Crisis Assessment Tools: The Good, the Bad, and the Available

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Behavioral clinicians, mental health counselors, psychiatric nurses, psychiatrists, psychologists, and social workers are frequently called upon to make a rapid and accurate assessment of the magnitude of a client’s crisis state. Until recently, there has been a dearth of empirically based crisis assessment instruments with strong psychometrics. This article documents the need and explicates the rationale for the development of the Lewis and Roberts Multidimensional Crisis Assessment Scale (Lewis-Roberts MCAS). In addition, we identify and discuss the distinct differences between stressful life events, traumatic events, coping skills and other mediators of a crisis, and an active crisis episode. Finally, we examine the advantages and limitations of several crisis specific measurement tools used in a structured interview format. [Brief Treatment and Crisis Intervention 1:17–28 (2001)]

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Samantha is a single mother who just found out that her fiancé has been cheating on her. She has come into the local community mental health center because she feels like her world is coming to an end and she has nowhere else to turn. Samantha has had a hard life and learned at a young age how to “hold it together” to appear and sound like she is okay.

Many individuals have had relationship problems at some point in life and for some the above scenario would seem like no big deal, for others, however, it would be a crisis. After listening to Samantha’s plight, an intake worker or crisis counselor has several choices:

1. Put her on the waiting list for a therapy appointment;
2. Determine the magnitude of Samantha’s crisis state by measuring her perception about the gravity of the situation as well as her perceived ability to cope with the situation;
3. Tell Samantha that there are a lot of other people with bigger problems than hers.

Of course the correct choice is number two. However, how do clinicians accurately assess
the magnitude of a client’s crisis state? Crisis assessment is the subject of this article.

Crisis intervention is the most widely used form of brief treatment used by behavioral clinicians, counselors, psychiatric nurses, psychologists, social workers, and other mental health professionals worldwide (Roberts, 2000). There have been a number of books and articles written about crisis intervention models and techniques, and the one thing that is common with all writings on the topic is the importance placed on assessment. What is remarkable, however, is the lack of empirically based and standardized crisis assessment protocols, including instruments with strong psychometrics that are available to practitioners. To date, few crisis assessment scales with strong psychometric qualities are available and none of them are capable of measuring the magnitude (duration and intensity) of a crisis state from the subjective vantage point of the client. The most challenging issues facing this dilemma are as follows:

- How do clinicians and clinical supervisors identify possible assessment instruments that measure the magnitude of the multidimensional aspects of a crisis state?
- Why is it important to accurately measure the magnitude of the crisis episode, and to objectively measure when crisis resolution has taken place?
- What are the strengths and weaknesses of the structured intake interview and rapid assessment instruments?

This article will begin to answer these three questions to assist clinicians with their assessment of a client’s potential crisis state, as well as the client’s progress. We will discuss the operational definition and parameters of a crisis, the importance of standardized crisis assessment tools with which the reliability and validity are known, the pros and cons of client self-assessment and clinician assessment, assessment tools that are currently available, and finally, issue a call for future research.

**Primary Assumptions of Crisis Theory**

According to Roberts (2000), the application of crisis intervention models and techniques, based on crisis theory, has proliferated throughout the United States and Canada due to cost containment concerns driven by declining mental health and social services dollars. “Reference to the application of crisis theory is so frequent within the social work practice literature that it is often difficult to distinguish the unique components of crisis intervention from those of other social work interventions” (Ell, 1995, p. 662). Another confusing aspect of crisis theory is the lexicon used to describe its features. It is very difficult to discriminate between discussions of theory and method. This article is essentially about method; however, theory must first be reviewed briefly to justify, or at minimum, better understand the use of crisis intervention methods.

There is not a single crisis theory that encompasses all views of what defines a crisis event (the phenomenon), a crisis response (human response to the phenomenon), or a crisis intervention (the helping process) (Gilliland & James, 1993). Instead there exists a body of literature that is grounded in the seminal work of Lindemann (1944), Caplan (1964), Roberts (1970), Roberts and Grau (1970), and Burgess and Baldwin (1981) and a synthesis of ego and cognitive psychology as well as individual stress theories. Parad and Parad (1990) and Roberts (1990, 2000) suggest that within this compilation of theories rests several primary assumptions. It is through these tenets that practitioners, often through more practice wisdom than research, design, implement, and practice crisis interventions (Parad & Parad, 1990). The assumptions are as follows:
• Everyone, at sometime in his or her life will experience acute stress that is not necessarily pathological. It is the overall context in the person’s life that deems whether or not the stressor is a crisis event.
• Homeostasis is a natural state that all people seek and when an individual is in a state of emotional disequilibrium he or she strives to regain emotional balance.
• A period of disequilibrium in which the individual (or family) is vulnerable to further deterioration or assistance is present when a stressful event becomes a crisis.
• This disequilibrium makes the individual more amenable to intervention.
• New coping mechanisms are needed to deal with the crisis event.
• The dearth of prior experience with the crisis event creates increased anxiety and struggle and the individual often discovers hidden resources.
• The duration of the crisis is somewhat limited depending on the precipitating event, response patterns, and available resources.
• Certain affective, cognitive, and behavioral tasks must be mastered throughout the crisis phase to move to resolution regardless of the stressor.

An operational definition for crisis is delineated by Roberts (2000) in the glossary to his Crisis Intervention Handbook: Assessment, Treatment and Research as follows:

An acute disruption of psychological homeostasis in which one’s usual coping mechanisms fail and there exists evidence of distress and functional impairment. The subjective reaction to a stressful life experience that compromises the individual’s stability and ability to cope or function. The main cause of a crisis is an intensely stressful, traumatic, or hazardous event, but two other conditions are also necessary: (1) the individual’s perception of the event as the cause of considerable upset and/or disruption; and (2) the individual’s inability to resolve the disruption by previously used coping methods. Crisis also refers to “an upset in the steady state.” It often has five components: a hazardous or traumatic event, a vulnerable state, a precipitating factor, an active crisis state, and a resolution of the crisis (p. 516).

Crisis Assessment—The Common Link

Roberts’ (1970) classic research on the first 24 suicide prevention agencies developed in the United States during the 1960s found that all of these programs and 24-hour hotlines had a three-stage initial crisis intervention procedure in common: (a) Establish rapport, (b) make an assessment of suicide potential; and (c) develop an action plan (Roberts, 1970; Roberts & Grau, 1970). Twenty-four hour crisis hotlines and crisis intervention programs have grown dramatically from 33 in 1969 to over 10,000 such programs currently available in cities, counties, and states throughout the nation (Roberts, 2000).

In the early part of the 21st century, there are several models of crisis intervention that all have unique components. The one aspect, however, that each crisis intervention model has in common is a general psychosocial assessment. With regard to uniqueness, Roberts (1991, 1996, 2000) was the first practice model to identify and discuss both the biopsychosocial and lethality components, and specific questions and instruments that should be included in a thorough crisis assessment protocol. The first stage of Roberts’ (1996, 2000) seven-stage crisis intervention model is: “Plan and conduct a thorough assessment (including lethality, dangerousness to self or others, perception of the precipitating event, and immediate biopsychosocial needs).”

Several of the crisis intervention models men-
tion the general importance of conducting an assessment, but neglect to give much specificity or detailed information. Kanel’s (1999, p. 5) recommendation that is conceptually and semantically based on Jones’s (1968) ABC method asserts that several aspects of the presenting problem need to be assessed, “After demographic information has been gathered and as rapport is developing, the crisis worker starts to focus on the client’s presenting crisis. This is the second step in the ABC method and the most crucial one.” Aguilera (1998, p. 20) states: “Assessment of the individual and his problem is the first phase. It requires the therapist to use active focusing techniques to obtain an accurate assessment of the precipitating event and the resulting crisis that brought the individual to seek professional help.” Janosik (1994, p. 11) explains, “In the beginning of the assessment, the crisis worker should trace a chronology of events by asking what happened, when various events occurred, who was involved, what actions were taken before seeking assistance, and what were the effects of those actions.” Gilliland and James (1993, p. 76) state that assessment is: “overarching, continuous, and dynamically on-going throughout the crisis; evaluating the client’s present and past situational crisis in terms of the client’s ability to cope, personal threat, mobility or immobility, and making a judgment regarding type of action needed by the crisis worker.”

Because of the present unavailability of a multidimensional crisis assessment scale (one is currently being validated; see Corcoran & Roberts, 2000, or contact Professor Roberts, Editor-in-Chief of this journal), most intake workers have failed to distinguish between stressful life events, traumatic events, coping skills and other mediators of a crisis, and an active crisis state. Most crisis episodes are preceded by one or more stressful, hazardous, and/or traumatic events. However, not all stressed or traumatized individuals move into a crisis state. Every day thousands of individuals completely avert a crisis, while many other thousands of individuals quickly escalate into a crisis state.

Reactions and mental status in the aftermath of a traumatic or stressful life event can be categorized into four types: (a) attitudinal, behavioral, or life style changes; (b) a crisis state; (c) developing a pathological disorder; or (d) a post-traumatic stress disorder (PTSD). Young (1995) identified and discussed three stress and trauma reactions, namely, crisis, pathology, and PTSD. She focuses on the elements that help to define the uniqueness and impact of a tragedy, disaster, or violent crime. Personal impact can be measured by determining the following:

- **Warning time.** Time to prepare for the traumatic event (e.g., a hurricane or tornado) can help to lessen the impact. Events with no warning such as a violent crime against the person (e.g., mugging, aggravated assault, attempted murder) can lead to intense anger, fear, intrusive thoughts, psychological distress, avoidant behavior, and/or hyper-vigilance and increased arousal.
- **Spatial dimensions.** The closer the person is to the center of the tragedy the greater the stress (e.g., being in the path of a tornado as opposed to living in the same town in which a tornado passed through). This also applies to the death of a loved one. The closer the client is to the lost loved one, the greater the likelihood of entering into a crisis state.
- **Taking stock.** Taking inventory of property damage and/or injuries sustained, medical/mental health triage may contribute to self-blame, guilt, frustration and despair, outrage, and feelings of disillusionment by survivors.
- **Subjective time clock.** The duration (estimated time frame) that an individual is affected by the community disaster, crime, or other tragedy. There are three basic
types of duration: (a) the length of time of the disaster, rape, assault, accident, or other stressful event; (b) the duration of sensual experiences, the smell of fire, the taste of a gag; and (c) society’s response to the aftermath of the traumatic event. The greater the duration of the event in the above three ways, the greater the stress.

- **Reoccurrence (perceived).** The more the perceived likelihood that the tragedy will happen again, the greater the likelihood of intense fears, which contribute to an active crisis state on the part of the survivor (Young, 1995).

“The general guideline is that the longer the survivor is engaged in the disaster in any of these ways, the greater the likelihood for experiencing severe crisis . . .” (Young, 1995, p. 169). Crisis assessments need to include an understanding of the crisis precipitant(s), the subjective perception of the stressor as well as coping efficacy of the client. Another important dimension of a crisis assessment is the appraisal of psychosocial variables including the client’s available resources, and culturally appropriate behavior.

When examining the literature on crisis assessment and/or measurement one can find two basic forms of assessment tools for different aspects of a crisis. One type of instrument is a paper and pencil rapid assessment instrument (RAI). RAIs are short, easy to complete, standardized questionnaires that capture the subjective experience of the client. The benefit of these scales is that the psychometric properties (minimum of reliability and validity) are known for specific groups. This means that clinicians can pick up a ready-made instrument and know whether or not they are measuring what they think they are measuring and with what consistency they are measuring it. In a study that investigated the use of multiple suicide assessment techniques with psychologists, psychiatrists, and social workers, Jobes, Eyman, and Yufit (1995) found that few clinicians use standardized rapid assessment tools. Clinicians in that study claim that they are not useful, and linked their concerns to issues of validity and reliability. Psychologists, who have specialized training in the use of instrumentation, tended to use RAIs at a higher rate, and found them more useful than the other groups.

The second form of assessment is a structured interview. According to Myer and Ottens (1994), the structured interview appears to be the most appropriate and most widely used in crisis intervention assessment. This is consistent with Jobes et al.’s (1995) findings that clinicians tend to value interview questions more than suicide specific RAIs or other psychological tests. The strength of the structured interview with crisis assessment is that the clinician is the one who completes the assessment form and the severity of the crisis state is not likely to impede the completion of the assessment tool.

**Why Measure?**

How does a clinician justify treatment for one client and not another? He or she probably uses some format to calculate risk and benefit; however, it may not be a conscious act. Instrumentation, or measurement, helps a clinician to stay focused on task, and assess the construct that he or she is attempting to assess. Measurement devices should never replace practice wisdom but instead enhance it. So what is measurement?

Nunnally (1978) claims that measurement can be defined quite simply as the “systematic process of assigning a number to something” (p. 126). These “things” or variables are the client’s thoughts or cognitions, behaviors, affect, feelings, or perceptions. The assignment of a number, or the quantification of the variable, allows clinicians to monitor change mathematically (Corcoran & Fischer, 2000). Standard-
ized measurement is needed in the field of crisis intervention in order to understand the comprehensive nature of the client’s crisis state with greater accuracy (Nurius & Hudson, 1993).

Accurate measurement is also necessary to gauge the magnitude of the crisis state and to monitor progress from an objective standpoint. Accurately measuring the severity of different aspects of a crisis state permits the clinician to intervene upon both the area that is most germane to the current crisis, and to use the appropriate degree of intervention. This is not to say that standardized measurement should replace the assessment of the clinician, but instead the measure can be used to triangulate—or to provide additional information in which to look for congruence of assessment (Nurius & Hudson, 1993).

Many practitioners have long forgotten the standards that they learned in their advanced research classes, and are unable to determine what the best instrument would be for their practice. Corcoran and Fischer (2000) provide a very easy to follow guide for instrument selection and Hudson (1982), although out of print and difficult to find, is worth the search effort to facilitate understanding of key measurement concepts and the use of instruments in practice. A few very basic rules to follow are:

- Reliability coefficients should be .90 or better when measuring individuals as opposed to groups (Springer, Abell, & Hudson, in press). (In 1982, Hudson claimed that coefficient alpha should be .80 but raised the standard in 2000.)
- Construct, content, factorial, and predictive validity should all be reported and criteria used should be discussed.
- The exact construct that the scale measures should be clearly defined.
- Standard error of measurement (SEM) should be less than 5% of the range of scale scores (Springer, Abell, & Hudson, in press).

- The population on which the instrument was tested should be known and comparable with the group on which the instrument will be used.

### Measurement in Crisis Assessment

One major problem with readily available, standardized instruments that are categorized under crisis assessment is that most of them are focused on the potential for suicide or buffers against suicide. Even though a lethality assessment is a tremendously important part of a crisis assessment, it is not the only part of the assessment process. Not all individuals who are in crisis are either suicidal or homicidal.

In order to assess aspects of a crisis state, other than lethality, clinicians generally measure the event that precipitates the crisis, the stress caused by that event, or the emotional consequences of unresolved crisis such as depression or anxiety (Corcoran & Roberts, 2000). Several problems exist with measuring the magnitude of a crisis state or the resolution of a crisis state by these variables (precipitating event, stress caused by the event, and emotional consequences of the event). Roberts (1996, 2000), and Ell (1995) agree that it is the context in which an individual experiences an event and the individual’s subjective response to that event that determines whether an event is or is not a crisis. If this assumption holds, then any event may or not be a crisis event and it is the subjective response and not the event itself that is the determinate.

Experts in stress theory (Lazarus & Folkman, 1984), in addition to the aforementioned experts in crisis theory, claim that stress is a natural state of being, and that it is the subjective overall context of an individual’s life circumstances and perception of resources that determines whether the stress induces a crisis state. Again, it is the individual’s perception of the available
resources in relation to the stressor that leads to the crisis state, not the stress itself. Finally, a crisis state does not equate with pathology; thus, measures of depression and other severe psychological states do not capture the crisis state construct (Ell, 1995; Golan, 1987; Parad & Parad, 1990; Roberts, 1996, 2000).

The difficult task at hand, therefore, is to measure the psychological state considered to be a “crisis state” and not the precipitating event or pathological states that may be the result of poor negotiation within the crisis state. One of Hudson's axioms states that, “if it exists, it is measurable,” therefore, if a crisis state exists and it is a unique psychological state, the crisis state itself should be measurable (1982). To date no RAI that measures the subjective severity or magnitude of personal and/or social dysfunction considered to be aspects of a crisis state from the client’s perspective has been developed and psychometrically tested.

Clinician Rated–Crisis Specific Measurement Tools

According to a literature search through several major databases (PsycLIT, Sociofile, Infotrac, PubMed) there are three standardized, multidimensional instruments that are designed specifically for crisis assessment (not solely lethality) on which the psychometrics are known that are currently available for noninstitutionalized adults. All three instruments are in a structured interview format. The first scale is the Crisis Triage Rating Scale (CTRS), and was developed by Bengelsdorf, Levy, Emerson, and Barile (1984). The interviewer using the instrument chooses one of five descriptive statements in each of the following three categories: dangerousness, support system, and ability to cooperate. Scores range from 3 to 25 and individuals with scores lower than 10 are recommended for inpatient treatment, and individuals with scores of 11 or more are recommended for outpatient treatment. Turner and Turner (1991) reassessed the instrument and their findings were consistent with those of Bengelsdorf et al.

Myer and Ottens (1994) developed the Triage Assessment Form: Crisis Intervention (TAF), that aids clinicians in assessing the type and severity of crisis experienced by college students. As with the CTRS, the clinician and not the client uses the instrument to quantify a crisis state. The TAF uses a three-dimensional model that includes affective responses, cognitive perceptions, and behavioral coping to the crisis situation. Waters (1997) tested the instrument with five distinct groups: undergraduates and graduates in a crisis intervention class (n = 22), graduating recruits from the Memphis Police Academy (n = 29), graduate students in the counseling department (n = 24), crisis intervention personnel (n = 31), and experts in the field of crisis intervention (n = 3). Reliability coefficients ranged from 0.63 to 0.94.

The Suicide Assessment Checklist (Rogers, 1994) (otherwise known as the Crisis Line Suicide Risk Scale) is a two-part suicide risk assessment tool. The first part of the instrument is used to collect information on relevant demographic variables and the second part is counselor ratings of psychological, psychosocial, and clinical factors. The instrument has good inter-rater reliability estimates from 0.83 to 0.84 and a four-week test-retest reliability estimate of 0.82. Internal consistency reliability estimate ranged from 0.74 to 0.81. Criterion validity was established through expert ratings of test audiotape role-play suicide calls. Rogers et al., unlike many instrument designers, are appropriately cautious in their conclusions and clearly state:

SAC scores are for research use only and are not intended to be predictive of suicidal behavior. The SAC information should be combined with other sources of information such as third party data, clinical experience, and
intuition for the final judgment of suicide risk level. (p. 365)

The Scale for Suicide Ideation (SSI) (Beck, Kovacs, & Weissman, 1979) is a widely used instrument with strong psychometric properties as demonstrated in several studies (Beck et al., 1979; Beck, Steer, Kovacs, & Garrison, 1985; Clum & Yang, 1995). The scale contains 3 factors, active suicidal desire (10 items), passive suicidal desire (3 items), and preparation (3 items). The total score is the sum of all items across factors with a maximum score of 57. Construct validity of the instrument was established with strong correlation to the self-harm items of the Beck Depression Inventory (Beck et al., 1979) and convergent validity was found with positive correlations with daily self-monitoring of suicidal ideation (Clum & Curtin, 1993). One disadvantage to the SSI is that it was designed to be administered solely by a trained clinician and not paraprofessionals.

A scale that is similar to the SSI, but can be completed by paraprofessionals is the Modified Scale for Suicide Ideation (SSI-M) (Miller, Norman, Bishop, & Dow, 1986). The SSI-M has three factors: suicidal desire (9 items), preparation for attempt (6 items), and perceived capability of making an attempt (3 items) (Clum & Yang, 1995). The SSI-M has good internal consistency as demonstrated by reported coefficient alpha scores ranging from 0.87 to 0.94. (Clum & Yang, 1995; Miller et al., 1986). Evidence of concurrent validity was shown through high correlation with the suicide item from the Beck Depression Inventory (0.34; Miller et al., 1986) and the Zung Depression Scale (0.45; Clum & Yang, 1995).

Crisis-Oriented Rapid Assessment Instruments (Self-Rated)

There are several rapid assessment instruments that fall under this rubric. They are crisis oriented, but not crisis specific. Corcoran and Fischer (2000) have compiled over 400 RAIs in a wide range of problem areas; none, however, assess the magnitude of a crisis state. There five scales related to suicide in Corcoran and Fischer, but the editors suggest also looking under depression and life satisfaction. A few of the scales not listed in Corcoran and Fischer that could possibly be appropriate for portions of a crisis assessment are:

- Brief Psychiatric Rating Scale (Overall & Gorham, 1962).
- Brief Symptom Inventory (Boulet & Boss, 1991).
- Reasons for Living Inventory (Linehan, Goodstein, Nielsen, & Chiles, 1983).
- Adult Suicidal Ideation Questionnaire (Reynolds, 1991).
- Suicide Probability Scale (Cull & Gill, 1982).
- Suicide Intervention Response Inventory (Cotton & Range, 1992), and
- Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974).

Call for Further Research

Crisis theory was introduced to hospitals, mental health centers, and crisis clinics through the work of Erich Lindemann (1944), Gerald Caplan (1964), Howard Parad (1961), Lydia Rapoport (1962), David Kaplan (1968), Naomi Golan (1969), Ann Burgess and Bruce Baldwin (1981), and Albert R. Roberts (1970). Golan (1986) states that as early as the 1950s the use of crisis intervention techniques by social workers was being reported at national and regional conferences and in the professional literature. Roberts’ (1970) first national study of the organizational structure and functions of 24 suicide prevention centers throughout the United States documented the work of newly established 24-hour
crisis and suicide prevention hotlines during
the late 1960s. According to Roberts and Grau
(1970), when a crisis hotline worker answered
the cry for help, his/her primary responsibility
was to “initiate crisis intervention services. The
first step was to establish rapport with the per-
son at risk and to communicate to him the
worker’s willingness to help. . . . As the worker
listened to the client, he/she evaluated his/her
suicidal potential” (p. 693).

Roberts (2000) documented the fact that there
are over 10,000 crisis intervention programs and
hotlines at local community mental health cen-
ters, victim assistance programs, battered wom-
men’s shelters, child abuse agencies, rape crisis
programs, emergency psychiatric services, chem-
ical dependency treatment programs, and sui-
cide prevention centers.

The prevalence of crisis and crisis interven-
tion during the past decade has been estimated
at over 30 million crisis episodes annually, and is
in part due to the brief nature of the interven-
tion (Roberts, 1996). Short-term treatment ap-
proaches are becoming the norm for several rea-
sons, including but not limited to, shrinking
human service budgets and the recognition that
many clients are not interested in long-term
therapy. In this issue of *Brief Treatment and Cri-
sis Intervention*, MacNeil (2001) documents the
fact that cognitive-behavioral therapy is usually
completed in 4 to 12 sessions, while Bloom’s
(2001) review of 40 studies documents the fre-
cquent use of single-session treatment. Even in
private practice the length of outpatient treat-
ment is usually less than 26 sessions (Pardes &
Pincus, 1981) and Garfield (1978) found that
50% of clients are lost before the eighth session.

Crisis intervention techniques, which are
based in crisis theory, are useful with a number
of populations: services for the aged, in chil-
ren’s courts, victim services, medical situa-
tions, neonatal intensive care units, terminal ill-
ness, and other traumatic situations (Golan,
1986). The first step in crisis intervention is
swift assessment of not only lethality, but also
other dimensions that are believed to be associ-
ated with a crisis state.

Most clinicians recognize that a crisis state is
comprised of several dimensions and attempt to
cover all them all with a shotgun-type interview
approach (Jobes et al., 1995). Due to the loose
structure of the interview; however, pertinent
information may be missed. A solution to this
to this potentially disastrous problem is the use of
assessment instruments. There are currently a few
instruments that are specifically designed to
measure the magnitude of a crisis state. These
instruments are clinician-rated scales that mea-
sure three or more dimensions of a crisis.

There are currently no rapid assessment in-
struments that attempt to measure the magni-
tude of a crisis state from the subjective vantage
point of the client. Perhaps one of the reasons
for this lacuna is that crisis counselors have not
called for such an instrument. Research has
shown that clinicians, other than psychologists,
rarely use instruments, so why would they state
a need for one? This, it seems is an issue of the
proverbial chicken or the egg: Do clinicians not
use instruments because there are no useful
ones, or are there no useful instruments because
clinicians don’t use them? It is time for re-
searchers and clinicians to come together on this
issue. It is not enough for a researcher to under-
stand the construct at hand and the validation
process. He or she must work with clinicians to
better understand the crisis intake environment
so that useful scales can be constructed and val-
idated. A crisis assessment measurement tool
created out of this partnership can be used to
not only determine the magnitude of a crisis
state but also monitor the effectiveness of the
crisis intervention. Finally, an RAI that mea-
sures the magnitude of a crisis state will be avail-
able to further study the effectiveness of differ-
ent techniques with different populations un-
der different stressors to determine the most
effective treatment for each group, and that is
ultimately the goal of most social science researchers as well as clinicians.

Conclusion

The Lewis-Roberts Multidimensional Crisis Assessment Scale (Lewis-Roberts MCAS) is currently being validated with 600 college students. The Lewis-Roberts MCAS will measure the magnitude (duration, intensity, and severity) of the each person’s crisis state. In other words, the MCAS will measure “… the individual's functioning level associated with the perception of crisis.” (Corcoran and Roberts, 2000, p. 456). It is our earnest anticipation that the Lewis-Roberts MCAS will be the catalyst to more methodologically rigorous research and outcome studies in the field of crisis intervention. For further information on the Lewis-Roberts MCAS, contact Dr. Roberts, Editor-in-Chief of this journal, after July 1, 2001. At that time, Professor Lewis will have completed the large-scale study of the revised MCAS. In the meantime, clinicians should continue to rely on a combination of the older rapid assessment scales and structured clinical interviews to measure symptomatology, and personal as well as social dysfunction, and behavior change.

References


