

The Seven-Stage Crisis Intervention Model: A Road Map to Goal Attainment, Problem Solving, and Crisis Resolution

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This article explicates a systematic and structured conceptual model for crisis assessment and intervention that facilitates planning for effective brief treatment in outpatient psychiatric clinics, community mental health centers, counseling centers, or crisis intervention settings. Application of Roberts' seven-stage crisis intervention model can facilitate the clinician's effective intervening by emphasizing rapid assessment of the client's problem and resources, collaborating on goal selection and attainment, finding alternative coping methods, developing a working alliance, and building upon the client's strengths. Limitations on treatment time by insurance companies and managed care organizations have made evidence-based crisis intervention a critical necessity for millions of persons presenting to mental health clinics and hospital-based programs in the midst of acute crisis episodes. Having a crisis intervention protocol facilitates treatment planning and intervention. The authors clarify the distinct differences between disaster management and crisis intervention and when each is critically needed. Also, noted is the importance of built-in evaluations, outcome measures, and performance indicators for all crisis intervention services and programs. We are recommending that the Roberts' crisis intervention tool be used for time-limited response to persons in acute crisis. [*Brief Treatment and Crisis Intervention* 5:329–339 (2005)]

KEY WORDS: crisis intervention, lethality assessment, establish rapport, coping, performance indicators, precipitating event, disaster management.

We live in an era in which crisis-inducing events and acute crisis episodes are prevalent. Each year, millions of people are confronted with crisis-inducing events that they cannot

resolve on their own, and they often turn for help to crisis units of community mental health centers, psychiatric screening units, outpatient clinics, hospital emergency rooms, college counseling centers, family counseling agencies, and domestic violence programs (Roberts, 2005).

Imagine the following scenarios:

- You are a community social worker or psychologist working with the Houston

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Police Department to deliver crisis intervention services to police, emergency responders, and survivors of Hurricane Katrina who just arrived at the Houston Astrodome disaster shelter. It is midnight and one of the survivors (who was brutally raped 1 week prior to Hurricane Katrina) wakes up screaming and throwing things at the young man in the cot next to hers. You were walking out the door to drive home and get a few hours sleep, but instead you are called on the loudspeaker to defuse the acute crisis episode and provide crisis intervention services.

- You are a crisis consultant to a large Fortune 500 corporation, and a volatile domestic violence-related shooting took place last week at the corporate headquarters. The employee assistance counselor, the director of training, the director of strategic planning, and the director of disaster planning want you to provide crisis intervention training to all employee assistance counselors and all corporate security officers.
- You are the new psychiatrist in an inpatient psychiatric unit with 50 patients diagnosed with co-occurring disorders; over the weekend a patient assaulted the psychiatric resident you are supervising. The resident wants to be transferred to another unit of the hospital because he had a nightmare and cold sweats last night. What do you do now? What types of training should be provided to all psychiatric residents and mental health clinicians in order to prevent patient–staff conflict from reaching a crisis point?
- You are the counseling psychologist at a state university assigned to see walk-in emergency clients. An 18-year-old freshman appears one afternoon and tells

you she just came from her residence hall room and found her boyfriend in bed with her “best friend” roommate. Now she tells you she is seriously considering taking an overdose of nonaspirin pain capsules in their presence to “teach them a lesson.” How can crisis intervention help her to find adaptive coping skills and a more effective problem-solving approach to her predicament?

This article delineates and discusses a systematic and structured conceptual model for crisis intervention useful with persons calling or walking into an outpatient psychiatric clinic, psychiatric screening center, counseling center, or crisis intervention program. A model is a prototype of the real-life clinical process the crisis clinician/counselor would like to implement. A systematic crisis intervention model is analogous to establishing a road map as a model of the actual roads, highways, and directions one will be taking on a trip. Thus, the clinician can visualize the implications of each proposed crisis intervention guidepost and technique in the model’s process and sequence of events and make any necessary adjustments before the program is fully operational. The model is a series of guideposts that makes it easier to remember alternative methods and techniques, thus facilitating the counseling process. By learning about each component or stage of a model, the clinician will better understand how each component relates to one another and should facilitate goal attainment, problem solving, and crisis resolution.

The focus of this article is on the clinical application of Roberts’ seven-stage crisis intervention model (R-SSCIM) to those clients who present in a crisis state as a consequence of an interpersonal conflict (e.g., broken romance or divorce), a crisis-inducing event (e.g., dating violence and sexual assault), or a preexisting mental health problem that flares-up.

Crisis states can be precipitated by natural disasters, such as Hurricane Katrina, which took place as this article went to press. However, there is a functional difference between crisis intervention and disaster management. A large-scale community disaster such as a major hurricane first requires disaster management, then emergency rescue services. The first two phases address the event itself, rather than the psychological needs and responses of those who experienced the disaster. For some, the event will overwhelm their ability to cope; it is those people for whom R-SSCIM is invaluable. We will discuss the differences between disaster management and crisis intervention later in this article.

Crisis clinicians must respond quickly to the challenges posed by clients presenting in a crisis state. Critical decisions need to be made on behalf of the client. Clinicians need to be aware that some clients in crisis are making one last heroic effort to seek help and hence may be highly motivated to try something different. Thus, a time of crisis seems to be an opportunity to maximize the crisis clinician's ability to intervene effectively as long as he or she is focused in the here and now, willing to rapidly assess the client's problem and resources, suggest goals and alternative coping methods, develop a working alliance, and build upon the client's strengths. At the start it is critically important to establish rapport while assessing lethality and determining the precipitating events/situations. It is then important to identify the primary presenting problem and mutually agree on short-term goals and tasks. By its nature, crisis intervention involves identifying failed coping skills and then helping the client to replace them with adaptive coping skills.

It is imperative that all mental health clinicians—counseling psychologists, mental health counselors, clinical psychologists, psychiatrists, psychiatric nurses, social workers,

and crisis hotline workers—be well versed and knowledgeable in the principles and practices of crisis intervention. Several million individuals encounter crisis-inducing events annually, and crisis intervention seems to be the emerging therapeutic method of choice for most individuals.

Crisis Intervention: The Need for a Model

A “crisis” has been defined as

An acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and there exists evidence of distress and functional impairment. The subjective reaction to a stressful life experience that compromises the individual's stability and ability to cope or function. The main cause of a crisis is an intensely stressful, traumatic, or hazardous event, but two other conditions are also necessary: (1) the individual's perception of the event as the cause of considerable upset and/or disruption; and (2) the individual's inability to resolve the disruption by previously used coping mechanisms. Crisis also refers to “an upset in the steady state.” It 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. (Roberts, 2005, p. 778)

Given such a definition, it is imperative that crisis workers have in mind a framework or blueprint to guide them in responding. In short, a crisis intervention model is needed, and one is needed for a host of reasons, such as the ones given as follows.

When confronted by a person in crisis, clinicians need to address that person's distress,

impairment, and instability by operating in a logical and orderly process (Greenstone & Leviton, 2002). The crisis worker, often with limited clinical experience, is less likely to exacerbate the crisis with well-intentioned but haphazard responding when trained to work within the framework of a systematic crisis intervention model. A comprehensive model allows the novice as well as the experienced clinician to be mindful of maintaining the fine line that allows for a response that is active and directive enough but does not take problem ownership away from the client. Finally, a model should suggest steps for how the crisis worker can intentionally meet the client where he or she is at, assess level of risk, mobilize client resources, and move strategically to stabilize the crisis and improve functioning.

Crisis intervention is no longer regarded as a passing fad or as an emerging discipline. It has now evolved into a specialty mental health field that stands on its own. Based on a solid theoretical foundation and a praxis that is born out of over 50 years of empirical and experiential grounding, crisis intervention has become a multidimensional and flexible intervention method. The roots of crisis intervention come from the pioneering work of two community psychiatrists—Erich Lindemann and Gerald Caplan in the mid-1940s, 1950s, and 1960s. We have come a far cry from its inception in the 1950s and 1960s. Specifically, in 1943 and 1944 community psychiatrist, Dr. Erich Lindemann at Massachusetts General Hospital conceptualized crisis theory based on his work with many acute and grief stricken survivors and relatives of the 493 dead victims of Boston's worst nightclub fire at the Coconut Grove. Gerald Caplan, a psychiatry professor at Massachusetts General Hospital and the Harvard School of Public Health, expanded Lindemann's (1944) pioneering work. Caplan (1961, 1964) was the first clinician to describe and document the four stages of a crisis reaction: initial rise of tension from the

emotionally hazardous crisis precipitating event, increased disruption of daily living because the individual is stuck and cannot resolve the crisis quickly, tension rapidly increases as the individual fails to resolve the crisis through emergency problem-solving methods, and the person goes into a depression or mental collapse or may partially resolve the crisis by using new coping methods.

A number of crisis intervention practice models have been promulgated over the years (e.g., Collins & Collins, 2005; Greenstone & Leviton, 2002; Jones, 1968; Roberts & Grau, 1970). However, there is one crisis intervention model that builds upon and expands the seminal thinking of the founders of crisis theory, Caplan (1964), Golan (1978), and Lindemann (1944): the R-SSCIM (Roberts, 1991, 1995, 1998, 2005). It represents a practical example of a stepwise blueprint for crisis responding that has applicability across a broad spectrum of crisis situations. What follows is an explication of that model.

Roberts' Seven-Stage Crisis Intervention Model

In conceptualizing the process of crisis intervention, Roberts (1991, 2000, 2005) has identified seven critical stages through which clients typically pass on the road to crisis stabilization, resolution, and mastery (Figure 1). These stages, listed below, are essential, sequential, and sometimes overlapping in the process of crisis intervention:

1. plan and conduct a thorough biopsychosocial and lethality/imminent danger assessment;
2. make psychological contact and rapidly establish the collaborative relationship;
3. identify the major problems, including crisis precipitants;

4. encourage an exploration of feelings and emotions;
5. generate and explore alternatives and new coping strategies;
6. restore functioning through implementation of an action plan;
7. plan follow-up and booster sessions.

Stage I: Psychosocial and Lethality Assessment

The crisis worker must conduct a swift but thorough biopsychosocial assessment. At a minimum, this assessment should cover the client's environmental supports and stressors, medical needs and medications, current use of drugs and alcohol, and internal and external coping methods and resources (Eaton & Ertl, 2000).

What follows is an explication of that model.

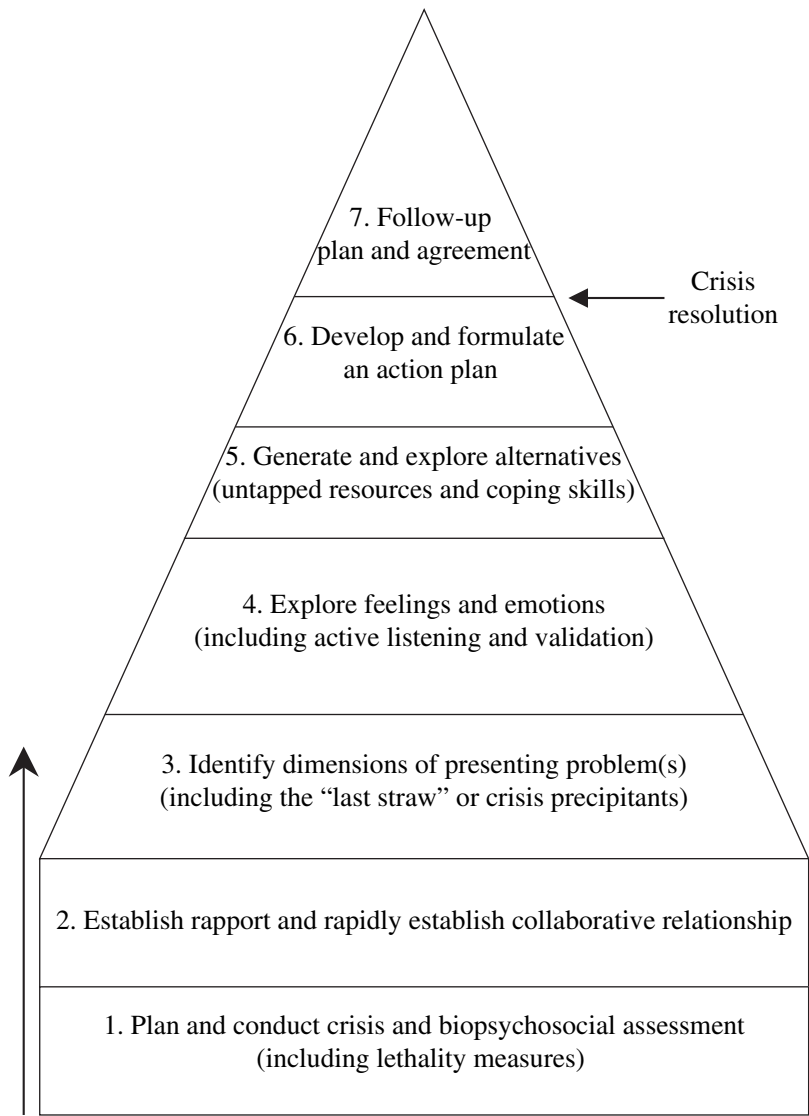


FIGURE 1
Roberts' Seven Stage Crisis Intervention Model
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One useful (and rapid) method for assessing the emotional, cognitive, and behavioral aspects of a crisis reaction is the triage assessment model (Myer, 2001; Myer, Williams, Ottens, & Schmidt, 1992, Roberts, 2002).

Assessing lethality, first and foremost, involves ascertaining whether the client has actually initiated a suicide attempt, such as ingesting a poison or overdose of medication. If no suicide attempt is in progress, the crisis worker should inquire about the client's "potential" for self-harm. This assessment requires

- asking about suicidal thoughts and feelings (e.g., "When you say you can't take it anymore, is that an indication you are thinking of hurting yourself?");
- estimating the strength of the client's psychological intent to inflict deadly harm (e.g., a hotline caller who suffers from a fatal disease or painful condition may have strong intent);
- gauging the lethality of suicide plan (e.g., does the person in crisis have a plan? how feasible is the plan? does the person in crisis have a method in mind to carry out the plan? how lethal is the method? does the person have access to a means of self-harm, such as drugs or a firearm?);
- inquiring about suicide history;
- taking into consideration certain risk factors (e.g., is the client socially isolated or depressed, experiencing a significant loss such as divorce or layoff?).

With regard to imminent danger, the crisis worker must establish, for example, if the caller on the hotline is now a target of domestic violence, a violent stalker, or sexual abuse.

Rather than grilling the client for assessment information, the sensitive clinician or counselor uses an artful interviewing style that allows this information to emerge as the client's story unfolds. A good assessment is likely to have

occurred if the clinician has a solid understanding of the client's situation, and the client, in this process, feels as though he or she has been heard and understood. Thus, it is quite understandable that in the Roberts model, Stage I—Assessment and Stage II—Rapidly Establish Rapport are very much intertwined.

Stage II: Rapidly Establish Rapport

Rapport is facilitated by the presence of counselor-offered conditions such as genuineness, respect, and acceptance of the client (Roberts, 2005). This is also the stage in which the traits, behaviors, or fundamental character strengths of the crisis worker come to fore in order to instill trust and confidence in the client. Although a host of such strengths have been identified, some of the most prominent include good eye contact, nonjudgmental attitude, creativity, flexibility, positive mental attitude, reinforcing small gains, and resiliency.

Stage III: Identify the Major Problems or Crisis Precipitants

Crisis intervention focuses on the client's current problems, which are often the ones that precipitated the crisis. As Ewing (1978) pointed out, the crisis worker is interested in elucidating just what in the client's life has led her or him to require help at the present time. Thus, the question asked from a variety of angles is "Why now?"

Roberts (2005) suggested not only inquiring about the precipitating event (the proverbial "last straw") but also prioritizing problems in terms of which to work on first, a concept referred to as "looking for leverage" (Egan, 2002). In the course of understanding how the event escalated into a crisis, the clinician gains an evolving conceptualization of the client's "modal coping style"—one that will likely require modification if the present crisis is to be resolved and future crises prevented. For

example, Ottens and Pinson (2005) in their work with caregivers in crisis have identified a repetitive coping style—argue with care recipient—acquiesce to care recipient’s demands—blame self when giving in fails—that can eventually escalate into a crisis.

Stage IV: Deal With Feelings and Emotions

There are two aspects to Stage IV. The crisis worker strives to allow the client to express feelings, to vent and heal, and to explain her or his story about the current crisis situation. To do this, the crisis worker relies on the familiar “active listening” skills like paraphrasing, reflecting feelings, and probing (Egan, 2002). Very cautiously, the crisis worker must eventually work challenging responses into the crisis-counseling dialogue. Challenging responses can include giving information, reframing, interpretations, and playing “devil’s advocate.” Challenging responses, if appropriately applied, help to loosen clients’ maladaptive beliefs and to consider other behavioral options. For example, in our earlier example of the young woman who found boyfriend and roommate locked in a cheating embrace, the counselor at Stage IV allows the woman to express her feelings of hurt and jealousy and to tell her story of trust betrayed. The counselor, at a judicious moment, will wonder out loud whether taking an overdose of acetaminophen will be the most effective way of getting her point across.

Stage V: Generate and Explore Alternatives

This stage can often be the most difficult to accomplish in crisis intervention. Clients in crisis, by definition, lack the equanimity to study the big picture and tend to doggedly cling to familiar ways of coping even when they are backfiring. However, if Stage IV has been achieved, the client in crisis has probably worked through enough feelings to re-establish

some emotional balance. Now, clinician and client can begin to put options on the table, like a no-suicide contract or brief hospitalization, for ensuring the client’s safety; or discuss alternatives for finding temporary housing; or consider the pros and cons of various programs for treating chemical dependency. It is important to keep in mind that these alternatives are better when they are generated collaboratively and when the alternatives selected are “owned” by the client.

The clinician certainly can inquire about what the client has found that works in similar situations. For example, it frequently happens that relatively recent immigrants or bicultural clients will experience crises that occur as a result of a cultural clash or “mismatch,” as when values or customs of the traditional culture are ignored or violated in the United States. For example, in Mexico the custom is to accompany or be an escort when one’s daughter starts dating. The United States has no such custom. It may help to consider how the client has coped with or negotiated other cultural mismatches. If this crisis precipitant is a unique experience, then clinician and client can brainstorm alternatives—sometimes the more outlandish, the better—that can be applied to the current event. Solution-focused therapy techniques, such as “Amplifying Solution Talk” (DeJong & Berg, 1998) can be integrated into Stage IV.

Stage VI: Implement an Action Plan

Here is where strategies become integrated into an empowering treatment plan or coordinated intervention. Jobes, Berman, and Martin (2005), who described crisis intervention with high-risk, suicidal youth, noted the shift that occurs at Stage VI from crisis to resolution. For these suicidal youth, an action plan can involve several elements:

- removing the means—involving parents or significant others in the removal of

all lethal means and safeguarding the environment;

- negotiating safety—time-limited agreements during which the client will agree to maintain his or her safety;
- future linkage—scheduling phone calls, subsequent clinical contacts, events to look forward to;
- decreasing anxiety and sleep loss—if acutely anxious, medication may be indicated but carefully monitored;
- decreasing isolation—friends, family, neighbors need to be mobilized to keep ongoing contact with the youth in crisis;
- hospitalization—a necessary intervention if risk remains unabated and the patient is unable to contract for his or her own safety (see Jobes et al., 2005, p. 411).

Obviously, the concrete action plans taken at this stage (e.g., entering a 12-step treatment program, joining a support group, seeking temporary residence in a women's shelter) are critical for restoring the client's equilibrium and psychological balance. However, there is another dimension that is essential to Stage VI, as Roberts (2005) indicated, and that is the cognitive dimension. Thus, recovering from a divorce or death of a child or drug overdose requires making some meaning out of the crisis event: why did it happen? What does it mean? What are alternative constructions that could have been placed on the event? Who was involved? How did actual events conflict with one's expectations? What responses (cognitive or behavioral) to the crisis actually made things worse? Working through the meaning of the event is important for gaining mastery over the situation and for being able to cope with similar situations in the future.

Stage VII: Follow-Up

Crisis workers should plan for a follow-up contact with the client after the initial in-

tervention to ensure that the crisis is on its way to being resolved and to evaluate the postcrisis status of the client. This postcrisis evaluation of the client can include

- physical condition of the client (e.g., sleeping, nutrition, hygiene);
- cognitive mastery of the precipitating event (does the client have a better understanding of what happened and why it happened?);
- an assessment of overall functioning including, social, spiritual, employment, and academic;
- satisfaction and progress with ongoing treatment (e.g., financial counseling);
- any current stressors and how those are being handled;
- need for possible referrals (e.g., legal, housing, medical).

Follow-up can also include the scheduling of a "booster" session in about a month after the crisis intervention has been terminated. Treatment gains and potential problems can be discussed at the booster session. For those counselors working with grieving clients, it is recommended that a follow-up session be scheduled around the anniversary date of the deceased's death (Worden, 2002). Similarly, for those crisis counselors working with victims of violent crimes, it is recommended that a follow-up session be scheduled at the 1-month and 1-year anniversary of the victimization.

Differentiating Crisis Intervention From Disaster Management

For those in need, the third phase of disaster response—crisis intervention—usually begins 1–4 weeks after the disaster unfolds. Phase I is generally known as "Impact" and Phase II is known as the "Heroic or Rescue"

phase. Phases I and II involve the disaster management and emergency relief efforts of local and state police, firefighters and rescue squads, emergency medical technicians, the American Red Cross volunteers, the Salvation Army, and the Federal Emergency Management Agency. The disaster and emergency management agencies focus on public safety; on locating disaster shelters, temporary housing units, and host homes; and on providing food, clean water, clothing, transportation, and medical care for survivors and their families. After the survivors and their families are rescued and transported to dry land and safe shelter, the goal is to provide them with well-balanced meals, continued medical care, sleep, and rest. It is also critically important to help survivors to reconnect and reunite with family members and close friends. Then, 1–4 weeks after surviving the loss of their home, neighbors, and/or community, Phase III—crisis intervention can begin—if it is requested.

Crisis intervention must be voluntary, delivered quickly, and provided on an as-needed basis. A crisis is personal and is dependent on the individual's perception of the potentially crisis-inducing event, their personality and temperament, life experiences, and varying degrees of coping skills (Roberts, 2005). A crisis event can provide an opportunity, a challenge to life goals, a rapid deterioration of functioning, or a positive turning point in the quality of one's life (Roberts & Dziegielewski, 1995). One person with inner strengths and resiliency may bounce back quickly after an earthquake, tornado or hurricane, whereas another person of the same age with a preexisting mental disorder may completely fall apart and go into an acute crisis state. A young emergency room physician might adapt well upon reaching Atlanta or Houston, whereas a young social worker suffering from major depression may completely go to pieces upon arrival at her cousin's house in Dallas, TX.

R-SSCIM is the same for survivors of community disaster. But we suggest that extra care be taken in applying R-SSCIM so that the mental health professional understands and distinguishes an acute stress reaction from the intense impact of the disaster from which most people rapidly recover. This takes skill on the surface because both reactions often look the same. Normal and specific reactions frequently include shock, numbness, exhaustion, disbelief, sadness, indecisiveness, frustration, anxiety, anger, impulsiveness, and fear.

Evaluation Research and Outcome Measures

The current approach in healthcare and mental health settings is to apply best practices based on evidence-based systematic reviews such as the R-SSCIM in order to assist clinicians by providing a stable sequential framework for quickly addressing acute crisis episodes in a continuously changing care environment. A growing number of studies have provided evidence of the effectiveness of time-limited crisis intervention (Corcoran & Roberts, 2000; Davis & Taylor, 1997; Neimeyer & Pfeiffer, 1994; Roberts & Grau, 1970; Rudd, Joiner, & Rajab, 1995). The research literature on quasi-experimental studies of the effectiveness of crisis intervention compared to other treatments supports the use of time-limited and intensive crisis intervention. However, despite promising crisis treatment effects, we cannot yet determine the long-term impact of evidence-based crisis intervention until longitudinal studies are completed. First, crisis intervention applications need to be refined so that booster sessions after 1, 6, and 12 months are implemented. Otherwise, we will probably continue to see positive outcomes wash out after 12 months postcrisis intervention completion. As a growing number of clinicians move

into crisis intervention work, it is imperative that they become familiar with best practices based on evidence-based reviews and the need for built-in evaluations.

In order to measure effectiveness and crisis resolution, as well as facilitate accountability and quality improvement, it is critical that outcome measures are clearly explicated in behavioral and quantifiable terms. Common performance indicators and measures should eventually lead to quality mental health and effective crisis intervention services. Teague, Trabin, and Ray (2004) in their chapter in the book *Evidence-Based Practice Manual: Research and Outcome Measures in Health and Human Services* identified and discussed key concepts and common performance indicators and measures. We have applied four of these performance indicators to a crisis intervention program:

1. *Treatment duration*: mean length of crisis service during the reporting period for persons receiving services in each of three levels of care: 24-hr crisis intervention hotline, crisis intervention at outpatient clinic, and inpatient psychiatry crisis services.
2. *Follow-up after hospitalization*: percentage of persons discharged from 24-hr inpatient psychiatric care who receive follow-up ambulatory, day treatment, or outpatient crisis intervention within 30 days of discharge.
3. *Initiation of crisis intervention for persons with mental health problems*: the percentage of persons identified during the year with a new crisis episode related to major depression, schizophrenia, schizoaffective disorder, or bipolar disorder who have had either an inpatient encounter for treatment of that disorder or a subsequent treatment encounter within 14 days after a first crisis intervention session.
4. *Engagement in treatment for mental health problems*: the percentage of persons identified during the year with a new episode of major depression, social phobia, panic disorder, schizophrenia, schizoaffective disorder, or bipolar disorder who have had either a single inpatient encounter or two outpatient treatment encounters within 30 days after the initiation of crisis intervention (Teague et al., 2004, p. 59.).

Conclusion

The R-SSCIM has applicability for the wide range of crisis workers—counselors, paraprofessionals, clinical social workers, clergy, or psychologists—who are called upon to make rapid assessments and clinical decisions when faced with a client who is in the midst of a crisis-inducing or traumatic event. If done properly, crisis intervention can facilitate an earlier resolution of acute stress disorders or crisis episodes. Not only does this model give the crisis worker an overarching plan for how to proceed, but the components of the model take into consideration what the persons in crisis bring with themselves to every crisis-counseling encounter—their inner strengths and resiliency.

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