A Partnership Between Roberts’ Crisis Intervention Model and the Multicultural Competencies

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Crisis intervention services are an integral component of the mental health continuum of care. Numerous models of crisis intervention offer extensive steps, strategies, and plans for intervening effectively with individuals in crisis. African Americans, as a population, underutilize services offered by the mental health system. The use of multicultural competencies (counselor awareness of own values and biases; counselor awareness of client worldview; culturally appropriate intervention strategies) applied to Roberts’ crisis intervention model creates a partnership that may provide crisis intervention specialists with a framework for increasing effectiveness with African Americans. [Brief Treatment and Crisis Intervention 4:367–375 (2004)]

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Crisis intervention services are an integral part of the mental health treatment delivery system. Crisis intervention specialists have specific training designed to allow them to intervene effectively with clients who are experiencing debilitating circumstances in their lives.

While perusing the mental health literature on crisis and crisis intervention, we have found ourselves wondering, “At what point is an experience a crisis?” The literature offers numerous definitions that will be covered later, but the question persists. In reflecting on our own life, we have thought about two specific crises that we have encountered, one in which the death of a loved one was a possibility and the other in which the death of a loved one was imminent. In an attempt to integrate what we have gleaned from the literature, and in consideration of these two personal crises, we have come to the conclusion that the point of crisis is reached during an experience in which the individual’s repertoire of life experiences does not contain a response that is equal to the crisis circumstance. What comes to mind are cognitions such as: “What am I supposed to do?” “I can’t deal with this.” “I don’t know what to do.” “I can’t figure out what to do.”

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“How am I going to get out of this?” Such thoughts suggest that the person does not have an experiential reservoir from which to draw that will allow him to cope effectively with what is perceived as some degree of upheaval in his life. Therefore, an experience becomes a crisis at the moment the individual thinks there is something insurmountable happening about which he can do nothing.

**Crisis Intervention Literature**

The literature on crisis and crisis intervention is plentiful and rich. For our purposes, we chose three definitions that cover a span of 42 years in the literature. Caplan (1961) states that “people are in crisis when they face an obstacle that is, for a time, insurmountable by the use of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made” (p. 18). Brammer (1985) considers crisis to be a “state of disorganization in which people face frustration of important life goals or profound disruption of their life cycles and methods of coping with stressors. The term crisis usually refers to a person’s feelings of fear, shock and distress about the disruption, not the disruption itself” (p. 94). Lastly, Marino (1995) delineates four stages of crisis: “(a) A critical situation occurs in which a determination is made as to whether a person’s normal coping mechanisms will suffice; (b) increased tension and disorganization surrounding the event escalate beyond the person’s coping ability; (c) a demand for additional resources (such as counseling) to resolve the event is needed; and (d) referral may be required to resolve a major personality disorganization” (p. 3).

Crisis intervention services are a specialty in the mental health treatment continuum. There are numerous models of crisis intervention, but first, it is necessary to consider crisis theory upon which crisis intervention rests. Golan (1978) posits that a hazardous event or a series of successive stressors in rapid sequence upsets the individual’s homeostasis, rendering the person vulnerable. If the stressful circumstances persist, and the person cannot continually draw on adequate coping responses, a state of disequilibrium results. As the crisis situation evolves, the person may perceive the stressors as threatening to some aspect of his or her person or circumstance. What is important here is that the crisis is a part of life, an obstacle or impediment to everyday functioning. Golan (1978) suggests that the period of disequilibrium is time limited, depending upon the nature of the crisis, but usually lasts 4 to 6 weeks. The resolution of the crisis occurs when the person realizes that to this point the coping responses are inadequate and help is necessary and possibly welcomed. With appropriate and adequate intervention, the person enters the reintegration phase (Golan, 1978) and emerges with new and appropriate responses with the experience and new learning integrated into the self. Without help, however, pathological or maladaptive behaviors may be the outcome.

Crisis intervention services are a necessary and vital component of mental health treatment services. Few individuals in life do not experience some degree of crisis at one time or another. Many people are able to respond effectively, end the disequilibrium, and resolve the crisis. But for some people, the experience is so far beyond their ability to cope, or the event is so catastrophic, that crisis intervention by a professional is required.

Crisis intervention is a specialty that requires specific training in how to evaluate the degree of the crisis and determine the intensity of the ensuing interventions. The intervention specialist learns models and strategies of crisis intervention. There are numerous crisis intervention models, for example Caplan’s (1961) equilibrium model and the cognitive models of
Ellis (1962), Beck (1976), and Meichenbaum (1977). The model on which we wish to focus is Roberts’ (2000) assimilation of models developed by Aguilera and Messick (1982), Beck (1976), Burns (1980), Caplan (1964), Golan (1978), Parad (1965), and Puryear (1979). Roberts’ (2000) model provides a seven-step process designed to address the crisis and to restore functioning for the person:

Step 1. Plan and conduct crisis assessment (including lethality measures).
Step 2. Establish rapport and rapidly establish a relationship.
Step 3. Identify major problems (include the “last straw” or crisis precipitants).
Step 4. Deal with feelings and emotions (including active listening and validation).
Step 5. Generate and explore alternatives.
Step 6. Develop and formulate an action plan.
Step 7. Follow-up and come to agreement.

African Americans and Mental Health Services

No one is immune from crisis in life. Our existence does not offer any guarantees that we are going to be free of experiences that are debilitating and catastrophic. Many people find it necessary in times of crisis to seek professional help. Also in times of emotional distress, not necessarily crises, individuals seek therapy to assist them with their difficulties. The literature on who seeks mental health treatment suggests that African Americans as a group underutilize mental health services. Certainly, this includes crisis intervention services.

According to the U.S. Surgeon General’s Report (U.S. Department of Health and Human Services, 2001), African Americans in high-need populations are at particular risk for mental illness. Environment, economics, and social factors among African Americans contribute to risk rates as well as psychological distress rather than intrapsychic factors (Neighbors, 1991). African Americans who are susceptible to experiencing mental illness have the tendency to underutilize mental health services. Particularly, it has been noted that factors such as access to insurance coverage, affordable services, perceptions of discrimination, and ethnicity of the service providers serve as barriers to service among African Americans (Cornelius, 2000; Hoberman, 1992).

Utilization of services research indicates that African Americans are likely to use emergency services or seek treatment from a primary care physician rather than a mental health professional. A question to ask is, “Why is this phenomenon occurring?” Some research indicates that for African Americans, the culture of the provider and the severity of the problem impact the decision to seek services. The 2001 Surgeon General’s Report indicates that the percentage of African American mental health service providers is proportionally small. African American mental health professionals are psychiatrists (2%), psychologists (2%), and social workers (4%). No figures for licensed clinical professional counselors were presented. Service providers who are not African American must build upon the cultural strengths of the people in their care.

In the section of the National Survey of Black Americans dealing with utilization of mental health services, Neighbors (1991) found that problem severity and problem type contributed to help-seeking behavior among African Americans. African Americans more often sought professional help for physical health problems rather than emotional adjustment problems, death of a loved one, interpersonal difficulties, or economic difficulties. Furthermore, in terms of age and gender, women were more likely to seek help than men, and older people (35–54
and 55 and older) were more likely to seek help than younger people (18–24). Lastly, people who rated their problems as severe were more likely to utilize some form of professional health service.

According to Sue and Sue (2003), 50% of African American patients terminate after the first session, while 30% of European American patients terminate after the first session. In the same study, African Americans attended an average of 4.7 sessions, while European Americans attended an average of 8.7 sessions. Clearly, African Americans are not as responsive to treatment services as their European American counterparts. The implications of this phenomenon warrant attention. If African Americans drop out of treatment after one session, we as therapists conclude that the problems have not been resolved and said problem continues to impair functioning. Perhaps the lack of multicultural competencies on the part of the professional is a contributing factor in the equation, to such an extent that the client makes a decision before the interactions are complete that he or she is not returning.

When racially/culturally different clients enter the system for crisis intervention services, what assumptions do they bring with them? and are these assumptions more accurate than the ones made about them by the mental health professional? The racially/culturally different client may make the following assumptions of suspicion and mistrust of the system:

Are these white people any different than all the other ones out there?
Is this just an extension of the screwed-up system that sent me here in the first place?
These white people have already decided about me without even knowing me.

Given that there may be some degree of accuracy to these assumptions, it is incumbent upon the crisis intervention professional to work toward elimination of the conditions and treatments that produce them. Sue and Sue (2003) recommended that mental health professionals have a “personal and professional responsibility to (a) confront, become aware of, and take actions in dealing with our biases, stereotypes, values and assumptions about human behavior; (b) become aware of the worldviews, values, biases and assumptions of clients who differ from us; (c) develop appropriate help-giving practices, intervention strategies, and structures that take into account the historical, cultural and environmental experiences and influences of our clients; and (d) change the policies, practices, programs, and structures of the institutions that oppress groups in our society” (p. 38).

In the process of coming to understand the worldviews of racially/culturally different clients, the crisis intervention professional is going to find that racially/culturally different clients perceive reality differently from the crisis intervention specialist, and these perceptual differences are direct by-products of thinking and being different. Ho (1987) delineates significant value differences between white middle-class Americans and Asian Americans, American Indians, Hispanic Americans (Latinos), and African Americans. In comparing these ethnic groups, Ho suggests that African Americans perceive nature, time, people relations, activity, and the nature of man differently than European Americans. Parham, White, and Ajamu (1999) compare eight dimensions of being, which are presented in Table I.

The previous information represents some of the ways in which African Americans may differ from Euro-Americans. It is not inclusive of other groups or of all possible differences; however, it does provide valuable information for the professional to be aware of in approaching crisis intervention with African Americans.
The professional must accept that the differences in orientation to life, the world, and even death are real and that the crisis intervention specialist cannot intervene appropriately without awareness, knowledge, and skills that address the differences. The underutilization of mental health services by African Americans is in part related to the inability of professionals to understand the complexities associated with African Americans seeking services in the mental health system.

In calling for cultural competency from mental health professionals, it is to be stressed that the professional must possess an understanding of the sociopolitical realities that exist in the United States. Professionals cannot be in denial that specific groups of people are denied access to full participation in economic and social life in our country. These forces that support exclusion are not random, nor are the phenomena of poverty, violence, and involvement in the criminal justice system all attributable to personal irresponsibility. One task that professionals must know they need to accomplish is to assist racially/culturally different clients in maintaining a sense of cultural integrity when the clients may not be in systems that value their welfare and well-being. Professionals must understand the role of advocacy in counseling. The development of awareness, knowledge, and skills in both the intra- and interpersonal domains will lead to counselors responding in culturally appropriate ways that invite the racially/culturally different client to invest in the counseling relationship or in the resolution of the crisis.

White counselors need to know that their assumptions about people who are racially/culturally different may be culture bound if the counselor has not had significant contact with individuals who are racially/culturally different. The absence of significant contact will likely result in the white counselor having assumptions about racially/culturally different people that are based upon stereotypes and are therefore inaccurate. Bringing inaccurate information into the crisis intervention situation is a detriment to establishing rapport and prevents the counselor from learning who the client is. Therefore, the counselor must be able and willing to recognize her limitations in cultural competence and allow herself to become the student of the client so that the counselor can develop an awareness of who the client really is and not project culture-bound assumptions. The counselor’s attitude of being teachable allows for the all-important rapport to be established. The counselor with this cultural skill can respond with accurate empathy, thus increasing the therapeutic bond.
Crisis intervention services are a microcosm of the continuum of mental health services. Since there is a dearth of research on African American utilization of crisis intervention services, we speculate that this population’s involvement in using this mental health specialization is mirrored in its use of other mental health services. Perhaps there is a need to provide a partnership between models of crisis intervention and culturally appropriate intervention strategies.

Sue, Arredondo, and McDavis (1992) proposed a set of specific multicultural competencies for counselors. The competencies address three areas in which the counselor must have mastery. The first is counselors’ awareness of their own cultural values and biases; second is counselors’ awareness of the clients’ worldview; and third is culturally appropriate intervention strategies. When we juxtapose these areas with Roberts’ (2000) model of crisis intervention, there is a sensible fit.

Application: the partnership between Roberts’ crisis intervention model and the multicultural competencies in case format. Stacy is a 36-year-old African American woman with three children, ages 3, 10, and 12. Stacy lost her job 3 months ago and has been unable to secure new employment. She is a certified public accountant. The father of the two oldest children is deceased and did not carry any life insurance, thus leaving the children with no financial support. The father of the 3-year-old is unemployed and is able to contribute only a limited amount of financial support for his son. Stacy has been experiencing increasing financial difficulty and is now living day to day. The pressure is mounting and her fear and anxieties are doing the same. Stacy has been informed today that she must withdraw her oldest child from an after-school program due to an inability to pay. This is the last straw for Stacy. She presents at the clinic overwhelmed, anxious, depressed, and angry over her situation and unable to act for the moment in her own best interests.

The first domain of multicultural competencies and the earliest stages of crisis intervention—making psychological contact and rapidly establishing the relationship—seem to dovetail with the notion that counselors need to be aware of their own cultural values and biases in order to make psychological contact with clients. A culturally unaware counselor runs the risk of losing the client if the counselor has no sense of who he or she is as a cultural being. A lack of awareness such as this jeopardizes the counselor’s ability to make significant human contact with the client. For example, a European American counselor who does not understand that he or she has negative attitudes toward African Americans interacts with the client with an undercurrent of bias; the client senses this and responds with feelings of mistrust toward the counselor. Harboring such ethnocentric attitudes leads the counselor to determine that the client possessing different values is inferior or abnormal. In this encounter, psychological contact is at best not established, and at worst the encounter is detrimental to the client, who does not return and remains in crisis and possibly ultimately develops maladaptive patterns of behavior to cope, which may become chronic. According to Sue and Sue (2003), the culturally competent professional is one who has respect for and is comfortable with differences and has an awareness of his or her own racist, sexist beliefs and attitudes and how these affect clients. The professional who has not done this work will in all likelihood have a negative impression of Stacy, and reciprocally Stacy will have a negative reaction to the professional, creating an impasse that may result in Stacy losing faith that this process is going to be helpful. Therefore, the first domain of the competencies is the portal through which the professional must pass in order to aspire to the second and third.
In the second domain of multicultural competencies—counselor awareness of clients’ worldview—culturally unaware counselors can impede the establishment of psychological contact if they are unable to understand the clients’ worldview (i.e., internal frame of reference). In this circumstance, if the counselors’ experiences in life are far removed from those of the clients (e.g., marginalization, poverty, oppression) and these experiences shape the clients’ worldview, the counselor may be unable to bridge the distance between the respective life experiences. Making psychological contact may be particularly difficult if the counselor operates from the assumption that “we all have the same life experiences.” When the professionals possess the knowledge contained in the second domain, they can respond to Stacy in a respectful and therapeutic manner.

In consideration of the third domain—culturally appropriate intervention strategies—a lack of ability to respond to clients’ contextual existence may result in the use of intervention strategies that are not useful to the clients. As reflected in practice, the professional is capable of responding in ways that are consistent with Stacy’s cultural background and context and is able to communicate intimately with the client. Further, the professional knows when it is necessary to move the process out of the counseling dyad and become an advocate for Stacy when she is facing institutional and/or sociopolitical forces that limit her ability to function more fully. The culturally competent crisis intervention professional will engage Stacy with a degree of self-awareness that has allowed for the development of the knowledge and skills necessary to work effectively with this racially/culturally different client.

Each of the three domains of multicultural competencies needs to be applied to each of the seven stages of Roberts’ (2000) crisis intervention model. When the counselor approaches a stage through the domains of the competencies, the crisis intervention model is contextualized to the client. For example, if counselors understand their negative attitudes toward African American clients, they can take the necessary steps to neutralize the impact of the negative attitude. In the second domain, counselors allow clients to imprint their worldview(s) upon the counselors without the latter’s own worldview(s) interfering with their ability to understand the clients. In the third domain, counselors make efforts to understand the cultural context of the clients and tailor interventions that are consistent with the clients’ life experiences.

The culturally competent professional understands the implications of possessing dominant-culture values, recognizes them as such, and possesses an understanding that said values are not superior but different and avoids passing judgment on the value systems of the racially/culturally different client.

Implications for Counselors

Given the degree to which African Americans underutilize mental health treatment services, it is safe to assume that some degree of that underutilization is due to counselors’ lack of multicultural competencies. The dropout rates and limited number of sessions that African Americans attend in comparison with white Americans are in part related to the lack of cultural awareness of professionals. Some may take the perspective that they treat every client the same, that when a human being is in crisis, the issues are the same regardless of the racial/cultural background of the client. Others may work from the point of view of color blindness. That is, the professional does not see color when working with a client, so the racial/cultural background of the client has no meaning.
Both of these approaches, while noble in that they try to get at the clinical/crisis issues straightforwardly and immediately, leave much to be desired when working with culturally/racially different clients. To treat everyone the same suggests a lack of idiosyncratic approaches and a generic application of crisis interventions regardless of the racial/cultural background of the client. Each approach de-contextualizes clients who may be racially/culturally different by essentially denying and discarding any factor or issue that may be related to the client’s racial or cultural background. There may very well be clients who are racially and culturally different vis-à-vis the dominant group who believe that the difference has had no meaning in the shaping of their lives, but the counselor cannot be the person making this determination. That can only come from the client, and only then can the professional work without paying attention to the racial or cultural difference.

Crisis intervention trainers, counselor educators, social workers, psychologists, counselors, and clinical supervisors need to incorporate multicultural competencies into their coursework, training, and supervision. The first domain of the multicultural competencies is intrapersonal work that the counselor or counselor in training needs to accomplish. The second domain of the multicultural competencies is interpersonal work wherein the counselor, now aware of his or her values and biases, becomes able to make psychological contact because the work in the first domain allows the counselor to understand the client’s subjective view of reality. The third domain of the multicultural competencies assimilates the first two domains, and when melded with Roberts’ (2000) crisis intervention model, the counselor is now able to partner with the client to determine the necessary coping strategies and solutions that are culturally sensitive and necessary to bring the crisis to resolution.

References


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