CHAPTER 1

Understanding Crisis

Boston Marathon Bombing: *April 15, 2013: Two bombs went off near the finish line of the Boston Marathon, killing three spectators and wounding more than 260 other people, many of them with catastrophic injuries. Coverage of the disaster saturated all forms of media for weeks, bringing into everyone's living room images of destruction. The search for the two terrorist brothers also shut down the entire city of Boston.*

Superstorm Sandy: *October-November, 2012: Hurricane Sandy, dubbed a superstorm because of its ferocity, was the deadliest and most destructive hurricane of the 2012 Atlantic hurricane season as well as the second costliest in U.S. history. It resulted in the deaths of 233 people in eight different countries before it hit the east coast of the United States. The states of New Jersey and New York were particularly hard hit. Flooding and high winds resulted in property damage, loss of power, and relocation of families to temporary shelters throughout the area. School buildings also were destroyed, keeping children and families in a recurring nightmare as relief efforts faltered.*

9–11 and the Twin Towers; President Vows Exact Punishment for "Evil:" *(New York Times September 12, 2001, New York City): Hijackers rammed jetliners into each of New York's World Trade Center towers yesterday, toppling both in a hellish storm of ash, smoke, glass and leaping victims; third plane crashes into Pentagon in Virginia and a fourth plunges to the ground near Pittsburgh; military is put on highest alert; National Guard units called at Washington and New York, two aircraft carriers are called to New York harbor.*

Tales of crisis and of people in the throes of crisis appear in all forms of media on any given day, in any city or town in the United States. Whether the article is about a terrorist attack, a domestic violence incident, a kidnapping, a school shooting, a rape, an earthquake, or any other natural disaster, it can resonate across communities and whole nations. Suddenly, unexpectedly, and without forewarning, individuals are left to their own devices in the immediate aftermath of such events. Most individuals do find some means of coping after a crisis, relying on assistance from their own social support networks consisting of extended family members, friends, or trusted individuals like clergy or other members of the community. However, there are those who feel overwhelmed and immobilized, or who find that they are unable to cope, even with the assistance of well-meaning friends or family members. Some also find that the ways they might have used to cope in the past are not working for them in dealing with the present crisis.

Often when one hears the term, "crisis intervention," one may immediately think of those services which would ordinarily be provided by mental health professionals in a mental health clinic, a private practitioner's office, or a hospital emergency room. While psychiatrists, psychologists, psychiatric social workers, and professional counselors often do provide these services, one must also consider the array of other individuals who are either at the scene of the crisis event or who arrive shortly after. Police officers, teachers, school counselors, college counselors, firefighters, rescue workers, community volunteers, first aid squads, nurses, physicians, clergy, funeral directors, attorneys, employee assistance counselors, human resource managers, neighbors, friends, roommates, family, and other relatives may find themselves performing crisis intervention services, sometimes without realizing it.

It might appear that there are more crisis situations and traumatic events that take place in today's society, but this perception is due, in part, to the media coverage of such events. What is clearly different today is that there are many more types of crisis delivery services than there were forty or fifty years ago: hotlines; mobile emergency teams trained in crisis intervention; school intervention personnel, such as school psychologists and student assistance counselors; workplace intervention specialists, such as employee assistance counselors; and emergency room services, which include crisis services for both psychiatric emergencies and substance abuse.

This chapter provides an overview of crisis intervention, definitions of and types of crises, and diagnostic considerations that are part of the crisis experience. Multicultural issues related to crisis considerations also is discussed. Finally, the chapter includes a brief historical overview of the field of crisis intervention and some examples of the assessment and intervention models that have evolved.

DEFINING CRISIS

As suggested by Graf (personal communication, August 19, 2002), a broad definition of crisis is *a predictable or unpredictable life event which is perceived by an individual as stressful to the extent that normal coping mechanisms are insufficient.* Gerard Caplan, one of the early pioneers in the Crisis Intervention field, was the first to articulate what he referred to as Crisis Theory. In order to understand his Crisis Theory, it is helpful to look at how he defined *crisis.* For Caplan (1964), a crisis is a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving, and by the potential for a radically positive or negative outcome. There are many assumptions made by Caplan which are implicit in his definition.

First, *a crisis begins with a precipitating event.* These precipitants can be specific predictable life events, such as getting married, graduating from school, moving to a new town, a planned pregnancy, and retirement; or they can be unpredictable, such as natural disasters, accidents, an untimely death of a loved one, or other traumatic events, such as being a victim of rape. The second assumption made is that a crisis state, by its very definition is "*time-limited.*" Caplan claimed that the immediate impact of a crisis usually lasts from six to eight weeks, depending on the nature and intensity of the crisis. This is not to say that

there are not long-lasting effects to many of the crises that are experienced. The third assumption is that *crises create a state of disequilibrium and disorganization* for the individual. Therefore, individuals who tend to be organized and operate with a certain degree of predictability, now are faced with days filled with chaos as the crisis event sometimes controls or dominates their every waking moment.

Another assumption of Caplan's is that once the crisis event takes place, there is a *cognitive interpretation* or appraisal of the event, which accounts for the notion that not everyone reacts to a crisis in the same way. For example, being fired from a job may seem like the end of the world to one person, while for another, it can be a chance to take a few months off, do some traveling, and relax between jobs. The Greek philosopher, Epictetus, once said, "It's not the events of life that make men mad, but rather the view we take of them." It's the "view we take of them" that suggests this cognitive interpretation of crisis events.

Finally, *crisis events will cause a breakdown in one's ability to cope.* The goal of crisis intervention, therefore, is to help clients mobilize their own coping resources in an effort to restore balance or equilibrium. In developing his crisis theory, Caplan was interested not only in identifying the crisis itself, but also in assessing the individual's ego functioning in the aftermath of the crisis situation as they attempt to cope with it. According to Caplan, adequate ego functioning was the basis of one's mental health.

DANGER VS. OPPORTUNITY

According to Slaikeu (1990), the word *crisis* itself is very rich in psychological meaning. In Chinese, the word for *crisis* is made up of two symbols, "danger" and "opportunity" (Wilhelm, 1967). The word, therefore, connotes not only a time of danger, which may be physical (as with assault, natural disaster, medical illness) or psychological (losing one's job or going through a divorce), but also the opportunity for personal growth that results from having experienced a crisis and having come to the realization of one's inner strength. This would be the case with rape victims who come to the realization that they have survived and can use their strength to help other rape victims, or the person who experiences a job layoff and obtains training to get a better or more satisfying job. Of course, while a person is going through a crisis, the notion of "opportunity" probably doesn't make much sense. It sometimes isn't until months or years after the crisis has passed that one realizes the personal growth and self-efficacy that has been achieved. Perhaps the old English proverb sums this up best, "A smooth sea never made a skilled mariner."

The English derivative of the word *crisis* is taken from the Greek word, *krinein* that means "to decide" (Lidell & Scott, 1968), emphasizing that a crisis is a time for decision making, a turning point or moment of reckoning. In some instances, these decisions will help to improve one's life. Slaikeu (1990, p. 15) notes the potential for a "radically positive or negative outcome" in the aftermath of a crisis. In a fundamental way, the direction that the outcome takes depends on the decisions made by the affected individuals as part of the crisis resolution process. Often the decision reached because of a crisis enables that individual to thrive. In other instances, however, these decisions may lead to a life that is negatively impacted and/or diminished in some way. To acknowledge this potential for positive or negative outcomes and the role of the individual's decisions in determining the outcome

is not as simple as implying that all the person in crisis needs to do is to "think positively." To suggest this would be to deny the unique complexity of crisis events and the often-insurmountable difficulties that they pose to affected individuals.

TYPES OF CRISES

Based on these definitions, one could argue that just about any stressor could bring about a crisis situation. In order to further delineate this term, it is helpful to conceptualize crises as being grouped into three areas: normal *developmental* crises, *traumatic event* crises, and *existential* crises (Brammer, 1985). A fourth area, *psychiatric crises*, also can be included, since there are many instances where a psychiatric condition can serve as the catalyst to the crisis state (e.g., a person who suffers from bipolar disorder may begin to experience a manic episode which results in a gambling spree). Conversely, a crisis can exacerbate an already existing psychiatric condition (e.g., stops taking her medication after being evicted from the boarding home where she had been living).

Developmental Crises

What is unique to developmental crises is that the precipitating event of the crisis or the stimulus event is embedded in normal maturational processes (Slaikeu, 1990). Throughout the lifespan, human beings are constantly changing; yet the normal growth process is characterized by continuity, as one passes from one stage to the next, through a series of life transitions.

Erikson (1963) was one of the first developmental theorists to point out that development continues through the lifespan. What was also unique to his approach was his assertion that at each stage of development, there is a major task or conflict to be resolved by the individual in order to move onto the next stage. The table below summarizes Erikson's developmental stages, outlining both the transitional theme and the developmental tasks associated with each stage. It also identifies conflicts or events that could potentially precipitate a developmental crisis for an individual at each identifiable stage. What Erikson referred to as a potential crisis imbedded in each of his eight stages might also be considered a "challenge" instead; that is, a test of the individual to master the needs of each stage before moving onto the next one. The Latin derivation of the word "impediment" comes from the word "impedimenta," meaning "heavy baggage," and it is just this excess baggage that individuals drag with them to the next developmental stage. It is as if their unfinished business at one stage will impede their ability to master the challenges of subsequent ones.

Erikson (1963) considered a major task of adolescence to be identity formation. He believed that by the end of the teen years, healthy individuals must develop some sense of identity, including who and what kind of persons they are in relationships, what their strengths and weaknesses are, and what they see as future life goals and/or directions. The teenager who is unable to "find" their identity may wander aimlessly from job-to-job, or from college-to-college feeling depressed and lonely. "Stuck" in a developmental crisis that Erikson refers to as "role confusion;" these individuals may be unable to proceed with the

Table 1.1 Erickson's Developmental Stages

Stage	Transitional Theme	Developmental Tasks	Potential Conflicts
Infancy (Birth–1 yr.)	Trust vs Mistrust	Development of a trusting relationship with a caregiver who will tend to his/her needs	Lack of trust that needs will be met by others; attachment issues may linger
Toddlerhood (1-2 yrs.)	Autonomy vs shame and doubt	Development of independence	Independence thwarted by overprotective or neglectful caregivers
Early childhood (2-6 yrs.)	Initiative vs guilt	Continued development of independence; child given freedom to explore, practice newfound motor skills; toilet training	Feelings of self-blame and guilt as caregivers discourage child's need to explore
Middle Childhood (6-12 yrs.)	Industry vs inferiority	Development of academic mastery; consolidation of social network; comparison of self with others	A sense that the child doesn't "measure up" to others in academic, social areas
Adolescence (12-18 yrs.)	Identity vs role confusion	Adjusting to puberty; defining one's identity; acknowledging one's strengths, weaknesses	Self-consciousness re: body image, sexuality; indecisiveness about life goals
Young adulthood (18-34 yrs.)	Intimacy vs isolation	Development of intimate relationship with significant other; settling down with career choice established	Rejection by others; difficulty with intimacy in relationships
Middle adulthood (35-retirement)	Generativity vs stagnation	Adjusting to middle age, parenting; dealing with aging parents; developing sense of productivity, advancement in the workplace	Workplace issues challenging and unrewarding; parenting concerns with growing children
Older adulthood (after retirement)	Ego integrity vs despair	Adjusting to retirement, to aging; evaluating level of success in one's career, in one's personal/family life; dealing with health issues and physical decline	Despair over perceived lack of productivity; sense of loss as health declines, friends begin to die

later developmental tasks of young adulthood, including establishing intimate, committed relationships, and achieving occupational stability.

Male midlife crisis is another example of a developmental crisis (Mayer, 1978; Levinson, 1978). This crisis may occur as men begin to experience various emotions of anxiety or sadness or fear of death as they contemplate and take stock of the accomplishments in

their lives. These emotions may be exacerbated as they take on the developmental tasks of adjusting to aging and preparing to retire. Women may experience a similar type of midlife crises with the onset of menopause or as grown children leave home, resulting in "the empty nest syndrome." Certainly, not every man or woman experiences a crisis as they navigate these life transitions, but for some individuals the normal developmental passages do indeed precipitate crisis responses.

It should be emphasized that when individuals are experiencing what may be a developmental crisis, it is not always certain that they will seek professional help, nor will they identify their problem as "developmental" in nature. Instead, they may experience frustration, anxiety, loneliness, depression or may express other complaints. It should also be noted that developmental crises can sometimes occur simultaneously, as would be the case with a 50-year-old man or woman who is going through a divorce and having to make decisions regarding the care of his or her elderly parents.

Traumatic Event Crises

Traumatic event crises are what most people imagine a crisis to be, and each of the events reported at the beginning of this chapter were, in fact, traumatic event crises. The most distinguishing characteristic of traumatic event crises is that there is a clear external precipitating event. The traumatic event is usually an uncommon or extraordinary incident, which one cannot predict, nor control. Unlike the developmental crises described above, traumatic event crises can occur at any time in one's development, commonly have a sudden onset, are unpredictable, have an emergent quality, and can impact more than one person (e.g., an entire state, county, or community). Examples of traumatic event crises include community-wide disasters (e.g., fires, floods, tornados, devastating nor'easters, man-made disasters, train/airline crashes, nuclear and toxic waste accidents, terrorist attacks, school shootings, homicides, suicides, car accidents, industrial accidents, sudden medical illnesses, domestic violence, and crimes, including assaults, robberies, murders, rapes, child sexual abuse, and child abuse.

The ruthless destruction of human life caused by terrorist bombings at the Boston marathon site, by hijacked planes used as bombs at the World Trade Center and Pentagon, or the bombing of the Federal Building in Oklahoma City, are examples of unpredictable traumatic emergencies that create untold suffering, leaving the survivors, and surviving family members with tremendous grief as they try to rebuild their lives. The "time-limited" nature of such crises cannot take into account how these events will permanently scar those who are affected.

Existential Crises

An existential crisis takes place when one begins to question the meaning of life or the meaninglessness of one's existence, the lack of connectedness with other people, or the futility of one's work or profession. This type of crisis is often experienced in the wake of some particular crisis event. For example, in the aftermath of a high school student's suicide, many of her friends began to question the importance and meaning of their own day-to-day existence. Having made certain choices in life or perhaps by not being given

choices, the realization that one's life has been inexorably altered in profound ways can induce a personal crisis in many individuals. This was best illustrated in the film, *It's a Wonderful Life,* when George Bailey experiences an existential crisis, which brings him to the brink of suicide on the realization that his lot in life cannot be changed.

Existential crises are probably the most difficult to identify because, as with developmental crises, the person experiencing this type of crisis, may present with other complaints or with other symptoms. It is only once the crisis intervention counselor begins to scratch the surface of the presenting complaints that they begin to find that the individual's issues go much deeper than an upset over day-to-day hassles or annoyances.

Psychiatric Crises

As with developmental and existential crises, the triggering psychiatric crisis event may not be readily discernible. For example, a person with bipolar disorder who stops taking medication will often begin to re-experience the extreme mood fluctuations that represent the "highs" of the manic state or the "lows" of the depression that usually follows. This information may not be reliably conveyed to the crisis worker. Or a person with a substance use history may unintentionally overdose on painkillers, yet when that person is brought to the emergency room, he may appear to be sedated and unable to provide an accurate account of what pills he had taken. When psychiatric crises take hold of some persons, they sometimes may come on without rhyme or reason, yet they can be so debilitating and send the person into an intense state of crisis. It is important to note, however, that not everyone with a psychiatric condition necessarily experiences crisis as part of their illness. However, when those who suffer from psychiatric conditions experience crisis situations or traumatic events, it can often add to the feelings of devastation.

It should be noted that it is quite possible for people to be experiencing more than one crisis at the same time. It would be helpful if crises only came along one at a time or at intervals that allowed people to resolve one crisis before having to tackle another. However, this is often not the case. Instead, it is common for people to experience multiple and rather complex crises simultaneously. Such would be the case with a woman whose husband was killed in the World Trade Center, who is now faced with major decisions about whether to move; whose 8- and 10-year-old daughters are going through major grief reactions and are now failing in school; as a result, whose in-laws are pressuring her to sue the U.S. government rather than accept her portion of the victim compensation funds; and who herself is naturally going through major grief reactions over the loss of her husband. Crises have no timetable, nor do they wait for people to prepare for them.

CRISES REACTIONS: A CONTINUUM OF RESPONSE

People who experience any of the aforementioned crises often vary in the way they respond to that particular crisis event. As stated earlier in the various definitions of *crisis,* the person in crisis usually does experience extreme upset and disorganization in functioning. One result of this disorganization is increased vulnerability, and the normal defenses that may have helped the person to cope in the past are no longer effective. Acute crisis reactions are

debilitating and can result in extreme levels of perceived psychological distress. However, until such time that some sense of equilibrium has been restored and the crisis has been constructively resolved, these individuals may feel that they are "going crazy."

Many individuals in crisis will experience a "fight, flight, or freeze" response in the face of the immediate crisis event. The fight or flight response is that programmed, biological response that allows human beings to react in the face of imminent danger by either fighting off the danger (fight) or by fleeing (flight). This adrenalin surge and redirection of blood flow to the large muscles of the legs and arms allows the fight or flight response to occur. However, it is also natural for people to "freeze" in the face of imminent danger. People who have experienced car accidents will often describe a feeling of being "suspended in time" or in "slow motion" as they watch the other car collide with theirs. The "freeze" response is also common in rape and sexual assault victims who fear for their lives, but are unable to scream, run, or fight. There are also some individuals who will not experience psychological distress in the aftermath of a crisis event. These individuals seem to have the capacity to repress the event and, therefore, will go about their daily business as if nothing had happened. The ego defense mechanism of repression, first described by both Sigmund Freud and elaborated on by his daughter, Anna, allows the mind to repress the traumatic event or push it out of conscious awareness.

Some individuals will experience various symptoms in response to the crisis they have experienced. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5, 2013), presents various diagnoses which may occur in the aftermath of some of the aforementioned crisis events. Many crises will reach some resolution within the six to eight-week period, and those individuals will attain some degree of equilibrium; however, there may also be more enduring reactions or responses to crisis events. Although the goal of crisis intervention is not to label individuals or to pathologize their reactions to trauma or crisis, the rendering of a diagnosis does serve the purpose of conveying to other professionals that the person who is victimized by a trauma or crisis event is experiencing a particular set of symptoms or sequelae, the identification of which may become important in effectively treating that individual.

For example, it is common for victims of sexual assault, such as a rape or molestation to blame themselves for the incident: "I shouldn't have gone out to the store that night," or "I should have dressed differently." These are common statements of self-blame. In the treatment of sexual abuse victims, it is important to help the sexual abuse survivor relinquish these self-blaming perceptions. Hence, it is important that the diagnosis convey to other professionals some similar features they have experienced among people suffering from the same crisis or trauma.

The three most common diagnoses given to individuals who experience trauma or crisis events are Posttraumatic Stress Disorder (PTSD), Acute Stress Disorder, and Adjustment Disorder.

PTSD is a rather complex diagnostic entity which encompasses thoughts, feelings, interactions with others, changes in self-concept, and in overall daily functioning. Trauma can have a tremendous impact on the individual, whether they are a combat veteran, a rape victim, a domestic violence victim, a car accident victim, or a person who witnesses violence like a shooting. A diagnosis of PTSD also lends itself more readily to traumatic event crises as described above. One of the criteria for PTSD specifies that the individual must have experienced or witnessed a traumatic event in order to qualify for this diagnosis.

Those who *witnessed* the horrifying scene of hijacked planes crashing into the World Trade Center, for example, also experienced PTSD reactions, just as those people who were in the Towers at the time and experienced the impact of the crash, but managed to escape.

The DSM-5 also includes the following indicators of PTSD:

- Exposure to a traumatic event via directly experiencing it, witnessing it, or learning that it happened to a close family member or friend
- Recurrent distressing memories or dreams of the event
- Flashbacks in which the individual feels as if the event were recurring
- Distress caused by any internal or external cue that serves as a reminder of the event
- Persistent avoidance of stimuli associated with the event
- Persistent negative cognitions and moods in the aftermath of the event

Related, but slightly different indicators of PTSD for children six years of age or younger also can be found in DSM-5. Individuals with Acute Stress Disorder experience the same severity and type of symptoms as the person with PTSD; however, what is unique to this diagnosis is the time frame. Acute Stress Disorder reactions are reserved for those who experience symptoms within the first month after exposure to the traumatic event; unlike PTSD, these symptoms last from three days to one month. Those who continue to experience symptoms after this time period would be diagnosed with PTSD. This is why the symptoms listed for both Posttraumatic Stress Disorder and Acute Stress Disorder are similar.

It is rare that a person going through a developmental or existential crisis would meet the DSM-5 criteria for PTSD. For those individuals, a diagnosis of Adjustment Disorder would most likely characterize their symptoms. The Adjustment Disorder diagnosis indicates that a "stressor" is the catalyst to the symptomatology. These stressors might include a breakup in a relationship, a separation, a divorce, a layoff from one's job, or could emanate from various developmental events, such as going away to school, leaving home, getting married, becoming a parent, failing to attain occupational goals, or retiring. The subtypes also allow for the clinician to determine what is the predominant response to the stressor: for example, is it depression, anxiety, acting out behavior (disturbance of conduct), or a mixed emotional or behavioral state? Again, it is important to note that individuals react quite differently to stressors.

DSM-5 lists the diagnostic criteria for Adjustment Disorder:

- Emotional or behavioral symptoms occurring within three months of the onset of a stressor
- Distress is out of proportion to the severity or intensity of the stressor
- Significant impairment in social, occupational, or other areas of functioning
- Subtypes of the disorder include those which present with: depressed mood, anxiety, mixed anxiety and depressed mood, disturbance of conduct, mixed disturbance of emotions and conduct, or unspecified

The issue of diagnosis pertaining to crisis intervention is quite controversial. This is true especially among individuals who are victims of domestic violence or rape. Many professionals who work with domestic violence and rape survivors feel that to diagnose these women is to pathologize otherwise normal reactions to horrific situations. The women's movement has made significant inroads in this area by educating both mental health and medical professionals about the psychological/emotional impact of victimization. While domestic violence survivors and rape survivors like Vietnam veterans may share similar symptomatology, this should not be interpreted to mean that these individuals are "sick," "crazy," or "weak of character." The question then becomes, "why diagnose at all?" As indicated earlier, a diagnosis allows professionals to communicate information about an individual without needing to come up with an endless list of symptoms. A diagnosis may also help the survivor to understand that what they are experiencing is to be expected, given the trauma. For example, a rape survivor who is experiencing emotional numbing or who is unable to recall specific events of the rape may understand that this is a normal PTSD reaction to rape trauma. This, in turn, may also help significant others in her life to understand that the numbing reaction is part of the PTSD reaction and not indicative of indifference to the traumatic event. On a practical level, a diagnosis also allows survivors of trauma to use their medical insurance benefits, should they decide to seek professional counseling.

MULTICULTURAL AWARENESS AND CRISIS INTERVENTION

Whether you are a professional crisis counselor or the first police officer to arrive at the scene of a crisis event, it is of utmost importance to take cultural, ethnic, and religious backgrounds into consideration in order to fully appreciate an individual's response to a crisis. For example, consider a person who states in a crisis interview that she is "possessed by evil spirits." At first glance, and without any prior knowledge of this individual's cultural background, the crisis counselor may begin to think that this person is suffering from some type of profound psychiatric disorder. However, what if this individual is of Native American ancestry, a culture that is rich with tales of spirit influence? Or what if this person is of Hispanic or Latino ancestry, a culture which has many beliefs about white magic as well as evil or black magic? Or what if this person is of Italian ancestry, a culture that believes that bad people can cast "the evil eye" on others? Arthur Kleinman (1991) has done extensive research into multicultural aspects of psychiatric disorders. He points to the example of a Native American from one of the Plains nations who may hear the voice of a deceased relative from the afterworld, and how that experience would be considered normal from that cultural perspective. Yet, if a non-Native American were to hear such "voices," he or she might be considered psychotic.

It also important to consider that there is often a great deal of diversity within a particular racial group, culture, or ethnicity. For example, Spanish-speaking individuals may prefer to be called Mexican Americans, Spanish Americans, Cuban Americans, Puerto Rican Americans, Hispanics, or Latinos depending on their country of origin.

Native Americans represent a very diverse population composed of 554 federally recognized tribes or nations and Alaskan native villages each with its own social organization, rituals, customs, and language.

Similarly, there are some who prefer the term Black, as opposed to African American, because these individuals do not identify Africa as their country of origin or with

pre-slavery connotations. It is important for counselors to be aware of these differences and to be careful not to make assumptions that because one is of a particular racial, ethnic, or religious group that they necessarily identify with a particular cultural heritage.

Religious beliefs and culture may also influence how a particular crisis is defined or how it evolves. Examples of this are found within suicide rate statistics. In Catholic and Muslim countries, suicide rates are lower, presumably because those religions view suicide as sinful. In Western industrialized countries, suicide rates are higher. In Japan, suicide may be viewed as an "honorable" solution to one having dishonored one's family. Or in the instance of kamikaze pilots during World War II, it was considered an honor to die for one's country. The following excerpt helps to illustrate cultural influences: A young Japanese woman living in Los Angeles was distraught over discovering that her husband was having an affair. She had no work skills, spoke no English, and felt worthless and helpless. She became increasingly depressed and dysfunctional. One spring day, she took her infant and four-year-old to the beach, bought lunch, and then walked into the ocean with the children to commit family suicide. Bystanders witnessed the act and were able to summon help. The woman survived, but both children drowned. Although she was jailed and accused of murder, the Japanese American community, sympathetic to her effort to resolve her dilemma through the suicide that included her children, rallied to her support. They argued that in traditional Japanese communities, the family is the unit, not the individual, and they called it Japanese suicide, not American murder (Group for the Advancement of Psychiatry, 1989).

Multicultural considerations must be taken into account, especially when providing crisis intervention services. For example, Dr. Marilyn Aguirre-Molina (Aguirre-Molina & Molina, 1994) describes how a counselor not familiar with Hispanic culture can offend the head of the family (often the father) by not asking their permission to see the identified patient (for example, the son or daughter). By demonstrating *respeto* (respect) to elders and persons of authority, one is being culturally sensitive to an important Hispanic value, the importance of showing deference and obedience to elders and those in authority (Marin & Marin, 1991). Similarly, a crisis counselor working with an African American family must be aware of the important role of spirituality. Strong spiritual belief is thought to have sustained African Americans through the horrors of slavery and racism (Robinson, Perry, & Carey, 1995). For the counselor working with an Asian American individual or family, awareness of the importance of the family as the unit of social and cultural activities is important (Dana, 1993). The counselor should also be aware that in many of the diverse Asian cultures, it is considered a sign of disrespect to look someone directly in the eye. Instead it is considered deferential to look away, so as to not appear to be "staring the person down." For the crisis counselor unaware of this custom, they may misinterpret this behavior as being disrespectful, instead of as a sign of respect.

It is important therefore, that all counselors develop a sense of *cultural competence*. According to Castro, Proescholdbell, Abeita, and Rodriquez (1999) cultural competence refers to "the capacity of a service provider or an organization to understand and work effectively with the cultural beliefs and practices of persons from a given ethnic/racial group" (p. 504). They conclude that cultural competence is of utmost importance in the delivery of effective mental health and human services to diverse special populations. When counselors or agencies fail to acknowledge and appreciate the important differences in values, beliefs, and rituals then individuals from these diverse populations may feel skeptical, misunderstood, and untrusting that these counselors or agencies will be able to meet their needs (Castro et al., 1999).

Box 1.1: Intervening in Crisis: The L-A-P-C Model

Name: _____ Age: _____

Listen **A**ssess **P**lan **C**ommit

L I S T E N

I What are they saying about the crisis?

S What happened? When did it happen?

T What type of crisis was it? (Traumatic Event, Developmental, Psychiatric, Existential)

E Did they mention anything that indicates danger?

N Other relevant information about the crisis

A S S E S S

S **F**eeling: Is their predominant emotional state one of:

S anger sadness hopelessness

E anxiety panic numbness

suicidal? If yes, complete lethality assessment/suicide.
homicidal? If yes, complete lethality assessment/violence.

S **A**cting: Is their behavior

active/restless consistent with mood
passive/withdrawn good eye contact

S **T**hinking: Are they

logical/making sense coherent/expressing self well
insightful focused on topic
evasive/changing subject

Other: Any medical problems? Physical limitations?
Hospitalizations? Need for hospitalization?

P L A N

L What needs to be done now?

A What alternative plans have been discussed?

N Are these plans reasonable? Able to be carried out?

C O M M I T

O Which plan of action have they chosen?

Do they have the resources/support to implement the plan?

M Are they motivated to implement the plan?

M What other resources/support may be needed?

I
- friend
- family member
- neighbor
- mental health provider
- public agency (law enforcement, child protective services, social services)
- medical (hospitalization, medication)

T

Several authors have conceptualized the ability to work with members of diverse populations as existing along a continuum (Castro et al., 1999; Cross, Bazron, Dennis & Isaacs, 1989; Kim, McLeod, & Shantzis, 1992). At the far end of this continuum is *cultural destructiveness,* which can be defined as counselors or agencies manifesting negative attitudes toward diverse populations or considering them to be inferior to the mainstream, dominant culture. The next step along the continuum is one of *cultural blindness,* a philosophy which advocates that all people are alike and therefore should be treated equally. However, the problem with this service delivery approach is that it fails to consider the many cultural differences *necessary* to acknowledge in order to help someone effectively resolve their crisis. The next step along the continuum is *cultural sensitivity,* which is where the counselor or agency is open to acknowledging and working with issues of multicultural diversity. The next stage is *cultural competence* that was defined earlier, followed by *cultural proficiency,* the highest level of cultural capacity, here defined as the counselor's ability to

understand the nuances of cultural diversity in greater depth and to implement new and more effective service delivery approaches based on the appreciation and understanding of these differences.

For the crisis counselor, the first step toward cultural competence and hopefully toward cultural proficiency, it not to assume that everyone views things from your own values or beliefs systems. When one does this, it reflects *ethnocentrism,* which is the cultural equivalent of egocentrism, only here, the belief is that all cultures function in the same way that one's own culture does. Therefore, when in doubt about particular customs, rituals, values, or belief systems it is better to ask rather than to assume.

RESOURCES FOR CHAPTER ENRICHMENT

Suggested Readings

Caplan, G. (1961). *An approach to community mental health*. New York, NY: Grune & Stratton.

*Caplan, G. (1964). *Principles of preventative psychiatry*. New York, NY: Basic Books.

*Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology*. Boston, MA: Allyn & Bacon.

*Erikson, E. (1963). *Childhood and society* (2nd ed.). New York, NY: Norton Press.

Suggested Websites

Crisis: The Journal of Crisis Intervention & Suicide Prevention (www.hhpub.com/journals/crisis) This is a journal devoted exclusively to crisis intervention and provides an excellent example of how crisis intervention has become accepted as a specialized field within the human services professions.

Brief Treatment and Crisis Intervention (www.brief-treatment.oupjournals.org) This is also a professional journal devoted exclusively to crisis intervention and brief treatment. The journal provides up-to-date research and clinical recommendations for managing a variety of crisis situations.

Trauma Response (http://www.aaets.org) This is the journal of the American Academy of Experts in Traumatic Stress. Both the journal and the AAETS provide excellent, up-to-date information within the field of crisis intervention and traumatic stress response. The AAETS also provides specialized certifications for qualified professionals.

Journal of Traumatic Stress (http://www.wkap.nl/journalhome.htm/) This is the official journal of the International Society for Traumatic Stress Studies. The journal contains excellent, up-to-date information on various empirical studies dealing with trauma resulting from domestic violence, rape, sexual assault, combat, work-related trauma, and natural disasters.