

# Chapter 13

## Brief Therapy and Crisis Intervention

### Brief Therapy: Definition

According to the National Institutes of Health (Center for Substance Abuse Treatment, 1999a, 1999b, Chapter 3, p. 1), brief therapy is, “a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies.” Brief therapy techniques can be applied when the therapist is following one or a combination of several therapies, including cognitive-behavioral therapy, brief strategic and interactional therapies, brief humanistic and existential therapies, brief psychodynamic therapy, short-term family therapy, and time-limited group therapy. When used in correctional counseling, it is appropriate for both juvenile and adult offenders.

In its discussion of brief therapy, the National Institutes of Health (Center for Substance Abuse Treatment, 1999a, 1999b, Chapter 3) notes that various names have been used to describe brief therapy, including reality therapy, crisis intervention, and other names, and that the number of therapy sessions with clients may range from one to several or even 20 or more. It was also noted that some interventions are brief and may only involve one session, as is the case with many crisis intervention sessions. However, the main difference between brief therapy and therapy that comes about in a situation where the client needs immediate counseling as a result of some unexpected tragedy is that brief therapy is planned and time limited. The National Institutes of Health (Center for Substance Abuse Treatment, 1999a, 1999b, Chapter 1, pp. 1–2), referring to the use of brief therapy in substance abuse counseling, distinguishes a difference between brief interventions and brief therapy, stating that “Interventions are generally aimed at motivating a client to perform a particular action (e.g. to enter treatment, change a behavior, think differently about a situation), whereas therapies are used to address larger concerns (such as altering personality, maintaining abstinence, or addressing long-standing problems that exacerbate substance abuse).” Other differences between brief interventions and brief therapies include:

- Length of the sessions (from 5 min for an intervention to more than six 1-h therapy sessions)
- Extensiveness of assessment (which will be greater for therapies than for interventions)
- Setting (nontraditional treatment settings such as a social service or primary care setting, which will use interventions exclusively, versus traditional substance abuse treatment settings where counseling and treatment will be used in addition to interventions)
- Personnel delivering the treatment (brief interventions can be administered by a wide range of professionals, but therapy requires training in specific therapeutic modalities)
- Materials and media used (certain materials such as written booklets or computer programs may be used in the delivery of interventions but not therapies)

A number of approaches to counseling and treating criminal and juvenile offenders that are similar to the approach followed in brief therapy have been advocated and implemented. For example, Rachin (1974, pp. 45–53) claimed that David Glasser's reality therapy concentrates on the present, on the "here and now" rather than the "there and then." He notes that nothing can change the past and the major purpose of therapy is to have the client adjust to the present and prepare for the future. When working with criminal and juvenile justice law offenders, the therapist should become personally involved; reveal self; concentrate on the here and now; emphasize behavior; rarely ask why the deviant behavior occurred, but how it can be changed; help the person evaluate the behavior, particularly how it has affected others; help develop a plan for future behavior that will be rewarding as well as law abiding; reject excuses for past behavior; offer no tears of sympathy; praise and approve responsible behavior; believe people are capable of change; try to work in groups; not label people and even if the person recidivates; and not give up (Rachin, pp. 50–51).

Bersani (1989, p. 179), commenting on Glasser's conception of reality therapy, states, "A major difference between reality therapy and conventional therapy is the type of client-counselor involvement desired in reality therapy. To varying degrees, conventional therapists remain impersonal and objective. For Glasser, the eventual achievement of involvement begins with a distinctive type of client-counselor relationship that goes beyond understanding and empathizing with the client. Mutual trust and respect are achieved through a process of involvement where both the counselor and the client convey respect, genuineness, and acceptance of each other as unique persons."

Clark (1996, p. 57) observes, "In the steady stream of publications that pour from our nation's universities, criminal justice scholars seldom mention using offender strengths as an aspect of 'what works' in offender rehabilitation. Brief therapy focuses on the strengths of the client being counseled. The concept brief therapy, also referred to as competency-based brief therapy, brief family therapy, and other titles, as with reality therapy, focuses on the strengths of the client, mutual respect of client and counselor, cooperation and goal setting."

The description of brief therapy given by National Institutes of Health (Center for Substance Abuse Treatment, 1999a, 1999b, p. 1) states “Brief therapy differs from longer term therapy in that it focuses more on the present, downplays psychic causality, emphasizes using effective therapeutic tools in a shorter time, and focuses on a specific behavioral change rather than large-scale or pervasive change.” This description is similar to that given by Glasser in describing reality therapy.

## Utilization of Brief Therapy in Family Counseling and with Juvenile Offenders

Clark (1996, p. 58) using the concept *brief solution-focused work* describes the guiding principles of the strengths-based method. The principles are:

- **Focus on Strengths.** Clark notes that “All offenders and families have some resources such as skills, capabilities, interests, and positive character traits, even perseverance and hope, which can be brought to bear for exiting our system”. “It is a simple yet profound truth that solutions are not reached through offenders’ weaknesses and failures but through offenders’ strengths and healthy patterns.”
- **Utilization.** Utilize the skills, traits, and talents the offender (family) brings to the counseling session. Clark (1996, p. 58) states, “Problem-solving abilities are called from the past to be utilized in the present . . . Although teaching and skill building will always have a place in our field, consider that it is far easier to utilize what is already present or what has been successful than to import vocabulary, methods, or strategies foreign to those we work with. Finding and capitalizing on what is already present is one aspect of what makes brief work brief.”
- **Cooperation.** Clark (1996, p. 59) concludes that “The most influential contributor to change is the client, not the therapy, nor the technique, not the therapist—but the client.” Applying brief therapy with juveniles and families requires considerable input from the youth and family members as to having them determine what are their most immediate needs and goals. For a parent, they might have to isolate their child from a deviant peer group and how to get the child to adhere to the rules established by the family. For the juvenile, the most immediate needs may be self-serving such as how to get parents “off my back” or how to gain more freedom from parental control. Cooperation is gained by allowing the client to offer suggestions on the means that can be used to address the immediate problem and to draw on their personal skills and traits.
- **Task Orientation.** Clark (1996, p. 59) notes, “A Solution-Focused approach does not belabor the past, nor does it fully need to understand the problem before solution work can begin.” For example, when a youth is brought before a justice agency, the problem, that is, the deviant behavior, has been identified. Some of the initial interviewing by a law enforcement agent or juvenile court intake officer might reveal some of the causes for the deviant behavior. Brief solution-

focused counseling can now be applied by focusing on the present situation and what changes need to be made in the future. If the youth's problem behavior is related to family situations in some way, both the youth and parents have the responsibility for finding the methods to bring about the changes in behavior desired, and both must be held accountable. Clark (1996, p. 59) states, "It would be a mistake to believe that greater offender participation and developing a cooperative relationship is enough to bring about behavior change. For real change to happen, the offender and family need to change the way they think about and perceive the problem(s) and to do something that is behaviorally different than before."

- **Goal Setting.** Clark (1996, p. 60) gives two basic criteria to follow when a counselor is working with a juvenile offender and family on setting up goals. First, the goals must be meaningful to the youth and parents and be realistic in terms of the youth's problem/s with the family, school, police, juvenile court, or the community. For example, a juvenile referred to a police diversion program for curfew violation will generally have an opportunity to have input on developing a plan to change the behavior that will be acceptable to the diversion counselor and parents. However, if the youth is referred to the juvenile court for allegedly sexually molesting a small child, the amount of input the juvenile offender will have on the best method to correct the problem will probably be minimal. A second principle to be followed when the counselor and client are engaged in goal setting is that goals must be small and interactional. Therapists often speak of short-term goals, intermediate goals, and long-range goals. In the case of a delinquent offender, the long-range goals for a youth might be not to engage in any delinquent behavior and establish a good relationship with the family and the school administrators. The brief solution therapist does not ignore long-range goals but is most concerned with short-range goals, that is, what behavioral changes can be made now, immediately. If the youth's problem is related to constantly losing his temper and physically hitting his younger siblings when angry, the short-range goal for behavioral change must pertain to the problem on anger and physical violence and how to change the behavior.

## **Brief Therapy in Substance Abuse Treatment**

In a National Institutes of Health Report (Center for Substance Abuse Treatment, 1999a, 1999b) on the use of brief therapy for substance abuse treatment, the authors do not advocate brief therapy be used over all other existing therapy approaches. The circumstances surrounding the need for treatment, whether the treatment is mandated by a court or voluntary, the ability of the individual to pay for the treatment, and the strength of the dependency on the drug or alcohol may all be factors determining the type of treatment given. For example, some substance abusers, such as occasional binge alcohol drinkers, may not need more than a few sessions with a therapist. It may be determined on assessment that some abuser

would benefit the most by long-term counseling, but the individual's insurance will only cover a small limited number of sessions. If the therapist is in private employment and still decides to follow a long-term model, it is likely that the sessions will terminate once the insurance coverage is ended, even though only a portion of the therapy plan has been completed. If the person is incarcerated, the demand for alcohol/drug counseling is likely to be high, and the resources and therapists available to fill the needs of the substance abuser inmates are so limited that brief therapy is the only option. Still in other cases, the person may have several problems that may not be related, and several brief therapies are used, each addressing a separate problem.

The National Institutes of Health Report (Center for Substance Abuse Treatment, 1999a, 1999b, Chapter 3, p. 5) states that "regardless of the specific brief therapy approach used, all brief therapies have common characteristics. In addition, brief therapies should incorporate several stages, including screening and assessment, an opening session that includes the establishment of treatment goals, subsequent sessions, maintenance strategies, ending treatment and follow-up." A short explanation of the steps listed above is given here.

**Screening and Assessment** "Screening is a process in which clients are identified according to characteristics that indicate that they are possibly abusing substances" (Center for Substance Abuse Treatment, 1999a, 1999b, Chapter 3, p. 5). Screening identifies the risk of the person being an abuser, but does not identify the depth of dependency or extent of abuse. Often the information used in the screening process can be found in official records such as an arrest form or a health report. After screening and assessment, which involves a thorough analysis of the factors contributing to the person's substance abuse problems, an evaluation of the depth of the problem takes place. The information is obtained through a face-to-face interview as well as the completion of standardized instruments. The resources the client has available that will assist in the therapy are also gathered during the assessment. For example, if it is determined that the person's problems are likely to be of short duration and the person has strong support in the family, at place of employment and in the community, it is likely that brief therapy can be used and a positive outcome expected. Also, the person's financial situation may be a factor in determining if brief therapy will be followed.

**Opening Session.** The therapist generally will have a certain amount of information on the client before they meet for the opening session. "This information comes from the intake worker, who probably would have completed the screening and assessment, or from the referral source, a service agency, or a court, if the therapy is mandated. Other information gathering options include asking intake workers to administer questionnaires, using computerized assessments, or asking the client to complete an assessment form before the first session. During the first session, the main goals for the therapist are to gain a broad understanding of the client's present problems, begin to establish rapport and an effective working relationship, and implement an initial intervention" (Center for Substance Abuse Treatment, 1999a, 1999b, Chapter 3, p. 6).

Several critical tasks to complete during the first session are:

Produce rapid engagement.

Identifying, focusing, and prioritizing problems.

Working with the client to develop possible solutions to substance problems and a treatment plan that requires the clients' active participation.

Negotiating the route toward change with the client (which may involve a contract between client and therapist).

Eliciting client concerns about problems and solutions

Understanding clients' expectations.

Explaining the structural framework of brief therapy including the process and its limits (i.e., those items not within the scope of that treatment segment or the agency's work).

Making referrals for critical needs that have been identified but cannot be met within the treatment setting.

**Goals of Treatment** The client must be involved in the establishment of the goals of the therapy. The therapist helps guide the client toward the desired outcomes and recommends specific goals that, if accomplished, will address the changes the client must make to alleviate the problem. For example, goals might consist of making measurable changes in behavior; helping the client gain a better understanding of the issues relating to the problem; improving personal relationships with family, friends, and work associates; and resolving other problems such as those pertaining to employment, management of anger, and hostility.

**Subsequent Sessions.** After the initial session, additional brief therapy sessions are geared toward:

- Work with the client to help maintain motivation and address identified problems, monitoring whether any accomplishments are consistent with the treatment plan and the client's expectations.
- Reinforce—through an ongoing review of the treatment plan and the clients' expectations—the need to do the work of brief therapy (e.g., maintain problem focus, stay on track).
- Remain prepared to rapidly identify and troubleshoot problems.
- Maintain an emphasis on the skills, strengths, and resources currently available to the client.
- Maintain a focus on what can be done immediately to address the client's problem.
- Consider, as part of an ongoing assessment of progress, whether the client needs further therapy or other services and how these services might best be provided.
- Review with the client any reasons for dropping out of treatment (e.g., medical problems, incarceration, emergence of severe psychopathology, treatment noncompliance).

**Maintenance Strategies** The therapist must continue to provide support and assistance throughout the brief therapy sessions through providing feedback on progress, identifying problems that may be interfering with the attainment of the goals, developing new strategies when needed, helping the client to use personal strengths and skills to the upmost capacity, emphasizing self-sufficiency, and developing plans for future support from other help groups, family, and the community.

**Ending Treatment (Center for Substance Abuse Treatment, 1999a, 1999b, Chapter 3, p. 9)** It is recommended that the termination date for treatment be planned well in advance of the actual date. When planning termination, the therapist should:

- Leave the client on good terms, with an enhanced sense of hope for continued change and maintenance of changes already accomplished.
- Leave the door open for possible future sessions dealing with the clients' other problems.
- Elicit commitment from the client to try to follow through on what has been learned or achieved.
- Review what possible outcomes the client can expect.
- Review possible pitfalls the client may encounter (e.g., social situations, old friends, relationship issues), and talk about the likelihood of a good outcome and indicators of a poor outcome.
- Review the early indicators of relapse (e.g., depression, stress, anger).

## **Brief Therapy in Jails, Mental Health Facilities, Community Treatment Centers, and Correctional Facilities**

Criminal and juvenile delinquent offenders who are under some form of criminal justice supervision in the United States experience many forms of mental health problems. These mental health problems including depression, anxiety, extreme stress, fear, and hostility may be associated with the problem that brought them into contact with the justice system, such as substance abuse, driving under the influence, molesting of children, or violent behavior. The problems might also have been brought on by the present situation and the unknown future they now face with after being charged with or convicted of a crime. For many of those under the supervision of a justice agency, it is their first experience with law and justice agencies, and they are often not prepared to respond to their new situation. This is particularly true for those held in jail awaiting a hearing. When separated from family and other support groups, individuals who fear for their personal safety or feel despondent and shamed after being detected or exposed who do not have a supportive person to turn to for guidance may decide to take drastic action and end it all by suicide. Byrne, Lurigio, and Pimentel (2009, p. 40) note, "The elevated risk

of suicide among detainees is significantly higher than the risk in the general population. Heightened risk stems from a variety of dispositional and situational factors. With respect to the former, jail detainees have a disproportionately high rates of psychiatric, substance use, and personality disorders as well as histories of unemployment, weak social ties, and homelessness--all of which increase the risk for suicide.”

Although less than half of those charged with a crime are held in jail for an extended period of time while in pretrial status (Kyuckelhahn & Cohen, 2008), many of those who are released into the community on bail or some form of pretrial supervision may be in need of some form of intervention or counseling by professional counselors. In regard to suicide, Byrne et al. (2009, p. 41) found that, for those released into the community awaiting trial on their offense, “On one hand the risk of suicide might be lower than the people in confinement. They might have less serious criminal histories and greater levels of financial resources and family support than those in custody. On the other hand, their risks for suicide might be higher than the people in confinement. They might be less likely to be assessed for suicide risk and to receive service to lower the risk of suicide. Furthermore, pre-trial defendants in the community have more access to the means to commit suicide and cannot be watched to prevent or respond to attempts.”

Dr. Thomas Anuskiewicz, president of Marion Psychological, Inc. and a licensed clinical psychologist, serves as the chief psychologist for the Stark County Jail located in Canton, Ohio. Prior to receiving his Ph.D. and obtaining his license as a clinical psychologist, he was employed at a school for delinquent youth and problem behavior youth and as the administrator for an alternative education school.

### **Box 13.1: Interview with Thomas Anuskiewicz**

**Interview completed by Peter C. Kratoski on April 30, 2016**

*QPK = question; ATA = answer*

QPK: As president of Marion Psychological, Inc., what are your major responsibilities?

ATA: Marion is a small organization. It became incorporated in 1987. I wanted to have my own business to give me the opportunity to be able to have my own clients as well as to obtain contracts with other private and public organizations that provide psychological services to their clients. I looked at it as a challenge. I wanted to be able to provide service to those who needed the type of counseling that related to most of my experiences. Thus, I handle a large portion of the cases as well as serve as the chief psychologist with the Stark County Jail and manage the business.

PCK: What types of services do you provide that are related in some way to the justice system?

(continued)

**Box 13.1** (continued)

ATA: I and other Marion psychologists work with jails, prisons, police and sheriff's departments, and the courts. We provide services such as crisis intervention, counseling, and case management, provide 24-h on-call service, and complete psychological evaluations and preemployment counseling to the inmates and staff at the correctional settings. We have provided training for correctional officers in the areas of human relations and how to recognize the symptoms of mental health problems. We also have consulted with the administration of correctional facilities on policies and program development. Our work with the courts consists mainly of providing court-ordered forensic evaluations, evaluating for mental competency, sex offender assessments, presentence evaluations, and completing risk assessments for violent offenders, and I have served as an expert witness for the prosecutor as well as for defendants. Occasionally, I have been asked to provide psychological evaluations for police departments when a "high-ranking officer" was involved in a situation that, if not resolved, could become a problem for the department.

PCK: Are there other psychologists employed at the Stark County Jail?

ATA: Yes, but only as part-time employees. I considered hiring a full-time psychologist to assist me at the jail, but it is difficult to find the person with the credentials who is willing to take on the pressure and liability of decisions a professional must deal with when working in a correctional institution. Many of the inmates can be intimidating and some do not give the staff much respect. The fact that one is working in a secure locked-up building where one does not have the freedom to move about is not the type of work situation desired by many professionals. Also, there is the matter of professional attitude. The psychologist must perceive each person counseled as being deserving of the services provided, regardless of what type of crime was committed. The psychologists who work part-time at the jail were selected because they had experience working in correctional settings and were able to obtain the rapport and mutual respect from the inmates and staff.

QPCK: Do you make a distinction between crisis intervention and brief therapy?

ATA: Crisis intervention focuses on immediate psychological (emotional/behavioral/cognitive) stabilization. Brief therapy focuses on solving or resolving a current concern, need, or problem. This could also include helping a client gain insight into a stated concern or problem through discussion, reflection, or education.

QPCK: Do you use brief therapy in the jail setting or with your other patients?

(continued)

**Box 13.1** (continued)

ATA: Yes. To assist with short-term coping problems in the jail and also to discuss concerns related to home or their case situation.

QPCK: Please give an example of how you used brief therapy with a jail inmate.

ATA: The problem consisted of an inmate who perceived that a correctional officer who was assigned to his unit was giving him unfair and harassing treatment. I allowed the inmate to express his feelings and thoughts on the matter. I asked the inmate what he felt were his immediate needs. The inmate was allowed to provide some suggestions on how the impact of the alleged harassment of the officer could be reduced. We also discussed if the actions by the corrections officer were definitely harassing or perhaps just his way of doing his job. I also gave some suggestions on avenues that could be taken, such as sending a kite (message) to the supervisor or even filing a grievance.

QPCK: When working in the jail setting, how often are you required to provide crisis intervention counseling?

ATA: It depends. Some days it is quiet; other days intervention is required frequently. For example, one inmate threatens to harm another inmate or threatens to harm himself. Other situations which require crisis intervention are when something sets them off, and they become hysterical. Often it is related to something that happened at home with their families.

PCK: What factors are related to crisis situations in the jail?

ATA: There are many; the most frequent are:

Emotional instability resulting from receiving a heavy sentence

Acute psychotic episodes (hallucinations/delusions)

Conflicts between inmates and staff and inmates

Drug/alcohol detoxification

High-profile inmates who have extensive media coverage resulting in threats by other inmates

Incidents of inmate-to-inmate sexual abuse

Borderline personality disorder inmates who self-mutilate

Q: PCK: Please give a specific example of a crisis situation you handled and give a step by step explanation of how the crisis was resolved.

ATA: A person had a cell mate who demanded a single cell for himself. There was no reason for him to be assigned a single cell (no health reason, no disability, no mental health history). When the inmate's request was denied, he began a cycle of self-mutilation and disruption (cutting himself, putting items up his penis and anal cavity, banging on all doors, urinating under the cell door). I spoke to him several times regarding the situation and his

(continued)

**Box 13.1** (continued)

perceived needs. Finally, when the behavior did not change, I placed him in isolation on limited foods and no clothes except for a special psychiatric blanket. If his disruptive behavior resumed, he was to be placed in a restraining chair. I continued to talk with the inmate to calm him and gave him ways to cope with the incarceration. Finally, his behavior stabilized and he was able to return to the general population housed with a cell mate.

Baillargeon, Penn, Williams, and Murray (2009), on reviewing the outcomes of a more than 75,000 criminal offenders over a 6-year period, found that those with a major mental disorder such as depression, bipolar disorders, schizophrenia, and other psychotic disorders had a substantially higher risk of being reincarcerated than those criminal offenders who did not have mental health problems. Stewart and Wilson (2014, p. 79) concluded in their study of institutionalized inmates in a Canadian facility that “The current study found that offenders with mental disorders had poorer institutional and community outcomes than non-mentally disordered offenders, even when other factors related to criminality were controlled. The results demonstrate the complex needs of mentally disordered offenders and the requirement for correctional agencies to be prepared to provide specialized interventions that address both their mental health and criminogenic needs.”

Anno (2001) notes that the US Supreme Court has determined that the criminal justice system is responsible for health care from the point at which a police pursuit begins until the individual is released from a correctional facility. However, when a person is released from incarceration, the state or local justice agencies are no longer required to provide health care to the person released from jail or prison. Research by Potter (2014, p. 92), in which there is an attempt to uncover the role of public health care providers and social service providers for persons who are in the criminal justice system and living in the community, showed that only a small proportion of men involved in the criminal justice system who were supervised in the community utilized health services and other social services. There may be various reasons for non-usage of mental health and social services by offenders who are under some form of community supervision. The services required may not be available in the community, or, if services are available, the offender may not have access to the services because of a lack of health insurance or insufficient funds to pay for the health services. Another reason for not obtaining treatment even when treatment is needed is a lack of motivation. He notes, “Many criminal justice involved individuals come to the system with a track record of failure to follow-through on educational, health, and social welfare activities that have been recommended for them” (Potter, 2014, p. 92).

## Crisis Intervention

Roberts (1991, p. 778) defines a personal crisis as “An acute disruption of psychological homeostasis in which one’s usual coping mechanisms fail and there exists evidence of distress and functional impairment.” There may be a number of reasons why a “crisis” may occur in a person’s life, but in general the cause of a crisis is related to a traumatic stressful situation, engagement in a hazardous event, or involvement in a situation for which the person cannot control the outcome or feels he/she does not have the skills to determine the outcome. Roberts (1991, p. 778) states, “A crisis often has five components: a hazardous or traumatic event, a vulnerable or unbalanced state, a precipitating factor, an active crisis state based on the person’s perception, and the resolution of the crisis.” A personal crisis should be distinguished from a crisis situation, such as a disaster brought on by a flood, fire or earthquake, or economic depressions. Depending on personal strengths, some people can quickly adjust, start rebuilding their lives, and plan for the future. However such situations experienced by other individuals may result in those persons feeling unable to cope with the situation, trying to escape from the situation through drugs, alcohol, or even suicide. The following observations of a person experiencing a personal crisis were made by a student completing an internship and observing the operations of a county jail (Pollard, 2016, p. 3): “I saw one female in particular withdrawing from opiates. In my schooling and education, I’ve read much about opiate withdrawals, and what they can do to the body. This woman showed almost all of the classic withdrawal effects. She was cold, had diarrhea, vomiting all over herself and her dorm, she had the chills and was very weak. All the nurse could do for her was give her Gatorade to keep her hydrated and Pepto-Bismol for nausea. She looked absolutely consumed by this addiction and withdrawal. This was dreadful to see. I’ve learned a lot about drug addiction in several of my courses. These classes teach you the repercussions of drugs, but is not something you can understand until you actually see it. You don’t understand until you actually watch someone’s life fall apart.”

It should be noted that a person may use a coping mechanism that was the initial cause of the crisis to try to deal with a crisis. For example, excessive use of alcohol or drugs for recreation may result in loss of employment, estrangement from spouse and family, and rejection by friends. The person feeling rejected and isolated may believe that the only way to cope is to continue and even increase the alcohol or drug consumption.

Crisis intervention counseling can be applied in a variety of settings. The specific setting and nature of the crisis will determine the type of immediate response to the crisis that the counselor or caregiver will take. One of several models may be followed. For example, in the Training Guide for Crisis Intervention written by the Michigan Department of Community Health for Health (1985, p. 2), it states that crisis intervention may be used in mental hospitals:

- To provide for self-defense or the defense of others
- To prevent an individual from causing self-harm

- To stop a disturbance that threatens physical injury to any person
- To obtain possession of a weapon or any dangerous object that is in possession of the individual causing the crisis
- To prevent “serious” property destruction

In the training document, it is emphasized that physical intervention should be used only as determined to be necessary and only the amount that is needed until the persons involved in the crisis situation are under self-control. Once the immediate crisis is under control, a rehabilitative crisis intervention plan should be followed. The training guide (Michigan Department of Community Health, 1985, pp. 3–4) lists a variety of responses that can be used in a crisis intervention situation. Several of those most likely to be followed are aversive techniques, providing an unpleasant stimulus and blocks; defensive techniques that protect the staff person from objects that may be thrown at them; hands down—a light touching technique used to stop the person who appears to be out of control and likely to hurt self or others; intrusive techniques that encroach upon the bodily integrity of the personal space of the individual; nonphysical intervention; and a gentle approach to calming the individual/s involved in the crisis situation. Physical management, a technique used to restrain the movement of the individual, restraint, prone immobilization, standard wraparounds, and seclusion are recommended for use only in the more extreme cases.

The factors mentioned above as reasons for initiating crisis intervention are applicable to any community correctional facility, including jails, community correctional facilities, juvenile detention centers, group homes, and residential treatment centers, as well as long-term correctional facilities and prisons. In addition, most of the techniques used to respond to a crisis are applicable to most of the correctional facilities mentioned above. The exceptions would be in nonsecure juvenile or adult residential treatment facilities, where the behavior of a resident may be so threatening to him/herself or others that the person needs to be transported to a secure facility.

Slaikeu (1983) states crisis intervention should not be considered a response to the immediate crisis. Rehabilitative crisis intervention should focus on assisting the individual to stay focused and, through being successful in problem-solving, learn skills that are transferable to all areas of their lives and can be used to resolve future crises. Even though the focus is on current problems, many clients come to understand how past, unresolved trauma contributed to maladaptive attempts to solve the present crisis.

Slaikeu (1983), in discussing the goals and steps of crisis intervention with mental health patients, alcohol and drug abusers, and gambling addicted patients and with families, notes that not only can a variety of techniques and methods be used in providing therapeutic counseling services, but also a variety of personnel can provide useful services. Not all of the personnel need to be licensed counselors and trained in counseling. Other personnel and volunteers can provide support and service to those who experienced a crisis, had responded to the crisis by engaging in some type of maladaptive behavior, and who are now trying to make a new adjustment to their life situation. The assistance can come from many corners.

Slaikue (1983, p. 2), in discussing a multidisciplinary team approach to therapeutic crisis intervention with families, notes, "Some crisis workers excel at using community resources for providing concrete services. Others excel at assessing problems, helping families communicate better, or listening in a way that makes families willing to talk openly. Some crisis workers are especially good at accompanying clients to a well-baby clinic, to a physician's office, to prospective employment, or even to a grocery store, thereby helping them feel successful in accomplishing a task. Some crisis workers are better at supportive confrontation or placing limits on inappropriate behaviors. Drawing on each team member's strengths greatly enhances service delivery." Roberts and Ottens (2005, p. 334) developed a crisis intervention model consisting of several stages, including planning and conducting a thorough biopsychosocial and lethality/imminent danger assessment, establishing interpersonal contact and rapidly establishing a collaborative relationship, identifying the major problem areas and the factors that precipitate the crisis, encouraging the person in a crisis state to express his/her feelings and emotions, generating and exploring new ways to cope with the crisis, and implementing an action plan that will help client to eventually lead to the restoring of the person's normal state. A follow-up plan is also suggested and, if needed, booster sessions.

## Summary

Brief therapy modalities and crisis intervention counseling are designed to assist an individual in dealing with an immediate problem or problems that have affected his/her life to the extent that the person can no longer function in a normal way. Crisis intervention and brief therapy are frequently used with persons experiencing mental health problems, those who have attempted suicide, or those who are addicted to drugs or alcohol, as well as with those who have had a recent traumatic experience, such as being a victim of a violent crime or the death of a family member. Crisis intervention is used to bring some relief to the problem and uncover the cause of the maladaptive behavior as quickly as possible. The manner in which professionals respond to the person's crisis depends on the situation and the type of behavior being manifested. If the person is exhibiting behavior that appears to be dangerous or life-threatening to self or others, an immediate response that will eliminate or reduce the danger is required. Once the immediate problem is eliminated or reduced, the therapist can begin to work on the elimination of the source of the problem. If it is impossible to change the situation, the therapist can help the individual to accept the situation, stabilize his/her life, and adapt to other problems the person may be experiencing. For many of the clients, the crisis intervention and brief therapy provided are the first steps toward making an adjustment to his/her life situation. If the client learns how to focus on problems that are likely to emerge throughout his/her life and to find solutions to the problems by either using his/her own resources or knowing when to ask for assistance from others, the crisis intervention and brief counseling provided can be considered successful.

## Discussion Questions

1. Discuss the similarities and differences between brief therapy and crisis intervention.
2. If you were employed as a correctional officer in a jail and an inmate began to scream, tear off his clothes, and become hysterical, what crisis intervention methods would you employ to try to calm the person and bring him under control?
3. Discuss how brief therapy differs from other forms of therapy.
4. Discuss the difference between a personal crisis and a crisis situation. Give an example of each, and discuss how a counselor would likely proceed with counseling in the examples provided.
5. Why does incarceration in jail often become a crisis for those incarcerated? What steps can jail personnel take to prevent those who are mentally ill from creating a crisis situation?
6. Discuss how a typical person might react to a crisis situation such as a terrorist attack in a subway station.
7. What are the characteristics of reality therapy? Assume you were the counselor who was providing reality therapy to James, a 15-year-old boy who was arrested for shoplifting at a department store. How would you approach the counseling relationship with James?
8. The behavior of Alice, a 16-year girl, has caused a great deal of conflict in Alice's family. She has been sneaking out at night and at times coming home in the early evening hours. She has gained a reputation of being sexually promiscuous, a source of embarrassment for her twin brother. However, her younger sister admires Alice for the way she dresses and her defiance toward her father. Alice's father blames Alice for all of the conflict in the family and would like to establish some strict behavior rules with the ultimatum that, if she does not adhere to the rules, she will be forced to leave the family. However her mother sides with Alice and tries to convince her husband that Alice is just going through a phase. When Alice is referred to the juvenile court for curfew violation and drinking alcohol, the court diversion director recommends family counseling. Assume you are the family counselor. How would you proceed in counseling the family? What counseling technique might be effective in counseling this family?
9. Discuss how rehabilitative crisis intervention would be applied in a case of an individual who has experienced a traumatic crisis such as being a victim of battery by her husband.
10. Discuss the multidisciplinary approach to crisis intervention. Why is this approach necessary in situations in which the criminal justice system responds to crises?

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