Written descriptions of how to do crisis intervention advocate a wide range of therapeutic techniques. However, most published articles are actually clinical reports dealing with small numbers of cases, as opposed to systematic studies on the effectiveness of specific procedures across a large sample (Auerbach and Kilmann 1977; Butcher and Koss 1978; Butcher and Maudal 1976; Slaikeu, et al. 1975). We are not at a point where we can summarize tried and true principles or strategies of crisis intervention. One of the difficulties has been that few studies examine both process (what therapists say and do) and outcome (what happens to clients as a result). In their review of crisis intervention literature, Butcher and Koss point out that “the actual processes by which various crisis interventions bring about desired individual changes have not received enough attention to enable evaluation of them . . . In general, with the exception of a few studies, very little research effort has been directed toward examining the theoretical model underlying crisis intervention strategies” (p. 746).

For now, we must admit that we do not know all we would like to about what works and what does not. At the same time, a review of clinical and research reports yields a remarkable consistency across articles with regard to several distinguishing characteristics of crisis intervention. These consistencies provide a starting point for a model on how to help a person through a crisis. Though few of the principles listed here have been the subject of rigorous research, their reappearance in the clinical literature attests to their staying power and provides a challenge to investigators to take note of them as possible variables for future research. For our purposes, they are the important data or raw materials from which a comprehensive crisis intervention model will emerge. What follows is a look at what practitioners—people who daily help others manage crises—tell us about the distinguishing characteristics of crisis intervention.

CLINICAL PRINCIPLES

Timing

Short-term, time-limited therapy is the treatment of choice in crisis situations. The literature suggests that the helping process should take about as long as the time it takes for most people to regain equilibrium after a crisis event, or about six weeks according to Caplan (1964). Most writers describe crisis intervention as taking anywhere from one to six weeks (Aguilera et al. 1974, Burgess and Baldwin 1981), as distinguished from interventions that go on for months or for years in long-term psychotherapy. More important, short-term therapy is not seen as a second best approach. Having fewer sessions poses clear economic advantages and offering therapy during the immediacy of the crisis has additional therapeutic advantages as well. We maximize the client’s chances of growing through a crisis by offering assistance to help him/her gain mastery over the situation, and move toward reorganization of a disorganized life.

An extension of this idea is Hansel’s Law: The effectiveness of a crisis intervention service increases directly as a function of its proximity in both time and place to the crisis event (McGee 1976). Since the crisis experience is a time of high stakes for both client and family, help needs to be available immediately and in an easily accessible location. Accordingly, twenty-four-hour telephone services operating 365 days a year, as well as walk-in counseling services, have been used extensively since the late 1950s. In addition, many centers have outreach services allowing counselors to visit people wherever crises occur. The assumption is that if a client has to wait hours, days, or weeks to receive help, the danger factor in the crisis might increase, resulting in loss of life (suicide or homicide). Another danger is that dysfunctional habits and patterns of thinking might become so strongly ingrained in the client’s life that they become extremely difficult to change later on. In summary, the emphasis on timing is calculated to both reduce danger and, at the same time, to capitalize on the client’s motivation to find some new approach (whether attitudinal or behavioral) to cope with life’s circumstances.

Goals

A common theme in the crisis intervention literature is that the chief goal is to help the person regain the level of functioning that existed immediately prior to the crisis event. Some define this as restoration of equilibrium, while others focus on the reattainment of the individual’s ability to cope with the situation. As one clinician put it, “My goal is to help people get off the ropes and back into the center of the ring.” Notice the difference between this strategy and the goals of long-term psychotherapy—symptom reduction, personality reorganization, or behavior change.

Most therapists recognize, however, that a client never “goes back” to the previous level of functioning. By successfully working through and resolving a life crisis, the person learns new ways of coping. The client may end up conceptualizing life differently than before the crisis occurred (oftentimes more realistically), and may be able to chart entirely new directions for the future. Many clinicians view these outcomes as secondary benefits of crisis intervention. Unfortunately, this view leaves aside the uniqueness of the crisis experience, namely, an opportunity to rework unfinished personal issues, to reorganize
one’s life after everything has fallen apart. The solution adopted in the present volume rests on the distinction between first- and second-order intervention (discussed later in this chapter). The goal of the former—reestablishing coping—is much more limited, while the goal of the latter—crisis resolution—focuses directly on assisting the client in learning from the crisis, resulting potentially in a higher level of functioning than before the crisis.

Assessment

It is important that assessment involves both strengths and weaknesses of each of the systems involved in the crisis. This intervention principle grows from the general systems perspective on life crises outlined in Chapter 2. Data on what is going wrong in a person’s life (crumbling marital relationship) is complemented with data on what is still functional (a supportive network of friends). Social strengths and resources can be used to help a person cope with the distress of crisis. Based on the fact that each person’s crisis occurs within the context of family, work, neighborhood, and community systems, the clinician’s task is to determine which environmental variables precipitated the crisis, which are maintaining the disorganization and suffering, and which can be mobilized to facilitate constructive change in the situation. Employing this analysis leads to a variety of strategies for change, ranging from such measures as assistance in securing food stamps or legal counsel to a referral for one-to-one counseling or vocational guidance.

Helper Behavior*

One of the most salient aspects of crisis work is that therapists are more active, directive, and goal-oriented than in noncrisis situations. Since time is short, therapists become active participants in assessing the difficulty, pinpointing immediate needs, and mobilizing helping resources. In some situations, crisis counselors give advice and initiate referrals to help a person “make it through the night.” The challenge of crisis intervention lies not only in working efficiently and effectively with the client, but also in being flexible enough to mobilize a full range of suprasystem resources (family and community) in working toward crisis resolution for the client.

While therapists are relatively more goal-oriented and directive in crisis work, a basic intervention principle holds that clients should be encouraged to do as much as they can for themselves. The crisis counselor takes the more directive action steps (calling a parent, driving a person home, initiating emergency hospitalization) only when the extreme disorganization and upset preclude the client from acting on his or her own behalf. Implicit in this stepwise approach is an attempt to reinforce clients’ strengths as they work toward mastery of the situation. Since clients are expected to be on their own in a matter of weeks anyway, counselor behavior is geared as much as possible toward facilitating/encouraging that subsequent independence.

*Since crisis intervention is considered to include strategies used by a wide range of professional and paraprofessional workers, throughout this chapter the terms helper, therapist, counselor, and worker will be used interchangeably to refer to the person in the helping or care-giving role.
The intervention literature describes various approaches to helping a person or family survive a crisis. We will summarize several of these approaches as a backdrop for the comprehensive model described in this volume. (See also Aguilera et al. 1974; Burgess and Baldwin 1981; Butcher and Maudal 1976; Crow 1977; Getz et al. 1974; Hoff 1978; Puryear 1979).

McGee and his colleagues identify two areas of counselor performance: clinical and technical effectiveness (Fowler and McGee 1973; Knickerbocker and McGee 1972; McGee 1974). The former refers to the counselor’s ability to show empathy, genuineness, and warmth to the client. Technical effectiveness refers to the counselor’s ability to assess lethality in suicide cases, explore resources, make an appropriate referral, and the like. Walfish and his colleagues have further developed the latter by designing a crisis contracting scale that looks at the extent to which counselors assess the present crisis, explore resources, and move toward action steps on a contractual basis (Walfish et al. 1976). In this same vein, Berg has outlined five aspects of counselor performance in working with a telephone caller in crisis. Counselors are expected to communicate empathy, demonstrate an understanding of the problem to the caller, summarize the problem, survey resources available to the caller, and assist the caller in developing an action plan (Berg 1970).

Some articles focus both on what counselors do and on the training required to do it in defining different crisis interventions. For example, Jacobson et al. (1968) differentiate between four levels of crisis intervention: environmental manipulation (linking a person to a helping resource such as minister, friend, or agency), general support (empathic listening done by neighbors, or bartenders, and the like), the generic approach (short-term work by persons trained in crisis intervention), and individually tailored crisis intervention by persons with extensive training in abnormal psychology, personality theory, crisis theory, and related areas.

Many theorists draw heavily on the early work of Lindemann (1944) regarding the grief process in defining what therapists should do to help crisis clients. In Lindemann’s framework, the therapist helps the person accept the pain of bereavement, review the relationship with the deceased, express the sorrow and sense of loss fully, find an acceptable formulation of future relationships with the deceased, verbalize feelings of guilt, and also find persons around whom new patterns for conduct can be established.

In line with this tradition, Pasewark and Albers (1972) talk about crisis intervention as involving three general areas: (1) establishing or facilitating communication (between persons in crisis, significant others, agencies, etc.), (2) assisting the individual or family in perceiving the situation correctly (with a focus on concrete events, their meaning, and possible outcomes) and finally (3) assisting the individual or family in managing feelings and emotions in an open manner.

Similarly, Viney (1976) describes practitioners and researchers as helping clients to regain the homeostasis lost by the crisis; achieve cognitive mastery over the crisis; and make behavioral changes. The first area relies on techniques facilitating catharsis or working through feelings. In the second area, the therapist assists the person in gaining an understanding of the cognitive maps and expectancies that have been violated by the crisis event, with a goal of developing new conceptualizations of self and others. In the final area (behavioral), new ways of responding or coping are discussed, rehearsed, and then implemented.

Another set of variables determining helper activity relates to the responsibility of the counselor to take action regarding a specific crisis. McMurrain (1975), for example, dis-
First- and Second-Order Crisis Intervention

The themes of the intervention literature regarding timing, goals, assessment, and strategies leave a number of questions unanswered. For example, if interventions range from one to six sessions, how is a “one-shot” helping session different from an intervention with more extended contact (several weeks)? How do the interventions differ in terms of goals and procedures? Which community helpers should be involved in each? Do we not expect a different sort of intervention from a busy attorney talking to a distraught divorcee than from a trained pastoral counselor or social worker talking with the same person the next day?

Most intervention articles do not adequately answer these questions. Some writers present crisis intervention as a primarily behavioral enterprise (setting up a referral, finding a place for a client to spend the night), while others clearly indicate that the helping tasks are more psychological in nature. The range of goals for crisis intervention includes everything from a narrow linkage to helping resources at one extreme to broader crisis resolution at the other. Short- and long-term goals are seldom clearly differentiated and specified in most articles.

A comprehensive crisis intervention model must make a number of important distinctions regarding techniques, length of treatment, specific services delivered, goals, and training. The model must take into account what we already know about life crises, namely, that crises involve disequilibrium, high stakes, sense of urgency, and immediacy. The model needs to consider the individual as an active participant in many different community systems (family, work, church, neighborhood), a participant who daily engages in transactions with the environment.

Table 3.1 presents an intervention model designed to address these issues directly. Building on the consistencies represented in existing clinical and research reports, the comprehensive model proceeds further by making a distinction between first- and second-order crisis intervention.

We can begin by describing psychological first aid, or first-order crisis intervention, which involves immediate assistance and usually takes only one session. Psychological first aid is primarily intended to provide support, reduce lethality, and link the person in crisis
to other helping resources. Furthermore, it can and should be given by persons who first see the need, at the time and place it arises. Parents can be taught to give psychological first aid to their children just as they are now taught to give physical first aid in emergency situations. (Indeed, some of the early “parenting” literature seemed to have this aim [Ginott 1965; Gordon 1970]). Police give psychological first aid when they intervene in domestic quarrels, as attorneys do when they take time to counsel an emotional client and then refer him or her for counseling or psychotherapy later on.

As Table 3.1 indicates, psychological first aid is a brief intervention taking anywhere from several minutes to several hours, depending upon the severity of the disorganization or emotional upset of the person in crisis and on the skill of the helper. Following the clinical tradition in crisis work, its goals are limited. Immediate coping is the main focus (getting through the day/night; planning the best next step). In practice, this is broken down into the three subgoals: providing support, reducing lethality (in child abuse, spouse battering, suicide, and homicide cases), and linking to helping resources (referral for counseling). The entire first aid contact is aimed at these areas, and no more; no effort is made to finalize psychological resolution of the crisis.

A special set of problem-solving procedures, tailored to account for the intensity of crisis situations, provides a guide for counselor/helper behavior. Identified in Table 3.1 as the five components of psychological first aid, these procedures cover the necessary and sufficient steps for the very first critical contact with a person in crisis. Each component entails skills and behaviors which can be taught and measured.

Second-order crisis intervention, or crisis therapy, on the other hand, refers to a short-term therapeutic process that goes beyond restoration of immediate coping and aims instead at crisis resolution. As Table 3.1 indicates, crisis resolution means assisting the person in working through the crisis experience (expressing feelings, gaining cognitive mastery of the situation, etc.) so that the event becomes integrated into the fabric of life. The desired outcome is for the individual to emerge ready and better equipped to face the future. Put another way, crisis therapy seeks to minimize the chance that the person will become a psychological casualty of the crisis event, whether the crisis is developmental (mid-life transition) or situational (unexpected death of loved one) in nature. As a therapeutic process, crisis therapy is best understood as a short-term venture (several weeks to several months). Ideally, it will accompany the six-week-plus period during which equilibrium following a crisis is restored.

Not only does crisis therapy require more time than psychological first aid, it also requires more skill and training on the part of the helper than psychological first aid does. “Psychotherapist” is perhaps the best general category under which to include psychiatrists, psychologists, social workers, pastoral counselors, psychiatric nurses, school counselors, and others who have had formal training in short-term therapy.

Similarly, psychological first aid and crisis therapy differ from one another by the location of the service. While psychological first aid can be offered almost anywhere (over the telephone, in a bus station, home, hallway, or office), crisis therapy has the same physical space requirements as any other form of counseling or psychotherapy (private room in which a counselor and client or family can talk/work for an hour or more per session).

Finally, crisis therapy is distinguished by its procedures. Building on the work of Lazarus (1976, 1981), multimodal crisis therapy examines behavioral, affective, somatic, interpersonal, and cognitive aspects of any client’s crisis. The entire therapeutic endeavor is structured around four tasks of crisis resolution (each of which engages one or more of
the person’s subsystems: physical survival, expression of feelings, cognitive mastery, and behavioral/interpersonal adjustments.

The distinction between first- and second-order crisis intervention provides answers to many of the questions raised earlier in this chapter, such as, the difference between crisis intervention by an attorney (psychological first aid) and a counselor at a mental health clinic (both psychological first aid and crisis therapy). Where the model does not yield immediate clarity, it lays the groundwork for research that can do so. We remember, for example, from reviews of crisis intervention research (Auerbach and Kilmann 1977), that few studies offer clear ties between the process of crisis intervention and client outcome. The psychological first aid and multimodal crisis therapy training procedures can be coded for use in process and outcome research.

IN SUMMARY

The distinction between psychological first aid and crisis therapy as presented in Table 3.1 is both faithful to the recent clinical history of crisis work, and, at the same time, conducive to the growth of much needed research programs in the field. We will discuss each set of interventions in detail. We will look closely at how to give psychological first aid using the five components approach, and how to conduct crisis therapy using Lazarus’s multimodal format. Each approach is also applied to illustrative cases of situational and developmental crises.

<table>
<thead>
<tr>
<th>TABLE 3.1 Crisis Intervention: A Comprehensive Model</th>
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<tbody>
<tr>
<td><strong>First-Order Intervention:</strong> Psychological First Aid</td>
</tr>
<tr>
<td><strong>How long?</strong></td>
</tr>
<tr>
<td><strong>By whom?</strong></td>
</tr>
<tr>
<td><strong>Where?</strong></td>
</tr>
<tr>
<td><strong>Goals?</strong></td>
</tr>
<tr>
<td><strong>Procedure?</strong></td>
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</table>
First-Order Intervention

PSYCHOLOGICAL FIRST AID

A woman asks the crisis hotline volunteer if she should try to break down the door at her boyfriend’s apartment. She is afraid he might have taken pills in an attempt to commit suicide.

A twelve-year-old boy calls his minister from a phone booth: “Dad beat me up again. I’m afraid to go home.”

A bank teller confesses to his supervisor that “marital problems” are the cause of his recent poor performance at work. Five days ago his wife left him. He has been drinking heavily ever since.

A social worker is asked to talk with two young parents in the emergency room of a general hospital. They’ve just learned that their four-year-old son died after being struck by a car.

Each of the helpers represented in these cases—hotline worker, minister, bank supervisor, and case worker—is faced with the challenge of giving psychological first aid to a person or family in crisis. We recall from the previous chapter that these first-order interventions are short (usually one session), can be provided by a wide range of community helpers, and are most effective early in the crisis.

GOALS

The chief goal of psychological first aid is to re-establish immediate coping. According to Caplan (1964) and other theorists, life crises are characterized by a breakdown of previously adequate problem-solving or coping abilities. For the person in crisis, the crux of the matter is that he/she simply feels unable to deal with the overwhelming circumstances confronted at that time. The helper’s primary aim, then, is to assist the person in taking concrete steps toward coping with the crisis, which includes managing the feelings or subjective components of the situation, and beginning the problem-solving process (Lazarus 1980).

There are three subgoals of psychological first aid that give direction to helper activity. Providing support is the first and rests on the premise that it is better for people not to be alone as they bear extraordinary burdens. By helping people shoulder part of the load, support becomes one of the more humane aspects of crisis intervention. Concretely, it means allowing people to talk to us, extending warmth and concern, and providing an atmosphere in which fear and anger can be expressed. It also means reinforcing strengths for people who are conscious only of their own weakness during the crisis. Providing support is certainly not a new concept. On the contrary, it is one that runs through the history of such fields as medicine, ministry, and other human/social services.
Reducing lethality, the second subgoal of psychological first aid, aims at saving lives and preventing physical injury during crises. It is not uncommon, especially in a society where violence is so much a part of daily life, for some crises to lead to physical harm (child, spouse battering) or even death (suicide, homicide). A critical subgoal of psychological first aid, then, is to take measures to minimize destructive possibilities and to defuse the situation. This may involve removing weapons, arranging for the sustained contact of a trusted friend for several hours, talking a person through a stressful situation or, in some cases, initiating emergency hospitalization.

Finally, providing linkage to helping resources, the third subgoal, ties directly to our definition of life crisis as a time when personal supplies and resources have been exhausted (Miller and Iscoe 1963). Rather than trying to solve the whole problem immediately, the helper pinpoints critical needs and then makes an appropriate referral to some other helping person or agency. Often this referral will be for individual counseling of the short-term (crisis therapy) variety. Other times it will be for legal assistance or help from a social service agency. In any case, the bottom line in psychological first aid is to provide an appropriate linkage so that the person can begin to take concrete steps toward working through the crisis. Referral provides both guidance and relief for the worker. It directs the helping process, and also puts limits on what is expected of any one person, whether a parent, hotline worker, neighbor, attorney, or employer.

FIVE COMPONENTS OF PSYCHOLOGICAL FIRST AID

We can conceptualize the process of psychological first aid by building on key elements of representative crisis intervention training models (Berg 1970; Knickerbocker and McGee 1972; Lester and Brockopp 1973; Lister 1976a). The common element in each of these, though often not fully articulated, is a basic problem-solving model, amended in light of the intense emotions of crisis situations. What emerges is a five-step approach that includes:

making psychological contact,
examining dimensions of the problem,
exploring possible solutions,
assisting in taking concrete action,
and following up to check progress.

Table 3.2 lists the components as well as the helper behavior and objectives involved in each step of the model.

Making Psychological Contact

Some people describe this component as empathy or “tuning in” to a person’s feelings during a crisis. Identified most strongly with Carl Roger’s (1951) client-centered therapy, empathic listening is a precondition for any helping activity. In the present context, it means listening for both facts and feelings (what happened, as well as how the person feels about it), and using reflective statements so the person knows we have really heard what has been said. In the disorganization and upset of a crisis, often the newness or strangeness of the
experience is the most frightening part. The helper’s first task, then, is to listen for how the client views the situation, and communicate whatever understanding emerges.

Table 3.2 lists the central helper behaviors involved in making psychological contact, for example, inviting the person to talk, listening both for what happened (facts) and the person’s reaction to the event (feelings), making reflective statements, and so on. When feelings are obviously present (nonverbal cues), though not yet put into words and thereby legitimized, helpers gently comment on this: “I can sense by the way you talk how upset you are about what has happened,” or, “It seems that you also are very angry about what has happened, and rightly so.”

Crow (1977) identifies the feeling or affective concomitants of crisis as usually being anxiety, anger, or depression (“yellow, red, and black” crises, respectively). He describes the helper’s task as not only to recognize these feelings but also to respond in a calm and controlled manner, resisting the tendency to become caught up (becoming anxious, angry, or depressed) in the intensity of the client’s feelings.

Psychological contact is not always made solely through verbal communications. Sometimes nonverbal physical contact is most effective, for example, touching or holding

<table>
<thead>
<tr>
<th>Component</th>
<th>Helper Behavior</th>
<th>Objective</th>
</tr>
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<tbody>
<tr>
<td>1. Make psychological contact</td>
<td>Invite client to talk; Listen for facts and feelings; Summarizing/reflect facts and feelings; Make empathic statements; Communicate concern; Physically touch/hold; Bring “calm control” to an intense situation.</td>
<td>Client to feel heard, understood, accepted, supported. Intensity of emotional distress reduced. Problem-solving capabilities reactivated.</td>
</tr>
<tr>
<td>2. Explore dimensions of the problem</td>
<td>Inquire about: Immediate past; Precipitating event; Precrisis BASIC functioning (strengths and weaknesses); Present; BASIC functioning now (strengths and weaknesses); Personal (inner) resources; Social (outer) resources; Lethality. Immediate future; Impending decisions—tonight, weekend, next several days/weeks.</td>
<td>Rank order: (a) Immediate needs; and (b) Later needs.</td>
</tr>
</tbody>
</table>
TABLE 3.2  Five Components of Psychological First Aid (continued)

<table>
<thead>
<tr>
<th>Component</th>
<th>Helper Behavior</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Examine possible solutions</td>
<td>Ask what client has attempted thus far; Explore what client can/could do now; Propose other alternatives: new client behavior; redefinition of the problem; outside (3rd party) assistance; environmental change.</td>
<td>Identify one or more solutions to immediate needs and later needs.</td>
</tr>
<tr>
<td>4. Assist in taking concrete action</td>
<td>See below.</td>
<td>Implement immediate solutions intended to meet immediate needs.</td>
</tr>
</tbody>
</table>

Concrete Action: Helper Behavior

If: (a) Lethality is low, and (b) person is capable of acting on own behalf, then

Facilitative Stance

“We talk”; “You act”; and Contract for action is between helper and client.

Ranges from active listening to giving advice.

Directive Stance

“We talk”; “I may act on your behalf”; and Contract for action might include family and other community resources.

Ranges from actively mobilizing resources to controlling the situation

5. Follow-up

Secure identifying information; explore possible follow-up procedures; Set up contract for recontact.

Secure feedback on 3 subgoals of psychological first aid: Support received; Lethality reduced; Linkage to resources accomplished.

Set next phase in motion: Later solutions; If (a) immediate needs were met by immediate solutions and concrete action taken, and if (b) linkage for later needs is made, then STOP. If not, go back to Step 2 (Dimensions of Problem) and CONTINUE.
a person who is very upset. Clinicians and clients report that a gentle touch or an arm around the shoulder can often have an important calming effect in addition to signifying human concern. In some situations, of course, touching is inappropriate and can detract from a therapeutic interaction. Clinicians need to be sensitive to how such contact will be perceived by the client.

There are several objectives for making psychological contact. The first is for the person in crisis to feel heard, accepted, understood, and supported, which in turn leads to a reduction of the intensity of the emotions. Psychological contact serves to reduce the pain of being alone during a crisis, but it actually aims for more than this. By recognizing and legitimizing feelings of anger, hurt, fear, etc., and thus reducing emotional intensity, energy may then be redirected toward doing something about the situation. We shall see later how pivotal the contact part of psychological first aid becomes.

Exploring Dimensions of the Problem

The second component of psychological first aid involves assessing the dimensions or parameters of the problem. Inquiry focuses on three areas: immediate past, present, and immediate future. Immediate past refers to events leading up to the crisis state, especially the specific event that triggered or precipitated the crisis (the death of a loved one, unemployment, injury, separation from spouse).

It is also important to determine the person’s BASIC functioning prior to the crisis. Without engaging in a systematic inquiry, the helper can listen for the most salient characteristics of the person’s behavioral, affective, somatic, interpersonal, and cognitive life prior to the crisis. What were the most apparent strengths, for example, a steady job (behavioral modality)? What were the person’s chief weaknesses or deficits, for example, poor self-image (cognitive), few friends (interpersonal), and so on? Why did problem solving break down at this particular time? Has anything like this ever happened before? The inquiry here is guided by the premise from crisis theory that for most people the crisis state has a precipitating event (what is it?), and an inability to cope leads to crisis (why can’t he/she cope now?).

Inquiry about the present situation involves the “who, what, where, when, how” questions of an investigative reporter. We need to find out who is involved, what happened, when it happened, and so on. This is most often accomplished by simply having the person tell the story. In addition, it is important to listen for the most salient characteristics of the person’s BASIC crisis functioning. How does the person feel right now (affective)? Is he/she intoxicated or under the influence of any other drug right now? (See box, “Psychological First Aid with Clients Under the Influence of Alcohol and Other Drugs,” pp. 52–3.) What is the impact of the crisis on family life and friendships (interpersonal) and physical health (somatic)? How has his/her daily routine been affected (behavioral)? What is the nature of the person’s mental ruminations, including thoughts and fantasies as well as day and night dreams during the crisis (cognitive)?

Attention is given to both strengths and weaknesses during the time of crisis. For example, which aspects of the person’s life have not been affected by the crisis? What activities or routines (such as physical exercise) are part of the person’s lifestyle and might be called into play in working through the difficult situation? Which family members or
friends might be available to help? If there is any indication of physical harm (to the client or to someone else), an assessment of lethality is made. Particular attention is given to previous attempts, the nature of the suicide/homicide plan, and willingness to maintain contact with “significant others,” each of which is discussed in detail later in this chapter.

Finally, what are the likely future difficulties for the person and his or her family? A runaway teenager needs a place to stay for the night (week) as decisions are made about what to do next. A woman recently separated from her husband might need counsel on how to manage loneliness and on how to talk to her children about the recent events. Depending upon the circumstances, she might also need short-term counseling later on to help her sort through and learn from the breakup. Whatever the case, in this component of psychological first aid, these needs are noted as dimensions of the problem.

The main objective of this second aspect of psychological first aid is to work toward a rank ordering of the person’s needs within two categories: (1) issues that need to be addressed immediately; and (2) issues that can be postponed until later. In the confusion and disorganization of the crisis state, people often attempt to deal with everything all at once. Many times there is little awareness of what must be dealt with right away and what can wait a few days, weeks, or even months. An important role for the helper, then, is to assist in this sorting-out process. Examples of issues that might need immediate attention would be: finding a place to spend the night, talking a person out of killing himself tonight, or “buying time” in a family dispute so everyone can talk again in a less heated moment. Later needs cover anything that does not need to be taken care of in the next several hours or days and might include such things as a need for legal assistance, marital counseling, individual crisis therapy, vocational rehabilitation, and the like. Any of these alternatives might be instrumental in the subsequent psychological resolution of the crisis experience.

Many times, of course, there is little time to explore all aspects of the difficulty, and many of these questions are postponed. Also, more often than not, clients volunteer much of the information so that helpers seldom need conduct a rigorous step-by-step inquiry. Whether he/she is a policeman intervening in a domestic quarrel, a hotline worker talking to a suicidal caller, or a minister visiting a grief-stricken parent at a hospital, the effective intervenor has the preceding framework in mind as she/he talks with the person in crisis. Though the helper may not ask directly about each of the categories mentioned above, he/she listens with these categories in mind. As we shall elaborate, the categories provide a cognitive map to help direct the assessment of crisis situations.

Finally, as with the reflective statements of psychological contact, it is noteworthy that simply telling the story in very concrete terms to someone who cares often yields both emotional release and understanding (by the client) of what needs to be done to get through the crisis. The information-gathering aspect of first aid, then, can have an immediate therapeutic benefit for the client, and also assist both helper and client in planning next steps.

**Examining Possible Solutions**

The third component of psychological first aid involves identifying a range of alternative solutions to both the immediate needs and the later needs identified previously. As Table 3.2 indicates, the helper takes a step-by-step approach, asking first about what has been tried
already, then getting the person in crisis to generate alternatives, followed by the helper’s adding other possibilities. Pluses and minuses (or gains and losses) of each solution are explored. These are then summarized and categorized as appropriate to the immediate and later needs identified earlier.

Following from a basic principle of crisis intervention, we get people to do as much as they can for themselves, even if only in generating alternatives about what to do in this particular situation. The premise is that helplessness can be checked by encouraging the client to generate ideas about what to do next, that is, helping the client operate from a position of strength rather than weakness. This can evolve from asking questions about how the client has dealt with previous problems. Only after exploring client suggestions does the counselor join in a brainstorming process to generate other solutions to the problem.

Two other process issues deserve to be mentioned here. The first is the importance of coaching some clients to even consider the idea that possible solutions exist. The counselor

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**Psychological First Aid with Clients Under the Influence of Alcohol and Other Drugs**

The presence of alcohol and other drugs complicates any crisis. Extremes in BASIC functioning are the norm in these situations, and assessment can present a challenge to helpers. The effect of chemicals on cognitive functioning makes it hard for the client to help in answering such critical questions as: How much of what drugs have been ingested, and how long ago? At times it is difficult to differentiate between intoxication and mental illness, since symptoms may be a reflection of either or both. To further complicate the picture, many abusers mix illicit substances, and often combine them with alcohol. Also, drugs available in the 1990s are not the same as those available twenty or thirty years earlier. Newer forms of older drugs have been developed, such as crack cocaine, which is smoked and produces a much shorter and more intense and addictive reaction than cocaine in other forms.

A review of the literature on drug and alcohol abuse suggest the following guidelines for counselors offering psychological first aid to these individuals: (1) Routinely inquire about whether or not crisis clients have taken alcohol or other drugs (this includes observing client behavior, and asking family/friends who accompany client); (2) Attend to common physical indicators of substance abuse (drowsiness and nodding; pinpointed or dilated pupils; flushed, moist, or dry skin; burn marks or needle tracks; fractures; and coordination difficulties), behavioral indications (silliness, pressured speech, boisterousness, and aggressiveness), and emotional changes (euphoria, tranquility, heightened awareness, enhanced sensory facilitation, as well as irritability, anger, depression, panic, anxiety, jitteriness, paranoia) (Robbins, Katz, and Stern 1985); (3) Remember that lethality is increased with the presence of alcohol and drugs,
may have to structure the discussion with comments like: “Let’s just consider what if you were to (talk to her, go home tonight, call child welfare, call your parents, etc.). What might happen?” In such cases, the counselor makes room in the first-aid process for untried, prematurely rejected options, and guides the crisis client in fully considering them. Similarly the client can be asked, “What kind of solutions might someone else try? Think of someone who might know what to do—what would that person’s ideas be?” A second issue is the importance of examining obstacles to implementation of a particular plan, for example, nonassertive manner as an obstacle to face-to-face confrontation of spouse, or lack of car as hindrance to keeping an appointment for individual counseling. Counselors cannot leave such issues to chance. Instead, they think ahead to possible obstacles and make it their responsibility to see that these are addressed before an action plan is set in motion.

Table 3.2 states the objective of this component of psychological first aid as identifying one or more solutions to meet both the immediate and the later needs. This is especially true of the former. Some feasible steps must be identified for addressing the most
pressing needs. Psychological first aid is not complete until these steps have been identified. Further, in most cases (barring a client so confused as to be unable to participate in the process), there should be agreement between client and counselor on the acceptability of the solutions chosen. If this has not been accomplished, then some “obstacle” has likely
Taking Concrete Action

Relating directly to the action and goal orientation of crisis intervention, the fourth component of psychological first aid involves helping the person to take some concrete action to deal with the crisis. The objective is actually very limited, no more than taking the best next step given the situation. According to Table 3.2 this means implementing the agreed upon immediate solution(s) aimed at dealing with the immediate need(s). The action step may be as simple as an agreement to meet again the next day, or as complicated as initiating emergency hospitalization.

It is important to remember that we want the client to do as much as he/she is capable of doing. Only when circumstances severely impair a client’s ability to act does a counselor take an active role, and even then this is done in a stepwise fashion.

Depending upon two major factors (lethality and capability of the person in crisis to act on his or her own behalf), the helper takes either a facilitative or directive stance in helping the client deal with the crisis. If the situation is high in lethality (danger to the client, himself, or to someone else), or if the person is not capable of taking care of him/herself (is drunk, or so emotionally distraught as to be incapacitated), then the helper’s stance is directive. When there is no danger to self or others, and when a person, though emotionally distraught and disorganized, is still capable of doing such things as driving home, calling a spouse, enduring a long weekend, then the helper’s role is more facilitative than directive.

To further clarify these distinctions (Table 3.2) we can think of the facilitative stance as one in which (1) helper and client talk about the situation, but (2) client takes major responsibility for any action. Further, (3) any contract regarding action is a matter involving only the helper and the client. For example, the client and counselor may talk and then agree that it would be good for the client to talk to her husband on the phone before making any major decisions about leaving home or returning home this weekend. She alone, however, would make the phone call, and later report to the counselor how it turned out. The contract involves just the two, counselor and client.

Under a directive stance, however, the approach is somewhat different. Though the (1) talk is again between client and helper, the (2) action part may include helper as well as client. Similarly, the (3) contract for action might involve others, for example, spouse who is not present during the initial session, or another agency (child welfare, police, hospital personnel).

There are other differences between facilitative and directive action stances. As Table 3.2 indicates, facilitative approaches may range from active listening to advice. The former means primarily listening and reflecting back the content of the message through various phases of the discussion. In other cases, the facilitative stance includes advice or the helper advocating a particular course of action, for example, “I am worried about what might happen to you. I really believe you should...”

Many times the advice has as much to do with thoughts as with behavior, as when the helper provides new labels or ways to define the problem. For most people the extreme disorganization and upset characteristic of crisis are both frightening and new. Lacking ways to
conceptualize and understand the experience, many crisis clients talk about being afraid of “going crazy,” “cracking up,” “losing control,” as if their feelings are a sign of mental illness. The therapist then has the opportunity/responsibility to supply labels that are both accurate and facilitative of crisis resolution. In such situations it is not uncommon for an effective therapist to make statements such as: “You might feel like you’re going crazy or becoming mentally ill, but I don’t believe you are,” or, “Given all that has happened, I would be surprised if you didn’t feel disorganized, confused, helpless. It seems to me like you are having a rather normal response to abnormal events. You know, I would be worried about

Mother Apparently “Chickened Out”

MOUNT CLEMENS, Mich. (UPI) A Detroit-area divorcee held in the slaying of her three children left behind a will and apparently planned to kill herself, too, but “chickened out,” detectives said Saturday.

Patricia Dueweke faced three counts of first-degree murder in the shootings of her daughter, Cynthia, 16, and sons Mark, 15, and Karl, who would have been 13 Friday. She was held without bond in the Macomb County Jail.

Police speculated that Mrs. Dueweke waited for the children to return home from school Thursday, shooting them one-by-one with a six-shot, .357-magnum pistol she had purchased about a week after her August 23 divorce.

It appeared that the woman sat up all night with the bodies, then telephoned her husband, Ralph, Friday morning to tell him of the shootings. Dueweke was at the home when police arrived.

“She had planned on killing herself but she chickened out,” said Lt. Lloyd Rivard, chief of detectives at the Macomb County Sheriffs Department. “She couldn’t do it.”

Police arriving at the home found the woman “wrote a will leaving everything to her husband. She specified her choice of a funeral home,” Detective Sgt. Gail Caudle said.

Police said they found 24 spent bullet casings in the home, some of them in the basement, where Mrs. Dueweke apparently had set up a target to practice with the pistol.

One friend said Mrs. Dueweke, 42, had been despondent over her divorce and the prospect of raising the children alone.

“She was unsure about her future because she had no job training,” said Roger Gill, a next-door neighbor and long-time friend of the woman and her ex-husband, a school social worker.

Neighbors said the Duewekes were active in school affairs and led a quiet life prior to the divorce. They enjoyed camping and often were seen canoeing on the Clinton River, which ran near their home.

“She was just a super good neighbor,” Caudle said. “She was a timid individual who kept everything to herself and never created any problems for anybody.”

you if you weren’t reacting so strongly to all of this.” The language of the therapist is critical since the way crisis clients conceptualize their pain plays an important role in subsequent adjustment. People who label themselves as mentally ill often impose limits on their later recovery. On the other hand, people who view their upset and disorganization as something temporary and expected of normal people when life’s circumstances are severe can unleash creative energy toward getting over the crisis, thereby developing a hopeful view of their own future.

Directive action ranges from actively mobilizing community resources to taking very controlling action (e.g., emergency hospitalization of a suicidal person). In so far as the client is incapable of taking the steps needed to defuse the situation, to buy time, or to accomplish linkage to helping/supportive resources (whether family or agency), the counselor needs to either get someone else involved or do it him/herself, thereby controlling the short-run outcome. In the latter case, the counselor acts to ensure that the needed next step is taken. An example of this would be removing an abused child from a home or providing for immediate, constant contact for a homicidal/suicidal person when all other avenues have failed. Congruent with our stepwise approach, such action would occur only when all other less restrictive possibilities have been considered or attempted, and when the high stakes indicate that the situation cannot be left as it is. We will give a more detailed explanation of how to assess lethality, as well as guidelines for initiating directive actions later in this chapter. For now, it is important to note that, in crisis situations, certain directive/controlling actions are legitimate on the continuum of helper behavior.

Needless to say, the directive stance in crisis work raises a number of important ethical and legal issues. Building on our criteria for directive counselor action (high lethality, incapacity of client), there are several important guidelines:

1. Any counselor action must be done within existing law. It is incumbent upon crisis workers to be aware of the laws in their community that relate directly to their work. For example, in most states, the law requires human service workers (if not ordinary citizens) to report any knowledge of child abuse to the authorities. Similarly, most communities have laws protecting the rights of citizens concerning involuntary emergency hospitalization. The criterion of “danger to self or others” is common to most jurisdictions as grounds for directive/controlling intervention in crisis cases.

2. As suggested earlier, controlling interventions occur only after everything else has been found wanting.

3. Following both legal precedent and common sense, confidentiality in a therapy context needs to be amended to square with other community realities (Bersoff 1976, re: Tarasoff v. Regents of the University of California). A physical threat to human life (self or other) takes precedence over supreme allegiance to confidentiality in a helping contract.

4. Finally, by conceptualizing all action plans as part of a contract (whether written or not) between the parties involved (client, counselor, family, agency), counselors can lend both clarity and protection to the process. Contracting in a psychological first aid model refers to agreements reached between helper, person in crisis, and any other relevant parties. In extreme cases, the contract for action involves a legal component, for example, when a judge signs an order for emergency hospitalization
of a psychotic or dangerously suicidal person. Usually, however, the contract is not a written legal document but is, instead, verbal and reflects the agreement between the parties involved about what will take place. Minimally, it involves an oral restatement between helper and the person in crisis of who will take what next steps, and for what reason.

Before any directive action is taken, counselors should think through who will do what, toward what end, for how long, with what risks, and with what safeguards. Every effort should be made for an “above board” quality to characterize these actions; for example, “If you won’t let child welfare visit your home, then I feel I must call them myself. This is why . . .”

Table 3.2 indicates that the “contract for action” in a facilitative stance involves only two people (helper and person in crisis), but that under a directive stance, it may involve third parties. By giving psychological first aid a contractual quality, our intention is for at least one person in the process to assure that appropriate protections are present, and that a framework conductive to feedback and follow up exists.

**Following Up**

The last component of psychological first aid involves eliciting information and setting up a procedure to allow for following up to check progress. As Table 3.2 indicates, the main helper activity here is to specify a procedure for client and helper to be in contact at a later time. Follow up can occur through a face-to-face meeting, or by telephone. It is important to specify who will call whom, or who will visit whom, as well as the time and place of contact. All of this fits into what might be called a “contract for recontact.” Psychological first aid is not complete until such procedures have been agreed upon.

The objective of following up is first and foremost to complete the feedback loop, or to determine whether or not the goals of psychological first aid have been achieved: support provided, lethality reduced, and linkage to resources accomplished. In addition, following up facilitates other steps toward crisis resolution. It allows the helper to operationalize the later solutions described previously (such as referral for subsequent crisis therapy).

In each case, there is a check on whether or not the particular immediate solution was appropriate for the immediate need. If the immediate needs have been met by one of the agreed upon immediate solutions, followed by the concrete action steps, and if linkage for the later needs has been accomplished, then the process is complete and the counselor/helper responsibility terminates. If, on the other hand, these conditions have not been met (for example, the agreed upon action did not help the way it was intended) then the helper goes back to Step 2 (exploring dimensions of the problem) and reexamines the situation as it presently stands. The process then continues through possible solutions, concrete action, and follow up.
RESPONDING TO THREATS OF SUICIDE OR HOMICIDE: ASSESSMENT OF LETHALITY

As the first helping contact with the person in crisis, psychological first aid includes an assessment of whether or not the person is so upset, desperate, or disorganized that suicide or homicide might be the eventual outcome of the crisis. Every year there are over 20,000 people who commit suicide, and at least that many who commit homicide, in the United States (Crime in the United States 1979; Frederick 1977a). Death by firearms constitutes the greatest number of both suicides and homicides. In 1985, for example, 58 percent of all homicides were by firearms, 41 percent of all the victims were acquainted with their assailants, and 39 percent of all murders involved arguments between acquaintances (Crime in the United States 1985).

Prediction of whether or not someone will engage in a lethal act has been the subject of considerable investigation, with results that are far less conclusive than most practitioners would desire (Beck, et al. 1974; Farberow and Litman 1975; Lester 1974; Shneidman and Farberow 1957; Wekstein 1979). There is consensus in the literature, however, on the following:

1. There are many possible reasons for the occurrence of suicidal behavior: cry for help, attempt to manipulate others, result of psychotic episode (delusions, hallucinations), political statement, hopelessness and helplessness in the face of insurmountable life problems, or a reasoned end to emotional or physical suffering.
2. The desire to end one’s life is usually imbedded in a network of ambivalent feelings. This may take the form of contradictory messages (e.g., taking a lethal dose of sleeping pills, but allowing oneself to be discovered in time to prevent death) or a simple awareness that a person both wants to live and wants to die. The clinical task is to draw out the client’s feelings and other life circumstances on both sides as groundwork for contracting to hold off on the decision to kill oneself.
3. Most people are intensely suicidal for only a short period of time, usually a matter of days, and often change their minds about killing themselves; crisis intervention aims at getting people to postpone irreversible decisions until other help can be brought to bear on the situation.
4. Most people who kill themselves or someone else offer some warning or clue to their intentions well before completing the act (Farberow and Litman 1975).
5. Danger to human life is highest when someone in crisis has both a lethal plan and the means to carry it out.
6. The goal of saving human life supersedes total allegiance to confidentiality. In extreme cases, relatives or local authorities may need to be informed of the client’s potentially suicidal behavior in order to prevent the person from killing him/herself.
7. Since lifesaving measures involve either an individual’s voluntarily agreeing not to commit a lethal act, or an outside person stopping him/her from doing so, maintaining some form of contact with a potentially dangerous person can be a critical ingredient in preventing suicide or homicide.
8. With stakes as high as life and death, it is especially important that helpers be (a) aware of their own feelings and attitudes about death and the act of suicide, (b) ready to consult with colleagues or supervisors about the appropriateness of
any directive steps taken, and (c) prepared to deal with “failure,” that is, the completed suicide of a client. Regarding the latter, opportunities for guilt following the completed suicide of a friend, relative, co-worker, or client are much greater than with the “failure” of other attempts to provide help. It is very important that workers develop a network of supportive colleagues for shared decision making during crisis intervention, and for working through the intense feelings generated by suicide intervention work.

Assessment of lethality in psychological first aid involves first listening for clues to physical danger, and then conducting a structured inquiry to gather information as a basis for implementing an appropriate action plan. Clues to either suicide or homicide can take several forms:
Verbal

“I sometimes feel like I can’t go on/could kill her/want to end it all/wish I were dead/would like to hurt people/will do something rash, etc.”

“If it happens again, I’ll kill him,” or a victim’s recalling that “he was so mad he tried to kill me.” (Any statement that indicates directly or obliquely that someone could be physically hurt as a part of this crisis.)

Also, any reference to previous attempts at suicide/homicide: “I tried that once before,” or reference to previous fights between individuals, or, reports that with more precision, previous injuries might have resulted in death.

Nonverbal

For suicide, increased listlessness, arrangement of affairs and preparation for death (e.g., giving away cherished possessions), abnormal sleep patterns (too much or too little), depressed mood, sudden lifting of depression (as if decision has been made). For
homicide, the occurrence of a fight in the bedroom or kitchen, or baiting of the aggressor by the victim with belittling remarks.

**Concern of Other People**

Report of sudden changes in behavior, or even a gut feeling that a person might hurt him/herself. Regarding homicide, the reputation of the aggressor for his/her impulsiveness or bad temper.

On noting such threatening signs, the helper should look for an opportunity to make a straightforward inquiry to clarify their meaning (Farberow and Litman 1975). The idea that practitioners should be careful lest they give clients ideas that had not been thought of is a common myth of helpers new to crisis work. It is far more likely that the person in crisis will experience a sense of relief that someone has heard the distress and cares enough to ask about the situation.

A useful tactic to begin the inquiry is to phrase questions using the individual’s own words. For example, “You said that you feel like you can’t go on anymore. Tell me what you mean by that.” If the forthcoming answers remain vague, the helper should be direct: “Are you thinking of hurting yourself or committing suicide?” The aim of the question is to find out the person’s intent and what he/she wants to happen by the fantasy or gesture. Again, this is best determined by direct questions such as “What do you want to happen?” or “What would you hope to accomplish by that?” These are not questions offered with a critical or judgmental attitude or with a view to condemning the act or feeling. They are, instead, simple requests for information. Possible answers might be “To stop the pain; to show him/her how badly I feel; to pay her back for what she did; to die,” and so on. The information generated by this line of inquiry can be useful later in negotiating for possible alternative means to achieve the same ends. Our assumption here is that suicide or homicide has been chosen as one possible solution to a particular problem. Inquiry in the early stages aims at recognizing the suicidal/homicidal threat or gesture and finding out the problem it was/is intended to solve.

Assessment of dangerousness, whether on a telephone hotline, in a physician’s examining room, or in a guidance counselor’s office, must include three key variables: plan, history of previous attempts, and willingness to make use of outside helpers should suicide or homicide seem imminent.

**a. Plan**

How far has the person proceeded in thinking about committing suicide or hurting someone? If a man is depressed over losing his job and has thoughts of suicide, but does not know how he will do it, he is less of a risk than if he has indeed gone so far as to plan his death. Further, if he has the means to carry out the plan, he is a greater risk. An individual who has not thought of a plan, or who has thought of a plan to take pills but does not have any on hand at the time, is at less risk. A person who thinks he might shoot himself, and has a gun and ammunition with him at all times, is at high risk.
b. Previous Attempts
A person who has never attempted to commit suicide is a lower risk than one who has attempted to do so previously. The probability of success increases with each attempt. Even though an attempt may be a cry for help or a manipulation, there is the possibility that an individual will die by accident (e.g., taking a higher dose of pills than intended). For each previous attempt, it is important to inquire about what the person’s intention was in taking pills, breathing gas, or whatever, and what the outcome of the attempt was. The helper should be alert for the difference between taking a dose of pills that the person knew would not be lethal, and being discovered by a spouse returning from work at the usual time, as opposed to a truly accidental discovery when the dosage was known by the person in crisis to be lethal. Ask what the person wanted to happen when the previous attempt was made. For homicide threats, the inquiry focuses on previous fantasies and their outcomes, and on previous aggressive behavior and its result. As with suicide attempts, it is important to inquire about what precipitated the action.

c. Willingness to Make Use of Outside Resources
Individuals who live alone and have no family or friends are greater risks than those who have others to whom they can turn. It is particularly important to differentiate between the availability of others and the individual’s willingness to reach out to them in a time of real need. To an outsider, the person may appear to have many friends to whom he/she can turn. Indeed, friends may tell the person to “call on me if you need me.” It is important, however, to ask the person in crisis if he/she will call on these others in time of need. Some people are too depressed to ask for help. Others can give no assurance that they will be able to control their behavior. They need to be treated differently than those who promise to call when the going gets very rough, or if circumstances change in some way. Individuals afraid of their homicidal fantasies may admit that they will not be able to call for help in time, or that they would rather kill than be stopped.

Inquiry in these three areas captures the most critical variables in determining how dangerous a person is and how directive the helper should be. Lethality is judged to be low if the answers to plan, previous attempts, and isolation are negative. For example, the risk of suicide is low if an individual has been depressed and contemplating suicide, although there is neither a plan nor means to implement one, and there have been no previous attempts. The lethality is lessened further if the individual will maintain contact with outside resources should things take a turn for the worse. According to our psychological first aid model, the helper takes a facilitative stance in these cases. On the other hand, dangerousness increases with an affirmative answer to one or more of the three main categories of plan, previous attempt, and isolation. In these cases, the helper takes a directive stance with respect to the person and his/her crisis.

Action Steps
If lethality is judged to be low as a result of the previous inquiry, then the helper’s approach is to assist by talking through the problem, offering emotional support, and suggesting further outside help, such as referral for counseling. The approach is to draw out the ambiva-
lent feelings of the person in crisis and to explore alternatives for both immediate and later needs. It is especially important to set up an agreement specifying that the person will recon-
tact the helper should there be a change in the situation, such as increased depression and hopelessness leading to further, more concrete suicidal thoughts. The helper should make
him/herself available by telephone, or negotiate an agreement that if needed the individual
will make use of close friends, family, or other resources in the next several days.

When lethality is high, the helper takes a more directive stance. In each case, a step-
wise approach is followed, beginning with the least directive and intrusive avenue possible.
An attempt can be made to contract for the following: for the client to not commit suicide
in the next several days, to get rid of the lethal means for the time being (guns, pills), to not
stay alone over the weekend, and/or to promise to call the helper if things become worse.
The aim is to buy time, to postpone irreversible and final decisions, and to take whatever
steps are necessary to separate distraught crisis clients from lethal means to take human life.

Tarasoff vs. Regents of the University of California

During the course of voluntary outpatient psychotherapy conducted at a university hospital
clinic, a client informed his therapist that he was going to murder a young woman when she
returned from a summer vacation (Cohen 1978). The woman went unnamed but was readily
identifiable by the therapist when the client concluded his visit. The therapist conferred with
two other clinicians who decided that the client should be committed to a mental hospital for
observation. The psychologist telephoned the campus police (followed by a formal letter) re-
questing their help in committing the young man. Subsequently, three officers took the client
into custody, but, satisfied that he was rational, released him on his promise to stay away from
the woman. With the knowledge of the campus policemen’s action, the psychologist’s superior
had the police return the therapist’s letter and directed that all copies of it and the therapy
notes be destroyed. He ordered no further action with regard to commitment. Two months
later, the ex-client carried out his threat and killed the woman. Parents of the victim filed suit
in California State Court against the school’s governing body, the therapist, his supervisors,
and the campus police. Though the complaint was at first dismissed by the trial judge, the ac-
tion was later reversed by the Supreme Court of California. The Court ruled that when a psy-
chotherapist determines that threats made by a patient during therapy are neither idle nor re-

dome, public policy dictates that the value of the disclosure of the threat to a third party
outweighs the benefits of preserving the confidentiality of the communication. The Tarasoff
case set a precedent which has been followed by other Courts, prompting discussions by ther-
apists and lawyers on the practical implications for clinical work (Bersoff 1976). L. Wilson
(1981), writing as general counsel to the New Jersey Psychological Association, offers the fol-
lowing general guidelines for practitioners in light of the Tarasoff ruling:
Agreement to such a contract can be facilitated by drawing on the ambivalent feelings that may have emerged in the discussion, such as “I want to die, but I love my children and don’t want to hurt them.” In such a case a contract for postponing the decision of suicide for the next several days might rest squarely on love for the children and not wanting to hurt them. Whatever tactic is chosen, the objective is to secure cooperation in not committing suicide for an agreed upon period of time.

If the person cannot or will not make these assurances, then other people (possibly family members, roommate, or, in the case of homicide, potential victim and police) may need to be informed of the dangerousness of the situation. Though the approach depends on the particular obstacle (unwillingness to give up weapon, or inability to promise to call if needed), the assumption is that when the individual cannot promise to take precautions against suicide or homicide others in the immediate social milieu must be involved.
In most cases, this can be done with the individual’s permission: for example, “I am concerned enough about you right now, Jane, that I think you shouldn’t be alone tonight. I think your husband needs to know how bad things are. You could call him or, if you prefer, I will.” If such contact or protective observation in the natural environment is not possible, either because no one is available or the individual refuses to include anyone else at that time, then voluntary hospitalization might be needed. Many suicidal people are quite amenable to a “time away from all of this” to rest, recuperate, and not have to deal with everything. Others will resist the idea because of the negative implications associated with hospitalization. Whatever the situation, the approach (as outlined previously under the five components of psychological first aid) is to deal openly and directly with each of these potential obstacles.

In extreme cases, when lethality is very high (lethal plan, previous attempts, isolation), and cooperation in the service of self-protection is not forthcoming (due to the individual’s resistance, psychotic state, or debilitation due to drugs or alcohol), involuntary hospitalization is necessary. When this occurs, it is important that hospitalization takes place according to local law and that family members are helped to deal with the negative implications associated with hospitalization (Armstrong 1980); this can be assessed by following the procedures outlined previously. Following the case of Tarasoff v. Regents of the University of California (Bersoff 1976), helpers also have the responsibility of informing potential homicide victims of imminent danger (see preceding box).

Extremely dangerous situations are still the exception rather than the rule in crisis work, though they present themselves often enough that practitioners need to be prepared to deal with them. While the research literature does not provide us with hard and fast guidelines to predict all suicides or homicides, we do know the steps that need to be taken to reduce the probability of a lethal outcome. Lethality is reduced if lethal means to complete a violent act are removed; an individual makes a commitment to postpone a lethal act; and/or the dangerous individual is under constant observation. The foregoing procedures are aimed at taking steps to meet at least one of these conditions.

**PRACTICAL CONSIDERATIONS**

Several considerations are important in applying the five components of psychological first aid to crisis situations.

1. It is helpful to use the five components as a conceptual framework or “cognitive map” for guiding helper behavior (statements, questions, actions). The steps need not, however, take place one after the other in sequential fashion. This would be artificial since many times the process begins with talk of solutions, then later moves to definition of the problem, then back to solutions, and so forth. Also, one helper statement can actually serve goals under more than one component. For example, an empathic (contact) statement may also serve to further explore parameters of the problem. Also, a line of inquiry on dimensions of the problem may quite readily generate possible solutions.
Instead of sequential steps, then, the components are best used as a cognitive map or guide for helper statements. Helpers should ask themselves throughout: What sort of contact have I achieved with this person? How well have I explored the dimensions of the problem? Are possible solutions matched to rank-ordered needs? What concrete action needs to be taken? Who will take it? Am I clear about following up?

Such an inquiry reminds helpers that they have responsibilities under each heading. Our assumption is that, in so far as one component of psychological first aid is neglected, the intervention is incomplete. It is not enough, for example, to simply offer empathic understanding to an emotionally distraught client. However, by thinking of the five components as a cognitive map or guidebook, the worker can monitor his/her activities at any moment during the intervention process. On termination of the contact, he/she can go through a mental check to see if any part has been left out and now needs attention.

2. Another use of the five components is to assist helpers when the intervention seems to be going poorly. Just as this framework can help a worker decide what to do next, it is also useful in diagnosing difficulties in the helping process. For example, a client may resist any discussion of concrete actions to address the crisis. The client may either give a number of “yes, but”’s or talk about how nothing suggested will work. This is often an indication that either the worker needs to spend more time exploring dimensions of the problem or to simply give more attention to making good contact with the client. Many times when clients feel that they are not being heard or understood in the midst of an emotionally distressing situation, they will resist overtures to solve the problem. When things are not going well in the helping process, workers may need to backtrack. The first aid framework gives clues on areas within which to take temporary retreat until the process becomes unstuck.

3. Although each of the components has been discussed in considerable detail, the goals of psychological first aid are limited. The entire process is only a first step toward crisis resolution. In evaluating their performance, workers should have the sub goals in mind: providing support, reducing lethality, linking to other resources. Also, as a brief (several minutes to several hours) first step, helpers might move very quickly through various components, spending more time on one or the other depending upon the circumstances. One sentence (or a glance) might serve to establish psychological contact between people who already know one another, with most of the time being devoted to generating viable solutions. In other cases, just the opposite may be true—considerable energy may be devoted toward reaching someone who has cut off contact with friends and potential allies. In sum, helpers work within all five components, while the time and energy spent on any one component will vary with the circumstances; moreover, all this takes place with a view to the limited and important goal of re-establishing coping.

4. The first aid format of this chapter can be used as a guide for the supervision process in human service agencies. It provides a framework within which to critique a worker’s/student’s performance. For example, “How well did you make contact with this person? Were you able to identify both immediate and later
solutions appropriate to the identified immediate and later needs? At the end of the conversation, were both of you clear on what the best next step would be? Was lethality assessed? Were follow-up procedures specified?” A supervisor using the five components to examine a student’s work both monitors performance with the immediate case, and at the same time teaches a model that the student can use later for self-critique.

5. Finally, the psychological first aid model can be used in research to code the process of first order crisis intervention in process/outcome studies. Previously, we noted a major criticism of existing research on crisis intervention, namely, that too often the process variables are poorly specified (either too vague and broad) or, even when specific, are incomplete.

### TABLE 3.3 Do's and Don'ts of Psychological First Aid

<table>
<thead>
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<th>Do</th>
<th>Don't</th>
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<tr>
<td><strong>1. Contact</strong></td>
<td><strong>Listen carefully.</strong></td>
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<td><strong>Reflect feelings and facts.</strong></td>
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<td><strong>Communicate acceptance.</strong></td>
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<td><strong>2. Dimensions of problem</strong></td>
<td><strong>Ask open ended questions.</strong></td>
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<td><strong>Ask person to be concrete.</strong></td>
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<td><strong>Assess lethality.</strong></td>
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<td><strong>3. Possible solutions</strong></td>
<td><strong>Encourage brainstorming.</strong></td>
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<td><strong>Deal directly with blocks.</strong></td>
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<td><strong>Set priorities.</strong></td>
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<td><strong>4. Concrete action</strong></td>
<td><strong>Take one step at a time.</strong></td>
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<td><strong>Set specific short-term goals.</strong></td>
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<td><strong>Confront when necessary.</strong></td>
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<td><strong>Be directive, if and only if, you must.</strong></td>
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<tr>
<td><strong>5. Follow up</strong></td>
<td><strong>Make a contract for recontact.</strong></td>
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<td><strong>Evaluate action steps.</strong></td>
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IN SUMMARY

In this chapter, we have identified strategies or components of psychological first aid, and specified the helper behavior and objectives involved in each. For the process to more fully come alive we need to see it in action, to witness application of the five components in case examples. The following serves this function by examining applications of psychological first aid in representative situational and developmental crises, and further pinpointing the critical helper choice points in each.

Psychological First Aid

CASE EXAMPLES

In this section, two cases are presented which illustrate the use of the five components of psychological first aid. These early interventions are aimed at helping the person in crisis to take the first important steps necessary to reestablish coping. The marginal headings and the comments section at the end of each case relate the case material to the model presented earlier in this chapter.

PSYCHOLOGICAL FIRST AID DURING A MARITAL CRISIS

Bob wondered about the knock at the door. Who would be out at this time—11:30 P.M.—on a cold December night? Having just finished a busy day in his law practice (interviews with clients, four hours in court, three hours in meetings with staff and other attorneys), he was ready to turn in for the night.

He opened the door to find one of his law clerks, Tom, asking if he could come in to talk. As they walked toward the living room, Tom began: “I’m sorry to barge in on you like this, but I’ve got trouble. It looks like Sue and I are going to get a divorce.” Choking back tears, he spoke rapidly about what had happened earlier that evening. Tom’s wife, Sue, had said she “wanted to tell him something.” After a little coaxing she confessed that for the last four months she had been having an affair with a man who was a good friend of Tom’s. Not believing his ears, Tom reacted at first with a shocked/dazed look, and then with a series of questions, some of which Sue couldn’t or wouldn’t answer. Struggling to keep feelings of hurt from becoming too apparent, Tom finally broke off the conversation and said he was leaving. He then grabbed his jacket, walked quickly out of the apartment, and drove away. After driving around for about 30 minutes, Tom turned up on Bob’s door step.

Tom’s first words came out in a torrent, and to hear him tell it, everything, including his marriage, was over. Barely stopping to sip the tea Bob had offered
him, he told of loving his wife, not wanting to lose her, but feeling that it was inevitable that he would. After all, she was supposedly “in love” with this other man.

Tom and Sue had been married just over three years. They had moved to this community two years ago so Tom could attend law school. Sue had been the primary bread winner with her job as a high school math teacher. They had dated each other for about four years in college prior to being married at graduation. They grew up in the same small rural southern community, and attended the state university for their undergraduate degrees. Though each had dated other people in high school, neither had any “serious” romantic involvements prior to marriage. Both came from devout Roman Catholic backgrounds, though neither had attended church regularly for the past year or so. For the most part, the marriage had undergone few stresses and strains up to this point. Since they knew each other quite well before marriage, they had many things in common, for example, interest in music and jogging, and felt comfortable with one another. The main concern over the past year for Tom had been Sue’s unexpected flirtatiousness with other men at parties. At first it didn’t bother him, though as it became more obvious, it led to frequent quarrels after social events. At no point, however, had he any concern that Sue might go any further than talk.

Bob’s reaction to all of this was to listen sympathetically, interrupting every now and then to paraphrase, or play back what he was hearing.

“I can see how upsetting all of this is for you.”

“So you’re feeling that Sue has really betrayed you by this.”

“You also seem to feel that now that she had this affair, you will never be able to stay together.”

Bob listened to what Tom was saying and used Tom’s own words whenever possible in reflecting back what had happened and how Tom felt about it. In this particular crisis, Tom felt tremendous emotional pain, which he experienced as hurt, almost as if he was wounded. He felt Sue had betrayed him. He was very upset over the fact that she had “lied to him.” He also seemed to be turning much of this crisis back on himself, suggesting that he was “no good” since he had been rejected for another man. He saw the whole matter as a reflection on his manhood.

Bob encouraged Tom to talk concretely about how things had been going prior to this “news.” Tom reported that he thought their relationship had been a good one. To be sure, Sue’s flirtations had bothered him some. Moreover the two had sometimes thought that they might have married too young, allowing for little experience with other people before getting married. Nevertheless, the affair was a complete surprise to Tom.

Tom made few distinctions between what happened in the past, his current situation (that very evening), and the future (beginning with tomorrow, and extending into the next several months and years). As a matter of fact, he was collapsing all of these categories together, and talking painfully of how his whole world was coming down on him right now. In this case, his “whole world” referred to his marriage, his self-image, his career (“I’ll never be able to
study for the exam I have in two days, and I might fail it”), and the rest of his life (talking surely as if he could never trust another woman again). His self-statements were critical:

“What’s wrong with me? Why wasn’t I good enough for her?”

“It’s all my fault!”

Bob continued to listen, offering empathic and understanding responses, all in an attempt to offer support and hopefully thereby ease some of the emotional stress of that evening.

After about thirty minutes of this kind of talk, Bob directed the conversation toward the difficulties which confronted Tom immediately:

**Immediate Problems**

- Where to spend the night—to go home or not;
- What to say to Sue the next time he saw her—if not tonight, then tomorrow;
- What to do about the exam he needed to take on Friday—two days away—how to prepare for it when he was so emotionally upset.

Other matters would certainly need to be dealt with at some time, but were out of reach that night. Tom would need to talk to Sue to find out about what the affair actually meant to her. What were the implications for their relationship? Was divorce really the only option? Might they not work through this crisis, learn from it, make adjustments in their marriage because of it, and stay together after all?

Bob’s approach was to say straight out to Tom: “Let’s see what you need to deal with right now, tonight, and what can wait until morning.”

Bob then confronted Tom with the idea that although divorce was certainly a possibility, it was not something he needed to decide on that night. Bob then asked Tom what he would like to do about the most immediate needs that had been identified, that is, where to stay, how to deal with Sue, and the pending exam. Bob’s aim was to get Tom to generate as many acceptable solutions as possible, and, if these were found wanting, for Bob to offer some of his own. In his distraught state, Tom had not separated the issues in this way. He also had no solutions to any of these difficulties. He thought he might simply “drive around” and then sleep in the car. He was afraid to confront Sue, not knowing what to say to her, and afraid that he would break down and cry in her presence, giving her yet another reflection against his manhood. The exam increased his panic further. It was a major exam in constitutional law, given on one day only, with very little chance of make up. Besides, if he were to ask for a make up he would have to admit to his marital difficulties to a very stern professor.

Bob continued to work toward boiling the problems down into smaller pieces, examining possible avenues for each. He said to Tom that the whole problem could not be solved right then, so they would need to take the pieces that needed the most attention and deal with them first. The issue of where to spend the night was the easiest to deal with. Bob assertively told Tom that driving around would not be a good idea and that he should stay there that night, sleeping on the couch. After a little resistance, Tom accepted this idea.
Dealing with Sue presented a different problem. Since Tom’s chief concern seemed to be that he would not know what to say to her, and that he might break down, Bob took it upon himself to offer a few ideas of his own at this point. He said, first of all, that breaking down was a rather human reaction to this crisis, and that Tom should be careful about passing judgment on his manhood based on something like this. In a friendly joking manner, he criticized Tom for assuming he had to take a “John Wayne” approach to this, that is, show no emotion for fear it would be a sign of weakness. Bob suggested that both Tom and Sue see a marriage counselor soon, even tomorrow, and talk in the presence of a third party.

As they discussed options such as the student counseling center on campus, the mere mention of a counselor raised other problems for Tom. Would it be confidential? Would seeing a “shrink” be on his record, possibly something he might have to mention in his application for the state bar? The application had recently come in the mail. Tom had noted that there was a question something like “Have you ever been treated for a nervous or mental disorder”? Tom certainly felt that at the time he was having a nervous and mental disorder, like he was “cracking up.” He didn’t want to have to tell anybody about it, surely not the state bar. Bob and Tom talked this one over for several minutes, moving toward an agreement that this would be marriage counseling, and not something that he would need to list on his bar application. No one was having his/her head “shrunk” by a psychiatrist or anyone else. This would be short-term counseling for working through a crisis. Bob was sure that the records at the student counseling center were confidential. In any case, a decision did not need to be made right then; it would wait until morning. Tom could call the counseling center and ask these questions before setting up an appointment.

They talked over the upcoming exam as well. Tom’s chief concern was that he couldn’t concentrate enough to study. Again, Bob reminded him that he surely would not be able to concentrate tonight, and that he shouldn’t try to study. If he needed to ask for an extension, he should do that. He would not have to tell the professor all of the circumstances. Again, he could see how he felt in the morning. Though he surely didn’t feel like studying, he might well be able to put in a couple of hours tomorrow in the afternoon.

The conversation proceeded with Bob helping Tom work toward acceptable solutions to each of the immediate concerns. At times, Tom would try to inject issues about what happened in the past, or about the future (e.g., “I wonder how many times she slept with him,” “How long does it take to get a divorce?”). When this happened, Bob recognized that this was a concern (e.g., “I know you must wonder about that”), but reminded Tom that he had time to find out about these things. Surely nothing could or needed to be decided on right now. The strategy was to articulate that these were concerns but that they didn’t need to be dealt with now. When they talked again, they would see when, how, and whether these concerns would be addressed.

After an hour-and-half talk, Bob convinced Tom that it was time to get some rest. They had agreed that Tom would sleep there that evening and call Sue in the morning to ask if she would consent to their talking with a marriage counselor soon, even tomorrow, and talk in the presence of a third party.
counselor that afternoon. Next they had agreed that Tom would call the student counseling center to ask for an appointment, and at the same time ask questions about confidentiality. Finally, Tom would put the whole exam question on a shelf until later in the afternoon, after classes, at which time he would try to put in one or two hours of studying. He would call Bob later that afternoon to let him know how things worked out.

Follow up

Almost as an afterthought for both of them, they realized that Sue might wonder where Tom was, and whether he would be coming home. Though Tom was reluctant to talk to her right then, he agreed to call and tell her, at least, that he had come over to Bob’s for a talk, that he would stay there that evening, and would call her in the morning. Tom made the brief call, and Bob gave him a blanket and pillow for sleeping on the couch. The two then retired for the evening.

Comment

This case demonstrates how a helper can take a facilitative stance during the early stages of crisis. We can highlight the more salient features of the help given by discussing them according to the five components of psychological first aid.

Psychological Contact

Bob’s main tactic was to listen, and to reflect back what he was hearing about Tom’s crisis: facts (what happened) and feelings (how Tom was reacting to it all). Bob avoided the cardinal error of taking sides in the marital dispute: he was careful not to volunteer his own judgment of Sue. Any judgments he had to offer were about how Tom might cope with his most pressing concerns that very night.

Dimensions of the Problem

Tom presented Bob with classic crisis behavior: disorganization, confusion, and worrying over everything all at once. Tom’s crisis can be understood from a cognitive viewpoint (Taplin 1971): the affair violated Tom’s expectations about marriage and conditions for its survival, that is, fidelity. His panic grew, in part, from his “catastrophizing” (“this one affair means all we had in the past and might have had together in the future is lost”) and over interpreting (“her sleeping with this man must be a reflection on me and my inadequacies”). How this crisis event interacts with Tom’s values, expectancies, self-image, and the like will need to be addressed in some way or another as Tom works through the crisis. Should he begin short-term crisis therapy, this interaction will be at the heart of the working through process.

The meaning of the affair to each spouse will need to be explored. It may be possible to examine this as a developmental issue in Tom and Sue’s marriage, discussion of which might lead to a re-examination of a whole range of issues. As a result, everything from their sex life to the way they talk to one another, express affection, or divide household chores may be addressed. During psychological first aid, however, these factors are given scant attention. Skilled therapists who offer psychological first aid might pick up on these cues
for use in subsequent sessions. As a friend offering help, Bob likely had little understand-
ing of the cognitive processes or mechanisms involved in Tom’s specific crisis reaction.

What Bob did do, using the principles of psychological first aid, was to help Tom sort through what needed attention right now and what could wait until the next day; he helped in taking the first steps toward problem solving. Since there was no talk of Tom physically hurting himself or anyone else, Bob did not have to take steps to reduce lethality. (However, he did reduce the chance of an automobile accident by keeping Tom from aimlessly driv-
ing around in the early hours of the morning.)

Possible Solutions

It is interesting to note the way Tom began the conversation: “It looks like we will be get-
ting a divorce.” It is not uncommon for clients to begin by identifying one solution or a seemingly inevitable outcome to their crises. It needs to be acknowledged that this is one possible solution to a client’s problem, one which should be recognized, but not be allowed to bind either the person in crisis or the helper. The tactic is to recognize the solution, state it in words as a possibility, something that may in fact happen (such as divorce), but to gen-
erate other alternatives as well. The aim is to keep clients from moving toward singular solutions for complex problems. Bob did this by encouraging Tom to put this issue on a back burner and deal with the most pressing concerns first.

In this case, Bob also had to deal with a number of obstacles to the solutions gener-
ated, for example, what seeing a “shrink” might mean to Tom’s law career. Throughout, Bob’s tactic was to work toward generating viable alternatives, a process that required rechecking the alternatives with Tom to see how acceptable they really were and whether he would be able to carry them out.

Concrete Action

Since lethality was low, and since Tom, though distraught, was capable of taking care of him-
self and acting on the best next steps, Bob’s stance was facilitative according to the action con-
tinuum of psychological first aid (Chapter 3). He became actively involved in the decision-
making process, however, since Bob found himself giving Tom advice on certain aspects of the crisis (not driving around that night, not assuming that divorce was inevitable, not assum-
ning that his own manhood was necessarily in question simply because Sue had an affair).

It is important to note that, in each case, the advice given to Tom was limited; its aim was to calm things down, to buy time so issues could be examined more calmly, and to keep options open.

Tom will need to make his own decisions on other aspects of this crisis (e.g., will he stay in the relationship with Sue or not). For now, given the fact that Tom’s own state of upset seemed to be standing in the way of several immediate decisions, Bob allowed him-
self to give advice on what to do. Following the “Do’s and Don’ts” of psychological first aid (Chapter 3), Bob attempted to dissuade Tom from making any decisions about the future right then, or drawing any major conclusions about his own self-worth. Instead, Tom was encouraged to wait until he had a chance for marital counseling. All of the advice given by Bob, then, was aimed at specific objectives, namely, managing the immediate situation, and taking initial steps toward problem solving (talking to a marriage counselor).
Follow up

The agreement to talk to one another over the phone the next afternoon (after Tom’s talk with Sue, his law professor, and the student counseling center) satisfied the condition of follow up in psychological first aid. The follow up agreement added focus to what Tom would do the next day. It signaled Bob’s continued interest in Tom’s problem, and it built in a feedback loop to see if something else might be needed the next day, such as another counseling resource besides the student counseling center.

At the end of this late night conversation, the three objectives of psychological first aid had been achieved.

(a) Bob had provided support for Tom, through listening and talking, and further offering physical assistance in the form of a couch on which to spend the night. Though Bob clearly could not take away the hurt that Tom felt that night, he provided an atmosphere within which Tom could express his feelings and share them with another person who cared. Tom will need to live with his hurt for a while before its eventual impact on his life is clear. That evening, however, he was provided support from a friend.

(b) Lethality was low in this case, precluding the need for directive action.

(c) Linkage to a helping resource was accomplished through the student counseling center referral. Marital counseling seemed the best approach to take to help Tom and Sue work through this crisis.

The extent to which the assistance offered will in fact facilitate coping cannot be judged until some time later. According to Lazarus’s coping paradigm (1980), the question will be whether psychological first aid given that night assisted Tom in both managing his upset and in beginning the problem-solving process.

DIRECTIVE ACTION IN A SUICIDAL CRISIS

Paul kept his gun in the trunk of his car. Until now the .22-caliber rifle had been used for target shooting in the country near his boyhood hometown. Today, however, he was thinking it might serve another purpose. Although he didn’t mention it on his visit to the university counseling center, Paul took some comfort in knowing that the gun might be a solution to his problem. It might slip out sooner or later, but Paul felt uncomfortable in saying straight out that he was thinking of shooting himself. He began, instead, by writing “depressed” on the information sheet he was asked to complete before seeing a counselor.

After about a twenty-minute wait, Paul found himself sitting in the counselor’s office attempting to respond to the offer to talk about “what is troubling you, and how might I help?”

Paul began haltingly at first, eyes turned away from the gaze of the counselor, preferring to look around the room, stopping now and then to see the expression on the counselor’s face as the story unfolded. Paul’s first words were about his parents, how prominent they were in their community, and how
impossible it would be for them to accept what he now felt they suspected: that their eighteen-year-old son was a homosexual. The relationship between Paul and his parents had never been a smooth one, his father having had high expectations and ambitions for his son (athletic success, political career) that were quite different from Paul’s own interests. His mother had always played the mediator role between the two, with very little success, especially in the past several years.

Paul moved from his small hometown to the state capital to attend the state university six months ago, taking a room in a large dormitory. He had enjoyed the freedom of being away from home, found university life stimulating, and was a successful student. He had also developed a close intimate friendship with another young man, a relationship that in the past week or so had experienced considerable stress. Paul was reluctant to discuss his difficulties with his boyfriend, preferring instead to withdraw, which in turn led to increased frustration for both of them. Things had deteriorated so that the previous day his lover threatened to break off the relationship.

It was shortly after this “fight” that Paul’s parents stopped in unexpectedly while visiting the city on business. Paul managed to hide the source of his distress, though not the fact that he was upset. Jumbled conversation between Paul and his parents left no one very satisfied.

The counselor listened attentively as Paul spoke, frequently making reflective statements aimed at clarifying Paul’s situation and his feelings about it. Whenever possible, and in as accepting a manner as he could, the counselor tried to help identify the feelings of frustration and anger (with the lover), anxiety (about dealing with parents), and depression (at there being no apparent solution) that Paul had experienced in the past two days.

At one point early on in the hour, Paul said that he felt “it would be better if I were to end it all,” a comment to which the counselor did not respond immediately. At a natural break in the conversation, however, the counselor came back to the comment, using Paul’s own words:

**CO:** “Tell me what you mean when you say it would be better if you would end it all.”

**PAUL:** “Well, kill myself.”

**CO:** “Do you want to die?”

**PAUL:** “I just think that that might be the best thing all around. I can’t deal with them [his parents]. They can’t know about this. It would destroy them. My father’s career would be ruined. His political ambitions would be shot.”

**CO:** “But what about you? How about your future and what you want?”

**PAUL:** “That doesn’t matter either anymore. I can’t handle anything.”

**Ambivalence**

The counselor continued talking with Paul about the ideas that grew from his thought that he would like to end it all. Without arguing with him, he sought elaboration in a number of important areas. He distilled from the array of facts and feelings Paul’s ambivalence about dying as a solution. Paul talked in terms
of a part of him wanting to die, and another part wanting to live. Suicide might stop the intense emotional pain, though it would certainly not be a perfect solution. It would mean the end of a life that had many very satisfying moments, at least prior to this crisis. Paul had been a bright student, a talented musician, and had for many years envisioned a career as a concert pianist. As Paul and the counselor talked, it became increasingly apparent that Paul wanted more to end his depression, and to find some way of dealing with his current problem, than to end his life. The counselor also explored with Paul the angry messages (toward boyfriend and parents) implicit in the suicidal threat.

The counselor inquired about previous suicide attempts, and found that Paul had once taken an overdose of sleeping pills in high school. His intention then was also not to die, but to get back at his parents, with whom he had had tremendous conflict. The situation was compounded by the fact that Paul felt isolated and left out by friends at school. His parents had found him unconscious in his room and had taken him to the local hospital emergency room to have his stomach pumped. In further inquiry about Paul’s current suicidal thoughts, the counselor discovered that Paul’s plan this time would be to use his rifle. It had been in the closet over the weekend, though Paul had moved it to the trunk of his car last night. Also, while standing alone in the parking lot late the previous evening, he had put the muzzle of the gun to his head, to check to see if he could reach the trigger with his hand.

Paul and the counselor talked back and forth over several alternatives for dealing with his most immediate concerns: confronting his parents and resolving the difficulties with his boyfriend. Paul had never been a very assertive individual and felt wholly inadequate at confronting either his parents or his boyfriend about his most intimate and, at times most troublesome feelings. He certainly felt unprepared for talking to either of them right now. The counselor found himself coaching Paul on how he might confront his parents about his homosexuality when he felt ready to do so. The counselor also talked about dealing with parents as an especially important developmental issue for gay young people, one requiring considerable thought and, sometimes, support from others who had been through the experience themselves. The counselor told him of an organization of homosexual men in the community that offered group counseling aimed at helping individuals with this very task.

The counselor helped Paul look at the confrontation with his boyfriend as one that would need to be explored further before concluding that the relationship was necessarily at an end. They discussed the possibility of counseling sessions at the center for the two of them together. Paul was encouraged, then, to not draw too firm a conclusion about the eventual outcome of this conflict (for good or ill) until matters were explored further, and outside assistance utilized.

The counselor’s immediate concern, however, was to reduce the probability of Paul taking his own life, and to establish some link for further work on the difficulties with the boyfriend and parents. The counselor therefore suggested having another session the next day, perhaps with Paul’s boyfriend included.
Regarding Paul’s talk of suicide, the counselor confronted Paul with a serious concern about the dangerousness of the situation: possession of lethal weapon and rehearsal of killing himself the previous night, coupled with a previous attempt. The counselor drew heavily on the ambivalence that had emerged earlier in the conversation: both wanting to die and wanting to live. The counselor suggested at least postponing such a major decision until there was some time for things to cool off. He secured a commitment from Paul that he would not take his life in the immediate future. He also suggested that Paul not carry a loaded gun in the trunk of his car right now, and offered to go with Paul to the parking lot after the session and transfer the weapon to the counselor’s car trunk.

**Contract**

The counselor was also concerned, however, that at least one other person in Paul’s immediate social network know of his intense depression and suicidal thoughts, and be available to Paul in the next several days. Paul was strongly against any contact with either his boyfriend or parents about his situation, so the counselor suggested the possibility of his (the counselor’s) calling the resident assistant in Paul’s dormitory. (Paul had earlier indicated that this was the only person he had really talked to since coming to the university.) Although Paul was at first reluctant to include the resident assistant in all of this, the counselor convinced him that the potential gain in allowing this friend to help right now should outweigh Paul’s desire to “go it alone.” The phone call was placed to the resident assistant while Paul was still in the room. Paul agreed also to call the counselor should things take a turn for the worse in the next twenty-four hours (until the appointment with the counselor the next afternoon at 3:00). The counselor gave Paul his home phone number, and approximately one hour after the two first met they said goodbye, and agreed to meet again the next afternoon.

**Comment**

The help given Paul can be analyzed according to the five components of psychological first aid.

**Psychological Contact**

As identified in the headings in the left margin above, rapport was achieved primarily through reflective statements from the counselor. The counselor summarized, as accurately as possible, the events leading to the current crisis, and also identified Paul’s unique reaction to each. By summarizing accurately what he was hearing and expressing empathy (“I can imagine how upsetting that must have been”), he communicated that he both understood and cared about what was taking place.

**Dimensions of the Problem**

The precipitating event for Paul’s crisis was the encounter with his parents the previous day. His inability to cope in this particular situation grew from the fact that two seemingly insurmountable obstacles had been thrown in his path: an irresolvable conflict with his lover, and
suspicion of his parents about his homosexuality. Paul’s inability to cope in this case was tied to his inability to deal assertively with his lover and parents. Thus, recent events had impinged directly on one of his skill deficits. Had the issue of suicide not arisen, the counselor might well have spent most of the time on this very issue, helping Paul to deal more directly with both his parents and his lover about his concerns.

The issue requiring immediate attention was Paul’s suicidal ideation. The counselor judged the situation as highly lethal since Paul had attempted suicide previously, had a lethal and available means (gun) to take his life, and had poor contact with others in his immediate social network. The later issues uncovered by the counselor, which would be addressed in future therapy sessions, included Paul’s need for assertive skills in dealing with those close to him, whether or not and when to “come out” as a homosexual, and his use (at least twice) of suicidal threats as a means of solving current difficulties. The counselor recognized that Paul’s crisis had both situational (move to a new city and school six months ago) and developmental (identity, intimacy) components to it. For this first session, however, the main issues were offering support, reducing the lethality of the entire crisis, and providing some link to a helping resource.

**Possible Solutions and Concrete Action**

The tactic adopted by the counselor throughout the session was to enlist Paul’s cooperation in any maneuver made to reduce lethality. He began by listening and uncovering Paul’s feelings about suicide as a possibility, attempting to frame the ambivalence in such a way that it could be used later in the negotiation process. While hospitalization, calling parents, or some other similarly controlling intervention would have been possible, the counselor elected (appropriately) to take a stepwise approach to reduce lethality, with each maneuver having the cooperation and consent of Paul.

According to the PFA flow chart (Table 3.2), the counselor took a directive stance characterized by both contractual negotiations with Paul (about the gun) and actively mobilizing other resources (resident assistant). By approaching it in this manner, trust was preserved and the therapeutic relationship between the counselor and Paul was maintained. Disposing of the gun and having Paul agree not to attempt suicide in the immediate future were the most direct means to reducing lethality. Setting up contact with the resident assistant in the dormitory and the counselor offering to be available by the phone that evening served to broaden the base of social support. The counselor’s goal was clearly not to try to solve everything in that one session, but rather to set priorities, to buy time, and to take reasonable steps to insure that Paul would be alive to talk about the difficulty the next day.

The linkage to further helping resources dealt primarily with setting the appointment for Paul to see the counselor the next day, plus the contact with the gay community services group the following week. Again, the overall strategy was to broaden the base of support and assistance in as many ways as possible. The assumption was that Paul could profit from the support and guidance of other homosexuals who had confronted the issue of dealing with parents.

Another example of the directive stance taken by the counselor in this helping session was his coaching Paul on how to deal with both parents and roommate in the immediate future. Though he clearly could not teach Paul appropriate assertive behavior in one session, he was able to model the various possibilities, to demonstrate their potential
usefulness, and add legitimacy to Paul’s taking an assertive stance with his lover and parents around his current difficulties.

Follow up

The principal mechanism for follow up was the appointment which was set for the next afternoon. The first session ended, then, with both Paul and the counselor knowing that there would be a specific time to check progress and/or make other arrangements to assist Paul.

The counselor’s chief criteria in evaluating the effectiveness of his helping contact rested with whether he (a) provided support, (b) reduced lethality, and (c) made an appropriate linkage to another helping resource. In this particular case the counselor left the session with the impression that he had done each of these. Paul talked at the end about feeling somewhat better as a result of the conversation (the support); he agreed to give up his rifle and contact the counselor should the need arise that evening (lethality); and, he agreed to come in for a visit the next day (linkage to helping resource). When they went their separate ways after an hour’s talk, the counselor had reasonable assurance that he had done as much as he could at that time.

At the follow-up session, the counselor planned to examine the outcome of his intervention by checking on Paul’s reactions even further. He anticipated determining the extent to which Paul had in fact taken steps toward increased coping with the situation. The counselor would look for concrete indications that Paul was managing the subjective reactions (feelings of upset, anxiety, and the like) associated with the crisis, and that Paul was moving, toward implementing the action steps (contacting the gay support group, talking to his lover, making decisions on how to deal with his parents) necessary to work through the crisis.