The Crisis Intervention Semi-Structured Interview

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The purpose of this article is to introduce the Crisis Intervention Semi-Structured Interview (CISSI) (Kulic, 2001), and to describe the validation research completed on the instrument. The CISSI is intended for use by novice and experienced clinicians working with clients in crisis situations who may require emergency psychiatric care. The goal of the instrument is to provide a standardized method of arriving at psychiatric intervention decisions. [Brief Treatment and Crisis Intervention 5:143–157 (2005)]

KEY WORDS: crisis intervention, clinical assessment, reliability, validity.

Crisis intervention as a coherent school of thought has existed for several decades. Before its emergence in the professional research literature, it was practiced by those who knew it best—those on the front lines of emergency situations, such as police, fire, medical, and psychiatric personnel. Several writers and theorists throughout the mid-twentieth century first documented crisis intervention as a coherently emerging field, with the earliest and most influential works coming from Lindemann (1944), Erickson (1959, 1963), and Caplan (1964).

Lindemann’s (1944) study of the survivors of the 1943 Coconut Grove fire in Boston led him to posit a theory of sequential stages of crisis or grieving. Later, Erickson (1959, 1963) provided the dividing line between two major, yet different, types of crisis—maturational-developmental and accidental-situational. Maturational-developmental crises occur along the continuum of Erickson’s developmental theory of personality. Crises occur at the points at which individuals either get stuck or progress in their development as persons, from the earliest stage of trust vs. mistrust of others, to the last stage of coming to terms with whether or not one has made a significant contribution to the world. Accidental-situational crises arise when individuals are affected by unexpected life events, such as the death of a loved one, or other major personal loss or trauma. The literature on crisis intervention notes that individuals in crisis are somewhat open to suggestion, more so than they would normally be. It is at the highly suggestible point that professional intervention can have a particularly beneficial effect.

Crisis intervention as it stands today is a still-growing field that leaves much to be desired in...
terms of both training and service delivery. Crisis intervention skills are an integral component of good training programs for clinicians and ought to be a closely supervised part of any clinical services training program. Unfortunately, this is often not the case. In any given master’s or doctoral training program, there is often not a component of training specifically dedicated to crisis intervention. Baldwin (1979) commented that although crisis intervention as a standard of care was, at the time, on the rise, it was not being strongly emphasized in graduate psychology training. Bongar and Harmatz (1989) conducted a survey of member departments (N = 115) of the Council of University Directors of Clinical Psychology Programs (CUDCP) to discover how much training in suicidology (research and treatment of suicide) was being offered. They noted that of the 92 (80%) departments that responded, only 35% offered any formal training in the study of suicide. In a survey of the National Council of Schools of Professional Psychology (NCSPP) and the CUDCP, Bongar and Harmatz (1991) found that only 40% of all graduate programs in clinical psychology offered formal training in the study of suicide. Fauman (1983) lamented the absence of crisis intervention training for psychiatrists, noting that psychiatrists often develop crisis intervention skills through luck and that emergency services in psychiatry are typically accorded a lower level of prestige than other areas of professional psychiatric practice. Another example of the acute need for training in crisis intervention was demonstrated in a study by King, Price, Telljohann, and Wahl (1999). This study sought to measure high school counselors’ perceived self-efficacy in recognizing students at risk for suicide. Out of 183 respondents, 87% of the counselors surveyed believed it was their responsibility to identify students at risk for suicide, yet only 38% believed that they could do it. Finally, in its “Report on Education and Training in Behavioral Emergencies” (American Psychological Association [APA], 2000), APA’s Division 12, Section 7 (Clinical Emergencies and Crises) noted that “[d]espite the data on the incidence and impact of patient life-threatening behaviors on clinicians, the profession of psychology appears to have done little to prepare clinicians specifically to cope with such events.” Additionally, the report states that “virtually all psychology practitioners have behavioral emergencies of one type or another in their practice . . . all practitioners need to be formally educated and trained to deal with them.” Roberts (2002) continues to note the dearth of training opportunities in graduate and postgraduate settings, though he predicts that these opportunities will grow as a response to the terrorist attacks of 9/11.

The significance of having a valid and reliable assessment instrument for crisis situations is of great importance; the prediction of dangerousness to self or others has long been a goal of psychiatry, psychology, and related human service fields (Douglas, Cox, & Webster, 1999). Prior to the 1980s, accurate prediction of risk of violence to self or others was not considered likely to occur. Douglas et al. (1999) noted, “Until fairly recently, it may have been argued that the state of knowledge did not provide any sort of reliable or trustworthy direction on violence risk assessment. This position seems no longer tenable” (p. 149). Throughout the 1980s and 1990s evidence began to accumulate that risk prediction was possible (Dolan & Doyle, 2000). Steadman (2000) believes that the next quarter-century will provide clinicians with practically useful tools to use in risk prediction, the likes of which would not have been possible 20 years prior. Mossman (2000), however, argues that research is unlikely to produce an instrument that will be practically helpful in predicting violence.

The prediction of risk of violence to self or others is a difficult task. Suicide and other forms
of dangerous behavior are low-occurrence events, even in special populations (e.g., the mentally ill), making accurate prediction of these behaviors difficult because of the relative rarity of the event(s) (Shergill & Szumukler, 1998). Fremouw, de Perczel, and Ellis (1990) explain the problem of low-occurrence events as the “base-rate problem.” The term base-rate refers to how often an event occurs given a particular population. Low base-rate occurrence of an event makes it extremely difficult to predict behavior on an individual basis; predictions for low base-rate events are more reliable when made as a group. Predictive difficulties are not unique to suicide but result from statistical probabilities (Fremouw et al., 1990). Better results for group-based predictions, however, are of no comfort to the clinician who needs to determine the safety of a client, or to the crisis intervention worker dealing with a possibly psychotic and homicidal patient, or to the telephone hotline worker trying to convince a person in crisis to reveal her address so police personnel can complete a safety check. However, recent research points to the possibility of successful prediction of violence to both self and others at both the individual and group levels (Douglas et al., 1999).

There are two types of risk prediction: clinical and actuarial (Groth-Marnat, 1997; Marchese, 1992). Clinical risk prediction is defined as any prediction effort that is not a probability-based statistical prediction and is typically considered to be based solely on clinician assessment and judgment (Groth-Marnat, 1997; Steadman, 2000). Historically, clinical risk prediction was the predominant modality utilized by mental health professionals. Actuarial risk predictions, on the other hand, are based upon statistical probabilities and mathematical models (Steadman, 2000). Throughout the 1980s and 1990s there was a debate in the risk prediction literature as to which form successful risk prediction would take. Buchanan (1999) reported that actuarial methods were most likely to provide accurate prediction instruments. Some research has pointed to the effectiveness of actuarial risk prediction over clinical risk prediction (Gardner, Lidz, Mulvey, & Shaw, 1996). Fuller and Cowan (1999), however, demonstrated that clinical prediction could rival actuarial models.

Ferris et al. (1997) reviewed the literature on risk assessment of violence to third parties and found that risk assessment may be carried out in a number of ways, but must all be thorough and systematic. Davison (1997) also argues for an integrated approach to risk prediction. Monahan, a noted researcher in the risk prediction literature (APA, 1991), wrote that “actuarial approaches are more likely to be promoted as adjuncts to clinical judgment than as replacements for it” (Monahan, 1997, p. 167). Dolan and Doyle (2000), in a review of the research on violence risk prediction for mentally ill offenders, noted that “[s]ystematic/structured risk assessment approaches may enhance the accuracy of clinical prediction of violent outcomes. . . . [but] violence risk prediction is an inexact science and as such will continue to provoke debate” (p. 303). According to Litwack (2001), “in time, various actuarial assessment schemes will be developed and validated in a manner that significantly assists many dangerousness assessment tasks” (p. 443).

There are models available to help clinicians in their crisis assessment duties. For example, Roberts’ (2000) Seven Stage Crisis Intervention Model guides clinicians through the appropriate steps to take when dealing with a client in crisis. Similarly, Roberts’ (2002) ACT (Assessment, Crisis Intervention, and Trauma Treatment) intervention model for acute crisis and trauma treatment provides a framework for responding to many different types of crises, with inclusion of the Seven Stage Model (Roberts, 2000) and Critical Incident Stress
Debriefing (Mitchell & Everly, 1993) as components. However, a thorough review of the literature demonstrated that no semi-structured interview instrument existed that would help clinicians to assess crisis situations for the possibility of a behavioral emergency; for example, there is no crisis intervention instrument listed in Corcoran and Fisher’s (2000) review of published assessment scales. Therefore, the CISSI (Kulic, 2001) was created; it was designed to enable both the novice and the experienced clinician to assess clients in crisis intervention situations so that the best possible clinical outcome is achieved.

The Crisis Intervention Semi-Structured Interview

The CISSI was developed from an integration of the literature and practical experience in crisis assessment. Initial construction and continual refinement of the CISSI have resulted in an instrument with a possible total of 78 questions. Because the questions of the CISSI are asked in a decision-tree format, many questions and/or sections may be omitted based upon the presenting problem(s).

Scales

The CISSI is composed of six scales. Each scale includes scored and nonscored questions. The scored questions are used to determine the client’s overall score as well as the client’s scale scores. The nonscored questions are intended to assist the clinician in gathering as much relevant data as possible (e.g., if the client has been losing weight, how much weight in how long of a time?), to add to the clinical decision-making process and assist in building rapport.

There are two types of scales in the instrument: primary scales and secondary, or moderator, scales. The primary scales (depression/suicide, psychosis/homicide, and substance abuse) are considered to be the main sources of risk to the patient and others. Any one of these scales alone, elevated enough, may result in the need for radical intervention for the patient (i.e., hospitalization or the need for further evaluation). However, the moderator scales (general risk factors, social support, and individual/support needs) are not weighted enough by themselves or in combination with one another to categorize a patient as a clinical imminent risk. The moderator scales are conceptualized much like the masculinity/femininity scale of the Minnesota Multiphasic Personality Inventory; they tend to “color” the primary scales to some degree (Groth-Marnat, 1997, p. 248). Clearly, if a patient is at imminent risk for harm to self according to the depression/suicide scale, then no amount of moderator, great or small, should have an effect on the clinician’s decision. Yet, a moderate score of suicidality, combined with poor scores on the moderating scales, should raise a red flag for the clinician.

Subjects

The sample comprised 47 master’s- and doctoral-level counseling students from a large university in the southeastern United States. There were 15 males (31.9%) and 32 females (68.1%). Thirty-two of the subjects were white (68.1%), 12 were African American (25.5%), 1 was Latino/a (2.1%), 1 was Asian/Pacific Islander (2.1%), and 1 was unspecified (2.1%). The average subject’s age was 28.3 years old (range, 22 to 47).

Design

The CISSI was validated through the use of an analogue videotape design, which was used in the initial evaluation of the SAD PERSONS scale (Patterson, Dohn, Bird, & Patterson, 1983) (Sex, Age, Depression Previous attempt, Ethanol
abuse, Rational thinking loss, Social supports lacking, Organized plan, No spouse, Sickness). In the Patterson et al. study, two videotapes were created for viewing by study subjects. One tape featured an interview with an individual judged by three experts to be at low risk for suicide; the second tape, with an individual judged to be at high risk for suicide. A similar, though modified, design was utilized in the current study.

The two scales of the CISSI validated in the current study were the depression/suicide scale and the psychosis/homicide scale.

Procedures

First, the subject completed a demographic information form, then watched a videotape of a counselor using the CISSI to evaluate an analogue client. While watching the video, the subject completed the CISSI along with the counselor but was unable to view the counselor's CISSI. The subject was asked to complete the instrument according to the answers provided by the client in the interview. Subjects were not trained in the use of the CISSI but were briefly introduced to it, and several important details about its construction and layout were explained to them. Because the CISSI is a lengthy instrument, questions the subjects were required to answer were printed in bold to avoid their missing questions and getting lost during the interview. Additionally, subjects were permitted to stop the videotape and rewatch portions if the tape went too fast for them. The rationale behind stopping the videotape if needed was that the study was not measuring how quickly subjects could fill out the CISSI or whether they could keep up with the counselor in the video.

After the subjects finished watching the video and completed the CISSI, they were asked to complete a validated instrument that was hypothesized to measure the same content as one of the two validated scales of the CISSI. Subjects viewing the depressed and possibly suicidal white female filled out the Scale for Suicide Ideation (SSI) (Beck, Kovacs, & Weissman, 1979) for comparison against the depression/suicide scale. Those viewing the psychotic and possibly homicidal black male filled out the Manchester Scale (MS) (Krawiecka, Goldberg, & Vaughan, 1977) for comparison against the psychosis/homicide scale. For the purposes of the current study, the first three scales of the MS (depression, anxiety, and medication effects) were omitted from the comparisons: Psychologists at the present time are not qualified to make judgments about psychiatric medication, and the depression and anxiety subscales have not been borne out by research (Jackson, Burgess, Minas, & Joshua, 1990).

Next the subjects watched a second video vignette. The second set of video vignettes consisted of the same clients from the first set of vignettes, discussing their symptoms in monologues, directly to the camera. After viewing the second, shorter vignette, the subjects were asked to make a decision about the severity of the clients based on the monologue. Subjects completed a short form asking whether the clients' symptoms were severe enough to warrant further action, such as psychiatric hospitalization, medical detoxification, or outpatient treatment. Additionally, subjects were asked questions about whether they would seek supervision or consultation for the clients, and why.

Results

There were four research hypotheses proposed at the outset of the current study: (1) The CISSI scale for depression/suicide will achieve acceptable levels of convergent validity (r > .70) as determined by correlation with the SSI; (2) the CISSI scale for psychosis/homicide will
achieve acceptable levels of convergent validity ($r > .70$) as determined by correlation with the MS; (3) individual items of the CISSI will correctly be endorsed by a majority of raters when presented with symptom-based video analogues, as determined through item analysis; and (4) the CISSI will differentiate between video analogue severity levels more successfully than raters not utilizing the instrument, who rely solely upon clinical judgment.

**Convergent Validity of the Crisis Intervention Semi-Structured Interview**

**Depression/Suicide Subscale.** A Pearson correlation coefficient was calculated between the depression/suicide scale and the SSI (Beck et al., 1979) to establish convergent validity. Subjects ($n = 17$) who viewed videotapes of the mild, moderate, or severe levels of symptomatology in the depressed/suicidal female completed both a CISSI and an SSI. A one-tailed correlation produced a correlation of .70 between the two scales, which is statistically significant at the .01 level of significance. This correlation suggests that the depression/suicide scale measures a similar construct as the SSI, i.e., depression elevated to the level at which suicide subjectively becomes a possible behavior for the client. A statistically significant correlation between the depression/suicide scale of the CISSI and the SSI demonstrates convergent validity for this scale.

**Psychosis/Homicide Scale.** A Pearson correlation coefficient was calculated between the psychosis/homicide scale and the MS (Krawiecka et al., 1977) to establish convergent validity. Subjects ($n = 15$) who viewed videotapes of the mild, moderate, or severe levels of symptomatology in the psychotic/homicidal male completed both a CISSI and an MS. A one-tailed correlation produced a correlation of .81 between the two scales, which was statistically significant at the .01 level of significance. This suggests that the psychosis/homicide scale measures a similar construct as the MS, i.e., psychotic behavior. A statistically significant correlation between the psychosis/homicide scale of the CISSI and the MS demonstrates convergent validity for this scale.

**Item Analysis of Specific Scales of the Crisis Intervention Semi-Structured Interview**

The items in the CISSI were analyzed by conducting a frequency count for the answers to each item and comparing the frequency count with an answer key. Traditional correlational reliability measures could not be used in the data analysis because of the type of data collected, so the frequency of item answers was analyzed and then discussed in order to make inferences about the reliability and effectiveness of the CISSI.

For each data set a frequency count was conducted to measure the number of different responses given for each item. This item frequency list was then examined to note differences in answer patterns within each analogue client’s data sets. The main criterion used for supporting the reliability of the CISSI was whether subjects correctly answered the questions on the CISSI, as defined by the answer key for each analogue client. If the analogues were well constructed, and if the CISSI is a perfectly reliable instrument, all of the answers provided on the analogue CISSIs should have been correct. Of course, perfection was not achieved, but the results were encouraging for further development and clinical use of the CISSI.

**Analogue Client 1: Depressed and Possibly Suicidal White Female.** For the severely depressed white female, both the general scale and the depression/suicide scale demonstrated significant variability. Subjects incorrectly
assessed important information related to the details of the client’s suicidal ideation and whether the client could guarantee her own safety. However, many of these items were answered correctly by a majority (83.3%) of subjects. For the moderate client, the depression/suicide scale demonstrated some variability, as was expected. The client was not suicidal but was rated as suicidal by half of the subjects. This result is troubling, because rating a client as suicidal could result in an unnecessary hospitalization. The data continue along a somewhat incongruous path, with some of the subjects who interpreted the client as suicidal endorsing various things about that client’s suicidality, though the number of subjects consistently measuring suicidality is not constant. However, it is gratifying to see that when subjects interpret suicidality as being present, they continue to assess it. For the mildly depressed white female, the CISSI appears to have performed acceptably. See Table I for the breakdown of correctly and incorrectly answered questions for this client.

**Analogue Client 2: Psychotic and Possibly Homicidal Black Male.** For the severely psychotic black male client, the CISSI performed acceptably. The general scale as utilized by subjects was accurate, and the psychosis/homicide scale performed well. However, one of the items that was incorrectly answered by a subject could result in the unnecessary hospitalization of the client. For the moderately psychotic black male, the CISSI performed acceptably. Two important items on the psychosis/homicide scale demonstrated variability, yet only one of these items could adversely impact the client’s disposition. For the mildly psychotic black male, the general scale and the psychosis/homicide scale performed well. The only item that caused concern dealt with the severity of the client’s hallucinations. See Table II for the breakdown of correctly and incorrectly answered questions for this client.

**Analogue Client 3: Alcoholic and Possibly Depressed White Male.** For the severely alcoholic white male, the general, substance abuse, and depression/suicide scales performed well. There were several minor variations in clinician responses, none critical. For the
moderately alcoholic white male, the substance abuse and depression/suicide scales fared positively. The general scale demonstrated some variability, with the continued anomaly of subjects underinterpreting what constituted major life events for clients. For the mildly alcoholic white male, the CISSI performed acceptably. Two items from the general scale demonstrated variability, one of which was problematic throughout the data. The other incorrect item required the subjects to demonstrate good listening and inferential skills with the client, which may help explain some variability in answers. Several of the items from the substance abuse scale demonstrated variance, but the majority of subjects (80%) answered almost all items correctly. All of the depression/suicide scale items were answered correctly (100%), which is a positive result. See Table III for the breakdown of correctly and incorrectly answered questions for this client.

Table IV presents the average percentage of items answered correctly across all client analogues.

**Comparison of Unassisted Clinician Decision-Making Outcomes with CISSI-Assisted Outcomes**

A comparison was made between the hospitalization decisions made by subjects who used the CISSI to assess clients and the hospitalization decisions made by subjects using clinical judgment only. Subjects watched the video monologue, then answered the following questions: (1) Would you make an inpatient or outpatient referral for this client? (2) Would you seek immediate supervision or consultation on this decision? (3) If you do seek supervision/consultation, why? and (4) If you do not seek supervision/consultation, why not?

**Depressed and Possibly Suicidal White Female.** The CISSI and unassisted clinician decision making performed somewhat equally for the severe and moderate client analogues, with clinical judgment producing a better record. The CISSI did not achieve a 100% success
rate for the severe analogue client, which suggests that the depression/suicide scale may need further refinement. The numbers are reversed for the mild client analogue, with CISSI performance at 100% and clinical judgment at 40%. These results are unusual and merit further data collection.

**Psychotic and Possibly Homicidal Black Male.** The CISSI performed well compared with clinical judgment alone for the psychotic and possibly homicidal black male analogue client. For the severe client, the CISSI achieved 100% accuracy, while 80% of subjects made inaccurate referrals for this client, possibly endangering the client and/or others. For the moderate and mild client analogues, the CISSI continued to achieve a 100% success rate, whereas clinical judgment alone improved, though remaining only moderately effective, with 60% of clinicians making appropriate referrals and 40% making inappropriate referrals.

**Alcoholic and Possibly Depressed White Male.** The CISSI performed acceptably compared with clinical judgment alone for the alcoholic and possibly depressed white male. For the severe client, the CISSI achieved 100% accuracy, while 100% of subjects made inaccurate referrals for this client, possibly endangering the client. For the moderate client analogue, both the CISSI and unassisted clinical judgment achieved 100% accuracy. For the mild client analogue, the CISSI continued to achieved a 100% success rate, except for one subject who found reason to give a full scale score to the client on the depression/suicide scale, which would be equivalent to recommending an inpatient referral. Clinical judgment alone performed well, achieving a 100% accuracy rate with an outpatient referral.

<table>
<thead>
<tr>
<th>Analogue Client Type</th>
<th>Analogue Client Severity</th>
<th>Subscale Under Examination</th>
<th>Number and Percentage of Items Answered Completely Correctly</th>
<th>Number and Percentage of Items with 1 Incorrect Answer</th>
<th>Number and Percentage of Items with More Than 1 Incorrect Answer</th>
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<tbody>
<tr>
<td>Alcoholic and possibly depressed white male</td>
<td>Severe</td>
<td>General, 12 items Subtraction, 12 items Depression/suicide, 24 items</td>
<td>10 items, 83.3% 11 items, 91.7%</td>
<td>0 items, 0% 0 items, 0%</td>
<td>2 items, 16.7% 1 item, 8.3%</td>
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<td></td>
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<td></td>
<td>20 items, 80%</td>
<td>2 items, 8%</td>
<td>3 items, 12%</td>
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<tr>
<td></td>
<td>Moderate</td>
<td>General, 12 items Subtraction, 12 items Depression/suicide, 24 items</td>
<td>8 items, 66.7% 8 items, 66.7%</td>
<td>3 items, 25% 3 items, 25%</td>
<td>1 item, 8.3% 1 item, 8.3%</td>
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<td></td>
<td></td>
<td></td>
<td>24 items, 96%</td>
<td>0 items, 0%</td>
<td>1 item, 4%</td>
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<tr>
<td></td>
<td>Mild</td>
<td>General, 12 items Subtraction, 12 items Depression/suicide, 24 items</td>
<td>10 items, 83.3% 8 items, 66.7%</td>
<td>1 item, 8.3% 3 items, 25%</td>
<td>1 item, 8.3% 1 item, 8.3%</td>
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<tr>
<td></td>
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<td></td>
<td>24 items, 96%</td>
<td>1 item, 4%</td>
<td>0 items, 0%</td>
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Discussion

There are several implications for the development of a valid and reliable crisis intervention semistructured interview. Crisis intervention, as conceptualized by the current author, contains nine components: (1) recognition of a crisis or a crisis in development in the life of a client, (2) assessment of the client through his/her current and recent thoughts, feelings, and behaviors, (3) assessment of the client through reports from significant others, (4) consultation about the client with other professionals, (5) deciding whether the crisis has precipitated a behavioral emergency situation, (6) intervention with the client based on the full assessment, (7) intervention, (8) outcome assessment of crisis assessment and intervention, and (9) follow-up assessment of treatment outcome at a later date.

Deciding whether an individual may be a danger to self or others may often be difficult. Once that decision has been made, many of the remaining dispositional decisions are matters of routine, either outpatient referral or inpatient hospitalization/short-term stabilization. The current study appears to provide preliminary support for the use of the CISSI to assist in making critical decisions about clients in crisis. The data are equivocal for use of the CISSI with clients who are primarily depressed/suicidal, but they strongly favor use of the CISSI for clients who are psychotic/homicidal and for clients who are substance-abusing/depressed (the substance abuse scale has not yet been validated; this is the current subject of a follow-up study).

The CISSI (Kulic, 2001) was constructed to serve an important need in clinical service. Crises in clinical work are expected, yet there is little training in traditional graduate programs to account for crisis intervention training needs, such as how to deal with a suicidal client (Bongar & Harmatz, 1989, 1991). The accurate assessment of other clinical syndromes, such as psychosis and substance abuse, are similarly important. Training in crisis intervention is more often obtained during the delivery of clinical services, through accidental exposure rather than through intentional experiences. If student clinicians do not obtain experience in crisis intervention while being trained, it is unlikely that they will pursue that training on their own, which may leave them ill-equipped to effectively deal with crises.

In the course of the current study, two of the three major scales of the CISSI (depression/suicide and psychosis/homicide) were shown to possess convergent validity. Correlation with the SSI (Beck et al., 1979) demonstrates good convergent validity for the depression/suicide scale. Strong correlations of the psychosis/homicide scale with the MS (Krawiecka et al., 1977) further strengthen convergent validity.

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**TABLE 4.** Average Results Across All Client Analogues.

<table>
<thead>
<tr>
<th>Analogue Client Type</th>
<th>Subscale Under Examination</th>
<th>Average Percentage of Items Answered Completely Correctly</th>
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<tbody>
<tr>
<td>Depressed and possibly suicidal white female</td>
<td>General, 12 items</td>
<td>71.3%</td>
</tr>
<tr>
<td></td>
<td>Depression/suicide, 24 Items</td>
<td>45.3%; 80% when combined with questions answered incorrectly by only 1 subject</td>
</tr>
<tr>
<td>Psychotic and possibly homicidal black male</td>
<td>General, 12 items</td>
<td>80.6%</td>
</tr>
<tr>
<td></td>
<td>Psychosis/homicide, 20 Items</td>
<td>90%</td>
</tr>
<tr>
<td>Alcoholic and possibly depressed white male</td>
<td>General, 12 items</td>
<td>77.8%</td>
</tr>
<tr>
<td></td>
<td>Substance abuse, 12 items</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Depression/suicide, 24 items</td>
<td>90.7%</td>
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</table>
For two of the three analogue clients (the psychotic male and the alcoholic male), the CISSI proved to be an acceptable clinical assistant in helping clinicians make disposition decisions. For the depressed female analogue client, efficacy of the CISSI appeared to drop somewhat, though results were somewhat confusing. The CISSI’s effectiveness never dropped below 67%, while the accuracy of clinical judgment alone dropped below 50%. It appears that clinicians more reliably utilized the CISSI to make critical clinical decisions, such as whether to hospitalize a client, than they did utilizing clinical judgment alone. This result has important implications for the delivery of crisis intervention services. If the use of a structured clinical instrument can help the practicing clinician gather the most amount of relevant data in the shortest time possible, allowing for the best clinical decision to be made, then it possesses utility for use in practice. Though the CISSI is currently a research instrument, it shows promise for use in both training and practical settings. The revised CISSI is currently in its second round of research.

Crisis intervention as a field of study has remained largely atheoretical, enabling clinicians to practice crisis intervention as an extension of their therapeutic modality, rather than having to learn a new way of working with clients. However, the conceptualization of crisis intervention as atheoretical is not entirely accurate. It is possible to integrate the core principles of crisis intervention into almost any theoretical model, yet there is a specific skill set that a clinician needs to learn to effectively engage in crisis intervention. This skill set is largely congruent with brief therapy or solution-focused models and entails that clinicians be quick, efficient, and accurate in their thoughts and actions. Time is of the essence in crisis intervention.

The CISSI provides a symptom-based framework within which all clinicians can work, regardless of their theoretical orientation. Novice clinicians, who may be just forming a theoretical identity, can rely on the CISSI to assist them with the assessment of clients in crisis. The structure of the CISSI, because of its clearly outlined scales and decision-tree approach, may provide a guideline for the clinician to be effective in crisis situations. Standardization helps the CISSI to provide the structure of an effective clinical interview, while also allowing the clinician freedom to build rapport with the client.

Advanced clinicians, if not well versed in crisis intervention, can integrate the CISSI into their practice with the knowledge that the CISSI is another point of assessment that can assist them in their decision-making process. The structured format and decision-tree modeling ensure that all relevant data are collected. Even knowledgeable crisis interventionists can use the CISSI to standardize their practice. More data about clients are always advantageous for the clinician. Additionally, having the same type of data available about clients each time a clinician engages in crisis intervention can provide a sense of structure and process to what can be an unstructured and chaotic situation.

Training Uses

There is a slowly widening selection of training materials to choose from in crisis intervention, mostly small texts. The CISSI can be used as an important tool in the training of new clinicians. The current data show that when utilizing the CISSI, novice clinicians more reliably make the correct dispositional decision about some types of clients in crisis, as opposed to the utilization of clinical judgment alone. As scope of practice becomes an increasingly important issue, and as ethical/legal responsibility for clients increasingly takes center stage in the public and
professional awareness, it will be more important than ever to thoroughly train clinicians in crisis intervention. King et al. (1999) noted that only 38% of the school counselors surveyed believed that they could identify a student at risk for a suicide attempt. With the perception of school violence on the rise in the late twentieth and early twenty-first centuries, clinicians in schools, as well as many other settings, will continue to need improved crisis intervention skills, especially preventive ones.

The CISSI and its accompanying videos could be used as an assessment tool for clinicians in training at the graduate level. Competencies in crisis intervention could be tested by requiring students to go through a process similar to that experienced by the subjects in this study. After students have learned particular content areas, such as substance abuse, depression and suicide, and psychosis, they could be tested in their ability to accurately assess for these clinical issues. The mild symptom-severity videos could be utilized to help students recognize the signs of symptomatology, while the moderate and severe videos could be used to thoroughly test students’ assessment and crisis intervention abilities. By comparing students’ clinical judgment with their CISSI-assisted judgments, assessments could be made about students’ strengths and weaknesses. Instructors could create their own videos if they wanted to specify different symptom-severity levels, or could simply substitute symptoms in role-plays with students.

Professional Uses

The assessment of risk in crisis intervention is critical to the success of clinicians in protecting the client, the public, and themselves. Mulvey and Lidz (1998) noted that the current era of managed care and community management of patients has ushered in a new realm of responsibility in violence assessment and prediction and that accuracy of assessment is paramount in these efforts. The CISSI represents an attempt to integrate three primary areas of assessment in crisis intervention: depression and suicidal ideation, psychosis and homicidal ideation, and substance abuse. At the time the literature was reviewed for the current study, instruments existed to measure the primary content areas of crisis intervention separately, but few instruments existed that combined these content areas into one comprehensive crisis intervention assessment. No instrument existed that combined the necessary content areas into a comprehensive crisis intervention semistructured interview that could be used by clinicians at all skill and training levels. The CISSI effectively fills this gap in the professional literature and can serve as the basis for creating a valid and reliable suite of crisis intervention assessment instruments for use by mental health professionals with clients and their social support systems.

Limitations

There were several limitations in the current study. The first limitation lay in the methodology. It was not possible at the time of the study to test the CISSI with real clients, because of the complexities involved with interfacing with the mental health system, where clients in crisis are usually seen; an analogue methodology was used instead. Though the analogue methodology included three different types of clients across three levels of severity, it would have contributed greatly to external validity for the instrument to be piloted with actual clients. However, using the analogue clients provided the study with internal validity, because total control was retained over the clients’ characteristics. Actors were used in the filming of the videos, and these actors were coached and directed through multiple “takes,” to create the exact conditions that clinicians would
encounter with clients in crisis. The next logical step in the validation of the CISSI is to pilot the instrument with real clients, whether as an assessment for clients in crisis or as part of an intake and assessment process.

A second limitation of the current study also lay in the design. During the client analogue videos, the clinician was often forced to interpret what the client had said, because the subjects were unable to interact with the client. When interviewing clients for specific information, it is common to hear elaborate stories instead of discrete, concrete answers to questions. The analogue clients in the videos were intentionally scripted so that they sometimes rambled instead of giving simple answers, yet concrete symptoms were always provided in the rambling. It is up to the clinician, however, to harness that data and reflect them in the CISSI. The CISSI is intended to assist the clinician in consistently catching assessment data, though it is apparent from the results with one of the analogue clients—the depressed and possibly suicidal white female—that this task may sometimes be difficult.

The third limitation of the current study was the sample size. Data for 47 subjects were gathered, so each client analogue was observed by at least 5 clinicians. It would be helpful to increase the sample by at least threefold. It would also be helpful to gather data from two different populations, novice clinicians and experienced clinicians, to test for differences between them. The sample size for each analogue client was also small. Though the overall sample consisted of 47 subjects, each of the nine analogue clients were observed by 5 or 6 subjects. Though adequate for the current study, this small sample size for each analogue client limits the generalizability of the conclusions that can be drawn from the data. The data were reported in percentages in order to make comparisons across and within analogue clients, yet the conclusions drawn may not be as meaningful, for example when the difference between 60% and 80% of a sample represents 1 subject. It would be worthwhile to increase the sample size per analogue client in order to increase the power of the analyses.

A fourth limitation of the current study was ascertained after the study was completed. Subjects who watched an analogue video of a client in the semistructured interview did not watch the same client in the monologue video. Therefore, the subjects did not make judgments about the same client. It was reasoned that as long as the questions were answered by subjects with approximately the same level of clinical experience, the data would be fine, which was true. However, it would have been interesting to see whether subjects made the same referral decisions with the same client seen in the two different presentations; this would have provided a good demonstration of the difference between the two conditions. However, such a design may have caused difficulty if the subjects ascertained that they were watching the same client being presented in two different ways. It was for this reason that subjects watched two different clients in the two videos. Instead of comparing subjects with themselves, they were compared with other subjects, which enabled analysis for this set of data at the group level only. It would be helpful to be able to analyze the CISSI’s performance at the level of the individual clinician for particular client types.

**Future Directions**

The CISSI was created to enable both novice and experienced clinicians to make more informed decisions when working with clients in crisis. It is intended that the end result of the research on the CISSI will result in a valid and reliable instrument to help clinicians accurately assess clients in crisis. The current study lays the foundation for both the validity and the
reliability of the CISSI. Future research on this instrument should focus on (1) its implementation with an actual client population, rather than with client analogues, in order to measure real-world effectiveness, (2) validation of the remaining scales, specifically the substance abuse scale, and (3) use of the instrument with clinicians of widely varying skill levels and practice foci, so comparisons may be made among them. When it is determined that the CISSI is fully psychometrically sound, it may serve as both a critical training aid for the novice clinician and a valuable addition to the practicing clinician’s toolbox.

References


