Assessment for Crisis Intervention

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This article describes the triage assessment system (TAS) for crisis intervention. The TAS assesses affective, behavioral, and cognitive reactions of individuals to crisis events. This assessment model offers clinicians an understanding of the type of reactions clients are experiencing as well as the intensity of these reactions. The TAS provides a quick, accurate, and easy-to-use method that is directly usable in the intervention process. The system can also be used to monitor clients' progress during the intervention process. Two case illustrations are presented to demonstrate the use of the model. In addition, the Triage Assessment Form: Crisis Intervention is included as an Appendix. © 2006 Wiley Periodicals, Inc. J Clin Psychol: In Session 62: 959–970, 2006.

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Effective crisis intervention is dependent on accurate assessment that directly translates into focusing treatment when it is needed. This assessment should give clinicians the information required to answer questions such as the following: What resources are needed for this client to resolve the crisis situation? What approach will be the most effective for the client at this time? Does the client need to be hospitalized? What support from family, friends, or community agencies is needed? Is the client contemplating committing suicide or harming someone else? Answering these questions requires that assessment of clients in crisis be ongoing, and that reactions be monitored in order to adjust the intervention as needed. Simple reliance on diagnostic models, standardized tests, or intake protocols can mislead clinicians in these situations (Hoff, 1995; Myer, 2001). A model specifically designed for crises is needed to guide the assessment process.

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Triage Assessment System

The triage assessment system (TAS) for crisis intervention (Myer, Williams, Ottens, & Schmidt, 1992a) provides a framework for understanding clients' reactions during a crisis. This model integrates research from a variety of sources and presumes that reactions to crisis events are seen in three domains: (1) affective, (2) behavioral, and (3) cognitive. Clinicians assess clients' reactions along all three domains. This point is critical because failure to assess each domain can result in a collapse in the resolution of the crisis and lead to additional problems (James & Gilliland, 2005). The TAS guides clinicians in the identification of the complex interaction among the three domains and helps prevent protracted mental health concerns.

The TAS uses Crow's (1977) work on emotions associated with crises and research on primary emotions (National Advisory Health Council, 1995; Plutchick, 1980) as the foundation for identifying affective reactions clients experience when in crisis. These reactions are (1) anger/hostility, (2) anxiety/fear, and (3) sadness/melancholy. The expression of these feelings can range from negligible to extremely severe; however, uncomfortable levels of emotions are more characteristic reactions of people who are experiencing a crisis (Baldwin, 1979).

Assessing clients' emotional reactions is generally straightforward. It is relatively uncomplicated to determine whether clients are angry, afraid, or sad. However, often clients express a combination of these feelings, bouncing from one to another and back again. We suggest that determining the emotion most frequently expressed identifies the primary affective reaction. If others are present, these are considered as secondary or tertiary.

Clients' behavioral reactions can be assessed as (1) immobility, (2) avoidance, and (3) approach (Myer, Williams, Ottens, & Schimdt, 1992a). *Immobility* is defined as being stuck, or unable to sustain any consistent attempt to resolve the crisis. *Avoidance* is defined as an active attempt to escape or bypass problems associated with the crisis. In contrast, *approach* reactions are those that are active attempts to resolve problems resulting from the crisis.

In the cognitive domains, reactions are (1) transgression, (2) threat, and (3) loss. *Transgression* is seen as a "demeaning offense against me and mine" (Lazarus, 1993, p. 26). The perception of the event is that it is happening primarily in the present. *Threat*, on the other hand, is viewed as potential, that is, something that will occur in the future. The perception is that an impending catastrophe is approaching. The perception of *loss* is that it occurred in the past and is irrevocable. Clients' perceptions, whether accurate or not, are used in the assessment of cognitive reactions. The areas of clients' lives that are perceived to be affected by the crisis include (1) physical, such as health, shelter, safety; (2) psychological/self-concept, such as identity and emotional well-being; (3) social relationships, such as with family, friends, coworkers; and (4) moral/spiritual, such as personal integrity, values, and belief system. Clients can perceive a transgression, threat, or loss in each of these life dimensions.

The TAS has been operationalized through the development of the Triage Assessment Form: Crisis Intervention (Myer, Williams, Ottens, & Schmidt, 1992b). The Appendix contains a copy of the form. This form adds a severity scale to each domain that allows crisis workers to rate the severity of clients' reactions in each domain.

Reactions are rated on a scale of 1 to 10 with 10 the most severe reaction. A "rule out" process is the most efficient strategy to determine the severity of each reaction. We suggest beginning with 10 and going down the scale until finding a characteristic that meets the severity of reaction in that domain. This strategy of ruling out characteristics is the most rapid and accurate way to assess severity.

Initially, treatment should address the most severe reaction, permitting clinicians to address salient needs in a manner appropriate to the severity of the reactions. As the severity of the reaction varies throughout the crisis event and treatment, clinicians should adjust the treatment to meet clients' needs. By totaling the severity scales, crisis workers can also judge how intense and directive the treatment should be: the higher the score, the more direct the intervention. Generally speaking, low scores (3–12) indicate a recommendation for no treatment or a nondirective approach. Clients whose total on the severity scales is in this range may simply need a sounding board to resolve the crisis. Clients whose total on the severity scales is in the middle range (13–23) need clinicians to partner with them to help resolve the crisis. This approach is more collaborative, requiring clinicians to be more active. When clients' total score on the severity scales is high (24–30), a direct approach is needed. Clients in this range are vulnerable and need a support system. Clinicians will be extremely active and engage in active problem solving with clients. If any severity scale score is 10, hospitalization is strongly recommended.

Case 1

The case of Ann involves a crisis in which she was coping with her apartment's being burglarized. Ann was referred to the clinician by a friend, Gail, who was worried that she might need help in dealing with the burglary. Because our article concerns assessment, we report on the first 15 minutes of the interview. The setting is an urban agency that helps people who have been victims of a crime.

Client Description

Ann is a 26-year-old white female. With her was Gail, the friend who referred her to the agency. Ann insisted that Gail stay with her during the session. Ann continually looked around the room. On the intake form, Ann had indicated that she worked as a sales representative in a local business. She also reported that she was not on any medication and had not received any mental health services in the past. She identified having difficulty in concentrating and some trouble in sleeping. In addition, Ann reported being angry much of the time. She reported that these problems began the day after the burglary, which took place 8 days before.

During the first few minutes of the session, Gail blurted out that Ann was making statements that were crazy. Following up on this disclosure, the clinician discovered that Ann had been planning to get revenge on the person who burglarized her apartment. As Ann continued to talk she stated that she knew her former boyfriend had broken into the apartment. She repeatedly stated that she hated him for what he had done. As the session continued, the clinician discovered that Ann's boyfriend had been verbally and psychologically abusive during their 9-month relationship and that Ann had broken up with him about 1 week before the burglary. Ann stated that although she did not have any proof, she "knew" he was the only one who would have broken into her apartment. When questioned about her thoughts of reprisal, Ann admitted she wanted to make his life the hell he had made hers but was not specific beyond that. Ann stated that she did not want to harm him physically, but just spread lies about him to his friends. Ann wanted to say things such as they broke up because he is gay and has acquired immunodeficiency syndrome or that he was unable to perform sexually. Adding to Ann's anger was that when she reported the break-in to the police they said an investigation would be done but not to count on any conclusive resolution. At that time,

Gail chimed in, stating that she had told Ann repeatedly to be cool, but that was becoming increasingly difficult.

Case Formulation

The crisis event in Ann's case was the burglarizing of her apartment, allegedly by her former boyfriend; however, there was no proof for her belief. The crisis was complicated by the fact that Ann had lingering anger toward the boyfriend, who had apparently been abusive in the past. Sorting through the anger became the focus of treatment as the clinician worked to help Ann understand her feelings and not let them be the catalyst for taking action that would only result in more problems.

Affective Reaction. Ann's primary affective reaction is anger/hostility. She repeatedly made statements to this effect during the first few minutes of the session. However, she was not able to sort through this feeling in a constructive manner. In fact, over the past several days the anger had seemed to become increasingly pronounced. The severity scale rating was assessed at 8. Ann's mood was not under her control and her emotional reaction, although expected, seemed high. The reason the clinician assessed the affective reaction as too high was that it had become stronger until Ann was considering behaving in a manner that would likely make the situation worse.

Behavioral Reaction. The clinician assessed Ann's behavioral reaction as primarily approach. This assessment was predicated on the fact that although Ann had not acted on her wish to get revenge, she was close to acting on that desire. The severity of Ann's reaction was assessed as 8. Ann appeared to be performing the tasks of daily living such as eating and maintaining contact with others, with the exception of having difficulty in sleeping. However, she was contemplating engaging in behavior that could potentially complicate her crisis even more.

Cognitive Reaction. Ann's primary cognitive reaction was transgression in social relationship. She perceived that her boyfriend had wronged her by allegedly breaking into her apartment. Her severity scale rating was assessed as 7. Ann had frequent disturbances of concentration and her problem-solving ability was impaired. In addition, Ann had decided that her former boyfriend had committed the break-in yet had no facts to support this belief, meaning that her interpretation of the event could not be considered accurate at this time.

Course of Treatment

Ann's total score was 23, placing her in the range that suggests the clinician should use a more intense and directive treatment. Initially, the clinician addressed the behavioral reaction to help ensure Ann's safety. Because Ann reported that her boyfriend was verbally and psychologically abusive in the past, the clinician wanted to make certain she was not placing herself in harm's way. Knowing that Ann was feeling helpless, especially because the police seemed to offer little hope of finding the burglar, the clinician suggested she contact the police to ask about the status of the investigation. The goal of this suggestion was to empower Ann to take action that would be beneficial. The clinician also began helping Ann to separate her feelings of anger at being a victim of a crime from her feelings toward her former boyfriend. During the intervention the clinician included

Ann's friend, Gail, as part of the resolution. The clinician pointed out that Gail was a person whom she could trust who would help support her. A suggestion was made that Ann keep in touch with Gail on a daily basis in order to monitor her feelings.

Outcome

The severity of Ann's reactions dropped significantly during the session. Ann's affective reaction decreased to 5. Her emotions were more under control and seemed appropriate to the situation. Ann's behavioral reaction dropped to 3. The clinician assessed Ann at this severity level because her behavior regarding the resolution of the crisis had become helpful rather than harmful. Her cognitive reaction also decreased to a 4 because the thoughts regarding the burglary were still causing some difficulty in concentrating.

One lesson to be learned from this case involves allowing Ann's friend to participate in the assessment and intervention process. At first, the clinician was hesitant to allow Gail to take part. Yet Ann's insistence that Gail accompany them overrode the clinician's hesitancy. As it turned out, Gail provided useful information that would otherwise been difficult to obtain. This information allowed the clinician to make a better and more accurate assessment of Ann's reactions. In addition, Gail became part of the support system that Ann could rely upon as she grappled with her feelings of helplessness.

Case 2

The case of Bob demonstrates use of the Triage Assessment Form: Crisis Intervention in a crisis that poignantly demonstrates the need to listen to clients and not make assumptions. Initially the clinician made an assumption about the nature of Bob's crisis, only to discover that the precipitating event was not the actual crisis. Again the first 10 to 15 minutes of the interview are reported. The setting is an urban mental health clinic that offers a walk-in crisis service to anyone who enters.

Client Description

Bob, a white man in his mid-40s, entered the clinic late one afternoon. He was visibly anxious and his appearance was disheveled. His eyes were red and he spoke between sobs. He stated that he had been wandering around "all day" and needed to talk with someone as soon as possible. The on-call clinician was contacted and was available to see Bob immediately. The only information the on-call clinician had was that Bob had wandered into the clinic and he seemed to be in crisis.

While still in the waiting area Bob began to tell his story. His speech was slurred by his continuous sobbing, making it difficult to understand him. He kept repeating something about his wife's being ill and in the hospital. The clinician interrupted him and asked whether his wife was in the hospital. Bob put his head in his hands and began crying even harder, unable to speak. When he lifted his head he had a blank expression and said, "She's dead, you idiot; haven't you heard anything I've said?" The clinician responded by stating his sorrow about the loss. This statement seemed to calm Bob, and he said again that his wife had died last night. She had become ill quite suddenly and died within a week. He added that he had been wandering around all night not knowing what to do or whom to call. He said he had been talking to strangers on the street, anyone who would listen to him. Although Bob was dressed appropriately, his clothes looked unkempt. His personal hygiene also was poor as evidenced by body odor and bad breath. Bob did

not appear to be attentive to social cues, in that he disclosed personal details of his life loudly in the presence of others.

As we sat down in the office, Bob put his head in his hands and reported that his life "was ruined." As Bob told the story his feeling shifted from anxiety to anger. He kept saying, "My future is doomed; I can't live without her." Bob also repeatedly said he was scared, more scared than any time in his life. He constantly expressed that he did not know what to do and was "unable to handle" the situation. He was angrily saying that he made too many wrong decisions and he "owed too much." He admitted suicidal ideations but had no clear plans on which he could act. He stated he could not kill himself because he loved and wanted to live for his children.

At this point, the clinician again expressed his sorrow about the loss and said that the death of a spouse is difficult. At this statement Bob looked up and stated, "Yeah, especially when she is the one who makes all the money." This statement surprised the clinician, and he asked Bob what he needed to talk about. At this point, Bob disclosed that his wife was the "breadwinner," and that he had no idea how he would be able to keep up with the mortgage, let alone "every other bill." He said he was extremely sad about her death and loved her, but his biggest concern was money. Bob stated he had extended family and friends to help him with her death. What he needed help figuring out was how he was going to support his family.

Case Formulation

Assessment of a crisis begins by identifying the crisis. Clinicians should take care not to assume that the precipitating event is the crisis. In Bob's case, the clinician initially assumed the crisis was the sorrow Bob was experiencing about the death of his wife. This assumption was corrected when Bob indicated that his crisis was also the loss of income caused by his wife's death. Once the clinician understood the crisis, the meaning of many of Bob's earlier statements, such as being doomed, became clear.

Affective Reaction. Bob's affect was overtly evident in his red eyes, sobbing, and difficulty in articulating his thoughts. His revealing of personal information with an apparent lack of discretion indicated that his feelings were not entirely under his volitional control. In other words, he did not use forethought or good judgment in regard to what he was revealing or to whom. The easiest determinant of his affect, however, was his reporting that he "was scared." Assessing the severity reactions rested on observations made by the clinician during the first few minutes of the interview. Although Bob's affect was primarily anxiety/fear, his feelings were bouncing around from fear to anger with some sadness mixed in. His affective reaction also seemed incongruent with the situation and his mood appeared too intense. In addition, Bob was having difficulty controlling his emotions. As a result, the clinician placed him in the moderate impairment category for affect with a score of 7.

Behavioral Reaction. Bob's behavioral reaction was immobile and exacerbated his current crisis. Bob's wandering throughout the day without contacting anyone who might be able to provide him support suggested he was paralyzed and unable to make decisions for himself. This situation is not unusual and is expected, given the circumstances. Bob could not think beyond the immediacy of his inability to provide financial support for his family. Although Bob expressed suicidal ideations, the clinician determined these were not at a level of immediate danger. Bob's inability to perform routine personal grooming

was also an indication of the severity of Bob's behavioral reaction. The severity of Bob's reactions was certainly elevated beyond moderate impairment; that is, his coping behaviors exacerbated the situation, and his ability to perform daily tasks was markedly compromised. Thus, Bob's behavioral reactions to the crisis fell within the marked impairment range, a score of 9.

Cognitive Reaction. Bob's primary cognitive reaction was threat in the area of physical dimension. He also was perceiving a loss in social relationships and to a degree a threat to his psychological well being. Bob's neglect of some aspects of his routine living (wandering, disheveled appearance, etc.), though behavioral indicators, also demonstrated a lapse in cognitive functioning. He was able to recall personal information but needed prompting to do so. However, his perceptions of his financial status and the impending crisis were also critical factors in determining the severity of his cognitive reaction. These thoughts were intrusive and Bob seemed to have no control over them. Because more than half of the descriptors for marked impairment in the severity scale were met, Bob was evaluated with a score of 9.

Course of Treatment

The initial assessment indicated that Bob was experiencing a marked crisis across two of the three domains (behavior and cognition) with a total severity score of 25. This score suggested that the clinician should use a very direct approach in helping Bob. The immediate course of treatment involved using direct statements to place Bob on the shortest course to resolving the crisis. Although the behavioral and cognitive reactions were assessed at 9 on the severity scales, the clinician began by addressing Bob's behavioral reaction. The clinician chose this approach to ensure Bob's safety. The clinician worked to have Bob contact his family and use them as a support system. The discussion focused on helping Bob work out what he would say. After he talked with Bob for approximately 45 minutes, Bob was able to telephone his family to let them know where he was and that he was safe. During the call, Bob talked briefly with them about what had happened and asked them to pick him up, and they agreed to do so.

Before Bob's family arrived, the clinician began helping Bob sort out his thoughts. This process involved helping Bob develop a strategy to determine his financial status. The clinician recommended that Bob contact someone who would be able to determine his financial status. The thought was that Bob was not able at this time to gather this information on his own and someone with experience in this area would be of great assistance. Although Bob did not know of anyone with this expertise, he agreed to talk with his extended family about his fears and to ask their advice about whom he might contact.

Outcome

As the clinician and Bob worked through the severity of his behavioral and cognitive reactions both decreased to severity rating of 5, yet Bob's affective reaction remained stable at 7. This rating did not surprise the clinician because the intervention did not directly address his affect. Also given the experience of Bob's spouse's becoming ill and dying within a week, Bob's affective reaction was likely to remain elevated for a longer period, but how long was difficult to determine. However, because he had activated a support system in the form of Bob's extended family and provided him with a plan to

verify his financial status, the clinician believed that Bob would be able to resolve his crisis.

On reflection, the clinician learned the importance of understanding a crisis from the client's perspective. This point is critical for provision of effective and efficient interventions. Too often we have supervised clinicians who were confused and wondered why clients did not respond to their intervention. We frequently discover that the clinician has failed to appreciate the client's perspective. The clinician has either made an assumption about the nature of the crisis or imposed his or her perspective on the situation. Fortunately, in this case illustration, the clinician was able to recover from the faulty assumption and provide guidance to Bob.

Clinical Issues and Summary

Assessment in crisis intervention is different from that in other types of assessment with respect to goals, process, relation to treatment, and type of information gathered. Recognition of these differences is essential for clinicians who are involved in providing crisis intervention. Although skills learned for other types of assessment are useful, clinicians cannot rely on these in crises. At times the skills used in other types of assessment can actually hinder and prevent effective crisis intervention.

For example, clinicians must often be prepared to provide treatment within the first 5 minutes of contact. Clinicians must have assessed clients' reactions well enough to have begun the intervention process. The luxury of writing a report and getting results from standardized tests is not practical in crisis situations. Clinicians need to be trained to adapt skills and increase their effectiveness in crisis assessment.

The TAS is a valuable tool for helping in the assessment of people in crisis. The instrument provides structure for the assessment process that translates directly to treatment. Research indicates that interrater reliability is modest and content and criterion validity is promising (Watters, 1997); however, additional research is needed to establish validity of the TAS. The TAS may also be used to monitor reactions in order to adapt the intervention to the immediate needs of the clients. As clients move toward resolution of a crisis the severity of reactions is altered and clinicians must adjust interventions accordingly. The TAS provides a method for accomplishing this process.

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Appendix

TRIAGE ASSESSMENT FORM: CRISIS INTERVENTION*

CRISIS EVENT:

Identify and describe briefly the crisis situation:

_____

_____

_____

AFFECTIVE DOMAIN

Identify and describe briefly the affect that is present. (If more than one affect is experienced, rate with #1 being primary, #2 secondary, #3 tertiary.)

ANGER/HOSTILITY:

_____

_____

_____

ANXIETY/FEAR:

_____

_____

_____

SADNESS/MELANCHOLY:

_____

_____

_____

Affective Severity Scale

Circle the number that most closely corresponds with client's reaction to crisis.

1	2 3	4 5	6 7	8 9	10
No Impairment	Minimal Impairment	Low Impairment	Moderate Impairment	Marked Impairment	Severe Impairment
Stable mood with normal variation of affect appropriate to daily functioning.	Affect appropriate to situation. Brief periods during which negative mood is experienced slightly more intensely than situation warrants. Emotions are substantially under client control.	Affect appropriate to situation but increasingly longer periods during which negative mood is experienced slightly more intensely than situation warrants. Client perceives emotions as being substantially under control.	Affect may be incongruent with situation. Extended periods of intense negative moods. Mood is experienced noticeably more intensely than situation warrants. Lability of affect may be present. Effort required to control emotions.	Negative affect experienced at markedly higher level than situation warrants. Affects may be obviously incongruent with situation. Mood swings, if occurring, are pronounced. Onset of negative moods are perceived by client as not being under volitional control.	Decompensation or depersonalization evident.

BEHAVIORAL DOMAIN

Identify and describe briefly which behavior is currently being used. (If more than one behavior is utilized, rate with #1 being primary, #2 secondary, #3 tertiary.)

APPROACH:

_____
_____
_____

AVOIDANCE:

_____
_____
_____

IMMOBILITY:

_____
_____
_____

Behavioral Severity Scale

Circle the number that most closely corresponds with client's reaction to crisis.

1	2	3	4	5	6	7	8	9	10
No Impairment	Minimal Impairment		Low Impairment		Moderate Impairment		Marked Impairment		Severe Impairment
Coping behavior appropriate to crisis event. Client performs those tasks necessary for daily functioning.	Occasional utilization of ineffective coping behaviors. Client performs those tasks a necessary for daily functioning, but does so with noticeable effort.		Occasional utilization of ineffective coping behaviors. Client neglects some tasks necessary for daily functioning is noticeably compromised.		Client displays coping behaviors that may be ineffective and maladaptive. Ability to perform tasks necessary for daily functioning is noticeably compromised.		Client displays coping behaviors that are likely to exacerbate crisis situation. Ability to perform tasks necessary for daily functioning is markedly absent.		Behavior is erratic, unpredictable. Client's behaviors are harmful to self and/or others.

COGNITIVE DOMAIN

Identify if a transgression, threat, or loss has occurred in the following areas and describe briefly. (If more than one cognitive response occurs, rate with #1 being primary, #2 secondary, #3 tertiary

PHYSICAL (food, water, safety, shelter, etc.):
TRANSGRESSION _ THREAT _ LOSS ____

PSYCHOLOGICAL (self-concept, emotional well being, identity, etc.):
TRANSGRESSION _ THREAT _ LOSS ____

SOCIAL RELATIONSHIPS (family, friends, co-workers, etc.):
TRANSGRESSION _ THREAT _ LOSS ____

MORAL/SPIRITUAL (personal integrity, values, belief system, etc.):
TRANSGRESSION _ THREAT _ LOSS ____

Cognitive Severity Scale

Circle the number that most closely corresponds with client's reaction to crisis.

1	2 3	4 5	6 7	8 9	10
No Impairment	Minimal Impairment	Low Impairment	Moderate Impairment	Marked Impairment	Severe Impairment
Concentration intact. Client displays normal problem-solving and decision-making abilities. Client's perception and interpretation of crisis event match with reality of situation.	Client's thoughts may drift to crisis event but focus of thoughts is under volitional control. Problem-solving and decision-making abilities minimally affected. Client's perception and interpretation of crisis event substantially match with reality of situation.	Occasional disturbance of concentration. Client perceives diminished control over thoughts of crisis event. Client experiences recurrent difficulties with problem-solving and decision-making abilities. Client's perception and interpretation of crisis event may differ in some respects with reality of situation.	Frequent disturbance of concentration. Intrusive thoughts of crisis event with limited control. Problem-solving and decision-making abilities adversely affected by obsessiveness, self-doubt, confusion. Client's perception and interpretation of crisis event may differ noticeably with reality of situation.	Client plagued by intrusiveness of thoughts regarding crisis event. The appropriateness of client's problem-solving and decision-making abilities likely adversely affected by obsessiveness, self-doubt, confusion. Client's perception and interpretation of crisis event may differ substantially with reality of situation.	Gross inability to concentrate on anything except crisis event. Client so afflicted by obsessiveness, self-doubt, confusion that problem-solving and decision-making abilities have "shut down." Client's perception and interpretation of crisis event may differ so substantially from reality of situation as to constitute threat to client's welfare.

DOMAIN SEVERITY SCALE SUMMARY

Affective ____
Cognitive ____
Behavioral ____
Total ____