Assessment, Crisis Intervention, and Trauma Treatment: The Integrative ACT Intervention Model

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This article presents a conceptual three-stage framework and intervention model that should be useful in helping mental health professionals provide acute crisis and trauma treatment services. The ACT model stands for Assessment, Crisis Intervention, and Trauma Treatment. This new model may be thought of as a sequential set of assessments and intervention strategies. The ACT intervention model integrates various assessment and triage protocols with the seven-stage crisis intervention model, and the ten-step acute traumatic stress management protocol. In addition, this article introduces and briefly highlights the other eight narrative, theoretical, and empirically based papers in this issue that focus on mental health and crisis-oriented intervention strategies implemented within 1 month after the September 11, 2001, terroristic mass disaster at the World Trade Center and the Pentagon. [*Brief Treatment and Crisis Intervention* 2:1–21 (2002)]

KEY WORDS: assessment, triage, crisis assessment, crisis intervention, trauma treatment.

This special issue was prepared to provide administrators, clinicians, trainers, researchers, and mental health consultants with the latest theories, and best crisis intervention strategies and trauma treatment practices currently available. In order to assist all clinicians whose clients may be in a precrisis or crisis state, eight experts in crisis intervention or trauma treatment were invited to write articles for this issue of the journal.

As has been widely reported, the horrific events of September 11, 2001, resulted in the loss of approximately 2,838 lives in the World Trade Center, 125 in the Pentagon, and over 246 on four hijacked airliners. (The death toll for the World Trade Center has been revised several times to 2,838 as of February 16, 2002.) The suddenness and extreme severity of the terrorist attack, combined with the fear of additional terrorist actions that may lie ahead, serves as a wake-up call for all mental health professionals as we expand and coordinate interagency crisis response teams, crisis intervention programs, and trauma treat-

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ment resources. This commentary presents an overarching theoretical framework and intervention model that may be useful in helping mental health professionals provide crisis as well as trauma services.

This overview article is built on the premise that it is useful for counselors, psychologists, nurses, and social workers to have a conceptual framework, also known as a planning and intervention model in order to improve the delivery of services for persons in a precrisis or traumatic state. The second premise is that mental health professionals need an organizing framework to determine sequentially which assessment and intervention strategies to use first, second, and third. Thus, I developed a three-part conceptual framework that may be helpful in serving as a foundation model to initiate, implement, evaluate, and modify a well-coordinated crisis intervention and trauma treatment program in the aftermath of the September 11 catastrophes.

Terrorist acts of mass destruction are sudden, unexpected, dangerous and life-threatening, affecting large groups of people, and overwhelming to human adaptation and our basic coping skills. Unfortunately, as long as there are terrorists, senseless murders of innocent persons and destruction of property are likely to continue. Therefore, it is imperative that all emergency services personnel and crisis workers be trained to respond immediately and appropriately. In the aftermath of catastrophic terrorist tragedies, people experience different symptoms including surprise, shock, denial, numbness, fear, anger, adrenal surges, caring for others, attachment and bonding, isolation, loneliness, arousal, attentiveness, vigilance, irritability, sadness, and/or exhaustion. Many individuals, particularly those not living within 50 miles of the disaster sites and not losing a loved one, will generally adapt relatively quickly and return to their regular work schedules and routines of daily living. However, in the deep recesses of their minds is the knowledge that they may be the next victims. But for many of the survivors and those individuals living close to the disaster site and without personal resources and social supports, acute stress, crisis, and trauma reactions could be prevalent. In view of the most horrific and barbaric mass murders in American history—it has become critically important for all informed citizens to know the difference between acute stress, normal grief, acute crisis episodes, trauma reactions, and post-traumatic stress disorder (PTSD). This overview article and the articles by Joshua Miller, Gary Behrman and William Reid, Judith Waters, and Jenny Lowry and Jeffrey Lating examine the different definitions of acute stress, crisis, and psychological trauma as well as critical incident stress debriefing and crisis intervention strategies.

The poignant article by Linda Mills depicts the experiences and reactions of her five-year-old son, through her eyes, when they were uprooted from their apartment and his school, which were in close proximity to the World Trade Center site. Professor Mills's article is compelling and heart-wrenching because she writes about the horror that she and her family experienced, and its impact on her young child. Rachel Kaul, an emergency room social worker and American Red Cross disaster mental health responder, describes her 31 days working with survivors and family members near the Pentagon, and underscores the critical need for self-care among all crisis intervenors and emergency services personnel. Joshua Miller provides a thorough description of the emergency mental health system responses that he witnessed at the World Trade Center, and the responses of the survivors of the tragedy. Professor Miller was inspired by the resiliency of the survivors, their capacity to use this tragedy to reevaluate their lives, cherish their relationships, and strengthen their social bonds with family, friends, and colleagues.

According to Lenore Terr (1994), a professor of psychiatry, there are two types of trauma

among children. Type I refers to child victims who had experienced a single traumatic event, such as the 26 children from Chowchilla, California, who were kidnapped in 1976 and buried alive in their school bus for almost 27 hours. Type II trauma refers to child victims who experienced multiple traumatic events such as ongoing incest or child abuse. Research has demonstrated that most children experiencing a single isolated traumatic event had detailed memories of the event, but no dissociation or personality disorders, or memory loss. In sharp contrast, child survivors experiencing multiple or repetitious incest and/or child sexual abuse trauma (Type II trauma), exhibited dissociative disorders (also known as multiple personality disorders) or borderline personality disorder (BPD), recurring trance-like states, depression, suicidal ideation and/or suicide attempts, sleep disturbances, and to a lesser degree self-mutilation and PTSD (Terr, 1994; Valentine, 2000). The age of the incest victim frequently mediates the coping strategies of adult survivors who face crisis and trauma. Research has indicated that when the childhood incest was prolonged and severe, then an adult diagnosis of BPD, dissociative disorder, panic disorder, alcohol abuse or dependency, and/or PTSD occurs with greater frequency (Valentine, 2000). The exception to the low incidence of long-lasting mental disorders among victims of a Type I trauma is an extremely horrific single traumatic occurrence that is marked by multiple homicides and includes dehumanizing sights (e.g., dismembered bodies), piercing sounds, and strong odors (fire and smoke). The long-lasting psychological impact of the September 11 mass disasters will not be known for many years when prospective and retrospective longitudinal research studies will be completed.

The American Academy of Experts in Traumatic Stress (ATSM) is a multidisciplinary network of professionals dedicated to formulating and extending the use of traumatic stress reduction protocols with emergency responders (e.g., police officers, firefighters, EMS personnel, nurses, disaster response personnel, psychologists, social workers, funeral directors, and the clergy). Dr. Mark D. Lerner, a clinical psychologist and President of ATSM, and Dr. Raymond D. Shelton, Director of Emergency Medical Training at the Nassau County Police Training Academy and Director of Professional Development for ATSM, provide the following guidance for addressing psychological trauma quickly during traumatic events:

> All crisis intervention and trauma treatment specialists are in agreement that before intervening, a full assessment of the situation and the individual must take place. By reaching people early, during traumatic exposure, we may ultimately prevent acute traumatic stress reactions from becoming chronic stress disorders. The first three steps of Acute Traumatic Stress Management (ATSM) are: 1) assess for danger/safety for self and others; 2) consider the type and extent of property damage and/or physical injury and the way the injury was sustained (e.g., a terroristic explosion), and 3) evaluate the level of responsiveness—is the individual alert, in pain, aware of what has occurred, or in emotional shock or under the influence of drugs. (Lerner & Shelton, 2001, pp. 31–32)

Personal impact in the aftermath of potentially stressful and crisis-producing events can be measured by:

- *Spatial dimensions*. The closer the person is to the center of the tragedy, the greater the stress. (Similarly, the closer the person's relationship is to the homicide victim, the greater the likelihood of entering into a crisis state.)
- *Subjective time clock*. The greater the duration (estimated length of time exposed and

estimated length of exposure to sensory experiences, e.g., an odor of gasoline combined with the smell of a fire) of time that an individual is affected by the community disaster, violent crime, or other tragedy, the greater the stress.

- *Reoccurrence (perceived)*. The more the perceived likelihood that the tragedy will happen again, the greater the likelihood of intense fears, which contribute to an active crisis state on the part of the survivor (Young, 1995).

Need for Educational Curriculum, University-Based Certificate Programs, and Training in Crisis Intervention and Trauma Treatment in the Aftermath of Disasters

An unprecedented outpouring of offers to provide counseling to help survivors cope with grief from the loss of loved ones resulted from the events of September 11. Additionally, mental health professionals have reached out to assist thousands of people who survived the tragedy by escaping from the Pentagon, the World Trade Center, and from many nearby office buildings amid falling debris and thick black smoke. Many in the media and amid the general public have assumed that *all* clinicians have the proper training and experience to provide crisis counseling to persons traumatized by these events.

Due to the events of September 11, there is renewed recognition of the urgent need for more comprehensive crisis intervention course and workshop offerings. However, as of November 2001, the level of training among the vast majority of social workers, psychologists, and counselors to do crisis intervention work is limited. There is a dearth of certificate programs and training opportunities at graduate schools in the human service professions. The overwhelming majority of graduate programs in social work, clinical psychology, and counseling do not even require one course in crisis intervention. The most deficient curricula are within the 137 Masters of Social Work (MSW) accredited programs throughout the United States. Only a handful of these large educational programs offer a one-semester course in crisis intervention. Even the small number of programs that offer required course content related to crisis intervention and trauma treatment usually limit the content to just one to three (2 or 3 hour sessions) classes as partial fulfillment of a three-credit course on social work practice. I predict that this lack of education and skill building will change in the important years ahead. For example, Elaine Congress, Professor and Associate Dean at the Graduate School of Social Services of Fordham University in Manhattan, was quoted in the November 2001 issue of *NASW News* indicating that the curriculum committee at her school is developing crisis intervention courses and seminars. Some training for practitioners on crisis intervention (usually 2 to 5 days) is provided by such organizations as the National Organization for Victim Assistance (NOVA), the American Red Cross, and the Crisis Prevention Institute.

As helping professionals in the aftermath of the mass destruction caused by the terrorist attacks of September 11, we want to rush to action. However, I am calling for all mental health professionals to pause and assess. If we don't assess, we are likely to engage in well-intentioned but misguided and potentially harmful action. For example, a therapist with no training in crisis intervention or trauma treatment many encourage a survivor to make impulsive changes like breaking his or her lease on an apartment in lower Manhattan, and moving to New Jersey where the lengthy commute to work will be very stressful and expensive. As mental health professionals, what are the things we should as-

sess, and which methods should we use to conduct assessments in the aftermath of a mass disaster? The answers to this question provide the focus to the next section.

The ACT Intervention Model of Crisis and Trauma Assessment and Treatment

Assessment

Somatic stress, crisis and psychological trauma frequently take place in the wake of unnatural, human-induced disasters such as the terrorist mass murders of September 11. Most individuals have little or no preparation for traumatic events. The catastrophic nature of the World Trade Center and Pentagon disasters has impacted and threatened the safety of many American citizens. The important first step in determining the psychosocial needs of all survivors and their families and the grieving family members of the murder victims is assessment. Thus, the focus of the current section of this overview article is to examine the "A"—Assessment—component of the newly developed ACT Intervention Model for Acute Crisis and Trauma Treatment. First, I briefly identify psychiatric triage assessment and the different types of assessment protocols. Second, I identify and discuss the components of a crisis assessment. Third, I enumerate and review the dimensions of the biopsychosocial and cultural assessment. Finally, I briefly list the different types of rapid assessment instruments and scales used in mental health, crisis, and trauma assessments (Figure 1).

Triage Assessment

First responders, or crisis response team members, also known as frontline crisis intervention workers are called upon to conduct an immediate debriefing under less than stable circumstances, and sometimes have to delay the crisis assessment to right after immediate stabilization and support. With other disaster responses, an assessment can be completed simultaneously with the debriefing. According to many of the crisis intervention specialists who I have trained, ideally "A" (Assessment) precedes "C" (Crisis Intervention), but in the rough and tumble of the disaster or acute crisis, it is not always that linear.

In the immediate aftermath of a community disaster, the first type of assessment by disaster mental health specialists should be psychiatric triage. A triage/screening tool can be useful in gathering and recording information about the initial contact between a person experiencing crisis or trauma reactions, and the mental health specialist. The triage form should include essential demographic information (name, address, phone number, e-mail address, etc.), perception of the magnitude of the traumatic event, coping methods, any presenting problem(s), safety issues, previous traumatic experiences, social support network, drug and alcohol use, preexisting psychiatric conditions, suicide risk, and homicide risk (Eaton and Roberts, 2002). Several hundred articles have examined emergency medical triage, but very few publications have discussed emergency psychiatric triage (Liese, 1995, pp. 48–49). Triage has been defined as the medical "process of assigning patients to appropriate treatments depending on their medical conditions and available medical resources" (Liese, 1995, p. 48). Medical triage was first used in the military to respond quickly to the medical needs of our soldiers who were wounded in wars. Triage involves assigning physically ill or injured patients to different levels of care ranging from "emergent" (i.e., immediate treatment required) to "nonemergent" (i.e., no medical treatment required).

Psychiatric or psychological triage assessment refers to the immediate decision-making process in which the mental health worker determines

ACT Intervention Model for Acute Crisis And Trauma Treatment

A --Assessment/Appraisal of Immediate Medical Needs, Threats to Public Safety and Property Damage

--Triage Assessment, Crisis Assessment, Trauma Assessment and The Biopsychosocial and Cultural Assessment Protocols

C --Connecting to Support Groups, the Delivery of Disaster Relief And Social Services, and Critical Incident Stress Debriefing (Mitchell & Everly's CISD Model) Implemented

--Crisis intervention (Roberts' Seven-Stage Model) Implemented, Through Strengths Perspective & Coping Attempts Bolstered

T --Traumatic Stress Reactions, Sequelue, and Posttraumatic Stress Disorders (PTSD)

--Ten Step Acute Trauma and Stress Management Protocol (Lerner & Shelton), Trauma Treatment Plans and Recovery Strategies Implemented

FIGURE 1
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lethality and referral to one of the following alternatives: (a) emergency inpatient hospitalization, (b) outpatient treatment facility or private therapist, (c) support group or social service agency, or (d) no referral needed.

The "A" in my ACT Intervention Model refers to triage, crisis, and trauma assessments, and referral to appropriate community resources. With regard to triage assessment, emergency psychiatric response should take place when the rapid assessment indicates that the individual is a danger to himself or others, and is exhibiting intense and acute psychiatric symptoms. These survivors generally require short-term hospital-

ization and psychopharmacotherapy to protect themselves from self-harm (e.g., suicide attempts and self-injurious behavior) or harm to other persons (e.g., murder and attempted murder). The small number of individuals needing emergency psychiatric treatment generally are diagnosed with moderate to high potential lethality (e.g., suicidal ideation and/or homicidal thoughts) and acute mental disorders. In the small percentage of cases where emergency psychiatric treatment is indicated, these persons usually are suffering from a cumulation of several previous traumatic events (Burgess and Roberts, 2000).

With regard to the other categories of psychiatric triage, many individuals may be in a precrisis stage due to ineffective coping skills, a weak support system, or ambivalence about seeking mental health assistance. These same individuals may have no psychiatric symptoms and no suicide risk. However, because of the catastrophic nature of the September 11 disaster, persons who have suddenly lost a loved one and have no previous experience coping with sudden death may be particularly vulnerable to acute crisis or traumatic stress. Therefore, in the weeks and months post-September 11 it is imperative that all mental health professionals become knowledgeable about timely crisis and trauma assessments.

Another type of triage assessment used almost exclusively by crisis intervention and suicide prevention programs will now be addressed. Specifically, the 24-hour mobile crisis intervention services of Community Integration, Inc. of Erie, Pennsylvania developed an Intervention Priority Scale that should be utilized by other programs throughout North America. This Intervention Priority Scale allows a number from I to IV to be assigned at the time the triage information is collected, based on clinical criteria. Each number on the scale corresponds to an outside time limit considered to be safe for crisis response. Examples of a Priority I include requests for immediate assistance by police and emergency services personnel, suicide attempts in progress, suicidal or homicidal individuals with the means currently available, or individuals experiencing command hallucinations of a violent nature. Examples of a Priority II include individuals who are able to contract for safety or who have reliable supports present, individuals experiencing hallucinations or delusions, or individuals who are unable to meet basic human needs. Examples of a Priority III include individuals with fleeting suicidal ideation or major depression and no feasible suicide plan, or individuals suffering from mood disturbances. Priority IVs often include cases where there is no thought to harm self or others, there are no psychiatric symptoms present, and no other situational crises (Eaton and Ertl, 2000; Eaton and Roberts, 2002).

Crisis Assessment

The primary role of the crisis counselor and other clinical staff in conducting an assessment is to evaluate an individual in a crisis state in order to gather information that can help to resolve the crisis. Intake forms and rapid assessment instruments help the crisis clinician or mental health counselor to make better informed decisions on the type and duration of treatment recommended. While crisis assessment is oriented to the individual, it always must include an assessment of the person's immediate environment and interpersonal relationships. As Gitterman (2002) eloquently points out in The Life Model, "the purpose of social work is improving the level of fit between people and their environments, especially between people's needs and their environmental resources. . . . (The professional function of social work is as follows) . . . to help people mobilize and draw on personal and environmental resources for effective coping to alleviate life stressors and the associated stress" (p. 106).

Crisis assessment will facilitate treatment planning and decision making. The ultimate goal of

crisis assessment is to provide a systematic method of organizing client information related to personal characteristics, parameters of the crisis episode, and the intensity and duration of the crisis, and utilizing this data to develop effective treatment plans. In the words of Lewis and Roberts (2001): "Most intake workers have failed to distinguish between stressful life events, traumatic events, coping skills and other mediators of a crisis, and an active crisis state. Most crisis episodes are preceded by one or more stressful, hazardous, and/or traumatic events. However, not all stressed or traumatized individuals move into a crisis state. Every day thousands of individuals completely avert a crisis, while many other thousands of individuals quickly escalate into a crisis state" (p. 20). Therefore, it is extremely important to assess and measure whether or not a person is in a crisis state, so that individual treatment goals and an appropriate crisis intervention protocol can be implemented. For a detailed discussion of the crisis specific measurement tools, and crisis-oriented rapid assessment instruments see Lewis and Roberts (2001, 2002).

According to Eaton and Roberts (2002), there are eight fundamental questions that the crisis worker should ask the client when conducting a suicide risk assessment such as: "Are you/client having thoughts of self harm?" "Have you/client done anything to intentionally hurt yourself?" or "Do you feel there is hope that things can improve?" Eaton and Roberts (2002) also delineate nine questions for measuring homicide/violence risk such as, "Have you/client made any preparations to hurt others?" (p. 92).

Biopsychosocial and Cultural Assessments

There are different methods of assessment designed to measure clients' situations, stress levels, presenting problems, and acute crisis episodes. These assessment methods include: monitoring and observing, a client log, semistructured interviews, individualized rating scales, goal attainment scales, behavioral observations, self-reports, cognitive measures, and diagnostic systems and codes (LeCroy and Okamoto, 2002; Pike, 2002).

Vandiver and Corcoran (2002) aptly identify and discuss the biopsychosocial-cultural model of assessment as the first step in the clinical interview aimed at providing the necessary information to "establish treatment goals and an effective treatment plan" (p. 297). It is important for individual assessments to gather information on the following:

1. Current health status (e.g., hypertension) and past health status (e.g., diabetes), or injuries (e.g., brain injury); current medication use, and health and lifestyle behaviors (e.g., fitness exercises, nutrition, sleep patterns, substance abuse).
2. The psychological status of the client, including mental status, appearance and behavior, speech and language, thought process and content, mood and affect, cognitive functioning, concentration, memory, and insight and general intelligence. An additional critical area of assessment is the determination of suicidal or homicidal risk and possible need for an immediate referral.
3. The socio-cultural experiences and cultural background of the client, including ethnicity, language, assimilation, acculturation, spiritual beliefs, environmental connections (e.g., community ties, neighborhood, economic conditions, availability of food and shelter), social networks and relationships (e.g., family, friends, coworkers) (Vandiver and Corcoran, 2002, p. 298).

The assessment process should provide a step-by-step method for exploring, identifying, describing, measuring, classifying, diagnosing, and coding health or mental health problems, envi-

ronmental conditions, resilience and protective factors, positive lifestyle behaviors, and level of functioning. Austrian (2002) delineates the 10 basic components/elements of a biopsychosocial assessment:

1. Demographic data.
2. Current and previous agency contacts.
3. Medical, psychiatric, and substance abuse history.
4. Brief history of client and significant others.
5. Summary of clients' current situation.
6. Presenting request.
7. Presenting problem as defined by client and counselor.
8. Contract agreed on by client and counselor.
9. Intervention plan.
10. Intervention goals.

Some of the most popular assessment tools include:

- The Diagnostic and Statistical Manual-IV-TR (DSM-IV-TR) (APA, 2000; Munson, 2002; Williams, 2002).
- Rapid assessment instruments (RAIs) such as the Brief Symptom Inventory, the Beck Depression Inventory (BDI), the Derogatis Symptom Checklist—SCL-90, the Reasons for Living Scale, and the Impact of Events scale (see Corcoran & Boyer-Quick, 2002; Corcoran & Fischer, 2000).
- Person-in-Environment (PIE) system (Karls, 2002).
- Goal attainment scales (Pike, 2002).

Crisis Intervention Strategies

It is imperative for all communities throughout the United States and Canada to have a multidisciplinary and comprehensive crisis response, and crisis intervention plan ready for systematic implementation and mobilization in the aftermath of a major disaster. Crisis intervention models and techniques provide guidelines for practitioners to resolve clients' presenting problems, stress and psychological trauma, and emotional conflicts through a minimum number of contacts. Crisis-oriented treatment is time limited and goal directed, in contrast to long-term psychotherapy that can take 1 to 3 years to complete (Roberts, 2000).

Roberts's Seven-Stage Crisis Intervention Model

Although counselors, psychologists, and social workers have been trained in a variety of theoretical models, very little graduate coursework has prepared them with a crisis intervention protocol and guidelines to follow in dealing with crises. Roberts's (1991, 2000) Seven-Stage Crisis Intervention Model begins to provide practitioners with this useful framework.

Case Application. The 24-hour crisis intervention unit of a New Jersey mental health center received a call from the mother of a 22-year-old college senior whose father (who worked on the 95th floor of the World Trade Center) was killed on September 11. The college student had barricaded himself in his bedroom. His mother indicated that she had overheard a phone conversation between her depressed son, Jonathan and his cousin. Jonathan told his 19-year-old female cousin that he needed her to come over immediately because he was giving her his Super Nintendo set and CD collection. The mother was concerned about possible suicidal behavior because her son had never given away any of his prized possessions before. In addition, the past 2 weeks he was eating very little, sleeping 12 to 15 hours each day, refusing to return to college, and mentioning that heaven would be a nice place to live. His mom also overhead him asking his cousin if she thought there were basketball

hoops in heaven so that he and his father could play basketball again.

Roberts's (1996) seven-stage crisis intervention model (Figure 2) was initiated:

Stage 1: Assess Lethality. The mother phoning Crisis Services had some information about the current mental status on the client. She did indicate that she could hear her son speak very softly in a muffled voice through the locked and barricaded bedroom door. The mother further indicated that her son has stayed in his bedroom for about 12 hours since he telephoned his cousin and put his CDs and Super Nintendo game on the front porch. Crisis Services immediately dispatched a worker to the residence.

Stage 2: Establish Rapport. Understanding and support were two essential skills utilized by the crisis worker to establish a working relationship with the client. Immediately requesting him to open his bedroom door would not have been a helpful intervention. Workers need to begin where the client is. Through attentive listening, paraphrasing, and the use of open-ended questions, the worker eventually got the client to agree to let him in his room so they could hear each other better.

Stage 3: Identify Problems. Luckily, the client had not yet done anything to harm himself, but was contemplating suicide. He had a vague plan of overdosing, but no available method. The client expressed his major problem as the sudden death of dad.

Stage 4: Deal With Feelings. The worker allowed the client to tell his story about why he was feeling so bad. The worker was able to validate and identify his emotions. They then began to explore together more effective ways of coping with his upsetting feelings.

Stage 5: Explore Alternatives. Various options were discussed, including inpatient and outpatient mental health services. The client allowed his mother to join the worker and himself during this stage. The mother provided a lot of support and encouragement to the client as well. At this stage, the client indicated that he was feeling better and would not "do anything stupid."

Stage 6: Develop an Action Plan. The client, mother, and worker decided on the following action plan:

1. A contract for safety was signed by the client (this is a written agreement that the client agrees to call Crisis Services for help before he would act on any thought to harm himself or others).
2. A release of information was obtained by the worker to contact an outpatient provider.
3. An outpatient provider was contacted and the client received an appointment for the next afternoon.
4. Mother secured all medications per the recommendation of Crisis Services.
5. Both mother and client were given a crisis card to call if any additional concerns or issues arose.

Stage 7: Follow-Up. A follow-up phone call was made to the residence the next evening. Mother indicated that the client was in good spirits that day and had attended his first appointment with the therapist. The client told the crisis worker that he was doing great, thought his therapist was "really cool," and he had plans to "go bowling with friends on Saturday."

Effective crisis intervenors should be active, directive, focused, and hopeful. It is critically important that the crisis worker gauge the stages and completeness of the intervention. Roberts's Seven-Stage Crisis Intervention paradigm "should be viewed as a guide, not as a rigid process, since with some clients stages may overlap. Roberts' model of crisis intervention has been utilized for helping persons in acute psychological crisis, acute situational crises, and acute stress disorders" (Roberts, 2000; p. 15). The seven stages of

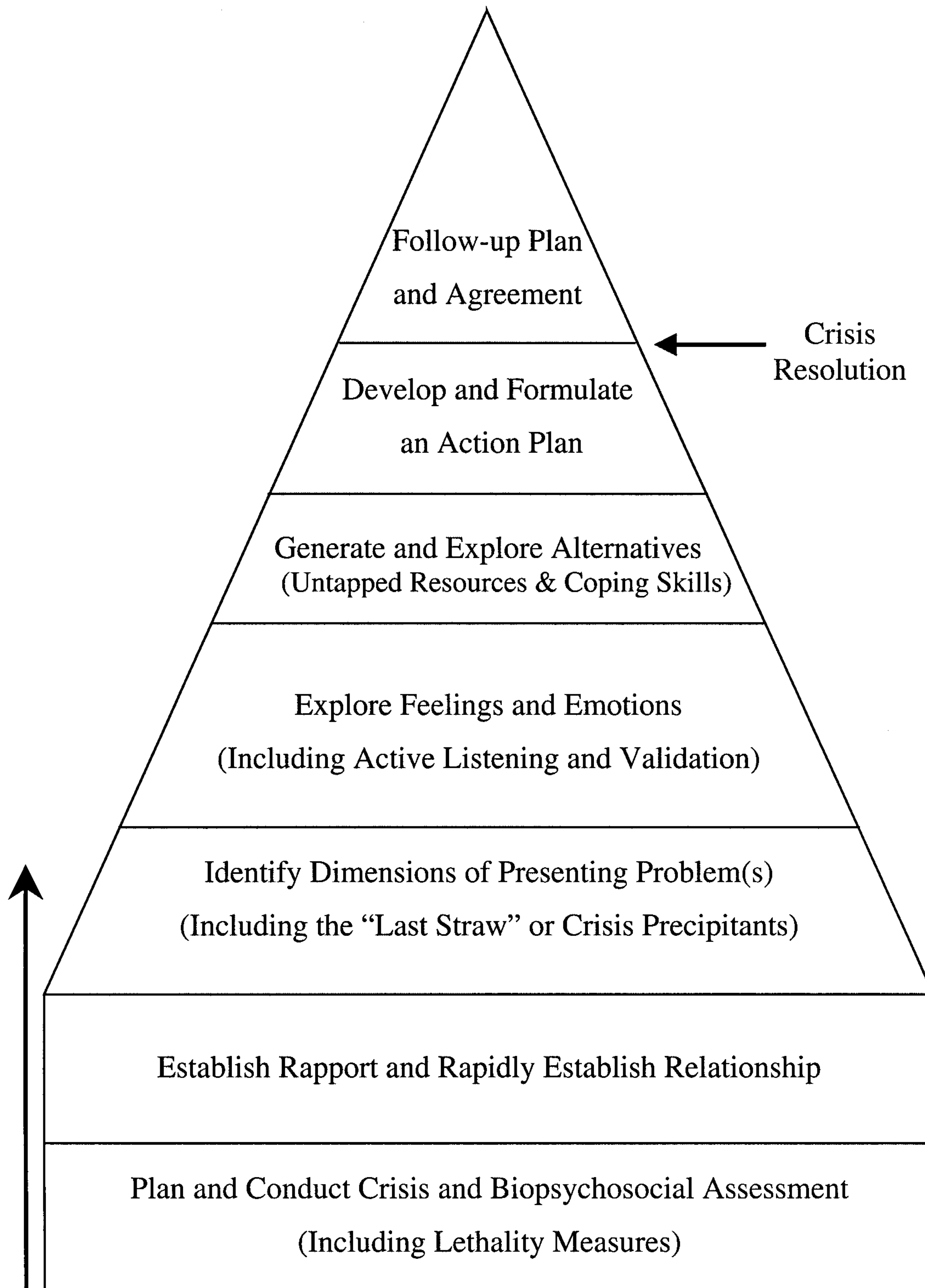

FIGURE 2
Roberts's Seven-Stage Crisis Intervention Model. © 1991 Albert R. Roberts. Reprinted by permission of the author.

crisis intervention combined with a strengths perspective will now be discussed.

Stage 1. Plan and conduct a thorough biopsychosocial and crisis assessment. This involves a quick assessment of risk and dangerousness, including suicide and homicide/violence risk assessment, need for medical attention, positive and negative coping strategies, and current drug or alcohol use (Eaton and Ertl, 2000; Roberts, 2000). If possible a medical assessment should include a brief summary of the presenting problem, any medical conditions, current medications (names, dosages, and last dose), and allergies. This medical information is essential to relay to emergency medical responders attempting to treat problems such as overdoses.

A drug or alcohol assessment should include information about drugs used, amount used, last use, and any withdrawal symptoms the client is experiencing. Any knowledge of angel dust, metamphetamine, or PCP ingestion should always precipitate a team crisis response with the police, due to the likelihood of violent and bizarre behavior.

The initial crisis assessment should examine resilience and protective factors, internal and external coping methods and resources, and the degree of extended family and/or informal support network. Many individuals in a precrisis, or crisis situation socially isolate themselves, and are unaware and lack insight into which persons would be most supportive in their efforts at crisis resolution and recovery. The crisis clinician can facilitate and bolster the clients' resilience by encouraging them to telephone or write a letter to persons who may well support their efforts at recovery. Seeking advice on how best to cope with a crisis related to self-destructive patterns such as polydrug abuse, binge drinking, self-injurious behavior, or depression can lead to overwhelming support, suggestions, advice, and encouragement from one's support network (Yeager and Gregoire, 2000).

Stage 2. Rapid establishment of rapport and the therapeutic relationship (often occurs simultaneously with Stage 1). Conveying respect and acceptance are key steps in this stage. Workers must meet the clients where they are, for example, if the client begins a conversation talking about his dog or parakeet, this is where we should begin (Roberts, 2000). We must display a neutral and nonjudgmental attitude as well, assuring that our personal opinions and values are not apparent or stated. Poise and maintaining a calm and in control appearance are essential skills in crisis work (Belkin, 1984).

Stage 3. Identify the issues pertinent to the client and any precipitants to the client's crisis contact. Use open-ended questions in asking clients to explain and describe their problems and to tell their stories in their own words (Roberts, 2000). This provides the crisis worker with valuable insights into the nature of the presenting problem. It is important for clients to feel that the worker is truly interested in them and understands them; this also helps build rapport and trust. Also helpful during both Stages 2 and 3 is using the questions of solution-focused therapy (SFT) in identifying clients' strengths and resources, which include discerning their effective past coping skills (Greene, Lee, Trask & Rheinscheld, 2000; also see Yeager and Gregoire, 2000). Some of the SFT questions that would be helpful are:

- Exception question (identifying times that the problematic situation is not present or is just a little bit better and what is different about those times compared to the present crisis situation).
- Coping question.
- Questions for identifying past success.

Identifying client strengths and resources should also help in developing rapport and trust since clients tend to develop comfort more quickly

with someone who is not focusing only on their short-comings—deficits, dysfunction, and failures (Greene, Lee, Trask, & Rheinscheld, 2000).

Stage 4. Deal with feelings and emotions by effectively using active listening skills. Show the client that you are listening to what they are saying by utilizing encouraging statements such as "uh huh" and "oh." These types of verbal feedback are especially important when providing telephone intervention. Additional skills include reflection, paraphrasing, and emotion labeling (Bolton, 1984). While reflection involves restating the words, feelings, or ideas of the client, paraphrasing involves restating the meaning of the client's words in the worker's own language. Emotion labeling involves the worker summarizing the emotions that seem to underlie the client's message, for example, "You sound very angry" (Eaton & Roberts, 2002).

Stage 5. Generate and explore alternatives by identifying the strengths of the client as well as previous successful coping mechanisms. Ideally, the ability of the worker and the client to work collaboratively during this stage should yield the widest array of potential resources and alternatives. According to Roberts (2000), the person in crisis is viewed as resourceful, resilient,

> and having untapped resources or latent inner coping skills from which to draw upon. . . . Integrating strengths and solution-focused approaches involves jogging clients' memories so they recall the last time everything seemed to be going well, and they were in a good mood rather than depressed and/or successfully dealt with a previous crisis in their lives. (p. 19)

Aguilera and Messick (1982) state that the ability of workers to be creative and flexible, adapting ideas to individual situations, is a key skill in effective workers.

Stage 6. Implement the action plan. The crisis worker should assist the client in the least restrictive manner, enabling the client to feel empowered. Important steps in this stage include identifying persons and referral sources to be contacted and providing coping mechanisms (Roberts and Roberts, 2000). Crisis workers at Community Integration, Inc. Crisis Services in Erie, Pennsylvania utilize carbon forms to record the plan developed with worker and client. This is a useful mechanism to provide clients with phone numbers and specifics of the plan to follow, but also provides the necessary documentation for other crisis workers to know what to encourage and reinforce on subsequent contacts with the client (Eaton and Ertl, 2000).

Stage 7. Establish a follow-up plan and agreement. Crisis workers should follow-up with the client after the initial intervention to assure the crisis has been resolved and to determine the postcrisis status of the client and the situation. This can be accomplished via telephone or face-to-face contact. In a team setting, when someone other than the original crisis worker will be conducting follow-ups, the utilization of a dry erase board can be a good organizational tool. At a glance, all workers can view the list of cases needing follow-up, when follow-up was requested, and items to address during follow-up contact. Of course, documentation in the client's chart would be more detailed and specific (Eaton and Roberts, 2002).

Critical Incident Stress Debriefing

Critical Incident Stress Debriefing has been found to be useful in the aftermath of floods, hurricanes, tornadoes, and large fires. Crisis response and crisis intervention work is demanding and highly stressful. Frontline crisis intervention workers may be exposed to gruesome and life-threatening events. Eaton and Ertl

(2000) indicate that incidents such as completed suicides, dead bodies, and/or threats/assaults on crisis workers warrant the use of Critical Incident Stress Management techniques. Keeping workers safe and assuring they can find satisfaction in their work as well as in their personal lives requires that they receive support in managing their own stress. Critical Incident Stress Management (CISM) can play an important part in providing that support to workers in crisis intervention programs. It includes a wide variety of techniques and interventions for individuals exposed to life threatening or traumatic events (Mitchell & Everly, 1993) and there are more than 300 crisis response teams utilizing a standardized model of CISM services internationally as listed by the International Critical Incident Stress Foundation (Everly, Lating, & Mitchell, 2000). The utilization of CISM techniques allows workers the opportunity to discuss the traumatic event, promotes group cohesion, and educates workers on stress reactions and coping techniques (Eaton & Roberts, 2002).

For a detailed discussion of the stress-crisis-trauma flow chart, with resilience and hardiness protective factors built in, see Judith A. Waters' article in this special issue. She also documents the perspectives of the most prominent clinical and research psychologists related to stress theory and trauma perspectives in the aftermath of September 11. Approximately 30 years ago, William Reid and Laura Epstein of the University of Chicago developed the first empirically tested time-limited social work treatment model—task-centered practice. As a result, I was delighted that Gary Behrman and William Reid wrote a special article for this issue that integrates task-centered practice with crisis intervention based on their work in New York. For those individuals planning a training workshop on crisis intervention, I suggest you review Maureen Underwood and John Kalafat's crisis intervention curriculum and evaluation in this issue. The latter article, written by a clinical social worker and a clinical psychologist, is representative of the multidisciplinary team approach that the journal's mission encourages.

Crisis Versus Trauma Reactions

For the most part, individuals function in their daily lives in a state of emotional balance. Occasionally, intensely stressful life events will stretch a person's sense of well-being and equilibrium. However, even stressful life events are frequently predictable within a person's ordinary routines, and he or she is able to mobilize effective coping methods to handle the stress. In sharp contrast, traumatic events lift people out of their usual realm of equilibrium and make it difficult to reestablish a sense of balance/equilibrium. Trauma reactions are often precipitated by a sudden, random, and arbitrary traumatic event. The most common types of traumatic inducing stressors are violent crimes, terrorism, and natural disasters (Young, 1995).

Trauma Assessment and Treatment

Traumatic events refer to overwhelming, unpredictable, and emotional shocking experiences. The potentially traumatizing event may be a large scale disaster like the September 11 mass murders, an earthquake, or the bombing of the Oklahoma City Federal Office Building, which were all disasters that occurred at one point in time. It may also be a series of traumatic events that may repeat themselves many times over months and years such as domestic violence, incest, hurricanes, floods, tornadoes, and/or war. The impact of the traumatic event(s) may be physical and/or psychological. Nevertheless, it is important to note that the majority of individuals who are exposed to a traumatic event experience psychological trauma symptoms, but never develop PTSD.

Working with survivors and secondary victims of mass murders poses special issues and problems for mental health professionals. Specialized knowledge, skills, and training should be required. For example, clients suffering from PTSD may need emergency appointments with little notice, or they may need to see their trauma therapist the morning after a night of intense nightmares and flashbacks. As a result of upsetting memories and insomnia after the nightmares, clients may have angry outbursts in the clinician's office. In addition, mental health practitioners working in outpatient and inpatient settings need to recognize that for some survivors of disaster-induced trauma, traumatic stress and grief reactions will last for 10 to 60 days and then totally subside. For others, there may be delayed acute crisis reactions, at the 1 month and 1 year anniversary of the disastrous event. Still others will develop full-blown PTSD, evidenced by their chronic intrusive thoughts, avoidance behavior, flashbacks, nightmares, and hyper-vigilance that may keep reoccurring and persist for years. The traumatic memories they keep trying to avoid keep intruding during the day and in the middle of the night until they become unbearable.

Research has indicated that the effects of community disasters on levels of psychological distress, transient stress reactions and acute stress disorder, generalized anxiety disorder, death anxiety, and PTSD vary from one study to the next (Blair, 2000; Chantarujikapong et al., 2001; Cheung-Chung et al., 2000; Ford, 1999; Fukuda et al., 2000; Regehr, 2001). PTSD and high levels of psychological distress seem to be dependent upon pre- and postwar factors, age, gender, personal resources and living arrangements, and quality of life after the traumatic event. Lev-wiesel's retrospective study of 170 Holocaust survivors 55 years later found that the most significant mediating factor in preventing PTSD was the child survivors' living arrangements at the end of the war. The study findings indicate that the most traumatic stress and PTSD was experienced by the child survivors placed in foster homes, and the lowest traumatic stress was found in the survivors who were sheltered by the partisans and/or hid in the woods (Lev-weisel, 2000). With regard to the influence of age and gender on the severity of depressive symptoms among 1,015 adults 1 year after the Armenian earthquake, the following was found: "persons between the ages of 31–55 reported significantly higher depressive ratings than individuals who were 17–30" years of age, and women had much higher scores on the Beck Depression Inventory (BDI) than the men in the study (Toukmanian, Jada, & Lawless, 2000, p. 289). Research demonstrates that resilience, personal resources, and social supports are important variables in mediating and mitigating against the development of PTSD (Fukuda et al., 2000; Gold et al., 2000; Lev-wiesel, 2000). In addition, while depressive symptomatology seems to be comorbid with PTSD, in studies of prisoners of war (POWs) higher educational levels and social support was associated with lower depressive symptoms and trauma (Gold et al., 2000; Solomon Mikulciner, & Avitzur, 1989).

Several studies have examined whether or not there is an association between trauma exposure during traumatic events and death anxiety after witnessing or experiencing life-threatening or near death encounters after a plane crash. For example, Cheung-Chung, Chung, and Easthope (2000) found that in the aftermath of the Coventry (England) airline crash in which the plane crashed near 150 private homes (none of the residents were killed, although multiple fires spread throughout the neighborhood as a result of the crash) 40% had instrusive thoughts, 30% found that other things kept making them think about the disaster, 36% had trouble falling or staying asleep, and 33% had pictures of the disaster popping into their minds. In sharp contrast, 70% reported that they either rarely or never had any dreams about the crash. With regard to

death anxiety or fear of death, close to one in three (29%) of the respondents expressed fears or anxiety about death. The above study indicates the different responses of residents witnessing an aircraft disaster. Unfortunately, these types of studies rarely conduct a psychiatric or biopsychosocial history to determine the relationship of preexisting psychiatric disorders, or physical illnesses on the development of partial and/or full-blown PTSD.

Post-traumatic stress reactions refer to a pattern of conscious and subconscious expressions of behavior and emotional responses related to handling recollections of the environmental stressors of the traumatic or catastrophic event and the immediate aftermath. First and foremost, public safety must be contained. In other words, police, firefighters, and emergency services personnel should make sure that all survivors are transported to a safe place and there is no further danger at the disaster site. Only after all survivors are in a safe place should group critical incident stress debriefing, group grief counseling, and mental health referrals begin. In the weeks and months postdisaster, mental health professionals and crisis intervenors need to be ready to conduct crisis and trauma assessments. Only mental health professionals experienced in crisis and trauma work should conduct the assessments and interventions. Rushed assessments by inexperienced professionals or volunteers, and use of standardized mental health intake rating forms have resulted in the false labeling of clients with post-traumatic stress reactions as having personality disorders (Briere & Runtz, 1989; Koss et al., 1994; Walker, 1991).

Kroll (1993) clearly delineates the differences between normative responses and adapting to traumatic events compared to the development of long-lasting PTSD symptoms. Kroll (1993) aptly suggests an addition to the DSM-IV V code—simply adding uncomplicated post-traumatic stress responses. This would help to differentiate between normal human responses to traumatic events and PTSD. It is critically important that every human tragedy and community-wide disaster not be labeled or classified as a mental disorder. Because of the catastrophic nature of the September 11 mass murders, the American Psychiatric Association diagnostic classification of PTSD may eventually need to be changed, particularly extending the time line of 30 days in the definition.

In the months following a community disaster, trauma therapists should be available and on-call for follow-up work. Once the traumatized person is referred to an experienced trauma therapist the following should take place:

1. A comprehensive biopsychosocial, crisis, and trauma assessment;
2. Specific treatment goals and a treatment plan should be developed;
3. An agreed number of sessions—formal or informal contract;
4. Both directive and nondirective counseling techniques should be utilized, as well as Eye Movement Desensitization and Reprocessing (EMDR), Traumatic Incident Recording, deep breathing, systematic muscle relaxation, encouraging hobbies, or other trauma intervention techniques;
5. Open door policy so the client can return periodically for booster sessions or follow-up treatment when needed.

The American Academy of Experts in Traumatic Stress is an interdisciplinary network of professionals providing emergency responses and timely intervention for survivors of traumatic events. Drs. Mark D. Lerner and Raymond D. Shelton have written a monograph that includes their detailed traumatic stress response protocol. As a member of the Board of Scientific and Professional Advisors of the American Academy of Experts in Traumatic Stress, I support the Academy's systematic and practical interventions and recently developed training work-

shops. The following summary of Lerner and Shelton's (2001) 10 stages of Acute Stress Management provides useful guideposts for all first responders (i.e., emergency service personnel, crisis response team members, and disaster mental health workers) in the direct aftermath of a community disaster:

1. Assess for danger/safety for self and others.
2. Consider the physical and perceptual mechanism of injury.
3. Evaluate the level of responsiveness.
4. Address medical needs.
5. Observe and identify each individual's signs of traumatic stress.
6. Introduce yourself, state your title and role, and begin to develop a connection.
7. Ground the individual by allowing him or her to tell his or her story.
8. Provide support through active and empathic listening.
9. Normalize, validate, and educate.
10. Bring the person to the present, describe future events, and provide referrals.

Another trauma treatment model that has had some degree of success, although it is viewed as controversial by many practitioners is Eye Movement Desensitization and Reprocessing (EMDR). The EMDR time-limited eight-stage treatment method is utilized after a therapeutic bond has been established with the patient. There is a growing amount of evidence that EMDR is effective with patients who have had one specific traumatic experience, when the treatment is implemented by an experienced therapist with extensive formal training in EMDR. The EMDR protocol includes eight phases with specific steps in each phase (Shapiro, 1995). EMDR integrates cognitive behavioral strategies, such as desensitization, imaginal exposure and cognitive restructuring, systematic bilateral stimulation, and relaxation techniques. There have been a number of studies, including a meta-analysis, which documented the efficacy of EMDR in treating PTSD, and its significant positive effects when compared with other treatment modalities or pharmacotherapy for PTSD and other trauma-induced problems (Rubin, 2002; Van Etten & Taylor, 1998). Rubin (2002) has also reviewed the controlled randomized studies that found positive effects, particularly with regard to reducing trauma symptoms in children who were suffering from a single trauma and/or loss of a loved one. In this issue of the journal, see Karen Knox's article for a relevant case application of EMDR with a young adult family member who lost a loved one in the World Trade Center terrorist disaster. It should be noted that the research has shown that EMDR has not been effective in reducing psychiatric sequelae of agoraphobia, social phobia, and generalized anxiety disorder (Rubin, 2002).

One cannot discuss working with populations effected by crisis and trauma without discussing the crisis counselor or social worker as well. An overlooked element of crisis work is the responsibility of the mental health professional to engage in appropriate self-care. Rachel Kaul's first person account of 31 days providing crisis counseling and psychological first-aid to victims and first responders after the attack on the Pentagon emphasizes this important feature of effective response to disasters. Inattention to elements of self-care can result in fatigue and in traumatic stress reactions on the part of the crisis clinician that can compromise his or her ability to provide mental health care for others.

Conclusion

The attack of September 11, 2001, resulted in huge personal, psychological, and financial traumas. Community disasters such as the terrorist perpetrated mass murders of September 11 can overload our traditional coping methods. This is particularly evident among the thou-

sands of citizens who worked in or lived near the World Trade Center or Pentagon prior to September 11. Mental health professionals and emergency responders are always ready and eager to aid persons in crisis. However, prior to September 11, no one had anticipated that the United States would be victimized in an assault of the magnitude that occurred; therefore, the health care and mental health organizations were not prepared with an interagency coordinated disaster mental health response. With the increased threat of terrorist activity in the future, in the United States and throughout the world, mental health educators and practitioners must develop the following: training and certification programs for crisis intervenors and trauma specialists; systematic and empirically tested procedures and protocols for crisis response, crisis intervention, and trauma treatment in the event of a future mass disaster or terrorist attack; and coordinated interagency disaster mental health teams on-call and ready for rapid deployment to community disasters in their respective regions.

Behavioral clinicians, mental health counselors, and social workers are increasingly being expected to respond quickly and efficiently to individuals and groups who are in need of crisis intervention and time-limited trauma focused treatment. This overview article presented the ACT—Assessment, Crisis Intervention, and Trauma Treatment conceptual model to help communities respond to survivors after the September 11 disasters, and prepare for the future. Concerns about the growing threat of violence within corporations, manufacturing facilities, hospitals and educational institutions are resulting in organizational pressure being placed on practitioners to be skilled in effectively assessing risks, unmet needs, and providing rapid intervention. Roberts's (1991, 2000) seven-stage crisis intervention model provides clinicians with a useful framework to follow. Lerner and Shelton's 10-step trauma assessment and intervention model also provides a useful framework to facilitate the recovery of survivors of traumatic events. The aforementioned conceptual models will assist practitioners in facilitating effective crisis resolution and trauma reduction.

A number of studies and a metaanalysis have demonstrated that certain population groups benefit from crisis intervention programs. Female individuals in both the 15–24 and 55–64 age groups benefited the most from suicide prevention and crisis intervention programs (Corcoran & Roberts, 2000). The research on the effectiveness of crisis intervention programs with people presenting with psychiatric emergencies also show positive outcomes; however, those clients with preexisting severe personality disorders usually benefited from crisis intervention only when it was augmented with short-term inpatient treatment followed by twice a week outpatient treatment and medication management (Corcoran & Roberts, 2000). The research on the effectiveness of crisis intervention after the September 11 terrorist attack has yet to be completed. Therefore, it is recommend that future studies should be strengthened by including standardized crisis assessments at pretest, posttest, and follow-ups, along with determining preexisting psychiatric conditions. In addition, whenever possible matched naturally occurring comparison groups or quasi-control groups (no crisis intervention) should be created. Most important, longitudinal follow-up studies, whether through face-to-face, or telephone contact should be administered at uniform periods (e.g., 1 month, 3 months, 6 months, 12 months, 24 months, 36 months, 5 years, and 10 years post-initial crisis intervention). Independent evaluators or researchers, or university-based researchers should be hired or contracted with by crisis intervention units of local community mental health centers, victim assistance programs, and outpatient hospital clinics.

In the next 5 to 10 years, we will begin to learn the results of longitudinal research on the psy-

chological impact of the September 11 terrorist disasters on children, adolescents, and adults. Therefore, it is important for disaster mental health researchers and criminologists to start planning and implementing studies now. Because of the vulnerability of American citizens to terrorist attacks, federal, state, and local training and educational curricula development activities should be given priority now, so that mental health professionals are better prepared to meet the mental health needs of our citizens in the event of future terrorist disasters.

References

Aguilera, D., & Messick, J. (1982). *Crisis intervention: Theory & methodology* (4th ed.). St. Louis: Mosby.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Austrian, S. (2002). Biopsychosocial assessment. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 204–208). New York: Oxford University Press.

Belkin, G. (1984). *Introduction to counseling* (2nd ed.). Dubuque, IA: William C. Brown.

Blair, R. (2000). Risk factors associated with PTSD and major depression among Cambodian refugees in Utah. *Health & Social Work, 25,* 23–30.

Bolton, R. (1984). *People skills.* Englewood Cliffs, NJ: Prentice-Hall.

Briere, J., & Runtz, M. (1989). The trauma symptoms checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4,* 151–163.

Burgess, A. W., & Roberts, A. R. (2000). Crisis intervention for persons diagnosed with clinical disorders based on the stress-crisis continuum. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (2nd ed., pp. 56–76). New York: Oxford University Press.

Chantarujikapong, S. I., Scherrer, J. F., Xian, H., Eisen, S. A., Lyons, M. J., Goldberg, J., Tsuang, M., & True, W. R. (2001). A twin study of generalized anxiety disorder symptoms, panic disorder symptoms and post-traumatic stress disorder in men. *Psychiatry Research, 103,* 133–145.

Cheung-Chung, M.C., Chung, C., & Easthope, Y. (2000). Traumatic stress and death anxiety among community residents exposed to an aircraft crash. *Death Studies, 24,* 689–704.

Corcoran, J., & Roberts, A. R. (2000). Research on crisis intervention and recommendations for future research. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (2nd ed., pp. 453–486). New York, Oxford University Press.

Corcoran, K., & Boyer-Quick, J. (2002). How clinicians can effectively use assessment tools to evidence medical necessity and throughout the treatment process. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 198–204). New York: Oxford University Press.

Corcoran, K., & Fischer, J. (2000). *Measures for clinical practice: A sourcebook, Vol. I and II* (3rd ed.). New York: The Free Press.

Eaton, Y., & Ertl, B. (2000). The comprehensive crisis intervention model of Community Integration, Inc. Crisis Services. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (2nd ed., pp. 373–387). New York: Oxford University Press.

Eaton, Y., & Roberts, A. R. (2002). Frontline crisis intervention: Step-by-step practice guidelines with case applications. In A. R. Roberts & G. J. Greene (Eds), *Social workers' desk reference* (pp. 89–96). New York: Oxford University Press.

Everly, G., Lating, J., & Mitchell, J. (2000). Innovation in group crisis intervention: Critical incident stress debriefing and critical incident stress management. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (2nd ed., pp. 77–97). New York: Oxford University Press.

Ford, J. D. (1999). Disorders of extreme stress following war-zone military trauma: Associated features of post-traumatic stress disorder (PTSD) or comorbid but distinct syndromes? [On-line]. Available: http://www.trauma-pages.com/ford99.htm

Fukuda, S., Morimoto, K., Mure, K., & Maruyama, S. (2000). Effect of the Hanshin-Awaji earthquake on posttraumatic stress, lifestyle changes, and corti-

sol levels of victims. *Archives of Environmental Health, 55,* 121–125.

Gitterman, A. (2002). The life model. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 105–107). New York: Oxford University Press.

Gold, P. B., Engdahl, B. E., Eberly, R. E., Blake, R. J., Page, W. F., & Frueh, B. C. (2000). Trauma exposure, resilience, social support, and PTSD construct validity among former prisoners of war. *Social Psychiatry & Psychiatric Epidemiology, 35,* 36–42.

Greene, G. J., Lee, M. L., Trask, R., & Rheinscheld, J. (2000). How to work with clients' strengths in crisis intervention: A solution-focused approach. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (2nd ed., pp. 31–55). New York: Oxford University Press.

Greenstone, J., & Leviton, S. (1993). *Elements of crisis intervention: Crises and how to respond to them*. Pacific Grove, CA: Brooks/Cole.

Hersh, J. (1985). Interviewing college students in crisis. *Journal of Counseling and Development, 63,* 286–289.

Karls, J. M. (2002). Person-in-Environment System: Its essence and applications. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 194–198). New York: Oxford University Press.

Koss, M., Goodman, L., Browne, A., Fitzgerald, L., Keita, G., and Russo, N. (1994). *No safe haven*. Washington, DC: American Psychological Association.

Kroll, J. (1993). PTSD: Borderlines in therapy. New York: Norton.

LeCroy, C., & Okamoto, S. (2002). Guidelines for selecting and using assessment tools with children. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 213–216). New York: Oxford University Press.

Lerner, M. D., & Shelton, R. D. (2001). Acute traumatic stress management: Addressing emergent psychological needs during traumatic events. Commack, NY: The American Academy of Experts in Traumatic Stress.

Lev-wiesel, R. (2000). Posttraumatic stress disorder symptoms, psychological distress, personal resources, and quality of life. *Family Process, 39,* 445–460.

Lewis, S., & Roberts, A. R. (2001). Crisis assessment tools: The good, the bad, and the available. *Brief Treatment and Crisis Intervention, 1,* 17–28.

Lewis, S., & Roberts, A. R. (2002). Crisis assessment tools. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 208–212). New York: Oxford University Press.

Liese, B. S. (1995). Integrating crisis intervention, cognitive therapy and triage. In A. R. Roberts (Ed.), *Crisis intervention and time-limited cognitive treatment* (pp. 28–51). Thousand Oaks, CA: Sage.

Mitchell, J., & Everly, G. (1993). *Critical incident stress debriefing: An operations manual for the prevention of traumatic stress among emergency services and disaster workers*. Ellicott City, MD: Chevron.

Munson, C. (2002). Guidelines for the Diagnostic and Statistical Manual (DSM-IV-TR) Multiaxial System Diagnosis. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 181–189). New York: Oxford University Press.

Pike, C. K. (2002). Developing client-focused measures. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 189–193). New York: Oxford University Press.

Regehr, C. (2001). Crisis debriefing groups for emergency responders: Reviewing the evidence. *Brief Treatment and Crisis Intervention, 1,* 87–100.

Roberts, A. R. (1991). Conceptualizing crisis theory and the crisis intervention model. In A. Roberts (Ed.), *Contemporary perspectives on crisis intervention and prevention* (pp. 3–17). Englewood Cliffs, NJ: Prentice-Hall.

Roberts, A. R. (1996). Epidemiology and definitions of acute crisis episodes. In A. Roberts (Ed.), *Crisis management and brief treatment* (pp. 16–33). Chicago: Nelson-Hall Publishers. (Distributed by Wadsworth Publishers of Belmont, CA)

Roberts, A. R. (2000). An overview of crisis theory and crisis intervention. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment and research* (2nd ed., pp. 3–30). New York: Oxford University Press.

Roberts, A. R., & Roberts, B. S. (2000). A compre-

hensive model for crisis intervention with battered women and their children. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (2nd ed., pp. 177–207). New York: Oxford University Press.

Rubin, A. (2002). Eye movement desensitization and reprocessing. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 412–417). New York: Oxford University Press.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford Press.

Solomon, Z., Mikulciner, M., Avitzur, E. (1989). Coping, locus of control, social support, and combat-related posttraumatic stress disorder: A prospective study. *Journal of Personality and Social Psychology, 55,* 279–285.

Terr, L. (1994). *Unchained memories: True stories of traumatic memories, lost and found*. New York: Basic Books.

Toukmanian, S. G., Jadaa, D., & Lawless, D. (2000). A cross-cultural study of depression in the aftermath of a natural disaster. *Anxiety, Stress, and Coping, 13,* 289–307.

Valentine, P. (2000). An application of crisis intervention to situational crises frequently experienced by adult survivors of incest. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (2nd ed., pp. 250–271). New York: Oxford University Press.

Vandiver, V. L., & Corcoran, K. (2002). Guidelines for establishing treatment goals and treatment plans with Axis I Disorders: Sample treatment plan for generalized anxiety disorder. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 297–304). New York: Oxford University Press.

Van Etten, M., & Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis. *Clinical Psychology and Psychotherapy. 5,* 126–145.

Walker, L. (1991). Post-traumatic stress disorder in women: Diagnosis and treatment of battered woman syndrome. *Psychotherapy, 28,* 21–29.

Williams, J. B. W. (2002). Using the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 171–180). New York: Oxford University Press.

Yeager, K. R., & Gregoire, T. K. (2000). Crisis intervention application of brief solution-focused therapy in addictions. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (2nd ed., pp. 275–306). New York: Oxford University Press.

Young, M. A. (1995). Crisis response teams in the aftermath of disasters. In A. R. Roberts (Ed.), *Crisis intervention and time-limited cognitive treatment* (pp. 151–187). Thousand Oaks, CA: Sage.