

Article 3

Providing Mental Health Services to Clients in Crisis or Disaster Situations

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Theories of crisis intervention are often traced back to the Cocoanut Grove fire in Boston in 1942. The Cocoanut Grove nightclub was the scene of a tragic fire in which nearly 500 individuals lost their lives. Eric Lindemann treated many of the survivors and soon discovered several similarities in their emotional suffering and needs. Based on this discovery, he began to formulate a theory of normal grief patterns. Gerald Caplan worked with the Cocoanut Grove fire survivors also (Collins & Collins, 2005) and, added to that experience, was his work with families who found themselves facing crises at the Harvard Public Health Family Guidance Center where he and Howard Parad identified five elements that influenced the families' ability to cope with crisis events. This ultimately led them to define the elements that constituted a crisis. Those five elements were that (1) the stressful event poses a problem which is, by definition, insoluble in the immediate future; (2) the problem overtaxes the psychological resources of the family, since it is beyond their traditional problem-solving methods; (3) the situation is perceived as a threat or danger to the life goals of the family members; (4) the crisis period is characterized by tension which mounts to a peak, then falls; and (5) the crisis situation awakens unresolved key problems for both the near and distant past (Parad & Caplan, 1960, pp. 11–12).

The argument can be made that today we live in a very troubled world. Terrorist attacks have hit major cities around the world leaving deep and profound scars on the psyches of many innocent people. Individuals suffer personal tragedy and loss all the time. While the effects of these personal crises are nonetheless painful or traumatic for the individual, the disasters that occur on a larger scale may need a somewhat different approach from the mental health professional. In the case of the individual or personal crisis, as traumatic as it may be for the individual, that individual's environment, save for the precipitating crisis event or loss, remains relatively constant prior, during, and following the event. In the case of a huge disaster, the environment could best be described as chaotic. There is interplay between that chaotic and devastated

environment, in which large numbers of people are impacted, and the individuals involved. Not only is their personal world being shaken and in a state of upheaval but everything with which, and everyone with whom, they come into contact is altered or traumatized as well. This has the effect of exacerbating the impact of the individual's experience.

James and Gilliland (2005) defined crisis as "...a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms" (p. 3). This definition can be applied to both of the scenarios just described. In essence, to distinguish between a personal crisis and a disaster, and to push their definition just a bit, a disaster could be defined as that event or situation (as mentioned) magnified or equal to more than the number of individuals reacting to the event.

There are several levels of coping response. Three are presented here for the sake of brevity. First, most individuals experiencing a crisis or a disaster will cope effectively and in a healthy and normal fashion. What they fail to understand is that their reaction, while extremely uncomfortable, unpleasant, and perhaps even frightening, is a normal reaction to an abnormal situation, that is, the crisis or disaster event. Many may even gain strength from the experience and a new appreciation for themselves with an enhanced self-concept. To be sure, this added strength will not come immediately but rather only upon reflection and perhaps with a bit of help from a mental health professional.

Second, there is a smaller group that will survive (i.e., get through the event), but in order to do so, they must block the event from their awareness. When this occurs there is a reasonable likelihood that if they face another crisis or disaster in the future, the unfinished business that they have buried relative to the first event will not only resurface but also serve to exacerbate their reaction to the current situation. Further, the composite of these two events will continue to be problematic for them until they come to grips with them and put them in their proper perspective. They may benefit from the services of a mental health professional.

Third, there are individuals who simply do not possess the coping ability to handle the crisis and are incapable of proceeding without the therapeutic assistance of mental health professionals. Their resilience may have become so eroded that they do not have the confidence to move forward on their own. Or, it may be due to their physical, mental, or emotional limitations.

There are many factors that influence an individual's response to a crisis or disaster. A little over 10 years ago, the American Red Cross (1995) identified some of these factors in broad terms. They noted that the nature of the event itself is one factor. Was the event man-made or natural in origin? What time of day did it occur? Did it come with a warning or without? How long did it last? These are questions that need to go into the overall assessment of the individual's response.

Another factor that influences the individual's response to a crisis or disaster is the individual him- or herself. What was their general state of emotional and physical health at the time of the occurrence? What type of social support system do they have in place? What has their previous exposure to crises or disasters been like? What are the demographics that describe this individual, such as age, physical abilities, financial situation, and issues of diversity? These factors must be assessed as well.

Other factors that influence the individual's reaction to the disaster or crisis have to do with the nature of the community. This area of concern raises questions such as the density of the population and number of people who are or could be impacted, the community's politics, the size of the community itself, the response resources available, and the history of that particular community relative to previous disasters.

Due to these general types of reactions and influencing factors, accurate assessment of the crisis or disaster client is of extreme importance. Myer (2001) differentiated five approaches to assessment. The first is *diagnostic assessment*, which looks for symptoms that are present to infer the presence of disease or disorder. This approach has also been referred to as the medical model. The second is *standardized testing assessment*, which involves a fixed process of administering selected standardized tests and develops a profile that identifies weaknesses and/or strengths. Another name for this might be the psychological approach. Third is *symptom assessment*, which simply identifies symptoms that may require further assessment or treatment that is most often used to screen clients and is useful in that it only requires a few minutes. Fourth, *psychological history assessment* describes the developmental, psychological, and social history of the

client and is most often used to assist the provider in gaining an understanding of the client from a psychological perspective within the environmental context. This approach could be called the social work model.

Fifth, Myer described *crisis assessment*, which focuses on the client's current level of functioning and gathers information regarding the crisis or disaster situation with the goal of assisting the client in mobilizing his or her resources to get through the immediate crisis. What makes this model unique is that the first four models described are used to make recommendations for future use. Crisis assessment gathers information for immediate use by the client.

Crisis assessment must be ongoing to monitor the clients' reactions to determine what level of intervention is needed. It can be assumed that the understanding gained through this assessment model should precede and guide the efforts of the mental health professional to facilitate change in his or her clients (Collins & Collins, 2005). In crisis intervention, the urgency of quick and accurate assessment is paramount. A mental health provider must often evaluate a client's reaction and initiate treatment in a matter of a few minutes (Myer, 2001). Faulty assessment can lead to ineffective helping and even serve to worsen the client's condition (Hoff, 1995; James & Gilliland, 2005).

Myer (2001) noted that the mental health professional may well be in greater risk of making faulty assessment decisions due to the nature of the disaster setting. Being distracted by the environment and the sheer massive need for services by so many clients can take the clinician's mind off the client at hand. The practitioner may also fall into the trap of having "heard the exact same problem so many times" and therefore offer preordained treatment as opposed to really hearing that particular client. The practitioner may be so overwhelmed by the situation and tremendous need that he or she is not aware of his or her own limitations in terms of energy and ability to focus. In addition, there is always the issue of the mental health professional who has little if any training in crisis intervention.

Perhaps the most frequent error in clinical judgment of a practitioner who is poorly trained in this area is to "pathologize" the clients. To be sure, the reactions of clients may be acute, may interfere with day-to-day functioning, and are uncomfortable and unnerving to say the least, given the disaster event; however, they are feelings, both physical and emotional, that one would expect following traumatization. Carried to the extreme, one outcome of poor assessment is overhospitalization (Hoff, 1995). Shapiro and Koocher (1996) have cautioned us that a basic assumption in crisis intervention is that most reactions

to crises are not pathological. Hoff (1995) stated it very clearly when he said that to simply diagnose (or overassess) a person who has gone through a crisis is to see crisis reactions as an illness rather than an opportunity for growth.

It is important to include a brief discussion of psychological triage. The average mental health professional does not normally have to consider approaching the delivery of services from a triage perspective. Our counselor education programs rarely touch on the subject. The triage approach provides a decision-making process for prioritizing treatment that will provide appropriate care to a maximum number of people and minimize losses to the best degree possible given the circumstances. The primary triage task is to identify those individuals impacted most significantly by the crisis or disaster so they can obtain immediate psychological first aid. It also involves making decisions regarding the need for psychological treatment on an ongoing basis. Further, it is a tool for identifying those individuals who may not need any support.

Myer (2001) maintained that the crisis intervention strategies that mental health professionals should keep in mind must meet three criteria to be most effective. First, crisis intervention must be time limited, having a duration of not more than 6 weeks. The number and length of sessions during this period will vary greatly depending on the severity of the particular issue(s) with which the client is dealing at the moment. Generally speaking, if a client needs mental health support beyond these 6 weeks it is best he or she be referred for ongoing therapy. James and Gilliland (2005) strongly advocated that the interventions during this period be action oriented, giving the client homework assignments to be accomplished outside of therapy.

Second, crisis intervention addresses a specific issue and attempts to assist the client in resolving that issue. It must therefore be focused on setting and maintaining realistic goals for that specific issue alone. If other issues arise, make sure that they are related to the resolution of the crisis or disaster event.

Third, there is the unique treatment dimension. Slaikeu (1990) said that the goal of first-order intervention is to reestablish immediate coping and provide support. This might be called psychological first aid, as mentioned earlier. It is of critical importance to get the client to re-own their strengths. This may require the practitioner to provide support, but the focus must be functionality. The second-order goal of crisis intervention is the integration of the experience into the client's life by developing new coping skills and adapting to the crisis or disaster as part of the client's

past (emphasis on past) to help them get to the point of "I am a survivor" as opposed to "I am a victim."

Greenstone and Leviton (2002) offered some sound advice for mental health professionals when it comes to effective crisis intervention. They suggested that you (1) act immediately to stop the "emotional bleeding," (2) take control and by doing so you help reorder the chaos that exists in the client's world at the moment, (3) accurately assess the situation to determine what is troubling the client at this precise moment, (4) decide how to handle the situation after you have assessed it by helping the client identify and mobilize his or her resources, (5) make a referral if needed, and (6) follow up with clients to make sure they have made contact with the referral agency.

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