CRISIS, DISASTER, AND TRAUMA COUNSELING: IMPLICATIONS FOR THE COUNSELING PROFESSION

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Abstract
Crisis, disaster, and trauma are inevitable truths of our life, preventable but sometimes completely avoidable, as they occur with or without any early signs. The psychological trauma in the aftermath can be devastating for individuals who have directly and or indirectly experienced the incident. As professional counselors, we will all encounter a client in crisis or trauma at some point in our careers. For this reason, counselors must possess a basic knowledge of crisis theory and intervention and must be able to recognize and assess for symptoms of trauma. This paper provides an overview of crisis, disaster, and trauma counseling and how each has emerged as a counseling specialty in the last 25 years. Crises and disasters are defined for the reader, and the DSM-5 definition of trauma and PTSD is provided. A brief history of the specialties is reviewed, followed by efforts of leadership organizations in the counseling field to increase training opportunities in crisis and trauma counseling. An overview of Psychological First Aid (PFA) is provided, and assessment practices for crisis and trauma counseling are reviewed. The paper concludes with a discussion on vicarious traumatization and counselor self-care.

Keywords-- crisis, disaster, trauma, interventions

INTRODUCTION

The concepts of disasters, crises, and trauma have existed for centuries, but crisis, disaster, and trauma counseling have only emerged as specialties in the counseling field within the last 25 years [1]. Crisis is a ubiquitous experience, and all counselors will inevitably encounter a client who is in crisis or has experienced a traumatic event. Thus, it is important for all counselors to have a basic understanding of crisis and trauma theories, assessment, and interventions. According to James (2008, p.1) [2], crisis is defined as "a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms." A *crisis* can be described as a state of disequilibrium which occurs when a person has reached a state where their resources and coping mechanisms are stretched too far [3]. Individuals who experienced the crisis might have irrational beliefs toward self, others, and the world [18]. A *disaster* can be natural, such as a hurricane, tsunami, or tornado, or can be man-made, such as a mass shooting or terrorist attack. It is a sudden event that disrupts the functioning of a community or society and often results in human, material, or economic losses.

Trauma is much more difficult to define as the term has often been used to describe almost any stressor experienced by an individual [4]. At the most basic level, trauma refers to the emotional response an individual has to an event that was perceived to be physically or emotionally harmful. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed; *DSM*-5; American Psychiatric Association [APA], 2013) [5] lists a traumatic stressor as: exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event, witnessing, in person, the event(s) as it occurred others, learning that the traumatic event(s) occurred to a close family member or close friend..., experiencing repeated or extreme exposure to aversive details of the traumatic events(s). (e.g., first responders collecting human remains…) (p. 271).

The traumatic event has "lasting adverse effects on an individual's mental, physical, social, and spiritual wellbeing" (p.7) [6]. While crises are relatively brief events, a trauma response is more extreme, enduring and involves specific psychological and physiological responses (Levers, 2012). Cohen and Mannarino (2015) [19] reported that trauma exposure is correlated with increased risks of medical and mental health problems, such as PTSD, depression, anxiety, substance abuse, attempted suicide, and so forth. The effects of trauma are prolonged, as individuals may have recurrent experiences of the event, amplified arousal, negative thoughts, moods or feelings and avoid thoughts, places, and memories related to the event [5].

While all traumas are caused by a crisis, not all crises result in trauma [4, 17]. Crises and traumatic events are highly subjective experiences from which people construct their own meaning. A person's response to a crisis or traumatic event is often determined by factors such as time, cultural beliefs, availability of social supports, and developmental stages [6]. For example, in some cultures, the subjugation of women is a common practice, and the experience of domestic violence is not necessarily considered to be a traumatic event.

HISTORY OF TRAUMA, DISASTER, AND CRISIS COUNSELING

A modern understanding of trauma began to develop in the mid-1800s when Jean-Martin Charcot, a French neurologist, studied symptoms of hysteria in women [4, 7]. Charcot recognized that many of his patients experienced sexual assault, violence, and poverty. He determined that the symptoms observed were psychological in nature and occurred as a result of an unbearable experience. Charcot named this phenomenon "nervous shock." Charcot's work caught the attention of Sigmund Freud, who

continued Charcot's studies [7]. In the late 1800s, Freud conducted a study on hysteria, in which he determined that hysteria resulted from trauma and that the symptoms could be alleviated through talking about the experience.

In 1896, Freud published *The Aetiology of Histeria,* a collection of 18 case studies on women [7]. In this work, Freud described hysteria as resulting from early sexual experiences in childhood; however, these ideas were so unpopular at the time that he recanted his statements. Freud resumed his work on trauma following World War I. In 1917, he published *Introductory Letters on Psychoanalysis*, in which he outlined symptoms of trauma that would later serve as the core of the classification of post-traumatic stress disorder (PTSD) in the *DSM-III* (1980) [4, 7]. Freud also expanded his concept of events that caused trauma to include war, accidents, and any event that could result in fatality [4].

The major catalyst for the beginning of crisis intervention occurred in 1942 with the Cocoanut Grove Nightclub fire, where almost 500 people died [2]. Eric Lindemann worked with many of the survivors and noted similar emotional responses that required psychological support. Lindemann's work was one of the first to conceptualize what thoughts, feelings, and behaviors may be "normal" following a crisis or disaster. Gerald Caplan's experiences with the survivors of the Cocoanut Grove fire led to some of the first attempts to explicate a crisis and to create a crisis theory [2].

Grassroots movements in the 1970s and 1980s led to the further development of crisis theory and trauma [2, 4, 7]. Veterans returning from the Vietnam War were exhibiting high levels of distress related to combat exposure [7]. The women's movement was also gaining momentum and women were drawing more attention to the negative consequences of rape, incest, and sexual assault [4, 7]. Psychiatrists began to notice similar symptoms in combat veterans and women who experienced sexual assault, including patterns of numbing, dissociative symptoms, and increased arousal [4]. This realization encouraged professionals in the field to broaden their concept of traumatic experiences.

The increased attention to crisis, traumatic experiences, and traumatic symptoms led to the incorporation of PTSD in the 1980 revision of the *DSM-III* (1980) [4]. Prior to the 1980 revision, stress-related conditions were defined narrowly and were said to be caused by combat or civilian catastrophes. The 1980 revision of the *DSM* removed lists of qualifying traumatic events and instead listed a "recognizable stressor" as the cause of stress [8]. Since then, substantial revisions have been made to trauma and PTSD in the *DSM*.

LEADERSHIP EFFORTS
In response to recent large scale disasters such as the September 11 terrorist attacks and Hurricane Katrina, the American Counseling Association (ACA) has placed an increased focus on training in disaster mental health ("Disaster Mental Health,"n.d.). Following the September 11th terrorist attacks, the ACA partnered with the American Red Cross to provide training and certification as a disaster mental health volunteer to licensed practitioners. Those who complete the training are eligible to be deployed by the American Red Cross either nationally or locally in the event of a disaster.

In 2003, the ACA developed the traumatology interest network to connect those who are interested in learning more about traumatology with those who are currently practicing trauma and disaster counseling [9]. This network has been useful in assisting counselor educators in implementing the new Council

for Accreditation of Counseling and Related Educational Programs (CACREP) standards pertaining to crisis intervention skills. The traumatology interest network creates and distributes fact sheets concerning crisis, disasters and trauma, which serve as a platform for learning skills and techniques associated with trauma, disaster, and crisis counseling. Lastly, the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the United States Department of Health and Human Services, has developed a working definition of trauma, described above, and is working closely with various agencies to promote trauma informed care[6].

In Asian countries, several studies have investigated trauma quality improvement, crisis management, disaster management, and so forth as part of the efforts to enhance public awareness, health providers, as well as professional counselors of their competencies in handling crisis and trauma during disasters or critical incidents. For example, Stelfox et al (2012) [20] found that there was a paucity of reliable data, lack of integrated trauma quality improvement activities, absence of standards of care, limited engagement of leaders, heavy clinical workload and limited resources. Similarly, counseling is a new concept for Chinese people in China, and rejection of assistance and psychological service during crisis, disaster and trauma is pretty high, especially following the Wenchuan Earthquake on May 12, 2008. Therefore, Chinese psychological professionals need to take extra steps to incorporate cultural elements in their services [21].

Changes to CACREP Standards
With the rise in human and man-made disasters, counseling professionals began to notice a need for properly trained professionals in disaster mental health and crisis counseling [10]. Counselors noted that working with clients in crisis required an additional skill set that was not being taught in counseling training programs. A study assessing the self-efficacy of new counselors' concerning crisis preparation and intervention skills indicated that master's level counseling trainees have limited exposure to crisis assessment and skills in their training [11]. However, most trainees in the study reported having to respond to high-level crises in their master's level practicum or internship or in their current workplace.

During the review standards process in 2006, CACREP received a grant from the US Department of Health and Human Services to study the need for counselor training in emergency preparedness and response [10]. This was due, in part, to the focus placed on counselors serving as responders following Hurricane Katrina. Feedback solicited from counselors revealed a strong support for the incorporation of crisis training into the counselor education curriculum. For this reason, crisis intervention techniques were included in the 2009 revision of the CACREP standards. The 2009 revision required that counselor education programs incorporate training regarding the effects of crises, disasters, and other trauma-causing events and include training on theories and models of crisis intervention, suicide assessment, and psychological first aid [12].

THE DAILY WORK OF COUNSELORS AND THE COUNSELING PROFESSION
Regardless of the setting, counselors are likely to encounter a client in crisis [3]. Most clients who present in a crisis state are experiencing chronic mental illness, acute interpersonal problems in their social environment, or a combination of the two [2]. More often than not, counselors will encounter a client who is experiencing a combination of the two, such as a trauma survivor battling addiction or a divorcee battling chronic depression. Counselors working in agencies are likely to

encounter clients living with chronic mental illness who may have a primary psychiatric diagnosis, in addition to other situational factors such as homelessness and poor social support.

Differences between Crisis Intervention and Therapy

Working with clients in crisis may differ significantly from a traditional therapeutic relationship [2, 3]. Crisis work is much more time-limited than long-term therapeutic work. The counselor typically has to build rapport quickly and may work with more resistant or overwhelmed clients [3]. What may occur over the course of a few weeks in long-term therapy may need to occur in a matter of hours in crisis intervention. Additionally, crisis work does not involve an in-depth exploration of the client's issues. The counselor works to understand the presenting problem, but does not explore further. Lastly, the therapist does not aim for long-term change in crisis counseling. The overarching goal is to move the client from a state of immobility to mobility and to return to his or her pre-crisis state.

Characteristics of an Effective Crisis Helper

When working with a client in crisis, counselors do not always have the time to reflect on which techniques and theories would be the most beneficial for the client [3]. For this reason, counselors should be introduced to and have a basic understanding of crisis theory and intervention techniques. Additionally, it is helpful if the counselor possesses some of the following characteristics: life experience, poise, creativity and flexibility, energy and resiliency, and quick mental reflexes [2].

Experiencing a situation similar to the client's can help counselors gain emotional maturity and enhance the depth and sensitivity of their interactions with clients [3]. While personal experience can be beneficial, it is also important for the counselor to be aware of and manage counter transference as it arises [2]. Poise refers to the counselor maintaining internal and emotional responses and appearing stable and in control for the client. A calming presence may help bring the client's emotional level down and can serve as a model for highly reactive clients.

Creativity and flexibility refers to the counselor's ability to adapt to the crisis situation [2]. There is no "right" way to approach a crisis situation, and counselors must be willing and able to draft a tentative course of treatment and then get rid of it if it is not working. If counselors attempt to adhere to a formula approach to crisis intervention, then they will likely be doing clients a disservice. Energy and resiliency refers to the counselor's personal wellness. Crisis work can be exhausting and can have many downs. It is important that counselors practice wellness to promote resiliency, which will be discussed further below. Lastly, crisis counselors must possess quick mental reflexes. Crisis work requires more activity and directiveness. Counselors need to be comfortable and assured in making quick decisions, especially in the assessment and action phases.

ASSESSMENT IN CRISIS COUNSELING

Assessment in crisis counseling is done rather quickly and with limited information [14, 2]. For this reason, the counselor must be able to ascertain the difference between a client who is emotionally upset and a client who is in a state of crisis [14]. Importance is placed on an accurate assessment because it is the baseline for the interventions and treatment planning. An assessment tool, such as the Triage Assessment Form (TAF) [15] is helpful in assisting counselors in providing quick, effective, and accurate assessments [2]. The TAF was developed to serve as a reliable and easy to use tool so counselors with limited assessment skills could use the form without difficulty.

In addition to formal instruments, the counselor can utilize informal measures to assess the client's affective, behavioral, and cognitive states [2]. The goal of these types of assessments is to gauge the severity of the crisis, the client's level of mobility, assess for suicidality or lethality and to assess the client's ability to think about the situation in a logical manner [2].

Recognizing Symptoms of Trauma and PTSD

Recognizing possible indicators of PTSD is an integral part of crisis counseling because it may be a precursor to some crisis situations such as substance abuse, or an after effect of others such as sexual assault [2]. PTSD frequently presents with a comorbid diagnosis, such as depression or substance use, and symptoms often get overlooked when the focus is placed on the personal or interpersonal distress that occurs as a result of the PTSD [4, 7]. Clients presenting with symptoms of trauma may seek treatment after a clearly identifiable traumatic event such as a disaster, illness, or assault [4]. Counselors may also encounter situations where the trauma presentation is less obvious, and past traumatic experiences are contributing to current difficulties.

For the response to be considered PTSD, the *DSM-5* states that following a traumatic stressor, an individual must experience symptoms in four clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and activity [5]. Intrusion refers to re-experiencing the event through nightmares, flashbacks or spontaneous memories of the traumatic event. Avoidance is marked by a persistent evasion of reminders of the event. Negative alterations refers to the range of negative emotions, beliefs, and cognitions (guilt, shame, anger) an individual may develop as a result of the traumatic event. Alterations in arousal are marked by hypervigilance, aggressive or self-destructive behaviors, and sleep disturbances. These symptoms must cause significant impairment in an individual's functioning and symptoms lasting for at least one month.

Trauma assessment is most commonly done through a structured clinical interview; however, counselors may find it useful to use additional assessment tools to increase understanding and treatment of a multitude of potential trauma responses [4]. It is also important for counselors to recognize symptoms of trauma so they can make accurate referrals in the action phase; when necessary. Counselors should be able to recognize when they are working outside of their competence and may risk doing more harm because of an ill-informed approach.

PSYCHOLOGICAL FIRST AID

Psychological first aid (PFA) has become the basic approach clinicians use when responding to crises. This approach attends to Maslow's hierarchy of needs, in which physical needs and safety are addressed before moving to emotional stabilization. Given the time-sensitive nature of crisis work, this approach is not meant to be curative. Rather, it is meant to alleviate the problem until further action can be taken. PFA is a non-intrusive method that offers practical assistance and stabilization. PFA is not meant to serve as a full-blown theory or intervention model. It is the basics of crisis intervention. Although PFA is presented in a step-by-step manner, crises are chaotic and often do not occur in a linear format [1]. For this reason, assessment is a continuous and ongoing process when working with a client in crisis.

The first three steps of PFA are focused on attending, observing, and understanding the client's problem (James, 2008). In the first step, counselors use their core listening skills to define and understand the problem from the client's perspective. In the next step, counselors assess the client's safety and work to minimize physical and psychological dangers. The third step involves providing emotional, instrumental, or informational support. The type of support is dependent upon the needs of the client;

however, this is when the counselor shows the client that they are valued and supported.

The final three steps of PFA are focused on taking action [2]. In the fourth step, the counselor and client examine appropriate choices that are available to the client. The amount of input from the client is dependent upon his or her level of distress. The counselor and client should examine social supports, coping mechanisms, or behaviors the client can engage in to get through the crisis, and positive and constructive thinking patterns to help reduce stress and anxiety. The fifth step in PFA involves making plans. The counselor and client identify additional people and referral sources that can be contacted for immediate support and develop concrete actions the client can do in the moment. This step is central in the client regaining control and autonomy. The final step involves obtaining a commitment from the client. This step is often very brief, and the goal is to have the client commit to one or more behaviors that will assist in restoring them to their pre-crisis state.

COUNSELOR SELF-CARE

Crisis, disaster, and trauma counseling is challenging work, and counselor self-care is an important and essential aspect [4, 7]. When working with clients in crisis or with people who have experienced intense psychic trauma, counselors are also at risk for experiencing vicarious traumatization (VT), or stress resulting from working with clients who have been traumatized or are suffering (Levers, 2012). Counselors may be at risk of experiencing symptoms similar to their clients. One way to mitigate the chances of experiencing VT is to seek out supportive and regular supervision [7]. Experiences in supervision often reflect experiences in the counseling relationship, and ongoing supervision may assist practitioners in recognizing when they may be experiencing symptoms of VT.

Counselors must take the time to promote their emotional, physical, mental, and spiritual wellbeing [13, 16]. Self-care is a time for reflection, healing and growth. Without it, the effectiveness of the crisis and trauma work may be diminished. Counselors cannot effectively assist clients without attending to their own emotional needs. When they engage in self-care, they are able to remain present and fully attend to the needs of the client. Counselor self-care can also assist clients in developing resiliency. While crises and trauma can be painful experiences for both the counselor and the client, working through them provides an opportunity for the client to recognize their strength and ability for growth.

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