agencies that can assist survivors in recovering to their pre-disaster level of functioning. (p. 467)

We view Lever’s definition as a bridge across the professional divides and note minor differences in intervention are apparent when one knows the clinician’s professional lens. For example, when confronted with crisis events, you, an emerging clinician may utilize a model of intervention designed for individual and developmentally oriented crises (The ACT Model of Crisis; Roberts, 2005) while a marriage and family therapist may use a systemic approach (Hill, 1949; McCubbin & Patterson, 1983). A social worker may view the crisis as stemming from contextual and environmental factors and consequently use a developmental and ecologically based model (Developmental-Ecological Model of Crisis; Boss, 2002) while a psychologist may view the crisis from a psychophysiological perspective and utilize the Bioecological Model of Crisis (Hoffman & Kruczek, 2011). Regardless of professional differences in definitions and treatment foci, most clinicians define crisis as an unexpected negative event, perceived intensely as a threat that briefly destabilizes and overwhelms one’s previous coping resulting in feelings of anxiety and vulnerability. Thus, all points of view have value when they contribute to positive outcomes for our clients and, after all, isn’t that the point of professional help! Exercise 1, at the end of the chapter, is provided to contextualize your learning about professional standards.

The History and Theories of Crisis Counseling

History

The history of contemporary crisis counseling and intervention is associated with a variety of societal issues emerging over the last two centuries. While an exhaustive list of historical antecedents is beyond the scope of this book, it would undoubtedly reach back well before written history. Significant historical events central to understanding crisis counseling and intervention are presented. As you read, we call your attention to the difference between current conceptualizations of crisis and historic ones.

The history of contemporary crisis counseling and intervention in the United States begins with the protection of those with suicidal ideation. In 1906, Harry Marsh Warren, a minister in New York City, founded the first organized volunteer

service dedicated to preventing suicide (Colt, 2006), the *Save-A-Life League*. Warren was contacted by a New York City hotel manager at the request of a distraught young woman. She was distressed after a break up and was contemplating suicide. The hotel manager was unable to reach Warren and the young woman was found near death the next morning. This event, as well as his knowledge of a young man who recently committed suicide after other ministers declined to see him, moved Warren to action. He rallied his parishioners from the pulpit saying, "I wish that all who believe death is the only solution for their problems would give me the chance to prove them wrong" (Barlow, 1933, p. 20, as cited in Miller & Gould, 2013). Warren's interventions were active and engaged. He placed newspaper ads in New York City papers asking those considering suicide to contact him directly and visited the homes and hospital rooms of those with suicidal ideation or where a suicide was attempted. Warren established a group of volunteers who responded to distressed individuals in the League's central office. Miller and Gould recount Warren's statement in 1921 in *The New York Times*, "The Save-A-Life League has received thousands of letters from different parts of the world telling of sorrows beyond human endurance and begging for all possible help. Quantities of inspirational literature, which the league publishes, have been sent out. At the headquarters hundreds and thousands have come either for personal help or in behalf of others" (p. 13). James and Gilliland (2017) note the National Save-a-Life League established the first crisis phone line in further demonstrating those in need could benefit from support from someone, outside their family. Warren's advocacy and actions are credited with saving at least 1,000 lives (Miller & Gould, 2013).

The second seminal event occurred in 1942 in Boston. The Cocoanut Grove nightclub was one of Boston's most popular venues. A series of unfortunate events contributed to the horrific fire and destruction that occurred on November 28, 1942. The Club's interior, a labyrinth of bars, lounges, and dining rooms, was decorated with highly flammable materials like palm fronds and heavy draperies. Additionally, the club's owner was believed to have locked and concealed exits to prevent patrons from skipping out on their tabs. The origin of the fire was undetermined, but the death toll, 492 souls, was catastrophic. Given the magnitude of the fire, death, and destruction, the need for crisis counseling and intervention to aid victims, their families, first responders, and the Boston community was obvious.

In response to the Cocoanut Grove disaster, Dr. Erich Lindemann (1944) described normal grief reaction upon which his colleague, Gerald Caplan, devised a theory of crisis. Not all crises receive the attention they deserve. For example, the Cocoanut Grove fire is often heralded as the event most associated with the development of modern crisis theories, yet our third historical event, the Rhythm Club fire, was as consequential for those involved. In 1940, two years *before* the Cocoanut Grove tragedy, a devastating fire occurred at the Rhythm Club in Natchez, Mississippi. Despite the deaths of 209 African Americans (Ward & Butler, 2008), there was no outcry for support for the 17 survivors, their families, or first responders, and no researchers or theorists studied the event. The only support came from the \$5,000 in donations to the Red Cross raised by local residents. As a counselor, it is critical you remain attuned to issues of social justice and injustice as our collective history is replete with tragic examples like this.

Three grassroots movements also contribute to the history of contemporary crisis counseling and intervention: Alcoholics Anonymous (AA), Vietnam veterans, and the Women's Movement of the 1970s. These groups addressed acute and chronic crises and resulting emotional, psychological, financial, vocational, and relational needs of those directly and indirectly suffering from alcoholism or alcohol dependence, the effects of the Vietnam War, or domestic violence, rape, or child abuse. Movements like these emerge when a critical mass of those affected informally comes together because no formal acknowledgment or systems exist. The sociopolitical influences of Vietnam veterans and Women's Movement are explored in greater depth in Chapter 4.

Specific to alcohol abuse, Mothers Against Drunk Driving (MADD) was formed in 1980 by Candance Lightner after the death of her daughter Cari. Lightner wanted to address the needs of families who lost a loved one at the hands of a drunk driver. Through their support groups, MADD members shared their grief and anger and sought to influence legislation through grassroots public advocacy. Most importantly, MADD partnered with Alcoholics Anonymous (AA) to address the need for formal recognition and treatment of alcoholism. While a review of AA is beyond the scope of this chapter, it is important to note the collaboration between AA chapters and veteran's groups in establishment of free storefront clinics for Vietnam veterans and veteran specific AA meetings. In essence, Candance Lightner transformed an acute traumatic crisis into assistance and support for those experiencing the chronic crises of alcoholism.

Theories

The pioneering work of Lindemann (1944) and later Gerald Caplan (1961; 1964) provide a firm theoretic foundation for crisis and crisis counseling. Building on their work, subsequent scholars and clinicians drew upon related psycho- and sociological theories to deepen and advance the knowledge base. As a result, theories and practices related to crisis were developed demonstrating that the previous focus on psychodynamic perspectives was insufficient. We agree with James and Gilliland (2017) who advise that the right blend of developmental, sociological, psychosomatic, ecological, and situational factors be considered as anyone can fall prey to brief pathological symptoms related to a crisis.

Theories presented in this section reflect the framework of expanded crisis theory (James & Gilliland, 2017) and draw on contributions from psychoanalysis, adaptational, and interpersonal, chaos, and systems theories. We extend this framework and include a discussion of transactional theories of appraisal and coping. The theories are presented in the approximate chronological order they contributed to our understanding of crisis theory.

Psychodynamic Theory

In Victorian times, grief was associated with the physical pain of a *broken heart*. Freud and others considered grief from a psychodynamic framework. Grief was believed to cause distress as survivors *let go* of their attachment to the deceased to move beyond their anguish (Neimeyer, 2001) and return to a new normal.

Lindemann (1944) and later others (Bowlby, 1980; Kübler-Ross, 1969, 1975; Parkes, 2006) examined the nature and pattern of responses to grief, expected (uncomplicated) and unexpected (complicated or pathological), as well as the processes: stages, phases, and course. A note of caution: you may be familiar with Kübler-Ross's stages of grief, which are commonly believed to describe how one grieves. For the past three decades, a growing number of scholars (Attig, 1991; Parkes, 2013; Stroebe, Schut, & Boerner, 2017) have challenged the accuracy and appropriateness of Kübler-Ross's stage model of grief noting (a) grieving and bereavement are a recursive, not linear process; (b) the absence of empirical support (Parkes, 2013) for the model; (c) the universal view of grieving ignores cultural or sub-cultural influences and practices; and (d) potential harm to clients (Silver & Wortman, 2007). Silver and Wortman's criticism serve as a warning to clinicians that their clients, whose grieving process fails to conform to Kübler-Ross's model, may feel their manner of grieving is wrong. The perception they are not grieving the right way leaves these individuals further isolated, criticized, and diminished by their supportive network and health care professionals. We note this challenge to Kübler-Ross's model as an example of how historic and current conceptualizations of a concept differ. Returning to Lindemann, he identified five symptoms of grief and related tasks experienced by mourners. Symptoms ranged from somatic/physical distress, preoccupation with the deceased, guilt, and hostility, to loss of routine. To achieve symptom relief, mourners were to free themselves from their attachment to the deceased, adjust to life without the deceased, and establish new relationships. For Lindemann, much like Freud and Bowlby, the process of letting go and forming new attachments allowed the mourner to focus on the future and to complete the grieving process.

Gerald Caplan (1964) and his colleagues expanded Lindemann's concepts of grief and bereavement and incorporated his experiences with post-World War II Israeli immigrants to devise his theory of crisis intervention. Caplan described a crisis as an upset in the steady state, aggravated by an abrupt and disruptive event, that overwhelms customary problem-solving strategies. Individuals in crisis seek a return to precrisis function and a sense of balance or homeostasis. He identified the subjective nature of crisis, namely that it was the individuals' emotional reaction to the problem that makes it a *crisis*, rather than the problem itself. An example may be helpful. During a suicide assessment you, the clinician, unexpectedly feel stressed, scared, and anxious. Despite your training and previous experiences with clients' suicidal ideation, you are unsure what to do next and feel incompetent. You have a colleague join the session and the suicidal client is voluntarily admitted to the hospital. In post-session supervision, you are in crisis. You feel anxious, confused, and wonder out loud why an issue you've handled numerous times—suicidal ideation—now has you panicking. For the next week, you feel depressed, can't sleep, and are irritable. Clearly, your previous coping skills are insufficient and, according to crisis theory, your appraisal of a previously experienced event (client's suicidal ideation) is different than before, (more about appraisal later in the chapter).

Like responses to other events, crisis responding follows a general pattern. Roberts and Ottens (2005) credit Caplan as the first clinician to "describe and

document the four stages of a crisis reaction” (p. 332). The first stage—increasing stress or anxiety associated with the crisis event—is followed closely by the second stage—daily disturbances functioning resulting from the unresolved crisis. Because the crisis remains unresolved, individuals’ stress and anxiety escalate, and they go “into a depression or mental collapse or may partially resolve the crisis by using new coping methods” (p. 332). Caplan’s contributions to crisis theory highlight the subjective nature of crises. According to the theory, the subjective definition arises out of a perceived imbalance between the difficult event and the individual’s available resources. Caplan argued physical or psychological threats engage the individual’s coping or problem-solving skills with the goal of restoring balance. This imbalance is experienced as disequilibrium causing distress because individuals continually seek balance but have yet to achieve it.

Psychoanalytic Theory

We distinguish psychodynamic from psychoanalytic theories, as the former focuses on inter- rather than intrapsychic process. As noted above, a psychodynamic view of grief involved the individual *letting go* of the attachment/interpersonal relationship to the deceased. A psychoanalytic view of grief, at its essence, focuses on client’s understanding of their postcrisis disequilibrium by accessing and processing their unconscious thoughts and past emotional experiences—a decidedly intraindividual experience. Further, psychoanalytic theorists posit that early childhood fixations, once explored, explain an individual’s response to events. Vulnerability to specific stressors is believed to be associated with factors such as ego organization, fixation, unconscious drive, and coping mechanisms (Fine, 1973). From this theoretical perspective, relief comes when the client recognizes and modifies ineffective defensive patterns through active engagement in suggestion, abreaction, clarification, and dynamic interpretation (Glick & Meyerson, 1981). Due to the dynamic nature of a crisis, clients are believed to be in a more regressed state signaling increased attention to and management of transference and countertransference issues.

Adaptational Theory

In her 1981 article, Schlossberg described adult adaptation to transitions and acknowledged the connection between her proposed model and Lindemann’s 1965 study on Cocoanut Grove survivors. Schlossberg intentionally rejects the term *crisis* due to the “negative connotations” (p. 6), opting for the term *transitions*. For her and others, (Parkes, 1971) transitions represented a more fluid process in which gains as well as losses are experienced and events—both dramatic and those less observable—result in “psychological growth” or “deterioration” (Moos & Tsu, 1976, p. 13; as cited in Schlossberg).

Adaptational theories applied to crisis counseling suggest that clients sustain the experience of a crisis through nonproductive behaviors, negative thoughts, denial, and rationalization. Adaptation results when the client engages in a series of thoughts, behaviors, and emotions to offset the experiences of crisis and reestablish a sense of balance or homeostasis. Specifically, adaptation is evidenced when

clients demonstrate a good enough balance between the experience of crisis, available interpersonal and tangible resources, and reduced feelings of anxiety. Thus, nonproductive behaviors replace adaptive ones. Schlossberg notes three factors believed to aid one's adaptation to transition. The first describes characteristics of the transition—gains/losses, positive/negative affect, source/event, duration, timing, and degree of stress. The second examines the pre- and post-transition support and environment. Individual demographics, values, and prior experience with similar type of transition complete the third factor. Schlossberg cautions these factors are not equally weighted for individuals, that is, some matter more than others. Consider the example of Pat who just found out he was immediately laid off from his job. His company sent him to you for counseling. Applying adaptational theories, you understand his transition (crisis) may be mitigated when he is able to acknowledge his family's financial stability—they own their home and his wife has a substantial and steady income. With counseling, Pat can reconcile and reframe being laid off as an opportunity to seek a management position—which he has desired—and feeling more in control, he can be encouraged to seek the support of his spouse. These adaptations should engender a return to pretransition functioning.

Interpersonal Theory

Interpersonal theory has its roots in Rogers's person-centered humanistic theory (1959). Fundamentally, persons experiencing a crisis experience incongruence and diminished positive regard and self-worth. Interpersonal theory applied to crisis counseling assumes individuals cannot sustain a personal state of crisis if they believe in themselves and others. This belief is an antecedent to the necessary confidence that helps them work toward a sense of self-actualization, build community with others, and eventually return to equilibrium. Clinicians utilizing this theoretical approach understand the importance of sharing, unconditional positive regard, accurate empathy, clients' locus of control, personal agency, and problem exploration and interpersonal support. This therapeutic approach enhances clients' self-esteem and self-confidence.

Chaos Theory

Chaos theory has been used to describe everything from the order of the universe, weather patterns, and problems in mathematics. Basically, chaos theory states there is order in chaos and from this chaos an open and ever-changing system of self-organization emerges. This theory is predicated on evolution, where order comes from chaos under the conditions of spontaneity, creativity, and cooperation. With respect to crisis counseling, clients in crisis experience a host of intense emotions: fear, dislocation, anxiety, and disruption. Clinicians aid clients in viewing the order or adaptive patterns that emerge from the chaos of the crisis event. Clinicians encourage and support clients' experimentation with trial and error. Through trial and error, clients attempt to instill order and acknowledge the relevance of false starts. Because clients continue to experiment, they come to recognize dead ends and learn to follow a course of action despite the outcome.

Clients actively engage to make personal sense of and cope with a crisis. The disorganization yields organization and, in the case of crisis intervention, recovery.

Whether in counseling or on their own, individuals use a process of trial and error to reestablish a sense of equilibrium and, eventually, homeostasis. Achieving a sense of homeostasis does not mean the individual is necessarily in a better position than they were prior to the crisis. It means they are less overwhelmed by their circumstances. Individuals constantly strive for a sense of homeostasis or balance, whatever that means to them personally, culturally, and environmentally. It reminds us of the adage, “It is better to dance with the devil you know than one you don’t know.”

Family Systems Theory

In the 1960s, Bowen (1978) applied systems thinking to families and developed family systems theory. The family is considered an emotional unit. Clinicians utilizing this perspective address clients’ concerns in the context of their families and include interpersonal and intrapersonal functioning. The client’s interrelationships, interdependence, interactions, roles, group norms, communication, and contextual factors between and among individuals in the client’s life, the crisis event(s), and the return to equilibrium are the focus of therapy. In sum, counselors explore what happens in the client, their system, and the interactions between and among relationships during and after the crisis.

A systemically oriented crisis counselor may reflect on questions such as “Who is most likely to support or criticize the client?” “How do these reactions impact relationships?” “How do members of the client’s system view crises?” and “What resources, if any, might the members of the system provide or withhold?” Remember, one’s system is culturally and relationally viewed from the client’s perspective. This means that *family* may include individuals who are not biologically related yet are deeply connected to the client. In this context, relationships may not conform to expected hierarchies of the dominant group and the offer or provision of resources is context dependent. Skilled clinicians encourage clients to identify individuals who comprise their system, to define the nature of those relationships and any cultural and personal values potentially influencing the system. The encouragement comes without pathologizing or judging the client and their culture.

Transactional Theory

Stress, or mental or emotional strain, was described by Hans Selye (1956) as a physiologically based pattern of responding. Selye viewed stress as a defense mechanism comprised of three successive stages—alarm, resistance, and exhaustion. Prolonged and severe stress impacts one’s adaption and health. He introduced the General Adaptation to Stress (GAS) model in which stress coping occurs in the alarm and resistance stages. Stress in the first two stages may be experienced positively or negatively, depending on one’s cognitive interpretation of their symptoms and experience. Thus, when one encounters a threat, the *alarm* response signals the sympathetic nervous system, increasing adrenaline, respiration, and

heart rate in preparation to confront or avoid the threat. The resistance response engenders the fight or flight response in reaction to the stressor in an attempt to regain homeostasis. The exhaustion stage occurs when the individual is unable to cope with the distress.

Lazarus (1966) viewed stress and coping as a dynamic process. He extended Selye's work beyond a physiological framework to a transactional theory of stress and coping. Transactions take place between the individual their systems— affective, cognitive, psychological, and the environment. One's evaluation or appraisal of these interactions determines whether they are experienced as stressful and in what manner the individual will respond or cope. Mechanic (1978) identified personal and contextual factors— capacities, skills, abilities, limitation, resources, and norms likely to influence one's view of a stressor has harmful.

Lazarus and Folkman (1984) noted three forms of appraisal: primary, secondary, and reappraisal. Primary appraisal involves evaluating the nature of the event and then determining whether the stressor is a threat. In *secondary appraisal*, one evaluates their resources— mental, physical, financial— available to confront the perceived threat. The final form, *reappraisal*, involves continual evaluation of the nature of the threat and available resources. Lazarus and Folkman noted individuals respond or cope with stress through emotion- or problem-focused coping. Emotion-focused coping is utilized by individuals who have appraised the stressful event and do not believe they can respond effectively. Experiencing a lack of control, the individual may dismiss or attempt to avoid the stress or engage in denial or magical thinking. Problem-focused coping is utilized by individuals who have appraised a stressful event and believe they have the resources to manage or address the stressor by engaging in analyzing, planning, and executing a response.

A person in crisis deems the situation as a threat and believes they have insufficient resources to cope. Similarly, Bard and Ellison (1974) defined a crisis as a subjective reaction to a stressful life experience. This reaction paired with an individual's inability to cope effectively equals a crisis. These internal experiences, particularly those that are severe and prolonged, may result in trauma and impair an individual's coping. The structure of a crisis event includes the perception of threat, an inability to reduce the impact of the event, increased fear or confusion, excessive discomfort, and disequilibrium followed by a "rapid transition to an active state of crisis" (Dass-Brailsford, 2007, p. 94). The speed at which one resolves a crisis and its impact can dictate whether a crisis evolves into a trauma.

The Process of Coping and Adaptation

The term coping is often used interchangeably with the term adaptation, creating confusion. Jackson-Cherry and Erford (2010) describe coping behavior as, "All actions taken in an effort to manage stress, regardless of whether they are successful..." (p. 12). An individual in crisis utilizes coping behaviors to assess the event or environment, the risk of harm or injury, and responses or reactions to minimize harm or injury. For example, a child bullied by another scans their environment to assess or anticipate where they may encounter the bully— school lunchroom or restroom. Anticipating verbal or physical altercations, the child evaluates potential

harm and gauges the degree of risk associated. Potential responses to limit harm might include limiting or avoiding eye contact, running away, fighting back, or submitting to the bully's demands. Additional responses include post-event strategies such as keeping the altercation a secret, telling only their peers, or informing school authorities or their parents. These behaviors, cognitions, and actions are ways the child copes with being bullied.

At their core, coping behaviors reduce emotional arousal (Jackson-Cherry & Erford, 2010). Effective coping behaviors are directly connected to events the individual wishes to manage. Ineffective coping behaviors may appear random, impulsive, and disconnected to the present event. For example, a client is fearful of speaking in public. Despite the requirements of their job, they actively avoid any situation where they may be asked to speak in front of others. They are considering leaving a job they love. As their counselor, you help them practice positive and encouraging self-talk (effective coping) during intense bouts of fear and self-doubt rather than resigning their job. The strategies identified represent control-based coping mechanisms. The client seeks to *control* their sense of fear and self-doubt when speaking publicly which may include an overwhelming desire to fight (refusing to speak), flight (avoiding settings where are expected to speak publicly), or freeze (being physically unable to speak). As their counselor, you encourage your client to engage in emotion- and problem-focused coping responses. Emotion- and problem-focused coping, described earlier, are clear and concise action-oriented behaviors used in the social environment. For example, you ask the client to practice their speech in front of you or supportive friends to successively gain feelings of control. Or you could suggest they practice deep focused breathing prior to their practice, utilize self-talk, visualization, or mental imagery to set a positive tone.

In contrast, adaptation is an outcome or result of stress or crisis and describes the degree to which one's functioning has *changed*, because of the event, over an extended period. When a personal crisis is maintained through cognitive distortions, maladaptive behaviors, and poor defense mechanisms, the overarching treatment goal is to reduce the client's dependence on maladaptive behaviors and install more adaptive ones. Theoretically, once adaptive behaviors are identified and employed, the crisis should be reduced or eliminated. Consider a client who suffered from physical abuse at the hands of an intimate partner. They come to you for counseling and state, despite being deeply in love with their current partner, they are afraid to engage in handholding, kissing, and cuddling. The client believes this will lead to the end of the relationship. The presence of a trusting and safe partner, who communicates clearly and manages expectations of physical closeness, should encourage the client to address their feelings of vulnerability or threat and build trust in the relationship. Therapeutic activities may include positive self-talk, risk taking, and open exchange of personal and environmental needs. This new ability to trust represents a positive adaptation to different relational circumstances.

Crises create stress and impel a response/reaction to restore psychological and physical safety (Baum, 1990). Puleo and McGlothlin (2010) note, "All actions taken in an effort to manage stress, regardless of whether they are successful or not, are referred to as coping" (p. 12). Coping with a crisis involves thinking and

behaving in a way that calculates the occurrence of an event and its propensity for harm. Coping strategies are not viewed as adaptive or maladaptive; instead they are evaluated against the specific purpose for which they were selected. That is, did the coping strategy reduce, increase, or have no effect on the crisis? While coping is considered an intentional behavior designed to relieve stress, resiliency is considered an innate nondeliberate behavior.

The ability of a person to cope or adapt when confronted with adversity (e.g., crisis) or other significant sources of stress is defined as resiliency (Puleo & McGlothlin, 2010). As an outcome of stress and crisis, resilience is considered to be a protective factor. Resilient individuals are believed to be protected by various innate factors such as attribution, response, cognitive styles, and problem-solving skills (Boss, 2002; Puleo & McGlothlin, 2010). Exercise 2 at the end of the chapter will help you apply and contextualize your understanding.

Classifying Crisis and Crisis Events

The breadth and depth of crisis, trauma, and disaster information can overwhelm readers. To address this concern, we created a classification system to order the types, categories, and nature of these events. We present a broad description of three classes of crisis followed by a discussion of distinguishing elements in each class. For example, *Types of Crisis* describes the origins of crises initiated by humans, nature, or technology. To provide context, each type of crisis is further distinguished in *Categories*—developmental, situational, existential, psychiatric, traumatic, and ecosystemic. *Nature*, the last class, describes the level at which impact crisis events occur—individual, group, and community crises—and distinguishes acute from chronic states. A similar classification scheme is presented in Chapter 4—Trauma, and Chapter 6—Disaster. We organized the information in this manner to provide structure and clarity to these concepts and we hope you find it useful.

Human-Initiated Crises

Human-initiated crises result from intentional and unintentional human activity impacting individuals, groups, and communities and occur on a smaller scale (intimate partner violence, microaggressions) or larger scale (terrorism, the Holocaust). In stories retold by Holocaust survivors, Dorsey (1968) identified characteristics of human-initiated traumas: life-endangering situations like chronic starvation, physical maltreatment, and fear of total annihilation; degradation to the point of dehumanization; recurrent terror episodes; assaults on one's identity resulting in changes of self-image; and a prolonged "living-dead existence" with no way to escape it (Dorsey, 1968, p. 64). These conditions often led to what Dorsey (1968) termed as the "Muselman" stage, a devastating physical and psychological condition where one has lost the will to live after enduring horrific and relentless deprivation of the concentration camps. The term "Muselman" seems to have originated from the crouched, prayer-like stance individuals in this condition exhibited. The posture was likened to that of Muslim in prayer. Common reactions to

human-initiated crisis events included emotional detachment, regression, identification with the aggressor, and numbness to life represented by a *living dead* or *walking dead* existence. Lifton (1968) studied those who survived the bombing of Hiroshima and found similar reactions. He noted, however, that while many of the reactions to this event were like Holocaust survivors, the difference was the *total unpreparedness* of the Japanese survivors (p. 171). In both studies, survivors recounted vivid and accurate memories of the event, sometimes decades later (Dorsey, 1968; Lifton, 1968), and feeling of “death in life” (Lifton, 1968, p. 173).

In war, some military personnel experience what Solomon, Laror, and McFarlane (1996) called a “combat stress reaction” (p. 106). Those affected attempted to distance themselves from their thoughts and others hoping to block intrusive memories and anxiety related to fear of death, guilt, loneliness, and loss of self-control. Distancing sometimes manifested in impulsive behaviors (aggression) and somatic complaints (fatigue, sleeplessness). War takes a significant toll on veterans, civilians, and the environment. Civilians in war-torn areas, such as Iraq and Rwanda, face a long-term threat to survival (Dyregov, 2003), an antecedent to PTSD. In a study of 317 children, researchers investigated the well-being and mental health consequences of residing in a war zone. Dyregov (2003) discovered many children and adolescents had come to see fear as a normal part of daily life. The youngest participants articulated their fear, understood the violence put them in great danger, and resulted in destruction and death. The common threads of constant fear and the knowledge that “we can all die” (Dyregov, 2003, p. 114) was present in all age groups.

Nature-Initiated Crises

Nature-initiated crises are defined as “biologic, climate-related, or geophysical” (Leaning & Guha-Sapir, 2013, p. 1836) events occurring separate from human activity. Hurricanes, earthquakes, tornadoes, volcanic eruptions, and wildfires are but a few of these natural-occurring and devastating events. The number of incidences of nature-initiated crises is increasing exponentially. There were three times as many nature-initiated crises from 2000 to 2009 as there were in the 1980s (p. 1836). Following a nature-initiated crisis there is an immediate need for medical, food, and housing services. Although temporary, many events result in longstanding impairments in health for the affected populations (Leaning & Guha-Sapir, 2013). The response to nature-initiated crises can lead to social injustice and differential responding. For example, Willison, Singer, Creary, and Greer (2019) found

the federal government responded on a larger scale and much more quickly across measures of federal money and staffing to Hurricanes Harvey and Irma in Texas and Florida, compared with Hurricane Maria in Puerto Rico. The variation in the responses was not commensurate with storm severity and need after landfall in the case of Puerto Rico compared with Texas and Florida. (p. 1)

Response inequities cause increased mortality and complicates individual and community recovery.

Technology-Initiated Crises

Technology-initiated crises describe a failure of a technological structure or human error in operating technology. Like nature-initiated crises, most technology-initiated crises involve human mismanagement and may also be categorized as human-initiated crises in that there is an *identifiable cause* attributable to a person or persons. Thus, as in human-initiated crises, the psychological impact on individuals and communities from technology-initiated crisis may be more detrimental (Goldsteen & Schorr, 1982).

The number and severity of technology-initiated crises are on the rise as technology becomes more complex, integrated, automated, and ever present. As of 2019, machine learning and artificial intelligence permit software programs to make decisions based on algorithms derived from big data embedded in software and applications. This means there may no longer be an identifiable cause attributable to a person, rendering technology-initiated crisis like nature-initiated crisis in that there is no one to blame. Technology-initiated crises most often occur at the communal or societal level—the 2008 U. S. financial crisis, Chernobyl nuclear meltdown, or Deepwater Horizon oil spill. Individually experienced technology-initiated crisis may take the form of identity theft or hectoring by internet bots—a form of automated cyberbullying.

Categories of Crises

The categorical depiction of crises began with Brammer (1985) and was extended by Cavaiola and Colford (2006, 2011) and James and Gilliland (2017). Using applied crisis theory, these authors identified six categories of crisis: developmental, situational, existential, psychiatric, traumatic, and ecosystemic. While these descriptive categories focus on the individual, it is clear the impact of the crisis may be equally experienced by groups and communities.

Developmental Crises

For infants and children, developmental crises occur within the milestones of human growth when a significant transformation or change occurs yielding atypical response (James & Gilliland, 2017). Puberty is a milestone indicative of significant physiological, psychological, and social changes in adolescence marked by increasing independence and autonomy from caregivers. While most progress through this development phase with minor disruptions, others experience disruptions that can last a lifetime. The hallmarks of developmental crises in adolescence include the constant redefining of self and seeking a sense of mastery of interpersonal, social, and academic skills and, depending on one's culture, a gradual acquisition of autonomy and independence. Developmental crises of adulthood tend to be centered on emerging and maintaining intimate relationships, adjustments to aging, raising children (negotiating adolescence and eventual emancipation),

choosing not to have children, retirement, and caretaking of one's parents or siblings, which involves familial role confusion, financial strain, and adjustment.

Infancy and Childhood

Developmental tasks associated with infancy include bringing hands and toys to mouth, visually following conversations, imitation of sounds, turning head and eyes toward sound, calming down while being rocked, and sleeping regularly for three to four hours at a time. According to the National Research Council (2000), early childhood is an acute period for brain expansion. Between birth and two years of age, the human brain more than triples in size, attaining 75% of its adult size by age two. The initial phases of neural development consist largely of primitive cells journeying to and forming particular sections of the brain. Recent research revealed that infants store memories as young as two months of age, within the limbic system of the brain (Markese, 2007). These memories are stored as somatosensory experiences. Thus, early distressing and traumatizing experiences, in infancy and toddlerhood, are stored in the brain as sensory experiences, even if the child cannot verbalize what has taken place (Green, Pouget, & Bavelier 2010; Markese, 2007). At birth, infants are reliant on their caregivers to meet their basic needs and to protect them from external stressors. Caregivers regulate the infant's sleep and eating cycles. Through countless interactions with caregivers, infants begin to control these cycles themselves. When caregivers repeatedly fail to protect infants from stressors or fail to support self-soothing behaviors, the infant's development and sense of security are impaired. Infants cannot yet communicate verbally and express their distress through behavior.

Emotional regulation is a process that begins in infancy with instinctive responses to distress (crying) and pleasure (eye contact, smiling). According to Ford (2009a), the purpose of emotional regulation is to utilize biological sources of information to screen and preserve the integrity of internal bodily conditions either automatically or self-reflectively. When an infant has repeated success in coping with mild, transitory incidents of fear, self-regulation is improved. Infants who endure a crisis and are traumatized may demonstrate increased distress, fussiness, and irregular sleeping and eating routines (Lieberman & Knorr, 2007). If the crisis or abuse continues, intensifies, or prevents new learning, unanticipated situations create an insecure basis for understanding and invoke fear and anxiety.

Newborns have multiple self-regulation systems—sucking, swallowing, breathing, thermoregulating, and vocalizing (Doussard-Roosevelt, Porges, Scanlon, Alemi, & Scanlon, 1997; Ford, 2009b). These innate processes depend on the brainstem and its functions to provide feedback along the vagus nerve bundle to biological organs. The vagus nerve is the longest of the 12 cranial nerves and monitors a range of crucial functions, communicating movement and sensory impulses to organs allowing one's body to adjust to a fluctuating environment. Self-regulation processes are the foundation for more multifaceted self-regulatory tasks that precede self-regulation in toddlerhood. Infancy is a period defined by low levels of responsiveness; this is partly due to limited stress hormone release and dormant hypothalamus pituitary adrenal axis reactivity (Andersen, 2003).

Consistent with the development of early dopamine chemical messenger systems, newborns continuously explore their environment (Rogeness & McClure, 1996). Environmental exploration, along with facilitative caregiver relationships described by Bowlby as goal-directed partnerships, are vital to the enhancement of self-regulation in infancy. Bowlby stated humans work throughout their life to acquire the ability to purposively adjust bodily, affective, and mental processes to have conscious control of self-regulation (Bowlby, 1992). Between six and twelve months of life, evolving neural pathways from the prefrontal cortex (PFC) to the amygdala and hippocampus provide the ability to discriminate unfamiliar and familiar things. Due to this phenomenon, fear of the unfamiliar will occur (Kagan, 2001). Infants develop the ability to discriminate through countless encounters. Infant self-regulation improves as they achieve regular success in handling mild, fleeting episodes of fear.

Developmental tasks associated with toddlerhood include managing emotions, delaying gratification, cooperating with others, acquiring new skills, and actively communicating. During the second and third year of life, continued rapid growth in the brain (Andersen, 2003) helps to organize consciousness of self and others as well as recognition of self as distinct with particular goals, emotions, and expectations (Adolphs, 2002). Once this process is complete, synaptogenesis and myelination begin (Nelson & Bosquet, 2000). Myelin is a fatty substance produced by glial cells that forms a sheath (myelination) around a nerve. The sheath allows more efficient movement of nerve impulses. Synaptogenesis is the process by which the speed of communication between brain cells and myelination increases. The speed of synaptic connections is highest in the first years of life. The toddler's processing speed is largely dependent on the quality of stimulation to which children are exposed. Positive child rearing experiences have been associated with increased synaptic connections, whereas traumatic early experiences have been associated with decreased synaptic pruning (Siegel, 1999).

Experiences shape the brain and alter neural networks throughout one's life, but never as much as in early childhood and adolescence. Although adjustments to neural pathways are possible throughout the lifespan, it is difficult to change personality after early childhood and challenging to change behavior, thinking, and emotion patterns after adolescence. With parental modeling and guidance, toddlers learn to experience and express emotions, recognize caregivers' emotional states, and learn emotional regulation. If development is interrupted during the first two to three years of life by significant traumatic events or compromised caregiving, the brain becomes organized around stress and reactivity. For example, frequent abuse and neglect in toddlerhood can lead to states of extreme emotional anguish and impairment in the ability to express or control these feelings and contingent behaviors (Cicchetti, Ackerman, & Izard, 1995). Ford (2009a) describes individuals who have encountered frequent early life traumatic experiences as developing a *survival brain*. The survival brain seeks to anticipate, prevent, or protect against the damage caused by potential or actual dangers, driven and reinforced by a search to identify threats, and attempts to mobilize and conserve bodily resources in the service of this vigilance and defensive adjustments to maintain bodily functioning (Ford, 2009a). Thus, psychosocial impairments involved

in complex traumatic stress disorders can be traced back to early life alterations in neural network development involving a shift, due to environmental adversity, from a learning brain to a survival brain. The shift causes lasting changes in key brain functions, neural/neurochemical activity, and key brain structures.

Attachment in Childhood

A preoccupation with survival is fundamentally incompatible with a child's development of dependable emotional bonds with caregivers. Indeed, most complex occurrences of psychological trauma tend to involve interactions with those closest to the child. Traumas that occur during a transitional period are likely to result in lasting changes in personality and self. Instead, experiencing a nurturing and engaging caregiver and appropriate environmental structure, the child subjected to crises or trauma learns to focus on survival and threat rather than on trust and learning. Nurturing bonds and the sense of security they provide advance the capacity for relational attachment. A secure attachment provides comfort and nurturance to the developing child and is necessary for the development of self-awareness (Bowlby, 1982).

Attachment is a relationship of interacting, affection, long-lasting emotional connection, and physical closeness (Thompson, 1998). Infants are born with attachment-promoting behaviors such as smiling, crying, and clinging. These behaviors elicit a response in the caregiver to comfort, protect, and feed the infant. Repeated and predictable positive interactions between infants and caregivers provide the infant security, predictability, a sense of identity, as well as an internal working model of relationships. Insecure attachment patterns emerge when the primary caregiver responses show a lack of predictability or when responses are harsh, punitive, or abusive (Ainsworth, Blehar, Waters, & Wall, 1978). Research demonstrates that the parental relationship plays a central role in the generational transmission of working models of attachment (Cohn, Silver, Cowan, Cowan, & Pearson, 1992). Repeated experiences with caregivers who have fractious relationships and provide inconsistent or abusive care may result in an internal working model that views relationships as unsafe and hurtful. If one's internal working model frames relationships as unpredictable and unsafe, when in crisis, the individual may resist or be mistrustful of help and support.

Individuals move through various phases of attachment (Bowlby, 1982). The initial phase lasts from birth through the first eight weeks of life. This period is recognized as an orientation phase when the infant is relatively indiscriminate in terms of the target of his or her attachment behaviors. The second phase occurs between the 8th and 12th week and involves an orientation phase and signaling toward one (or more) differentiated figure(s). The infant is beginning to show preference for one or more specific caregivers. The third phase has the infant or toddler seeking close physical proximity to the primary care giver by crawling or walking and verbal or nonverbal signals. This phase occurs from the 12th week to 18 months. The fourth phase of attachment begins at about 18 months and continues through adulthood. This phase is characterized by the formation of goal-corrected partnership where the toddler tests the limits of proximity and

safety. The main goal of these phases is to draw the caregiver in to close proximity for safety and security. As the child moves through the phases of attachment, the behaviors become increasingly discriminating in favor of the primary caregiver (Ainsworth, 1964).

Attachment Styles

Children who experience a loving, playful, consistent, and engaging caregiver develop a secure attachment pattern (Sroufe, 2000). Securely attached children cope with stress by using age-appropriate coping skills, are connected to their peer relationships, explore their environment, and demonstrate a balance of internalizing and externalizing behaviors. Children repeatedly exposed to inconsistent caregivers have limited or ineffective coping skills and are more isolated and at risk for developing one of several insecure attachment styles—dismissive/avoidant, anxious/ambivalent, disorganized/disoriented, or reactive (Ainsworth et al., 1978; American Psychiatric Association, 2013; Main & Solomon, 1986).

Dismissive/Avoidant

The dismissive/avoidant attachment style results from neglectful, absent, or unpredictable caregivers or environments and is marked by detached caregiving behaviors. The child with a dismissive/avoidant style of attachment rarely displays emotion, engages others in distant or detached manner, and may be viewed as hyper-independent. These children learn to avoid hurt and fear by dealing with events and emotions themselves, rather than depending on an unpredictable caregiver.

Anxious/Ambivalent

An anxious/ambivalent attachment style is rooted in inconsistent caregiver–infant attunement. The infant is confused by caregivers' behaviors that unpredictably oscillate between nurturing, attuned, and responsive to intrusive, insensitive, or unavailable. Understandably, these children feel confused, insecure, and suspicious of their caregivers yet cling to them to survive. Children with an anxious/ambivalent style behave unpredictably in relationships, have difficulty trusting others (Ainsworth et al., 1978), and remain wary in strange situations, even with the caregiver present. They respond to caregivers' departures and reunions with aggression/anger or helplessness/passivity, attempting to maintain a connection to the caregiver by varying their interpersonal responses—crying/fussing versus resignation/helplessness. These children reflect the relational inconsistencies experienced with their primary caregiver (Ainsworth et al., 1978).

Disorganized/Disoriented/Reactive

A disorganized/disoriented attachment style is often, but not exclusively, associated with grossly neglectful and abusive caregivers or environments. Children experience little to no caregiving, poor interpersonal boundaries, role-confusion, and pervasive errors in communication (Main & Solomon, 1986). Children with a disorganized/

disoriented attachment style demonstrate unique behavior in the playroom such as: rocking, freezing, and active dissociation. As the child matures, they have profound difficulties establishing intimate, enduring relationships, seem devoid of empathy, and experience low self-esteem, anxiety, and poor boundaries. Some children with a disorganized/disoriented attachment style are later diagnosed with reactive attachment disorder. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM—5)* characterizes reactive attachment disorder as “a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance” (American Psychiatric Association, 2013, p. 266). Reactive attachment disorder is hypothesized to emerge from pathogenic caregiving during infancy, child abuse or neglect, and frequent changes in primary caregiver. Distinctive behaviors associated with the disorder are extreme and sociopathic behavior, an inability to attach in relationships, and lack of conscience and empathy. Researchers and clinicians are not clear why some children develop this disorder and others do not; more research is needed to improve diagnosis and treatment.

Mikulincer and Shaver (2012) note one’s attachment style and associated coping skills learned in infancy and childhood continue into adulthood. Those with secure attachment styles trust and depend on others and expect to be loved and valued by their partners. Those with insecure attachment styles are, in varying degrees, distrustful of relationships, mistrust others, and avoid interpersonal dependency. According to Fraley and Waller (1998), the way one responds to an unresponsive caregiver can be defined in two dimensions of anxiety and avoidance. The anxious response is characterized by proximity-seeking behaviors—clinging, pursuit, or anger to provoke a response from the other person. The avoidance response is characterized by deactivation of attachment behaviors—limited eye contact, indifference—to avoid or limit emotional contact and suppress one’s emotional needs. The fearful-avoidant strategy is a combination of the two previous responses and is characterized by an individual seeking contact and then rejecting the contact when it is offered (Palmer & Lee, 2008). It is not difficult to imagine how one’s attachment style influences a response to a crisis or the offer of assistance after a crisis.

Childhood Trauma

Hirsch (2004) found a wide range in the development of PTSD across children who have experienced childhood maltreatment, were medically ill, or disaster survivors. For very young children, trauma-reexperiencing symptoms often manifest in repetitive play that is devoid of fun or creativity and that may resemble the content or emotions of the traumatic event. If the child is mobile, they may physically avoid reminders of the traumatic event. Alternatively, if the child is not yet mobile, they may avoid eye contact or, in the case of abuse or neglect, noticeably may be distraught by the presence of the abusive caregiver. These avoidance symptoms manifest in terms of the child’s developmental capacity.

A diagnosis of PTSD in young children is made using the same three criteria that are used to diagnose PTSD in adults: reexperiencing, avoidance, and hyperarousal (Coates & Gaensbauer, 2009; Levendosky, Huth-Bocks, Semel, & Shapiro, 2002).

To further elaborate, Lenore Terr (1991) described two types of trauma among children. Type I refers to child victims who had experienced a single traumatic event. Type II trauma refers to child victims who experienced multiple traumatic events such as ongoing incest or child abuse. Research demonstrates that most children who experienced a single traumatic event had detailed memories of the event but did not experience dissociation or memory loss. In contrast, child survivors experiencing multiple or repetitive incest and child sexual abuse trauma exhibited dissociative processes, recurring trance-like states, depression, suicidal ideation and suicide attempts, sleep disturbances, and, to a lesser degree, self-mutilation and PTSD (Ford, 2014).

Neurodevelopment and Plasticity

From a neurodevelopmental perspective, the human body reacts to extremely stressful situations by the brain's activation of the HPA system flooding the central nervous system with neurotransmitters, such as cortisol and norepinephrine. The HPS activation causes some individuals to experience a fight or flight response to the stressful situation (Kalat, 2013). Neuropeptides are small protein messengers that neurotransmitters use to communicate. Neuropeptide Y (NPY) is abundant and widespread in the human brain and has been evidenced as providing protection and mediating resilience (Enman, Sabban, McGonigle, & Van Bockstaele, 2015) during extreme stress. Studies attribute superior performance, positive feelings of self-confidence, and lower psychological stress during interrogation simulations in soldiers with the increased presence of NPY (Morgan et al., 2000; Morgan et al., 2001; Morgan et al., 2002).

The manifestation of emotions involves striatal (putamen, caudate, nucleus accumbens) brain regions that are stimulated by input or afferents from the cortex and selectively alter sensory perception via the thalamus. The hypothalamus, a small region of the brain, modulates bodily states by producing the production of neuropeptides while engaging the autonomic nervous system (Heim & Nemeroff, 2001). The limbic system governs emotions, attention and memories, and arousal as well as conscious responses based on the emotional significance of perceptual and memory retention data (Milad et al., 2007). It organizes responses based on the general context, including previous experiences and current situations (Bremner, 2008; Ford, 2009a).

Neural plasticity also known as neuroplasticity, brain plasticity, and cortical plasticity, is a developmental process over the lifespan. Plasticity refers to the capacity of the central nervous system (CNS) to alter its existing cortical structures (anatomy, organization) and functions (physiological mechanisms or processes) in response to experience, learning, training, or injury (Ballantyne, Spilkin, Hesselink, & Trauner, 2008; Hubel & Wiesel, 1970; Kolb, Gibb, & Robinson, 2003). In sum, brain structure and function are use dependent.

Researchers typically "map" brain structures and functions to indicate which region of the brain responds to what stimuli resulting in a particular understanding or representation (Buonomano & Merzenich, 1998). When an individual obtains new skills and information, the experience changes the neural "maps" (Wall, Xu, & Wang, 2002). The explication of these cognitive and motor activities and their

consequential synaptic pathways have been entitled *brain fitness*. Brain fitness must be intellectually stimulating and physically appropriate to bring about maximal benefits to the aging brain (Colcombe et al., 2006). Actively engaging in physical, motor, or intellectual exercises and multisensory stimulation is believed to prevent functional decline and preserve cognitive functions. Brain fitness creates structural and functional changes like neural reorganizations of the brain including the development of new neurons (neurogenesis) and glial cells (gliogenesis), creates new and strengthens existing synaptic connections (synaptogenesis), and creates new blood vessels (Buonomano & Merzenich, 1998; Cotman & Berchtold, 2002; Dong & Greenough, 2004; Ming & Song, 2005; Voelcker-Rehage & Willimczik, 2006; Ponti, Peretto, & Bonfanti, 2008). Consequently, activity-dependent neural plasticity is induced by extensive and brief-intensive practice (Ziemann, Iliac, Pauli, Meintzschel, & Ruge, 2004) and expands the size of adult gray matter in the posterior and lateral parietal sites (Draganski et al., 2006).

Adolescent Development and Crises

Adolescence, a socially constructed phase of development occurs between the ages of 13 and 19 and is characterized by the ability for abstract thought (Piaget, 1952). Developmental tasks of adolescence are many and varied. The transition from childhood into adolescence signals puberty, sexual maturation and attraction, independence from caregivers, maturing peer relationship, differentiation of morals, values and personal ethics, social role adoption, and career exploration (Havighurst, 1949). Developmental crises are a normal part of development and occur across the lifespan. For example, identity crises are common in adolescents (Kidwell, Dunham, Bacho, Pastorino, & Portes, 1995). However, normal aspects of development—acknowledging one's sexual orientation—can cause distress, confusion, impulsivity, and impaired coping. The crisis may be due to the intake of new stimuli that cannot or has yet to be incorporated into an individual's reality because of developmental constraints. This distress continues until it is reconciled. During adolescents, the prefrontal cortex continues to develop and refine executive functioning, allowing for improved coordination and management of thinking and behavior (Choudhury, Blakemore, & Charman, 2006). Age-appropriate interpersonal experiences during this developmental period solidify personality and identity formation influencing adulthood (Smith & Handler, 2007).

Kanel (2012) identified typical adolescent situations that can evolve into crises for some individuals. For example, adolescents simultaneously seek and test the extent or boundaries of their independence, their environment, and caregivers' nurturance. Appropriate testing by teens and congruent caregivers' responses reinforce attachment and promote individuation and self-efficacy. Inappropriate testing and incongruent or destructive caregiver responses may lead teens into dangerous, risky, or novel behaviors involving violence, illegal drugs, or illicit sex. Adolescents' capacity to negotiate their autonomy and independence is in large part dependent on their reaction to family/caregiver structure, feedback, and temperament.

Regarding adolescent brain development, Giedd et al. (1999) noted the brain continues to increase in total volume until 14 years of age. According to Lenroot

and Giedd (2006), a longitudinal magnetic resonance imaging (MRI) result demonstrates that human brain frontal and parietal grey matter volume peaks at about 14 years of age before deteriorating. The decrease in frontal and parietal grey matter volume is probably due to synaptic loss during adolescence. Many speculate the brain develops in response to experience and pertinent environmental needs—the “use it or lose it theory.” Synaptic pruning is a process by which redundant synapses overproduced in the early years of life are eliminated. In comparison to general development of structures in the infant or child brain, the adolescent brain is more specific. Indeed, neuro-developments are taking place in specific regions like the limbic system and prefrontal cortex (PFC). The limbic system is responsible for pleasure seeking and reward processing, emotional responses, and sleep regulation. The PFC manages the area responsible for executive functions like decision making, organization, impulse control, and planning (Blakemore & Robbins, 2012). Connected with these important changes are personality traits, including high novelty seeking and low harm avoidance (Cloninger, Sigvarsson, & Bohman, 1988; Wills, Vaccaro, & McNamara, 1994). Maturation occurs in all areas of the adolescent’s life and simultaneously promotes individuation and independence, which, in turn, increases the risk of harm, crises, and, for some, psychological disorders. Results of the National Comorbidity Survey Replication study of over 9,000 participants identified 14 years of age as the most common age for onset of a variety of mood, eating, and substance abuse disorders as well as psychosis and schizophrenia (Kessler et al., 2005). Important neuronal developments continue into adolescence and despite encountering crises, the adolescent brain has significant neural plasticity and high ability to change (Spear, 2013).

Adolescents in crises often encounter disturbed peer and family relationships, isolation, self-recrimination, and impaired academic performance not experienced in childhood. The calamitous flood at Buffalo Creek in 1972 illustrates this differential responding. On the night of February 26th, the coal slurry impound dam #3, located on a hillside, burst, flooding 16 coal-mining towns of Logan County, West Virginia. The consequences were catastrophic; 125 individuals killed, 1,121 injured, and over 4,000 individuals lost their homes (Stern, 1972). Two years after the Buffalo Creek Disaster, adolescents affected by the disaster were found to have higher levels of distress than younger children (Green et al., 1991). A major factor contributing to this tragedy was a loss of community as well as a belief in duplicity on the part of the mining company whose carelessness led to the disaster.

Adolescents traumatized by a crisis or traumatic event feel isolated and alone when peers are unable or unwilling to offer support. The presence of physical injuries may exacerbate their fragile self-concept and impair their fit with a peer group. Psychological injuries may result in confusion, withdrawal and isolation, antisocial behavior, suicidal ideation, academic failure, alcohol and drug abuse, sleep disturbance, depression, legal problems, and a host of physical complaints (Ford, Hartman, Hawke, & Chapman, 2008; Gordon, Farberow, & Maida, 1999; Halpern & Tramontin, 2007). Neural plasticity aids the adolescent’s coping with change and crises and is bolstered by more mature cognitive, language, and decision-making skills.

Adulthood and Older Age

In the latter stages of human development, individuals continue physical maturation, adopting adult roles, relationships, and responsibilities and have capacity for empathy and intimacy. The adult brain maintains its plasticity as one encounters their career, marriage, children, financial responsibilities, and, toward the end of this stage, the effects of aging. Recent research findings on the adult brain indicate they continue to change and develop in response to external stimuli (Sowell et al., 2004; Lenroot et al., 2007). Attachment in adults also continues and is based on the internal working models established in childhood. Adult attachment is defined as “the bond that exists between individuals who are emotionally connected to one another and who have primary significance in each other’s lives” (Palmer & Lee, 2008, p. 163). Biologically, humans are driven to find and preserve intimate relationships with a select few.

Older adults face continual transitions as they age, some of which may invoke a crisis. Loss of one’s intimate partner and status changes in vocation, health, and physical abilities (mobility, hearing, vision) impact one’s sense of self, independence, and quality of life. Long-term care and end of life issues frequently involve adult children and family caregivers, particularly when the older adult’s cognitive functioning is impaired.

Age Related Decline and Neural Plasticity

Gradual age-related decline in neural-behavioral functionality significantly influences adults 65 and older (Yan, Thomas, Stelmach, & Thomas, 2000). This includes a decline in cognitive, motor, social, psychological, and physical domains. In addition, some older adults experience increased anxiety, failing memory and waning attention, sluggish processing speeds, a decrease in motor control and learning capabilities, and greater behavioral unpredictability. The consequence of these changes can be neurodegenerative disorders like mild cognitive impairment (MCI), Alzheimer’s disease (AD), and dementia as well as impacts to physical mobility and hearing. Changes in functionality challenge the quality of life, often require support and resources, and may be, as noted earlier, experienced as a crisis in and of itself. For a moment, consider how older individuals, with age-related declines might respond to crisis events. They may be confused because of impaired hearing and slower to react and process events. What seems like cognitive impairment is actually hearing loss. Clinicians, working with older adults in crisis, must ensure clear unambiguous communication/directives are delivered while facing clients. Active engagement, cognitive challenges, and physical activities stimulate neural plasticity, support physical fitness, and contribute to overall well-being.

Situational Crises

Both situational and developmental crisis events have a significant impact on individuals and society. Situational crisis arises out of unusual, unexpected, or unpredicted events like sexual violence, suicide, or an accident. Situational

crises are “random, sudden, shocking, intense, and often catastrophic” (James & Gilliland, 2013; p. 17) impacting the individual, a system, or community. Recent situational crisis events include the human-initiated events like mass shootings at Stoneman Douglas High School or Tree of Life Synagogue and natural ones like the 2018 California wildfires or the 2019 floods in Nebraska.

Existential Crises

Existential crises are a turning point when one questions or considers their life's purpose and meaning, values, and responsibilities (James & Gilliland, 2013). For adolescents, existential crisis may be associated with identity development as they strive to understand who they are relative to their family and what they are *supposed* to be. Older adults may experience existential crises at transition points like marriage, vocational changes (new careers or retirement), and age-related changes in health and status. At its core, an existential crisis signals the individual that their way of being in the world no longer works. Faced with this dilemma, individuals experience anxiety and, for some, despair as they consider their beliefs and assumptions about freedom and responsibility, limitations and mortality, feelings of isolation, and life's meaning. This category of crisis can be challenging to identify since there are few, if any, outward signs of the experience; however, many individuals describe tumultuous or confusing inner experiences, such as depression, apathy, general dissatisfaction, lack of mental acuity, lethargy, and inability to focus and accomplish tasks (Cavaiola & Colford, 2006).

Psychiatric

While not everyone who meets the diagnostic criteria for a diagnosis within the DSM-5 of the American Psychiatric Association experiences a crisis, several psychiatric disorders may result in sense of crisis for those who suffer as well as their support system. A psychiatric crisis may be a component or a symptom of the disorder, particularly personality or anxiety disorders, and interferes with one's ability to effectively cope with a crisis. For example, an individual diagnosed with generalized anxiety disorder may feel a sense of fear when asked to leave their apartment during a fire. Their anxiety, fright/fear response, and hesitation to evacuate escalate the risk of harm to them and others. Similarly, an individual experiencing a dissociative fugue wanders away with no explanation or intention causing a crisis for family members who are terrified. Once the fugue remits, the individual and their family will deal with different categories of crisis, individual and situational.

Traumatic

A traumatic crisis is caused by a sudden, unanticipated, and intense event. The acute emotional shock and temporary feeling of being overwhelming may lead some to appraise the event as life threatening. Traumatic crisis events impel those experiencing crisis to immediately rely on habitual coping strategies as opposed to depending on coping strategies specific to the crisis event. Traumatic crisis events include nature- and human-initiated crises.

Ecosystemic Crises

An ecosystemic crisis originates from natural- or human-caused events. Akin to a disaster, an ecosystemic crisis negatively affects individuals within groups and communities (James & Gilliland, 2013) rather than a single individual. Earthquakes, epidemics, financial meltdowns, and terrorist attacks are examples of this type of crisis that requires advanced preparation, planning and communication, and resource management plans.

Nature of Crises

James and Gilliland (2017) offer a comprehensive array of crisis definitions in two categories: individual and systemic. Individual crises occur when one perceives an incident as unbearable and believes they possess insufficient resources and coping strategies to respond. Without support or assistance, the crisis may lead to emotional dysregulation, impaired cognition, ruptures in relationships, and behavioral acting out. In contrast, a systemic crisis occurs when response systems (medical, social, or governmental) cannot contain or control an event, and services, rather than individuals, are overwhelmed. The crisis event causes organizations, ecosystems, and societies to react, psychologically and physically, and may result in environmental or interpersonal volatility. In sum, the two categories provide helping professionals a vantage point and conceptual framework for the crisis event. Individual crisis definitions promote the experience of the individual while in crisis, whereas the systemic crisis definitions delineate a contextual experience based on interdependence and multiple crisis-oriented forces moving simultaneously.

Individual Crises

Grieving

Grief or bereavement affects every person at some point of their lives. Whether it be a parent or caregiver, a child, a partner, or another loved one, someone important to us will die and we experience their loss. For many, grief is expected to be a short-term experience as codified in many companies' two- to three-day bereavement leave benefits. However, intensity and length of grief not only varies from person to person, but from incident to incident and culture to culture. No two occurrences or reactions are the same. The American Psychiatric Association (2013) describes typical grieving as an "intense yearning or longing for the deceased, intense sorrow and emotional pain, and preoccupation with the deceased or the circumstances of the death" (p. 194). However, when symptoms persist for at least 12 months for adults or six months for children, grief is considered pathological and may result in a diagnosis of Persistent Complex Bereavement Disorder (p. 789). Grieving, not categorized in the *DSM*, may be associated with a loss of status—employment, divorce, homelessness; changes in functionality (age-related decline in mobility, independence, and sexual functioning); or longing for an earlier time. These experiences may be as disruptive as diagnosable disorders.

Suicide

Suicide or self-directed violence includes acts of fatal and nonfatal suicide attempts and is distinguished from nonsuicidal intentional self-harm—cutting or self-mutilation (Meyer et al., 2010). Suicide is the tenth leading cause of death among Americans (Centers for Disease Control and Prevention [CDC], 2012). In 2011, someone in the United States committed suicide every 13.3 minutes. According to the same report, women were more likely to have suicidal thoughts or ideations and men were more likely to die by suicide due to the lethality of their means. Evidence suggests that as we age our suicide risk increases. The highest suicide rate was among people ages 45 to 64, followed by those 85 and older. According to the Center for Disease Control and Prevention (2017) suicide rates were highest for American Indian/Alaska natives, non-Hispanic males and females, followed by White, non-Hispanic males and females. Lesbian, gay, bisexual, and transgendered youth are almost three times more likely to contemplate suicide and five times as likely to attempt suicide than their heterosexual peers.

Substance Abuse

Substances are divided into 10 classes, including caffeine, tobacco, alcohol, cannabis, inhalants, hallucinogens, opioids, sedatives, stimulants, and other substances. These substances trigger the reward system, which is directly implicated in the strengthening of memories and behaviors (American Psychiatric Association, 2013). Substance use becomes abuse when it is chronic and unremitting and leads to a chemical addiction characterized by the development of tolerance and withdrawal (American Psychiatric Association, 2013). It is important to note that substance abuse and misuse impacts more than the individual. Abuse and misuse often occur within the context of a family or community and affects the quality and nature of interpersonal relationships, employability, financial resources, housing, crime, and interpersonal violence.

Diagnosis of Chronic or Terminal Illness

The diagnosis of a chronic terminal illness impacts individuals and families on many levels. How one responds to the diagnosis depends largely on their access to resources (Ziebland & Kokanovic, 2012) and premorbid functioning. The disease or illness alters the course of individual's lives and roles (Papadopoulos, 1995), relationships, employability, spirituality/religious beliefs, and finances. Family systems change as partners or children become caretakers or family members take on unfamiliar responsibilities or respond to situations for which they are unprepared. Individuals diagnosed with a chronic or terminal illness confront issues of mortality, organizing their affairs and uncertainty, and grieve the loss of normalcy, autonomy, and their future. Crisis originates from one's perceptions about their change in status and subsequent adjustment to those changes.

Disability or Injury

Accidents that result in partial or permanent disability or injury are like traumatic crises because many occur suddenly and create a significant emotional shock to the individual. Examples of injury-inducing incidents include traffic accidents, work injuries, and physical assaults, among others (Koren, Arnon, & Klein, 1999). Injuries can result in disabilities like traumatic brain injuries, psychological disorders such as PTSD, paraplegia, blindness, loss of hearing, or other physical disabilities (Diedericks, 2014). Because of the sudden nature of many of these incidents, a long-term traumatic response may be elicited irrespective of the severity of the injury (Koren, Arnon, & Klein, 1999). Injuries and permanent disabilities impact family systems as roles may change to incorporate new expectations for family members as the person injured heals, or if permanent role changes are necessary. There may also be loss of income, legal involvement, or lack of access to adequate medical care that can result in a crisis for many individuals and families involved in accidents (Diedericks, 2014).

Group or Subsystem and Community Crises

Family Crisis

There are many ways in which families experience crisis including child or sibling abuse, intimate partner violence, neglect, or violence originating outside the family, financial hardships, homelessness, and immigration status. Wolf and Pillemer (1989) defined abuse as the infliction of physical pain or injury, or physical coercion (p. 18) through physical, sexual, and emotional violence. They include psychological/emotional abuse—anguish, name-calling, shaming, and humiliation—in their definition of family violence. Wolf and Pillemer (1989) also identified two types of neglect: *active neglect* or the refusal or failure to fulfill a caretaking obligation and *passive neglect* or the unintentional failure to fulfill a caretaking obligation because of “inadequate knowledge, laziness, infirmity or disputing the value of prescribed services” (p. 18). These neglect and abuse occur in all types of families to all kinds of individuals at any stage of life.

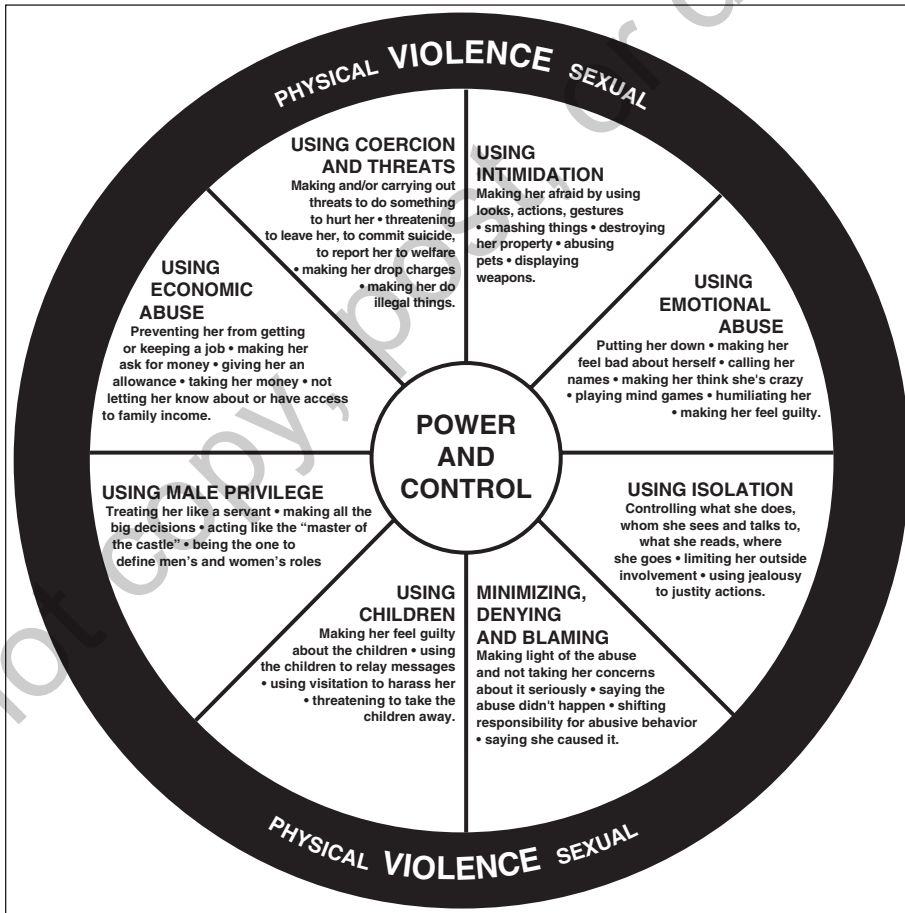
Elder abuse is similar in scope and type to that faced by infants, children, and adults. It ranges from the psychological, physical, sexual—and extends to violations of rights and material abuse—exploiting an aging person for material gain (Lau & Kosberg, 1979, as cited in Wolf & Pillemer, 1989). The additional types of abuse are indicative of vulnerable adults with adult rights but perhaps diminished capacity in some area of life. State by state, definitions of elder abuse vary. Some states define elder abuse only when there is an active abuser while others characterize elder abuse as an aging person not being able to meet their own needs and there is no intervention to assist them (Wolf & Pillemer, 1989). As a person ages into older adulthood, their vulnerability to abuse rises due to increased frailty and vulnerability and decreased ability to carry out everyday tasks. Elders often depend on others to meet their basic needs to rise (Wolf & Pillemer, 1989). In American culture, older adults are not valued as evidenced by the way we relegate them to

out-of-home facilities versus in-home care and the lack of adequate community programming that meets their needs and interests. The isolation and devaluation contribute to a loss of meaning (Newell, 1961, as cited in Wolf & Pillemer, 1989) and potential existential crises.

Aggression

Siann (1985) defined aggression as “involving an intent to inflict hurt or appear superior to others” (as cited in Loue, 2001, p. 1). Violence, on the other hand, was defined by Gelles and Straus (1979) as “an act carried out with the intention or perceived intention of physically hurting another person” (as cited in Loue, 2001, p. 1). This not only includes physical violence but also sexual assault. Also prominent in intimate partner violence is emotional abuse, such as intense criticism,

FIGURE 2.1 ● Power and Control Wheel



Note: This figure illustrates the eight elements of power and control in the context of intimate partner violence. Source: National Center on Domestic and Sexual Violence, 2014.

harassment, control, or withholding of basic needs (Karakurt, Smith, & Whiting, 2014). Intimate partner violence has less to do with the need of a person to inflict physical violence on their partner, and more about the need for power and control. Figure 2.1 presents the Power and Control Wheel that is used commonly to educate both survivors and perpetrators of intimate partner violence.

Divorce

According to the American Psychological Association (APA; 2014), 40% to 50% of marriages end in divorce. The impact of the divorce process extends well beyond the dissolution of a marriage, particularly if there are children involved (Blaisure & Saposnek, 2008). The process and aftermath of divorce often result in crises that stem from adjustment to living without a partner or without one parent. Family functioning is more difficult when there is conflict and blaming between the partners or spouses. Other common stressors associated with divorce can include loss of custody, emotional support, economic hardship, decline in parental control, changes in family roles, and changes in identity (Amato, 2000, p. 1271). Like other crises, it is important for clinicians to note, experiencing the same event does not equal experiencing it in the same way. Some members of the family, including partners, children, or grandparents, may feel relief while others experience mourning, loss, anger, and frustration.

Teen Pregnancy

Teen parents, particularly teen mothers, are highly stigmatized in the United States (Smith-Battle, Lorenz, & Leander, 2013). The stigma originates from religious and gendered expectations of young women to be pure, virtuous, and virginal prior to marriage in contrast to young men who are expected have sexual conquests and to sow their wild oats as a rite of passage. These differential expectations extend to teen mothers' decisions regarding the pregnancy. Should she marry the father, raise the child alone or with family, consider adoption, or abortion, and to what degree, if any, should she consider the father's perspective? Cultural or religious stigma and the resulting shame create significant barriers for teen mothers and fathers and accelerate role transition, delays of post-secondary education or desired vocation, encourages premature marriage or coupling and may put the infant at risk. Teen moms are stereotyped as unmotivated, irresponsible, neglectful (Lewis, Scarborough, Rose, & Quirkin, 2007; Usdansky, 2009), and sexually promiscuous. As a result, depression and other psychological disorders are common among teen mothers (Reid & Meadows-Oliver, 2007, as cited in Smith-Battle, Lorenz, & Leander, 2013). Many adolescent fathers experience psychological distress whether they were active in co-parenting, absent from parenting, or if the pregnancy was terminated. In a study of 2,522 young men (Buchanan & Robbins, 1990) first surveyed as seventh grade students, 15% were involved in a nonmarital adolescent pregnancy. At age 21, they reported shortened educational experiences, greater rates of divorce and job dissatisfaction, and lower income. Unexpected teen pregnancy is often viewed as a crisis because its unplanned nature creates disequilibrium in both family systems and alters the lives of all involved. Families

must consider how to inform others of the pregnancy and decide whether to continue or terminate the pregnancy. If the pregnancy is continued to term, matters of kinship care or adoption need to be addressed as well as anxieties about the future (American Academy of Child and Adolescent Psychiatry, 2012).

Hate Crimes

A hate crime is “a crime in which a victim is targeted because of the victim’s real or perceived group membership, which can be defined by race, religion, sexual orientation, gender, gender identity, ethnicity/nationality, disability, political affiliation, and so on” (Stotzer, 2007, as cited in Cheng, Ickes, & Kenworthy, 2013, p. 761). There are three types of hate crimes—crimes against people involving intimidation, simple assault, aggravated assault, and murder (Cheng, Ickes, & Kenworthy, 2013); crimes against property like vandalism, arson, larceny/theft, burglary, and robbery; and crimes against society like the *Pulse* nightclub shooting or terrorist attacks (Federal Bureau of Investigation, 2014). Hate crimes impact the victim’s mental health and result in anxiety, depression, or PTSD and decreased self-worth. Consistent with many historically marginalized populations, those victimized by hate crimes experience disempowerment and believe the world is no longer safe (Hein & Scharer, 2012).

Relocation

Families or individuals relocate for new employment, foreclosure, disruption, death, divorce, military assignment, or retirement. Relocation can create crisis for individuals and families due to the loss of a support network (Sluzki, 1992) or unfamiliarity of the new location. People who relocate may experience grief, isolation, uncertainty, loneliness, and difficulty adjusting to their new location or setting. For adolescents, the crisis may be magnified because of the loss of security and belonging to their previous peer group. For couples, relocation is a source of stress because one partner must find employment, child care, community resources, or a new educational program due to their partner’s relocation. Relocation can also result in initial isolation requiring couples to lean on each other for support in new and unexpected ways to meet needs that were previously met by others.

Financial Instability, Poverty, and Unemployment

During the U.S. economic crisis of 2008, the suicide rate accelerated by 3% to 8% (Reeves et al., 2012). This pattern continued throughout other countries also affected by the financial crisis, such as England and Wales (Kinderman, 2014). Financial instability is associated with sharp rises in foreclosures (Cagney, Browning, Iveniuk, & English, 2014). This group of researchers identified the need for crisis support among people and communities who experience high rates of financial instability, poverty, or unemployment. Foreclosure and community financial crisis are not just limited to the individuals and families they affect; it can also result in lower-density communities, degradation of available housing due to lack of maintenance, and a decrease in community investment among remaining residents (Cagney et al., 2014).

Community Crises

Community crises or socially generated crises are not easily defined (Enander, Lajskjö, & Tedfeldt, 2010) and change the very fabric of a community. Examples of community crises include large-scale events like the Flint Water crisis or personal data breaches and smaller scale events like a crime spree in a small community or high-profile hostage situation. Community crises are defined as any event that affects an identified community, results in loss of status for the community, evokes mistrust of authorities, or a sense of shame for the community. While there is a gradual return to normalcy after a community crisis event, conflicts may keep occurring, sometimes for generations.

Acute and Chronic Crises

Clinicians can offer short-term interventions to help individuals in crisis and are not expected to conduct long-term psychotherapy. Thus, as a crisis counselor, you are likely to find yourself coordinating ongoing care and services for those who may require longer-term care. Crisis care and coordination begin with assessment and evaluation of how and where clients experience disequilibrium and the suppleness of their functioning across all domains. Through an effective assessment, crisis counselors determine the acuity, chronicity, duration, and severity of the crisis, extent of the client's immobilization, resources available, lethality, and likely success of specific interventions (Kanel, 2012).

Crises vary in type, intensity, and severity. Clinicians respond to clients' acute crises by conducting one of several standard assessments such as a suicide checklist, mini-mental status exam, or triage assessment followed by application of appropriate and available resources designed to help the individual in need. The assessment helps you determine the level of need and needed resources. Consider the following example: Pat, mentioned earlier in the chapter, was informed this morning that he and others were laid off from their jobs. Pat has worked at the same firm as an accountant for 15 years. He walks into your counseling center, despondent and tearful, and tells the receptionist, "I don't want to live anymore. I am an embarrassment to my wife and kids. I want my boss to die. I need some help." The clinician conducts a clinical assessment or interview, reviews Pat's completed suicide or homicide checklist, and responds to his devastation and embarrassment over the loss of his job and fears of the future. Pat reports he is embarrassed to tell his wife and children. After about 30 minutes, the clinician and Pat normalize his grief and shock, explore how he has handled previous crises, and discuss future-oriented options like calling his wife to discuss the layoff. Although upset and tearful, Pat expresses a future orientation in his marketable skills, the generous separation package from his company, and his knowledge, deep down, that his wife will be supportive—she always has been. Pat is working his way back to state of precrisis equilibrium, or close to it, and can vocalize how he might utilize his previous ways of coping.

Chronic crises are approached differently. Individuals experiencing chronic crises benefit from reviewing their current coping skills, accessing community and familial resources, and support from the clinician. Chronic crises may include health or persistent mental health issues, child neglect, and the effects

of poverty. Those experiencing chronic crises can be urged or supported to recall times when they successfully negotiated the crisis, returned to a sense of empowerment, and saw themselves as capable rather than overwhelmed. Crisis counseling is not intended to provide long-term, in-depth psychotherapy, thus it is important to refer individuals with long-term, life histories of crisis to a helping or support professional with experience and resources to assist on an ongoing basis.

Models of Crisis Counseling

Common Crisis Concepts and Stages

We begin this section with an exploration of several universally understood concepts related to crisis counseling. As noted in Chapter 1, Yeager and Roberts (2003) and Young (1995) identified constructs related to the personal impact of a crisis situation, specifically, spatial dimensions or proximity to the crisis event, sense of a subjective time clock, and the perception the event will reoccur. Along with this information we add the common stages of a crisis.

Common stages and progression of crisis events begin with the precrisis status including personal demographics and ways of being. Next, an event occurs resulting in psychological disruption or disequilibrium and perception of threat. Threat appraisal and attempts at coping follow. Threats that are considered manageable with current resources support the individual's return to a state of equilibrium. When threats are considered overwhelming and beyond the individual's resources and coping skills, a crisis state emerges distressing the individual. In the sections that follow, we present crisis intervention and response models, ordered chronologically, utilized in crisis counseling. As you review each model, consider the progression, changes, and refinement of concepts and intervention strategies.

The Equilibrium Model of Crisis Counseling, Intervention, and Management

Erich Lindemann (1944) and Gerald Caplan (1964) were the architects of the equilibrium model. Lindemann's theory argued crisis intervention should be utilized when one experiences loss. Gerald Caplan expanded on Lindemann's theory with the premise that one's current state becomes impaired when they experience a crisis and cannot utilize adequate or traditional coping mechanisms to restore a sense of psychological equilibrium. If one's state of disequilibrium goes unaddressed and normal coping skills remain insufficient or inaccessible, then one falls into a state of temporary psychological distress (Wang, Chen, Yebing, Liu, & Miao, 2010). The equilibrium/disequilibrium paradigm attends to individuals whose normal coping strategies fail during the midst and in aftermath of a crisis. The model addresses disturbed equilibrium, brief therapy, clients working through the grief, and restoration of equilibrium (Brown, Shiang, & Bongar, 2003).

Empirical evidence supports the use of the equilibrium model in a cross-cultural setting. Wang, Chen, Yebing, Liu, and Miao (2010) evaluated the equilibrium model's effectiveness with Chinese families admitted to a hospital setting on an emergency basis. The authors sought participants whose family members were admitted to an ER, received some level of treatment, and died within 24 hours due to the gravity and extent of their wounds or presenting problem. Research participants were administered the Symptom Checklist-90 (SCL-90) Questionnaire three days after the death of their family member and were randomly assigned to either the intervention or control group. Participants receiving the intervention were given a four-step intervention that included self-introduction, expression of feelings, information to prevent negative feelings, and creation of effective support to increase coping capacity through appropriate training. Participants in the control group received no intervention. One month later, participants were again administered the SCL-90. The findings indicate that while both groups showed positive change, results for participants receiving the intervention reported fewer physical ailments and a greater reduction in the symptoms of depression, anxiety, and phobic anxiety as measured by the SCL-90.

The equilibrium model is focused on *psychological homeostasis* (Brown et al., 2003). As mentioned previously, crisis disrupts one's typical functioning or homeostasis as traditional coping mechanisms fail. Clinicians assess the client's current functioning and employ crisis counseling to contextualize events and aid the client's return to their precrisis functioning. It is important to note that a psychological crisis may last for four to six weeks, thus, it is imperative to assess and address signs of disequilibrium during each interaction before issues develop into more persistent concerns.

Gerald Caplan described the basics of crisis intervention in his landmark book, *Principles of Preventive Psychiatry* (1964). Effective interventions like conflict management and social skill instruction promote a positive-growth orientation and reduce factors known to contribute to psychological impairment. Caplan described a four-stage model of crisis reaction: first, tension is created and associated with the crisis event. Next, the client is unable to handle the degree tension and feels powerless to manage the crisis. Third, coping mechanisms fail and the client enters a state of despair, leading the client to seek different and usually less effective coping strategies. Caplan's interventions address the importance of identifying and employing alternative coping mechanisms until the client returns to a state of equilibrium. Zhang and Lester (2008) found clients who did not develop sufficient coping skills early in treatment were at increased risk for suicidal ideation, suicidal attempts, and psychological illnesses. Zhang et al.'s findings confirm the significance of using the appropriate assessments and interventions at the onset of a crisis to aid the client's return to the precrisis state; time is of the essence! Generally, research indicates that providing some form of crisis counseling after a crisis or trauma, aids one's return to equilibrium. The equilibrium model will not prevent posttraumatic stress disorder or any other diagnosable condition; rather the techniques are designed to contextualize events and support the individual's functioning. Following the establishment of their model, Lindemann and Caplan went on to collaborate on other crisis-oriented projects such as the Wellesley Project. Members of the Wellesley

Project (Caplan, 1964) focused on assisting individuals through a traumatic experience, specifically women who lost an infant or delivered a differently abled child. Women in this group received preventative psychiatry, which entailed early mental health consultation and support. Clinicians sought to lower participants' emotional distress to a nonacute level through coping strategies, appropriate referrals, physical exercise, and attendance of consultation groups.

The ABC-X Model of Crisis Counseling, Intervention, and Management

Reuben Hill (1949, 1958) applied crisis theory to families. The ABC-X Model of Crisis came into fruition because of Hill's research on families experiencing separation and reunion during World War II. The main thrust of Hill's ABC-X Model of Crisis focuses on the precrisis variables in families. The ABC-X model implies an interaction between (A) the crisis provoking stressful event(s) and (B) the family's resources and (C) the meanings/perceptions the family attaches to (A). The crisis (X) represents an acute state of disequilibrium and immobilization of the family system (Boss & Sheppard, 1988) and is an outcome of the interaction of ABC. The double ABC-X model of crisis counseling, intervention, and management expanded on Hill's 1958 model and was based on the longitudinal work of McCubbin and Patterson (1983). McCubbin and Patterson worked with families of Vietnam servicemen designated as missing in action or held as prisoners of war. McCubbin and Patterson added five considerations to predict and explain family's recovery in the post crisis/stress phase: additional life stressors and strains; psychological, intrafamilial, and social resources; changes in the family's definition; family-based coping strategies; and a range of possible outcomes.

The double ABC-X model displays the double A as the provoking stressor plus the buildup of other stressors, changes occurring unrelated to the event, and any consequences of attempts to cope. The family experiences greater intensity and the crisis seems more severe. The double B describes utilization of resources available to the family at the time of the crisis, tangible and intangible resources, plus resources external to the family system designed to address the severity of the crisis. The double C describes family members' perceptions and meaning assigned to the original provoking stressor, accumulated stressors, resources, and how best to restore stability to the family. Perceptions are influenced by religious beliefs, family and cultural values, and how the situation may have been framed or reframed. Finally, McCubbin and Patterson's Double X occurs later than the original X factor and includes the concept of adaptation. Adaptation is an outcome variable involving positive changes in functioning and perception and the degree to which long-term change occurred in response to the demands of the crisis event. It is important to note that adaptation is context dependent and what appears to be success for one family will differ from what looks like success in another family. Patterson (1988) noted the goal of the double ABC-X model was to explain the differentiation in postcrisis responding among families.

Psychosocial Transition Model of Crisis Counseling, Intervention, and Management

Parkes (1971) coined the phrase *psychosocial transition model of crisis counseling*, drawing on the works of Alfred Adler's Individual Psychology Theory (1956), Salvador Minuchin's Structural Family Theory (1974) and Erik Erikson's Psychosocial Development Theory (1997) as she developed the Psychosocial Transition model. The Psychosocial Transition model for crisis counseling asks clinicians to collaborate with clients to assess internal and external difficulties influencing the current crisis, aid them in choosing alternatives to current behaviors and attitudes, and encourage use of environmental resources. The focus of this model is on the client and their social system. Crisis counseling outcomes are limited when clients fail to modify social situations and do not accept or understand the dynamics of their relationships or the impact on adaptation. This model is most effective after the acute phase of the crisis. The psychosocial transition model assumes internal and external factors produce psychological and social disturbances that accompany the crisis. The concepts of psychosocial transition and posttraumatic growth are consistent with existential theory. Confronted with one's mortality, clients reevaluate and redefine life goals and priorities to emerge with a greater investment in and appreciation of life. The greater the magnitude of the threat posed by the stressor, the greater the opportunity for growth.

The psychosocial transition model has been examined by researchers. Studies involving parental adjustment to childhood diabetes (Lowe, Gregory, & Lyne, 2005), mental health, and coping mechanisms during war time (Carballo et. al, 2004) and post-traumatic growth in breast cancer survivors (Cohen & Numa, 2011) demonstrate initial efficacy of the model. Findings indicate the category, timing, and amount of social assistance provided those in crisis influenced the positive or negative outcomes of the event (Almedom, 2005).

A crisis counselor using this model assesses and addresses clients' emotions and cognitions and resources and interpersonal support. According to the model, these factors can be problematic for a client to overcome and interfere with postcrisis event stability. Interventions associated with this model are grounded in cognitive theories and target modifying behaviors, attitudes, and environmental systems. Consider your client, Shamika, with whom you are working. Shamika and her family's home was consumed by fire. She seems stuck and believes she is doomed. Shamika is immobilized and distraught. She asks you why "do things like this only happened to me?" To challenge her irrational beliefs, you may inquire, "The fire was due to a lightning strike from a severe thunderstorm, and two of your neighbors' homes burned as well. How do you explain that this only happened to you?" Later, you may work with Shamika to adjust her language and thinking patterns by replacing *musts*, *oughts*, and *shoulds* with more personally accountable language like *choose*, *desire*, and *opt to*. Helping Shamika create a sense of personal agency with internal and external language should result in a change in her assumptions, beliefs, and ultimately, her behavior.

Psychological First Aid Model of Crisis Counseling, Intervention, and Management

The term psychological first aid (PFA) was first used by Raphael (1977) to describe the issues that emerged from an Australian railway disaster (as cited in James & Gilliland, 2017). The PFA model is akin to Maslow's (1943) theory of human motivation and prepotent needs. A prepotent need is one that has the greatest influence on our behavior. For example, those affected by the 2017 mass shooting in Las Vegas sought first to flee to safety, before seeking medical care, nourishment, psychological support, loving, or belonging. Need fulfillment is hierarchical. While numerous authors criticize Maslow's theory for its ethnocentrism and failure to distinguish the social and intellectual needs of those reared in individually oriented societies from those reared in collective-oriented societies, in times of crisis, the basic human need to be safe and secure take primacy. Like Maslow, the PFA model focuses the clinician's assessment on a similar hierarchy, beginning with physiological and safety needs, progressing to belonging, self-esteem, and self-actualization. Thus, the criticisms Maslow faced may also extend to the PFA model. We urge counselors to avoid a *one size fits all* approach to responding to client crises.

Ruzek et al. (2007) reported that PFA was created as the initial component of a comprehensive crisis response model aimed at alleviating the negative effects of post-trauma distress. Steps in the model include (a) contact and engagement through crisis team debriefing and assessment of the situation; (b) safety and comfort associated with empathy; (c) stabilization by meeting basic needs; information gathering like personal contact information; (d) practical assistance—providing a phone or a blanket; (e) connection with social supports; (f) coping instruction like deep breathing or positive self-talk, and linkage with nonemergent collaborative services. PFA provides empathy and support, resources, information, and education to those experiencing a crisis based on their most immediate needs.

Prior to traditional counseling, probing, or reexperiencing of a traumatic event, survivors must meet their basic needs. For example, PFA was the intervention of choice used by first responders in New York on 9/11 (Jackson-Cherry & Erford, 2010), and James and Gilliland (2013), in the immediate aftermath of Hurricane Katrina (James & Gilliland, 2013), reported, "Many counselors, social workers, and psychologists helped meet basic support needs of food, shelter, clothing, and other survival needs . . . before they ever did any counseling." (p. 19). Thus, PFA is best suited for individuals and groups surviving a traumatic event, terrorism, or mass disaster (Everly, Phillips, Kane, & Feldman, 2006).

The ACT Intervention Model for Acute Crisis and Trauma Treatment

Albert Robert's (2002) ACT Model of Crisis Counseling is a three-stage model emphasizing assessment of the presenting problem, connecting clients to support systems, and helping those in crisis work through the distress and emotional pain. This sequential intervention model integrates assessment and triage

protocols with Robert's seven-stage crisis intervention model and was one of the first to address clinician self-care to avoid the negative effects of compassion fatigue and vicarious trauma. Self-care and counselor wellness are explored in greater detail in Chapter 8.

The acronym ACT stands for Assessment, Crisis Intervention, and Trauma Treatment. The *Assessment* component incorporates the psychiatric and psychological triage assessment and associated protocols. The clinician asks a series of questions or statements to determine the psychological and medical needs of the individual. Questions such as: Are you injured or hurt? Show me. Are you bleeding? Where and for how long? Please, tell me your name. Tell me where you are. Answers to these and other questions allow you to make time-sensitive decisions and involve other first responders. In this phase, client's concerns are triaged based on pre-agreed upon protocols. This assumes the clinician is aware of and has had training in those protocols. Hint: this means you are involved in your community. After the Assessment phase the clinician moves to the provision of *Crisis Intervention Strategies* including short-term (3–4) contacts to stabilize the client and connecting them with an appropriate support group, community relief groups, social services, and critical incident debriefing (Mitchell & Everly, 1993). The Crisis Intervention stage introduces Robert's Seven-Stage model (Roberts, 1996). *Trauma Treatment* is the final stage and incorporates interventions aimed at treating traumatic stress reactions, sequelae, and PTSD. This includes trauma interventions, trauma-informed treatment plans, recovery strategies, and the Ten Step Acute Trauma and Stress Management Protocol (Lerner & Shelton, 2001). In the ten steps, the clinician assesses for danger/lethality; determines the presence of physical and perceptual injuries; evaluates client responsiveness; addresses medical needs; observes and identifies presence of traumatic stress; introduces and connects the clinician; supports client telling of the trauma story for stabilization; listens actively; normalizes, validates, and educates; and encourages a present orientation and provides referrals. As with other models, the ACT model may not fit for all persons or in all settings the individual in context matters and the skilled counselor maintains a socially just mindset that emphasizes people over processes or models.

Cognitive Model of Crisis Counseling, Intervention, and Management

While Albert Ellis's Rational Emotive Behavior Therapy (REBT) and Aaron T. Beck's Cognitive Therapy (CT) are the foundation for the cognitive approach to counseling, neither specifically addressed crisis-situations. Roberts and Ottens (2005) are credited with the first cognitive model of crisis counseling, intervention, and management detailed in their 2005 article, "The Seven-Stage Crisis Intervention Model Road Map to Goal Attainment, Problem Solving, and Crisis Resolution." Robert's Seven-Stage Crisis Intervention Model (R-SSCIM) integrates brief cognitive therapy and crisis responding. The seven stages are: plan and conduct a thorough biopsychosocial and lethality/imminent danger assessment; make psychological contact and rapidly establish the collaborative relationship; identify the major problems, including crisis precipitants; encourage exploration of

feelings and emotions; generate and explore alternatives and new coping strategies; restore functioning through implementation of an action plan; and plan follow-up sessions.

Interventions utilized within Robert's Seven Stage Crisis Intervention Model are organized around the seven stages. Within the first stage, *Psychosocial and Lethality Assessment*, clinicians conduct a biopsychosocial assessment; assess client's environmental supports and stressors; address medical needs and medications; assess current use of drugs and alcohol; explore client's internal and external coping methods and resources, suicidal thoughts, and lethality; ascertain whether the client has initiated a suicide attempt; and inquire about client potential for self-harm. In the second stage, *Rapidly Establish Rapport*, the clinician establishes an efficient and time-sensitive therapeutic alliance through culturally responsive respect, acceptance, nonjudgmental attitudes, nonverbal behaviors such as eye contact, physical proximity, clinical flexibility, and a positive attitude to instill hope, reinforce treatment gains, and encourage resiliency. *Identify the Major Problems or Crisis Precipitants* is the third stage in which the clinician explores clients' precipitating event(s) and prioritizes problems. The fourth stage, *Dealing With Feelings and Emotions* has the clinician encourage the client to verbalize their feelings and stories related to their crisis. Clinicians use counseling skills such as active listening, paraphrasing, reflections, and probing questions and may challenge some elements to help reveal unfounded assumptions and errors in thinking. In the fifth stage, *Generate and Explore Alternatives*, the clinician and client explore alternative behaviors, thoughts, and feelings that worked for them in other crises. In stage six, *Implement an Action Plan*, client and clinician devise a treatment plan with action steps. Working together toward a positive outcome supports the client return to a sense of equilibrium. Lastly, stage seven, *Follow-Up*, describes how clinicians practice continuity of care by following up with the client to monitor the resolution of the crisis and assess the client's postcrisis functioning. Typically, postcrisis assessments occur at least one month after your last session and include an evaluation of the client's cognitions related to the crisis' precipitating event. Questions like: In what manner, if any, are their thoughts managed? Do they persevere on the crisis? Do they occasionally think about the crisis? Additional components evaluation examines the client's overall functioning, progress, need for additional referrals, and coordination of treatment. If the client is engaged with another clinician, ethical standards require coordination of care with the current clinician being mindful of anniversary dates marking the event, deaths, and other significant losses.

The Developmental-Ecological Model of Crisis Counseling, Intervention, and Management

Barbara and Thomas Collins provided a new perspective on crisis events through their developmental-ecological model of crisis counseling. Their book, *Crisis and Trauma: Developmental-Ecological Model* (2005) described crises from developmental and environmental standpoints. The Collinses considered the developmental phase, age, and level of cognition of the individual in crisis as well

as the impact of the community surrounding those in crisis. According to Zubenko and Capozzoli (2002), the developmental-ecological practitioner observes the interrelationships between the client and the world around them. Appropriate and inappropriate developmental interactions are witnessed over time and the changes are considered when making crisis-related decisions (Volling, 2005). The model is grounded on the work of Bronfenbrenner's Ecological Systems Theory, Erikson's Life-Stage Virtues, and Piaget's Developmental Stages (Guiffrida & Douthit, 2007). The developmental-ecological model of crisis counseling does not offer a specific set of techniques; instead, this model promotes a strength-based perspective grounded in developmental theory. According to Anderson and Mohr (2003) the model ". . . underscores the importance of recognizing that a child's development is affected by the context in which development occurs . . . that can either enhance or impede their development of competencies relating to a specific stage" (p. 58). Clinicians are encouraged to look past the individual to the environmental context of their lives (Murray & Hudson-Barr, 2006) and promote a more socially just model of service that considers the person, their development, and their development in the context of their environment. Although this model is emerging, there is evidence to suggest this theory of crisis counseling may be helpful to those who experience emotional disturbance that disrupts a developmental stage (Anderson & Mohr, 2003). Guiffrida and Douthit (2007) stated this model may be useful in response to natural disaster, domestic violence, terrorism, accidental disasters, death, school crisis, health crisis, child abuse and neglect, and sexual assault.

The Contextual-Ecological Model of Crisis Counseling, Intervention, and Management

Rick Myer and Holly Moore (2006) developed the contextual-ecological model (also called crisis in context theory [CCT]). Crisis in Context Theory presented a formula to gauge the impact of a crisis on the individual and system surrounding the individual. The CCT model is also grounded in Bronfenbrenner's Ecological Systems Theory, theorizing that individuals develop in relation to both proximal and distal environmental influences. Additionally, CCT is influenced, to a degree, by Kurt Lewin's Field Theory, which asserts that behavior is a function of person and environment. Given that this theory is relatively new, there is little to no empirical support for its application. The professional literature does indicate contextual factors affect crisis situations, specifically that social support decreases depressive symptomology following a flood (Tyler, 2000); high postcrisis stress levels and loss of economic standing are highly correlated with social support (Sattler, et al. 2002); familiar surroundings preserve family cohesion and a sense of community post-disaster (Galante & Foa, 1986); and women, viewed as the main emotional support for a family, become particularly overwhelmed during a crisis and the family adapting to this change (Shumaker & Brownell, 1984).

Although Myer and Moore (2006) do not offer specific CCT interventions, they do promote several premises: (a) The effect of a crisis is consistent with the proximity to the crisis event; (b) reactions are particular to their systems,

relationships, and individuals; (c) interactions of primary and secondary relationships influence recovery; and (d) the magnitude of change as well as the previous element are affected by time. The first premise asks you to discover the layers within a crisis. Essentially, the more a client discloses about their experience as it relates to a crisis, the better they will cope with the after effects. As the client elaborates on the macro and micro aspects of their experience, they begin to recall more details, achieve higher self-confidence, develop a more robust support system, and explore the deeper meaning attributed to their crisis. The second premise describes the reciprocal effect of the crisis on others and the degree of change triggered by the event. Recognizing interactions among primary and secondary relationships is essential to conceptualizing and effectively aiding those who have experienced a crisis. Primary relationships are defined as those which no intervening component mediates the relational connection like intimate partners or family members. Secondary relationships are indirect in nature and are mediated by indirect components of the crisis. The third premise addresses the degree of change triggered by the event and the degree to which a client and his or her systems modify their long- and short-term goals. The final premise of this model describes the discovery of the time factor. In general, as time passes, a crisis event has less impact and individuals and their systems are more likely to return to a state of equilibrium. This model brings attention to anniversary dates and holidays that may trigger a reexperiencing of the crisis and ask clinicians to thoughtfully explore the client's meaning of the experience, negative or positive. An example may be helpful. Joe is a 45-year-old Caucasian male living in southeast South Dakota. He owns several businesses and is a long-time resident. A nonmandatory evacuation order is issued for the Missouri River flooding, which passes through Joe's hometown. Joe and his family are torn between the decision to stay and protect their business or leave the area to be safe. Joe feels very anxious and is indecisive. He feels short-tempered and yells at his family about little things. Joe's family avoids him even though they need to prepare for the impending flood. Teri, Joe's wife, has been tearful; Max and Emma, their children, are now quiet and withdrawn. The more Max and Emma withdraw the more Joe yells to get their attention. Many of Joe's neighbors already evacuated. The flood comes; Joe and his family did not evacuate. Two of Joe's three businesses are incapacitated, and the family home is uninhabitable due to standing floodwaters. Joe is anxious and annoyed because he has not been able to run the day-to-day operations of his remaining business and cannot repair the other two. Orders go unfilled and Joe is sure his customers will go elsewhere. Teri's employer, located in a neighboring community, is not impacted by the flood, is supportive, and allows her to use sick time for days she's missed. Teri is relieved and focuses on caring for the kids and Joe. A clinician applying the CCT model to Joe's experience would examine the various factors involved in his crisis. Joe, Teri, Max, and Emma were in direct proximity to the flood. Joe experiences his family's withdrawal as abandonment, is worried sick about his business, and is tearful and tense. Teri is silent most of the time and Max and Emma just look scared. This flood and its aftermath have been going on for one week and are anticipated to continue for at least two months. The clinician's assessment indicates a significant crisis impact, from the

perspective of CCT. Therefore, immediate services, including psychosocial support, communication, short-term resources—housing and food—are needed to assist Joe and his family.

Unique and Common Elements Among Crisis, Trauma, and Disaster

Personal crises, such as suicide, homicide, and severe physical injury, and natural disaster, such as typhoons, earthquakes, and hurricanes, are terrifying and potentially traumatizing. Individuals have perceptions of the precipitating concerns and the crisis event based on their personal, cultural, and psychological histories. These perceptions play a major role in how the crisis affects individuals and their recovery. According to James and Gilliland (2017), the client's subjective interpretation of an event as a crisis and the clinician's understanding of the client's meaning significantly affect the client's experiences and recovery from a crisis. On an individual level, the consequence of a crisis can range from psychological trauma to intrapersonal resilience. Erikson (1976) provided the following definition of individual trauma, "By individual trauma I mean a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively" (pp. 153–154). While the construct of resilience is not the opposite of trauma, it provides an alternative to the experience of individual traumatization. Walsh defined resilience as "the capacity to rebound from adversity, strengthened and more resourceful. It is an active process of endurance, self-righting, and growth in response to crisis and challenge . . . the ability to withstand and rebound from disruptive life challenges" (Walsh, 2007; p. 4).

Perceptual Influences

Crisis counselors work to understand the felt meaning clients ascribe to crisis events. According to Kanel (2012), one's perception of the precipitating event and inability to cope with the subjective stress from the situation are key to understanding their psychological state following a crisis. For example, consider the child who witnesses repeated acts of interpersonal violence like fistfights at school, gang or gun violence, sexual battery of sex workers. This child is likely to have a very different perception of and sensitization toward aggressive acts when compared to another child who rarely witnesses interpersonal violence in their immediate environment of home, school, or neighborhood.

Proximity of Events

Crisis counselors consider clients' proximity to the crisis event. Considering the crisis event in the context of the client's day-to-day life is essential in understanding the impact of the event. For example, while many witnessed and mourned the devastation wrought by Hurricane Katrina, to the residents of New Orleans, particularly those in the Lower Ninth Ward, the horrors were beyond measure. Eighty-six percent (86%) of the 1,170 deaths in Louisiana attributed to Katrina occurred in Orleans and St. Bernard Parishes. Those who died were more likely

to die at home, be elderly, black, and male (Markwell & Ratard, 2014). Loss of life, livelihood, homes, community, belongings, and relocation to the convention center and Superdome disproportionately affected New Orleans most vulnerable residents. The direct proximity, intensity, and duration of these residents resulted in profound differences in experiences, attributions, coping trajectories, and restoration of health and well-being.

Individual, Group, and Communities Constructed Meanings of Crisis

Following a crisis, the individuals, groups, and communities involved in the event will eventually start a *meaning making process* (Saul, 2014). These meaning-making efforts typically involve the dissemination of information regarding the crisis and its impact through various mediums; word of mouth, social networks, broadcast television, local print outlets, and social media platforms. The sharing, interpretation, and contextualization of information as well as personal narratives provide the foundation for the creation of a *new normal*. The new normal provides a context for understanding the postcrisis environment and, often, focuses on the community or societal adaptations made because of the crisis. Crisis counselors work with individuals, groups, and communities to create functional adaptations following a crisis event.

While the authentic socially constructed meaning within any group of people should be honored, at times the crisis counselor must help crisis survivors to construct a meaning that will limit subsequent crises. For example, if a survivor of school bullying punches their bully, school officials may expel the bullied student for fighting rather than understanding the lack of school-based support for bullied children. Helping individuals and their systems understand the context and meaning of the crisis event does not excuse the survivor's behavior but explains why crises may occur without appropriate interventions and resources.

Crisis counselors cannot rid clients of all subjective distress. The task of the clinician is to help clients contextualize their perceptions of precipitating events and encourage coping behaviors. Without discomfort, clients are often not as motivated to change. The crisis counselor works with clients' disequilibrium and vulnerability to promote cognitive, emotional, and behavioral change. Clients with adequate ego strength and no history of mental illness can often psychologically work through a crisis without ongoing counseling or medication. Others may require medication, therapy, or a combination of the two to support them through the initial crisis. Understanding when the situation calls for more resources in addition to therapy is a vital skill for crisis workers.

Individual Appraisal and Coping Methods/Behaviors

According to Pearlin and Schooler (1978), any effort taken to deal with stress may be considered coping. Thus, coping is a process and requires cognitive and behavioral activities. Cognitively, people under stress appraise what is happening and assess any potential for harm. They also evaluate the consequences of possible response actions. According to Lazarus (1966), appraisals occur before coping

mechanisms are employed. Following the appraisal, there are three types of coping responses that may be used, including direct actions like removing oneself from a dangerous environment, managing mental imagery, and regulation of emotions. When a person is unable to use coping behaviors and is faced with an overwhelming stressor they experience a subjective state of crisis.

Subjective distress, such as anxiety or grief, overwhelms the individual, preventing them from coping or functioning in a variety of areas. When such individuals realize they can no longer function at work, home, in social situations, or emotionally, many seek counseling. In the postacute phase of a crisis, clinicians help clients identify and employ coping strategies. Caplan's (1964) seven characteristics of effective coping behavior include (a) actively exploring reality and searching for information; (b) freely expressing both positive and negative feelings and tolerating frustration; (c) actively invoking help from others; (d) breaking problems down into manageable bits and working through them one at a time; (e) awareness of fatigue and pacing coping efforts while maintaining functioning; (f) mastering feelings where possible, being flexible and willing to change; and (g) trusting in oneself and others and having a basic optimism about the outcome. These coping behaviors guide the clinician in creatively constructing a treatment plan that changes cognitions, lowers subjective distress, and increases functioning.

The Physiology of Anxiety

Anxiety increases in times of stress. Individuals in crisis experience shock, disbelief, distress, or panic. In certain circumstances, anxiety has the power to generate energy and increase coping abilities. For example, when a child is in danger, their parent rushes in to rescue them, or when a natural disaster occurs and individuals tune out extraneous stimuli to focus on rescuing others, despite threats to themselves. Anxiety has a curvilinear relationship in that too much overwhelms and immobilizes people while too little leaves them in a state of apathy or with undirected and disintegrative energy (Janosik, 1986).

Following a traumatic event or witnessing a traumatic event, the central nervous system (CNS) begins to develop neurochemical pathways and physiological adaptations to respond to the situation. Areas of the brain that involve memory, such as the amygdala and hippocampus, have increased reactivity to stimuli following acute situations (Yehuda, 2002). Individuals are also believed to experience changes in hippocampal functioning and memory processing, which suggests a possible reason for the postcrisis frequent reexperiencing of the event. Individuals diagnosed with posttraumatic stress disorder (PTSD) can demonstrate increased levels of norepinephrine, a chemical or neurotransmitter released from the locus coeruleus, a structure located in the brain stem. Researchers believe increased levels of norepinephrine are responsible for the fight, flight, or freeze response commonly witnessed in PTSD survivors. The increased levels of CNS norepinephrine have the secondary effect of increased reactivity of the alpha 2 adrenergic receptors, which are associated with increased heart rate, blood pressure, and anxiety responding. Increased levels of norepinephrine, coupled with increased sensitivity of the adrenergic binding sites, promote worsening of the anxiety symptoms common in PTSD and anxiety disorders. Researchers and training programs have

recently begun to incorporate a more holistic view of crisis and trauma responding, one which includes bio-psycho-physio-social aspects of individuals.

Physiologically speaking, anxiety disorders such as generalized anxiety disorder, panic disorder, and PTSD are characterized by a CNS imbalance between two distinct neurotransmitters: serotonin and norepinephrine. Serotonin, which is responsible for mood regulation in the brain, is found to be normal to slightly diminished in persons diagnosed with anxiety disorders. The serotonin center of the brain is located within the upper brain stem in the form of two organelles: the dorsal and rostral raphe nuclei. An organelle is a specialized component or subunit of a cell with a particular function. The raphe nuclei release serotonin for mood regulation as well as other bodily functions such as gastrointestinal regulation, skeletal muscle tone, platelet function, and temperature regulation. Located just near the rostral raphe nuclei is the norepinephrine center of the brain, the locus coeruleus. Norepinephrine released from this structure increases anxiety, tremors, focus, and blood pressure. When an increase in norepinephrine is overlaid with normal to decreased serotonin function, crisis survivors present with symptoms attributable to extreme anxiety or more significant pathology (Charney, Woods, Goodman, & Heninger, 1987). Clients may present with nervousness, agitation, sleep disturbances, hypervigilance, and heightened memory and thought processing. Secondly, they may also complain of somatic symptoms of anxiety, such as tachycardia; high blood pressure; rapid, shallow breathing; and tremors.

Perceptions Regarding Precipitating Events

Precipitating events are triggers that set the stage for the crisis event and associated responding. For individuals and communities, precipitating events may be interpreted as both a threat and an opportunity (Echterling, Presbury, & McKee, 2005; Kanel, 2012) but rarely does this interpretation occur in the immediate throes of a crisis! According to Kanel (2012), identification of the precipitating event and the meaning attributed to it by the client are important elements associated with recovery. Herman, (1997) and Kanel (2012) suggest clients benefit from describing the precipitating event(s) contributing to the crisis, the meaning of the event(s), painful feelings related to the crisis, and other losses or changes related to the crisis and the postcrisis aftermath, like occupational, academic, behavioral, and social challenges.

Summary

Crisis events, no matter their origin, intensity, severity, or duration, have the potential to effect long-term changes in the lives of people who experience them. Additionally, no matter what their impact on an individual, crisis events are rarely isolated to a single person; it is important to remember that a crisis event can affect a whole

family, community, or society. This chapter presented the history, theories, categories, and models of crisis and crisis intervention. Special attention was paid to human development, neuropsychological functioning, and a systemic view of crisis.

Extended Learning Exercises

Exercise 1: ACA and APA Chartered Divisions

Directions: Review the chartered divisions within the American Counseling Association (ACA) and the American Psychological Association (APA). Write down the names of two divisions within ACA and two additional divisions from APA that are likely to have an emphasis in crisis counseling. Type out the four chartered divisions and, beneath every name, brainstorm the different ways they will assist you in becoming a more effective crisis counselor. Next, review what you brainstormed and indicate the divisions that produced the most interest. Do a web-based search for the ACA/APA divisions that were most salient and review their websites. Find out member benefits, name of the professional journal associated with the division, when and where the next division meeting will be, and determine the requirements for becoming a member.

Exercise 2: Youth and Family Trauma Professional Organizations

Directions: Locate the websites for the Child Trauma Academy, Learning Center for Child

and Adolescent Trauma, National Center for PTSD, and Penn Center for Youth and Family Trauma Response and Recovery. Within each website, you will find resources for helping youth, parents, and individuals suffering from trauma and PTSD. As you are reviewing, consider which professional organization has the most rigorous set of resources and pay attention to the unique aspects of each organization.

Exercise 3: Unique and Common Elements of Crisis Counseling

Directions: Review the roots, tenets, and history of each model of crisis counseling. Consider how each model is similar and different. As you are reflecting on these factors, write down the elements of each model that you find interesting, exciting, and inspiring and consider which model seems to be more in line with your interests and inspiration. Next, begin creating a list of crisis counseling tenets, from various models, that you find meaningful and add something unique to your emerging model.

Additional Resources

Helpful Links

Alameda County Behavioral Health Care Services: http://www.acbhcs.org/providers/QA/docs/2013/TR_Suicide-Homicide_Risk_Assesment.pdf

American Academy of Experts in Traumatic Stress: <https://www.aaets.org/index.htm>

The Federal Emergency Management Agency: <https://www.fema.gov/>

Mothers Against Drunk Driving: <http://www.madd.org/>

The National Domestic Violence Hotline: <http://www.thehotline.org/>

National Suicide Prevention Lifeline: <http://suicidepreventionlifeline.org/>

West Virginia Division of Culture and History, Buffalo Creek Disaster: <http://www.wvculture.org/history/buffcreek/bctitle.html>

Helpful Books

Acute Traumatic Stress Management: Addressing Emergent Psychological Needs During Traumatic Events. (2001). Mark Lerner & Ray Shelton.

Crisis Intervention Strategies, 8th Edition (2017). Richard K. James & Burl E. Gilliland.

Crisis Intervention Handbook: Assessment, Treatment, and Research, 3rd Edition (2005). Albert R. Roberts.

Crisis Assessment, Intervention, and Prevention, 2nd Edition (2017). Lisa Jackson-Cherry & Bradley Erford

The Complete Guide to Crisis & Trauma Counseling: What to Do and Say When It Matters Most! (2011). H. Norman Wright

Healing the Fragmented Selves of Trauma Survivors (2017). Janina Fisher