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• **PROFESSIONAL FORUM**

The Integrated Problem-Solving Model of Crisis Intervention: Overview and Application

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Crisis intervention is a role that fits exceedingly well with counseling psychologists' interests and skills. This article provides an overview of a new crisis intervention model, the Integrated Problem-Solving Model (IPSM), and demonstrates its application to a specific crisis, sexual assault. It is hoped that this article will encourage counseling psychologists to become more involved in crisis intervention itself as well as in research and training in this important area.

Recently, significant crisis events (e.g., sexual assaults, school shootings, terrorist attacks, and other violent crimes) have received major media attention. This has led, among other things, to an increased interest in this topic as a subspecialty among human service providers (James & Gilliland, 2001). In addition, it appears that we live in an increasingly fast-paced and technological society in which individuals may be less connected with family and other positive influences than in the past (Pitcher & Poland, 1992). Mental health professionals need to be prepared to help society cope with such crises, and counseling psychologists are particularly well suited for this type of intervention. Coping with life transitions, a major focus of counseling psychology throughout its history, sometimes involves the successful negotiation of crises (Brown & Lent, 2000). Counseling psychologists are particularly skilled in promoting self-enhancement among relatively healthy individuals, which is often the case in crisis situations. In addition, crisis intervention matches well with counseling psychologists' skills at implementing brief, problem-solving, developmental, educational, and self-empowering intervention approaches.

Relatively few articles have been published in *The Counseling Psychologist* concerning crisis intervention and the role of the counseling psycholo-

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gist. Indeed, we believe that the field of counseling psychology has not historically seen itself as working extensively in this area. Interestingly, in 1979—more than 20 years ago—Baldwin published an excellent manuscript in *The Counseling Psychologist*, wherein he reviewed crisis theory, discussed types of crises, and described his own stage model of crisis intervention. Baldwin's model consisted of the following major steps: catharsis/assessment, focusing/contracting, intervention/resolution, and termination/integration. Since 1979, however, there has been little in this journal explicitly dealing with the topic of generic crisis intervention per se as a major role of counseling psychologists. A review of the articles written concerning the last major counseling psychology conference (the Georgia conference) (Weissberg et al., 1988) yields few indications that crisis intervention per se has been an explicit major area of concern for the field of counseling psychology. However, it should be noted that in our view, things are changing. At the Fourth National Conference for Counseling Psychology (the Houston conference), a large number of work/social action groups addressed a wide spectrum of social issues, many of which relate to crisis intervention. In addition, it is important to note that *The Counseling Psychologist* recently published a major contribution on suicide (Westefeld et al., 2000), which is obviously a crisis-laden phenomenon. Because we believe that crisis intervention is an emerging and important area for counseling psychologists, we present this article in an effort to augment the current knowledge base in this area. Rather than review the numerous existing crisis intervention models (e.g., Baldwin, 1979; James & Gilliland, 2001; Roberts, 1991), this article presents the authors' Integrated Problem-Solving Model (IPSM) of crisis intervention, which is based on many of the principles of the specialty of counseling psychology as a profession. We then present an exemplar of how this model may be used in a specific type of crisis that counseling psychologists may encounter: sexual assault.

For the purposes of this article, the term *crisis* is defined as a relatively and usually brief reaction of severe distress in response to a typically unexpected event or series of events that can lead to extreme and severe disequilibrium, growth, or both, depending on the effectiveness of the crisis management strategies employed. This definition draws on the work of James and Gilliland (2001), Pitcher and Poland (1992), Roberts (1991, 1995), and a variety of others. It emphasizes the unexpected and time-limited nature of a crisis (e.g., sudden death of a child), the subjective perception of the situation as overwhelming to the resources available, and the experience of disequilibrium or disorganization among several areas of functioning (i.e., affective, cognitive, behavioral). In addition, it emphasizes that the short- and long-term consequences of a crisis can involve deterioration, growth, or some combination of the two, depending on the nature of the crisis intervention utilized. In fact, the

ancient Greek term for crisis came from two root words meaning "decision" and "turning point," and the Chinese ideograph for crisis combines two symbols representing "danger" and "opportunity" (Roberts, 1995).

BRIEF SUMMARY OF EXISTING CRISIS INTERVENTION WORK

The mental health literature concerning crisis intervention work is obviously very extensive and includes such diverse writings as Erikson's (1950) stage model of normal developmental crises, recommendations based on World War II experiences with combat fatigue (Roberts, 1995), and reactions to bereavement after a major fire at the Coconut Grove nightclub in Boston (Lindemann, 1944). A flurry of crisis intervention work after the deinstitutionalization of many mentally ill individuals by the Community Mental Health Centers Act of 1963 led to an upsurge in research and the increased popularity of using paraprofessionals and crisis hotlines in the 1970s and 1980s. Currently, financial strains on the healthcare system are leading to greater accountability and briefer treatment approaches than previously used (Pitcher & Poland, 1992).

Numerous crisis intervention models have been developed during the past decade. To cite just two of many examples, Roberts's (1991) model and James and Gilliland's (2001) six-step model can be used by professional human service providers and laypersons alike. Roberts's excellent model is based on facilitating positive change via a somewhat time-limited and goal-directed approach (Roberts, 1991, 1995). The highly regarded model by James and Gilliland (2001), as they stated, is based on assessing, listening, and acting, and "the entire six-step process is carried out under an umbrella of assessment" (p. 33). James and Gilliland also provided an excellent discussion concerning many other crisis intervention theories/models. Extensive data-based empirical research examining crisis intervention models, however, appears to be lacking; as such, we propose the IPSM as a model that lends itself to such research because the IPSM is a graduated approach, draws on cognitive-behavioral approaches, and has a multicultural perspective. We hope that this model will be sufficiently user-friendly to encourage researchers and clinicians alike to increase their participation in crisis intervention research and practice.

The authors' model—the IPSM—involves 10 stages and is designed to provide step-by-step detail in responding to a crisis from beginning to postcrisis. As a point of contrast, Roberts's (1991) model has seven steps and James and Gilliland's (2001) model has six steps. The IPSM also draws on several of the models to which we earlier alluded. We believe that the IPSM

does have several advantages over some previous models in that it is very detailed in terms of exploring and implementing options and plans, places emphasis on immediately and explicitly establishing and maintaining rapport, and in particular is based on a framework that focuses on cultural context and empowerment. We feel that the notion of empowerment is especially critical to our model and is consistent with the philosophy of counseling psychology, that is, a focus on the existing assets that clients can utilize to continue to grow and develop. Moreover, our model is distinct from some others in that we feel that evaluating outcome is an important part of any therapeutic intervention, and we explicitly identify this as a very critical step in our model. Finally, as counseling psychologists, we decided to frame the intervention explicitly in positive terms by including "set goals" rather than to "define the problem" as in some previous models. For these reasons, we feel that our model updates and advances the literature.

OVERVIEW OF THE IPSM

The IPSM is a wide-ranging integration of several different perspectives, including the crisis-intervention (e.g., Baldwin, 1979; James & Gilliland, 2001; Pitcher & Poland, 1992; Roberts, 1991, 1995) and trauma-theory (Herman, 1997) literatures, the cognitive-behavioral problem-solving approach developed by D'Zurilla and colleagues (D'Zurilla, 1986; D'Zurilla & Goldfried, 1971; D'Zurilla & Mashcka, 1988; D'Zurilla & Nezu, 1982; D'Zurilla & Sheedy, 1991), narrative and solution-focused therapies (Greene, Lee, Trask, & Rheinscheld, 2000; Semmler & Williams, 2000), and multicultural counseling (Sue & Sue, 1990). The perspectives incorporated into the IPSM framework are described as follows.

The IPSM is consistent with current trauma theory in that it begins with a focus on safety, stabilization, and self-care; moves to processing the traumatic event; and finally, encourages integration of this material into everyday life (Herman, 1997). Some earlier approaches to trauma treatment involved primarily psychodynamic processing of the traumatic material to the exclusion of the other two stages. This may have left clients somewhat defenseless and incapacitated, albeit insightful and in touch with emotions, yet unable to function in the outside world. Therefore, we prefer a graduated approach to dealing with trauma: first enhancing coping skills and safety, then processing traumatic material, and finally, generalizing this foundation to broader life arenas (Herman, 1997). This more recent approach would also seem to be more consistent with multicultural perspectives in which diverse clientele are empowered to identify and utilize existing strengths and who seem to appre-

ciate practical strategies for coping with everyday life (Sue & Sue, 1990). The IPSM differs from some previous crisis-intervention models because it also provides opportunities for processing traumatic material or at least for goals to be set along these lines for future reference. It is interesting that despite their relevance and similarities to one another, the crisis-intervention and trauma-theory literatures have not been well integrated yet.

The IPSM draws heavily from cognitive-behavioral approaches, which seem to be the most popular and have the most empirical support for use in crisis counseling (Dattilio & Freeman, 1994; Muran & DiGuiseppe, 1994). Cognitive-behavioral approaches are appropriate for crisis intervention because they are active, directive, structured, often time limited, and psychoeducational in nature (Dattilio & Freeman, 1994). Clients in crisis can benefit from this type of approach because crises are often time limited, clients may be in such a state of disorganization that they may need a firm guiding hand, and they may benefit from education because the experience may be unlike anything they have ever experienced before. Problem-solving approaches in particular may lend themselves to crisis situations in that they are structured, efficient, concrete, and directive, yet flexible (Spiegler & Guevremont, 1993). Clients from underrepresented groups may especially appreciate the structured, directive, and present-focused qualities (Sue & Sue, 1990) of the IPSM. As Sue and Sue (1990) pointed out, many minorities and immigrants may be more familiar and comfortable with medical as opposed to psychological treatment and therefore expect immediate and concrete solutions to their problems provided by authoritative "experts."

As counseling psychologists, we are also particularly influenced by solution-focused models (Greene et al., 2000) that emphasize the existing strengths and resources of clients in improving their own situations. This approach has clients identify what strategies have worked well in the past and encourages clients to increasingly employ the strategies in the future; thus, the approach focuses on solutions rather than problems. Solution-focused models are well suited to crisis intervention situations because clients are encouraged to draw on all available resources and implement concrete solutions. Again, such characteristics also provide a good match for diverse clientele. Therefore, in the IPSM, we have clients frame the events as much as possible in a positive light. For example, we designate a step to set goals as opposed to identify the problem as is done in some other crisis intervention models, and we use the term *survivor* as opposed to *victim* with people who have experienced sexual assault.

Similarly, we utilize aspects of narrative therapy (Semmler & Williams, 2000) to help clients empower themselves and increase their sense of control by developing their own adaptive accounts of the traumatic events and their

outcomes. This can be accomplished by helping clients understand the meanings that they have created of historical events and then by assisting clients in reconstructing a new "story" (Kelley, 1998). A common narrative technique is to help clients view the problem as external but the solution as internal to them. For example, women who have been sexually assaulted often blame themselves for the rape. A narrative approach can help survivors appropriately place blame on the perpetrators and can help women see that the way they can fight back is to progress in their recovery. By emphasizing the strategies that clients have used to cope with and survive a situation, narrative clinicians might help clients "restory" the crisis event. Clients would also likely be encouraged to develop an audience—social support—with roles to play in their new, more adaptive life story. As we mentioned previously, such positive and empowering approaches are appropriate for multicultural clientele and, in the case of narrative therapy, may even help such clients progress along the stages of cultural identity by moving from self-deprecation to self-appreciation (Helms, 1994).

To reiterate, it should be clear that the frameworks used to form the foundation of the IPSM are all consistent with the philosophy of counseling psychology in terms of empowering people to draw on their inherent strengths, resources, and coping skills. Other potential benefits of the IPSM are that it is a specific, clear, detailed, and step-by-step method that comprehensively integrates previous models using an empowerment framework. We feel that for these reasons the IPSM could be easily utilized by counseling psychologist clinicians and researchers alike. However, the IPSM would also be flexible enough to accommodate various types of crisis situations. The following is a description of the stages involved in the IPSM (see Table 1).

1. Establish and Maintain Rapport

As in all therapeutic encounters, rapport building is a crucial first step in effective intervention. This may be all the more true in crisis situations due to client distress, vulnerability, distrust, and fragility. Relationship building includes all of the standard tools that a counseling psychologist would utilize in other therapeutic situations, although the crisis situation involves a compressed time frame. These tools include basic attending and listening skills, empathy, reflection of affect, encouragement, support, and instillation of hope (Ivey & Ivey, 1999). Rapport building can foster a thorough and accurate assessment of client safety and form the background for other subsequent stages. Special attention should be paid to contextual or sociocultural factors that may influence the way in which a client copes with the crisis situation. For example, extra efforts may need to be taken in building rapport

TABLE 1: Westefeld and Heckman-Stone Model

1. Establish and maintain rapport.
2. Ensure safety.
3. Assess client and begin processing trauma.
4. Set goals.
5. Generate options.
6. Evaluate options.
7. Select plan.
8. Implement plan.
9. Evaluate outcome.
10. Follow-up.

when intervening with a person of color who may feel a "cultural mistrust" (Sue & Sue, 1990) of traditional mental health and other social support agencies. Kiselica (1998) reminded us that we may also have to be ready to use a wide variety of strategies in helping clients from diverse cultures. Clearly, a key here is empathy throughout this stage and, in fact, throughout the entire model. In 1959, Rogers described empathy as the ability to access another's view/feelings as if the helper were the helpee but without taking on the helpee's emotional state. In crisis response, it seems to us that this is especially crucial in that true empathy, as discussed by Rogers (1959), provides an opportunity for assistance while at the same time reducing the chance of burnout on the part of the helper.

2. Ensure Safety

Ensuring safety should be an early intervention and remain a focus throughout the entire crisis response period. Clients need to be assessed as to their level of safety in terms of overall physical environment and physical health, self-destructiveness, harm toward others, and/or harm by others toward them, depending on the nature of the crisis. If safety is of concern, this takes priority over other issues in terms of problem solving and implementing plans for resolution. Suicide, in particular, may be an initial and/or continuing safety concern. See Westefeld et al. (2000) for some specific guidelines related to suicide.

3. Assess Client and Begin Processing Trauma

In addition to safety issues, other areas for assessment include circumstances of the crisis event, past and current coping abilities, social support and other practical resources, related developmental and historical events, as

well as psychological distress and basic functioning. Quantitative measures can be used, although crisis situations typically limit time and available resources. Due to the frequently limited time frame of crisis intervention, processing of traumatic material and assessment of the client often need to occur simultaneously. However, if more time is needed for cognitive and emotional processing, this can be identified as a potential goal to be explored during the following stages.

4. Set Goals

Based on the assessment of the client, problems can be defined and goals set. As counseling psychologists, we feel it is important to reframe negative problems into positive goals, and this is a key aspect of our model. Sample solution-focused goals are improving self-care, developing coping skills or resources, processing and managing emotions and cognitions, and improving relationships. These goals should allow clients to increase their sense of control over constructing the current narrative of the traumatic experience, for example, by externalizing the problem yet internalizing the solution (Greene et al., 2000). This also may be framed as growth through dealing with adversity.

5. Generate Options

This step involves the client and counseling psychologist working together in thinking creatively to generate a variety of potential actions to achieve the stated goals. The particular focus is on adaptive techniques that the client is already employing and those that would continue to shape a desirable narrative.

6. Evaluate Options

Here, the client and counseling psychologist discuss the advantages and disadvantages of each option depending on desirability, feasibility, available resources, and so forth.

7. Select Plan

Based on the evaluation of options, the client and counseling psychologist now collaboratively decide on a plan of action, which frequently has multiple components and steps. Developing a plan in a crisis situation may involve a more directive approach than in other clinical situations because the client may be quite disorganized and/or time is often a critical issue.

8. Implement Plan

During this step, the components of the action plan are carried out. The counseling psychologist should ensure that the client has sufficient preparation and support for this step, which may require taking on the role of advocate, particularly if members of certain oppressed groups plan to interact with traditional social services agencies with which they may lack experience or have had negative experiences. However, the client should have as much control over selection and implementation of the plan as possible.

9. Evaluate Outcome

During this stage, it is important to elicit and process feedback from the client about the plan, how it is working, how the client feels about it, and so forth, in case the plan needs modification. This step can help the client to identify how the client has grown (again, a key principle from counseling psychology), how the narrative has changed, and what has been learned from the crisis experience for future reference. If preintervention measures have been used, corresponding postintervention measures can be administered.

10. Follow-Up

Follow-up can occur with the original counseling psychologist or with a referral source such as other therapists, physicians, community organizations, religious and other support groups, traditional healers, and so forth. Regardless, the client should have future appointments scheduled after the initial crisis to help ensure that the client follows through with the plan, that it continues to be beneficial, and that new skills become integrated into the client's everyday narrative. The entire crisis intervention process may take only one extended session or several sessions during days or weeks, depending on the nature of the crisis and the functioning level of the client. Extended follow-up is crucial and is another key aspect of our model.

APPLICATION OF THE IPSM TO SEXUAL ASSAULT

Because sexual assault is such an important societal issue and an issue with which many counseling psychologists may deal, we now present an overview of the phenomenon of sexual assault and the application of the IPSM to its intervention. We hope that applying our model to one very important example of a crisis will help to operationalize the model. "Sexual assault is the fastest growing, most frequently committed and most underreported

violent crime" (Dunn & Gilchrist, 1993, p. 359) and "is a highly traumatic event from which many victims never completely recover" (Resick & Mechanic, 1995, p. 97). It can result in posttraumatic stress disorder (PTSD), depression, problems with self-esteem, anger and hostility, somatic symptoms, and difficulties in relationships including sexual dysfunction. Approximately a quarter of untreated sexual assault survivors report normal functioning 1 year after the assault, but many report continuing problems for 1 year or more (Gilbert, 1994).

Sexual assault crisis intervention generally corresponds to the three stages of recovery from rape or "rape trauma syndrome," first described by Burgess and Holmstrom in 1974. These stages are (a) acute disorganization, (b) denial and avoidance, and (c) help seeking and working through. Crisis intervention for sexual assault usually occurs during the acute disorganization phase, but crises can occur during the other phases as well. The goals of rape crisis counseling are to "reduce the victim's emotional distress, enhance her coping strategies, and prevent the development of more serious psychopathology" (Calhoun & Atkeson, 1991, p. 39). The use of the IPSM specifically with the population of sexual assault survivors is now described.

1. Establish and maintain rapport. Due to the brief and urgent nature of rape crisis counseling, it must be more active, directive, and supportive than other modes (Calhoun & Atkeson, 1991). Crisis workers should exhibit the following characteristics as well as behaviors: warmth and calmness, patience, availability but not intrusiveness or control, acceptance and understanding, empathy and concern, effective listening skills, trustworthiness, and encouragement of appropriate referrals and support seeking. The messages the survivor should hear are "I'm sorry this happened to you," "You are safe now," and "This wasn't your fault" (Kitchen, 1991, 35); and "I know you handled the situation right because you're alive" (Dunn & Gilchrist, 1993, p. 364). These messages and statements may be particularly important for members of certain oppressed and stigmatized groups to receive to alter their preexisting and potentially self-depreciating narratives.

2. Ensure safety. Safety must be assessed/addressed in terms of client self-destructiveness or suicidality and potential situations in which the victim may come in contact with the perpetrator. Common coping mechanisms include self-mutilation, eating disorders, substance abuse, and promiscuity and other types of risk-taking behaviors. Ensuring safety is a critical step in which clients must be assessed and empowered to develop effective safety plans and/or contracts, which may be incorporated into subsequent stages. Resources should be identified for potential use by the survivor.

3. Assess client and begin processing trauma. Identifying the stage of recovery from rape trauma syndrome is important in guiding treatment interventions (Daane, 1991; Petretic-Jackson & Jackson, 1990). The crisis intervention strategies presented here are structured with these stages in mind. The initial, acute phase of recovery from rape involves somatic, emotional, and cognitive disorganization and lasts for a few days to several weeks or months. Victims experience feelings of shock, helplessness, fear, hypervigilance, guilt, shame, intrusive recollections, and exhaustion. The behavioral response varies widely among victims and has been characterized as either expressed or controlled. The expressed response refers to anxious, angry, fearful, tense, and restless reactions, whereas controlled tends to involve masked emotions and a calm, composed, and subdued appearance. Of course, responses may vary along cultural and numerous other dimensions as well. Assessment may reveal that the client is in the acute phase of recovery and not yet prepared to participate in the more in-depth processing of the trauma that may occur in later stages of recovery. However, potential goals to be addressed in the following intervention stages may be (a) to process the trauma at the intensity level that the client can tolerate at any given time, and (b) to construct the trauma into a narrative that is more adaptive and empowering than the existing one. The narrative approach may be especially helpful for women with histories of prior traumatic experiences in that it can help them acknowledge and develop the courage and strength that helped them survive in the past (Draucker, 1998).

"Triage (rapid assessment and prioritizing of needs) is necessary to determine what type of intervention is appropriate and whether some approaches are contraindicated" (Resick & Mechanic, 1995, p. 101). Risk of decompensation, suicide, self-harm, or lack of sufficient coping resources must be assessed and the client stabilized before intensive techniques such as exposure are utilized. Assessment of immediate presenting problem, daily functioning, the specific nature of the assault, reactions to the event and coping skills utilized, available social support, premorbid adjustment, interpersonal relationships, and previous traumatic experiences is necessary to determine the severity of the crisis and plan for treatment.

The effect of the assault on the individual and the length of recovery depend on many factors, including

> age, race/ethnicity, family background, cultural and religious mores, community attitudes, type of abuse experienced, length of time and intensity of victimization, attitudes about sex roles, attitudes of family and support persons following disclosure/discovery of the abuse, and effects of policy or legal proceedings following disclosure/discovery of the abuse. (Williams & Holmes, 1981, as cited in Gilliland & James, 1997, pp. 224-225)

Certain types of clients who may on occasion require alternative crisis intervention approaches are children, incest survivors, victims of gang rape, racial or ethnic minorities, men, people with disabilities, suicidal clients, gay men, lesbians, and so forth. For example, the mental health concerns of some male sexual assault survivors may be somewhat different from those of some female survivors in that the former may face a different type of prejudice and stigmatization and use different coping skills to deal with and express emotions such as anger, shame, and helplessness (Evans, 1990). Likewise, African Americans and other racial/ethnic minorities' care may sometimes be affected by stereotypes about their sexuality and personalities, and in some cases minority women may be reluctant to "betray" members of their communities if the perpetrators also happen to be members of the same minority group (McNair & Neville, 1996). Similar discriminatory attitudes and assumptions may prevent gay and lesbian assault survivors from obtaining the unique care that they need (Orzek, 1989). A solution-focused framework could help the client identify current coping skills yet expand these to become a more flexible and comprehensive repertoire and therefore a more adaptive narrative.

4 and 5. Set goals and generate options. Sexual assault may result in a series of crises from the assault itself to reporting the attack, appearing in court, and resolving intimate relationships (Pruett & Brown, 1990). The counseling psychologist

> must help the victim deal with the following issues during the acute phase: 1) medical attention, 2) legal matters and police contacts, 3) notification of family or friends, 4) current practical concern, 5) clarification of factual information, 6) emotional responses, and 7) psychiatric consultation. (Fox & Scherl, 1972, p. 38)

Again, these situations may be exacerbated because of cultural issues such as a lack of experience or previous unsatisfactory experiences with various agencies (Sue & Sue, 1990), and these factors must be taken into account when developing and implementing the action plan.

6 and 7. Evaluate options and select plan. Control is a major issue of concern for rape survivors. They have experienced an extreme loss of control and need "to be reassured that that loss of control is neither total nor permanent" (Gilliland & James, 1997, p. 239) while being given as many choices as possible in their recovery, such as whom to tell and where to stay. In this way, clients can restory their traumatic narrative into one in which they have more power and control and thus facilitate their long-term recovery. The reasons for seeking medical attention and what to expect during the examination

should be presented (Muran & DiGuiseppe, 1994). The counseling psychologist should help the survivor decide whether to discuss the situation with an attorney and the consequences of reporting or not reporting the crime (Fox & Scherl, 1972). The survivor should be made aware of the importance of social support to recovery, and potential difficulties with intimacy and sexual functioning should be discussed (Muran & DiGuiseppe, 1994). Survivors should be helped decide with whom they feel comfortable talking and how to disclose the assault (Fox & Scherl, 1972). The survivor may receive unsupportive responses from police, lawyers, physicians, or even friends and relatives, so the clinician may be in the unique position of countering these responses with supportive ones.

Specific cognitive-behavioral approaches such as exposure, cognitive restructuring, and stress-inoculation seem to be popular and have good empirical support for use in rape crisis counseling (Muran & DiGuiseppe, 1994). Advantages and disadvantages of these approaches should be discussed with clients so that they can provide informed consent for their use. It is important to remember that establishing a therapeutic alliance is just as important in cognitive-behavioral crisis intervention with rape survivors as in any other treatment modality. The counseling psychologist must efficiently establish rapport and communicate effectively. Both verbal and nonverbal strategies are required to convey sensitivity, understanding, validation, and hope. The counseling psychologist should discuss the goals and frustrations of the counseling process to reduce attrition. The goal of many survivors, whether explicit or implicit, is to be able to avoid dealing with rape-related issues. The achievability and appropriateness of this common goal will need to be discussed by the psychologist.

8. Implement plan. Important components of cognitive-behavioral interventions in cases of sexual assault crises include verbal and imaginal exposure to the traumatic event (Muran & DiGuiseppe, 1994). Counseling psychologists should actively address resistance to these approaches caused by shame or fear by using cognitive restructuring techniques. The client's support network may actively encourage the client to avoid dwelling on the rape, which—according to behavioral theory—may strengthen the anxiety related to the stimuli and the avoidance response. Therefore, the counseling psychologist may be in the unique position of encouraging and reinforcing the client for the cathartic recounting of the entire trauma. The counseling psychologist should help the survivor focus on emotions and also address maladaptive cognitions (Calhoun & Atkeson, 1991). Rape myths, cultural stereotypes, and the victim's own attitudes about sexual assault should be explored. These can be revised as part of a more healthy narrative of the traumatic experience. Because it may be difficult for the survivor to absorb all of this information,

written summaries should be provided, and the client should be encouraged to share this information with one's own support network (Calhoun & Atkeson, 1991).

Stress inoculation training (SIT) (Meichenbaum & Deffenbacher, 1988) has been adapted for use with rape survivors. SIT was originally designed to be used in 12 weekly sessions (Muran & DiGuiseppe, 1994), but selective elements were chosen for this Brief Behavioral Intervention Procedure (BBIP) that involves two 2-hour crisis intervention sessions (Calhoun & Atkeson, 1991). The first phase of BBIP involves imaginal reexperiencing of the rape and education about learning theory and rape-related physiological, behavioral, and cognitive responses (Muran & DiGuiseppe, 1994). This provides normalization for current reactions and anticipatory guidance for future ones. The second phase is coping-skills training to deal with fear and anxiety. These skills include controlled breathing, muscle relaxation, covert modeling, role playing, cognitive restructuring, thought stopping, and guided self-dialogue. Techniques should be individually selected based on the strengths and characteristics of the particular client so that her new narrative is appropriate and empowering to her. Petretic-Jackson and Jackson (1990) recommend that the clinician "set the stage for the development of a survivor mentality" (p. 138). This can be accomplished by sharing experiences and coping strategies used by other assault survivors. A group of culturally similar survivor members might be ideal. In accordance with solution-focused approaches, counseling psychologists can help to highlight the survival skills the client has demonstrated thus far and help build on those strategies.

Clients should also be encouraged to reduce their usual responsibilities and develop a plan to gradually work toward resuming normal functioning including some daily structure and regular social contact (Calhoun & Atkeson, 1991). The counseling psychologist can help the client mobilize social support by discussing its importance, hypothesizing about possible reactions of others, even notifying significant others and educating them about what to expect and how to cope. These measures can help create a supportive audience with roles scripted by the client for the new narrative. The counseling psychologist should help the client explore strategies to increase feelings of physical safety such as staying with friends, installing locks or security systems, or even changing residence.

9. Evaluate outcome. At the end of the first session and in future sessions, the client should be given the opportunity to express reactions to the interventions and the therapist, including what has been helpful, not helpful, difficult, and so forth. Most important, the client should be given the opportunity to consider what strengths have been demonstrated thus far and those that will continue to be drawn on in the face of future distress. This stage offers a way

in which (a) survivors can be empowered to continue developing their own narrative, and (b) the counseling psychologist can improve future clinical work based on empirical support.

10. Follow-up. The client should have a specific plan for the next 24 to 48 hours (Petretic-Jackson & Jackson, 1990), including mental health and other community referral information for future use (Fox & Scherl, 1972). Permission to contact the client by telephone within the next few days for follow-up is desirable, because client follow-up is often poor (Calhoun & Atkeson, 1991). The counseling psychologist may need to be in contact with the survivor daily in the immediate aftermath of the crisis to listen to and support the survivor as well as assist with arrangements for medical care or legal services (Fox & Scherl, 1972). Assessment and treatment planning can continue during this time. Petretic-Jackson and Jackson (1990) recommend follow-up at 24 hours, 48 to 72 hours, 1 week, 4 to 6 weeks, 3 months, 1 year, and whenever the survivor or the victim's support system requests assistance.

During the second or denial phase of recovery, help seeking decreases. This pseudoadjustment response is normal and should be supported rather than challenging defenses (Fox & Scherl, 1972). The counseling psychologist may simply encourage keeping follow-up appointments, although this may be somewhat futile. The counseling psychologist can also continue to help support persons by educating them about rape and helping them deal with their own and the survivor's reactions. Despite the lack of external signs at this stage, survivors often continue to struggle with feelings of alienation, depression, nightmares, sleeplessness, flashbacks, somatic symptoms, decreased self-esteem, feelings of being out of control, and anxiety (Daane, 1991).

The third phase generally involves depression, help seeking, working through, and then integration (Fox & Scherl, 1972). Therapy can help survivors work through their feelings of guilt and anger toward themselves and the perpetrators. It is during this phase that survivors are more likely to be open to more intense, longer term modalities such as prolonged exposure and extended cognitive therapies, interpersonal therapy, or psychodynamic approaches. Personal growth and maturation often result from such interventions, with survivors developing a more independent, self-reliant, and self-accepting narrative (Moscarello, 1990).

Counseling psychologists and other mental health professionals are at risk of becoming overinvolved with survivors of trauma and becoming burned out due to the shock and rage over the horrible traumas that have been perpetrated (Gilliland & James, 1997). Working with survivors may disrupt the therapist's own sense of security. Counseling psychologists must utilize self-care strategies such as consultation because "if the therapist believes that the trau-

matic experience is too difficult to face, the client's avoidance will be reinforced" (Muran & DiGuiseppe, 1994, p. 174).

SUMMARY AND FUTURE DIRECTIONS IN RESEARCH AND TRAINING

This article introduced the IPSM of crisis intervention and applied it to a specific type of crisis. We believe that the IPSM is a thorough yet user-friendly model that we hope other psychologists will help us critique and investigate. As the role of counseling psychologists adjusts to new societal demands, crisis intervention is clearly gaining importance. More research needs to be conducted in this area to determine the validity and helpfulness of current theories and practices. We realize that crisis intervention research is extremely challenging due to the nature of the client population, the nature of the interventions, the difficulty in maintaining experimental control, and the variability of methodologies across studies (Kolotkin & Johnson, 1981). However, we would like to see more outcome and comparison studies of the current intervention models, studies that use diverse client groups, and studies that apply the models to specific types of crises. This appears to us to be a gap in literature, and we encourage counseling psychologists to undertake such studies. What we especially need to know is the long-term helpfulness of a variety of crisis intervention strategies because crises can often yield delayed long-term reactions. In addition, models may have more—or less—utility with different groups.

Research and training are, of course, linked. Commenting on counseling psychology training, Patton (2000) wrote, "Each program should use teaching and learning methods to help students acquire both the declarative knowledge base in scientific and counseling psychology and procedural knowledge of research and practice in complex learning situations" (p. 703). In our view, these suggestions are clearly relevant to the area of crisis intervention. It is our contention that more training in crisis intervention needs to be included in our counseling psychology curricula. The problem, as always, is when, where, and how to do this. Clearly, our curricula are already often operating at capacity. However, it seems imperative that crisis intervention skills be developed by our current trainees. These skills could be embedded in a wide variety of courses such as prepracticum, practicum, assessment, psychodiagnostics, therapy theory and practice, multicultural and ethics courses, and/or offered in one targeted course. We advocate a curriculum that would combine generic theoretical and empirical information on crisis intervention with practical training in how to respond to specific crises. For a number of

years, the senior author has taught a crisis intervention seminar that includes general information as well as training in responding to suicide, sexual assault, domestic violence, disaster response, psychotic events, and PTSD. In addition, survivors of some of these crises have given presentations directly to the crisis intervention class. This is one example of a specific training mechanism that includes breadth and depth but certainly not the only one. Few programs include extensive, specific training in crisis intervention (Pitcher & Poland, 1992), and we believe this should change. This would allow the counseling psychologists of the future to respond competently to societal needs in this very critical area.

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