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Crisis Support The Legacy and Future of Helplines

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 Lifeline

Abstract

Helplines have played a vital role in the community services landscape for over half a century and are currently active in over 60 countries. They have developed a strong and respected profile as providers of accessible help to people in crisis and featured prominently in shaping the history and current practice of suicide intervention. Crisis intervention and support have been widely recognised, signature features of these services. However, compared to other areas of counselling or clinical practice, the conceptual foundations, practice principles and empirically demonstrated utility of crisis support have not always been clearly described. The challenge of clearly articulating the purpose, nature and benefits of crisis support is a foundational step for helplines as they position their services within the community and shape their future role. The purpose of this paper is to inform and hopefully promote productive discussion and planning about how helplines can become known for service excellence in providing crisis support.

Context

People in crisis

Crises often evoke images of upheaval in people's lives from natural disasters around the globe and close to home. These events and their aftermath are dramatically visible and suddenly impactful. For many, however, crises reflect private struggles with stressful circumstances and transitions that challenge their coping capacity and call for new levels of resourcefulness.

Typical 'crisis' issues that callers to helplines present with include: relationship breakdowns, indebtedness and financial struggles, domestic violence, exposure to traumatic events, workplace conflicts, bullying, general and mental health problems, housing, drug and alcohol use, gambling and addictive behaviors, as well as general perceptions of aloneness and social exclusion. Suicidal presentations also pose a crisis in themselves, reflecting a level of desperation about the caller's current life situation.

Despite the stressful, sometimes devastating, experience of personal crises many show remarkable resilience in addressing them (Bonanno, 2009, 2011). However, encounters with impactful events can lead people into unfamiliar psychological territory that escalates anxiety, disrupts daily functioning and overwhelms established patterns of coping (Caplan, 1964; Flannery & Everly, 2000). These circumstances can press people to consider new ways of viewing and addressing their concerns and prompt fresh openness to social support.

Crisis care?

Impactful events and turbulent life transitions are universal, even though exposure to them and vulnerability to their effects varies greatly. It is therefore surprising and concerning that crisis theory and intervention practice lacks the prominent status in contemporary discussion of primary health care that it deserves. Curiously, there is practically no mention of the crisis construct in the extensive primary care documents published by the WHO (2008) or in Australia's primary care Report (2009) and Strategy (2010). Similarly, the Fourth National Mental Health Plan in Australia (2009) and the National eMental Health Strategy (2012) make no mention specifically of the place of crisis support in mental health frameworks. Furthermore, the Australian Living is For Everyone (LIFE) Framework for Suicide Prevention, while acknowledging the part of proximal factors in suicidal behavior, and trigger points through a lifespan view of suicide, does not explicitly set crisis support as part of its action areas.

This oversight is puzzling. The capacity to anticipate, prepare for and respond resourcefully to personal crises addresses psychosocial elements of health and wellbeing that are foundational to primary mental health care and suicide prevention. Timely, community-based interventions can help people manage stressful or traumatic experiences, alleviate current distress and keep safe when suicide risk is present (e.g. Mitchell & Mitchell, 2006; Kalafat, Gould, Harris Munfakh, & Kleinman, 2007; Gould, Kalafat, Harris Munfakh, & Kleinman, 2007). They also have the capacity to link people in crisis to informal support networks and illumine pathways to further care as needed (Snyder, 1971; Farberow, Heilig & Parad, 1994). Further, to the extent that early intervention can prevent crises escalating into more serious health concerns it is cost effective when compared with treatment in institutional settings (Bengelsdorf, Church, Kaye, Orlowski & Alden, 1993).

Given the ubiquity of crises, there are strong grounds for routinely integrating crisis assessment and management protocols into health and psychosocial care in community and institutional settings (Hoff & Adamowski, 1998; Rosen, 1998). This requires formal recognition of the value of crisis care accompanied by appropriate training and support for people in crisis intervention roles.

The capacity for crisis response has been significantly developed in some specialised areas, most notably in the protocols and practices for helping people manage community disasters (e.g. Nucifora, Langlieb, Siegal, Everly & Kaminsky, 2007; Forbes & Creamer, 2009).

However, generic crisis responses in community and health services are often fragmented and lack any clear articulation of their underlying rationale, practice principles or structure. Hoff and Adamowski (1998) observed that the proliferation of terms and practices surrounding various manifestations of crisis intervention practice betrays the immaturity of the field and risks reducing these strategies to formulaic procedures unmoored from their theoretical foundations or core purpose. This contrasts significantly with Caplan's (1989) model that captured and integrated developments from the first 25 years of crisis intervention theory and practice.

Revisiting the crisis paradigm

This paper seeks to stimulate and inform a conversation to address this concern. A good outcome from that conversation would be the restoration of crisis theory and practice to the mainstream role in primary care that it once fulfilled in public health. Crisis intervention can be an indispensable, integral part of a vibrant and effective population strategy that delivers quality primary mental health care.

The paper reviews literature to support the contention that crisis theory and practice principles provide a coherent framework that warrants recognition as a distinct discipline that can be learned, applied, evaluated and continuously improved through reflection on practice and research findings.

The discussion will review formative influences and key themes in the development of crisis theory and practice. What emerges from this review is a living heritage of ideas, strategies and possibilities that can inspire and inform current and future practice in crisis care. It features a guiding philosophy, models, tools and tasks that people could be mentored to apply or equipped to provide through training.

The living legacy of crisis theory and practice is a bifocal perspective that embeds intervention activities within a prevention strategy. It has broad prevention goals targeted at everyone in the community. This prevention focus is complemented by specific intervention strategies for helping individuals who are vulnerably exposed to hazardous events and painful life transitions.

This paper explores the interaction of prevention and intervention objectives as the key to the vital contribution that crisis theory and practice offers primary care. The specific contribution of suicide prevention to the advancement of crisis intervention will be discussed. Concluding sections will review the practice principles of crisis intervention and identify frameworks that prepare and support people to provide this care competently in formal and informal settings.

Conceptual Foundations

The formative context

Crisis theory and intervention practice emerged as part of a paradigm shift that challenged inherited assumptions about the mental health needs of the public and ways of addressing them (Cohen & Nelson, 1983; Hoff & Adamowski, 1998; Wallace, 2001). Mental health care moved beyond exclusive preoccupation with mental illness to address social and personal factors affecting wellbeing and personal growth. Interventions focused not only on treatment but on supporting people to make healthy choices in their encounters with challenging transitions and life situations.

This broader mental health agenda transformed the service delivery landscape. These changes required an expanded repertoire of helper roles and services and widened the circle of potential care-givers to include volunteers and paid non-clinical workers in health or community services and pastoral care (Whitlock, 1970; McGee & Jennings, 2002). The establishment of helplines played a particular role in crisis care (Mishara & Daigle, 2001; Dominish, 2001).

Helping models used by these services were present-focused and strengths-oriented (e.g. Glasser 1965; Clinebell, 1966; Egan, 1975). This distinguished them from the prevailing emphasis at that time on exploring the psychological antecedents of problems that were presumed to reflect psychopathology. Typically, interventions were short-term. They focused on immediate concerns, personal growth, proactive problem solving and building coping competencies. They usually occurred in the community or over the phone rather than in clinics or institutional settings.

Such approaches are commonplace today. However, the role that crisis intervention theory and practice played in shaping this new paradigm of mental health care is often overlooked. Reviewing the rationale and defining features of crisis care is instructive to applying its benefits today.

The crisis construct

The word 'crisis' entered English in the sixteenth century to describe the pivotal point in a disease that could lead either to improvement or a deteriorating potentially fatal course (Oxford Dictionary, 2011). While references to some medical states as 'critical' reflect this usage, 'crisis' was soon applied outside medicine. Etymologically, 'crises' are defining moments where 'decisions' play a key role in resolution of a threatening situation. Choices are integral to resolving them. Individuals are encouraged to be agents, not bystanders or passive victims, in addressing them.

Caplan (1964) introduced the crisis construct into the lexicon of health, psychiatry and psychology through his pioneering work at the Harvard School of Public Health. Crises were conceptualised as time-limited periods of vulnerability when stressful life experiences or transitions significantly destabilise and sometimes temporarily overwhelm a person's capacity to cope. They intensify when people recognise or believe that their usual strategies for managing emotionally distressing experiences and seemingly intractable problems are not working or exhausted. In this unstable environment anxiety escalates and the capacity to manage everyday tasks is diminished.

A foundational tenet of Caplan's framework was that many manifestations of pain and distress troubling people's lives were not necessarily evidence of pathology. They were often understandable, transient responses to circumstances that sometimes aroused anxiety to intolerable levels and overwhelmed an individual's natural coping resources. They represent a critical point when internal coping and external supports are seriously challenged and need to be strengthened to meet current demands.

Time and timing

The crisis state was believed to be inherently time-limited (Caplan, 1964; Kalafat, 2002a). The intensity was such that resolution one way or another is inevitable. The challenge for individuals in crisis and those around them was to summon resources to address their predicament in an adaptive way.

Since crises sometimes also elevated suicide risk, the need to assess and reduce immediate threats to life and safety was a priority (Farberow, Heilig & Litman, 1994). Crisis intervention therefore is a fundamental component of a comprehensive suicide prevention framework.

The painful and disabling crisis state called for a timely response to alleviate distress and fortify coping. In crisis theory, the desperation to find a way forward made people more amenable to seek and respond to help or to consider internal changes they may not otherwise have entertained.

The crisis context

According to Caplan (1964, 1989) crises emerged from exposure to hazardous interpersonal and community environments. Precipitating factors included exposure to stressful events, particularly those that featured loss, but were also associated with developmental life transitions (Erikson, 1963). More recently, composite interactive crisis models have highlighted the importance of sociocultural influences and transitions in the development and resolution of crises (Hoff, Hallisley & Hoff, 2009). Applications of crisis theory to a wide range of specific presenting concerns have been widely documented (e.g. Roberts, 2000; France, 2007; Dattilio & Freeman, 2007).

The crisis experience

However, crises are uniquely individual and are ultimately about the internal experience and interpretation of events or transitions rather than inevitable products of exposure to stressors (Morley, 1970). This interaction between events and their subjective meaning as the fulcrum for understanding crises was later embedded in cognitive therapy and definitions of post-traumatic stress (e.g. Everly & Lating, 2005). It identified individuals' experience and appraisal of stressful events and their coping capacity as a key factor influencing outcomes.

Crisis dynamics

The influence of Caplan's crisis theory is widely evident in current crisis intervention practice (e.g. Roberts, 2000; France, 2007). However, his guiding assumptions about crisis dynamics have been the focus of discussion and debate (Hoff, Hallisley & Hoff, 2009). While Caplan challenged and broadened many working assumptions of his medical colleagues the influence of disease and illness concepts was more prominent in his early work than they are in crisis intervention practice today.

Similarly, his explanatory models, especially in the early years, were strongly influenced by analytic theory, particularly ego psychology. Its focus on the coping part of the personality became a bridge to his articulation of competency as a key construct in later refinements of his model (Caplan, 1989). In this later work, Caplan also integrated contributions from stress, coping and social support literature as well as cognitive-behavioural theory into his model of crisis intervention which became more interactive and less linear. These influences have become more prominent in contemporary crisis theory and practice (e.g. Everly & Lating, 2005; Dattilio & Freeman, 2007).

Perhaps the most contentious assumption in Caplan's early work was his reliance on prevailing mechanistic models for explaining crisis dynamics (Ramsay, 1997). Crises were viewed as a disruption to the state of equilibrium presumed to exist in the pre-crisis state and crisis intervention sought to restore the balance. However, this somewhat static perspective subsequently developed to include more interactive working models (Caplan, 1989).

Arguably, restoration of equilibrium is a limited and sometimes unattainable goal in the immediate aftermath of crises. Attaining some level of stability and safety during a crisis provides a psychological platform for developing changes in cognitive outlook, coping style and behavior that might include improved capacity to live with volatile, continually changing environments.

Contemporary approaches have also placed greater emphasis on the the role of resilience in dealing with crises (Bonanno, 2009, 211) and their capacity to engender growth (Joseph, 2011).

Mapping the psychological terrain of crises in their original conceptualisations and subsequent refinements established foundations for navigating them safely, resourcefully and purposefully. However, before considering how crisis theory shaped intervention frameworks it is important to review the wider prevention function these interventions were designed to fulfill.

Positioning and Role in Primary Care

According to the seminal WHO report:

...primary care brings promotion and prevention, cure and care together in a safe, effective and socially productive way at the interface between the population and the health system....[and needs to] give balanced consideration to health and well-being as well as to the values and capacities of the population and the health workers (WHO, 2008, p.41).

Crisis intervention was originally framed and positioned as part of a broad strategy with a health promotion goal and an intervention strategy that served a prevention purpose. The following review illustrates how closely the original formulations of crisis theory and practice align with this WHO framework for primary care.

Crisis intervention as a prevention strategy

Timely accessible crisis interventions were positioned as part of a preventive strategy designed not only to provide valued support during a crisis but also reduce the likelihood of more severe mental health complications (Caplan, 1964). The risk of such complications was believed to increase if failure to address the crisis led to escalation of anxiety and progressive inability to address the challenges it presented.

Caplan acknowledged the influence of his Harvard colleague, Erich Lindemann on his own formulations of crisis theory and belief in the preventive potential of crisis intervention (Caplan, et al.,1984). Lindemann (1944) had published one of the earliest studies on bereavement, based largely on people impacted by a 1942 fire in the Cocoanut Grove Melody Lounge in Boston which claimed 492 lives. One conclusion from the study was that 'grief work' following significant loss contributed to adaptive outcomes while people who subsequently developed health complications had become stuck in the grieving process. The interest in community prevention arising from this study provided impetus to establishing the Wellesley Project in Boston, arguably one of the first community mental health centres to apply principles of preventive care (Morley, 1970).

Caplan (1964) developed a taxonomy first articulated in the 1950s that distinguished three domains of prevention activity. Primary strategies were designed to reduce the incidence (new cases) of mental disorders. Secondary responses focused on early intervention and sought to limit the severity and duration of crises and of nascent mental health problems while tertiary initiatives had a recovery focus that sought to contain residual impairment from a mental health condition.

Caplan's (1964) approach to crisis intervention focused mainly on primary prevention. In this framework, the broader contextual goal was to modify the conditions of risk. It sought to reform policy and ameliorate socio-economic factors and other hazardous conditions likely to increase stress in people exposed to them. Community awareness, health promotion and education activities also played a role. However, since complete elimination of such hazards was unrealistic and individual responses to them varied so greatly, a second goal was more personally directed. It sought to understand life crises and find ways to enable adaptive responses to them.

Uncontained emotional arousal in stressful situations has also been shown to increase vulnerability to physical or mental illness (Caplan, 1981). Key mechanisms included the detrimental effect of emotional arousal on cognitive functioning and problem solving and an erosion in the individual's belief in their ability to manage stressful situations. This finding highlights the importance of informal supports and formal interventions in helping to contain emotional arousal, improve morale and enhance problem solving capabilities.

Caplan (1964, pp16-17) articulated the thinking behind preventive mental health.

Insofar as we direct our programs to populations rather than to individuals we have the chance of altering the general balance of forces so that, although not all will benefit, many may have a greater chance of escaping illness. Certain individuals may have so fortunate a position or privileged a background that even apart from our program they would not become ill. Other individuals may have the dice so loaded against them by their idiosyncratic situation and experience that no amelioration of the general community picture would be sufficient to prevent their falling sick. The target of the community program of primary prevention is the large intermediate group, consisting of individuals in whom the balance of forces is not clearly loaded in one direction or another, and who would be enabled to find a healthy way of solving life's problems if the latter were somewhat reduced or if they get a little extra help.

Caplan progressively refined his crisis intervention framework into an overarching conceptual structure named the *recurring themes model of primary prevention* (Caplan, 1989; Caplan, Caplan & Erchul, 1994). Within this model, historical and current risk factors such as bio-psychosocial stressors and vulnerabilities were mediated by crisis management processes such as coping competencies and social supports to influence outcomes. Community initiatives, crisis intervention, consultation and the provision of social support were among intervention strategies designed to improve the prospects of good outcomes. These later refinements in the model reflected the increasing influence of cognitive-behavioural studies on stress and coping (e.g. Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Moos, 1986).

Some strategies to implement the model sought to anticipate stressful challenges, such as hospitalisation. They offered '*anticipatory guidance and emotional inoculation*' by reviewing common emotional reactions to such events so that these responses, if experienced, would be viewed as normal. The goal was emotional preparation and practical rehearsal.

Other '*preventive intervention*' strategies aimed to strengthen coping during a crisis. They sought instill hope by reminding people of their pre-crisis identity and capabilities and of how others have worked through similar experiences. They enhanced competencies to address the immediate crisis while containing negative emotions that may disable or underline coping capabilities.

Crisis intervention to prevent suicide

The emerging emphasis on prevention, crisis intervention and community care also significantly influenced the birth and growth of the suicide prevention movement in the 1960s (Wallace, 2001). The discipline of suicide prevention took shape through the pioneering clinical and research work of the Los Angeles Suicide Prevention Center – LASPC (Farberow, Shneidman & Litman, 1966; Farberow, Heilig & Parad, 1994). The growing interest in prevention is evident in the evolution of the Center's work from follow-up of people hospitalised after suicidal behavior to anticipating and addressing suicidal crises before self-injury occurred as a way of preventing suicide deaths.

The Center's clinical team conceptualised suicide as a crisis and their model of care was crisis intervention. They focused particularly on the 'pre-suicidal state' as a transient period of vulnerability exhibited by some individuals in the aftermath of trauma or significant stress which typically featured loss of something or someone of value to them. They observed that this period of vulnerability to suicide occurs 'when people are overwhelmed in a given situation and feel helpless to influence the outcome. There is a painful sense of hopelessness and a constriction of perception, especially of choices or options' (Litman, 1994, p. 120). The goal of crisis intervention in their approach was to help individuals at risk safely manage this transient period of elevated suicide risk so that further help could be accessed and underlying issues could be addressed.

The practical challenge was to identify who may be entering what Litman (1989) called the 'suicide zone'. Guidance came from discoveries associated with psychological autopsies of unequivocal suicides which found that 90% of these individuals gave clues about their intentions in the weeks preceding their suicide deaths (Shneidman, 1996). Work with suicidal persons yielded the further insight that most people considering suicide were ambivalent about it and would rather live if they could find a way through painful, seemingly intractable problems in living (Litman, 1996).

These two discoveries – awareness of suicide clues and ambivalence – presented the intervention opportunity and remain foundational to suicide prevention today. Signaling suicidal intent provided ways of recognising and engaging persons at risk. Ambivalence invited understanding of what lay behind thoughts of suicide but also provided an entrée into the person's desire to live that could arouse interest in getting help and motivation for keeping safe.

Consistent with crisis theory, clinical experience at the LASPC indicated that if people could be safely assisted through periods of suicidal intensity, prospects of receiving further assistance for concerns associated with the suicidal crisis could be addressed.

However, Litman's follow-up studies led him to conclude that the crisis model was most suited to people who had a psychologically stable baseline before encountering traumatic events and that crisis intervention needed to be complemented by other treatment plans for persons who were chronically suicidal (Litman, 1970; Litman, 1994).

The work of the LASPC and the crisis lines that adopted its intervention model addressed all three levels in Caplan's prevention model. They promoted primary prevention by raising awareness of suicide as a public health problem and encouraging help-seeking by reducing stigma. They were first to challenge suicide myths (Shneidman & Mandelkorn, 1994). Reducing the incidence of suicidal behavior by responding to people in a pre-suicidal state is also a primary prevention strategy. The focus on early intervention was a secondary prevention strategy that sought to limit the duration and severity of suicidal episodes. Tertiary prevention is reflected in the LASPC's interest in follow-up aftercare for people who had already exhibited suicidal behavior.

Evaluation themes

Caplan (1989) acknowledged that while the clinical utility of the crisis model has been widely recognised, research validation of crisis intervention's prevention role has proved challenging. He identified the fundamental methodological obstacle associated with obtaining objective measures of an individual's pre-crisis state so that intervention effects could be measured. For this reason, Caplan believed that crisis concepts were appropriately viewed as clinically valuable models not yet fully grounded in scientific theory.

By contrast, Caplan (1989) reviewed research demonstrating the beneficial impact of social support for highly stressed individuals. These studies showed that less supported people were much more likely to develop subsequent physical or mental health complications than those who were well supported. Personal capacity to seek and maintain these supports also play a critical role in realising these benefits. Personality traits are likely to be a key element in this capacity.

Research on helplines has assessed their capacity to facilitate measurable changes in callers' crisis or suicidal state (Kalafat et al., 2007; Gould et al., 2007). Results showed significant positive changes during the call consistent with service crisis management and suicide intervention objectives and found that follow-on benefits from crisis line contact were evident at follow-up in the weeks immediately after the call. The studies also identified challenges associated with variable standards in service provision, highlighting performance issues discussed later in this paper.

Preventive interventions with people bereaved by suicide have also been the subject of research inquiry. An active postvention program at the Baton Rouge Crisis Intervention Center significantly shortened the elapsed time before bereaved individuals were linked into supports (Campbell, Cataldie, McIntosh and Millet, 2004). A review of the literature on responses to suicide survivors found evidence of some beneficial impact, but noted that further work was needed to scientifically verify good outcomes (Jordan & McMenamy, 2004). A research agenda in this field has been proposed (McIntosh & Jordan, 2011).

Overall, while crisis intervention practitioners and consumers who receive crisis support often attest to the benefit of these services, evaluation support is best characterised as promising but fragmentary. The development of more standardised practices, training and consultative processes will provide stronger foundations for evaluation and research. Description of crisis intervention practice principles and requisite helper competencies that enable their implementation are key elements in achieving this goal and are discussed in the concluding sections of this paper.

Connecting prevention goals and crisis intervention practices

Crisis care cannot be fully understood without reference to its positioning as a public health, primary care strategy with a population focus and a prevention purpose.

Contextually, crisis care views health, wellbeing and safety through a wide lens that captures the whole landscape of environments that can contribute to and escalate problems in living but also provide resources for their effective resolution. However, the practice of crisis intervention is viewed through a more tightly focused lens that reveals the dynamics of individual crises and identifies specific strategies and competencies that help address them resourcefully.

Practice Principles in Crisis Intervention

Crisis intervention works collaboratively with people to reduce anxiety, contain disabling emotions, fortify coping and broaden the person's repertoire of internal resources and external supports. Acknowledging distress, understanding the personal meaning of the crisis and helping people review their appraisal of options and resources are also key elements.

Crisis intervention is a time-limited strategy, focused on immediate concerns, to help people manage painful life experiences and transitions. The intensity and sense of urgency associated with the crisis potentially increases the person's openness to consider and attempt new ways of managing the situation.

Key elements in crisis management

Caplan (1989) identified *competence* and *social support* as key domains to address in crisis intervention. Competence captured inherited traits and learned skills that could improve adaptive responses to crises. Social support was designed to enhance the protective and enabling resources available to people during stressful periods. The focus was on the individual's willingness and ability to seek, secure and sustain these supports but also on assisting those surrounding a person in crisis to provide appropriate crisis care.

Subsequent refinements of crisis intervention theory and practice have sought to elaborate on key elements that assist crisis management. For example, Moos (1986) clustered coping skills into appraisals (which assign meaning and frame perceptions of the challenge), problem solving (including support seeking and problem solving action) and management of emotion (how people express, modulate and contain their affective response to the crisis).

Studies on resilience have sought to identify factors that influence the capacity of individuals to respond in adaptive and growth-oriented ways to highly disruptive stressors (e.g. Bonanno, 2004; Bonanno et al., 2007).

France (2007) has summarized research indicating that avoidant coping patterns or those that focus exclusively on emotional catharsis and tension-relief have limited sustained impact on problem resolution. By contrast, problem solving strategies are consistently related to good outcomes by addressing key issues at the heart of the crisis (e.g. Kalafat, 2002a; Kalafat, 2002b).

The enhancement of coping skills (including appraisal review and improved problem solving) need to be applied not only to the presenting stressors but also to attitudes and behaviours toward social supports, including potential referrals. These may feature maladaptive personality styles which display rigid, often self-defeating patterns of engagement with others (Millon & Davis, 1996). They may also be influenced by readiness for change and invite intervention strategies that improve motivation. For Miller (1989) this motivation is primarily about problem acknowledgement and searching for a different way of addressing it more effectively.

Whatever the factors involved, it is vital that intervention works with people in crisis not only to address their presenting concerns but also their attitudes and behaviours toward engaging and sustaining informal and formal sources help. In some cases, addressing factors that impede or enable prompt access to safety or further support may be the primary focus of the intervention. If links to further, appropriate, help are strengthened, people can readily access care or treatment that helps them deal with the more substantial issues behind the crisis. Active engagement with the processes that affect seeking and sustaining helping relationships is likely to be more effective than simply providing referral options and information at the end of an intervention.

Crisis intervention tasks

Understanding these key elements in crisis management invites consideration of intervention activities that will address them effectively. The following tasks are grounded in the review of relevant literature in this paper and provide ways of enhancing competency, coping and social support in people managing crises.

- **Build understanding.** Crises are uniquely personal and intervention begins with making contact that establishes trust and promotes understanding. It is important to hear each person's unique perspective on the meaning of stressful events and experiences in their lives and why they are causing significant distress now. Their appraisal of the situation they are facing, its potential implications and their own capacity to meet its challenges provides a starting point for the intervention but also clues about concerns it will need to address.
- **Alleviate distress.** Effective crisis management will seek to mitigate the impact of stressful situations and then reduce the intensity of the crisis state by attending to anxiety, pain and other disabling thoughts or feelings about present concerns and future uncertainties. Alleviation of distress helps reduce emotional pressures that create a sense of urgency, cloud judgement and impair decision-making. Balancing opportunities for emotional expression with affective containment helps people unburden their distress but not to the point where it immobilises practical coping.
- **Focus and assess.** The caregiver and person in crisis need to work toward a shared understanding of those dimensions of the crisis that most need attention now. Since persons in crisis typically feel overwhelmed, crisis intervention needs to limit the focus to achievable short-term goals which, when successfully addressed, can restore confidence and reaffirm competency. Assessment of immediate threats to life or safety is an essential part of this process along with a review of the problem and current resources. Specific assessment protocols are needed for particular situations such as when thoughts of suicide are present.
- **Manage problems.** Problem-focused coping is central to crisis management and seeks actively to engage those practical aspects of the crisis that need immediate attention. Key aims are to collaborate with the person to break down immediate problems into manageable elements and develop an achievable action plan to address them. The strategy often includes providing information and may involve withdrawing from a hazardous or dangerous situation or keeping safe from harm or suicide. It will seek ways to reduce or overcome stressors that are amenable to change or to live more resourcefully with permanent new realities. Since crises typically challenge and sometimes defeat traditional coping patterns, crisis resolution typically calls for an expanded repertoire of internal coping capabilities.
- **Increase social support.** Crisis management strategies require a collaborative review of available sources of informal and formal support and decisions about what further specific sources of help, if any, are needed. The person's attitudes toward potential supports, helpseeking behaviours and patterns of service utilisation form part of this review to improve the likelihood that social supports will actually be engaged and sustained. Follow-up to ensure continuity of care is also indicated along with direct engagement of those surrounding the person in crisis so that their networks can work together to address immediate and ongoing concerns.

Crisis intervention process

Crisis theory and practice also guides the helping process within which intervention tasks are addressed. A fundamental premise is that people in crises have within them the capacity to manage stressful events and can be enabled to do so through expanding their own coping resourcefulness or accessing supplementary supports. Caplan (1989) viewed the helper's role in preventive interventions as an auxiliary ego that supplemented the flagging morale and resources of individuals in crisis.

Accordingly, the intervention process seeks non-hierarchical, empowering strategies that establish trustful connections with people in crisis and work as collaboratively as possible with them to address their concerns. To achieve this, crisis intervention must acknowledge and balance two competing realities. To the extent that current coping capacity is stressed or overwhelmed, guidance and support is needed. However, it is important not to intensify helplessness or foster dependency but rather to increase individuals' confidence in their ability to get through stressful times and to find fresh sources of strength within themselves or through more flexible, informed use of supports.

Part of this process has been characterised as balancing directive and non-directive helping styles (Rogers, 1942). Mishara and colleagues found establishing good contact had the strongest association with good caller outcomes followed by collaborative problem solving in research with crisis line workers (Mishara, Chagnon, Daigle, Balan, Raymond, Marcoux, Bardon, Campbell & Berman, 2007). Observer ratings in the study also found that a mixed, collaborative style was associated with the best outcomes in research with crisis line volunteers.

Working with this balance involves knowing when to be directive and when to adopt a more facilitative approach that enables people to find their own solutions. These process decisions will be influenced by assessing an individual's needs and capabilities at a given point in the crisis and remaining sensitive to how these change in an evolving crisis situation and its aftermath.

Applications to suicide intervention

The generic template of crisis intervention tasks and collaborative processes provides a framework that can be enhanced by specific measures that address particular crisis situations – including those that pose immediate threats to life or safety.

When the presence of suicidal thoughts has been identified it is imperative that intervention gives priority attention to increasing the person's immediate safety. A safeplan needs to be individually tailored, address factors contributing to immediate risk and enabled by measures and resources that increase immediate safety and prevent a suicide death.

While discussion of suicide assessment and intervention in suicidal crises is beyond the scope of this paper, it is noteworthy that a significant literature is available (e.g. Farberow et al., 1994; Shneidman, 1999; Rudd, Joiner & Rajab, 2001; Joiner, 2005; Jobes, 2006). Specific evidence-informed suicide risk assessment frameworks for crisis lines have also been proposed (Joiner, Kalafat, Draper, Stokes, Knudson, Berman, & McKeon, 2007).

Crisis interventions with suicidal persons are guided by Shneidman's (1996) insight that desperation from unbearable pain is at the heart of most suicidal crises and that finding ways to hear and alleviate this pain improves prospects for safe outcomes. Joiner has proposed a more interpersonal understanding that views perceived burdensomeness and thwarted belonging as key elements in the psychological pain that ignites suicidal desire (Joiner, 2005; Ribeiro & Joiner, 2009). In his model, the prospect for fatal outcomes is increased when suicidal desire is complemented by suicidal capability through sustained exposure to painful events and the desensitisation associated with previous suicide attempts.

Overall, crisis intervention needs to be vigilant about the presence of suicide thoughts or desire. While understanding, assessing and responding to suicidal crises needs to be cognisant of common presenting themes, attending to the specific safety needs of each individual is paramount.

Preparing helpers to provide crisis care

Crisis theory and intervention practice has focused not only on key tasks and processes but also on those who provide help. It has believed and demonstrated that crisis care can be applied in diverse settings by informal helpers as well as those in professional service roles. It has sought to improve the quality of that care by identifying desirable helper characteristics. It has also described and modeled ways that people can be prepared and supported to fulfill specific crisis intervention roles to a high standard. This section briefly reviews these themes and practices along with the literature that supports them.

Crisis intervention helpers

Crisis intervention was influenced by and contributed to a broadening view of who could play a role in providing care to people managing stressful circumstances or experiencing mental health needs. Accordingly, crisis intervention practice addresses significant primary care priorities such as enabling affordable access, collaborative networks and continuity of support.

The decision to engage a wider range of helpers was adopted, partly, to remedy a human resources capacity problem in providing access to care. Proximity was also a guiding principle, providing access in person or through crisis lines to people where they lived. Further, since crisis intervention comprised a discrete skillset for managing transient adaptation challenges, wider clinical training was not a pre-requisite, provided that people focused on role-appropriate tasks within the range of their competencies and training preparation.

Volunteers played an increasingly prominent role. The pioneering work of the Samaritans, later called Befrienders, Crisis Centres in North America and Europe and Lifeline in Australia laid foundations for deployment of volunteers in crisis lines and other service settings (Varah, 1973, 2001; Mishara & Daigle, 2001; Bezencon, 2001; Dominish, 2001).

The impact of this human resources revolution was such that Dublin (1969), a pioneering figure in suicide prevention, noted that 'the lay volunteer was probably the single most important discovery in the fifty year history of suicide prevention' up to that time.

The valued contribution of trained volunteers was also recognised by the clinical staff at the Los Angeles Suicide Prevention Center (Farberow, 1994). They noted that professional scepticism about these services was allayed by recognising their capacity to deal with immediate suicidal crises and then provide a gatekeeper role as an entrée into ongoing care.

The effectiveness of volunteers ('paraprofessionals') was reflected in a review of 1700 published studies on their work, 51 of which were related to crisis intervention (Durlak & Roth, 1983). Findings were generally supportive of their value, provided these workers focused on roles that they had been trained to fulfill. However, issues of variable performance were noted along with methodological challenges, including the lack of standardised practices or evaluation measures. More recent research on crisis lines has supported volunteers' effectiveness in crisis intervention and suicide prevention while noting variable performance and emphasising the need for supervision and training (Mishara et al., 2007; Kalafat et al., 2007) These challenges apply equally to professional helpers in front line crisis support roles, highlighting a need for improved quality control in primary prevention supported by training and consultation processes (Caplan, Caplan & Erchul, 1994; Caplan & Caplan, 2001).

Helper Characteristics

One avenue for improving effectiveness of crisis support helpers has been to identify personal characteristics that facilitate good outcomes. This approach draws on Rogers' (1985) work on the importance of a non-judgemental accepting environment that establishes trust and builds empathic understanding.

The unique potential of trained volunteers was increasingly recognised in early crisis line literature.

What matters most, especially in the more acute cases, are those traits of human concern for people, good judgement, and determination to intervene which cut across disciplines or professional – nonprofessional categories (McGee & Jennings, 2002 p. 232).

Recent research has found that the crisis line workers' capacity to show empathy and respect improved the prospects for good outcomes (Mishara et al., 2007). The authors noted that these were natural personal qualities helpers bring to their role rather than skills fashioned through training – highlighting the importance of selecting people with attributes suited to their roles.

Kalafat (1983, 2002b) outlined specific requirements for crisis line workers.

The job calls for an active approach that has as its aim the development of a collaborative relationship with an essentially healthy individual or the search for competence in an acutely or chronically dysfunctional individual. It also entails the liaison with and mobilisation of a variety of institutional and / or interpersonal support systems. In addition, crisis workers must be able to engage in this problemsolving in a wide variety of stressful situations, while resisting the temptation to assume complete responsibility for confused individuals in crisis (Kalafat, 2002b, p. 261).

Thus, while crisis care is guided by intervention frameworks, the role also calls for people who can respond flexibly and resourcefully to the requirements of individuals seeking their assistance. Crisis intervention literature has proposed various strategies to develop these competencies.

Role boundaries and harm avoidance

A foundational responsibility is to ensure that interveners do no harm. This issue was identified in Varah's (1975, 2001) early work with the Samaritans and has been addressed specifically in crisis intervention literature. Unnecessarily intrusive interventions have been targeted along with those that complicate rather than resolve crises

Caregiving professionals, often with the best of intentions, intervene uninvited in situations that they define as abnormal, or as predicting the development of later psychopathology because the cases fall into a statistically high-risk category. Such interventions may in fact be unnecessary and uneconomic, recruiting cases that might have been resolved by themselves. But more seriously, they can be positively harmful, adding pathogenic influences and an extra dimension of trouble to the lives of people, thereby mocking the whole purpose of primary prevention (Caplan et al., 1994, p.9).

The authors encourage consideration of the capacity for resilience and natural crisis resolution capability in the majority of people exposed to stressors.

Two broad causes of iatrogenic harm from helpers are identified. One involves attempting intervention tasks that are beyond the range of the helper's knowledge or skill which can sometimes elevate distress rather than containing it. The second more complex transgression concerns caregivers who overestimate their competence but lack the professional judgement to use skills appropriately or consider the wider implications of their interventions (Caplan et al., 1994; Caplan & Caplan, 1999).

These observations emphasise the importance of self-awareness in caregivers, appreciation of role boundaries, recognition of limits to competence and the importance of enabling links to wider supports and higher levels of care, when needed. Good judgement as well as sound knowledge and competencies are needed.

Developing crisis intervention competencies

Competency is a central construct in crisis intervention (Caplan, 1989). Crisis intervention competencies in helpers are designed to enhance the capacity of people in crisis to manage stressful experiences. Preparation for crisis support has therefore prominently featured competency-based training that builds on adult learning principles and addresses the domains of knowledge, attitudes and skills (Knowles, 1973; Egan, 1975; Klemp, 1980).

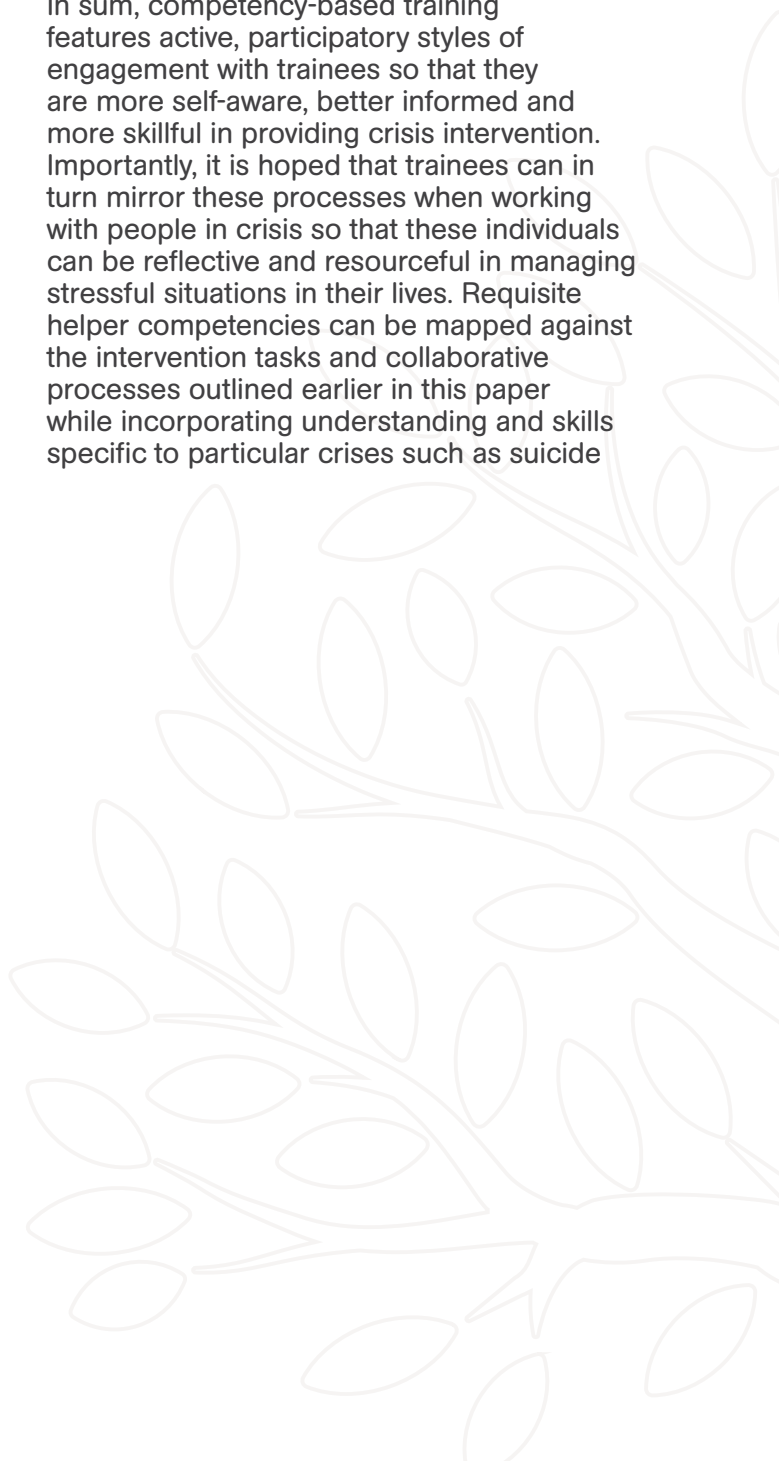
Adopting this framework, Kalafat (1983) stressed the importance of building helpers' capacity to apply core crisis intervention principles flexibly to the needs of specific individuals. The key to achieving this goal in his framework was participatory learning as distinct from relying solely on passive learning such as lectures. Active learning was seen as an essential preparation for equipping helpers to encourage resourceful problem solving with people in crisis.

Kalafat (1983) noted how a fundamental tenet of crisis intervention was to minimise the gap between helpers and consumers by encouraging people in crisis to identify, expand and mobilise coping resources within and around them. This ensures that crisis helpers remain 'transitional figures' rather than permanent fixtures who foster dependency. Crisis intervention training therefore sought to model and parallel this process by encouraging trainees to tap into their own strengths, think resourcefully and access wisdom resident within the group as well as trainers' expertise. Promoting self-awareness about personal factors likely to help or hinder an intervention were also incorporated. This approach has been foundational to training crisis line workers (Kalafat, 1983; 2002b).

Comprehensive training programs were also developed for suicide intervention. There was a particular focus on developing and disseminating such programs for community 'gatekeepers' in formal and informal helping roles (Snyder, 1971). Rothman's (1980) research and development model provided a framework for developing curricula that would facilitate research and clinical knowledge transfer to people in formal and informal frontline helping roles.

This model was adopted in the 1980s by the developers of LivingWorks' two-day suicide intervention workshop, subsequently called ASIST (Ramsay, Tanney, Lang, Kinzel & Tierney, 2004). This process of facilitating knowledge transfer epitomised the commitment in crisis intervention to avoid quarantining professional knowledge within clinical circles. It sought to demystify key concepts, making knowledge accessible to both helpers and consumers.

In sum, competency-based training features active, participatory styles of engagement with trainees so that they are more self-aware, better informed and more skillful in providing crisis intervention. Importantly, it is hoped that trainees can in turn mirror these processes when working with people in crisis so that these individuals can be reflective and resourceful in managing stressful situations in their lives. Requisite helper competencies can be mapped against the intervention tasks and collaborative processes outlined earlier in this paper while incorporating understanding and skills specific to particular crises such as suicide



Developing consultative and collaborative processes

While training provides foundational preparation for crisis intervention, a need for ongoing learning informed by reflection on practice was identified. Since the 1950s, Caplan developed and progressively refined a framework for mental health consultation as a public health strategy. It was distinguished from counselling in that the client's welfare was paramount. However, it sought to focus less on the details of the client's situation than on factors in the consultee (such as knowledge limitations, attitudinal barriers or skills deficits) that affected their ability to provide appropriate assistance to individuals in crisis (Caplan et al., 1994). Consultation was viewed as a primary prevention tool in that more competent interventions would enhance the quality of care within organisations and the wider community and reduce the likelihood transient crises would deteriorate into more sustained mental health problems. The consultation framework was mapped to Caplan's 'recurring themes model of primary prevention'.

A fundamental assumption behind the consultative process was that people from a wide range of professional contexts and those in volunteer roles could, with appropriate support, be resourced to provide crisis care. Applications to specific organisational and helper settings have been discussed and illustrated (Caplan & Caplan, 2003.). Non-hierarchical relationships between consultants and consultees were designed to mirror and model the collaborative, competency-based helping styles that carers were encouraged to adopt when working with individuals in crisis.



Summary and Future Directions

The experience of human crises is an integral part of the human journey and a present reality for many impacted by public disasters or painful personal circumstances.

Helplines have an opportunity to articulate and demonstrate the purpose, nature and benefits of crisis care as they position and promote the distinctive role and contributions of their services, worldwide.

Crisis support seeks to provide immediate benefit to people in crisis by enabling them to manage stressful experiences more resourcefully. However, timely intervention also seeks to alter the trajectory of escalating crises so that their pathway is oriented toward help and healing rather than negative health complications or suicide.

A key theme in crisis intervention has been its capacity to engage a diverse range of paid and volunteer workers. This, along with the widespread utilisation of phone and more recently webbased services, has helped make care accessible to people close to their everyday life situation. It strengthens community capacity for crisis response and is cost effective.

A review of the origins and development of crisis intervention reveals a living legacy of conceptual frameworks, practice models, tasks and processes that can inform the current implementation and future development of crisis care within the community.

However, it also identifies challenges surrounding the development of practice models and standardised approaches to crisis intervention that would promote consistent practice and provide more stable foundations for research, evaluation and service development. The establishment of core competencies in crisis intervention would focus the roles and requirements of those who provide care. It would also inform education and training and guide consultation, supervision and mentoring strategies that improve performance of crisis workers and enable better outcomes for consumers.

Articulating strategies to address these challenges would help progress the whole field of crisis intervention and strengthen its contribution to primary care.

Since Erich Lindemann's pre-natal role in crisis intervention is widely acknowledged, it is fitting that a concluding reflection for this paper is provided by Warren Vaughan, one of his protégés. Vaughan reports a visit from his mentor to the model community mental health centre he had developed as part of a local hospital. Noting the 'Crisis Intervention' sign above an office door, Lindemann remarked: 'Ah, here it is! It's finally built into the system' (Caplan et al., 1985). This 1970s declaration may well have been premature, but it offers a vision to which primary care practitioners could well aspire today.

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