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The Efficacy Of A Crisis Intervention And Resilience Building Training Program For Counselors-In-Training

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THE EFFICACY OF A CRISIS INTERVENTION AND RESILIENCE BUILDING TRAINING PROGRAM FOR COUNSELORS-IN-TRAINING

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DEDICATION

This dissertation is dedicated to my mother and my best friend, Margaret Davenport. Thank you for loving and supporting me, even when I went against the grain. Thank you for always listening to me and believing in me. Thank you for being the consummate optimist no matter what life placed in front of me. Thank you for motivating me to do my best, while inspiring me to be the best person that I can be. Thank you for caring for Ameerah while I went to work or to school or when I just needed a break. Thank you for being a genuinely kind, caring, and loving individual. I could not have asked for a better mother. I aspire to be the mother to Ameerah that you are to me. I love you with all my heart.

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CHAPTER 1

Introduction

From war and disasters to interpersonal violence and community violence, potentially traumatic events have become all too familiar and widespread in our society. Researchers estimate that yearly, 20% of individuals in North America experience a traumatic event and 60% of individuals will be subjected to at least one traumatic event during their lifetime (Meichenbaum, 2012). After a traumatic event a person may enter a state of crisis, which may adversely affect their long and short-term mental health. Given the pervasiveness of potentially traumatic events, counselors in all settings, such as private practice, community agencies, and psychiatric hospitals will assist individuals in crisis (Echterling, 2005; Trippany, White Kress, & Wilcoxon, 2004).

The American Psychiatric Association defines a trauma as “exposure to actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2013, p. 271) It further states that the individual can be affected either by directly experiencing or being a witness to the event, being informed that the event affected a close family member or friend, or being in a situation where the individual is repeatedly told or subjected to aversive details of the event (American Psychiatric Association, 2013). Traumatic events can be classified as either “Acts of God”, such as natural disasters, accidents or illnesses where there is no direct culprit or that which is “human induced”, where responsibility can be placed (Courtois & Gold, 2009). The prevalence of these experiences in our society is evident when considering events such as the September 11, 2001 attacks, Hurricane Katrina, the 2004 Asian Tsunami, or the over one million violent crimes in the United States such as, rape, robbery and aggravated

assault reported to law enforcement agencies in 2012 (NCVS; Bureau of Justice Statistics, 2012).

Crisis

Immediately following a traumatic event the individual is said to be in crisis, a period of time which can lead to either some degree of trauma symptomology or psychological resilience. A crisis by definition is a "period of psychological disequilibrium, experienced as a result of a hazardous event or situation that constitutes a significant problem that cannot be remedied by using familiar coping strategies" (A. R. Roberts, 2005, p. 11). Thus, it is not the event that determines whether an individual enters a state of crisis, but the individuals' subjective appraisal and reaction to the event, therefore what may constitute as a crisis to one person may not be a crisis to another. Hence, not all traumatic events lead to a crisis and not all crises lead to the development of trauma symptomology. According to Kanel (2007), a crisis consists of three main components (1) a precipitating event; (2) the individuals perception of the event producing subjective distress; and (3) the inability to utilize familiar coping methods, reducing their level of functioning. Crises can either be developmental, stemming from normal life transitions or situational, resulting from unusual, extraordinary or traumatic events.

During a state of crisis, an individual may experience feelings of anxiety, emotional unrest, anxiety, panic, helplessness, hopelessness, inadequacy, physical complaints, anger, guilt, shock, confusion, and disbelief resulting in lowered functioning and higher vulnerability. Crisis has been conceptualized as a point in an individuals' life where there is "both danger and opportunity"(A. R. Roberts, 2005, p. 12). Danger exists

because there is the possibility of the individuals' coping mechanisms being overwhelmed, potentially resulting in pathology, suicide and/or homicide. But a state of crisis may also provide an opportunity for the individual, because the desire by the individual to ascertain a level of homeostasis or terminate the disequilibrium serves as an impetus, to seek counseling, learn new coping skills and foster or demonstrate psychological resilience.

The extent of the crisis is based on the severity of the traumatic or precipitating event as well as the individuals psychological and social resources (Slaikeu, 1990). Crisis management in many instances is invaluable in mitigating the potential injurious mental health effects which may arise and therefore is an integral and necessary component in the field of counseling (Hoff, Hallisey, & Hoff, 2009). Whether a client enters therapy to specifically address the crisis, or a crisis arises during on-going therapy, for counselors the need to use crisis intervention is inevitable. Crisis interventions are methods and strategies implemented to assist the individuals in coping with the negative effects of the crisis.

Crisis Management

Crisis management defines an entire process, from crisis onset to resolution and includes two distinct phases, first-order and second-order interventions (Slaikeu, 1990). First-order interventions or psychological first aid focuses on the stabilization of the individual and consists of interventions that are generally performed in the immediate phase, usually by trained volunteers, typically up to 96 hours post- trauma. According to

the National Institute of Mental Health (2002), psychological first aid includes ensuring the safety of the individual, minimizing their stress-related symptoms, allowing for physical rest and recuperation, and connecting them to viable resources and supports.

Second-order interventions (secondary prevention interventions) or what is referred to as, crisis therapy, early interventions for trauma, or crisis counseling should be performed by trained mental health practitioners and occurs in the acute period, which may be days, weeks, or even months post-trauma and specifically focuses on the cognitive, affective and behavioral consequences of the crisis (Hoff et al., 2009). During counseling the counselor attempts to understand the clients "cognitive key" or the meanings the client assigns to the event (Slaikeu, 1990).

There are significant differences between general counseling and crisis counseling. For instance, a crisis is inherently time-limited because an individual can only endure being in psychological disequilibrium for approximately four to six weeks without any form of intervention (Kanel, 2007). While general counseling and crisis counseling, both utilize similar counseling techniques, the specific emphasis on problem solving and mitigation of hazardous events in crisis therapy in lieu of psychological issues separate these modalities. Furthermore, the tasks of crisis counseling which include ensuring physical survival, assisting in expression of feelings, gaining cognitive mastery and making necessary behavioral adjustments for future functioning are definitive from the onset (Slaikeu, 1990).

Crisis Intervention Training

This current study was in part based on research addressing the lack of and need for crisis counseling in counselor preparation curricula. A study by Morris and

Minton (2012), assessed the level of preparation, crisis intervention self-efficacy and extent of crisis intervention experience for counselors (N=193) who had completed their degree within the past two years. The trend of results was alarming. For example, only 20% of participants (n=40) stated that they had completed a formal course in crisis intervention. Similarly, a majority of participants noted that they had received little to no preparation in a number of specialized crisis areas, such as crisis theory, crisis management skills, individual or family-level trauma, violence intervention, community disaster, and crises related to physical assault, sexual assault, and partner violence.

Furthermore, in a sample of 129 students attending a graduate program accredited by the American Psychological Association (APA) in Texas only 35.6% of respondents reported extensive training in traumatology and 25% of the students reported working with clients affected by a traumatic incident with no formal training (Adams & Riggs, 2008). Bride, Smith Hatcher, and Humble (2009), surveyed 225 members of the National Association of Alcohol and Drug Addiction Counselors to determine their level of trauma training, practices as well as the prevalence of secondary traumatic stress symptoms. They concluded that although almost 97% of the counselors indicated that they had traumatized clients on their case load, they had limited formal academic training in trauma. This lack of training was also shown to reflect the counselors' practices when treating clients. For instance, counselors reported that they regularly assessed clients for traumas relative to abuse but less frequently for experiences related to disaster or crime victimization.

The lack of assessment for trauma is problematic given that a history of trauma can not only result in symptoms of posttraumatic stress disorder (PTSD) but also

symptoms of acute stress disorder and depression, dissociative disorders, anxiety symptoms and disorders, substance abuse issues, personality disorders, and psychosis (Gold, 2004). This shortage of training in crisis management and traumatology in counseling programs is even more problematic when considering that individuals with a mental illness are more susceptible than most to being in a state of crisis (Hoff et al., 2009).

This research also in part, addressed the 2009 Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards mandate for the implementation of crisis and traumatology curricula as well as theories highlighting facets of resilience. These standards outline a number of areas related to crisis management, resilience, and self-care that students must demonstrate knowledge in including:

(1) In professional orientation and ethical practice they must have an understanding of:

   a. Their roles and responsibilities as a member of a response team during a crisis, disaster or other trauma-causing event;
   b. Self- care strategies.

(2) In human growth and development they must have an understanding of:

   a. Effects of trauma-causing events for persons of all ages;
   b. Theories and models of resilience.

(3) In helping relationships they must have an understanding of:

   a. Crisis intervention, suicide prevention models, and psychological first aid strategies (CACREP;2009).

Thus, training in crisis preparation is not only necessary because of the unavoidability of crisis counseling but also because it is mandated by the accrediting body for counselor education programs.

Psychological Resilience

During a crisis because the individual has appraised the event as deleterious and believes that they lack the self-efficacy to cope, essentially, they are unaware of, underutilizing, or don't know how to use their strengths or coping mechanisms (Dziegielewski & Powers, 2005). Resilience involves the individuals' ability to successfully adapt and maintain a relatively stable equilibrium after facing a potentially traumatic event, if one's adaptational systems are functional, resilience occurs; if impaired or overwhelmed, symptomology results (Bonanno, 2004; Masten, 2001; Meichenbaum, 2012). Psychological resilience or ability to successfully adapt consists of a "set of flexible cognitive, behavioral, and emotional responses…. which can be learned and are within the grasp of everyone"(Neenan, 2009, p. 17).

The resilience approach is potentially a powerful strategy, which allows counselors to assist the client in utilizing their own psychological strength to promote positive change. Hoff et al. (2009) stated that, "the heart and soul of successful crisis resolution consists of reducing one's vulnerability while enhancing one's resilience and capacity for emotional growth" (p. 5). Therefore, it is essential that counselors are trained to assist the individual in recalling, assessing, and applying if viable, previous facets of resilience used as well as learning new ways to build resilience. Although the psychological disequilibrium will naturally subside without professional intervention, the crisis may not be resolved and may result in future mental health issues. When

counseling or crisis resolution is provided in this state of susceptibility the individual will stabilize at a point of greater functioning (Kanel, 2007). Assistance provided by the counselor at this juncture is pivotal because it affects not only the individuals' current and future mental health but also their level of coping self-efficacy when faced with future crises (Dziegielewski & Powers, 2005).

This concept of building psychological resilience after crisis is not novel, but to date has been minimally used in clinical practice. The paucity of using resilience building is due to the overwhelming use of psychopathology or risk factors as opposed to resiliency factors guiding the therapeutic treatment of individuals exposed to traumatic events. Particularly, since the legitimization of posttraumatic stress disorder (PTSD) by the American Psychiatric Association (DSM; 1980) as a response to traumatic events, literature and clinical practice have been predominantly focused on pathology. Evading the fact that although over half of adults will experience at least one traumatic event in their lifetime, the prevalence rate of PTSD in civilian populations is only 7.9% (Ozer, Best, Lipsey, & Weiss, 2003).

This deficit-focused approach centers on the negative symptomology presented by the individual, as opposed to their strengths and the enhancement of their coping abilities. This limited approach also disregards the multiple trajectories of response to trauma that an individual may exhibit, such as resilience, recovery, delayed dysfunction and chronic dysfunction (Bonanno, 2004; Norris, Tracy, & Galea, 2009). Thus, while normative posttraumatic stress reactions may occur immediately following a traumatic event or sporadically in the weeks following, the most common outcome after

experiencing a potentially traumatic event is resilience (Bonanno, 2004, 2005; Bonanno, Galea, Bucciarelli, & Vlahov, 2006).

Psychological resilience building is becoming an integral component in the assistance of individuals pre- and post-trauma as well as in the mental health field in general. For instance, the Practice Directorate of the American Psychological Association after the September 11, 2001 terrorist attacks launched their public education initiative "The Road to Resilience" to inform individuals about ways to build resilience in everyday living and when faced with adversity. Similarly, the military has developed a number of preventative resilience building programs and organizations in an effort to proactively mitigate the negative effects of adverse stress and trauma of military personnel (Bowles & Bates, 2010; Cornum, Matthews, & Seligman, 2011). While in clinical practice, practitioners have begun to utilize and outline how resiliency determinants found in individuals without psychopathology post-trauma may assist those individuals who do have difficulties (Mancini & Bonanno, 2006; Neenan, 2009).

For example, in the treatment of survivors of Hurricane Andrew in 1995 members of the American Red Cross Disaster Mental Health Services noted the need to use a strengths-based approach in order to increase their effectiveness (Shelby & Tredinnick, 1995). The pervasive concern of helplessness exhibited in the adult survivors prompted the counselors to explore possible preexisting resilience factors. Although these two counselors utilized different theoretical approaches, cognitive-behavioral and brief solution-focused approach, they ultimately implemented comparable procedures. Thus, the focus on interventions and strategies varied in time and depth but overall involved the same process: (a) building a therapeutic relationship, (b) allowing clients to describe

past coping experiences, (c) building on the individuals' perceived strengths, and the use of stress reduction exercises (Shelby & Tredinnick, 1995).

Secondary Traumatic Stress

Practitioners who work with traumatized individuals must have a certain knowledge base and skill set, while also understanding the damaging psychological influence these experiences can have on their own mental health and coping mechanisms (Courtois & Gold, 2009). Because of the intensity of working with individuals post-trauma, the psychological health of counselors may also be negatively affected. This vicarious traumatization (McCann & Pearlman, 1990) that may occur is the result of the counselors' "empathic engagement with the clients' traumatic material", it affects the counselors worldview, psychological state, and cognitions (Salston & Figley, 2003). The scarcity of training in crisis management and traumatology has been delineated as a major contributor to trauma-related stress, interchangeably referred to as secondary traumatic stress (Figley, 1995), vicarious traumatization (McCann & Pearlman, 1990), secondary traumatization (Stamm, 1995) or compassion fatigue (Figley, 1995) experienced by mental health workers (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995).

Counselor educators have an ethical obligation to not only warn student counselors about the hazards of working with individuals exposed to trauma but to train them on ways to cope after exposure (Munroe, 1999). If counselors are to continue working effectively after repeatedly being exposed to their clients' trauma-material, they must themselves be psychologically healthy. Thus, it is essential that counselors receive training in crisis intervention strategies that foster their own resilience and

resilience in their clients. Resilience building as an integral part of a crisis intervention program may serve to be beneficial in alleviating or deterring symptomology in both clients and counselors.

Statement of Problem

Given the pervasiveness of potentially traumatic events, counselors in all settings, will inevitably have to assist individuals in crisis, yet counselors receive minimal training in their graduate-level courses (Echterling, 2005; Morris & Minton, 2012; Trippany et al., 2004). Many counselors may be required to use crisis intervention skills, as early as the internship phase of their counseling program (Minton & Pease-Carter, 2011; Morris & Minton, 2012). Although the 2009 CACREP standards require the inclusion of crisis intervention into masters level curricula, status as a CACREP accredited program has shown to have no effect on the level of crisis preparation received (Morris & Minton, 2012). This lack of training may have deleterious and compounding effects for the client, who may as a result be further traumatized and the counselor who may experience secondary traumatic stress. Similarly, because of the traditional focus on negative symptomology the use of resilience enhancing strategies is minimal in counselor education programs.

According to the American Counseling Association Code of Ethics, counselors should practice “only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience” (ACA, 2014, p. 8). Given the inevitability of using crisis counseling, it is the ethical responsibility of counselor educators to provide a curriculum that teaches not only crisis counseling but also the vicarious traumatization

or secondary traumatic stress that could potentially result from such work and ways of mitigating its harmful effects.

Courtois and Gold (2009), stressed the importance of training all mental health professionals to adequately assist individuals who have been psychologically traumatized, stating that the proscription of “do no harm” should in actuality be “do no more harm”. They further suggest that ill-prepared professionals may be unable to effectively respond to their clients and in fact may cause a “second injury” or re-traumatize these individuals. Therefore, they call for the extensive implementation of trauma curricula beginning in undergraduate level classes and a dedicated focus on the graduate level, particularly, in clinical and supervision classes.

Litz (2008) stressed the need of utilizing key components of the cognitive behavioral framework to devise early interventions for trauma which “reduces symptoms, increases functioning, promoting agency, hope, acceptance, and meaning-making, assisting individual’s garnering of personal and social resources, and fostering a planful and strategic approach to future trauma-related challenges”(p. 505). This training attempts to address this issue by integrating the essential counseling strategy of resilience building with rational emotive behavioral therapy.

Similarly, many counselors may lack training in ways to build resilience although it may minimize or prevent negative symptomology for individuals in crisis following a traumatic event. To date, no studies have focused on training counseling students to build resilience in their clients, foster resilience during a crisis and only one study has focused on increasing resilience in counselors to enhance their personal self-care

(Skovholt, Grier, & Hanson, 2001) but no studies have attempted to bridge these inner-connected concepts.

Purpose of the Study

The purpose of this study was to evaluate the effectiveness of a crisis preparation training and resilience building program, which was grounded in the principles of rational emotive behavioral therapy (REBT). The goal of this training program was to increase crisis preparation in counselors-in-training and increase the practice of resilience building as an applicable intervention strategy, amongst other strategies, post-trauma. Because counselors who have taken at least one course in crisis management during their master's program, note higher levels of crisis self-efficacy (Morris & Minton, 2012) this study sought to examine whether a crisis preparation and resilience building training program for Master's level students would increase their crisis counseling self-efficacy. Additionally, this study sought to determine whether the resilience component taught as part of the training would enhance the resilience of the counselor-in-training.

This training program included the necessary pre-crisis preparation areas essential for mental health professionals. McAdams III and Keener (2008), indicated that pre-crisis preparation should include: (a) attaining information regarding crisis epidemiology and effect; (b) knowledge regarding evaluation for potential risk factors; (c) developing a knowledge base for crisis response procedures; and (d) understanding the philosophy regarding the etiology of crises and who is responsible for intervening when one occurs.

The study specifically focused on assisting adult individuals in crisis as opposed to groups or children. Because this module is developed for counselors-in-training, it specifically focuses on crisis management performed by mental health professionals as opposed to non-professionals conducting crisis interventions. In this model resilience building is used as a treatment strategy for assisting clients and as a preventative measure for assisting counselors in evading secondary traumatic stress.

Research Questions

Research Question 1: Does a crisis intervention and resilience building training program increase crisis counseling self-efficacy for counselors-in-training?

Research Question 2: Does a crisis intervention and resilience building training program increase the resilience of counselors-in-training?

Research Hypotheses

Hypothesis 1: A crisis intervention and resilience building training program will increase crisis counseling self-efficacy for counselors-in-training.

Hypothesis 2: A crisis intervention and resilience building training program will increase the psychological resilience of counselors-in-training.

Definition of Terms

Trauma: exposure to actual or threatened death, serious injury, or sexual violence either by directly experiencing or being a witness to the event, being informed that the event effected a close family member or friend, or being in a situation where you are repeatedly told or subjected to aversive details of the event (American Psychiatric Association, 2013).

Crisis: "A period of psychological disequilibrium, experienced as a result of a hazardous event or situation that constitutes a significant problem that cannot be remedied by using familiar coping strategies" (A. R. Roberts, 2005, p. 11).

Crisis intervention: Methods and strategies employed to assist individuals in coping with the negative effects of a crisis.

Crisis counseling: a time-limited component of crisis resolution conducted by mental professionals with the specific emphasis on problem solving and mitigation of the cognitive, emotional, and behavioral consequences of a hazardous event.

Psychological resilience: Resilience is the ability to successfully adapt and maintain a relatively stable equilibrium after facing a potentially traumatic event (Bonanno, 2004).

Resilience building: A multidimensional approach used by mental health professionals to assist clients in achieving positive outcomes following adversity (i.e. meaning-making, coping styles, psychological strengths, self-efficacy beliefs).

Rational emotive behavior therapy (REBT): Developed by Albert Ellis, REBT is a cognitive behavioral approach which is based on the premise that our emotions result mainly from our beliefs and reactions to an event. REBT uses the ABC framework to assist clients in understanding and changing (if necessary) their beliefs and feelings. In this model (A) represents the activating event, (B) the belief about the event, and (C) the emotional or behavioral consequence(s), (D) disputing intervention, (E) effect and (F) new feeling.

Counselor-in-training: For this study a counselor-in-training refers to a graduate student pursuing their master's degree in Counseling at a Midwest urban university.

Secondary traumatic stress: Secondary traumatic stress is the negative emotional consequence, comparable to symptoms of posttraumatic stress disorder (PTSD), experienced after hearing firsthand of traumatic event experienced by another. For this study, the secondary traumatic stress is the result of counselors being exposed to clients' trauma material in a clinical setting.

Assumptions

1. The participants have a foundational knowledge of the counseling process and theories of counseling.
2. Participants have the cognitive ability and foundational knowledge to comprehend the information given during the training and complete the corresponding outcome measures.
3. Participants will respond to the outcome measures honestly.
4. The instruments used as part of the study have reliability.

Limitations

1. The study was limited to master's level counselors-in-training at a single university who have completed the introduction to counseling or foundations of rehabilitation counseling course as well as the theories of counseling course.
2. The study was limited by the small sample size; therefore generalizability of the study is limited.
3. The research specifically focused on counselors in training and did not include trained volunteers.
4. The research specifically focuses on crisis interventions utilized with adults as opposed to children.

Chapter 2

REVIEW OF LITERATURE

Introduction

While individuals post-trauma may experience transient trauma symptomology, in general the most prevalent response to trauma is resilience (Bonanno, 2004, 2005). Psychological resilience is the ability to successfully adapt and maintain a relatively stable equilibrium after facing a potentially traumatic event (Bonanno, 2004). Resilience is not a trait because an individual may not display resilient outcomes during every adversity; but a multidimensional construct which has been and can be learned by anyone (Luthar & Cicchetti, 2000; Neenan, 2009).

After a traumatic event mental health counselors may be required to utilize crisis management skills to assist individuals who do have difficulties in functioning by building resilience. Building resilience may work to curtail or mitigate potential posttraumatic symptomology. In crisis counseling the counselor can assist in building resilience by focusing on modifiable dimensions of the resilience construct such as self-efficacy beliefs, coping style, perceived strengths, strengthening social relationships and ultimately the meaning assigned to the event. However, counselors may not have had sufficient preparation in crisis management and due to the focus of psychopathology may not be trained in the practice of resilience building.

Due to the frequency of which counselors may have to provide crisis counseling and the disclosure of intimate details of the traumatic event during this process, counselors may be subject to distressing material, intense emotions and thus subject to posttraumatic symptomology similar to that of the client (Figley, 1995). This secondary

traumatic stress experienced by counselors may be minimized by increasing their knowledge base regarding crisis counseling as well as teaching them strategies to build their own resilience.

By combining an effectual theoretical intervention such as rational emotive behavior therapy with positive psychology counselors may be able to minimize posttraumatic symptoms, as well as increase their current and future resilience and their clients. Thus this chapter will review literature pertinent to understanding crisis counseling, building resilience after trauma, rational emotive behavior therapy, and secondary traumatic stress.

Crisis Counseling

Crisis counseling can be defined as "a time-limited aspect of crisis resolution focusing on the emotional, cognitive, and behavioral ramifications of a crisis" (Hoff et al., 2009) performed by trained mental health professionals. Because of the state of our society all counselors at some point will have to perform crisis counseling. However, individuals in crisis may differ from clients who are seen in everyday practice in that although they may be in emotional turmoil they may not have a clinically diagnosable illness. Particularly, in the instance of situational crises because the event is unanticipated and out of the individuals control it may potentially be traumatic. Situational crisis are the result of (1) human-caused or environmental catastrophes, such as the September 11 terrorist attack or Hurricane Katrina, (2) personal or physical illness or harm such as a motor vehicle accidents, sexual assault or heart attack, and (3) significant interpersonal or social changes such as the death of a close family member or friend (Hoff et al., 2009).

As described by Tyhurst (1951, as cited in Hoff et al., 2009) crises are believed to progress as distinguishable phases. The first phase is designated as a period of impact or the experiencing of the event which causes an increase in tension and anxiety. If the individual is unable to call upon their usual methods of problem-solving to mitigate the situation they enter a "period of recoil" in which they consciously become more aware of what has taken place and their corresponding emotions. In the third "posttrauma" phase, the individual attempts to recall and apply any all resources, new and old, they deem potentially beneficial due to their intense negative emotional state. During these latter stages along with the intense emotions they are experiencing, the individual must also begin to navigate the potential consequences and losses of the event, whether financial or social. If the individual is resilient, changes the meanings, beliefs or subsequent goals related to the hazardous event the crisis is averted, if not the individual enters a state of active crisis.

Assessment in Crisis Management

When utilizing crisis counseling, a key component is to understand how the crisis has manifested in the individuals life and whether it has caused impairment. The degree of impairment in functioning will dictate the level of treatment and the degree of resilience demonstrated. Typically, impairment will be displayed as intense emotions, biophysical changes such as headaches, exhaustion, or abdominal pains, a disruption or change in cognitive schemas, as well as behavioral changes such as the inability to perform work tasks (Hoff et al., 2009). Thus assessment is a first step in crisis resolution followed by plan development, implementation of the plan, and follow-up and evaluation. Assessment typically utilizes pre-functioning status as a baseline and

consists of two distinct levels (1) level one, which assess whether the individual is a threat to self or others and should be done by everyone and (2) level two which is a comprehensive assessment performed by a trained mental health professional (Hoff et al., 2009).

According to (Hoff et al., 2009) the level two assessment should include information regarding the crisis, what phase of crisis the individual is in, how the crisis is manifesting from a cognitive, affective, behavioral and somatic perspective, the individuals resources including strengths, and environmental factors that affect their functioning. A common crisis assessment tool used is the BASIC ID (Lazarus, 1989), which refers to the modalities of a personality. This acronym stands for (B) behaviors, (A) affect, (S) sensations, (I) cognitive images or mental pictures, (C) cognitions or beliefs, (I) interpersonal relationships and (D) drugs or biological functions, all of which may be altered as a result of a crisis.

Because the goal is to develop a plan of action to assist the individual in achieving a positive resolution to the crisis, the counselor should also assess for strengths, which is a core component of resilient outcomes. If deficits are the focus during assessment, they will remain the focus throughout the helping process for the client and the mental health professional (Saleebey, 2002). By focusing on the clients strengths and instances in which they have had resilient outcomes the counselor is able to foster hope, highlight that alternatives are attainable, and activate areas of previous competency used by the individual (Saleebey, 2002). Psychological strengths can be evaluated in terms of cognitions, emotions, motivation, coping style and methods, and interpersonal functioning (Saleebey, 2002). Regardless of the extensiveness of the

crisis intervention plan resilience building should be integrated. Ultimately the plan of action should comprise of strategies which enhance coping skills, promote growth, and prevent deleterious outcomes.

Standards for Implementing Crisis Interventions

One conundrum that has plagued mental health professionals is whether early psychological intervention should be administered and if so, when and how. The Department of Veterans Affairs (VA)/ Department of Defense (DOD) have set out a number of clinical guidelines for management of acute stress and interventions to prevent posttraumatic stress disorder. According to their guidelines, in the four days post-trauma psychological first aid should be utilized in an effort to stabilize the individual and attend to their basic needs and safety (Nash & Watson, 2012).

> Psychological first aid is a flexible conversational approach that provides comfort, support, connectedness, information, and fosters coping in the immediate interval. The assumption is that because of personal shock, confusion, disorganization, and disconnection, and systemic, familial, and organizational failure or dysfunction, the individual and cultural resources individuals (and groups) would otherwise call upon to heal and recover from trauma are unavailable. (Litz, 2008, p. 504)

However, they further state that if symptoms of distress or impairment persist, then trauma-focused cognitive-behavioral (TF-CBT) should be utilized to assist the individual for approximately four to five sessions (Nash & Watson, 2012). This strategy attempts to allow for natural resilience or restorative factors to be employed but does not delay assistance to the extent that functioning is severely disrupted. This approach is in contrast to the one-size-fits all intervention critical incident stress debriefing which is no longer thought to be practical and may actually be psychologically harmful (Litz, 2008).

Resilience and psychological response to trauma

To date, after a traumatic event resilience building has been relegated and posttraumatic stress disorder (PTSD) has taken the forefront as the most well-known, commonly referenced and researched outcome. This narrow focus also negates the fact that individuals may also have an increased vulnerability to acute stress disorder, dissociation, depression, anxiety disorders, psychosis, substance abuse disorder, personality disorders and physical illnesses(Courtois & Gold, 2009). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5;2013) specifically delineates PTSD and Acute Stress Disorder (ASD) as conditions which may develop as result of experiencing a traumatic event(s). The criteria for PTSD includes: (a) intrusive symptoms such as distressing memories, dreams, flashbacks, or physiological reactions; (b) persistent avoidance of stimuli associated with the event; (c) negative changes in cognitions or mood developing or worsening after the event; (d) changes in the individuals arousal and reactivity post-event and; (e) clinically significant impairment in areas of functioning such as social or occupational functioning (American Psychiatric Association, 2013). Similarly, symptoms of Acute Stress Disorder (ASD) may include: (a) intrusive symptoms; (b) negative mood; (c) dissociative symptoms; (d) avoidance symptoms; (e) arousal symptoms and (f) clinically significant impairment in areas of functioning (American Psychiatric Association, 2013).

After a traumatic event, although commonly thought of as one phenomenon recovery distinctly differs from resilience (Bonanno, 2004, 2005; Norris et al., 2009). Recovery entails a temporary presentation of psychopathology usually lasting several months and a return to pre-event functioning. In contrast, resilience may involve a short

period of distress, however this is minimal and the individual, in general, is able to function effectively, maintaining a stable psychological and physical equilibrium (Bonanno, 2004, 2005). While most individuals only experience transient posttraumatic symptomology, for those individuals who do experience significant distress or impairment a key component in crisis counseling is to increase their resilience (Hoff et al., 2009). Therefore, the first line of defense in mitigating or preventing posttraumatic reactions should include resilience building.

Theoretically there has been heterogeneity in the definition of resilience however, Luthar and Cicchetti (2000) note the two widely accepted major constructs of this process include adversity and positive adaptation. Resilience is not a trait because an individual may not display resilient outcomes during every adversity; but a multidimensional construct which has been and can be learned by anyone (Luthar & Cicchetti, 2000; Neenan, 2009). In crisis counseling, the counselor can assist in building resilience by focusing on particular dimensions of the construct such as self-efficacy beliefs, coping style, positive emotions and perceived strengths which are modifiable and grounded in the individuals thinking or beliefs about the event (Fredrickson, Tugade, Waugh, & Larkin, 2003; Masten & Reed, 2002). Resilience may be displayed differently manifesting in one's thoughts, behavior or affect during day-to-day struggles or when faced with extreme adversity. Resilience is also commonly used interchangeably with coping and while similar, coping consists of strategies employed by the individual during adversity, whereas resilience demarcates an outcome (Campbell-Sills, Cohan, & Stein, 2006).

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Risk Factors and Protective Factors Related to Resilience

Individual risk factors for the development of symptomology or alternatively protective factors that increase resilience can be classified in terms of pre-traumatic, peritraumatic or posttraumatic factors. Brewin, Andrews, and Valentine (2000), in their meta-analysis of risk factors of PTSD noted that peritraumatic and posttraumatic factors such as the magnitude of the trauma, perceived social support, and subsequent life stress had a stronger predictive effect than did pre-traumatic variables such as education and childhood adversity. While understanding that the risk factors for posttraumatic symptomology are significant and have been traditionally highlighted, understanding what factors that aid in the enactment of psychological resilience may be just as valuable.

Bonanno, Galea, Bucciarelli, and Vlahov (2007), examined socio-contextual factors that predicted psychological resilience six months after the September 11, 2001 attacks in adults (*N*= 2,752) living in the greater New York area. The degree of resilience was measured by the number of PTSD symptoms present, with zero or one symptom indicating resilience and two or more symptoms, without a PTSD diagnosis, signifying mild to moderate trauma. While individuals classified as having probable PTSD was based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). In this study, they were able to distinguish between, resilience, mild-moderate categories of PTSD and probable PTSD based on being directly affected by the event, age, depression symptomology, recent stressors, gender, change in income and income level, history of trauma and traumatic event post- September 11, and marijuana use.

Although there was asymmetry within these variables, in general the results showed that women were less likely to be resilient and there was no distinction in resilience amongst racial-ethnic groups, except for Asian Americans who more likely to be resilient. Furthermore, individuals over the age of 65 were three times more resilient than the counterparts in the 18-24 year old age group. In terms of resources, individuals who were negatively affected financially in the aftermath of the September 11 attacks were less likely to be resilient. While similar to the meta-analysis conducted by (Brewin et al., 2000), which found that perceived lack of social support predicted PTSD, perceived social support was found to predict resilience.

In a meta-analysis examining the relationship between psychological variables such as risk and protective factors, demographic factors and the construct of resilience, Lee et al. (2013) reviewed 33 studies from 2001 to 2010. Because of their supported validity the researchers chose to use only studies that were conducted using the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) or the Resilience Scale (RS; Wagnild & Young, 1993). As a result, they concluded that the largest effect on resilience was a result of protective factors, while risk factors produced a medium effect and demographic factors the smallest. Particularly, protective factors of self-efficacy, positive affect and self-esteem, respectively, were strongly and positively correlated to resilience, indicating that these may be pertinent factors in the composition of this construct.

Self-efficacy is a pivotal component in attaining a resilient outcome. Self-efficacy is the individual's belief that they are capable of managing their own functioning, the demands placed on them as well as the ability to exercise control over the events in

their lives (Bandura, 1997, 2001). Efficacy to exercise control in one's life is central post-trauma, if an individuals does not feel confident in their ability to manage an event or believes it surpasses their coping mechanisms the psychological effects can be debilitating. In assisting clients to increase their self-efficacy and thus promote a resilient outcome interventions should include personal learning experiences the client has experienced in which they had a resilient outcome, vicarious learning or learning what others did to achieve a resilient outcome, social persuasion or encouraging the client that they do have ability to achieve their outcome given past examples, and altering physiological and affective states by changing their thinking as highlighted in cognitive behavioral therapy.

A study by Campbell-Sills, Forde & Stein (2006) investigated the relationship between resilience and neuroticism, extraversion, openness, agreeableness, and conscientiousness or the "big five" dimensions of personality, in young adults attending college. Their results showed that there was a strong negative relationship with resilience and neuroticism and a positive relationship with resilience and extraversion as well as conscientiousness. These authors concluded that the negative relationship between resilience and neuroticism could be explained by understanding components of neuroticism which may affect resilience, such as negative emotions, poor impulse control, and poor coping mechanisms. This study also explored the relationship of resilience to coping styles and found that task-oriented coping which is associated with a conscientiousness personality trait was positively related to resilience. Similarly, they concluded that the strong relationship between extraversion and resilience was facilitated by the affective-coping style used by individuals with an extroverted

personality. This research gives insight into the type of coping patterns that promote resilience in individuals who face traumatic events.

Efficacy of resilience training

The most established resilience training programs are the Penn Resilience Program (PRP), the U.S. Army Master Resilience (MRT) course and the APEX program (Reivich, Seligman, & McBride, 2011). These training modules specifically focus on protective factors such as self-efficacy, flexibility, interpersonal relationships or social support, and problem-solving which have been found to be vital in achieving resilient outcomes (Masten & Reed, 2002). The U.S. Army Master Resilience in particular, consists of a 10-day training which teaches resilience skills to noncommissioned officers who in turn teach soldiers. This program has demonstrated that it is in fact feasible and efficient to teach resilience to one group of individuals who will teach others. The PRP was specifically developed for children in late childhood to early adolescence but has since been utilized under the APEX program for college students. Reivich et al. (2011), notes that a number of studies evaluating the efficacy of these programs have found that they can reduce symptoms of anxiety and depression as well as other issues related to conduct and adjustment disorders. Similarly, Brunwasser, Gillham, and Kim (2009), concluded in their meta-analysis that at least up to a year after receiving the PRP training individuals had significantly lower depression symptoms.

Cognitive Behavioral Therapy

Cognitive behavioral therapy in crisis management provides the framework to assist the client in addressing their cognitions and as a result their behavior and feelings. According to Slaikeu, “the cognitive modality captures the heart of the crisis experience

since it focuses on the meaning of the crisis event(s) to the individual"(1990, p. 165). The usefulness of cognitive behavioral therapy post-trauma is predicated on the cognitions and beliefs regarding the event. As cited in Beck, Jacobs-Lentz, Jones McNiff, Olsen, and Clapp (2014) a number of theorists have attempted to explain the cognition-based psychological process that occur leading to negative symptomology following trauma including changes in schema (Horowitz, 1986), belief structures (Janoff-Bulman,1992; McCann & Pearlman, 1990), pervasive fear structures (Foa, Steketee, & Rothbaum, 1989) as well as sense of threat, mental defeat, dysfunctional coping strategies and specific appraisals (Ehlers & Clark, 2000). Park (2010), elaborated on the cognitive perspective in finding that a violation of life goals or a violation of the individuals hierarchy of goals increased distress post-trauma. Although these theories have a number of distinguishing features, overall they all propose that traumatic events may affect negative cognitions regarding the self and the world, beliefs about what their post-trauma symptoms mean, and feelings of helplessness due to mental defeat or perceived loss of control and autonomy (Beck et al., 2014). For instance, cognitive processing of the event, negative appraisal of initial symptoms, perception of other individuals responses, perception of change, and deleterious beliefs regarding the trauma have been shown to correlate with PTSD severity at six and 9 months post-event (Dunmore, Clark, & Ehlers, 2001).

To address the dysfunctional cognitions and beliefs which have been associated with post-trauma symptomology and increase resilience, cognitive behavioral therapy has been delineated as an evidence-based approach. N. P. Roberts, Kitchiner, Kenardy, and Bisson (2009), in a meta-analysis examining the efficacy of crisis

counseling concluded that up to three months post trauma trauma-focused cognitive behavioral therapy (TF-CBT) was the only theoretical intervention efficacious in minimizing or thwarting posttraumatic symptomology. Similarly, trials of cognitive behavior therapy utilized for early psychological intervention with adult survivors of trauma have found this therapeutic approach to be more effective in mitigating PTSD symptomology than general supportive counseling (Ehlers & Clark, 2003).

Rational Emotive Behavior Therapy

The basic supposition of crisis counseling and the foundation of TF-CBT is analogous to Rational Emotive Behavior Therapy (REBT), which is considered to be one of the oldest forms of cognitive behavior therapy (Corey, 2009). According to REBT, which was developed by Albert Ellis, people contribute to their own psychological issues and symptoms in how they interpret events (Corey, 2009). Ellis further postulated that people upset themselves through their belief systems, becoming disturbed about the consequences resulting from an unfortunate activating event, or what he referred to as disturbed by disturbances. This concept has been echoed by other theorists who have stated the development and maintenance of PTSD is in part a result of the individuals beliefs about what their posttrauma symptoms mean (Beck et al., 2014). REBT also describes the concept of low frustration tolerance stating that individuals who cannot tolerate frustration easily are more likely to be disturbed than those who can. This concept is signified by individuals who consistently complain and display self-pity when faced with adversity.

In REBT, although cognitions are seen as the prominent force, because cognitions influence how we feel and behave these concepts have an interdependent

relationship. According to REBT, irrational beliefs which are learned in childhood and reinforced throughout life have been internalized and aid in the maintenance of emotional disturbance. REBT further hypothesizes that we have strong tendencies to escalate our desires and preferences into dogmatic should, oughts, musts, and demands, referred to as “musturbation”. This musturbation falls under three main categories: self-demandingness, other-demandingness and world-demandingness. Self-demandingness is the belief that the individual must do well and gain the approval of others or they are no good. Other-demandingness implies that people must always treat them well and in exactly the way they want to be treated or that person deserves to be condemned and punished. Lastly, world-demandingness stresses the belief that the world and the individuals living conditions must be comfortable and acceptable or it is awful and unbearable.

In the instance of a trauma, because the event was not planned and is in conflict with their irrational belief system of “demandingness”, if negative cognitions or beliefs in relation to the event persist, symptomology results (Beck et al., 2014).This irrational thinking manifests through the use of overgeneralizations, personalizing, catastrophizing and statements of musturbation. With overgeneralizations the individual draws conclusion about other facets of their life based on the traumatic event because they believe the event will happen again, resulting in the catastrophizing or expecting the worse. Similarly, the individual may personalize the traumatic event and believe that they are in a sense “doomed” because the event was in reaction to them or their fault. While behaviorally, the individual questions their reaction during and after the event, the reactions of others, as well as the extent to which the event has affected their

functioning. Essentially, irrational thinking leads the individual to process the present or future events how they were in the past, although these conditions no longer exist. This irrational thinking and "demandingness" is inflexible and in opposition to having a resilient attitude, which includes being able to adapt to new situations, understanding what is in one's locus of control, deciphering between real and rational cognitions as opposed to irrational thoughts, and searching for new methods of problem solving (Neenan, 2009). However, it must also be noted that in some instances, immediately after a traumatic event irrational thinking is not the cause of lowered functioning but simply the event itself (Reivich & Shatte, 2002).

The basic principle used in REBT is the ABC outline, which is used to assist clients' in changing their thinking and behaving and ultimately their feelings. In this model (A) represents the activating event, (B) the belief about the event, and (C) the emotional or behavioral consequence(s). REBT suggests that individuals conclude that it is (A) the activating event causing (C) the consequence(s), when in actuality their (B) belief about the event is causing the (C) consequence (s). When people live by A-C thinking, in essence they believe their responses or the (C) consequence(s) are out of their control. However, when people adopt a B-C philosophy, they are able to change the meanings, attitudes, or beliefs about the event and display resilience. Thus, similar to second-order interventions, the counselor works to change the clients perception of the precipitating event, adopting an A-B-C philosophy, in an effort to decrease their subjective distress (Kanel, 2007). In REBT, changing the individuals' irrational philosophy to an (E) effective new philosophy can be done by (D) disputing their irrational beliefs. Disputing consists of detecting irrational beliefs, debating whether or

not the belief is flexible and realistic and discriminating between those beliefs that are self-helping as opposed to self-defeating. This effective new philosophy includes rationally and unconditionally accepting oneself, others, the world we live in terms of what is actual or real and not based on the past. This effective (E) new philosophy essentially results in new feelings (F) for the individual.

Operationalization of Resilience and REBT

A basic premise of REBT is that how you feel and behave is the result of how you interpret an event, not the event itself. Furthermore, there is considerable interaction between cognitions, emotions, behaviors, which has a reciprocal cause-and-effect relationship (Corey, 2009). On the basis of this philosophy and the straightforwardness of the ABC framework a number of authors and researchers have utilized this theory as a foundation for developing resilience, which can be utilized in crisis counseling (Neenan, 2009; Padesky & Mooney, 2012; Reivich et al., 2011; Reivich & Shatte, 2002). According to Reivich and Shatte (2002) the ABC framework "equips you with the skill to detect your thoughts when you are in the midst of an adversity and to understand the emotional impact of those beliefs" (p. 66). Essentially, the use of REBT in building resilience entails changing one's philosophy of demandingness (e.g. self-demandingness, other-demandingness, or world-demandingness).

Neenan (2009), utilizes REBT and the ABC framework to build resilience by teaching how to change thinking patterns and address irrational beliefs, manage negative emotions, understand locus of control and define strengths. In the first stages the author uses the ABC model to describe how to move from A-C to B-C thinking in an

effort to encourage new thinking patterns, cognitive flexibility, and increase perceived control of thoughts and emotions when faced with an adversity. Similarly, Neenan (2009), also focuses on attitudes that undermine resilience, such as pessimism and negative explanatory style. Lastly, this author outlines a number of strengths which serve as the foundation in people achieving resilient outcomes, they include high frustration tolerance, self-acceptance, self-belief, humor, keeping things in perspective, emotional control, support from others, curiosity, problem-solving skills, focusing on interests, finding meaning in the adversity, and being adaptable.

Reivich and Shatte (2002), outline seven key skills which can be used to build resilience and are grounded in the philosophy of REBT. These fundamental skills serve as the core components in the Penn Resilience Program (PRP), the APEX program and the U.S. Army Master Resilience (MRT) course (Reivich et al., 2011). The first skill consists of learning the ABC strategy, to assist in understanding the role cognitions in affecting emotions and behavior, as well as how to be cognizant of one's thoughts. The second skill outlines how to avoid traps in thinking that are repeatedly made. Next, the authors work on detecting what they refer to as "icebergs" or the deeply held beliefs that people live by and which may lead to intense emotional reactions. After detecting the iceberg the individual can be prompted to determine its usefulness. The next skill works on challenging beliefs about the causes of a difficulty in an effort to better problem solve. The authors next describe a skill they call "putting it in perspective". This skill works on minimizing "what-if" thinking to better focus on actual current issues and those events which are more likely to occur. The last two skills "calming and focusing" and

"real-time resilience" are used simultaneously. They work on challenging adversity in the moment by challenging beliefs and putting the adversity into perspective.

Padesky and Mooney (2012), developed a resilience-based cognitive behavioral approach that focuses on assisting individuals in building resilience when presented with numerous and various adversities as opposed to directing their approach towards specific disorders. This four-step model emphasizes collaboration between the counselor and client as well as experiments to gauge suitability to client. They stress the belief that there are numerous pathways to resilience, thus the first step is the collaborative search for strengths within the clients normal routine. They highlight the assumption that individuals are already resilient in multiple facets of their being but do not necessarily classify their strategies or personal assets as a display of resilience. Therefore, in many instances the counselor must attempt to assist the individual in reframing their thinking.

The second step of the model by Padesky and Mooney (2012) consists of the counselor and client collaboratively creating what the authors refer to as a personal model of resilience (PMR) based on facets of resilience generated in the first phase. In the third phase, the client and counselor work together assessing how to generalize their resilience so that it is applicable in other life areas. And lastly, the client and counselor develop "experiments to test the quality and utility of the clients PMR" (Padesky & Mooney, 2012). If successful the client is urged to search for, apply and practice their PMR in everyday situations. A key feature of this model that differs from other interventions is that it is not aimed at the client resolving the issue or obstacle but

simply remaining resilient through it, which is a hallmark component of crisis intervention.

Secondary Traumatic Stress

The concept of secondary traumatic stress has gained credence in the mental health field over the past few years as a potential consequence of working with clients who have experienced a trauma(s). Secondary traumatic stress has been found to negatively affect social intimacy, communication patterns, satisfaction in romantic relationships (Robinson-Keilig, 2014), schemas regarding the world, as well as perceptions of and attitudes towards self and others (Cohen & Collens, 2012). In a meta-synthesis conducted by Cohen and Collens (2012) evaluating 20 articles which referenced secondary traumatic stress or vicarious trauma a number of themes emerged regarding its psychological effect. Common emotional reactions reported included anger, fright, frustration, helplessness, powerlessness, hopelessness and shock. While common somatic complaints include numbness, nausea, and cravings. Furthermore, mental health professionals noted that as a result of these reactions they had attachment issues, trust issues, difficulty maintaining boundaries, and a decline in counselor work performance.

Although terminology and conceptual definitions differ amongst therapists, researchers and educators, the basic premise of the concept and the deleterious effects it can have on the clinician are widely accepted. Whereas secondary traumatic stress refers to all caregivers and can occur after a single exposure, vicarious traumatization specifically references mental health therapists and is said to be a result of cumulative interactions (Figley, 1995; McCann & Pearlman, 1990). However, these concepts are

typically referenced as a single phenomenon, whereas burnout is said to result from general psychological stress (Figley, 1995; Trippany et al., 2004). Furthermore, as opposed to past versions of the Diagnostic and Statistical Manual of Mental Disorders the most recent DSM 5 (American Psychiatric Association, 2013) takes into account not only individuals directly exposed to traumatic events but individuals exposed to the aversive details of the event, such as counselors.

In a nationally representative study of alcohol and addiction counselors 75% of respondents reported experiencing at least one symptom in the previous week of secondary traumatic stress (STS) and 19% met the criteria for posttraumatic stress disorder (PTSD) as delineated by the DSM-IV-TR (Bride et al., 2009). In a study of mental health practitioners (n=30) and the extent of vicarious traumatization in New Orleans post-Katrina, therapists reported feelings of anxiety (73%), suspiciousness (72%), increased feelings of personal vulnerability (46%), and avoidance (42%), as a direct result of their work with clients' traumatic material (Culver, McKinney, & Paradise, 2011). Consequently, fifty-percent of these clinicians also reported disruptions in their own frame of reference.

This mixed-methods study by Culver et al. (2011) also consisted of a qualitative portion, in which directors of mental health agencies were solicited via email to further understand their perceptions of their staffs' experiences of working with traumatized clients. Common themes that emerged included the fact that although a traumatic event is not necessarily why the client is in counseling, it is a common problem. Similarly, the need for training and education to better assist trauma victims emerged as a theme. This need for training was supported by the fact that in the quantitative phase of this

study a significant inverse relationship was found between the degree of coursework preparation and altered counselor self-perceptions (r=-.423, p=< .05).

Summary

This chapter presented a literature review in the areas of crisis counseling, psychological resilience, cognitive behavioral therapy and secondary traumatic stress relative to this study. This chapter explored standards for facets of crisis counseling pertinent to training counselors and potential outcomes which can develop as a result of experiencing a traumatic event. This chapter also discussed the use of cognitive-behavioral therapy, specifically REBT as a foundation in operationalizing resilience-building in clients and counselors. Lastly, this chapter discussed secondary traumatic stress as a potential negative outcome for counselors who perform crisis and counseling.

Chapter III will describe the design of the study including participants, setting, issues related to validity, instruments and the training program which serves as the intervention.

CHAPTER III

Methodology

This chapter presents the research design, a description of the dependent and independent variables, the setting, the instrumentation utilized, the procedure and the data analyses for evaluating the effectiveness of a crisis intervention and resilience building training program, grounded in REBT for counselors-in-training.

The participants were recruited from a Counselor Education and Rehabilitation Counseling master's program at an urban university in Michigan. The study was limited to participants who had completed either the Introduction to Counseling or Foundations of Rehabilitation counseling course as well as the Theories of Counseling course.

Research Design

This study utilized a quasi-experimental switching replications design consisting of two groups and three waves of measurement. The main rationale for the selection of the switching replication design was the need to train counseling students who are willing, about crisis counseling and resilience building. Although there are subtle variations between the first and second treatment, the switching replications design is relatively strong (Shadish, Cook, & Campbell, 2002). By applying the treatment or training to more than one group the design allows for greater reliability in conclusions.

In the initial phase of the study participants attended a pre-study informational meeting, in which they were apprised of the format of the study, including the time commitment necessary to complete the training and the test instruments to be given. During the informational meeting the participants completed the consent form, a demographic questionnaire, and the two pre-test instruments which were a modified

version of the Current Crisis Intervention Skills Self-efficacy Scale (Morris & Minton, 2012) and the Connor-Davidson Resilience Scale (CD-RISC;Connor & Davidson, 2003). The two pre-test instruments were used to establish a baseline regarding the counselors-in-training crisis counseling self-efficacy as well as their level of psychological resilience.

The training was conducted over a four week period, with each group having two weeks of training and each session being three hours in length. The first session focused on crisis intervention and crisis counseling. The second session focused on utilizing cognitive-behavioral therapy, specifically REBT as a foundational theory to build resilience while conducting crisis counseling. During the informational meeting participants were assigned to groups based on their availability. In the first phase of the study the first treatment group participated in a two week training while the second group acted as a control group. After the two week training, participants for both groups completed the post-test instruments to determine the differential effects of the training program. In the second phase of the study, the original treatment group served as the control group and the original control group received the training. After the second training both groups again completed the post-test instruments. The elegance of this switching replications design allows for all participants to receive the training/treatment making it one of the most ethical research designs available.

Table 1

Quasi-Experimental Switching Replications Design for Hypotheses

Research Group	Pretest	Experiment (Training)	Posttest	Experiment (Training)	Posttest
Treatment Group A (non-equivalent groups)	O_1	X	O_2		O_3
Treatment Group B (non-equivalent groups)	O_4		O_5	X	O_6

Validity

Threats to validity are of particular importance in research. Specifically internal validity or whether the treatment did in fact significantly make a difference and external validity or the degree and extent to which the findings can be generalized.

Internal validity.

According to Shadish et al. (2002) there are a number of reasons why the inference that the relationship between the treatment variable and the dependent variable is causal may be incorrect. However, the more alternative explanations the researcher is able to exclude the greater the internal validity. Threats to internal validity include ambiguous temporal precedence, selection, history, maturation, regression, attrition, testing, instrumentation, and additive and interactive threats (Shadish et al., 2002). The switching replications design by default works to minimize or mitigate a number of these threats to validity, specifically by the addition of a second posttest and by each group "switching" their roles between treatment group and control group. Thus key threats to the internal validity of concern in this study included history, maturation, attrition, testing, and instrumentation.

History. History refers to any events that occur during the period that the treatment/training is administered that may influence the observed outcome. Although

none of the courses in the program specifically addresses crisis intervention and resilience history may be of special concern in the academic setting, due to participants constantly being exposed to general counseling information. However, this threat to validity was minimized by using a two-group design and multiple post-tests. To control for the effects of history the posttests were given at the same time to both groups and the treatment was given over a shortened interval of time to minimize the chances of participants being exposed to extraneous events.

Maturation. Maturation includes changes which would have occurred in the absence of the treatment, such as "growing older, hungrier, wiser, stronger or more experienced" (Shadish et al., 2002). These include normal developmental changes that may occur. However, it is expected that these changes would occur somewhat synchronously amongst participants. The effect of maturation was also accounted for by the use of multiple posttests at different points of exposure to the treatment.

Attrition. Due to the multiple measures of outcome, attrition or participants failing to complete the posttests of the study may have been a threat to internal validity.

Testing. Because the tests were given a total of three times, validity may have been threatened by participants "learning the test", becoming familiar with it, or responding to questions in what they deem to be a socially acceptable manner. Thus changes in outcome measures could simply be the result of taking the test for a second or third time. However, because both groups were privy to and completed the multiple measures, differential effects due to testing were minimized. Moreover, because the assessments were based on subjective perceptions the significance of testing to validity was minimal.

Instrumentation. Whereas testing error refers to changes in the participant instrumentation as a threat relates to changes in the actual instrument (Shadish et al., 2002). This effect was minimized by the use of standardized instruments which were scored by the researcher using the same instructions and procedures.

External validity.

External validity refers to the degree to which the findings can be generalized to other units (persons), treatments, outcomes, or settings or across populations (Shadish et al., 2002). Because random sampling was not utilized generalizations in the study to populations is difficult, however generalizations can be made across populations. This study specifically was meant to be generalizable to graduate level counselors-in-training who have completed, at minimal introductory coursework within their program. While resilience-building and teaching resilience-building skills has been shown to be effective across an array of populations in various settings (Brunwasser et al., 2009) this research attempted to extend the generalizability to counselors-in-training. By using the switching replications design and replicating the treatment to a second group the external validity was strengthened.

Variables

Independent variable.

Resilience-Building and Crisis Intervention Training. The resilience-building crisis counseling training program was comprised of two sessions both three hours in length, for a total of six hours. The following table delineates the objectives of the training.

Table 2

Crisis Intervention and Resilience-Building Training Program Objectives

Session 1
• Participants will be able to define terminology related to crisis intervention and crisis counseling including, but not limited crisis, trauma, intervention, and crisis counseling. • Participants will be introduced to commonly experienced forms of crises. • Participants will be introduced to the range of potential mental health outcomes that an individual may experience following a potentially traumatic event, from resilience to symptomology. • Participants will be introduced to theories of crisis and crisis intervention. • Participants will be able to delineate the roles and responsibilities of counselors as part of a crisis or disaster response team. • Participants will be introduced to crisis intervention assessments such as BASICID (Lazarus, 1989) • Participants will become familiarized with how to asses for risk of harm to self or others. • Participants will be introduced to multicultural issues related to crisis intervention and counseling. • Participants will be able to describe psychological first aid and its various components. • Participants will be introduced to basic crisis intervention strategies from a cognitive behavioral approach. • Participants will be introduced to the concept of secondary traumatic stress as a potential outcome of providing crisis intervention and counseling.
Session 2
• Participants will be able to define resilience and understand the foundational components that contribute to resilient outcomes. • Participants will be able to describe risk and protective factors that correlate with resilient outcomes. • Participants will be introduced to the basic principles of rational emotive behavior therapy (REBT) philosophy. • Participants will be able to utilize the A-B-C framework of REBT and REBT techniques to enhance resilient thinking and encourage a resilient philosophy of living. • Participants will be introduced to techniques used to assist clients in building resilience and strengths. • Participants will be able to assists clients in developing a personal model of resilience (PMR;Padesky & Mooney, 2012).

Dependent Variables

Crisis intervention skills self-efficacy. For this study, level of crisis intervention skills self-efficacy was based on the counselor-in-trainings perceived knowledge of how to implement various aspects of crisis counseling as delineated by 2009 Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards.

Counselor-in-training resilience. Resilience includes a number of facets of the individual including their cognitive processing, behaviors, self-efficacy beliefs, coping style, affect, perceived strengths, and perceptions of social support all of which can be modified.

Research Questions and Hypotheses

Research Question 1: Does a crisis intervention and resilience building training program increase crisis counseling self-efficacy for counselors-in-training?

Hypothesis 1: A crisis intervention and resilience building training program will increase crisis counseling self-efficacy for counselors-in-training.

Null Hypothesis $\mu 1 = \mu 2 = \mu 3$

Alternative Hypothesis $\mu 1 \neq \mu 2 \neq \mu 3$

Instrument: Current Crisis Intervention Skills Self-efficacy Scale (Morris & Minton, 2012)

Research Question 2: Does a crisis intervention and resilience building training program increase the resilience of counselors-in-training?

Hypothesis 2: A crisis intervention and resilience building training program will increase the psychological resilience of counselors-in-training.

Null Hypothesis $\mu 1 = \mu 2 = \mu 3$

Alternative Hypothesis $\mu 1 \neq \mu 2 \neq \mu 3$

Instrument: Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003)

Setting

This study evaluated the effectiveness of a resilience building and crisis intervention training conducted at a large urban metropolitan state university. The student population at the university includes approximately 28,000 undergraduate and graduate students and offers 370 academic programs. The counselor education program in which the training was offered is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) for counselors-in-training and the Council on Rehabilitation Education (CORE) for rehabilitation counselors-in-training. Crisis counseling, which is considered to be a specialized area of clinical practice, is not offered as a specialization within this counseling program. The program offers the opportunity to obtain Masters of Arts degrees in School and Community (CACREP) or Rehabilitation (CORE) counseling as well as an Education Specialist certificate, or a Doctorate in Counselor Education and Supervision.

Participants

Characteristics of participants.

The study consisted of a non-equivalent group of participants who were enrolled in a master's degree counseling program at an urban university. The makeup of participants varied in terms of age, gender, ethnicity or cultural background, and socioeconomic status. Participants in the study at a minimal had completed the introductory coursework for the Counselor Education and Rehabilitation counseling

programs which include either Introduction of Counseling or Foundations of Rehabilitation Counseling and Theories of Counseling course. This requirement of advancement within the program was to ensure that participants had foundational knowledge of the counseling process as well as basic knowledge of theories utilized due to the integration of Rational Emotive Behavior Therapy (REBT) within the training.

Sample Size

A priori power analysis and sample size calculations were determined prior to the research study. In determining the sample size the researcher utilized the alpha level (α), power, and effect size. For this research study the α level was set at .05, which is standard in social science research (Wickens & Keppel, 2004). The researcher selected a power of .80. Due to the lack of research specifically focusing on crisis counseling training the researcher used an effect size of 0.7. Using G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007), the total sample size was calculated to be for t-Tests for independent samples (N = 68) and for t-Tests for dependent samples (N = 19).

Treatment Procedures

The researcher contacted professors teaching classes in which the researcher wished to recruit participants from and asked for permission to include their students in the study who were willing. Professors also were asked about their willingness to give extra-credit to students, to increase participation rate. After permission from the instructor, the researcher entered the various classes at the end of the class session. For students willing to participate, this time served as the informational meeting in which they completed a consent form, the demographic questionnaire and the two assessments, the Current Crisis Intervention Self-efficacy Scale (Morris & Minton, 2012)

and the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003). Participants were also asked to select their training dates based on availability. Based on availability they were placed in either group A (treatment group) or group B (control/delayed intervention group).

In subsequent weeks, each of the two groups received a total of six hours of training, divided into two training sessions for two weeks in a row. The treatment group received the two week training first and was immediately given the posttests. The treatment group was also given another set of posttests which they were asked to return via mail after two weeks. After the initial training the treatment group participated in, the control/delayed intervention group received the training. However, the control/delayed intervention group completed their posttests prior to participating in the treatment and after completing the treatment.

The training in this study included power point presentations, handouts, and group activities. The training for both groups was conducted by the researcher in the same classroom using the same materials. After the training, the students were issued certificates of completion.

Table 3

Participant Compensation Chart by Course

Introduction to Group Work	Counseling and Consulting in Community Agencies	Counseling Internship	Family Education and Counseling: Substance Abusers
▪ Extra 3 points in class	▪ Extra 3 points in class	▪ "Other" hours toward completion of Internship	▪ Extra 3 points in class
Cultural and Diversity Issues in Mental Health Treatment Research	**Techniques of Rehabilitation Counseling**	**Assessment for Counselors and Rehabilitation**	**Counseling Practicum**
▪ Extra 3 points in class	▪ Extra 3 points in class	▪ Extra 3 points in class	▪ "Other" hours toward completion of practicum

Instruments

A demographic questionnaire developed by the researcher specifically for this study was used to obtain characteristics of the participants, including the number of crisis courses or trainings they had attended. Prior to the study the researcher contacted via email the authors of both the Current Crisis Intervention Skills Self-efficacy Scale and the Connor-Davidson Resilience Scale and obtained permission for usage. These scales were used to assess crisis counseling self-efficacy and the resilience level of the counselor-in-training, respectively.

Demographic questionnaire.

The Demographic Questionnaire developed by the researcher consisted of five fixed demographic questions (i.e. age, gender, race/ethnicity, highest degree earned, and area of counseling concentration) and six questions used to determine participants counseling experience, as well as previous and current exposure to resilience and crisis intervention training received through coursework, workshops, or seminars.

Current Crisis Intervention Skills Self-efficacy Scale.

The Current Crisis Intervention Skills Self-efficacy Scale (CCIS-SES; (Morris & Minton, 2012) is an 11-item self-report instrument which is representative of major areas of crisis intervention as well as the 2009 CACREP standards for crisis counseling skills and knowledge areas. The five-point Likert scale asked respondents to rate how confident they were in their ability to perform a number of crisis intervention skills ranging from not at all (1); minimally (2); adequately (3); well (4); to very well (5). The items on the scale are summed to obtain a total score that could range from 11 to 55. Higher scores were indicative of higher levels of crisis intervention self-efficacy. According to the authors the internal consistency reliability for this instrument was acceptable (Cronbach's α=.96). For the present study, the scale had good internal consistency (Cronbach's α=.89) and good test-retest reliability (r=0.82).

Connor-Davidson Resilience Scale

The Connor-Davidson Resilience Scale (CD-RISC;Connor & Davidson, 2003) is a 25-item self-report scale used to assess resilience. The scale is comprised of a five-point Likert scale (0-4), with higher scores representing more resilience and total possible scores ranging from 0 and 100. The scale has been used to measure resilience in the general population and clinical samples, as well as after the application of various interventions with various age groups, gender, and socioeconomic statuses from a plethora of cultures. For this study participants were asked to rate each item from 0 (not true at all) – 4 (true nearly all the time) to indicate how each item reflected their resilience during the past month. According to (Connor & Davidson, 2003), the theoretical framework upon which the scale is based includes five distinct factors: (a)

"personal competence, high standards and tenacity;" (b) "trust in one's instincts, tolerance of negative affect, and strengthening effects of stress;" (c) "positive acceptance of change, and secure relationships;" (d) "control;" and (e) "spiritual influences." While the scale measures these five factors, a total score is used to measure resiliency. In the general population the scale has been shown to have good internal consistency (Cronbach's α=.89) and adequate test-retest reliability (r=0.87) (Connor & Davidson, 2003). A Cronbach alpha coefficient of .93 was obtained for the present study indicating excellent internal consistency. The test-retest correlation of .64 for the present study was low, but acceptable.

Data Collection

Over a course of two weeks the researcher entered various counseling classes to recruit participants willing to take part in the study. The informational meeting regarding the study was then conducted during this time for participants. During the informational meeting, using the pen and paper method, participants immediately completed and returned the informed consent, the demographic questionnaire, the Current Crisis Intervention Self-efficacy Scale (Morris & Minton, 2012) as well as the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003). All forms completed required a four-digit participant code, in which the respondents provided to protect anonymity throughout the study. The code was used to monitor respondents' completion of measures. During this informational meeting participants also chose their desired group, either group A, which served as the first treatment group or group B, which acted as the first control group.

Approximately one week after the recruitment period group A received the treatment/ training, while group B acted as the control group. At the conclusion of the training, participants in group A again used pen and paper to complete the Current Crisis Intervention Self-efficacy Scale (Morris & Minton, 2012) and the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) and immediately returned them to the researcher. The participants in group A were also given self-addressed envelopes with pre-paid postage which contained the third wave of assessments. Participants were told to complete the assessments in two weeks and return by mail. The assessments were received by the researcher via mail between two and three weeks after the conclusion of the original treatment groups' training.

Exactly one week after group A completed the training the groups "switched" roles, thus group B received the treatment and group A acted as the control group. Before beginning the training, group B using pen and paper completed the Current Crisis Intervention Skills Self-efficacy Scale (Morris & Minton, 2012) and the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003). Following their training, Group B was again given the posttests, which were immediately collected by the researcher.

Data Analysis

This study used a quasi-experimental switching replication design to analyze the research. The collected surveys were entered into an Excel file and checked for accuracy. The data were analyzed using version 22 of the Statistical Package for the Social Sciences (SPSS, 2013). The data analyses were divided into three sections. The first section used frequency distributions, cross-tabulations, and measures of central

tendency and dispersion to provide a profile of the participants. The second section compared the pretest scores between the participants who completed all sections of the study and those who dropped out prior to completion of the interventions using t-tests for two independent samples to determine if the dropouts were different from the completers. A second analysis using t-tests for two independent samples was performed to determine if the treatment group and control group differed prior to beginning the treatment. The third section of the data analysis used t-tests for independent samples and t-tests for dependent samples to address the research questions. Decisions on the statistical significance of the findings were made using a criterion alpha level of .05, except where multiple comparisons were made. When making multiple comparisons, Bonferroni corrections were manually calculated to reduce the probability of committing a Type I error. Table 4 presents the statistical analyses used with each of the research questions and associated hypotheses.

Table 4

Statistical Analysis of Hypothesis

Research Questions and Hypotheses	Variables and Instruments	Statistical Analysis Method
RQ1: Does a crisis intervention and resilience-building training program increase crisis counseling self-efficacy for counselors-in-training? H_1: A crisis intervention and resilience-building training program will increase crisis counseling self-efficacy for counselors-in-training.	Independent Variable: Crisis Intervention Training Dependent Variable: Crisis Counseling Self-efficacy Instrument: Current Crisis Intervention Skills Self-efficacy Scale (CCIS-SES)	t-Tests for independent samples t-Test for dependent samples
RQ 2: Does a crisis intervention and resilience-building training program increase the resilience of counselors-in-training? H_2: A crisis intervention and resilience-building training program will increase the psychological resilience of counselors-in-training.	Independent Variable: Resilience-building component within Crisis Intervention Training Dependent Variable: Counselor-in-training resilience Instrument: Connor-Davidson Resilience Scale (CD-RISC)	t-Tests for independent samples t-Test for dependent samples

Summary

Chapter III outlined the methodology for the study including the research design, independent and dependent variables, and a description of the setting and participants. This chapter also delineates the *a priori* determination of sample size, treatment procedures, a description of instruments, and data collection and analysis. The statistical results for this study will be detailed in chapter IV.

CHAPTER IV

RESULTS

This purpose of this study was to determine the effectiveness of a crisis intervention and resilience-building training for counselors-in-training. This chapter describes the demographic characteristics of the participants using cross-tabulations and measures of central tendency and dispersion yielded from responses on the demographic questionnaire. This chapter also presents the results of the statistical analysis from the Current Crisis Intervention Self-efficacy Scale (Morris & Minton, 2012) and the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) which were used to address the research questions.

Descriptive Statistics for Participants in Initial Phase

During the initial phase of the study the study consisted of 28 participants for group A and 33 participants for group B for a total of 61 participants. For group A, 17 participants completed all phases of the training. However, only 16 completed all of the posttests. For group B, 22 participants completed the first training session and thus the first posttest. However, only 21 participants completed all phases of training as well as posttests. Although the descriptive statistics include all 61 participants only those participants who completed all waves of measurement (N=37) were included in the data analysis.

Age

The participants were asked to indicate their age on the demographic questionnaire. The minimum and maximum age range, the mean, and median age as well as the standard deviation are listed Table 5.

Table 5

Descriptive Statistics of Age (N=61)

					Range	
Group	N	Mean	SD	Median	Minimum	Maximum
Treatment (1)	28	35.57	11.87	33	22	65
Control (1)	33	32.21	9.62	29	21	55
Total	61	33.75	10.75	29	21	65

Participants in the first treatment group ranged from 22 to 65 years old with a mean age of 35.57 (SD = 11.87) years, with a median age of 33 years. The mean age of the participants in the control group was 32.21 (SD = 9.62), with a median age of 29 years. The participants in the control group ranged in age from 21 to 55 years. For the sample (N=61) the participants ranged from 21 to 65 years of age. The mean age for the sample was 33.75 (SD=10.75) and the median age was 29.

Gender, Ethnicity, Highest Degree Earned

On the demographic questionnaire respondents for both Group A and Group B were asked to indicate their gender, ethnicity, and highest degree earned. The responses were summarized using frequency distributions as shown in Table 6.

Table 6

Cross-tabulations – Personal Characteristics (N=61)

	Group Membership					
	Treatment		Control		Total	
Personal Characteristics	N	%	N	%	N	%
Gender						
Male	1	3.6	4	12.1	5	8.2
Female	27	96.4	29	87.9	56	91.8
Total	28	100.0	33	100.0	61	100.0
Race/Ethnicity						
African American/Black	12	42.9	7	21.2	19	31.1
Asian	1	3.6	0	0	1	1.6
Hispanic/Latino	1	3.6	0	0	1	1.6
White/Caucasian	14	50	21	63.6	35	57.4
Multiracial	0	0	2	6.1	2	3.3
Other	0	0	3	9.1	3	4.9
Total	28	100	33	100	61	100
Highest Degree						
Bachelors	23	82.1	27	81.8	50	82
Masters	2	7.1	6	18.2	8	13.1
Education Specialist	1	3.6	0	0	1	1.6
Other	2	7.1	0	0	2	3.3
Total	28	100	33	100	61	100

The majority of the participants were female (n=56, 91.8%) with 5 (8.2%) of the participants indicating gender as being male. Thirty-five (57.4%) participants identified as being White/Caucasian and a large group identified as being African/American (n=19, 31.1%). Three (4.9%) participants identified as being “other” and specifically noted that they were Arab-American. Two (3.3%) participants identified as being multiracial, 1 (1.6%) identified as being Asian and 1 (1.6%) identified as being Hispanic/Latino. Because the participants were in a master’s level program all respondents had at least a bachelor’s degree. However, 8 (13.1%) indicated that they also held a master’s degree, 1 (1.6%) an educational specialist certificate and 2 (3.3%) “other”, noting specifically having a juris doctor.

Specialization

Participants were asked to indicate their area of counseling specialization. The results are summarized in Table 7.

Table 7

Cross-tabulations – Counseling Specialization (N=61)

	Group Membership					
	Treatment		Control		Total	
Specialization	N	%	N	%	N	%
Community	17	60.7	18	54.5	35	57.4
School	3	10.7	3	9.1	6	9.8
School and Community	5	17.9	10	30.3.	15	24.6
Rehabilitation	3	10.7	1	3.0	4	6.6
Other	0	0	1	1.6	1	1.6
Total	28	100	33	100	61	100

The majority of the participants indicated that they were specializing in community counseling (n=35, 57.4%). Fifteen (24.6%) participants indicated that they were specializing in school and community counseling. Of those participants specializing in community counseling, nine participants also noted that they were specializing in art therapy and one participant in rehabilitation counseling. Only 9.8% (n=6) of the participants noted that they were specializing in school counseling, 6.6% (n=4) rehabilitation counseling, and 1.6% (n=1) “other”, specifying art therapy.

Training

Participants indicated the number of courses, workshops, and seminars they had taken or were currently taking in regards to building resilience, secondary traumatic stress (STS), and crisis intervention. The results are summarized in Table 8.

Table 8

Cross-tabulations – Courses in Resilience, STS and Crisis Intervention (N=61)

	Group Membership					
	Treatment		Control		Total	
Courses/Workshops	N	%	N	%	N	%
Courses on resilience						
None	25	89.3	31	93.9	56	91.8
One	1	3.6	2	6.1	3	4.9
Two	2	3.3	0	0	2	3.3
Total	28	100	33	100	61	100
Courses on STS						
None	25	89.3	24	72.7	49	80.3
One	2	7.1	8	24.2	10	16.4
Two	1	3.6	1	3.0	2	3.3
Total	28	100	33	200	61	100
Crisis intervention courses						
None	24	85.7	28	84.8	52	85.2
One	4	14.3	5	15.2	9	14.8
Total	28	100	33	100	61	100
Courses that included crisis intervention						
None	25	89.3	27	81.8	52	85.2
One	2	7.1	5	15.2	7	11.5
Two	1	3.6	1	1.6	2	3.3
Total	28	100	33	100	61	100
Crisis Intervention workshops/seminars						
None	22	78.6	19	57.6	41	67.2
One	5	17.9	9	27.3	14	23
Two	1	3.6	3	9.1	4	6.6
Three	0	0	1	3.0	1	1.6
Four	0	0	1	3.0	1	1.6
Total	28	100	33	100	61	100

The majority of participants (n=56, 91.8%) had not taken any courses which specifically discussed building client resilience. Three (4.9%) participants had taken one course and 2 (3.3%) participants had taken two.

The majority of students (n=49, 80.3%) indicated that they were not taking and had not previously taken any courses which specifically discuss secondary traumatic stress or vicarious traumatization. Ten (16.4%) participants indicated that they had taken one course that discussed secondary traumatic stress and 2 (3.3%) participants indicated that they had taken two courses.

The majority of participants (n=52, 85.2%) indicated that they had not taken any courses which specifically focused on crisis intervention or traumatology. Whereas 9 (14.8%), participants had taken or were currently taking a course which focused on crisis intervention or traumatology.

Fifty-two (85.2%) participants did indicate that they had not taken any courses which included crisis intervention or traumatology. Seven participants (11.5%) indicated that they had taken one course which included crisis intervention and 2 (3.3%) participants indicated that they had taken two courses which included it.

The majority of participants (n=41, 67.2%) also indicated that they had not attended any workshops or seminars which focused on crisis intervention or traumatology. Fourteen (23%) had attended one workshop focused on crisis intervention and traumatology, 4 (6.6%) had attended two workshops, 1 (1.6%) had attended three workshops and 1 (1.6%) had attended four.

Comparison of Samples

Preliminary statistics of the initial assessments revealed that there was not a significant difference between those who completed the study and those who did not. The group statistics comparing the samples are summarized in Table 9.

Table 9

Comparison of Samples- Assessment One of CD-RISC and CCIS-SES

Assessment	Dropout	N	Mean	SD	SEM
CD-RISC One	Yes No	24 37	78.25 74.54	10.87 10.57	2.22 1.74
CCIS-SES One	Yes No	24 37	23.33 26.00	7.29 8.97	1.49 1.48

The mean score of 78.25 (SD=10.87) on the initial resilience assessment for those who did not complete the study (N=24) is slightly higher than the mean score of 74.54 (SD=10.57) for those who did complete the study (N=37). Whereas the mean score of 23.33 (SD=7.29) on the crisis intervention skills self-efficacy scale for those who did not complete the study (N=24) was slightly lower of 26 (SD=8.97) for those individuals (N=37) who did complete the study.

The independent samples t-Test used to evaluate the equality of the means between the two groups revealed that there was not a significant difference in the resilience scores of those who dropped out of the study and those who remained, $t(59)= 1.33$, $p= .19$. There was also not a significant difference in the current crisis intervention skills self-efficacy scores for those individuals who remained in the study and those who dropped out, $t(59)= -1.22$, $p=.23$.

Descriptive Statistics for Participants Completing Study

A total of 37 participants completed all facets of the study. For Group A (N=16), 18 participants attended the initial session, one participant did not attend the second session and one participant did not return the final assessments. For Group B (N=21), 22 participants attended the initial session and one participant did not complete the second session.

Age

The age of the participants (N=37) completing the study ranged from 22 to 55 years. The mean age for the participants was 34.76 (SD=10.93) and the median age was 30. The minimum and maximum age range, the mean, and median age as well as the standard deviation are listed Table 10.

Table 10

Descriptive Statistics of Age (N=37)

					Range	
Group	N	Mean	SD	Median	Minimum	Maximum
Treatment (1)	16	35.31	12.18	32.50	22	55
Control (1)	21	34.33	10.18	30.00	24	55
Total	37	34.76	10.93	30.00	22	55

The age of the participants in the treatment group ranged from 22 to 55 years old with a mean age of 35.31 (SD = 12.18) years and a median age of 32.50 years. The mean age of the participants in the control group was 34.33 (SD = 10.18) and the median age was 30 years. The participants' in the control group age ranged from 24 to 55 years.

Gender, Ethnicity, Highest Degree Earned

Participants completing the study (N=37) provided demographic information, including gender, ethnicity, and their highest degree. The demographic information for the 37 participants who completed the study are summarized in Table 11.

Table 11

Cross-tabulations – Personal Characteristics (N=37)

	Group Membership					
	Treatment		Control		Total	
Personal Characteristics	N	%	N	%	N	%
Gender						
Male	0	0	3	14.3	3	8.1
Female	16	100	18	85.7	34	91.9
Total	16	100	21	100	37	100
Race/Ethnicity						
African American/Black	6	37.5	3	14.3	9	24.3
Asian	1	6.3	0	0	1	2.7
White/Caucasian	9	56.3	16	76.2	25	67.6
Multiracial	0	0	1	4.8	1	2.7
Other	0	0	1	4.8	1	2.7
Total	16	100	21	100	37	100
Highest Degree						
Bachelors	14	87.8	18	85.7	32	86.5
Masters	0	0	3	14.3	3	8.1
Education Specialist	1	6.3	0	0	1	2.7
Other	1	6.3	0	0	1	2.7
Total	16	100	21	100	37	100

The majority of the participants were female (n=34, 91.9%) and 3 (8.1%) participants were male. Twenty-five (67.6%) of the participants identified as White/Caucasian, with the sample including African American (n=9, 24.3%), Asian (n = 1, 2.7%), multiracial (n=1, 2.7%), and “other” (n=1, 2.7%). The participant identifying as “other” indicated that he/she was Arab-American.

The preponderance of participants had at least a bachelor's degree (n = 32, 86.5%). Three (8.1%) participants indicated that they had completed a master's degree, 1 (2.7%) an educational specialist certificate and 1 (2.7%) reported that he/she had "other," noting specifically having a juris doctor.

Specialization

Participants were asked to indicate their area of counseling specialization. The results for participants whom completed the study are summarized in Table 12.

Table 12

Cross-tabulations – Counseling Specialization (N=37)

	Group Membership					
	Treatment		Control		Total	
Specialization	N	%	N	%	N	%
Community	9	56.3	12	57.1	21	56.8
School	2	12.5	1	4.8	3	8.1
School and Community	3	18.8	6	28.6	9	24.3
Rehabilitation	2	12.5	1	4.8	3	8.1
Other	0	0	1	4.8	1	2.7
Total	16	100	21	100	37	100

The majority of participants (n = 21, 56.8%) indicated that they were specializing in community counseling, with (n = 9, 24.3%) specializing in school and community counseling. Of those participants specializing in community counseling, five participants also noted that they were specializing in art therapy and one participant in rehabilitation counseling. Three (8.1%) participants explained that they were specializing in school

counseling, 3 (8.1%) in rehabilitation counseling, and 1 (2.7%) in “other,” specifying art therapy.

Training

Participants indicated the number of courses, workshops, and seminars they had taken or were currently taking in regards to building resilience, secondary traumatic stress (STS), and crisis intervention. The results for participants (N=37) whom completed the study are summarized in Table 13.

Table 13

Cross-tabulations – Courses in Resilience, STS and Crisis Intervention (N=37)

	Group Membership					
	Treatment		Control		Total	
Courses/ Workshops	N	%	N	%	N	%
Courses on resilience						
None	13	81.3	20	95.2	33	89.2
One	1	6.3	1	4.8	2	5.4
Two	2	12.5	0	0	2	5.4
Total	16	100	21	21	37	100
Courses on STS						
None	15	93.8	16	76.2	31	83.8
One	1	6.3	4	19	5	13.5
Two	0	0	1	4.8	1	2.7
Total	16	100	21	100	37	100
Crisis intervention courses						
None	14	87.5	18	85.7	32	86.5
One	2	12.5	3	14.3	5	13.5
Total	16	100	21	100	37	100
Courses that included crisis intervention						
None	15	93.8	17	81	32	86.5
One	1	6.3	4	19	5	13.5
Total	16	100	21	100	37	100
Crisis Intervention workshops/seminars						
None	12	75	13	61.9	25	67.6
One	4	25	7	33.3	11	29.7
Four	0	0	1	4.8	1	2.7
Total	16	100	21	100	37	100

Thirty-three (89.2%) of participants had not taken any courses which specifically discussed building client resilience. Two (5.4%) participants had taken one course and 2 (5.4%) participants had taken two. Thirty-one (83.8%) also indicated that they were not taking and had not previously taken any courses which specifically discuss secondary traumatic stress or vicarious traumatization. Five (13.5%) participants indicated that they had taken one course that discussed secondary traumatic stress and 1 (2.7%) participant indicated that he/she had taken two courses. Thirty-two (86.5%)

participants indicated that they had not taken any courses which specifically focused on crisis intervention or traumatology and 5 (13.5%), had taken or were currently taking one course. Thirty-two (86.5%) of participants did indicate that they had not taken any courses which included crisis intervention or traumatology and 5 (13.5%) participants had taken one course which included it. Twenty-five (67.6%) participants indicated that they had not attended any workshops or seminars which focused on crisis intervention or traumatology. While 11 (29.7%) participants had attended one workshop which focused on crisis intervention and 1 (2.7%) had attended four.

Scaled Variables

The Conner-Davison Resilience Scale (CD-RISC) and Crisis Counseling Intervention Skills Self-Efficacy Scale (CCIS-SES) were scored by summing the responses and dividing by the number of items on the scales to obtain a total score for each scale. The total scores for each participant were summarized using descriptive statistics. Table 14 presents results of this analysis.

Table 14

Descriptive Statistics: Scaled Variables (N = 37)

					Actual Range		Possible Range	
Scale	N	Mean	SD	Median	Minimum	Maximum	Minimum	Maximum
CD-RISC	37	74.54	10.57	74	53	92	0	100
CCIS-SES	37	26.00	8.97	24	12	48	11	55

The mean score for the participants on the CD-RISC was 74.54 (SD = 10.57), with a median of 74. The actual range of scores was from 53 to 92, with possible scores ranging from 0 to 100. The CCIS-SES had a mean score of 26.00 (SD = 8.97), with a

median of 24. The actual scores ranged from 12 to 48, with possible scores ranging from 11 to 55.

Prior to testing the hypotheses, t-tests for two independent samples were used to determine the statistical equivalency of the experimental and control groups prior to conducting the study. The results of these analyses are presented in Table 15.

Table 15

t-Tests for Independent Samples: Scaled Variables (N = 37)

Scale	N	Mean	SD	DF	t-Value	Sig
CD-RISC						
Experimental Group	16	75.25	11.94	35	.35	.727
Control Group	21	74.00	9.66			
CCIS-SES						
Experimental Group	16	26.56	6.77	35	.33	.744
Control Group	21	25.57	10.49			

The comparison of the experimental and control groups on the total scores for the CD-RISC and the CCIS-SES prior to beginning the treatment were not statistically significant. Based on this finding, the groups were considered statistically equivalent prior to starting the treatment.

Research Questions and Hypotheses

Two research questions and associated hypotheses were developed for this study. Each hypothesis was tested using inferential statistical analysis. The criterion alpha level used to determine statistical significance of the findings was initially set at .05. However, to control for Type I error, Bonferroni corrections were made. For the t-tests for independent samples, the manual Bonferroni correction resulted in a criterion

alpha level of .025 to account for the two comparisons. For the t-tests for dependent samples, which consisted of three comparisons, the manual Bonferroni correction resulted in a criterion alpha level of .0167, which was used to determine statistical significance of the findings.

Hypothesis 1

Research Question 1: Does a crisis intervention and resilience-building training program increase crisis counseling self-efficacy for counselors-in-training? The null hypothesis for this research question is: The crisis intervention and resilience-building training will not have a significant effect on crisis counseling self-efficacy.

Null Hypothesis $\mu_{\text{pre-test scores}} = \mu_{\text{post-test scores}} = \mu_{\text{post-test scores}}$

To determine if participation in the treatment had an effect on crisis counseling self-efficacy scores for the experimental and delayed intervention groups, t-tests for independent samples were used. Two separate comparisons were made. The first t-test compared the scores after completion of the treatment by the experimental group. The delayed intervention group then participated in the treatment and both groups were tested on the CCIS-SES. The manual Bonferroni correction resulted in a criterion alpha level of .025.The results of these analyses are presented in Table 16.

Table 16

t-Tests for Independent Samples – CCIS-SES at Time 2 and Time 3 (N = 37)

CCIS-SES	N	Mean	SD	DF	t-Value	Sig
Time 2						
Experimental Group	16	38.06	3.64	28.52	5.93	<.001
Control Group	21	25.76	8.54			
Time 3						
Experimental Group	16	39.63	5.90	35.00	-1.46	.154
Delayed Group	21	42.62	6.39			

The comparison of the CCIS-SES scores between the experimental group (M = 38.06, SD = 3.64) and the control group (M = 25.76, SD = 8.54) was statistically significant, t (28.52) = 5.93, p < .001. This finding indicated that following completion of the treatment, the experimental groups' level of crisis counseling intervention skills self-efficacy was significantly higher than the control groups'. However, after the delayed intervention group completed the treatment, the difference between the two groups was not statistically significant, t (35) = -1.46, p = .154. The mean score for the experimental group (M = 39.63, SD = 5.90) was lower than the mean score for the delayed intervention group (M = 42.62, SD = 6.39).

To determine if changes in crisis counseling self-efficacy scores changed within the groups, t-tests for dependent samples were used. The manual Bonferroni correction resulted in a criterion alpha level of .0167. The results of these analyses are presented in Table 17.

Table 17

t-Tests for Dependent Samples – CCIS-SES (N = 37)

CCIS-SES	N	Mean	SD	DF	t-Value	Sig
Experimental Group						
Time 1	16	26.56	6.77	15	6.69	<.001
Time 2	16	38.06	3.64			
Control Group						
Time 1	21	25.57	10.49	20	.15	.886
Time 2	21	25.76	8.54			
Experimental Group						
Time 2	16	38.06	3.64	15	1.59	.307
Time 3	16	39.63	5.90			
Delayed Group						
Time 2	21	25.76	8.54	20	7.83	<.001
Time 3	21	42.62	6.39			
Experimental Group						
Time 1	16	26.56	6.77	15	7.14	<.001
Time 3	16	39.63	5.90			
Delayed Group						
Time 1	21	25.57	10.49	20	6.73	<.001
Time 3	21	42.62	6.39			

. When the experimental group's scores for crisis counseling self-efficacy were compared from Time 1 (M = 26.56, SD = 6.77) to Time 2 (M = 38.06, SD = 3.64) using t-tests for dependent samples, the result was statistically significant, t (15) = 6.69, p < .001. This finding indicated that following the completion of the treatment, within the experimental group, there were higher levels of crisis counseling self-efficacy. When the mean scores for Time 1 (M = 25.57, SD = 10.49) were compared to Time 2 (M = 25.76, SD = 8.54) for the control group, the result was not statistically significant, t (20) = .15, p = .886. When the experimental group's scores for crisis counseling self-efficacy were compared from Time 2 (M = 38.06, SD = 3.64) to Time 3 (M = 39.63, SD = 5.90), the result was not statistically significant, t (15) = 1.59, p = .307. However, when the mean

scores for Time 2 (M = 25.76, SD = 8.54) were compared to Time 3 (M = 42.62, SD = 6.39) for the delayed intervention group, the result was statistically significant, t (20) = 7.83, p < .001. This finding indicated that following the completion of the treatment, within the delayed intervention group, there were higher levels of crisis counseling self-efficacy. Thus, when the experimental group's scores for crisis counseling self-efficacy were compared from Time 1 (M = 26.56, SD = 6.77) to Time 3 (M = 39.63, SD = 5.90), the result was statistically significant, t (15) = 7.14, p < .001. Similarly, when the delayed intervention groups' scores for crisis counseling self-efficacy was compared from Time 1 (M = 25.57, SD = 10.49) to Time 3 (M = 42.62, SD = 6.39), the result was statistically significant, t (20) = 6.73, p < .001. These findings indicate that from Time 1 to Time 3, within both the experimental group and the delayed intervention group there were higher levels of crisis counseling self-efficacy. The mean crisis counseling self-efficacy scores for the experimental and delayed intervention group are presented in Figure 1.

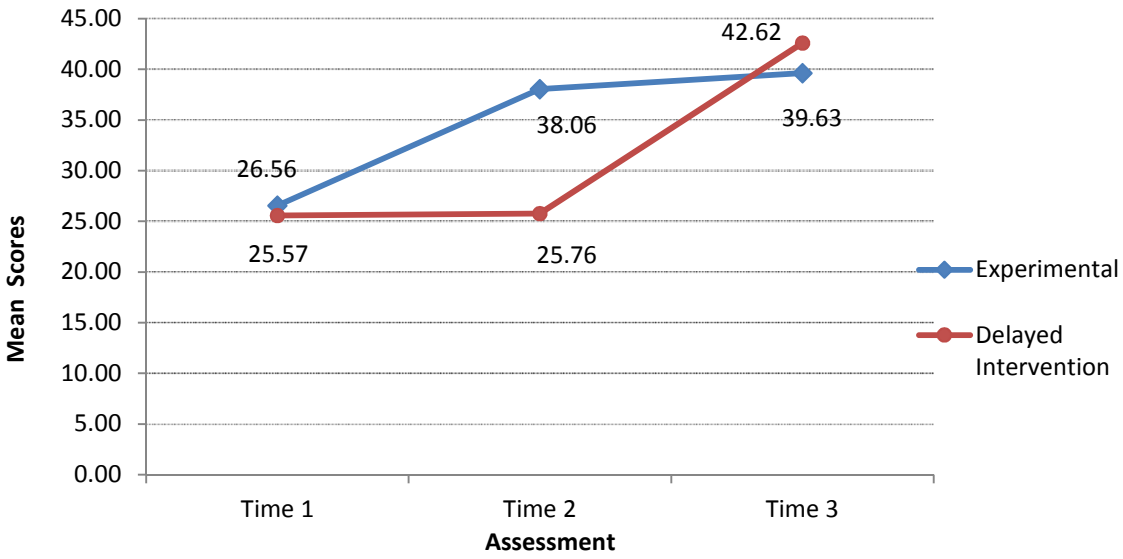

Figure 1. Mean scores on the CCIS-SES for the experimental and delayed intervention group (N=37) at Time 1, Time 2, and Time 3. The experimental group participated in the treatment at Time 2 and the delayed intervention group at Time 3.

Hypothesis 2

Research Question 2: Does a crisis intervention and resilience-building training program increase the resilience of counselors-in-training? The null hypothesis for this research question is: The crisis intervention and resilience-building training will not have a significant effect on resilience of counselors-in-training.

Null Hypothesis $\mu_{\text{pre-test scores}} = \mu_{\text{post-test scores}} = \mu_{\text{post-test scores}}$

To determine if participation in the treatment had an effect on resilience scores for the experimental and delayed intervention groups, t-tests for independent samples were used. Two separate comparisons were made. The first t-test compared the scores after completion of the treatment by the experimental group. The delayed intervention group then participated in the treatment and both groups were tested on the CD-RISC. The manual Bonferroni correction resulted in a criterion alpha level of .025. The results of these analyses are presented in Table 18.

Table 18

t-Tests for Independent Samples – CD-RISC at Time 2 and Time 3 (N = 37)

CD-RISC	N	Mean	SD	DF	t-Value	Sig
Time 2						
Experimental Group	16	79.44	10.50	35	.861	.395
Control Group	21	76.52	9.97			
Time 3						
Experimental Group	16	81.06	11.60	35	.124	.902
Delayed Group	21	80.62	10.08			

The comparison of the CD-RISC scores between the experimental group (M = 79.44, SD = 10.50) and the control group (M = 76.52, SD = 9.97) was not statistically

significant, t (35) = .861, p = .395. Similarly, after the delayed intervention group completed the treatment, the difference between the two groups was not statistically significant, t (35) = .124, p = .902. The mean score for the experimental group (M = 81.06, SD = 11.60) was higher than the mean score for the delayed intervention group (M = 80.62, SD = 10.08).

To determine if changes in resilience scores changed within the groups, t-tests for dependent samples were used. The manual Bonferroni correction resulted in a criterion alpha level of .0167. The results of these analyses are presented in Table 19.

Table 19

t-Tests for Dependent Samples – CD-RISC (N = 37)

CD-RISC	N	Mean	SD	DF	t-Value	Sig
Experimental Group						
Time 1	16	75.25	11.94	15	2.30	.037
Time 2	16	79.44	10.50			
Control Group						
Time 1	21	74.00	9.66	20	1.38	.183
Time 2	21	76.52	9.97			
Experimental Group						
Time 2	16	79.44	10.50	15	1.03	.319
Time 3	16	81.06	11.60			
Delayed Group						
Time 2	21	76.52	9.97	20	2.15	.044
Time 3	21	80.62	10.08			
Experimental Group						
Time 1	16	75.25	11.94	15	3.50	.003
Time 3	16	81.06	11.60			
Delayed Group						
Time 1	21	74.00	9.66	20	4.07	.001
Time 3	21	80.62	10.08			

When the experimental group's scores for resilience were compared from Time 1 (M = 75.25, SD = 11.94) to Time 2 (M = 79.44, SD = 10.50) using t-tests for dependent samples, the result was not statistically significant, t (15) = 2.30, p = .037. When the mean scores for Time 1 (M = 74.00, SD = 9.66) were compared to Time 2 (M = 76.52, SD = 9.97) for the control group, the result was not statistically significant, t (20) = 1.38, p = .183. When the experimental group's scores for resilience were compared from Time 2 (M = 79.44, SD = 10.50) to Time 3 (M = 81.06, SD = 11.60), the result was not statistically significant, t (15) = 1.03, p = .319. When the mean scores for scores for Time 2 (M = 76.52, SD = 9.97) were compared to Time 3 (M = 80.62, SD = 10.08) for the delayed intervention group, the result was not statistically significant, t (20) = 2.15, p = .044. However, when the experimental group's scores for resilience were compared from Time 1 (M = 75.25, SD = 11.94) to Time 3 (M = 81.06, SD = 11.60), the result was statistically significant, t (15) = 3.50, p = .003. Similarly, when the delayed intervention group's scores for resilience were compared from Time 1 (M = 74.00, SD = 9.66) to Time 3 (M = 80.62, SD = 10.08), the result was statistically significant, t (20) = 4.06, p = .001. These findings indicate that from Time 1 to Time 3, within both the experimental group and the delayed intervention group there were higher levels of resilience. The mean resilience scores for the experimental and delayed intervention group are presented in Figure 2.

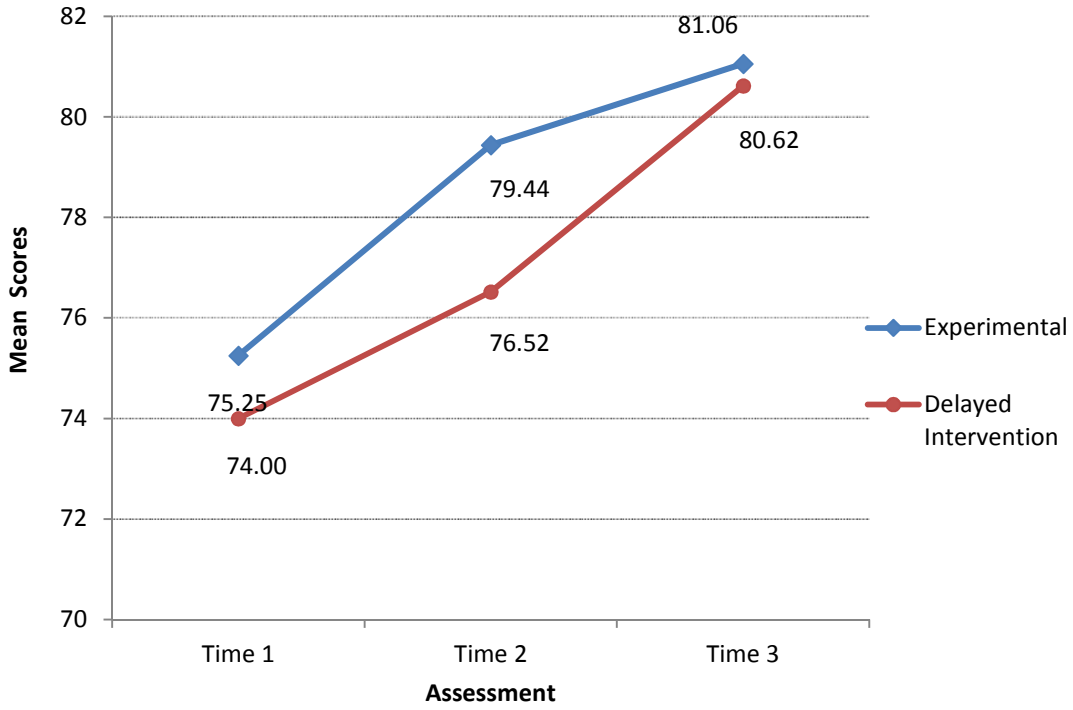

Figure 2. Mean scores on the CD-RISC for the experimental and delayed intervention group (N=37) at Time 1, Time 2, and Time 3. The experimental group participated in the treatment at Time 2 and the delayed intervention group at Time 3.

Summary

Chapter IV presented the results of the statistical analyses which were used to describe the sample and address the research questions. Chapter V will provide a discussion of conclusions and recommendations based on these findings. Chapter V will also discuss limitations of this research and suggestions for future research.

CHAPTER V

Summary and Discussion

Introduction

The purpose of this study was to examine the effectiveness of a crisis intervention and resilience building training program, grounded in REBT, for counselors-in-training. This chapter includes a brief summary of the crisis intervention and resilience literature, a discussion of the study findings, implications of the study, limitations, and recommendations for future research.

According to Meichenbaum (2012), 60% of individuals can expect to experience at least one traumatic event during their lifetime. After a potentially traumatic event, most individuals are resilient (Bonanno, 2004, 2005; Bonanno et al., 2006). This propensity for resilience after a potentially traumatic event is signified by the posttraumatic stress disorder (PTSD) prevalence rate of 7.9% that has been noted in civilian populations (Ozer, Best, Lipsey & Weiss, 2003). To assist individuals who do have difficulty posttrauma, mental health professionals have begun to use factors of resilience found in individuals who do not have difficulty posttrauma (Mancini & Bonanno, 2006). However, the plethora of research regarding posttrauma reactions and assisting individuals has continued to focus on posttraumatic stress disorder (PTSD).

This narrow focus on negative symptomology, such as PTSD, may thwart mental health professionals from considering post-trauma trajectories such as resilience, recovery, and delayed dysfunction. Furthermore, concentrating on negative symptomology early in treatment may contribute to a trend of focusing on what is wrong,

versus what is working for the individual throughout the counseling process (Saleebey, 2002).

In the aftermath of a potentially traumatic event, the extent of assistance needed, and the potential for negative symptomology is determined in part by the individuals' level of functioning. If the individuals' coping mechanisms are overwhelmed, or they are experiencing psychological disequilibrium, they are said to be in a state of crisis (A. R. Roberts, 2005). A state of crisis is typically brought about when an individual is exposed to a hazardous situation in which they believe they have experienced a loss, either concrete, such as the loss of a loved one, or intangible, such as the loss of coping self-efficacy. For individuals who enter a state of crisis and have decreased functioning, the application of crisis interventions may contribute to stabilization at a greater level of functioning (Kanel, 2007). Furthermore, successful crisis resolution may deter or mitigate the onset of chronic symptomology, such as PTSD.

Hoff, Hallisey & Hoff (2009), stressed the need to train future and current counselors in crisis intervention due to the innumerable potentially traumatic events in society and the magnitude to which counselors encounter individuals in crisis. However, many counselors receive little to no formal training in crisis intervention in their graduate-level courses (Morris & Minton, 2012).The importance of the need to train counselors in crisis intervention is stressed by the American Counseling Association Code of Ethics (ACA; 2014) and the 2009 Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2009). The ACA code of ethics specifically stated that counselors should only practice within the boundaries of their education, training, or experience. Whereas the CACREP standards mandated the inclusion of

crisis intervention and traumatology curricula into CACREP approved programs to prepare counselors on ways to assist clients.

On a personal level, the lack of training can be injurious to both the client and the counselor. According to Courtois and Gold (2009), a lack of training in crisis intervention and traumatology may actually re-traumatize or cause a "second injury" to the client. Similarly, a lack of training may contribute to secondary traumatic stress symptomology for counselors (Adams & Riggs, 2008).

Immediately following a potentially traumatic event, the individuals functioning can be gauged on a continuum extending from psychological resilience to a state of crisis. Bonanno (2004) stated that resilience is the ability to adapt in the face of adversity. "It is the basic strength underpinning all the positive characteristics in a person's emotional and psychological makeup"(Reivich & Shatte, 2002).

Resilience building has been described as the pivotal component in achieving successful crisis resolution and increasing functioning (Hoff et al., 2009). In an effort to simplify, operationalize, and teach resilience building, rational emotive behavior therapy has been used as the foundational theory (Neenan, 2009; Padesky & Mooney, 2012; Reivich et al., 2011; Reivich & Shatte, 2002). For example, the armed forces utilizes the U.S. Army Master Resilience Training (MRT) course, which is based upon the Penn Resilience Program, to train soldiers on ways enhance and build resilience using rational emotive behavior therapy as a framework (Reivich et al., 2011). Because counselors in every specialization and setting serve as the first line of intervention after potentially traumatic events, it may be just as important to train mental health care workers in resilience building as it is military personnel.

Similarly, because symptoms of secondary traumatic stress are comparable to symptoms experienced by clients in crisis or who have been traumatized, the need for counselors to learn how to build their own resilience is also important. If counselors are truly going to be prepared to practice in an ethical manner, it may be beneficial that they be trained in crisis intervention and resilience building. This is particularly important given that a lack of training and knowledge regarding crisis intervention and trauma can have detrimental effects on the client and the counselor.

Minimal research has addressed the efficacy of crisis intervention training. Similarly, the strategy of resilience building, which was previously only referenced regarding children under at-risk conditions, has not been studied in regards to counselors-in-training. Thus, this study sought to address the lack of training and determine the effectiveness of an intervention program.

Method

This study used a quasi-experimental, switching replications design consisting of two groups and three waves of measurement. The study evaluated the efficacy of crisis counseling and resilience-building training on crisis counseling self-efficacy and counselor resilience. A total of 37 participants completed study, including the training, a demographic questionnaire, and two assessments, the Current Crisis Intervention Self-efficacy Scale (Morris & Minton, 2012) and the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003), which were given at three different intervals.

Findings

The first wave of measurement was completed by 61 participants, including 28 participants for group A and 33 participants for group B. For group A, 16 participants

completed the training and the posttests. For group B, 21 participants completed training as well as posttests. Thus the study included 37 participants.

The participants (N=37) ranged in age from 22 to 55 years with the mean age being 34.76 (SD=10.93). The majority of the participants were female (91.9%) and 67.6% indicated that they were White/Caucasian, while 24.3% indicated that they were African American/ Black. The majority of participants indicated that their highest level of education was a bachelor's degree. Most of the participants (56.8%) indicated that their area of specialization within counseling was community counseling, with 24.3% indicating that they were specializing in school and community counseling.

In regards to training, 89.2% of participants had not taken a course that discussed resilience building and 83.8% had not taken a course that discussed secondary traumatic stress. The majority of participants 86.5% indicated that they had not taken any courses which focused on crisis intervention, 86.5% indicated that they had not taken any classes that included crisis intervention, and 67.6% had not taken a crisis intervention workshop.

Prior to testing the research hypotheses, a t-test for independent samples was performed to compare the pretest scores of those who completed the study (N=37) and those who did not (N=24). The statistical analysis found no significant difference in the mean scores of the CD-RISC or the CCIS-SES between the two groups. Thus, the participants who remained in the study and the participants who dropped out were considered to be statistically equivalent.

Statistical analysis was also performed prior to testing the research hypotheses to determine the statistical equivalency of the experimental (N=16) and control group

(N=21). The t-test for two independent samples indicated that the two groups could be considered statistically equivalent prior to starting the treatment

Two research questions were developed for this study. Each hypothesis was tested using inferential statistical analysis. Using Bonferroni corrections, decisions on the statistical significance of the findings were adjusted from the initial .05 criterion alpha level to a criterion alpha level of .025 for the t-tests for independent samples and to .0167 for the t-tests for dependent samples.

Research Questions

Research question 1: Does a crisis intervention and resilience-building training program increase crisis counseling self-efficacy for counselors-in-training? The null hypothesis for this research question is that the crisis intervention and resilience-building training will not have a significant effect on crisis counseling self-efficacy.

To test whether participation in the treatment had an effect on crisis counseling self-efficacy between the experimental group and the control/delayed intervention group, t-tests for independent samples were used. When comparing the scores of the CCIS-SES for the treatment group after the completion of the treatment the analysis indicated that two weeks of the crisis counseling and resilience-building training significantly increased the crisis counseling self-efficacy of the treatment group in comparison to the control group. When comparing the scores of the CCIS-SES after the completion of the treatment by the delayed intervention group, the results indicated that there was not a significant difference. However, this lack of significance was due to the scores for the delayed intervention group surpassing those in the treatment group.

Further analysis was performed to determine if participation in the treatment had an effect on crisis counseling self-efficacy within the groups. These analyses were performed using t-tests for dependent samples. These analyses revealed that for the treatment group, there were significantly higher scores on the CCIS-SES from Time 1 to Time 2. Similarly, after the treatment, the mean scores on the CCIS-SES for the delayed intervention group significantly increased from Time 2 to Time 3. Thus, both groups scores significantly increased from the pre-test (Time 1) to the second posttest (Time 3).

The analyses used to determine if participation in the treatment had an effect on crisis counseling self-efficacy between the groups and within the groups both yielded significantly higher scores on the CCIS-SES after the treatment. Based on these analyses, the null hypothesis that the crisis intervention and resilience-building training would not have a significant effect on crisis counseling self-efficacy was rejected.

Research question 2: Does a crisis intervention and resilience-building training program increase the resilience of counselors-in-training? The null hypothesis for this research question is that the crisis intervention and resilience-building training will not have a significant effect on resilience.

The t-tests for independent samples used to test if participation in the treatment had an effect on resilience between the experimental group and the delayed intervention groups were not statistically significant. The analysis indicated that although scores on the CD-RISC increased after the treatment, two weeks of the training did not at any point yield a significant difference between the treatment group and the delayed intervention group.

Further analysis was performed to determine if participation in the treatment had an effect on resilience within each group. For both the treatment group and the delayed intervention group, resilience scores significantly increased from the pre-test (Time 1) to the second posttest (Time 3). Because of the mixed findings on the analysis for resilience, a decision could not be made on the null hypotheses. There was not a statistically significant difference between the groups, although there were statistically significant differences within the groups.

Discussion of Findings

This purpose of this study was to evaluate the effectiveness of crisis intervention and resilience building training program using a switching replications design. Essentially, each group participated in the treatment at different times. However, the groups completed the assessments concurrently. Thus, given the replicated findings after participation in the treatment for each group, the reliability of the conclusions is strengthened.

In this study, the majority of the sample had not taken any crisis intervention courses, courses that included crisis intervention or crisis related workshops. This lack of crisis preparation was consistent with the literature which suggested that there was limited crisis and trauma counseling preparation in counselor education programs (Bride et al., 2009; Minton & Pease-Carter, 2011; Morris & Minton, 2012) . For instance, in the study by Morris and Minton (2012), only 20% had completed a crisis management course during their masters.

This lack of training is directly reflective of the low perceived crisis counseling self-efficacy indicated by participants on the initial assessment. On the first CCIS-SES

assessment, with possible scores ranging from 11 to 55, the mean score for perceived crisis counseling self-efficacy was 26 (SD = 8.97). However, after participation in the treatment, scores significantly increased and for the experimental group continued to increase slightly, even after being removed from the treatment.

Self-efficacy plays an important role in crisis preparation, secondary traumatic stress, and resilient outcomes. Having higher levels of crisis counseling self-efficacy may minimize the distress experienced when assisting clients in crisis, potentially contributing to greater counselor competence and enhanced client outcomes. According to Bandura (1997), self-efficacy is an individual's belief that they can exert control over their lives, that they are confident in their ability to complete the task or manage the event. The crisis counseling training in this study provided participant's with a learning experience that increased their belief that they could manage the task of assisting clients in crisis. These results indicated that just one seminar as opposed to one course in crisis preparation can improve perceived crisis counseling self-efficacy (Morris & Minton, 2012).

Of particular importance when attempting to increase crisis counseling self-efficacy is secondary traumatic stress. According to Figley (1995), the symptoms of secondary traumatic stress are similar to those of PTSD. Symptomology includes altered cognitions of the self and the world, feelings of vulnerability, and intrusive thoughts and feelings. These symptoms may in part be due to a lack of self-efficacy, which may result from a lack of preparation. Culver, McKinney and Paradise (2011), found an association between working with trauma victims and altered self -perception.

Similarly, they found an inverse relationship between the extent of crisis preparation and altered perceptions of self when working with trauma victims.

To deter symptoms of secondary traumatic stress it may advantageous for counselors to find ways to build their resilience in conjunction with increasing preparation. Resilience building strategies may be valuable for counselors performing crisis interventions, because it may assist them in remaining psychologically healthy and assist them in increasing resilience in their clients. However, there is little to no research regarding the efficacy of resilience building for current or future mental health professionals. Therefore, the training in this study was designed to increase the resilience of participants by teaching them key characteristics related to resilience building. Participants in the study had an initial mean resilience score of 74.54 (SD= 10.57). This resilience score was lower than the 80.70 in the general population for the United States, but higher than 71.80 in primary care patients found in the validation study of the CD-RISC (Connor & Davidson, 2003).

In recent years, the idea that resilience could be improved and was not simply inherent to certain individuals has been challenged (Luthar & Cicchetti, 2000). In this study, statistical analyses indicated that with resilience training grounded in REBT, resilience can be improved. For each group, the mean scores improved significantly from the initial assessment to the final assessment, although there was not a significant increase between groups. Previous research in military personnel and in children has similarly indicated that resilience can be improved. The Penn Resilience Program (PRP), which teaches resilience building to young adults to mitigate the effects of negative symptomology such as depression and anxiety, has been shown to be

effective in multiple controlled studies (Brunwasser et al., 2009; Reivich et al., 2011). Similarly, the Master Resilience Training (MRT), a 10 day course that teaches resilience building to commanding officers who in return teach soldiers, has been found to be effective (Reivich et al., 2011).

In comparison to previous studies, the lack of significance between the two groups in this study may be attributed to the short duration of the training and the dual foci on crisis intervention and resilience-building. However, the increase in resilience in the short period of time within the groups may have in part be due to knowledge of cognitive, affective, and behavioral components of resilience by the counselors-in-training, although findings indicated that they had not received formal training regarding the resilience construct.

Implications

Potentially traumatic events, which may lead to a state of crisis for individuals, are commonplace in our society. The need to assist individuals of every demographic continues to be part of a counselors routine functioning, especially considering that individuals with a mental illness are more vulnerable to being in crisis. Traumatology and crisis counseling by many professionals is considered a specialization because it requires specialized skills and training. However, all counselors should possess this type of training, given that clients who have experienced potentially traumatic events or are in crisis are present in all settings.

Counselor education programs have been given the responsibility to train counselors to be proficient in crisis management, to promote ethical practices and to enhance counselor self-care. A lack of knowledge, training, and familiarity with crisis

management can have detrimental effects on clients and counselors alike. Results from this study indicated that formal training is needed regarding resilience building, secondary traumatic stress, and crisis intervention. It may be important for counselor educators to assess their programs to determine the level and manner in which crisis management courses can be established or incorporated into current courses. Particularly since findings have indicated that the degree to which crisis management is infused within the curricula does not have to be extensive to impact crisis counseling self-efficacy.

Likewise, counselors-in-training and counselors in the field should evaluate their level of training and proficiency as it relates to crisis management. This assessment should include an understanding of the potential negative outcomes that may result if not trained, such as secondary traumatic stress. Similarly, ways in which to negate symptoms of secondary traumatic stress such as resilience building may prove beneficial if integrated into their repertoire.

This study is important in reinforcing the idea that resilience can be learned and that it may be a viable strategy when performing crisis interventions or general counseling. Of particular interest is the indication that even training which is short in duration can influence resilience. Practicing counselors and counselor educators may need to become more familiar with resilience building, its importance in mental health, as well as client and counselor well-being.

Limitations of Study

This study was limited to master's level counselors-in-training at a single university who had completed the introduction to counseling or foundations of

rehabilitation counseling course as well as the theories of counseling course. Thus, generalizability to other CACREP approved programs is limited. Although initial crisis intervention services may be performed by trained volunteers, this research specifically focused on counselors-in-training.

The generalizability of this research to counselors-in-training was further limited by a number of factors. For instance, the small sample size (N=37) influenced the generalizability of this study. This small sample size also decreased the power of the study and increased the probability of making a Type I error (rejecting the null hypothesis when it is actually true). Furthermore, in this small sample a significant number of participants indicated that they were female (91.9%), while 67.6% identified as being White/Caucasian.

The length of the study also served as a limitation, particularly in terms of measuring long term retention of crisis counseling self-efficacy and resilience. In addition, in terms of crisis counseling self-efficacy, self-reports were not based on the actual application of crisis counseling skills in practice with clients. Similarly, this research did not address whether individuals had been exposed to a potentially traumatic event or significant adversity and its relationship to their reported level of resilience. Lastly, the self-reports' used in this study were also a limitation, in that participants may have responded in a manner that they deemed to be socially appropriate.

Recommendations for Future Research

This study was beneficial in expanding knowledge regarding crisis counseling self-efficacy and resilience. However, future studies should be expanded to include

multiple counseling programs as well as individuals from more diverse demographics over a longer period of time. In addition, future studies may need to take into consideration the counselors exposure to potentially traumatic events and the role it plays in crisis counseling and resilience building.

This study addressed the relevance of a training program on perceived self-efficacy, however, future research is needed to test how well counselors-in-training actually understand crisis management and are able to apply it. Thus, longitudinal studies may be needed to assess the efficiency of training in regards to crisis counseling competence during internships and in clinical practice.

Resilience building is a relatively new concept in the mental health field. Particularly, in terms of assisting adults rather than minors and assisting individuals for purposes other than mitigating symptomology related to depression and anxiety, more research is needed. In addition, more research is needed to understand resilient factors and the ways in which resilient outcomes are achieved for various populations. Similarly, because of the contrasting results of this study in terms of building resilience, more research should focus on the time frames needed to successfully increase resilience within specific populations. Although research has indicated the effectiveness of the “train the trainer model”, research is needed to understand the effectiveness of implementing resilience-building strategies with clients when assisted by trained counselors. Additionally, because the format of classroom training differs from performing resilience building during crisis interventions, more research is needed on client outcomes in clinical practice.

In conclusion, resilience building is an integral yet minimally utilized component in crisis interventions provided by mental health professionals. This study served as a first step towards an integration of these concepts. However, more research is needed to understand how to merge crisis intervention and resilience building together in practice and in training to best assist current and future clients.

APPENDIX A: CONSENT AND PERMISSION FORMS

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NOTICE OF EXPEDITED APPROVAL

To: Sameerah Davenport
Theoretical & Behavior Foundations

From: Dr. Deborah Ellis or designee D. Ellis/ BB.
Chairperson, Behavioral Institutional Review Board (B3)

Date: February 24, 2015

RE: IRB #: 022015B3E
Protocol Title: Efficacy of Crisis Intervention and Resilience Training Program
Funding Source:
Protocol #: 1502013755

Expiration Date: February 23, 2016

Risk Level / Category: Research not involving greater than minimal risk

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The above-referenced protocol and items listed below (if applicable) were **APPROVED** following *Expedited Review* Category (#7)* by the Chairperson/designee *for* the Wayne State University Institutional Review Board (B3) for the period of 02/24/2015 through 02/23/2016. This approval does not replace any departmental or other approvals that may be required.

- Revised Protocol Summary Form (received in the IRB Office 2/22/2015)
- Protocol (received in the IRB Office 2/3/2015)
- Behavioral Research Informed Consent (dated 2/22/2015)
- Presentation Materials: Session 1 - Crisis Intervention and Counseling, Session 2 - Resilience-Building using Rational Emotive Behavior Therapy (REBT), ABC's of REBT and Resilience, Psychological Resilience - Building Worksheet, ADAPT Model Worksheet
- Data Collection Tools: Demographic Questionnaire, Connor-Davidson Resilience Scale 25 (CD-RISC-25) and Current Crisis Intervention Skills Self-efficacy Scale

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- Federal regulations require that all research be reviewed at least annually. You *may* receive a *"Continuation Renewal Reminder"* approximately two months prior to the expiration date; however, it is the Principal Investigator's responsibility to obtain review and continued approval ***before*** the expiration date. Data collected during a period of lapsed approval is unapproved research and can never be reported or published as research data.
- All changes or amendments to the above-referenced protocol require review and approval by the IRB **BEFORE** implementation.
- Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the IRB Administration Office Policy (http://www.irb.wayne.edu//policies-human-research.php).

NOTE:

1. Upon notification of an impending regulatory site visit, hold notification, and/or external audit the IRB Administration Office must be contacted immediately.
2. Forms should be downloaded from the IRB website at **each** use.

*Based on the Expedited Review List, revised November 1998

The Efficacy of Crisis Intervention and Resilience Building Training Program

[Behavioral] Research Informed Consent

Title of Study: *The Efficacy of a Crisis Intervention and Resilience-Building Training Program for Counselors-in-Training*

Principal Investigator (PI): Sameerah Davenport
Counselor Education
(313)244-4604

Purpose

You are being asked to be in a research study of the effectiveness of a training program used to increase knowledge and skills regarding crisis intervention and resilience-building because you as a counselor-in-training will likely have to utilize crisis intervention skills and resilience-building techniques to assist clients. This study is being conducted at Wayne State University. The estimated number of study participants to be enrolled at Wayne State University is forty-seven (47) throughout the United States. **Please read this form and ask any questions you may have before agreeing to be in the study.**

In this research study, a training program consisting of two (2) training sessions each 3 hours in length will be conducted. The first training session will focus on increasing knowledge and skill level regarding crisis intervention for counselors-in-training. The second session will focus on increasing knowledge and skills related to resilience-building based on the philosophy of rational emotive behavior therapy (REBT). The purpose of the study is to determine if the training program is helpful in increasing crisis counseling skills and helping counselors themselves cope better with stress.

Study Procedures

If you agree to take part in this research study, you will be asked to complete a 2-day training program focusing on crisis intervention and building resilience. You will also be asked to complete a demographic questionnaire and two different assessments at three different times.

1. You will complete two questionnaires asking about crisis counseling skills and your perception of your own resiliency. Based on your availability to start training right away or at a later time, participants will be assigned to Group A or Group B.
2. If you are assigned to "Group A":
   a. You will participate in a 3-hour training on crisis intervention
   b. One week later you will participate in a 3-hour training on resilience-building.
   c. Before leaving the second session you will be asked to complete the two questionnaires again (approximately 10 minutes).
   d. Two weeks after the completion of the training you will be asked to again complete the two questionnaires (approximately 10 minutes) and mail them back to the investigator.

3. If you are assigned to "Group B":
   a. You will attend a 3-hour training on crisis intervention.
   b. On the day of the first training, prior to beginning the training you will complete the two questionnaires again (approximately 10 minutes).
   c. One week later you will attend a 3-hour training on resilience-building.
   d. Before leaving the second session you will be asked to again complete the two questionnaires (10 minutes).
4. You have the option of not answering some of the questions and to still be able to remain in the study.

Benefits

The possible benefits to you for taking part in this research study are that you may increase your knowledge and skills regarding crisis intervention and resilience-building for clients you have in the future Furthermore, you may learn skills to increase your resilience to help you to better cope with and minimize the effects of day to day stressors, potentially traumatic events, and secondary traumatic stress. Other people may benefit from the results of this study now or in the future.

Risks

By taking part in this study, you may experience the following risks:
Every effort will be made to protect your confidentiality while participating in the study. However, there is a possibility that unauthorized persons could gain access to the study data.

Study Costs

Participation in this study will be of no cost to you.

Compensation

For taking part in this research study, you will not be paid; however you will be compensated for completing the study (e.g. points in class, ability to count hours toward "other" category).

Confidentiality

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. You will be identified in the research records by a code name or number. Information that identifies you personally will not be released without your written permission. However, the study sponsor, the Institutional Review Board (IRB) at Wayne State University, or federal agencies with appropriate regulatory oversight [e.g., Food and Drug Administration (FDA), Office for Human Research Protections (OHRP), Office of Civil Rights (OCR), etc.) may review your records.

When the results of this research are published or discussed in conferences, no information will be included that would reveal your identity.

The Efficacy of Crisis Intervention and Resilience Building Training Program

Voluntary Participation/Withdrawal

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you decide to take part in the study you can later change your mind and withdraw from the study. You are free to only answer questions that you want to answer. You are free to withdraw from participation in this study at any time. Your decisions will not change any present or future relationship with Wayne State University or its affiliates, or other services you are entitled to receive.

The PI may stop your participation in this study without your consent. The PI will make the decision and let you know if it is not possible for you to continue. The decision that is made is to protect your health and safety, or because you did not follow the instructions to take part in the study

Questions

If you have any questions about this study now or in the future, you may contact Sameerah Davenport at the following phone number (313) 244-4604. If you have questions or concerns about your rights as a research participant, the Chair of the Institutional Review Board can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call (313) 577-1628 to ask questions or voice concerns or complaints.

Consent to Participate in a Research Study

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read, or had read to you, this entire consent form, including the risks and benefits, and have had all of your questions answered. You will be given a copy of this consent form.

Signature of participant / Legally authorized representative *	Date
Printed name of participant / Legally authorized representative *	Time
Signature of witness**	Date
Printed of witness**	Time
Signature of person obtaining consent	Date
Printed name of person obtaining consent	Time

APPROVAL PERIOD
FEB 24 '15 FEB 23 '16
WAYNE STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

APPENDIX B: CORRESPONDENCE

RE: CD-RISC

From: Sameerah S. Davenport <sameerah.davenport@wayne.edu>
Sent: Wednesday, September 24, 2014 8:58 AM
To: Jonathan Davidson, M.D.
Subject: CD RISC

Dear Dr. Davidson,

I am a PhD student in the counselor education program at Wayne State University in Detroit, MI. I am currently working on my dissertation which includes teaching counselors-in-training ways to build resilience in their clients during a crisis and in themselves to deter symptoms of secondary traumatic stress. I would like to measure whether their resilience actually changes as a result of this training. I am utilizing a quasi-experimental pretest/post-test design to assess it's effectiveness.

I believe that the 25-item CD-RISC would be beneficial in assessing the effectiveness of this training. Would it be possible for me to utilize this instrument as part of my dissertation?

Sincerely,
Sameerah Davenport, MA, LPC

From: "Jonathan Davidson, M.D." <jonathan.davidson@duke.edu>
To: "Sameerah S. Davenport" <sameerah.davenport@wayne.edu>
Cc: mail@cd-risc.com
Sent: Wednesday, September 24, 2014 9:19:39 AM
Subject: Re: 10-item CD RISC

Hello Sameerah:

Thank you for your interest in the CD-RISC, which we would be glad to provide. If the enclosed agreement meets with your approval, could you kindly sign and return it, and make arrangements to pay the $30 user fee? We also would ask you to complete and return the brief project outline form.Once that's done we'll send the scale and manual right away.

With best regards,

Jonathan Davidson

Re: CD-RISC

September 26, 2014 2:33 PM

From: "Jonathan Davidson, M.D." <jonathan.davidson@duke.edu>
To: "Sameerah S. Davenport" <sameerah.davenport@wayne.edu>; mail@cd-risc.com
aRISC Manual 09-01-14.pdf (936.9 KB) DownloadaCD-RISC 01-01-13.pdf (153.8 KB) Download |
| Briefcase | Remove Briefcase | Remove
Download all attachments
Remove all attachments

Hello Sameerah:

Thank you for returning the forms and sending payment. I am pleased to enclose copies of the CD-RISC and user's manual. If there's anything else you need, please let me know.

Wishing you every success in your work.

Jonathan Davidson

RE: CURRENT CRISIS COUNSELING SELF-EFFICACY SCALE

On Sep 20, 2014, at 1:34 PM, "Sameerah S. Davenport" <sameerah.davenport@wayne.edu> wrote:

Dear Dr. Wachter Morris,

I am a PhD student in the counselor education program at Wayne State University in Detroit, MI. I am currently working on my dissertation which includes the development of a crisis counseling training program for master's level students. I would like to measure the effectiveness that this training has on their crisis preparation and self-efficacy. I am utilizing a quasi-experimental pretest/post-test design to assess it's effectiveness.

In your study titled Crisis in the curriculum? New counselors' preparation, experiences, and self-efficacy I noticed that your instrumentation included 20-items assessing crisis preparation as well as 11-items assessing self-perceived crisis skills. I believe that this instrument, particularly these items would be beneficial in assessing the effectiveness of this training. Would it be possible for me to utilize this instrument as part of my dissertation?

Sincerely,

Sameerah Davenport, MA, LPC

Re: Instrumentation used to assess crisis counseling preparation — September 20, 2014 2:44 PM

From: "Carrie Wachter Morris" <carrie.wachter@gmail.com>
To: "Sameerah S. Davenport" <sameerah.davenport@wayne.edu>
Absolutely. Do you need the instruments, or were they an appendix in the article? (I can't remember!)

Good luck,
CAWM

Fwd: Emailing: Wachter & Barrio Instrumentation.doc, Wachter & Barrio Minton survey monkey instrumentation.doc — September 30, 2014 12:38 PM

From: "Carrie Wachter Morris" <carrie.wachter@gmail.com>
To: "Sameerah S. Davenport" <sameerah.davenport@wayne.edu>
Wachter & Barri...rumentation.doc (185 KB) Download | Briefcase | Remove
Wachter & Barri...rumentation.doc (587 KB) Download | Briefcase | Remove

Download all attachments

Remove all attachments

Sameerah,

I am attaching two files, both of which (I think) hold the same information... The first is the word document of our survey. The second is the survey as it appeared on Survey Monkey. I believe the two are identical, but if there was any post-IRB updating, the Survey Monkey instrumentation would be the most up to date.

Good luck!
Carrie

Carrie A. Wachter Morris, Ph.D., NCC, ACS
Counseling and Development Program
Department of Educational Studies
BRNG 5166
Purdue University
100 N. University Street
West Lafayette, IN 47907-2098

Office: (765) 494-9625
Fax: (765) 496-1228
cawm@purdue.edu

APPENDIX C: INSTRUMENTS

Demographic Questionnaire

Please provide the following demographic information. This information will be used for research purposes and not to track you individually.

1. What is your age? _____

2. What is your gender? _____Male _____ Female _____ Other

3. What is your race/ethnicity?

_____ African American / Black
_____ American Indian /Alaska Native
_____ Asian
_____ Hispanic or Latino
_____ Native Hawaiin /Pacific Islander
_____ White/ Caucasian
_____ Multiracial
_____ Other (please specify)_____

4. What is your highest degree earned? _____

5. What is your area of concentration?

_____ Community Counseling
_____ School Counseling
_____ School and Community Counseling
_____ Rehabilitation Counseling
_____ Other, Please specify _____

6. Have you previously taken or currently taking any courses which specifically discuss building client resilience? _____ If yes, how many? _____

7. Have you previously taken or currently taking any courses which specifically discuss secondary traumatic stress or vicarious traumatization? _____ If yes, how many? ____

8. Have you previously taken or currently taking any courses which specifically focus on crisis intervention or traumatology? _____ If yes, how many? _____

9. Have you previously taken or currently taking any courses which include crisis intervention or traumatology as part of the course? _____If yes, how many? _____

10. Have you attended any professional workshops or seminars which specifically focused on crisis intervention or traumatology? _____ If yes, how many? _____

Connor-Davidson Resilience Scale 25 (CD-RISC-25)

initials ☐☐☐ *ID#* ☐☐☐☐☐☐☐ *date* ☐☐/☐☐/☐☐☐☐ *visit* ☐☐ *age* ☐☐

*For each item, please mark an "**x**" in the box below that best indicates how much you agree with the following statements as they apply to you over the last **month**. If a particular situation has not occurred recently, answer according to how you think you would have felt.*

		not true at all (0)	rarely true (1)	sometimes true (2)	often true (3)	true nearly all the time (4)
1.	I am able to adapt when changes occur.	☐	☐	☐	☐	☐
2.	I have at least one close and secure relationship that helps me when I am stressed.	☐	☐	☐	☐	☐
3.	When there are no clear solutions to my problems, sometimes fate or God can help.	☐	☐	☐	☐	☐
4.	I can deal with whatever comes my way.	☐	☐	☐	☐	☐
5.	Past successes give me confidence in dealing with new challenges and difficulties.	☐	☐	☐	☐	☐
6.	I try to see the humorous side of things when I am faced with problems.	☐	☐	☐	☐	☐
7.	Having to cope with stress can make me stronger.	☐	☐	☐	☐	☐
8.	I tend to bounce back after illness, injury, or other hardships.	☐	☐	☐	☐	☐
9.	Good or bad, I believe that most things happen for a reason.	☐	☐	☐	☐	☐
10.	I give my best effort no matter what the outcome may be.	☐	☐	☐	☐	☐
11.	I believe I can achieve my goals, even if there are obstacles.	☐	☐	☐	☐	☐
12.	Even when things look hopeless, I don't give up.	☐	☐	☐	☐	☐
13.	During times of stress/crisis, I know where to turn for help.	☐	☐	☐	☐	☐
14.	Under pressure, I stay focused and think clearly.	☐	☐	☐	☐	☐
15.	I prefer to take the lead in solving problems rather than letting others make all the decisions.	☐	☐	☐	☐	☐
16.	I am not easily discouraged by failure.	☐	☐	☐	☐	☐
17.	I think of myself as a strong person when dealing with life's challenges and difficulties.	☐	☐	☐	☐	☐
18.	I can make unpopular or difficult decisions that affect other people, if it is necessary.	☐	☐	☐	☐	☐
19.	I am able to handle unpleasant or painful feelings like sadness, fear, and anger.	☐	☐	☐	☐	☐
20.	In dealing with life's problems, sometimes you have to act on a hunch without knowing why.	☐	☐	☐	☐	☐
21.	I have a strong sense of purpose in life.	☐	☐	☐	☐	☐
22.	I feel in control of my life.	☐	☐	☐	☐	☐
23.	I like challenges.	☐	☐	☐	☐	☐
24.	I work to attain my goals no matter what roadblocks I encounter along the way.	☐	☐	☐	☐	☐
25.	I take pride in my achievements.	☐	☐	☐	☐	☐

Participant Code_____ Assessment#_____

Current Crisis Interevention Skills Self-efficacy Scale

Now, how confident are you in your ability to...

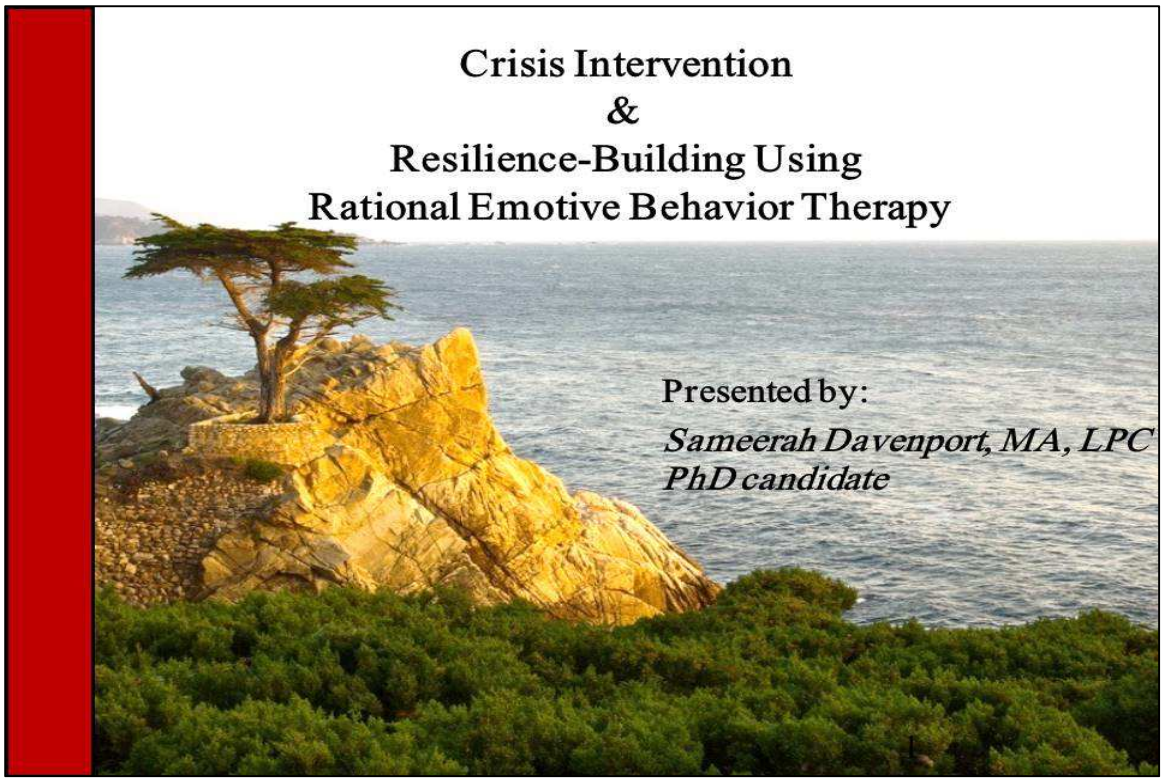
	Not at all	Minimally	Adequately	Well	Very Well
Enact basic crisis intervention skills (e.g., de-escalation, case management, collaboration with other professionals)					
Assess and manage risk of harm to self (e.g., suicide, self-injurious behavior)					
Assess and manage risk of harm to others					
Respond to client crises involving abuse or other victimization					
Assess and manage client crises related to severe mental health concerns or chemical dependency					
Respond to client crises involving other individual or family-level trauma (e.g., accident, fire)					

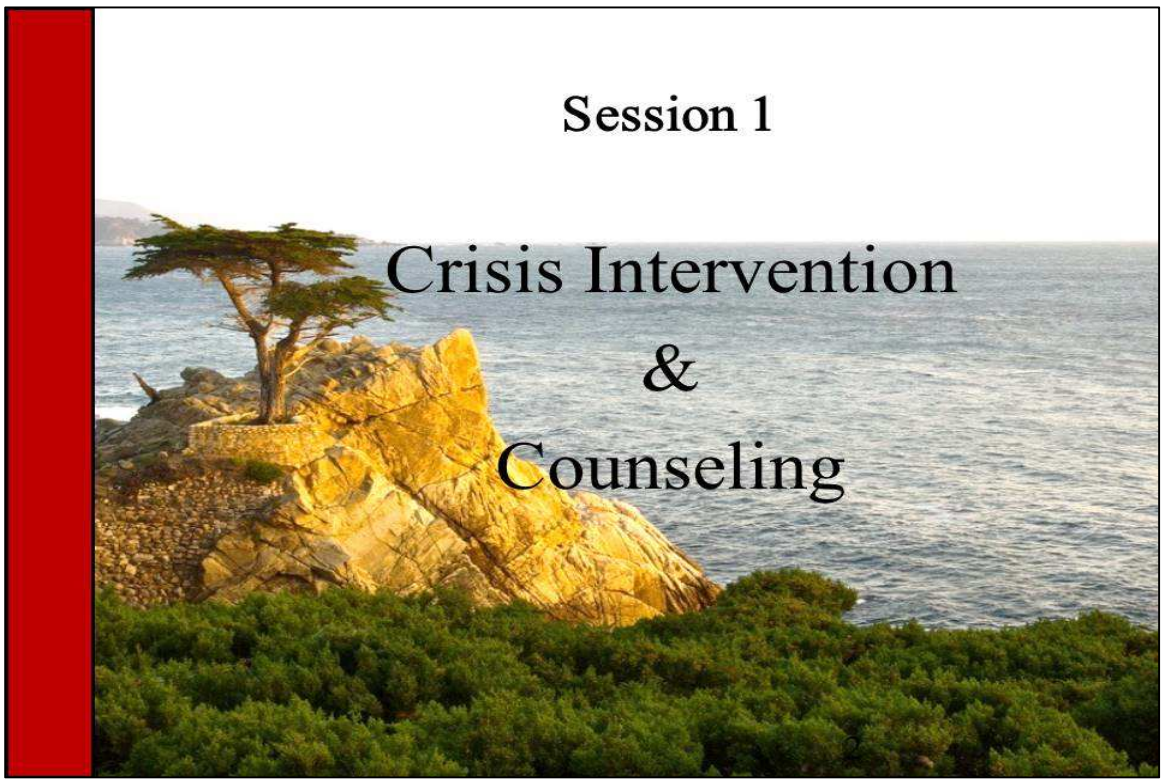
Participant Code_____ Assessment#_____

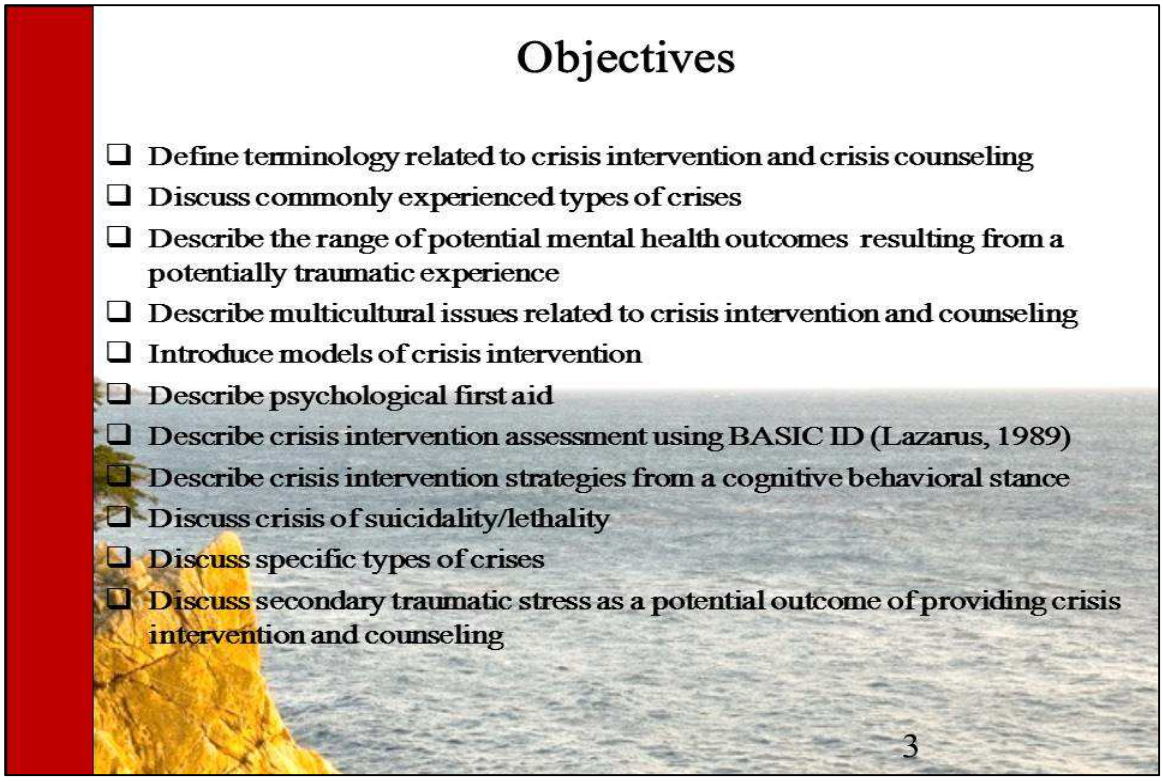
Respond to community-level disasters (e.g., hurricane, tornado, terrorism)					
Conceptualize the impact of crisis and/or disaster specific to your population					
Conceptualize the impact of crises, trauma, and/or disaster across the lifespan					
Administer psychological first aid in the event of crises, emergencies, and disasters					
Understand how to participate effectively on an organization's crisis team in the case of a crisis, emergency, or disaster					

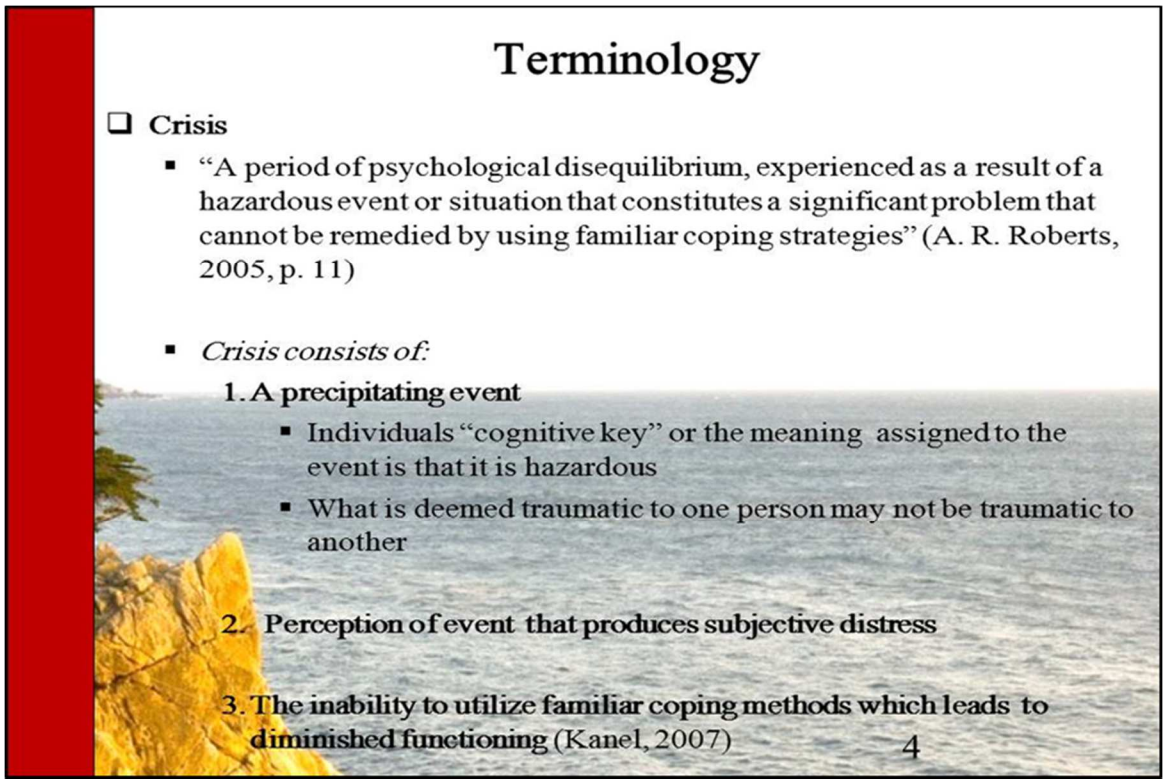
From: Morris, C. A. W., & Minton, C. A. B. (2012). Crisis in the Curriculum? New Counselors' Crisis Preparation, Experiences, and Self-Efficacy. *Counselor Education and Supervision, 51*(4), 256-269. Reprinted with permission.

APPENDIX D: TRAINING MATERIALS









Terminology

- **Trauma**
  - Exposure to actual or threatened death, serious injury, or sexual violence either by directly experiencing or being a witness to the event, being informed that the event effected a close family member or friend, or being in a situation where you are repeatedly told or subjected to aversive details of the event (American Psychiatric Association, 2013)

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Terminology

- **Crisis management**
  - The entire crisis-assistance process, from crisis onset to resolution, which may include first-order and second-order interventions
    - **First-order interventions or psychological first aid**: generally performed up to 96- hours post-event by trained volunteers
    - **Second-order interventions or crisis counseling**: performed in the days, weeks or months post-event by trained mental health professionals
- **Crisis intervention**
  - Methods and strategies employed to assist individuals in coping with the negative effects of a crisis

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Terminology

- **Psychological first aid**
  - "Psychological first aid is a flexible conversational approach that provides comfort, support, connectedness, information, and fosters coping in the immediate interval. The assumption is that because of personal shock, confusion, disorganization, and disconnection, and systemic, familial, and organizational failure or dysfunction, the individual and cultural resources individuals (and groups) would otherwise call upon to heal and recover from trauma are unavailable" (Litz, 2008, p. 504)
- **Crisis counseling**
  - A time-limited component of crisis resolution conducted by mental health professionals with the specific emphasis on problem solving and mitigation of the cognitive, emotional, and behavioral consequences of a hazardous event.

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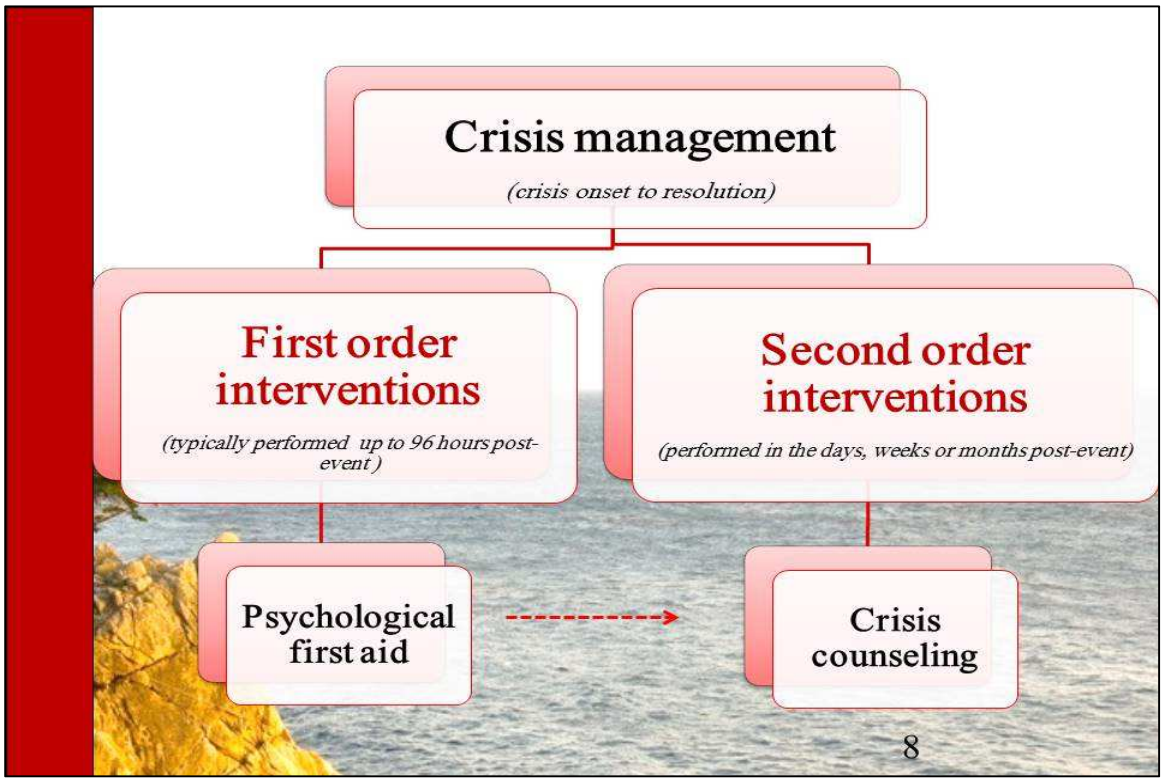

8

LONG-TERM COUNSELING	CRISIS INTERVENTION/ COUNSELING
Complete diagnostic evaluation	Rapid assessment
Treatment is focused on underlying issues and pattern of thinking, feeling and behaving	Treatment is focused on the current crisis/traumatic event
Focus is on addressing long-term needs and goals to assist in enhancing overall functioning	Focus is on minimizing/alleviating symptoms to assist in return to pre-crisis functioning
Client shows some degree of cognitive, affective, and behavioral functioning during treatment	Client affect as well their cognitive and behavioral functioning may be severely impaired

Types of Crises

- **Developmental crises**: crises resulting from normal life transitions
  - Adolescence
  - Parenthood
  - Marriage or Divorce
  - Older Age
- **Situational crises**: crises which are sudden and unexpected
  - **Human-caused or environmental catastrophes**
    - Hurricane
    - Mass shootings
  - **Harm or physical illness to self or close family member/friend**
    - Suicidality
    - Motor vehicle accidents
    - Sexual assault, victim of violence, witness to violence, workplace violence
    - Heart attack, HIV/AIDS, Disability
  - **Significant interpersonal or social changes**
    - Death of close friend or family member

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Context of Crisis Intervention

- **Primary Prevention** ***(prior to crisis event)***
  - Reduce occurrence of mental disorders
  - Methods:
    - Eliminate or modify hazard
    - Reduce exposure
    - Reduce vulnerability by increasing coping and resilience
- **Secondary Prevention** ***(immediately following event)***
  - Reduce debilitating effects and de-escalate
  - Methods:
    - Increase supportive services
    - Provide crisis services *(e.g. crisis intervention, PFA, crisis counseling)*
- **Tertiary Prevention** ***(years after event)***
  - Reduce long-term disabling effects (e.g. mental/emotional disorders)
  - Methods:
    - Long-term therapy
    - Medication

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Phases of Crisis

- Period of ***"impact"*** which causes increased tension and anxiety as individual attempts to utilize previous coping methods
- Period of ***"recoil"*** ensues in which the initial impact of event becomes apparent
- "***Posttrauma***" all consequences become apparent and attempt to utilize old and new potentially viable resources to mitigate negative affective state are utilized

State of crisis may be averted by :

- ***reduction of threat***
- ***success of new coping mechanisms***
- ***cognitive restructuring of beliefs or***
- ***giving up unattainable strongly held goals***

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Crisis as a danger & opportunity

- Crisis presents a danger because it can overwhelm the individuals coping mechanisms potentially resulting in self-destructive behavior
- Crisis also presents an opportunity because the need to restore homeostasis acts as motivation to seek help

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Opportunity and Danger

Crisis Intervention → **Opportunity**

Greater level of functioning
Insight into change of:
- Cognitions
- Affect
- Behavior

Development of coping skills
Increase of social support
Resilience-building

No intervention → **Danger**

Danger to self and/or others
Potential onset of mental disorder:
PTSD
Acute stress disorder
Dissociation
Depression
Anxiety Disorders
Psychosis
Substance Use Disorders
Personality Disorders
Physical illness

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Common symptoms exhibited during crisis			
Emotional	**Cognitive**	**Psychosomatic**	**Behavioral**
Grief	Difficulty with decision-making	Profuse sweating	Crying
Irritability	Attention deficits	Fatigue	Hypervigilance
Fear	Memory distortion	Chest pain	Impulsiveness
Anxiety	Intrusive thoughts	Increased heart rate	Risky behavior
Emotional unrest/loss of emotional control/ emotional numbness	Helplessness	Abdominal pain	Decreased functioning (e.g. work, school)
Guilt	Confusion	Nausea	Withdrawal
Panic	Disbelief	Diarrhea	Dissociative reactions
Shock	Exaggerated negative beliefs	Headaches	Compulsivity
Anger	Intrusive thoughts	Rash	Sleep disturbance
Hopelessness		Hyperventilation	
Spiritual			
Anger at God	Withdrawal from religious practices	Questioning of God/faith	

Extent of Crisis

- **Extent of the crisis and risk factors for negative posttrauma reactions include:**
  - severity of the precipitating event *(e.g. injury, threat to life, loss of life, proximity to event, duration of exposure, magnitude of trauma)*
  - psychological resources (e.g. maladaptive coping style, previous trauma or psychological disorder)
  - individual characteristics (e.g. female gender, low SES, younger age)
  - perceived social support
  - loss of financial resources

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Multicultural Issues and Crisis Intervention

- Diversity may exist between cultures and within individuals of the same cultures
- Commonality of event, reactions, and coping should be explored
- Culture plays a role in an individuals post-event cognitions, affect, behavior as well as their dependence upon, type of and use of social support
- Individual may attempt to call upon cultural beliefs to assist them in coping
- Language and ways of communicating vary amongst cultures
- Minorities in the United States utilize mental health services less frequently which is problematic given that they may be more negatively effected by traumatic events (James, 2008)

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Theoretical Models of Crisis Intervention

- **Equilibrium / Disequilibrium Model** (Caplan, 1961; Lindemann, 1944; as cited in James, 2008)
  - During a crisis an individual is in a state of psychological disequilibrium and therefore is unable to call upon previous methods of coping
  - Focus is on stabilization of individual
  - Goal of interventions is to assist individual in returning to pre-crisis functioning
- **Psychosocial Transition Model** (Dorn, 1986; Ansbacher & Ansbacher, 1956; Erikson, 1963; Minuchin, 1974; as cited in James, 2008)
  - Social environment and genetics affect an individuals way of being
  - Crisis is related to both external and internal factors
  - Stresses client understanding of the affect of social systems on adaptation to the crisis
  - Goal of interventions is to assist individual in addressing both internal and external factors as well as assisting them in developing more adaptive cognitions, behavior, and supports

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Theoretical Models of Crisis Intervention

- **Developmental- Ecological Model** (Collins & Collins, 2005; as cited in James, 2008)
  - Incorporates developmental stages and environmental factors
  - Assessment of relationship between current developmental stage and environment is vital.
  - Mastery of developmental stage is believed to affect extent of crisis.

- **Contextual- Ecological Model** (Myer & Moore, 2006)
  - Focus is on contextual factors of crisis (3 basic premises)
    - Premise 1: Contextual elements have layers
    - Premise 2: There is a reciprocal effect between the individual and the systems that are affected
    - Premise 3: Time has a direct effect on the crisis (e.g. time that has passed and memorial dates)

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Theoretical Models of Crisis Intervention *cont.*

- **Cognitive Model** (Ellis, 1982; Meichenbaum, 1977; Beck, 1976; as cited in James, 2008)
  - Maladaptive, faulty, or irrational thinking about the event not the event itself is what creates a state of crisis
  - Changing maladaptive, faulty, or irrational thinking is essential in order to work through the crisis
  - Goal of interventions is to assist individual in becoming aware of and change cognitions

- **Eclectic Crisis Intervention Theory** (Gilliand & James, 1998; James & Gilliand; Thorne, 1973)
  - Involves the "intentional and systematic" selection and integration of appropriate tenets and strategies from all approaches
  - Based on the premise that although all people and crises are unique all people and crises have similarities

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Practical Model of Crisis Intervention

Six Step Model of Crisis Intervention (James, 2008)

- **Assessment is continuous and all-encompassing**
- **Listening/ Psychological first aid**
  1. **Define problem**
     - From clients subjective perspective
  2. **Ensure client safety (on-going)**
     - Assessment of lethality/ suicidality or harm
  3. **Provide support**
- **Acting**
  4. **Examine alternatives**
     - Evaluate support system, coping mechanisms, positive and constructive thinking patterns
  5. **Make plans**
     - Should highlight control and autonomy, supportive services, coping mechanisms, measured in minutes, hours and days
  6. **Obtain commitment**

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Psychological First Aid

- **Purpose:**
  - Minimize initial distress
  - Improve functioning and coping
  - PFA is not a debriefing
  - Typically used in the aftermath of disaster trauma but can be after any type of potentially traumatic event

- **Why should counselors perform PFA**
  - Understanding of what not to do (e.g. be intrusive, debrief)
  - Formal knowledge of trauma reactions and risk factors
  - Formal training of core counseling skills
  - Able to provide referrals and resources

- https://www.youtube.com/watch?v=q2J4ZxIrKxA

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Psychological First Aid

- Eight core actions of PFA

1. **Contact and engage**
   - utilize "compassionate loitering"
2. **Provide safety and comfort**
3. **Stabilize**
   - calm and reorient individual(s)/ de-escalate (e.g. relaxation techniques)
4. **Gather information**
   - identify immediate needs and concerns

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Psychological First Aid

- Eight core actions of PFA *continued*

5. **Offer practical assistance**
   - attainment of immediate needs
6. **Connect with social supports**
   - connect with primary supports

   (e.g. family, friends, community resources)
7. **Provide information on coping**
   - provide information related to coping and stress/trauma reactions
8. **Connect with collaborative services**
   - connect with immediate or future services

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Psychological First Aid

- *PROTECT*
- *LISTEN*
- *CALM*
- *CONNECT*
- *DIRECT*

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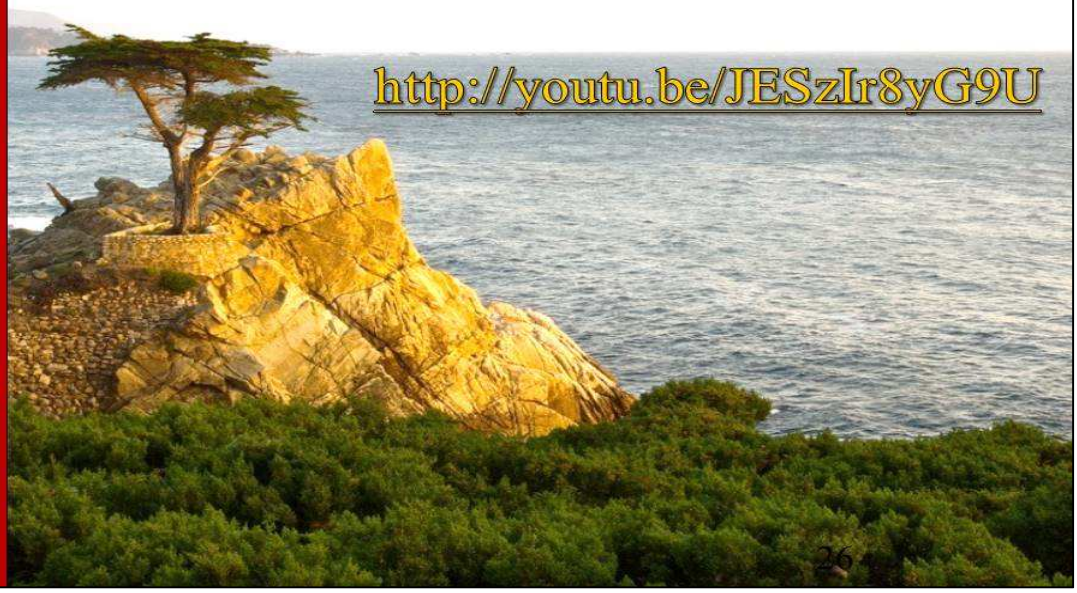
Psychological First Aid

http://youtu.be/JESzIr8yG9U



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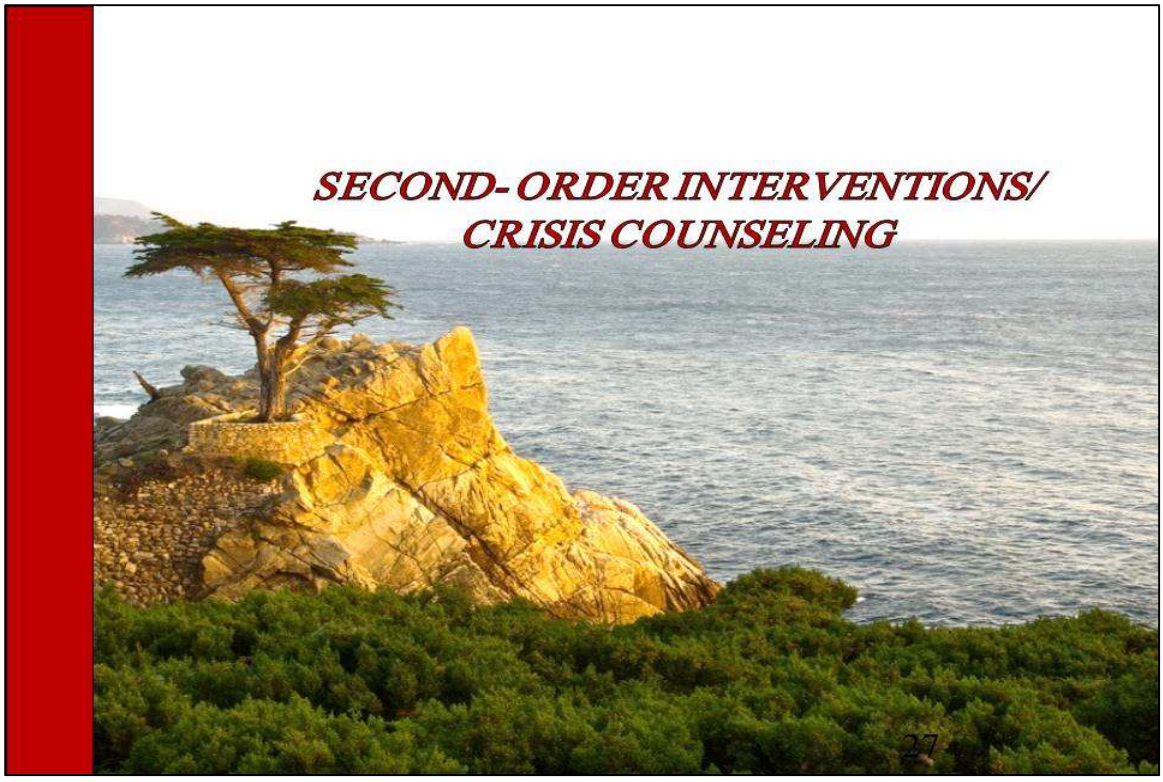

General tasks in crisis counseling

- Physical survival
  - Assessing threat to life is the first task in crisis intervention
    - Is the individual in danger or in harms way, a danger to self or others, or incapacitated
- Expression of feelings related to crisis
- Cognitive mastery
- Increase behavioral/interpersonal functioning

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BASIC ID'S

- Modified BASIC ID (Lazarus, 1989) (BASIC IDS) can be used to assess pre-crisis functioning and current crisis functioning and compare in an effort to restore homeostasis

- **Behavioral-** pattern of behavior (work, leisure, sex, diet etc.)
  - What activities have been affected/unaffected?
  - Which have been increased/decreased?
  - What coping strategies have been attempted and the outcome of each?
- **Affective**
  - What emotional reactions has the individual experienced since the event?
  - What feelings are being repressed/ expressed?
  - What are their feelings about their behavior?
- **Sensation**
  - What bodily sensations (e.g. pain, tension, rapid heartbeat, nausea, headaches) has the individual experienced since the crisis?
- **Imagery**
  - Is the individual experiencing intrusive cognitive images or flashbacks?

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BASIC ID'S

- **Cognitive**
  - What subjective meaning of the event does the individual have?
  - What self-talk is the individual utilizing?
  - What changes in the individuals pattern of thinking have developed as a result of the event?
- **Interpersonal**
  - Has event affected relationships with friends, family, etc.? And if so, how?
  - Does the individual have support systems and are they being used effectively?
- **Drugs- Biological functions**
  - What impact has the crisis had on the individuals drug use and biological functions/ physical health? Has drug use increased?
- **Spiritual/Meaning of life**
  - Has the meaning of life been altered?
  - Have the individuals spiritual beliefs/practices changed?

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Cognitive Behavior Therapy

- *Crisis intervention/counseling approach:*

1. *Rapidly establish relationship and build rapport*

2. *Assess crisis severity*
   - Gather as much factual information about what occurred as possible.
   - Use BASIC IDS to determine how crisis has affected functioning and determine level of psychological stability

3. *Assist client in assessing and mobilizing strengths and resources*
   - Assess and mobilize strengths using REBT and resilience-building strategies
   - Social support (e.g. friends, family, cultural supports, support groups)
   - Legal resources
   - Spiritual resources
   - Community organizations

(Dattilio & Freeman, 2010) 31

Cognitive Behavior Therapy

- *Crisis intervention/ counseling approach continued:*

4. *Work collaboratively to develop a plan*
   - Plan should address areas of functioning affected (e.g. BASIC IDS)
   - Plan should focus on immediate crisis
   - Plan should include facets of resilience
   - Plan should include social supports
   - Plan should take into account culture and lifestyle

5. *Implement plan, evaluate effectiveness of plan, refer if necessary and follow-up*

(Dattilio & Freeman, 2010) 32

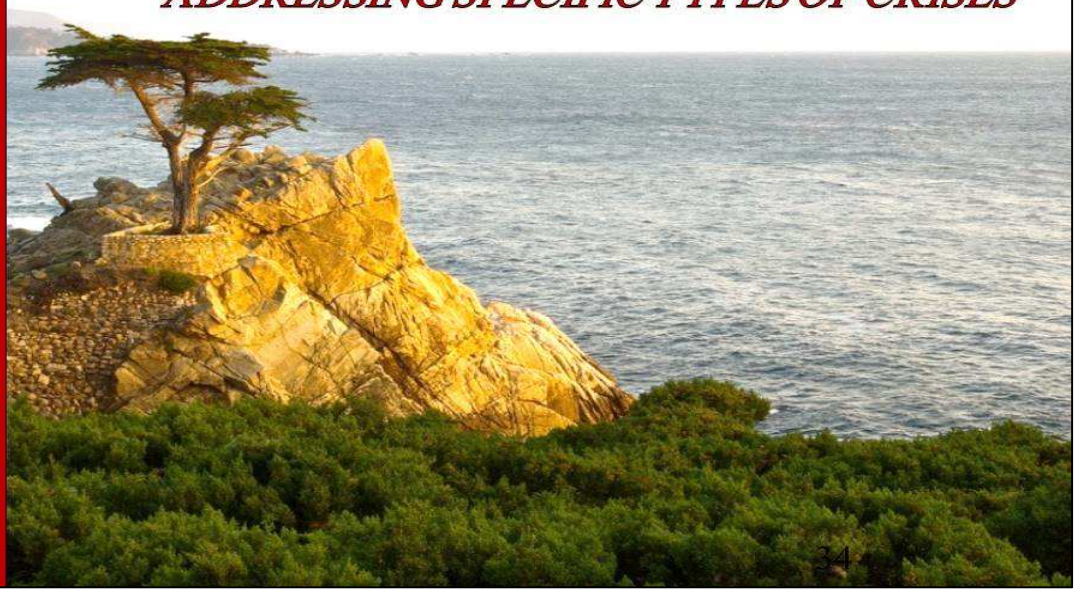
TF- Cognitive Behavior Therapy

- Specifically used with minors and their families
- PRACTICE acronym
  - Psychoeducation about childhood trauma and PTSD
  - Parenting component including parent management skills
  - Relaxation and stress management skills (individualized)
  - Affect expression and modulation
  - Cognitive coping: connecting thoughts, feeling and behaviors to the trauma
  - Trauma narration
  - In vivo mastery of trauma
  - Conjoint child-parent sessions
  - Enhancing future personal safety and enhancing optimal developmental trajectory

  through providing safety and social skills training as needed

(National Child Traumatic Stress Network, 2008) 33

ADDRESSING SPECIFIC TYPES OF CRISES



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Crises of Suicidality

- Suicidality is a crisis in itself
- Although individuals that attempt suicide may be in emotional turmoil they don't necessarily have a mental illness
- A caring person asking about suicide will not make an individual commit suicide
- Suicidality continuum
  - **Ideators**
  - **Attempters**
  - **Completers**
- Factors associated with suicide
  - Psychological and psychiatric
  - Demographic
  - Social and environmental

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Crises of Suicidality

- Categories of suicidal individuals by motivation (Freeman & Reinecke, 1993)
  - **Hopeless**- current situation is intolerable and the future is worse
  - **Psychotic**- command hallucinations or delusions
  - **Rational**- individuals whom face a terminal illness or progressive disease
  - **Histrionic or manipulative**- motivated by attention, revenge, stimulation or excitement

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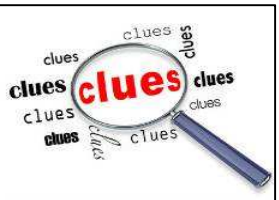
Crises of Suicidality



- **Verbal clues-** direct or indirect (I am of no use)
- **Behavioral clues-**"practice run", giving away possessions etc.
- **Situational clues-** concern over specific problem (e.g. bankruptcy)
- **Syndromatic clues-** constellation of suicidal symptoms (severe depression, hopelessness/helplessness etc.)

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Assessment of Suicidality

- Assessment should include (Dattilio & Freeman, 2010):
  - Current mood and feelings
  - Motivation for attempting suicide
  - Degree of intent to die
  - History of impulsivity
  - Adaptive and maladaptive coping strategies
  - Social supports
  - Cognitive flexibility
  - Deterrents (nature, durability, and strength)
  - Exploration of strengths, facets of resilience and resources
  - Ability to envision future
  - Attitude towards death

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Assessment of Suicidality

- SLAP Acronym
  - *Suicidal* ideation
    - Is client thinking about causing harm to self?
  - *Lethality* of method-
    - What are they thinking of doing?
  - *Availability* of means-
    - Do they have pills, guns, ammunition etc.?
  - Specificity of *plan*-
    - Do they have a plan in place or a plan to get the means?

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Assessment of Suicidality

- ***IS PATH WARM*** Acronym created by the American Association of Suicidology (AAS)

I = Ideation
S = Substance Use
P = Purposelessness
A = Anxiety
T = Trapped
H = Hopelessness
W = Withdrawal
A = Anger
R = Recklessness
M = Mood Change

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Crises of Suicidality

https://www.youtube.com/watch?v=1L0tuT60N7A

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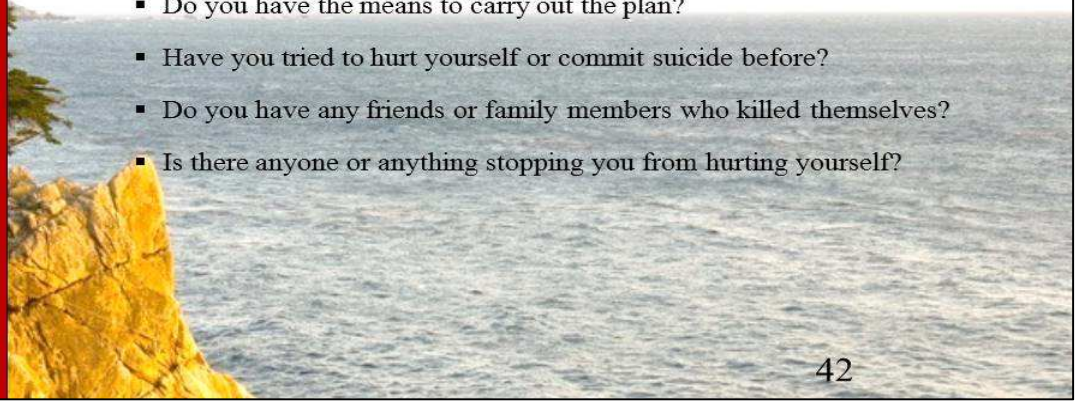
Assessment of Suicidality

Questions to ask:

- Are you thinking of hurting yourself?
- How often do you have thoughts about hurting yourself?
- Do you have a plan? If so, obtain specific information.
- Do you have the means to carry out the plan?
- Have you tried to hurt yourself or commit suicide before?
- Do you have any friends or family members who killed themselves?
- Is there anyone or anything stopping you from hurting yourself?



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Crises of Suicidality

- Goals from cognitive behavioral stance :
  - ***Primary goal is to ensure client safety by:***
    - Relieving environmental stressors
    - Increasing social supports and decrease isolation
    - Assisting with coping by changing beliefs, attitudes, etc. and decreasing anxiety directly related to present crisis
    - Orienting individual towards the future and the establishment of long-term goals
    - Developing no-suicide contract/ negotiate safety until next appointment
    - Decrease sleep loss
    - Hospitalization (if necessary)
  - ***Identify and resolve beliefs exacerbating and maintaining suicidal thoughts***

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Crises of Suicidality

- Process from cognitive behavioral stance :
  1. Identify negative emotions
  2. Identify events and thoughts that are believed to have triggered crisis
  3. Identify thoughts and perception of events maintaining emotional state
     - Identify and change negative "I" beliefs
       - ***Inescapable***
       - ***Intolerable***
       - ***Interminable*** *(never-ending)*

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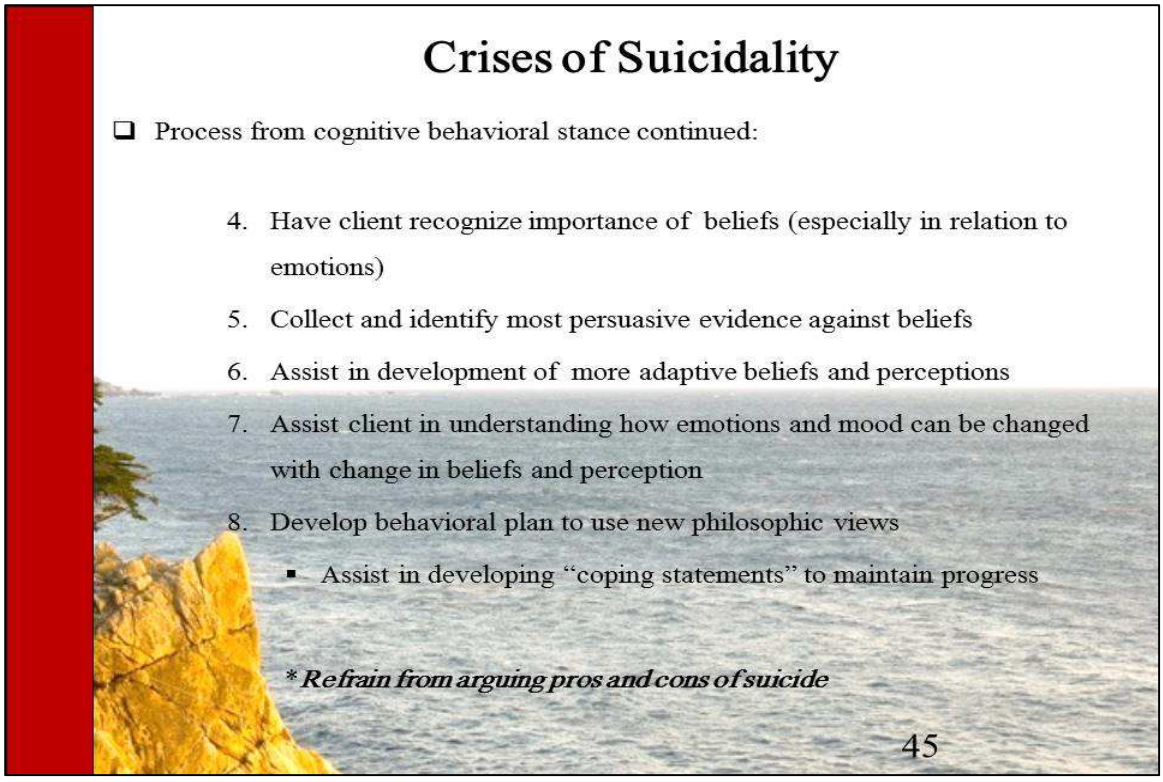

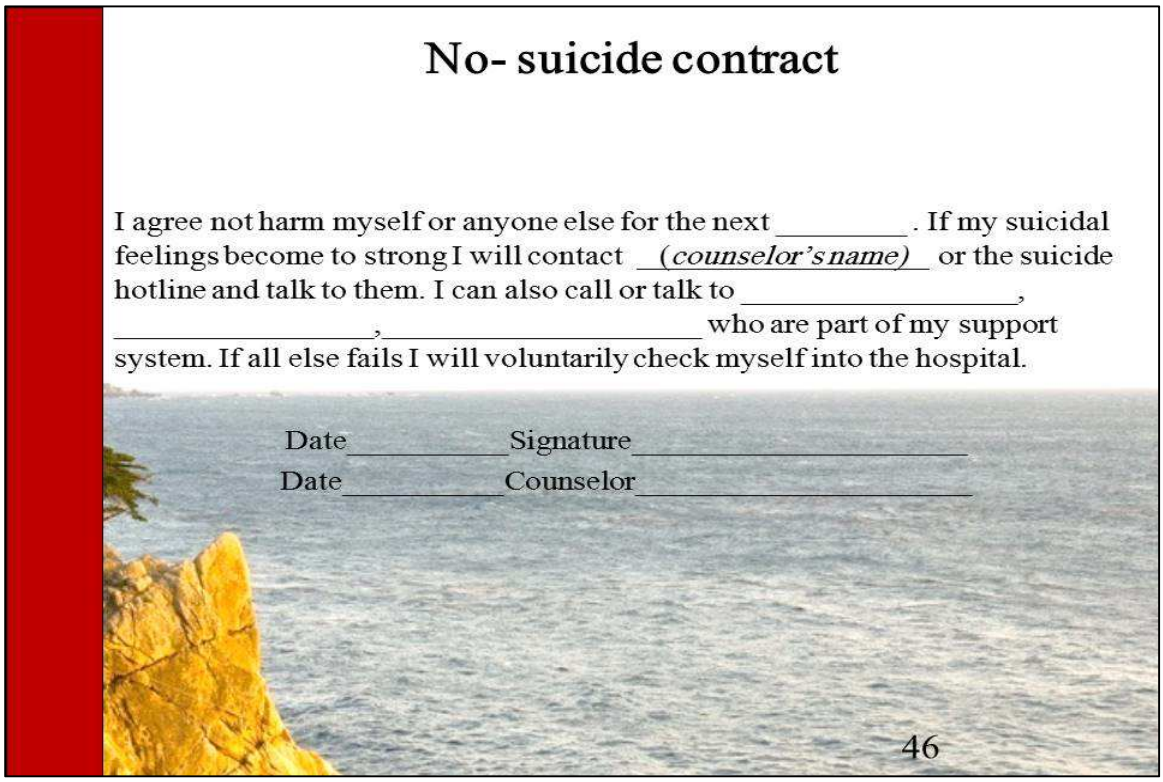

Crises of Lethality

- **Homicidal Risk Assessment**
  - Individuals who are suicidal are often homicidal.
  - Is the individual currently engaging in violent or dangerous behavior?
  - Has the individual verbally (directly or indirectly) stated that they are going to harm someone? *(duty to warn)*
  - Does the individual have a plan and the means to follow through with plan?

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Suicide Prevention Resources

Resources:

- National Suicide Prevention Lifeline
  - http://www.suicidepreventionlifeline.org/
  - 1-800-273-TALK (8255)
- American Foundation for Suicide Prevention
  - http://www.afsp.org/
- American Association of Suicidology
  - http://www.suicidology.org/

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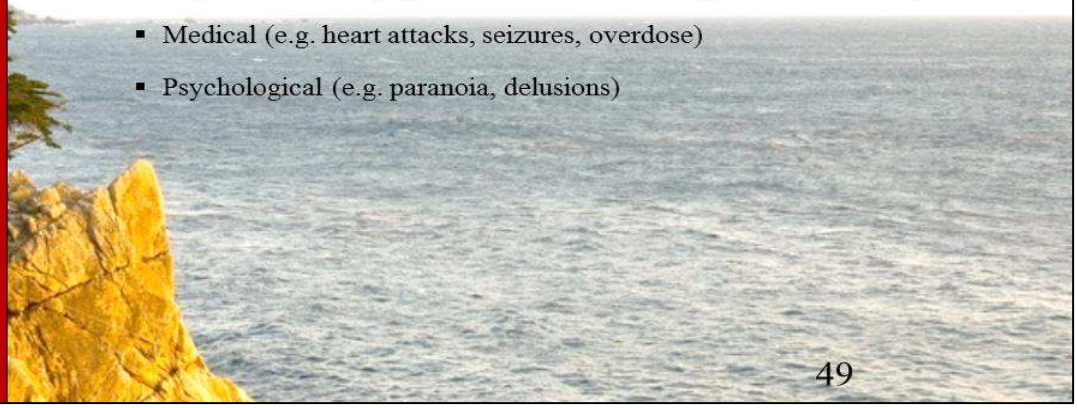
Crisis of Addiction

- ***Types of crises related to addiction:***
  - Legal (e.g. DUI's, criminal assault)
  - Accident-related injuries (e.g. car accidents, falls, suicide)
  - Physical violence (e.g. IPV and non-relationship-related violence)
  - Medical (e.g. heart attacks, seizures, overdose)
  - Psychological (e.g. paranoia, delusions)



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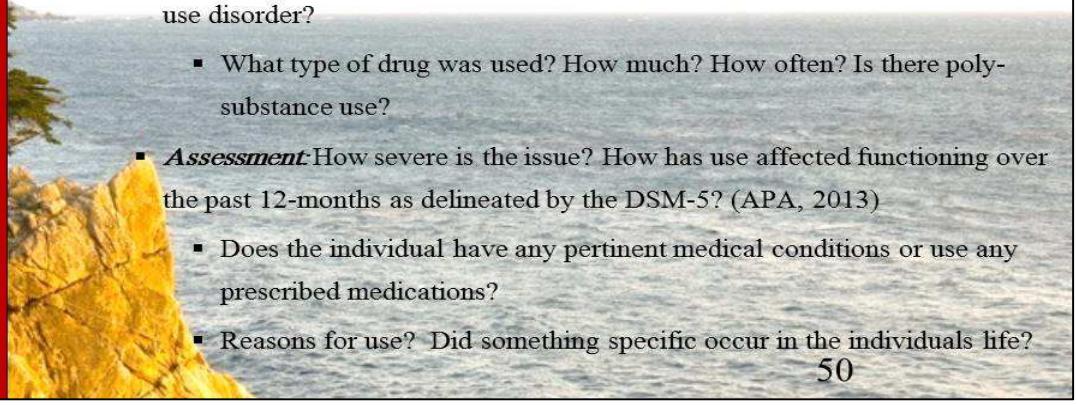
Crisis of Addiction

- ***Special considerations:***
  - Counseling under the influence
  - What are the individuals beliefs about alcohol and other drugs (AOD)? Do they believe using will result in positive or negative consequences? (cognitive-behavioral model)
  - ***Screening:*** Is use problematic? Does the individual in fact have a substance use disorder?
    - What type of drug was used? How much? How often? Is there poly-substance use?
  - ***Assessment:*** How severe is the issue? How has use affected functioning over the past 12-months as delineated by the DSM-5? (APA, 2013)
    - Does the individual have any pertinent medical conditions or use any prescribed medications?
    - Reasons for use? Did something specific occur in the individuals life?



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Crisis of Addiction

- ***Referrals***
  - Alcoholics Anonymous (AA)
  - SMART Recovery 4-point recovery system and support group
    - Building and maintaining motivation
    - Coping with urges
    - Managing thoughts, feelings and behaviors
    - Living a balanced life
  - Treatment facilities
    - Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locater
    - https://findtreatment.samhsa.gov/

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Crisis of Rape and Sexual Assault

- ***Special Considerations:***
  - Previously experienced victimization
  - Type of rape/ relationship to assailant/ abuser (returning to environment, trust issues, feelings toward perpetrator)
  - Feelings of shame and thoughts of blame
    - "I am tainted." I'm disgusting."
    - "I should have been able to stop it"
    - Male victims may "question their manhood"
  - Reporting assault and receiving forensic medical exam
  - Physical complications (e.g. STD's, pain, physical injury, infections)
  - Key tasks: Support, development of safety plan, education

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Crisis of Rape and Sexual Assault

- ***Referral***
  - Rape, Abuse and Incest National Network (RAINN)
    https://rainn.org/
    National Sexual Assault Hotline
    1-800-656-HOPE (4673)

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Families in crisis

- ***Special Considerations:***
  - What are the individual perceptions of the crisis and how does the crisis affect the family unit?
  - Family history must me gathered quickly
  - Irrational thinking should be brought to the forefront and disputed by family members.
  - Family interactions and relationships have a reciprocal impact on individual cognitions, behavior and affect. Teach families how to effectively communicate their thoughts and feelings regarding the event.
  - Individuals have an individual schemata and a family schemata (e.g. cognitions about the family and how it functions, how the family thinks and behaves) which influences their functioning within the family
  - Underlying "obstacles" may influence family functioning (homeostasis of family unit and individual within family)

(Dattilio & Freeman, 2010)

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Families in crisis

- *Special Considerations:*
  - Teach families how to effectively communicate their thoughts and feelings regarding the event.
  - Teach the family problem-solving and conflict resolution skills.
    - What is the problem?
    - What are possible solutions, including pros and cons?
    - Agree upon a solution as a family and implement.
    - Evaluate effectiveness of solution and amend if necessary.

(Dattilio & Freeman, 2010) 55

Therapeutic skills and techniques

- **Basic Attending and Reflecting Skills**
- **Validation**
  - Communicate that it safe for the individual to share their feelings, that it is understandable why they feel the way they do and they are not bad or crazy etc. for feeling that way
- **Understanding of the Crisis**
  - Help individual to better understand their thoughts and feelings about the event and how thoughts and feelings are connected
  - Recognize negative self-talk regarding the event
  - Minimize/mitigate irrational thinking
- **Psychoeducation**
  - Educational information given to the individual regarding mental disorders or symptomology (e.g. common reactions to trauma)
- **Reframing**
  - Changing of an ingrained, self-defeating, negative idea so that the client thinks about it in a new, more positive way

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Therapeutic skills and techniques

- Relaxation techniques
  - Breathing control
  - Progressive muscle relaxation training

  Relaxation exercise

- Coping card
  - Easily accessible card with available coping strategies (e.g. empowering self-talk, relaxation techniques) that the individual can later utilize

- Prolonged exposure (Foa et al., 2005)
  - Relaxation training (10 minutes – session 1)
  - Psychoeducation regarding common trauma reactions (≈ 25 minutes- session 2)
  - Imaginal exposure with habituation- telling of story within session (30-45 minutes- sessions 3-12)
  - *In vivo* exposure- hierarchy created an used as homework in between sessions
  - https://www.youtube.com/watch?v=rHg_SlEqJGc&list=PLyIOy1olCAlNcfZR3tROs_KCCNi-bBTdD&index=9

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Secondary Traumatic Stress

- **Secondary traumatic stress** is the negative emotional consequence, comparable to symptoms of posttraumatic stress disorder (PTSD), experienced after hearing firsthand of traumatic event experienced by another.

- **Symptoms:**
  - Anger, fright, frustration, helplessness, powerlessness, hopelessness, shock, numbness, nausea, cravings, attachment issues, trust issues, difficulty maintaining boundaries, and a decline in work performance

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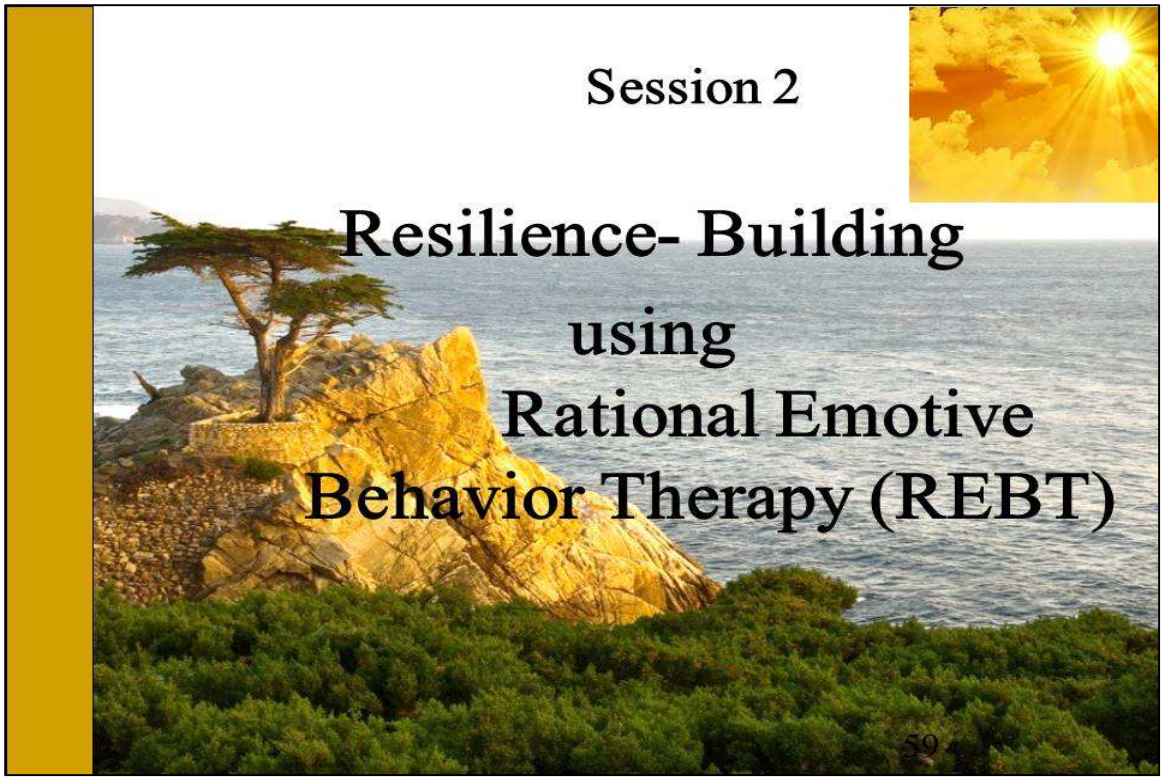

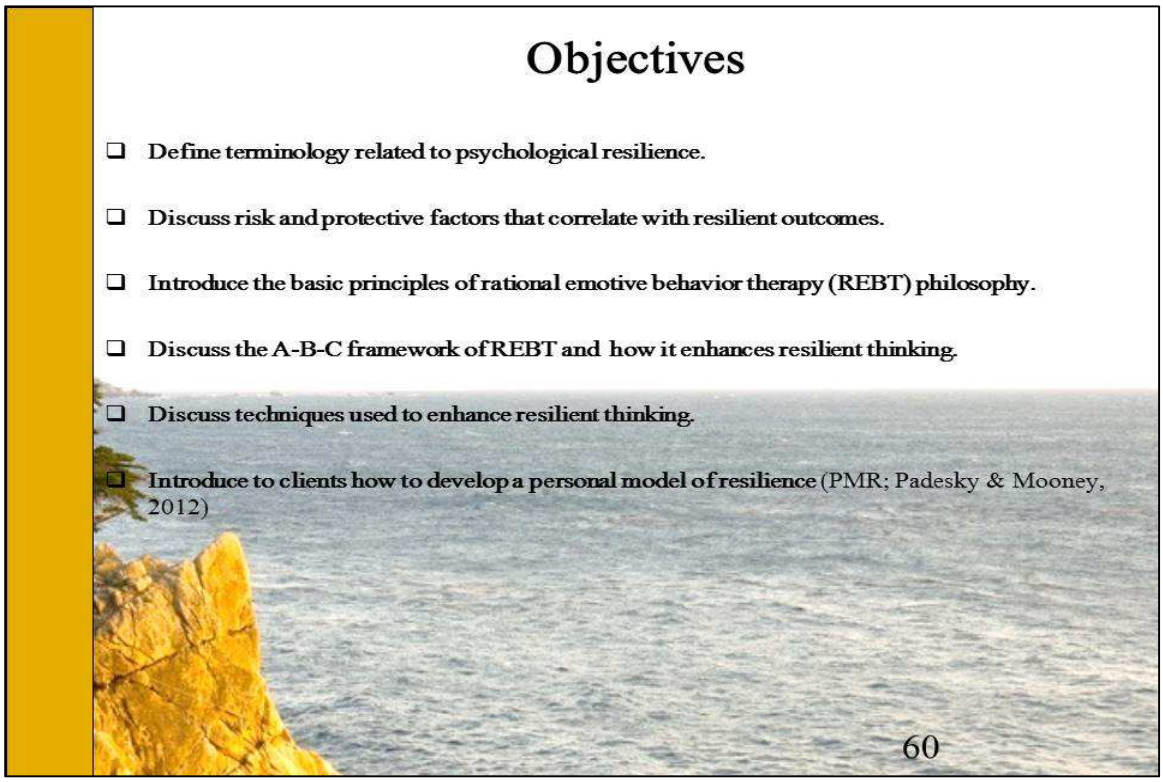

Psychological Resilience

What is resilience:

- **Psychological resilience**: Resilience is the ability to successfully adapt and maintain a relatively stable equilibrium after facing a potentially traumatic event (Bonanno, 2004).
  - Most common response to a traumatic event
  - Includes adversity and adaptation (Luthar & Cicchetti, 2000)
  - A multidimensional construct not a trait (Luthar & Cicchetti, 2000)

RESILIENCE CAN BE LEARNED

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Psychological Resilience

- **Resilience-building**: A multidimensional approach used by mental health professionals to assist clients in achieving positive outcomes following adversity

- **Change methods:**
  - Changing patterns of thinking (e.g. A-B-C thinking)
    - The basic principles of REBT are synonymous with resilient thinking
  - Enhancing positive meaning-making
  - Enhancing coping styles
  - Searching for psychological strengths
  - Enhancing self-efficacy beliefs

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Psychological Resilience

https://www.youtube.com/watch?v=phUjgRXFoaU&list=PLitjSv4SbrkwP-O8RRyt-FEC8wGLTXwZf&index=1

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Psychological Resilience

Protective factors	Risk factors
Self-efficacy	Negative emotions
Positive affect	Poor impulse control
Self-esteem	Poor coping mechanisms
Older in age (65+)	Being financial affected by event
Perceived social support	Rigid thinking

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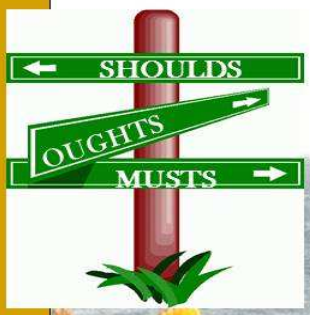
Basic principles of REBT

- Developed by Albert Ellis (1913-2007)
- The manner in which people interpret events contribute to their psychological disturbance and symptomology
- Emotions stem mainly from our beliefs, evaluations, interpretations and reactions to situations
- Counselors assists individual in understanding their core beliefs, particularly self-defeating beliefs or thoughts and understanding how those thoughts influence emotions and behavior
- Peoples "shoulds", "oughts", "musts", and demands create disruptive feelings and dysfunctional behaviors



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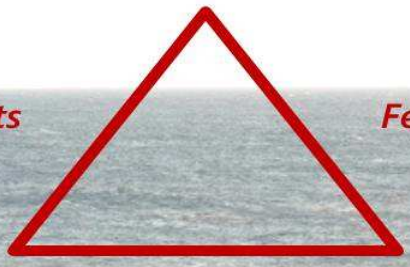
Basic principles of REBT

Thoughts, beliefs and behaviors are interconnected and interrelated

Counselors assists individuals in understanding their core beliefs and thoughts, particularly self-defeating beliefs or thoughts in order to understand how those thoughts influence feelings and actions



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Basic principles of REBT

- Irrational beliefs are derivatives of three basic musts:
  - **Self-demandingness** is the belief that one must do well and win the approval of others for their performance or they are no good
  - **Other-demandingness** is the belief that other people must always treat them considerately, fairly and kind and in exactly in the way they want to be treated; and if they don't that person is no good and they deserve to be condemned and punished
  - **World-demandingness** is the belief that the world and the individuals living conditions must be comfortable, gratifying and just, providing them with all they want in life and if not it is awful and unbearable

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Basic principles of REBT

- Listen for "shoulds," "musts," "oughts," or "I can't stand it's"
- Look for extreme negative emotions or self-defeating actions
- Basic irrational beliefs share four key elements they are:
  - Awfulizing
  - Demanding
  - They consist of low frustration tolerance, and
  - They consist of a global rating of self or others
- Counselors teach unconditional acceptance of self, others, and life given that all humans are fallible

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Basic principles of REBT

A-B-C-D-E-F philosophy

- *Slow down your thinking and use the ABC's*

A= Activating event or adversity contributes to the disturbance

B= Beliefs, attitude or thoughts about event contribute to the Consequences

C= Consequences (emotional or behavioral)

D= Disputation of irrational beliefs- changing the meaning of the event changes the emotional Consequences

- *Detecting, debating and discriminating*
  - **Rigid vs. flexible, realistic vs. unrealistic, helpful vs. unhelpful**
  - *Is there factual evidence to support the belief?*
  - *Are there alternative ways of looking at event?*
  - *What are the implications of event (what's the worst that can happen)?*
  - *What is the usefulness of the belief?*

E= Effective new philosophy

F= Feelings

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REBT and Resilience-building

Class Activity

Break into groups of two and complete the ABC's of resilience worksheet by discussing an adversity you have faced.

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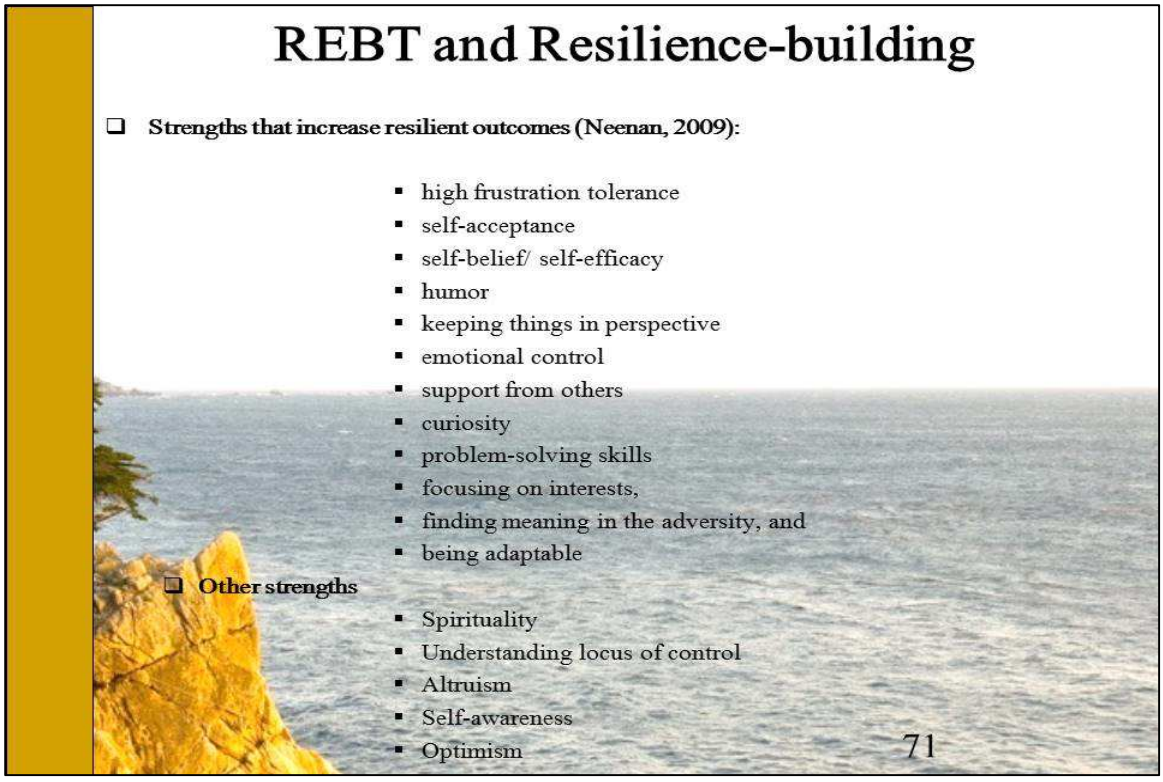

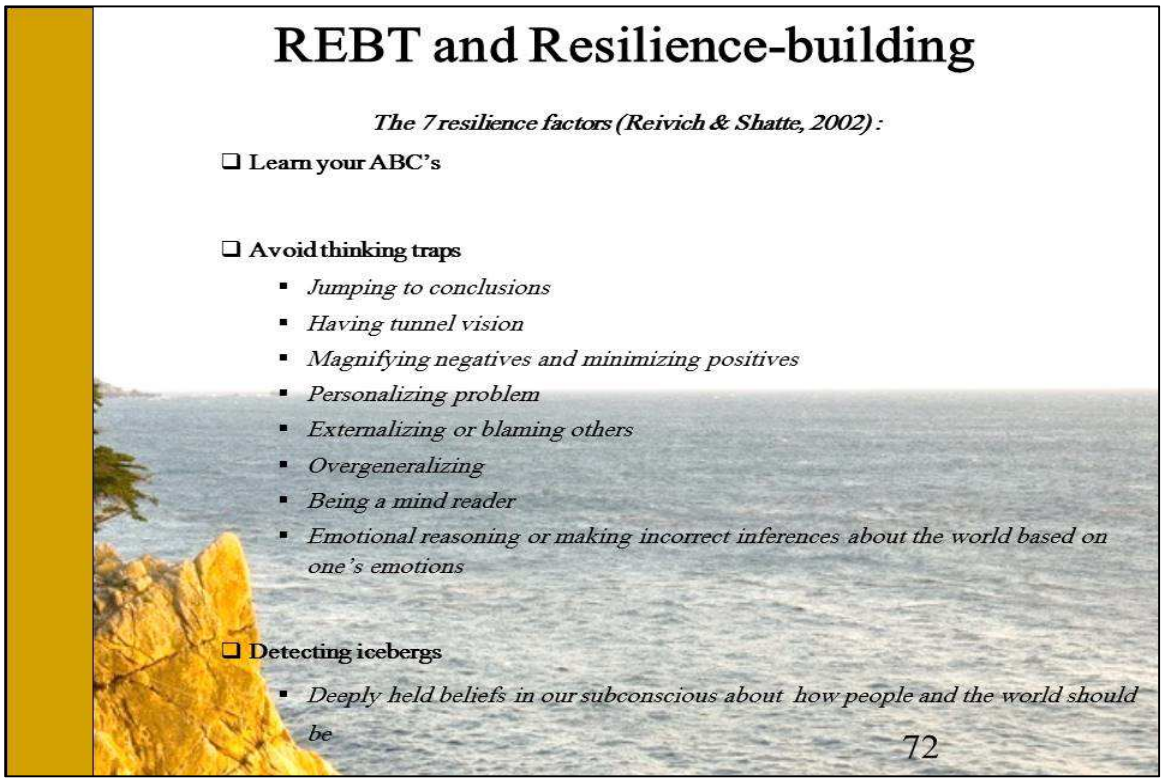

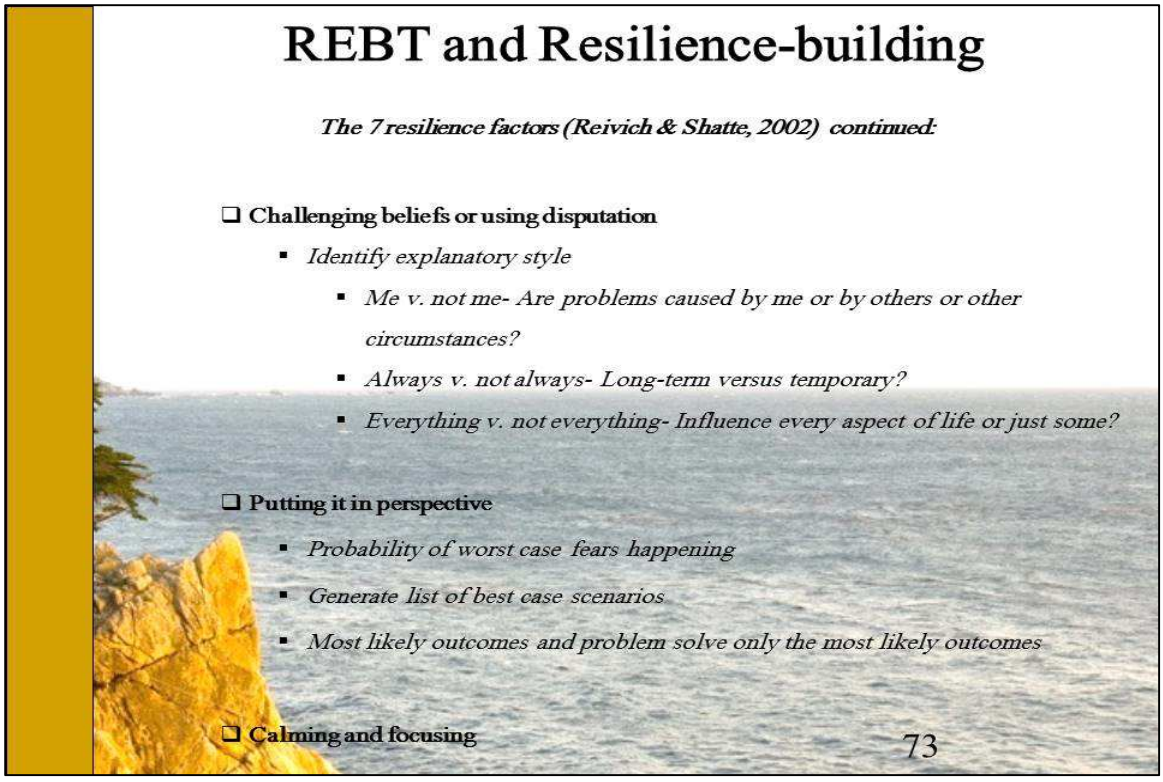

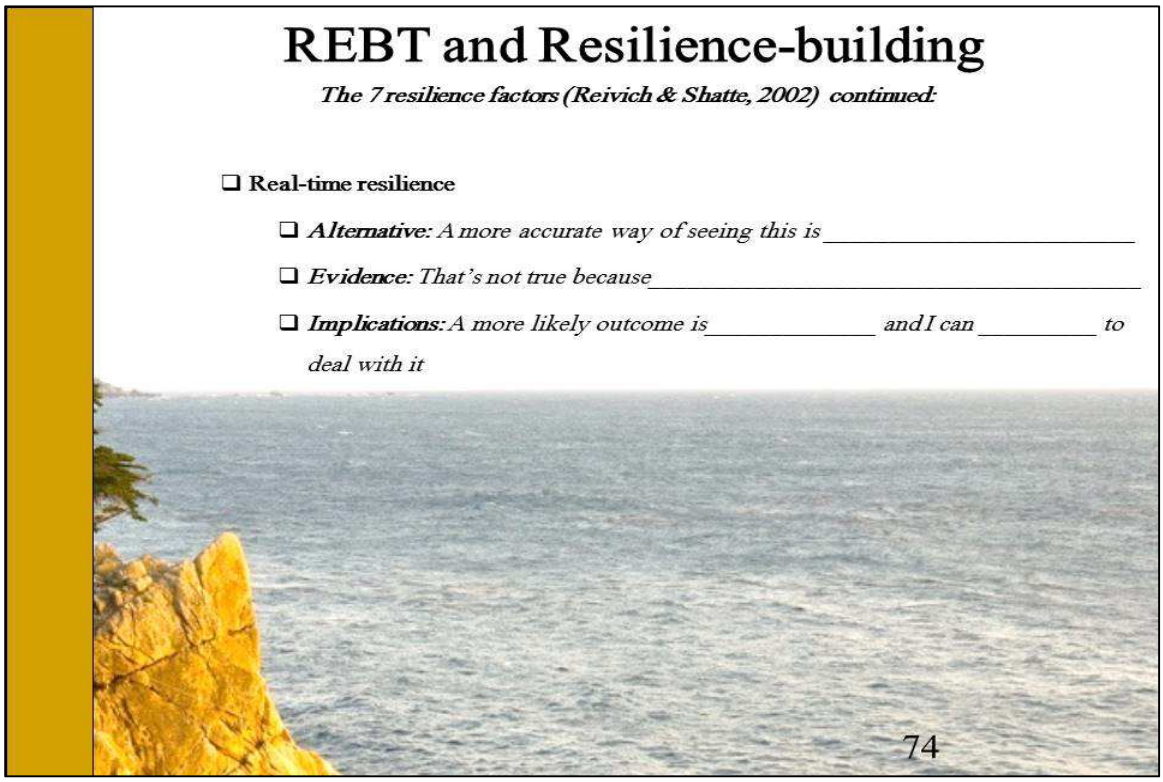

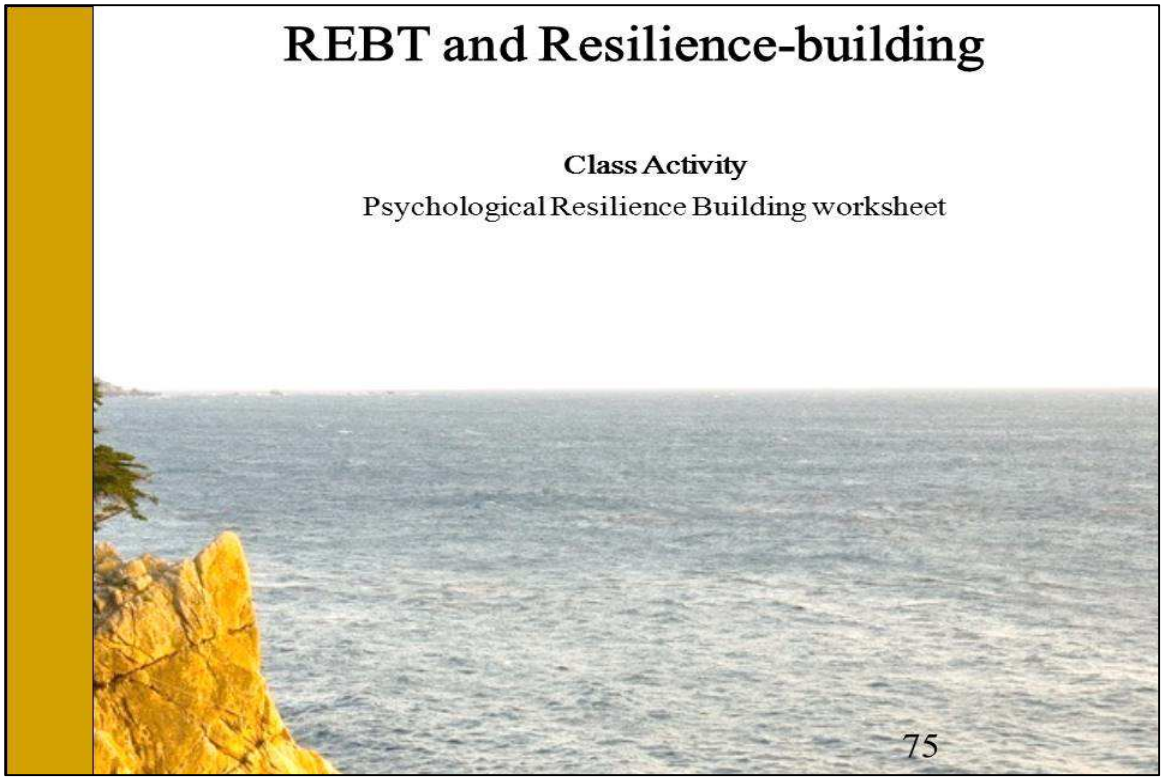

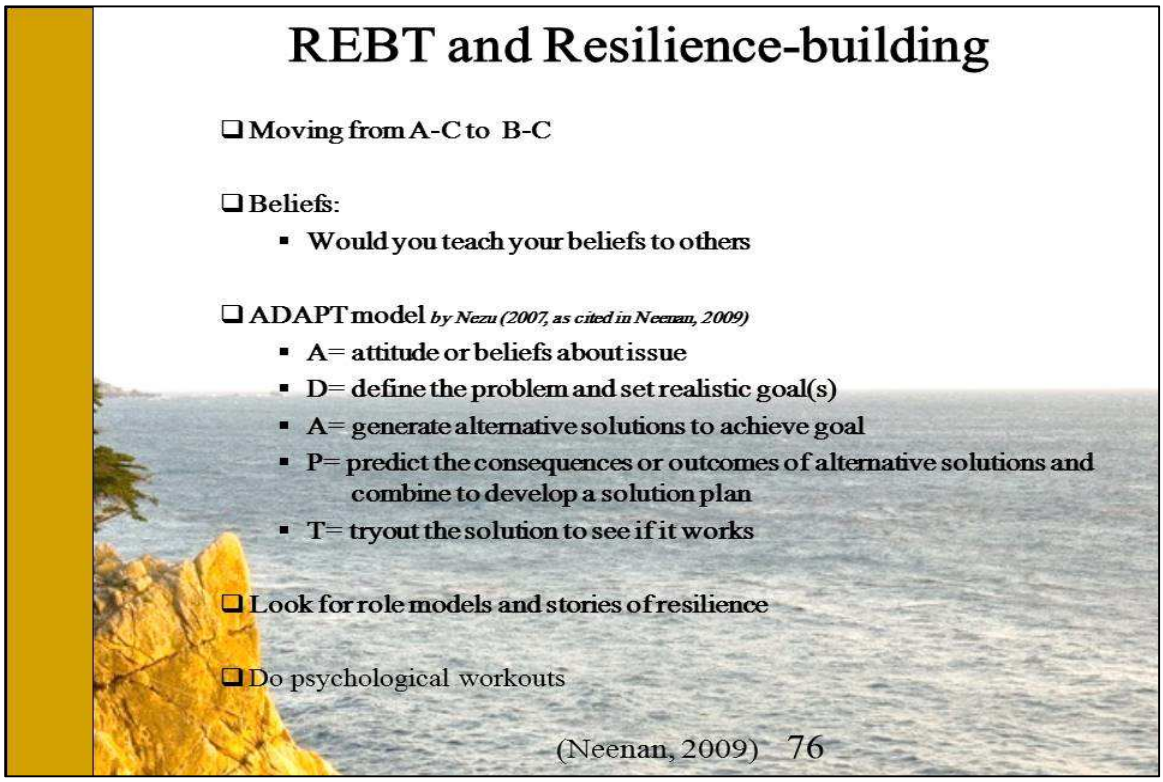

REBT and Resilience-building

Class Activity

Break into same groups of two and complete ADAPT model handout.

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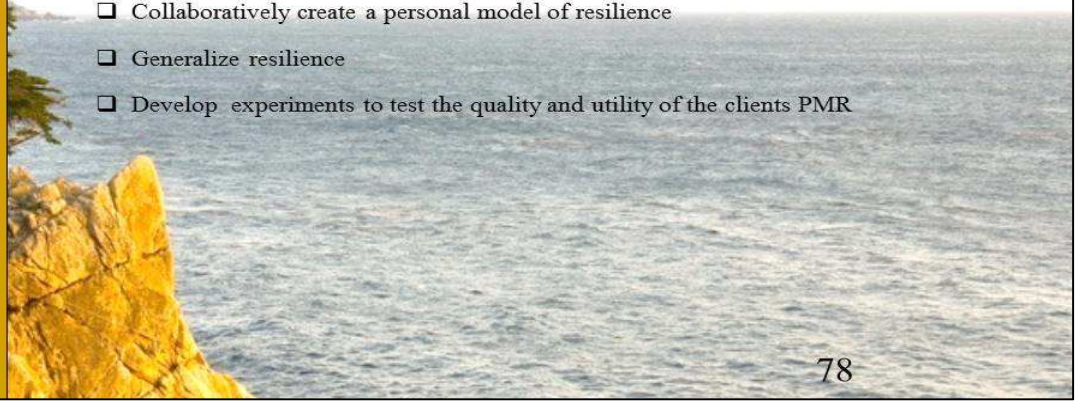
REBT and Resilience-building

Padesky & Mooney (2012) four-step model:

- Collaboratively search for strengths within the clients normal routine
  - Assist client in reframing thinking
- Collaboratively create a personal model of resilience
- Generalize resilience
- Develop experiments to test the quality and utility of the clients PMR



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ABC's of REBT and Resilience

Adversity=	
Belief=	New Belief=
Consequences=	New projected behavioral and emotional outcomes=
Disputation= ○ **Rigid vs. flexible, realistic vs. unrealistic, helpful vs. unhelpful** ○ *Is there factual evidence to support the belief?* ○ *Are there alternative ways of looking at event?* ○ *What are the implications of event (what's the worst that can happen)?* ○ *What is the usefulness of the belief?*	
Philosophy=	Effective new resilient philosophy=
Feelings=	New Feelings=

Psychological Resilience-Building Worksheet

Problem/Crisis/ or adversity:

_____
_____
_____
_____
_____

Worst case scenario:

_____
_____
_____
_____
_____

Attempted methods of coping and degree of success:

1. _____
2. _____
3. _____
4. _____
5. _____

Social Supports available:

1. _____
2. _____
3. _____
4. _____
5. _____

Social Supports utilized:

1. _____
2. _____
3. _____
4. _____
5. _____

Thinking traps utilized *(Reivich & Shatte, 2002):*

	Jumps to conclusions
	Has tunnel vision
	Magnifies negatives and minimizes positives
	Personalizes problems
	Externalizes or blames others
	Overgeneralizes
	Is a mind reader
	Makes incorrect inferences about the world based on emotions

Detecting Icebergs *(Reivich & Shatte, 2002):*

1. Are your behavioral and emotional consequences or responses proportional to your beliefs?
   _____ yes _____ no
2. Are you able to make simple decisions?
   _____ yes _____ no

Individual Strengths:

☐ High frustration tolerance	☐ Self-acceptance	☐ Self-belief/self-efficacy
☐ Humor	☐ Support from others	☐ Curiosity
☐ Problem-solving skills	☐ Focus on interests	☐ Finding meaning in adversity
☐ Being adaptable	☐ Emotional control	☐ Keeping things in perspective
☐ Spirituality	☐ Locus of control	☐ Other
☐ Other	☐ Other	☐ Other

Strengths used in daily functioning:

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

Explanatory Style: determine individuals explanatory style (***Reivich & Shatte, 2002)***

_____ **Me**	**vs.**	_____ **Not Me**
_____ **Always**	**vs.**	_____**Not Always**
_____ **Everything**	**vs.**	_____**Not everything**

Best case scenario:

_____
_____
_____
_____

Probable outcomes and solutions: What outcomes are most likely and how can they be dealt with.

1. _____
   _____
2. _____
   _____
3. _____
   _____

Real-time Resilience (*Reivich & Shatte, 2002):*

Alternative: A more accurate way of seeing this is

_____

_____

Evidence: That's not true because

_____

_____

Implications: A more likely outcome is

_____

and I can

_____

_____ to deal with it.

Application of resilience: Think of at least two ways that you can think differently of current events in your life using your personal model of resilience.

Example:

1. _____

   _____

   _____

   _____

2. _____

   _____

   _____

   _____

ADAPT Model Worksheet

Problem	Beliefs	Goals	Alternative Solutions	Consequences/ Solution plan	Outcome

*Goals should be realistic, measurable, and helpful

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ABSTRACT

THE EFFICACY OF A CRISIS INTERVENTION AND RESILIENCE BUILDING TRAINING PROGRAM FOR COUNSELORS-IN-TRAINING

by

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December 2015

Advisor: Dr. George P. Parris

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Because of the prevalence of potentially traumatic events, counselors-in-training may have to assist individuals in crisis, as early as the internship phase of their counseling program. However, counselors-in-training receive minimal training in crisis intervention, which may be deleterious to the counselor as well as the client. Similarly, counselors-in-training receive minimal training on resilience building, a key component of crisis intervention. Therefore, the purpose of this study was to examine the effectiveness of a crisis intervention and resilience building training program, grounded in REBT, for counselors-in-training.

This study used a quasi-experimental, switching replications design consisting of two groups and three waves of measurement. The participants (N=37) for this study which included 16 participants in the treatment group and 21 participants in the control/delayed intervention group were pretested using a demographic survey, the Conner-Davidson Resilience Scale (CD-RISC) and the Crisis Counseling Intervention Skills Self-Efficacy Scale (CCIS-SES). The treatment group then participated in a two-week training which entailed crisis intervention fundamentals and strategies as well as

resilience-building. At the conclusion of the training, both the treatment group and the control group completed posttests of the CD-RISC and the CCIS-SES. The treatment group and the control group then "switched" roles and the control/delayed intervention group participated in the training. Afterwards, both groups again completed posttests.

Results from the t-tests for independents samples and dependent samples indicated that the crisis intervention and resilience building training did significantly increase the crisis counseling self-efficacy between the treatment and delayed intervention groups at Time 2 ($t(28.52) = 5.93$, $p < .001$), as well as within these respective groups at Time 1 to 2 and Time 1 to 3 for the experimental group ($t(15) = 6.69$, $p < .001$ and $t(15) = 7.14$, $p < .001$) and Time 2 to 3 and Time 1 to 3 for the delayed intervention group ($t(20) = 7.83$, $p < .001$ and $t(20) = 6.73$, $p < .001$). Results also indicated that there was a significant difference in resilience within the experimental and delayed intervention groups at Time 1 to 3 ($t(15) = 3.50$, $p = .003$, $t(20) = 4.06$, $p = .001$). However, there was not a significant difference in resilience between the delayed intervention group and the treatment group at any point. The small sample size, the length of the study, as well as other limitations may have affected the study. Thus, future research that includes a larger sample size as well as that which extends over a longer period of time, are amongst the recommendations offered.

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