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Crisis Interventions

Sherry was a sophomore at an Ivy League institution when she committed suicide. Her parents, who amidst great hardship had emigrated from China, were devastated by their loss. They could not understand what they had done wrong and continued to blame themselves for the death of their daughter. With encouragement from Sherry's college counselor, the family eventually agreed to attend family counseling, although they did not have much confidence that it would help. Working from an empowering and ecological framework, the therapist's encouragement was successful.

The family identified what they had done well for their children, the social stressors prevalent in their upper-middle-class suburb, and ways to support their surviving children. Receiving information about the progression of grief reactions and what they could anticipate in the future helped the family feel that they could conquer a hopeless situation. Eventually, the parents were willing to attend a suicide survivors' group in a neighboring community to address their family trauma. They were determined to be better parents to their surviving children.

This chapter reviews effective principles and guidelines in crisis intervention. Detailed procedural steps inform the reader how to act immediately, make appropriate assessments of crises, conduct successful interventions, and make referrals. Different models of crisis intervention that assess the severity of a crisis from a multidimensional perspective are explored.

Finally, the chapter discusses how to assess suicidal ideation, how to deter-mine suicidal intent, and how to work with survivor families.

Definition

Caplan (1964) initially defined a crisis as occurring when individuals are con-fronted with problems that cannot be solved. These irresolvable issues result in an increase in tension, signs of anxiety, a subsequent state of emotional unrest, and an inability to function for extended periods. James and Gilliland (2005) define crises as events or situations perceived as intolerably difficult that exceed an individual's available resources and coping mechanisms. Similarly, Roberts (2000) defines a crisis as "a period of psychological dise-quilibrium, experienced as a result of a hazardous event or situation that con-stitutes a significant problem that cannot be remedied by using familiar coping strategies" (p. 7). The Chinese translation of the word "crisis" consists of two separate characters, which paradoxically mean danger and opportu-nity (Greene, Lee, Trask, & Rheinscheld, 2000). Crisis intervention thus pro-vides opportunities for clients to learn new coping skills while identifying, mobilizing, and enhancing those they already possess.

The following are characteristics of crisis events:

- The event precipitating the crisis is perceived as threatening.
- There is an apparent inability to modify or reduce the impact of stressful events.
- There is increased fear, tension, and/or confusion.
- There is a high level of subjective discomfort.
- A state of disequilibrium is followed by rapid transition to an active state of crisis.

The following are examples of crises:

- An accident (automobile or in home)
- Death/loss of a loved one
- Natural disaster
- Physical illness (self or significant other)
- Divorce/separation
- Unemployment
- Unexpected pregnancy
- Financial difficulties

The difficulty in discriminating whether the events listed above constitute crises or traumas may be obvious. A crisis is distinguished from a trauma by

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timing and by how quickly it is resolved. Most crises develop into traumas; conversely, most traumas begin as crises. Socioeconomic status, availability of emotional support, and the nature of the crisis will dictate how soon the individual can resolve it and resume regular functioning. In the aftermath of Hurricane Katrina in September, 2005, two individuals I worked with epitomized the differences between a crisis and a trauma:

Amelia had moved from New York City to New Orleans to seek employment. She was unable to evacuate the city before the hurricane hit. She temporarily stayed at the shelter where I worked as a disaster responder. Although Amelia was deeply affected by the pain and suffering that surrounded her, she had a clear plan of action. She was resolved to return closer to her family and chalk up her material losses in New Orleans to fate. Once her check came in from the American Red Cross, Amelia rented a car and drove to her home state. Her former company assured her that a new job awaited her. Amelia's crisis would soon be over.

Kenny also found himself at the shelter where I worked. However, Kenny, in contrast to Amelia, had lost everything including his childhood home, a parent and a sibling, and his pet dog. Kenny sat on the edge of his cot for hours, wearing a forlorn countenance as he tried to make sense of what had happened. He was overwhelmed and unclear about the direction his life would take in the following few months. He also anticipated the check from the American Red Cross, though he already knew that it was not going to entirely solve his problems. In the face of this crisis, he displayed complete hopelessness and helplessness, and a crisis therefore became a trauma for him.

Background on Crisis

Presumably, crises have always occurred, yet the movement to help individuals in crisis did not begin until 1906, when a suicide prevention center called the National Save a Life League was established in New York City. Several years later, the catalyst for contemporary conceptualization of crisis work occurred when Lindemann (1944) and his colleagues from the Massachusetts General Hospital introduced the concepts of crisis reactions and intervention in the aftermath of the Coconut Grove fire. This fire occurred in a nightclub in Boston in 1943. The concepts are based on the acute and delayed reactions of the fire's survivors and the family members of its victims.

Expanding on Lindemann's work, Caplan (1961) describes the four stages of a crisis reaction as follows:

1. An initial rise in tension occurs in response to an event.
2. Increased tension disrupts daily living.
3. Unresolved tension results in depression.
4. Failure to resolve the crisis may result in a psychological breakdown.

In the past 10 years, crisis intervention surged as a specialized field. The focus on this field began with the rise in school and community violence as well as the higher frequency of natural and national disasters. The trademark of a crisis is its unpredictability: The crisis itself is unpredictable, and its ability to affect people is unpredictable as well. Crises happen suddenly, unexpectedly, often to arbitrarily chosen victims. A full understanding of the cultural context in which the crisis occurred will help the responder comprehend how the affected community perceives it. This understanding will influence and inform the design of an appropriate intervention.

Currently, more people are aware that attending to crisis reactions immediately potentially prevents them from developing into serious psychological problems. When crises occur, this awareness motivates administrators to invite crisis responders to the workplace on a more regular basis (Thompson, Smith, & Bybee, 2005). Through the support of Employee Assistance Programs, employers appropriately support employee mental health needs; thus, crisis intervention can prevent the development of serious mental disorders.

Why Crisis Work?

The common motivation for doing crisis work, whether a person is a trained professional or a volunteer, is the need to help and care for others. Unfortunately, this altruistic motivation is not enough. Appropriate training is crucial and can determine whether a crisis worker will become a help or a hindrance to a community in crisis. In addition to altruism, the following are often-cited reasons for doing crisis work:

• Recognition that such work is important in ensuring the survival of the species
• Gratification that comes from helping others
• Bearing witness to others' experience
• Personal and professional validation
• Community and personal connections that result from crisis
• Desire to make a difference

Crisis Intervention Guidelines

Every crisis is different, but all crises require immediate intervention to interrupt and reduce crisis reactions and restore affected individuals to pre-crisis functioning. Crisis interventions provide victims with emotional first aid targeted to the particular circumstances of the crisis (Rosenbluh, 1981). Several guiding principles are involved in crisis intervention; some key principles are outlined below (Shapiro & Koocher, 1996).

- Making an accurate assessment is the most critical aspect of a crisis response because it guides the intervention. A wrong decision in response to a crisis can be potentially lethal. Although situations may be similar, each person is unique; therefore, care must be exercised to avoid overgeneralizing.
- The ability to think quickly and creatively is crucial. People under crisis sometimes develop tunnel vision or are unable to see options and possibilities. The crisis responder must maintain an open mind in order to help explore options and solve problems in an empowering manner with those affected. People in crisis already feel out of control; when opportunities to restore control present themselves, they should be grasped quickly.
- The responder must be able to stay calm and collected. Crisis work is not suitable for everyone. It requires the ability to maintain empathy while simultaneously avoiding subjective involvement in the crisis.
- Crisis intervention is always short term and involves establishing specific goals regarding specific behaviors that can be achieved within a short time frame. For example, in response to a suicidal client, a therapist may increase the frequency of therapy sessions until the client's ideation subsides. Management, rather than resolution, is the objective of crisis interventions.
- Crisis intervention is not process-oriented. It is action-oriented and situation-focused (Aguilera, 1998; Pollin, 1995). Crisis interventions prepare clients to manage the sequelae of a specific event. Therapists help clients recognize an event's impact and anticipate its emotional and behavioral consequences. Furthermore, clients learn to identify coping skills, resources, and support available to them. They learn to formulate a safety plan in an effort to cope with the current and anticipated challenges the event presents.
- A crisis is characterized by loss of control and safety. This loss makes it incumbent on the helper to focus on restoring power and control in the client's internal and external environment (Yassen & Harvey, 1998).
- The goal is not to ask exploratory questions, but rather to focus on the present ("here and now"). The crisis responder merely acts as an emotional support at a time when self-direction may be impossible (Greenstone & Leviton, 2002). Therapists do not attempt to change clients, but serve as catalysts for clients' discovery of their own resources, which they can then use to accomplish their goals (Saleebey, 1997).

- Since crisis intervention is the first intervention that a client may encounter after a calamity, the goal is always to reestablish immediate coping skills, provide support, and restore pre-crisis functioning.
- Crisis intervention requires responders to possess familiarity with the work setting. The ability to direct people to local shelters and other safe places and to offer help in locating loved ones is crucial in this work.
- Viewing the client holistically, rather than isolating the individual's emotional and cognitive functioning, will provide insight into the resources and support available to the victim.
- A solid training in crisis intervention (with a focus on identifying suicidal and homicidal ideation) as well as experience in counseling is indispensable.

Finally, although crises are universal and affect people from all cultures, culture mediates how individuals and communities express crisis reactions and how they ask for and accept help (Dykeman, 2005). Since culture defines individuals' pathways to healthy adjustment and how they reconstruct their lives after a crisis, the crisis responder has to be multiculturally competent.

Multicultural Competence

Self-knowledge and awareness of one's cultural biases are integral to effect culturally appropriate interventions. Flexibility and openness in using alternative strategies better suited to the cultural background of victims is an asset in responding to crisis. The responder has to be able to consider the worldview of the client to prevent making erroneous interpretations, judgments, and conclusions, which cause clients further harm (Arredondo, 1999; Sue & Sue, 1999).

A crisis can be culturally universal or culturally specific. For example, the mudslides in California and the tsunami in Asia were universal because either could happen to anyone, and neither occurrence was dependent on the cultural background of its victims. Teen pregnancy, on the other hand, is an example of a culturally specific crisis. Socioeconomic resources and religious as well as other cultural beliefs determine whether a crisis develops. In the case of teen pregnancy, these factors determine whether a woman has a choice in the outcome of her pregnancy. Awareness of biases within oneself and one's culture is indispensable when working with cultural groups that differ. For therapists working with culturally different groups, it is always advisable to ask for clarification rather than base conclusions on previous assumptions.

Assuming an understanding of the nonverbal communication of a client can be misleading, unless one is quite familiar with a client's culture.

Finally, crisis responders should be careful not to impose their personal values and coping strategies on clients. Instead, responders should always maintain openness to the client's coping strategies. If a client's method of coping is strongly faith-based, for example, and the responder's is not, tolerance and taking a nonjudgmental stance are strongly suggested. A crisis is neither the time nor the place to explore different cultural perspectives.

Factors Affecting Long-Term Recovery

Several factors are likely to affect the long-term recovery of those affected by a crisis. Some of these factors depend on individual characteristics and coping responses, while others depend on an individual's ecological environment and the support and resources inherent in this environment:

- Frequent triggers may remind people of the traumatic event and/or their losses (e.g., living in a chronically violent area);
- A second assault occurs when the media reports the traumatic event, when court appearances are made, or when the anniversary of the event approaches;
- Developmental factors, such as the victim's age, will play a role in the recovery process. Younger children and the elderly may need a large amount of additional support;
- Trauma history and the number of prior losses experienced will compound or intensify a person's current reactions;
- The availability of environmental support or lack of support will determine how the survivor experiences the traumatic event.

Working under conditions that are time-limited, the crisis responder will have to make a swift determination of the factors outlined above. A crisis intervention should not be approached as a psychological intervention; referrals for counseling or other help often follow crisis intervention.

Crisis Phases

Individuals affected by a crisis event experience reactions that may change over time. Individual characteristics, the event itself, and the ecological environment that the individual inhabits affect these changes. Researchers have identified three primary phases of crisis reactions (Herman, 1997; Horowitz, 1986; Yassen & Harvey, 1998). These phases are outlined below. However, these phases show a cyclical progression; when individuals are reminded of the crisis event, they appear to return to the acute phase.

Acute Phase

Initial crisis reactions in response to a traumatic event usually encompass the physiological and psychological realm. Reactions include overwhelming anxiety, despair, hopelessness, guilt, intense fears, grief, confusion, panic, disorientation, numbness, shock, and a sense of disbelief. In this acute stage of crisis, the victim may appear incoherent, disorganized, agitated, and volatile. Conversely, the victim may present as calm, subdued, withdrawn, and apathetic.

Outward Adjustment Phase

For some people, the outward adjustment phase can begin within 24 hours of the trauma. The individual may then attempt to gain mastery by resuming external control through engaging in routine activities (Yassen & Harvey, 1998). However, this should not preclude the possibility that victims who outwardly appear to be "back to normal" may inwardly remain "deeply affected." Other victims isolate themselves from sources of support; they may appear to have withdrawn from society completely. The tension and fluctuating reactions involved in this phase should be noted as an attempt to return to normal while still processing the trauma.

Integration Phase

In this phase, the victim attempts to make sense of what has happened. An important task of this phase is to resolve one's sense of blame and guilt. Individuals who can recognize and identify the assumptions about their world and others that have changed because of the trauma develop a sense of integration sooner. Most importantly, clients should begin to make the changes necessary to minimize the recurrence of a crisis.

Some clients will cycle and recycle through these phases as they attempt to come to terms with their trauma. There are also those clients who cycle through phases too quickly or even skip a phase altogether. It may come as no surprise to find these clients later overwhelmed.

Several years ago, I worked with a community in the aftermath of a shooting. The high-school–aged young man was walking with his girlfriend when a rival gang member shot him in the chest. People in the community described his girlfriend, Juliette, as "doing very well." She returned to school a few days after the shooting. She was determined to collaborate with a few community leaders on a project

aimed at ending violence in her urban environment. Though she appeared to be coping well, it came as no surprise when six months later I learned she had been brought into the psychiatric emergency room at the local hospital. She cried constantly and she had not slept in days. Furthermore, she was no longer attending school. Juliette had recycled from outward adjustment to the acute phase of crisis.

Models of Crisis Assessment and Intervention

There are three primary methods of assessing clients in crisis: standardized inventories, general personality tests interpreted in the light of the crisis, and client interviews. The interview is the most commonly used method. The models of crisis assessment and intervention outlined below, therefore, use the interview as a primary assessment tool.

Gilliland's Six-Step Model

Gilliland's Six-Step Model, which includes three listening and three action steps, is a useful crisis intervention model. Attending, observing, understanding, and responding with empathy, genuineness, respect, acceptance, nonjudgment, and caring are important elements of listening. Action steps are carried out in a nondirective and collaborative manner, which attends to the assessed needs of clients as well as the environmental supports available to them (James & Gilliland, 2005).

1. Listening
   o defining the problem
   o ensuring client safety
   o providing support

2. Action
   o examining alternatives
   o making plans
   o obtaining commitment

Triage Assessment System

The Triage Assessment System was developed by Myer (2001), who posits that it is necessary to assess crisis reactions in three domains: affective (emotional), cognitive (thinking), and behavioral (actions). According

to Myer, an assessment based on these three domains captures the complexity of crises. Affective reactions include anger, hostility, anxiety, fear, sadness, and melancholy. Cognitive reactions include transgression, threat, and loss. Behavioral reactions include approach/avoidance and immobility, and can be constructive or maladaptive. In addition, Myer (2001) describes four life dimensions that are affected by a crisis: physical, psychological, social, moral, or spiritual.

Seven-Stage Model of Crisis Intervention

This model, developed by Roberts (1990), contains seven stages:

1. Plan and conduct a thorough biopsychosocial and crisis assessment. This also includes assessing suicidal and homicidal risk, need for medical attention, drug and alcohol use, and negative coping strategies. Assessing resilience and protective factors as well as family and other support networks is helpful.

2. Make psychological contact and establish rapport. By conveying respect and acceptance, the responder develops a solid therapeutic relationship with the client. Displaying a nonjudgmental attitude and neutrality are important in crisis work.

3. Examine and define the dimensions of the problem or crisis. Identifying any issues and challenges the client may have faced, especially the precipitant to the crisis, will provide valuable insight into the presenting problem.

4. Encourage an exploration of feelings and emotions. This can be achieved by actively listening to the client and responding with encouraging statements. Reflection and paraphrasing can also help this process.

5. Explore past positive coping strategies and alternatives. Viewing the individual as a resourceful and resilient person with an array of potential resources and alternatives can help this process (Roberts, 2000). Crisis workers should be creative and flexible in resolving crisis situations.

6. Implement the action plan. At this stage, identify supportive individuals and contact referral sources. The client should be able to implement some coping strategies.

7. Establish a follow-up plan. It is important to follow up with clients after the initial intervention to determine the client's status and ensure that the crisis has been resolved.

An Empowering Model of Crisis Intervention

In my many years of responding to communities and individuals in crisis, I have found the following steps to be helpful. These steps are an integration

of the models outlined above, but also borrow some important principles from community psychology. The model consists of three steps: pre-intervention, assessment, and disposition.

Pre-Intervention

Before responding to a community or individual in crisis, find out as much as possible. Individuals in a crisis have difficulty remembering details, and asking questions for which they may not have answers may be perceived as disempowering. It is usually feasible to get background information from the person who initiates the crisis intervention. To prevent oneself from becoming overwhelmed by the crisis, alert supportive people such as supervisors, family, and colleagues about the crisis in order to introduce stress-reduction procedures immediately. By taking preliminary action, the responder appears stable and supportive when interfacing with distressed individuals or communities.

Assessment

Identify the victim's current concerns and triggers or precipitants to the crisis. Make the evaluation quick, accurate, and comprehensive. Gathering information about how similar crises were handled in the past is essential for problem solving. In addition, establishing what worked and what did not is useful in designing current interventions.

An ecological chart may be helpful in identifying sources of help and support. This chart is constructed with the affected individual or community in the middle, encircled by significant groups that are named as important by the client or the client's community. Exploring which groups can provide ongoing support is also informative when planning termination with the client.

Disposition

Allow the client to talk as little or as much as possible about the event. The telling and retelling of a trauma can assist in the healing process. Psycho-educational information on what actions can be taken to maintain safety and stabilization are valuable in empowering clients. Information helps them know what to expect so they will not be later taken by surprise. Decisions on how to handle the crisis are made by exploring options with clients, an action that supports client empowerment. Additionally, decisions that include active client participation promote client compliance. Thinking creatively with clients can resolve most problems. Since crisis intervention requires short-term involvement, it is important to refer a client to other

sources of help as soon as stability is established. Finally, responders should be aware that not all clients need mental health support in order to overcome a crisis.

Referral and Resource List

Keeping a referral and resource list is an important aspect of crisis work. The effective crisis responder researches and maintains information regarding agencies and programs in a client's community that can be sources of future help. If time allows, it might be helpful to visit these agencies before referring a client to them. Such visits increase the responder's familiarity with the services of the referral resources. Knowing whether they have a waiting list, sliding scale of payment, or whether they give priority to crisis victims is important additional information. Once a list is generated, make sure that phone numbers, addresses, and names of contact persons are constantly updated. It can be frustrating for clients in crisis to call a disconnected number for help.

Information about potential resources should be clearly printed on a card and carefully reviewed with clients. Clients are better informed if they have some knowledge about the process involved before services are sought. Remember, one of the challenges for people in crisis is the ability to concentrate and remain focused; short-term memory can often be seriously impaired. The crisis responder should have clients review their next steps before departing. It is a good idea to call clients after a few days to get an update on how they are feeling.

Helping Children and Adolescents

While the emotional effects of a crisis can significantly affect children and adolescents, most victims in this age range make a full recovery. The following crisis responses are likely to manifest in younger children (AAETS, 1999).

- Regressive behaviors are likely to occur among toddlers, preschool, and elementary school children. Thumb-sucking, bed-wetting, fear of the dark, and other past problematic behaviors can recur.
- Fears and anxiety are likely to be exhibited in separation anxiety and clinging behaviors. Children may have difficulty leaving a parent's side.
- Although school phobia and anxiety may develop, parents are encouraged to continue sending children to school to maintain routine. Children who are kept at home experience greater anxiety when they later return to the classroom.

Adolescents display generalized anxiety rather than the specific fears observed in younger children.

- As adolescents' anxiety increases, a decrease in academic performance and poor concentration may become evident. However, as with younger children, maintaining the routine of school attendance surpasses the benefits of staying at home.
- An increase in aggressive and oppositional behavior is possible. Controlling anger and frustration becomes a challenge for adolescents in crisis. Adolescents are also likely to display an increase in rebellious and risk-taking behaviors. They tend to defy rules both at home and at school. Antisocial behaviors of substance abuse and alcoholism may become prominent in this group.
- A general sense of sadness, loss of interest, and increase or decrease in appetite and sleeping can occur. Adolescents are likely to display moodiness and social withdrawal. Since adolescents are at risk for suicide, caregivers should be alert for suicidal ideation in this group.
- Denial is an effort to cope with the reality of the crisis. Adolescents are likely to deny that something bad happened; they may continue to use denial as a coping mechanism. It may be necessary to confront them in a sensitive but direct manner.

Understanding the responses of children and adolescents is a first step in helping them. This understanding will also help identify those children who may need professional assistance. Schools and homes are the places that children and adolescents are likely to spend most of their time. Teachers and caregivers become critical resources to help children cope with a crisis. The crisis worker can teach parents how to set boundaries and limits without shaming the child. Supportive and warm parenting can buffer adolescents from suicidality (Kaplan, Pelcovitz, Salzinger, Mandel, & Weiner, 1997; Perkins & Hartless, 2002). Similarly, researchers have found that adolescents who report a close relationship with their parents, positive family communication, and the receipt of adequate support and affection from their parents have a lower risk for later suicidality (Ferguson, Woodward, & Horwood, 2000; Prinstein, Boergers, Spirito, Little, & Grapentine, 2000).

An on-site school mental health program is an effective vehicle for engaging children and adolescents in treatment. When mental health assistance has to be provided quickly to a large number of students, school-based services are ideal. Receiving services in school is also less stigmatizing than receiving them in hospitals (Waxman, Weist, & Benson, 1999).

However, in order to make school interventions successful, strong collaboration between schools and mental health professionals must exist (Brock, Sandoval, & Lewis, 2001; Johnson, 2000). Within a school community,

there can be debate about who is primarily responsible for assisting with crisis intervention (Brock et al., 2001; Johnson, 2000). The American School Counselor Association (ASCA) designates the professional school counselor as this individual, with the primary role of providing direct counseling service during and after a traumatic incident (ASCA, 2000). School counselors are expected to serve students and school personnel during times of crisis by providing individual and group counseling. Consulting with administrators, teachers, parents, and professionals, as well as coordinating services within the school and in the community, are additional tasks for the school counselor (ASCA, 2000; King, Price, Telljohann, & Wahl, 2000; Riley & McDaniel, 2000). School counselors' training should be aligned with the demands of their profession to ensure solid preparation for responding to children's emotional needs during a crisis (Perusse, Goodnough, & Noel, 2001).

Suicide Assessment Issues

Working with a suicidal client in crisis is a scenario many counselors face. The American Association of Suicidology (2002) reports the following statistics in the United States:

- 31,655 individuals completed suicide in 2002, which equates to 86.7 people each day and one person approximately every 17.2 minutes.
- Suicide is the 11th leading cause of death in the United States; however, it is the third leading cause of death for youth (ages 15–24), exceeded only by accidents and homicides. Homicide is the 14th leading cause of death overall, indicating that more Americans kill themselves than are killed by others.
- Annually, 790,000 Americans attempt to kill themselves.
- The elderly (ages 65+) have the highest rate of completed suicides: Approximately 5,548 elders completed suicide in 2002. For every four older adults who attempt suicide, one successfully completes the act.
- Youth have the second highest rate of completed suicide: For every 100–200 young people who attempt suicide, one successfully completes the act.
- Women are three times more likely to attempt suicide than men, but men are four times more likely to complete it.
- Firearms are the most commonly used method for completing suicide (54% of all suicides were completed with a firearm); approximately 17,108 individuals used firearms in 2002.
- Each suicide intimately affects at least six other people; thus, for each suicide there are six new survivors.

Risk Factors

The first step in preventing suicide is to identify and understand risk factors. The Department of Health and Human Services (1999) identifies the following as risk factors:

- Previous suicide attempt(s)
- History of mental disorders, particularly depression
- History of alcohol and substance abuse
- Family history of suicide
- Family history of child maltreatment
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health, substance abuse disorders, or suicidal thoughts
- Cultural and religious beliefs, for instance, the belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide
- Isolation or a feeling of being disconnected from other people

Determining Suicidal Intent

With approximately one million people committing suicide worldwide each year (WHO, 2000), there is little doubt that suicidal behavior of a client is a crisis situation many counselors will encounter (Rosenberg, 1999). Assessing and determining suicidal intent is, therefore, a valuable skill to develop. Attention to the following guidelines will help counselors determine the suicidal intent of a client.

- Assessing the persistence of suicidal thoughts and the client's ability to control them and differentiating between active, passive, or compulsive suicidal thoughts are important first steps for determining intent. Understanding a clients reasons for living or dying, establishing specific motivating forces and their bases (i.e., feeling worthless), and determining the contributing psychosocial factors can shed more light on a clients' level of intentionality.
- Assessing the degree of planning involved, the method contemplated for use, its lethality, and the individual's access to weapons or other means can help a therapist determine the likelihood that the client will carry out the suicidal act.

For example, a client who has already rehearsed exactly how to carry out a suicidal plan, and who anticipates staying at home alone for an extended

period, should be regarded as high risk. Specificity in planning, opportunity, and a sense of "capability" to execute the attempt should be significant warning signals. The terms, intent, and lethality allow for an objective assessment of a client's level of suicidal ideation. Is the suicidal ideation a precursor of actual lethal intention? Is it a subjective means of gesturing? Is it merely a signal used to draw attention to one's inner pain?

Suicidal gesturing (also known as para-suicidal behavior) refers to individuals' use of less than lethal means to harm themselves; this gesturing can be complicated and confusing to the novice counselor. Those who "attempt" suicide may be ambivalent about dying, and their suicidal behavior could be perceived as a "cry for help."

- It is critical to assess the deterrents in the client's environment, such as family or religion, that may help prevent implementation of the suicidal plan. Identifying deterrents will help assess clients' ability to maintain safety once they leave the therapy session.
- It is helpful to ascertain prevailing co-morbid symptoms. When making an assessment, the crisis responder must know whether a client is actively abusing substances or suffering from depressive symptoms. This includes knowing whether the client takes any psychiatric medications, whether these medications have been recently changed, or whether a client has recently stopped taking the medication altogether.
- The specific characteristics of the suicidal ideation also provide helpful information. How often (frequency) does the client think about suicide and for how long (duration)? Does the client have control over suicidal thoughts?
- When a client has made actual preparation for suicide, or when a suicide note is written, the responder should proceed with great caution. Final acts in anticipation of death, such as cashing life insurance, securing a will, and distributing one's possessions as gifts, are a significant forewarning of serious intent. Additionally, a deception or concealment of a contemplated attempt (failure to communicate ideation) also serves to warn the crisis responder that a client is a high suicide risk.

How to Help

Several protective factors can buffer individuals from attempting suicide (Department of Health and Human Services, 1999):

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support
- Family and community support
- Support from ongoing medical and mental health services
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

Outpatient Issues

In outpatient treatment, it is crucial for all therapists to ask clients about a suicide history on their first visit. If the history is notable or active, a therapist must commit to assessing a client's suicidal ideation in every subsequent session. To gain additional information, previous treatment records should be requested from other agencies/institutions that may have served the client. This documentation offers the therapist an opportunity to cross-check information that the client has already provided. It may also indicate how past crises were resolved.

Issues of confidentiality are discussed ahead of time, especially if the therapist anticipates communicating with family members or other supportive individuals when a client's suicidal ideation accelerates.

It is essential to assess clients' level of compliance and whether they will follow through with a safety plan that instructs them to go to an emergency room when suicidal feelings increase. Medication for clients with a suicide history has to be actively monitored. Large prescriptions carry the risk of providing clients with a means to end their lives. Finally, therapists who treat suicidal clients have to obtain adequate coverage during periods of leave or vacation.

Working With Survivors of Suicide

Approximately 30,000 completed suicides occur annually in the U.S., leaving behind many family survivors (Kaslow & Aronson, 2004). Research illustrates the following:

- Partners who lose a loved one to suicide display more psychological distress and impairment than those whose partners die naturally (Farberow, Gallagher-Thompson, Liewski, & Thompson, 1992).
- Parents whose child commits suicide experience more shame than parents who lose their child in an accident (Seguin, Lesage, & Kiely, 1995).
- Mothers who lose a child from suicide are more likely to stay depressed than mothers who lose a child from an accident (Saarinen, Viinamäki, Hintikka, Lehtonen, & Lönnqvist, 1999).
- Children who lose a parent to suicide persistently reminisce about the loss, engage in self-destructive behavior, and are more likely to display behavioral and academic problems (Saarinen, Hintikka, Viinamäki, Lehtonen, & Lönnqvist, 2000).

When notifying a family of a loved one's suicide, a therapist should be clear, sympathetic, and offer immediate but continuing support. During the

meeting, address their concerns directly. In response to questions such as, "Why did this happen?" explain the multi-causal nature of suicide and appreciate the relevant stages of grief (anger, blame, bargaining, depression; see also Appendix III). Demystify "If only . . ." statements that are usually present among those who lose a family member to suicide, but accomplish this with sensitivity to the family's needs.

Avoid defensiveness and do not apologize. It is especially important to avoid a discussion of any wrongdoing. Maintain appropriate boundaries while showing caring and compassion. When a therapist expresses shock, family members may question the therapist's competence, yet a stoic therapist may be regarded as uncaring.

While working with survivors, it is recommended that therapists use techniques consistent with their own theoretical training; they should remember to consider the role of family traditions and other contextual or cultural factors. An awareness of the family's death and mourning rituals can be useful. Encourage family members to honor the dead by observing anniversaries and other important holidays or special family days. Establishing or following previously established traditions fosters the healing process and gives people permission to grieve.

Empowering interventions encourage family members to seek support from each other and their social network. Teaching the family about the stages of the grieving process and predictable responses to suicide can restore control. Some families also become concerned about inheriting a predisposition to suicidal behavior and may need additional support in this area (Brent, Oquendo, & Birmaher, 2002).

Although a therapist may be tempted to first work with child survivors, it is important to give adult survivors adequate support so that they, rather than strangers, can be psychologically available to their children. Informing them of available resources and educating them about what grief reactions they can expect their children to display can be initial steps in helping adults cope. Children should be encouraged to talk about their loss and be actively involved in memorializing the dead (see Appendix IV). They should be encouraged to resume normal peer, school, and extracurricular activities (Kaslow & Aronson, 2004).

Finally, client records and other documentation, such as termination and discharge summaries, should be completed as soon as possible. If family members request these records, regulations regarding confidentiality should be reviewed. A signed release form is needed from the administrator of the estate before any records are released to family members.

Conclusion

The high frequency and indiscriminateness of violent acts make many individuals vulnerable to crises. During a crisis, normal ways of dealing with the world are suddenly interrupted. Although reactions and responses to crises are time-limited, they may persist as symptoms of post-traumatic stress. Crises are universal and can affect people from all cultures; however, culture plays a strong role in how an individual interprets and reacts to a crisis. The recovery process and support individuals are offered by their communities is culture-bound.

For all these reasons, crisis intervention strategies should be structured and considerate of a culturally diverse and dynamically changing world. Crisis interventions are usually brief, and counselors can expect to have only a single session to work with a client. Although this time may appear to be limited, an effective counselor conveys an expectation that change will occur, that small changes can be sufficient to solve problems, and that the client's abilities and strengths are central to problem solving (Rosenbaum, Hoyt, & Talmon, 1990). The satisfaction of seeing people resume control after their lives have been shattered can be quite rewarding.

Resources for Further Understanding

The following books may be used as bibliotherapy for families bereaved by suicide. Counselors interested in increasing their understanding of suicide may also find these titles helpful.

Cammarota, D. (2001). *Someone I loved died by suicide: A story for child survivors and those who care for them.* Palm Beach Gardens, FL: Grief Guidance.

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