

# Differentiating Among Stress, Acute Stress Disorder, Crisis Episodes, Trauma, and PTSD: Paradigm and Treatment Goals

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Why focus on the distinguishing components among stressors, acute stress disorders, acute crisis episodes, and post-traumatic stress disorder (PTSD)? Can clear operational definitions and specific case illustrations clarify the parameters and differences between the four clinical concepts mentioned above? What types of treatment goals are effective in treating the persons encountering the four events and disorders? What are the components of a diagnostic Stress-Crisis-Trauma-PTSD Paradigm? This article answers these four vital questions. In addition, this article thoroughly examines the clinical issues and controversies, diagnostic indicators, and treatment goals necessary for advancing mental health assessment, crisis intervention, and trauma treatment. This article aims to enhance theory building, assessment, and practice skills in behavioral health and public health and medical settings. [*Brief Treatment and Crisis Intervention* 3:3–25 (2003)]

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There are few human conditions that are so diversely described as stress, crisis, and trauma. Many report that stress helps them to work productively and meet multiple deadlines; others report on the stressful burden of managing a professional career, parenting children, and car-

ing for aging parents that can lead to the individual launching into a downward spiral culminating in physical and emotional consequences of tremendous proportion. On the other hand there is the term *crisis*, and anyone who is having a bad day or has experienced something that is not going their way may describe their day as one crisis after another. In sharp contrast to stress and crisis perceptions, trauma reactions are frequently precipitated by a random, sudden, and arbitrary traumatic event such as natural disasters, terrorism and mass murders, violent sexual assaults, or sniper or drive-by killings (Roberts, 2000a, 2002). One reason leading to overuse of the words stress, crisis, and trauma is a lack of understanding of the true

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definition and parameters of each term. Frequently, within the academic literature the definitions of stress, crisis, and trauma are overlapping. Individuals do not respond to stress in the same manner. Responses are unique and often determined by each individual's personality and character, temperament, other stressors that day, protective factors and coping skills, adaptability to change and unexpected events, support system, as well as the intensity and duration of the stressor. Therefore, what is simple stress for one individual may result in the onset of a crisis episode or traumatic reaction for another (Corcoran & Roberts, 2000). At times this confusion leads to a denial and underestimation of stress and related conditions, and a build-up of multiple stressors without effectively adapting and coping.

This article delineates and presents for discussion a tri-modal approach in addressing stress, crisis, trauma, and post-traumatic stress disorder (PTSD). A foundation based on the definition of each term will be presented. There will be a comparison of each term outlining similarities contributing to confusion among mental health professionals. Case examples will demonstrate methodology to accurately delineate and discuss the degree and severity of the issue facing each individual, applying the solution-focused approach, crisis intervention, and strengths perspective.

### Defining Terms and Historical Overview

*Stress.* Any stimulus, internal state, situation, or event with an observable individual reaction, usually in the form of positively adapting or negatively adapting to a new or different situation in one's environment. The concept generally refers to the nature of an experience, resulting from the person interacting in the context of their environment,

through either over physiological arousal or underarousal, with an outcome of psychological or physiological distress (bad stress outcome) or eustress (good stress outcome). Stressors range from minor to major and can be positive or negative events. Generally, stressors are life events such as daily annoyances, pressures at home or on the job, marital discord and conflicts, emergencies, motor vehicle accidents, illness and injury. Positive stressful life events and transitions include birth of a newborn, graduation ceremony, a family vacation, or a job promotion. (Kaplan & Sadock, 1998)

Mason (1975) developed one of the most inclusive operational definitions of stress, stressors, and stressful experiences. Mason delineated a conceptual framework and application of three different definitions of stress in order to unravel some of the confusion with general usage of the concept. Stress can be referred to as (a) an internal state of the organism, also known as strain based on both the physiological and psychological reactions; (b) an external event or stressor including combat trauma and natural disasters, major life events such as marriage, divorce, or being laid off, or noxious environmental stressors such as air pollution or overcrowding, or role strain such as a bad marriage; or (c) an experience that arises from a transaction between a person and his or her environment, particularly those where there is a mismatch or poor fit between the individual's resources and the perceived challenge, threat or need (Mason).

Selye (1956) indicated in the findings of his influential physiological research that: "Stress is part of life. It is a natural by-product of all our activities. . . . The secret of life is the successful adjustment to ever-changing stress" (Selye, pp. 299–300). According to Selye's General Adaptation Syndrome (GAS) there are generally three stages in the human body's reaction to extreme stress. First, the alarm reaction in which

the body stirs up its defense mechanisms—the glands, hormones, and nervous system—into action. Second, the adaptation stage when the body fights back (e.g., the arteries can harden when the heart is under pressure); and third, the exhaustion stage when the body's defenses seem to be unable to cope, and the individual becomes seriously ill and may die (Selye). Selye concludes that the best way to survive and thrive is to adapt and respond in positive ways to the stress of life.

Stressors frequently are characterized as ranging from minor to major, and negative or positive stimuli or events. They are inclusive of daily problems. Sometimes they appear as pressure; other times stressors are described as disturbing annoyances. At various times throughout life individuals are faced with events such as intense marital strife/discord, physical illness of family members and friends, hospitalization of family members, caring for children and loved ones, accidents, emergencies, being responsible for a special needs child or terminally ill aging parent, job pressure to perform, financial difficulties, and even moving across town or severe weather can present as stressors. The challenges that are framed by stress both positive and negative provide defining structures for meaning in our day-to-day lives. The complete absence of stress can lead to boredom and lack of meaning in one's life. Too much stress or a pile-up of multiple stressors without effective coping frequently can have a detrimental impact on an individual's physical and mental health.

People in many high-stress careers—such as rescue workers, emergency service personnel, surgical and emergency nurses and physicians, and law enforcement officers—are known to have highly stressful and physically demanding jobs, with potential for thriving, continual reenergizing, and occupational growth, or encountering vicarious traumatization. Selye, a Nobel Laureate and founder of the International In-

stitute of Stress in Montreal, Canada, in an interview with *Modern Maturity* (Wixen, 1978) stated that he thrives with and enjoys considerable satisfaction from an extremely demanding schedule. Directly prior to the interview Selye had spoke at a major medical conference in Europe, slept 4 hours, then traveled 2,500 miles to Houston, Texas, and his next interview and conference speaking engagement. The next day he flew to Montreal and two days later to a 9-day speaking engagement throughout Scandinavia. Selye never tried to avoid stress; instead, he indicated that stress gives him pleasure and a great degree of satisfaction (Wixen, 1978). In contrast, Regehr's (2001) recent article focuses on vicarious traumatization of the hidden victims of disaster and emergency rescue work, as well as the positive and negative effects of group crisis intervention and critical incident stress debriefings with worker stress reactions and the symptoms of PTSD. Further, Regehr (2001) systematically reviews the strengths and limitations of crisis debriefing groups.

When intensely stressful life events and well-documented physiological events are placed into motion, these physiological responses to stressors are best described as a chain of biochemical reactions that have the potential to impact all major organ systems. Stress begins in the brain. Reaction to perceived stressful or emergency events trigger what Cannon (1927) described as the "fight or flight" response. In response to neurochemical messages a complex chain reaction is triggered, impacting neurochemicals (specifically serotonin, norepinephrine, and dopamine). Adrenal glands release adrenaline and other hormones. The immediate physiological response is an increased heart rate and blood pressure, dilated pupils, and a heightened sense of alertness. These responses are linked to the survival mechanism of the human, and have been present since the beginning of humankind (Chrousos & Gold, 1992; Haddy & Clover, 2001; McEwen, 1995).

Many have attempted to answer the question of the impact of stress. Simply put, how much stress is too much? There appears to be no definitive answer, as the same amount and type of stress may lead to negative consequences for one individual and have little to no impact on another. Holmes and Rahe (1967) constructed a social readjustment rating scale after asking hundreds of people, from a variety of backgrounds, their response to changing life events and to rank the relative degree of adjustment necessary to address these Life-Change Units (LCUs). For example: a child leaving for college = 28 LCUs, job promotion = 31 LCUs, marital separation = 56 LCUs, and death of a spouse = 100 LCUs. An accumulation of 200 or more life-change units in a single year increases the incidence of psychosomatic disorders.

Dohrenwend and Dohrenwend (1974) trace the relationship between stressful life events and physical illnesses as well as psychiatric disorders. Their review of the research studies indicate that a pile-up of certain types of stressful life events are correlated with depression, heart disease, and attempted suicide. There is some research evidence that specific types of stressful life events such as marriage, marked trouble with your boss, being incarcerated, or the death of a spouse can play a significant role in the causation of several psychosomatic and psychiatric disorders (Dohrenwend & Dohrenwend, 1974). However, it should be noted that Dohrenwend and Dohrenwend document the methodological flaws and sampling biases in many of the early studies, and aptly recommend greater use of prospective designs, controlled studies, development of reliable and measurable attributes of stressful life events, and environmentally anchored measures.

*Specific psychic stress.* May be defined as a specific personality or an unconscious conflict that causes a homeostatic disequilibrium contributing to the development of psychosomatic disorder. (Kaplan & Sadock, 1998)

The changes that the body experiences in response to stress have long been thought to present a remarkable health threat. Alexander (1950) hypothesized that unconscious conflicts are associated with certain psychosomatic disorders. For example, Friedman and Rosenman (1959) identified the high-strung, highly competitive, impatient, compulsive workaholic personality with generally tense muscles as the Type A personality, and as a patterned chronic stress response that predisposes a person to coronary heart disease and severe coronary atherosclerosis. Currently, clinical studies continue to confirm the connection between stress and poor coping skills, and vulnerability to illness.

Clinical studies have demonstrated a positive correlation between stress and decreased resistance to infection. For example, there is remarkable evidence that persons under intense stress for long periods of time are more susceptible to the common cold. Recent research demonstrated some of the impact of stress on the immune system's ability to fight illness. One such study demonstrated that women who scored highest on psychological stress scales had a shortage of cytokines, a set of proteins produced by the immune system to aid in the healing process. Despite recent advances in research medical researchers are unable to explain the highly individualized response to stress. Many conclude that environmental factors combined with genetic make-up and innate coping skills are the best determinates for the individual's personal reaction to stress (Powell & Matthews, 2002).

*Crisis.* 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 mechanisms. 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 the resolution of the crisis. (Roberts, 2000b)

The definition of a crisis stated above is particularly applicable to persons in acute crisis because these individuals usually seek help only after they have experienced a hazardous or traumatic event and are in a vulnerable state, have failed to cope and lessen the crisis through customary coping methods, lack family or community social supports, and want outside help. Acute psychological or situational crisis episodes may be viewed in various ways, but the definition we are using emphasizes that a crisis can be a turning point in a person's life. Crisis intervention generally refers to a counselor, behavioral clinician, or therapist entering into the life situation of an individual or family to alleviate the impact of a crisis episode in order to facilitate and mobilize the resources of those directly affected. Rapid assessment and timely intervention on the part of crisis counselors, social workers, psychologists, or child psychiatrists is of paramount importance. Crisis intervenors should be active and directive while displaying a nonjudgmental, accepting, hopeful, and positive attitude. Crisis intervenors need to help crisis clients to identify protective factors, inner strengths, psychological hardiness, or resiliency factors that can be utilized for ego bolstering. Effective crisis intervenors are able to gauge the seven stages of crisis intervention while being flexible and realizing that several stages of intervention may overlap. Crisis intervention should culminate with a restoration of cognitive functioning, crisis resolution, and cognitive mastery (Roberts, 2000a).

Personal impact in the aftermath of poten-

tially stressful and crisis-producing events can be measured by:

- *Spatial dimensions.* The closer the person is to the center of the tragedy, the greater the stress. (Similarly, the closer the person's relationship is to the homicide victim, the greater the likelihood of entering into a crisis state.)
- *Subjective time clock.* The greater the duration (estimated length of time exposed and estimated length of exposure to sensory experiences, e.g., an odor of gasoline combined with the smell of a fire) of time that an individual is affected by the community disaster, violent crime, or other tragedy, the greater the stress.
- *Reoccurrence (perceived).* The more the perceived likelihood that the tragedy will happen again, the greater the likelihood or intense fears, which contribute to an active crisis state on the part of the survivor. (Young, 1995)

*Acute stress disorder.* The development of characteristic anxiety, dissociative and other symptoms that occurs within one month after exposure to an extreme traumatic stressor. As a response to the traumatic event, the individual develops dissociative symptoms. Individuals with acute stress disorder may have a decrease in emotional responsiveness, often finding it difficult or impossible to experience pleasure in previously enjoyable activities, and frequently feel guilty about pursuing usual life tasks. (American Psychiatric Association [APA], 2000)

Beyond a physiological response to stress, a sudden remarkable stressor, such as physical violence or threatened physical violence, can provoke more than a "flight or fight" response, triggering a psychiatric illness referred to as acute stress disorder. This disorder is an anxiety disorder characterized by a combined grouping

of dissociative and anxiety symptoms with the avoidance of reminders of the traumatic event. Dissociative symptoms are frequently present and include emotional detachment, temporary loss of memory, derealization, and depersonalization. Potential anxiety-based symptoms associated with acute stress disorder may include but not be limited to irritability, confused and disordered thoughts, sleep disturbance, and being easily startled. The emergence of symptoms occurs within 1 month of a traumatic event. Associated features within the diagnostic criteria are that symptoms significantly interfere with normal social or vocational functioning and symptoms associated with acute stress disorder last between 2 days and 4 weeks. This disorder is a relatively new diagnostic category. It was introduced in 1994 in an effort to differentiate time-limited reaction to trauma and to provide clear delineation between brief stress reactions from extended reactions to trauma from PTSD (APA, 2002).

*Trauma.* Psychological trauma refers to human reactions to traumatic stress, violent crimes, infectious disease outbreaks, and other dangerous and life-threatening events. For psychological trauma to occur, the individual's adaptive pathways become shut off as a result of overexposure to stress hormones. Persistent hyperarousal mechanisms related to the traumatic event continually reoccur and are amplified by traumatic recollections stored in the brain. The victims of trauma find themselves rapidly alternating their mental states between relatively calm and peaceful states to states of intense anxiety, agitation, anger, hypervigilance, and extreme arousal. (Roberts, 2002)

Psychological trauma or the human trauma response can take place soon after observing or being the victim of a traumatic stressor or event. This is usually the case in an acute stress disorder.

However, many times individuals have a delayed reaction to a traumatic event, and this delay of several weeks to several months usually surfaces in the form of symptoms of psychological trauma such as avoidance of familiar surroundings, intense fears, sudden breaking of appointments, social isolation, trance-like states, sleep disturbances and repeated nightmares, depressive episodes, and hyperarousal.

According to Terr (1994), there are two primary types of trauma among children. Type I refers to victims who had experienced and suffered from a single traumatic event, such as the 26 Chowchilla, California, children who were kidnapped in 1976 and buried alive in their school bus for almost 27 hours. Type II trauma refers to experiencing multiple traumatic events such as ongoing and recurring incest, child abuse, and/or family violence. The exception is an extremely horrific single traumatic occurrence which is marked by multiple homicides and includes dehumanizing sights (e.g., dismembered bodies), piercing sounds, and strong odors such as fire and smoke (Roberts, 2002).

The American Academy of Experts in Traumatic Stress is a multidisciplinary network of professionals dedicated to formulating, and extending the use of traumatic stress reduction protocols with emergency responders (e.g., police, fire, EMS, nurses, disaster response personnel, psychologists, social workers, funeral directors, and the clergy). Dr. Mark D. Lerner, a clinical psychologist and President of the Academy, and Dr. Raymond D. Shelton, Director of Emergency Medical Training at the Nassau County Police Training Academy and Director of Professional Development for the Academy, provide the following expert guidance for addressing psychological trauma quickly during traumatic events:

All crisis intervention and trauma treatment specialists are in agreement that before intervening, a full assessment of the situation and

the individual must take place. By reaching people early, during traumatic exposure, we may ultimately prevent acute traumatic stress reactions from becoming chronic stress disorders. The first three steps of Acute Traumatic Stress Management (ATSM) are: 1) assess for danger/safety for self and others; 2) consider the type and extent of property damage and/or physical injury and the way the injury was sustained (e.g., a terroristic explosion), and 3) evaluate the level of responsiveness—is the individual alert, in pain, aware of what has occurred, or in emotional shock or under the influence of drugs. (Lerner & Shelton, 2001, pp. 31–32)

*PTSD.* A set of typical symptoms that develop after a person sees, is involved in, or hears of “an extreme traumatic stressor.” PTSD is an acute, chronic, delayed, debilitating, and complex mental disorder. It includes altered awareness, detachment, dissociative states, ego fragmentation, personality changes, paranoid ideation, trigger events, and vivid intrusive traumatic recollections. PTSD is often comorbid with major depression, dysthymia, alcohol or substance abuse, and generalized anxiety disorder. The person reacts to this experience with fear and helplessness, sleep disturbances, hyperarousal and hypervigilance, persistently reliving the event through graphic and magnified horrific flashbacks and intrusive thoughts, and unsuccessful attempts to avoid being reminded of it. The symptoms must last for more than a month and must significantly affect important areas of life. (APA, 2000)

Some stressors are so severe that almost anyone is susceptible to the overwhelming effects of the experience. This disorder can arise from wars, torture, natural disasters, terrorism, rape, assault, or serious accidents. A recent example reflective of this was the random sniper shoot-

ings in Rockville, Maryland, and Virginia. In today’s society the televised media is spreading individual reaction to traumatic stressors. Examples of this could be seen daily as persons cast their eyes to the sky in fear as an unusually loud jet flew over or when persons stooped beside their car while pumping gasoline, fearful of becoming the next target of the sniper. The complete impact of vicarious stressors as delivered through multimedia bombardment will not be examined in this article; however, this subject warrants further examination.

The history of PTSD stems from the work of Jacob DaCosta’s 1871 paper “On Irritable Heart” describing the symptoms of stress witnessed in Civil War soldiers. The disorder was referred to as traumatic neurosis resulting from the strong influence of psychoanalysis. However, this was replaced by the term *shell shock* during World War I, as psychiatrists hypothesized this was the impact of brain trauma resulting from the percussion blows of exploding bombshells. It was not until 1941, when the survivors of the Coconut Grove nightclub fire began to demonstrate symptoms of nervousness, nightmares, and graphic recollections of the tragedy, that the operational definition was expanded to operational fatigue, delayed grief, and/or combat neurosis. It was not until the return of Vietnam War veterans that the notion of PTSD emerged in the current context. Throughout the history of this disorder an inescapable fact has been present: the appearance of the disorder was roughly correlated with the severity of the disorder, with the most severe stressor resulting emergence of characteristic symptomatology in 75% of the victims.

The critical feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event involving direct or threatened death or severe injury, threat to one’s physical integrity or that of another person, or being witness to an un-

expected violent death, serious harm, or threat of injury to self or another. *DSM-IV-TR* (APA, 2002) criteria specify that the presence of symptoms of hyperarousal, avoidance, and reexperiencing the trauma must have been present for more than one month. A further delineation of time frame indicates that in patients who have experienced symptoms for less than 1 month, the diagnosis should be acute stress disorder. The *DSM-IV-TR* provides clinicians the opportunity to specify acute (with symptoms having lasted less than 3 months) or chronic (with symptoms lasting greater than 3 months). There is also provision for delayed onset, if the appearance of symptoms occurs 6 months or more after the stressful event.

The need for a consolidated approach to individual and group psychological crisis intervention appears to be significant. Breslau, Davis, Andreski, and Peterson (1991) indicated that 89.6% of adults may experience a traumatic event over the course of their lifetimes. Previous thought has linked the risk of exposure to trauma to specific occupational groups, including military, firefighters, and law enforcement. However, events over the past 5 years have expanded this scope to educators and emergency medical personnel. The most recent events in North America have expanded the scope of trauma to innocent bystanders, as demonstrated following the terrorist attack in New York City and sniper attacks in Rockville, Maryland, and northern Virginia. Previously, Everly and Mitchell (1999) indicated that conditional risk of developing a stress disorder for the general population was in excess of 9%, with high risk population potential ranging from 10–30%. It is too soon to measure the direct impact of recent events in North America on the general population; however, it is certain that many more persons are experiencing significant exposure to risk for stress, acute stress, crisis, and post-traumatic stress.

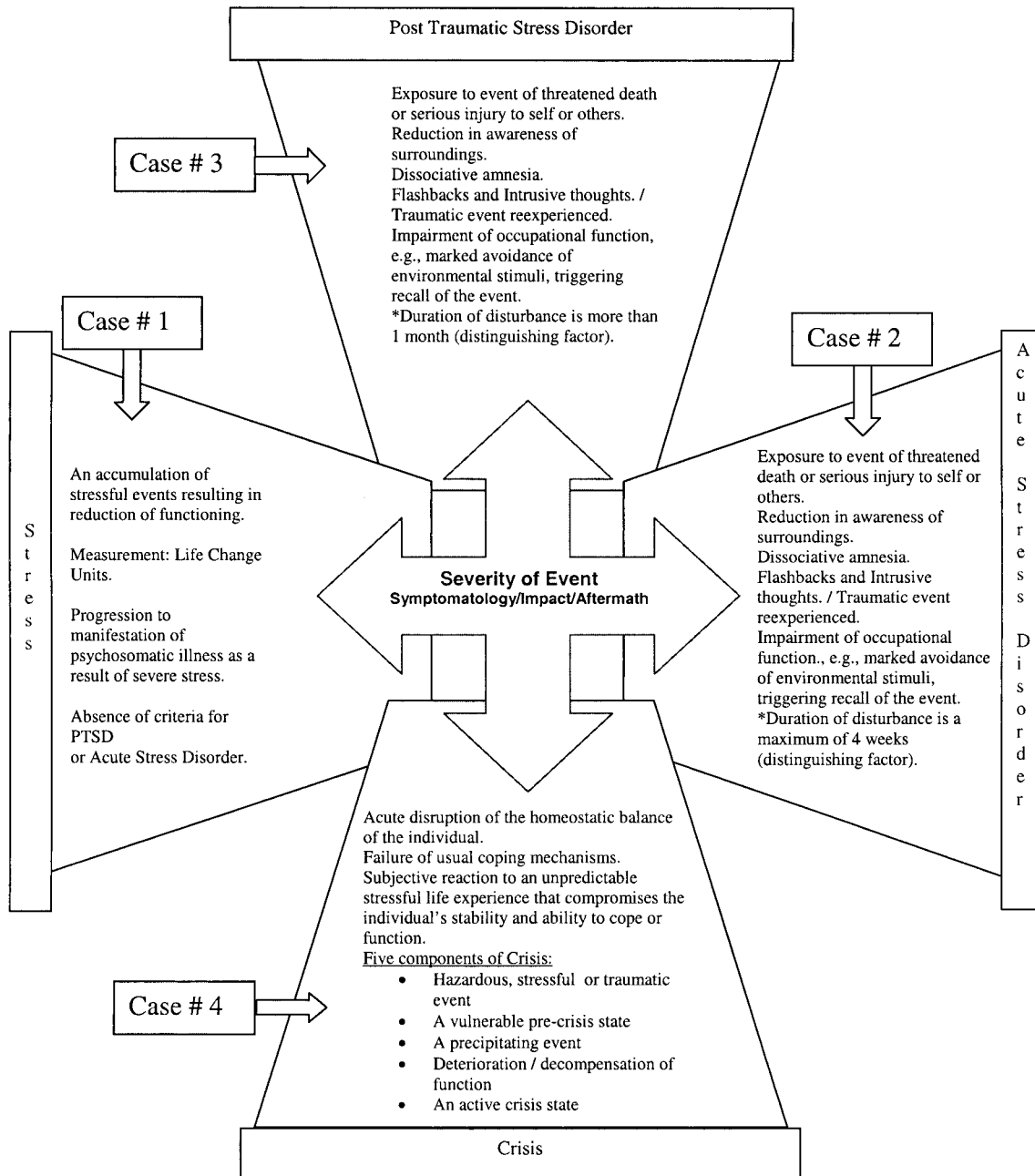
The need for prompt intervention cannot be

underestimated. Over a decade ago Swanson and Carbon (1989) began writing on the need for prompt intervention in cases of stress, crisis, and trauma for the APA's task force on the treatment of psychiatric disorders. Concurrently Roberts' Seven-Stage Model of Crisis Intervention emerged urging a systematic and eclectic approach to crisis intervention (Roberts, 1990, 1995, 2002). There is an emergent need and strong argument for providing immediate aid and forming a treatment alliance with victims of trauma with psychological trauma victims. Thus the question appears to be not whether to provide rapid crisis intervention and trauma treatment, but rather how to frame the interactions and diagnoses in a manner that facilitates accurate and consistent individualized care approaches.

### A Clinical Framework

It is not difficult to understand the confusion experienced by practitioners surrounding the terms stress, trauma, and crisis. These terms are interchanged to describe not only the event or situation, but also the individualized response to the event and at times the diagnosis associated with the individual's response to the event. Therefore, it is important to differentiate severity of event against the patient's perception and his or her unique abilities to cope with the event. In doing so the clinician will have a clearer picture of the appropriate diagnostic framework criteria and categories to be applied.

To utilize the diagram in Figure 1 the practitioner must first examine the severity of the event and its potential impact on the individual's response when accounting for individual personality and character, temperament, other stressors that day, protective factors and coping skills, adaptability to change and unexpected events, and support system, as well as the intensity and duration of the stressor.



**FIGURE 1**

Stress, crisis, PTSD classification paradigm. This construct provides an overview for practitioners differentiating among Stress, Crisis, Acute Stress Disorder, and Post Traumatic Stress Disorder. The center directional arrow leads practitioners to assess the severity of the initial event, symptomatology associated with the event, and aftermath of the initial event. Each diagnostic category associated with the directional arrow demonstrates diagnostic symptoms presented within each case sample, providing clues to diagnostic decision making and treatment planning processes.

Once the nature of the initial event is clearly understood the practitioner can construct an accurate depiction of the individual's condition and to assign the appropriate condition. Note that accurate differentiation between stress, crisis, acute stress disorder, and PTSD should be accomplished through a multimeasurement, multidisciplinary approach. This is accomplished through completion of informational interview, examination of social environment, application of scale measurement, and consultation with medical practitioners. This process is one of leading to a greater understanding of the factors impacting on the individual. Determinations made through this process are approximations, seeking to construct a framework to serve as a foundation for treatment planning and care delivery. This process is not a diagnostic criteria, nor is it intended to replace *DSM-IV-TR* classification.

What follows is an example of such a framework based on a series of case examples to differentiate among stress, crisis, acute stress disorder, and PTSD. Special emphasis will be placed on the event, the individual's response to the event, application of appropriate diagnostic criteria when warranted, resiliency factors, and treatment planning.

### ***Case Illustrations of the Events***

*Case Example 1.* Kevin is a manager within a large insurance corporation. He was brought in during a point of transition within the organization, replacing a less than effective but well-liked manager. Kevin has held this position for a period of 2 years. He has consistently found himself in the middle of critical and sensitive issues between department staff and administration. At this point in his life Kevin is responsible for the care of his elderly frail mother who was diagnosed with terminal cancer 3 months previously. He is a single parent with three children of which the eldest has recently left for college.

Kevin is experiencing financial difficulties and may be facing foreclosure on his house. He presents for counseling to address job stress, as he is fearful the company is looking at demotion or termination from his position. On the positive side Kevin reports that he has become involved in a significant new relationship, but fears that this will end when "the wheels come off in his employment."

*Case Example 2.* Jill is a nurse manager with 27 years of experience in critical care working in the transplant unit of a large metropolitan medical center. Two days prior to seeking assistance her last living and favorite uncle was admitted to the medical center following a mild heart attack. Jill reports on the first day of her uncle's hospitalization she assured him and his wife that they were in "the right place." Knowing the medical staff Jill arranged for her uncle to be seen by the very best cardiologist and followed by a group of nurses that she personally knew and felt would do excellent work. Jill left the unit that day feeling very good about her work. When she returned to work the next day she checked in on her uncle. A unit assistant told Jill he had been moved to a critical care pod and that his condition has worsened over the last shift. Jill approached the critical care pod as her uncle experienced a major cardiac event. She remained present throughout the code, assisting the residents, cardiologist, and anesthesiologist. Unfortunately, her uncle did not survive the event. Still Jill remained focused. She accompanied the cardiologist as he informed family of the unanticipated outcome. Jill contacted pastoral care to provide a private area for her aunt and cousins to grieve their loss. Jill was present until all arrangements had been made and her family had left the medical center. Realizing she could not work Jill took the nearest stairwell to her unit to explain her absence. She was unable to proceed and was found by staff sitting on the stairs tearful and overwhelmed by the experi-

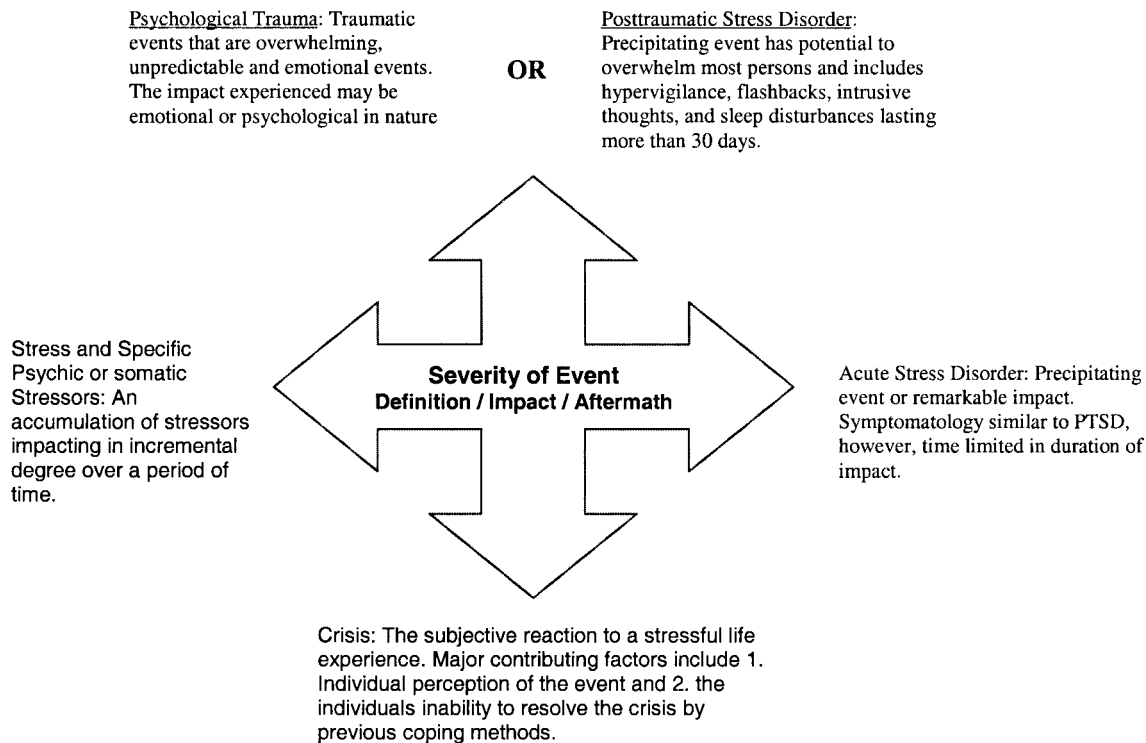
ence. Since that time she has relived the experience of the code, reporting vivid recollections of the death of her favorite uncle and the faces of her family members.

*Case Example 3.* Thomas is a firefighter with engine house one within a large metropolitan area, who presents following the loss of three peers during a warehouse fire. Tom accounts that the fire was intense. He and his brigade had been called to a fire within the garment district. Tom notes, "This is the most intense fire I had ever seen. The smoke was extremely thick and very toxic. As time progressed the heat was overwhelming." Tom notes that he and three peers were on the third floor of the warehouse when he heard a large explosion. "I knew it was bad; when you hear anything above the roar of the fire it's got to be very big and very dangerous." At the time of the explosion Tom had moved away from the team to secure equipment for advancement and to direct the reinforcement team. Tom reports, "After the explosion I turned around to see where my buddies were, but I didn't see them. . . [A]t first I thought it was the smoke, so I moved closer. . . Then I saw what really happened. . . [T]he floor had given way, it just fell out from under them, two of my buddies were on the next floor down, I could hear them screaming, they was in the middle of the fire, there wasn't anything I could do for them. I just sat there and watched them thrash, kick, scream, and die. I didn't see Vince at first, then I saw him. He was hanging on a pipe about four feet below me. I reached down for him. I had a chance . . . but when he reached up for my hand all I grabbed was his glove . . . I still see his face as he fell. After I got out I realized his glove was still in my hand . . . what I realized is . . . oh my God . . . the flesh of his hand was still in the glove. I hadn't missed there just wasn't nothin' there to grab, now I know what that look on his face was about . . . I can't seem to shake it . . . I haven't had a decent night's sleep for about 6

months . . . I was doing all I could to help. . . . It haunts me. Sometimes it's not even a dream. I'm just thinking and there it is boom . . . right in my face, like I'm living it all over again. I'm just not sure how much more of this I can take. I don't know how I got out . . . worse yet I don't know why."

*Case Example 4.* William is a 54-year-old Information Technology Director for a large manufacturing firm. While working in the plant one afternoon, William was struck by a large piece of equipment that was being moved via overhead crane. This resulted in a closed head trauma. Once physically stabilized, the true effects of William's injuries became apparent. William experienced moderate cognitive impairment affecting his ability to concentrate and to consistently complete logical problem solving activities. The head trauma had also impacted William's ability to ambulate. It became apparent that his rehabilitation was going to be difficult and lengthy, as William would be challenged to learn to walk again. To further complicate matters, William was plagued by chronic pain in the form of migraine headaches, which would present without warning, often lasting for days. William is the sole support for his family and found that he had no short-term disability and that his long-term disability was 60% of his income. William was faced with not only remarkable health issues, but also remarkable financial stressors. William's wife and family were extremely supportive and actively participated within each phase of his rehabilitation. William was connected with a social worker to begin the process of establishing social, emotional, and vocational rehabilitation.

Clearly conceptualizing each of the cases provides the opportunity for examination of the defining factors between stress, crisis, acute stress disorder, and PTSD. The five-way diagram in Figure 2 provides a roadmap for practitioners to process the nature of the individuals pre-



**FIGURE 2**  
Four-way diagram of initial or trigger-precipitating event. This diagram highlights specific response and differentiating factors associated with the initial, trigger, or precipitating event as related to stress, crisis, and acute stress disorder and post-traumatic disorder.

senting problems and precipitating event, and serves as a springboard for intervention based on the ACT Intervention Model (Roberts, 2002).

Within the onset of crisis, stress and trauma the single common event is an episode that challenges or threatens the individual, and their perception of the world around them. Based on the severity of the event, and the individual's perception of the acute stressor, situational stressor, or accumulation of stressors, each person will progress in their response to the trigger/precipitating event.

**The ACT Intervention Model**

A—Assessment of the presenting problem. This is inclusive of triage assessment, emergency psychiatric response based on crisis assessment/appraisal of immediate

medical needs, and trauma assessment including the biopsychosocial and cultural assessment protocols.

- C—Connecting to support groups, the delivery of social services, critical incident stress debriefing, and crisis intervention.
- T—Traumatic reactions, sequelae, and PTSD.

Immediate assessment of risk to self or others (e.g., suicide attempts, self-injurious behavior, and assessment of the individual's ability to care for self) or harm to others (e.g., potential for aggression toward others, attempted murder, murder) is the first step or "A" of the ACT Model. Individuals presenting with homicidal or suicidal ideation or the demonstrated inability to care for self will require a brief hospitalization to stabilize the individual. The primary objective of assessment is to provide data to better understand the nature of the event, the individual's

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## ACT Intervention Model for Acute Crisis And Trauma Treatment

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- A** --Assessment/Appraisal of Immediate Medical Needs, Threats to Public Safety and Property Damage
- Triage Assessment, Crisis Assessment, Trauma Assessment and The Biopsychosocial and Cultural Assessment Protocols
- C** --Connecting to Support Groups, the Delivery of Disaster Relief And Social Services, and Critical Incident Stress Debriefing (Mitchell & Everly's CISD Model) Implemented
- Crisis intervention (Roberts' Seven-Stage Model) Implemented, Through Strengths Perspective & Coping Attempts Bolstered
- T** --Traumatic Stress Reactions, Sequelae, and Posttraumatic Stress Disorders (PTSD)
- Ten Step Acute Trauma and Stress Management Protocol (Lerner & Shelton), Trauma Treatment Plans and Recovery Strategies Implemented

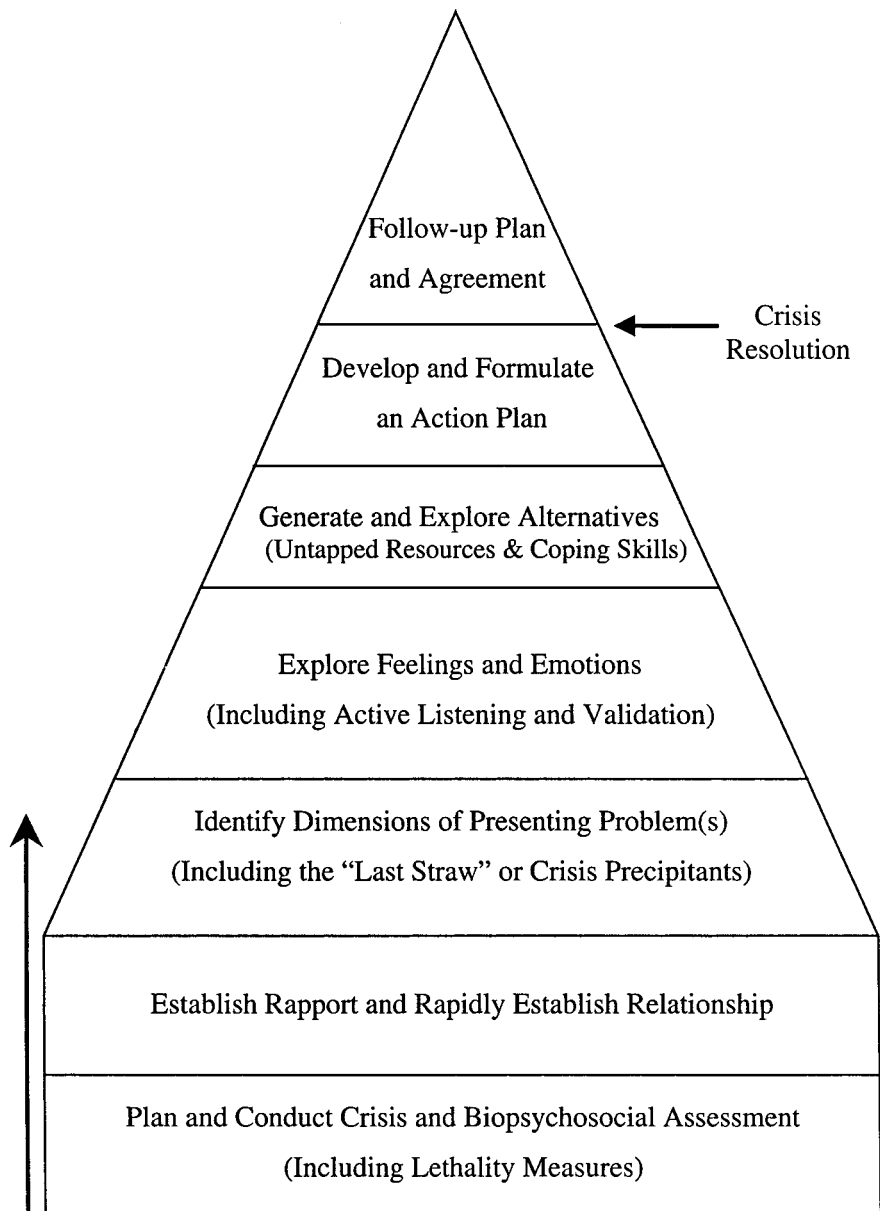
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**FIGURE 3**

ACT Intervention Model. © 2001 Albert R. Roberts. Reprinted by permission of the author.

perception and response to the event, extent of support system, effectiveness of coping mechanisms, and perceptions regarding willingness to seek assistance. Intake forms and rapid assessment instruments should be utilized to gather sufficiently accurate information to assist with the decision-making process. It is important to

note that while the assessment is of the individual, the practitioner should always consider the person's immediate environment; this is inclusive of seeking information into supportive interpersonal relationships (Lewis & Roberts, 2001, 2002). Accurate assessment will lead to accurate diagnosis of the individual condition and



**FIGURE 4**  
 Roberts' Seven-Stage Crisis Intervention Model. © 1991 Albert R. Roberts. Reprinted by permission of the author.

in turn will facilitate concise treatment interventions that are understandable, measurable, and accomplishable for the client.

The "C" in the ACT Model addresses crisis intervention and connection to services. While practitioners have training in a variety of theoretical approaches, this training is not easily applied to the nature of cases seen in actual prac-

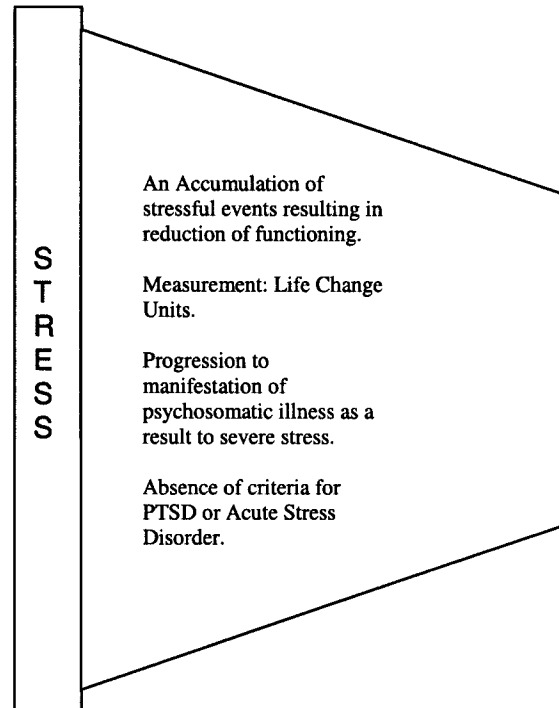
tice within an emergency or crisis setting. By nature of the criteria for admission to inpatient psychiatric treatment, patients must be homicidal, suicidal, or unable to care for self; while this is a very simplistic view of admission criteria, those working in psychiatry are acutely aware of the accuracy of this brief/overarching admission criteria.

The ability to apply a clear concise approach to crisis intervention regardless of diagnostic category or where the individual presents on the continuum of care need, practitioners are finding that traditional theoretical paradigms are not as effective as clear protocols. Roberts' (1991, 2000b) Seven-Stage Crisis Intervention Model (Figure 4) provides practitioners with such a framework.

The "T" in the ACT Model refers to trauma assessment and treatment. Traumatic events refer to overwhelming and highly emotionally charged experiences that remarkably impact the individual's ability to maintain psychological/psychiatric stability. It is also important to note that long term exposure to series traumatic events, such as domestic violence, may lead to deterioration of psychological well-being (Roberts, 2002). Furthermore, it is important to note that of those who experience traumatic events, only 3–5% develop PTSD.

Lerner and Shelton (2001) have developed a model of intervention that they believe is effective in intervening with traumatic stress and psychological trauma survivors to prevent individual escalation into PTSD. The model is as follows:

1. Assess for danger/safety for self and others.
2. Consider the physical and perceptual mechanism of injury.
3. Evaluate the level of responsiveness.
4. Address medical needs.
5. Observe and identify each individual's signs of traumatic stress.
6. Introduce yourself, state your title and role, and begin to develop a connection.
7. Ground the individual by allowing him or her to tell their story.
8. Provide support through active and empathic listening.
9. Normalize, validate, and educate.
10. Bring the person to the present, describe future events, and provide referrals.



**FIGURE 5**

This figure demonstrates key diagnostic decision and treatment factors presented in Case #1.

### Application of ACT Model and Seven-Stage Crisis Intervention Model

#### Case 1

Kevin presents with an accumulation of stress factors (Figure 5). Application of the LCU rating of common stressors indicates that Kevin has a cumulative stress score of 270. Kevin's psychosomatic symptoms are beginning to emerge as headaches and remarkable weight loss, accompanied with fleeting feelings of anxiety and hopelessness. Following assessment of Kevin's situation crisis intervention, in this case consisted of addressing the issues that Kevin prioritized in the first session. These were addressed as follows:

*Problem.* Job stress.

*Goal.* Increased understanding of your personal reaction to stress.

*Methods*

1. List stressful situations experienced in order of severity (Stage 3 of Roberts' Seven-Stage Model).
2. Consider alternatives to stress that have worked (Stage 5 of Roberts' Seven-Stage Model).
3. List alternative actions for given stressful situations (Stage 6 of Roberts' Seven-Stage Model).
4. Keep a log of activities and how these have impacted your stress level.

Initially, Kevin was reluctant to complete this task. In fact his first list consisted of looking at the employment listings on a daily basis and finding a new position. It was noted that this would be helpful, but would not resolve all of the problems Kevin was faced with. In subsequent sessions Kevin did complete a list of stressors that encompassed each identified in the initial assessment. He acknowledged that he needed to take better care of himself. His list of activities included: cut back on caffeinated and alcoholic beverages; improve his diet by staying away from fatty and fried foods, take a walk each day on his lunch break, and make time after work to do something fun with his family and friends versus focusing on the stressful daily events and how to "fix them."

Kevin experienced an accumulation of stressors that were transitioning him into a state of specific psychic stress that was impacting his personal health. Following accurate assessment Kevin was able to work through the seven-stage crisis intervention model to address the stressors in his life. Within Kevin's log there was a statement that demonstrated his understanding of the impact of stress on his life. It said:

I now understand that it is not my job or those around me that is causing my problems, it's all about what I do with what is given to me. If I focus on every little issue I will never be able to see my way out of the hole I am continually digging!

The "T" in the ACT Model was combined with the seventh step of Roberts' Seven-Stage Model "follow-up." Kevin indicated the pending loss of his mother would be a remarkably difficult time for him. He was able to process his concerns of this with his group. He shared that of all of his problems this was the final remaining issue. In the closing session Kevin shared a plan of whom he will utilize for support and the actions he will take following the loss of his mother. He was reassured that should there be a need to come for additional sessions that there would be openings for him. Kevin agreed to do so, if necessary.

*Case Autopsy.* Kevin attended a total of six 1-hour sessions. These sessions were based on a solution-focused approach combined with Roberts' Seven-Stage Crisis Intervention Model. Within each session clear goals were outlined. Homework sessions focused on specific actions to be taken based on collaborative interaction between Kevin and his therapist. Kevin did not change jobs. Rather, he chose to maintain his focus on completing the day-to-day tasks and removing himself from the office politics. He ran his division strictly by the book and documented every action according to company policy. The therapist capitalized on the strengths of Kevin's family, and their willingness to make changes to address pending issues. Kevin developed a plan to sell the home he was living in, as his family no longer required this large of a home. After speaking with his children Kevin purchased a smaller house with a pool and recreation room in the basement. He reports this has been an excellent compromise for him and his children. Kevin was able to remove the majority

of his financial stressors following the sale of his home. Kevin was careful to remove himself from office politics, and while he was walking at lunch one day his boss was terminated. Kevin reports working to build a more positive rapport with his staff.

*Factors of Resilience.* These factors include a supportive significant other or family, willingness to assess need for change, ability to enact changes, financial equity within his home to utilize for reduction of financial stressors, and/or consistent and steady full-time employment with good health benefits.

## Case 2

In this case the unanticipated outcome associated with the loss of Jill's favorite uncle precipitated a situational crisis. Jill was quite skilled in dealing with stressful situations; however, this situation was more than the typical stressor faced in her work environment. Assessment of this case included application of the Beck Anxiety Scale. Jill's score reflected significant anxiety associated with this experience. Assessment of competencies of nursing practice indicated minimal impact; however, emotionally Jill was not prepared to return to her work. There are many strong arguments for providing acute psychological counseling and forming a therapeutic rapport as early as possible following the traumatic event (Roberts, 2000a). Slaikeu (1984) argued that rapid intervention is essential to successful resolution of crisis. McGee (1974) cites Hansel's Law, indicating the successful outcome for individuals addressing traumatic events increases directly as a function of its proximity in both time and place to the crisis event.

In Jill's case the "C" and "T" of the ACT Model took the form of brief solution focused intervention, combined with Roberts' Seven-Stage Crisis Intervention model. This intervention

was instituted within 48 hours of the trauma event. The intervention occurred within the department of psychiatry associated with the hospital facility, thus providing proximity to the event. Jill's therapist provided support and assured her that the sessions would not be shared with her immediate supervisor, and that they would work together as a team to develop her ongoing plan of care. In this case Jill felt treatment within the institution of her employer was appropriate. These actions served to rapidly establish the therapeutic relationship between Jill and her therapist (Stage 2 of Roberts' Seven-Stage Model).

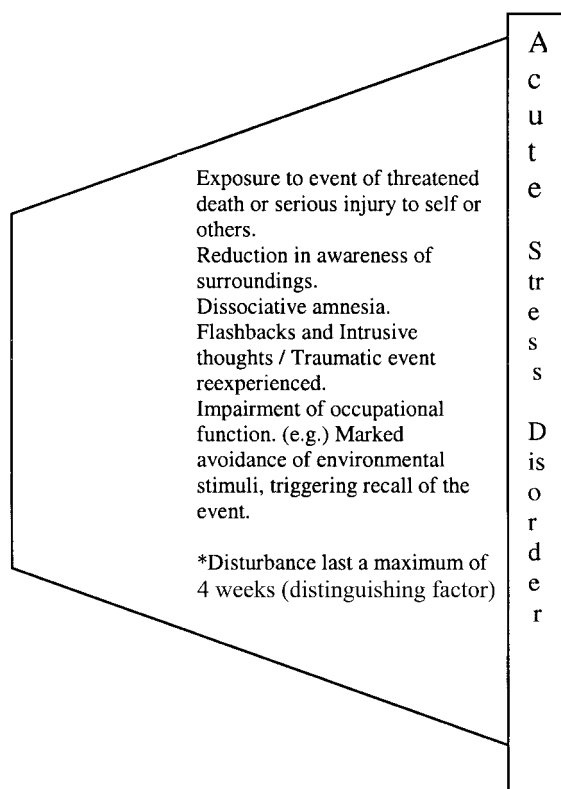
The function of the debriefing was to "psychologically deescalate" Jill, permitting the opportunity for Jill to explore and express feelings of guilt and her perception that she had not provided all of the assistance possible for her uncle (Stage 4 of Roberts' Seven-Stage Model). As the debriefing continued, a pattern materialized of Jill believing she had a greater level of responsibility for her uncle's death than was warranted. Jill was experiencing remarkable difficulties sleeping and maintaining concentration, which ultimately resulted in significant distress in social and occupational functioning. Finally, Jill was isolated from her primary support system, her family, as she felt her failure to do everything possible made it impossible for her to seek assistance from what would normally be her support system. Interventions associated with Jill's case utilized an integrated multicomponent approach as debriefing as a stand-alone therapy has not been found to be as successful as a multicomponent approach. Jill worked with her therapist to develop and formulate her treatment plan (Stage 6 of Roberts' Seven-Stage Model).

Interventions included:

1. Individual therapy sessions twice per week. Jill was encouraged to discuss the event and her subsequent reactions to the event.

2. Psychoeducational interventions, to increase her awareness of a variety of coping mechanisms (e.g., relaxation techniques).
3. Pharmacotherapy including the use of tricyclic medication (Elavil) and mild doses of sedatives as needed for sleep.
4. A family conference was utilized to provide education, and to permit cathartic ventilation in a manner that empowered family members to provide constructive support in the face of a demanding crisis situation.
5. Finally, Jill reported her strength being strong spiritual beliefs, and thus pastoral intervention was utilized to build upon the identified strength.

Jill responded almost immediately to the support of her family, indicating that she felt for the first time since the event that she was not alone. Within a one-week period of time Jill felt it was no longer necessary to utilize the sedative medication prescribed, however, she maintained compliance to the prescribed tricyclic medication. By the end of the second week of therapy Jill requested to return to her unit and visit her friends. Soon after this visit she related her belief in her ability to return to the workforce. Three weeks to the day after the traumatic event, Jill returned to her work function. It is important to note that Jill's experience met the diagnostic criteria for acute stress disorder (Figure 6), specifically the time component. Jill's disturbance occurred within 4 weeks of the event, and persisted for approximately 3 weeks, which is within the maximum four-week duration (APA, 2002).



**FIGURE 6**  
 This figure demonstrates key diagnostic decision and treatment factors presented in Case #2.

*Case Autopsy.* While Jill was no stranger to stressful experiences within the hospital setting, she was not prepared for the emotional trauma associated with the loss of her uncle within her work environment. Jill related during the therapy that the resident reported to her later that he felt it strange that she was on this unit; however, with the current nursing shortage, he assumed that Jill was covering an additional shift. In fact none of the crisis team responding to the code had been aware that this was a relative. It was not until the cardiologist arrived that team members were aware of the true nature of the event. Jill reports that the cardiologist asked her in the hall while going to speak with the family if she was "all right." To this date Jill is uncertain of her response. Jill attended six follow-up sessions over a 4-month period of time and has not experienced significant symptoms associated with the traumatic event. By the final session Jill had discontinued the Tricyclic medication.

*Factors of Resilience.* The presence of preincident training and preparation, strong family support, support within the work environment, rapid response of debriefing and initiation of crisis intervention, spiritual beliefs, and cognitive abilities to apply multicomponent approach.

### Case 3

Assessment of Tom indicated that he had been experiencing numerous diagnostic criteria for acute PTSD (Figure 7). Symptoms identified during the initial assessment included a response of intense feelings of helplessness and horror associated with the event. Tom also reported recurrent distressing recollections of the event. Specifically, images of his friend's face and the realization of why his friend was unable to hold on during his rescue efforts. Tom described intense feelings to suggest the presence of flashbacks relating to the episode, and reported that he had been experiencing recurrent distressful dreams of the event, which are uncharacteristically real. Tom reported feeling estranged from his peer group. There was a remarkable tendency toward isolation and reduction of participation in significant activities. Most importantly, Tom began to avoid thoughts, feelings, and conversations associated with the traumatic event. Finally, Tom was experiencing sleep disturbance, including insomnia and early morning wakening, difficulty concentrating, and had demonstrated in the course of this interview an exaggerated startle response.

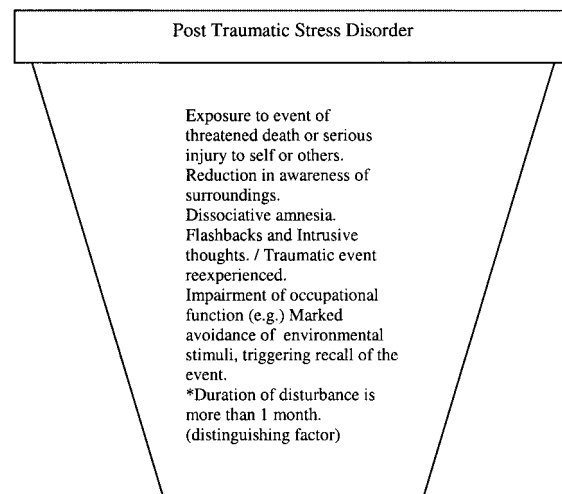
As time progressed Tom's condition began to deteriorate, until he reached the point of suicidal ideation. Tom stated, "I can't deal with the torture of reliving this event every day; I don't understand why I had to survive, I should be dead." In this case the "C" in the ACT model required admission to an inpatient psychiatric facility to facilitate psychiatric stabilization, within a safe environment. Pharmacotherapy

for Tom consisted of a selective serotonin reuptake inhibitor (SSRI) and Triazodone to assist with sleep.

Tom struggled to become involved in group therapy. He experienced remarkable difficulty relating to his peers on the unit. This was further complicated by the events of September 11, 2001, which occurred on the tenth day of Tom's treatment. On two separate occasions Tom experienced violent physical outbreaks after watching televised accounts of this tragedy. On a third occasion, Tom was triggered by the unit fire alarm. This event was so severe the crisis team was involved, and Tom was placed in seclusion to minimize stimuli. Zyprexa (5 mg) and Ativan (2 mg) were administered to minimize Tom's agitation.

Tom worked with the multidisciplinary treatment team to develop an integrated treatment plan. Development of the treatment plan was a slow process initially focusing on integration into the community.

*Problem.* Lack of participation in programming.



**FIGURE 7**  
This figure demonstrates key diagnostic decision and treatment factors presented in Case #3.

*Goal.* Increased involvement in programming.

*Objective*

1. Tom will meet with Mary Ann Jones, LISW, each morning and pick three groups to participate in each day.
2. Tom will talk with Mary Ann Jones at the end of the day and relate how these groups helped.
3. Tom will eat dinner in the community room with at least two peers.
4. Tom will limit his time watching the television to 1 hour per day.
5. Tom will sleep at least 8 hours per evening, utilizing medication as needed for sleep.

The focus of the initial goals were to establish relationships with his peers and staff. (Stage 2 of the Seven-Stage Crisis Intervention Model). As time progressed Tom found art therapy and music therapy to be helpful in relaxing him and improving his interactions on the unit. As time progressed and Tom became more active in group therapy he was challenged to identify his major problems (Stage 3 of Roberts' Seven-Stage Model). Tom shared that trusting again would be difficult. He continued by sharing the recurrent thoughts and dreams, first in the form of questions then in more detail. Within 3 weeks Tom was beginning to deal with the feelings and emotions associated with the traumatic event.

Tom transitioned into the partial hospitalization program. One day while in group Tom regressed as a result of an ambulance entering the emergency department with lights and sirens on. However, he was able to utilize the group to explore alternatives to his natural response to isolate and relieve his trauma. Tom worked with the group. He contracted to remain with two peers throughout the remainder of the day and to participate in art therapy as he felt this would be relaxing. Tom was able to build upon his

strengths and to utilize a solution-focused approach to develop a plan that functioned for that day.

*Case Autopsy.* Tom's treatment has been lengthy. He continues to follow up in the outpatient clinic twice monthly for therapy and medication management. Tom has not been able to return to his work. He has not returned to the firehouse or the now empty site of the warehouse fire. Tom's treatment plan continues to be solution focused, primarily dealing with environmental triggers. He has applied for vocational rehabilitation, and is interested in education surrounding computers. Tom occasionally attends a community-based support group for persons with PTSD; however, he acknowledges his ambivalence regarding the effectiveness of this group. Tom continues on medication and reports better results with low dose Risperdal than previously experienced with the SSRI.

*Factors of Resilience.* These factors include a strong will to survive, willingness to learn, and discovery of the ability to express emotion through art, crafts, and music.

#### **Case 4**

In the case of William, a series of neurocognitive testing indicated severe closed head trauma. William was facing life-changing and lifelong adjustments secondary to his crisis event (Figure 8). Remarkably enough William was open and willing to do whatever was necessary. Once medically stable William was transferred to a long-term residential physical rehabilitation facility. Assessment indicated the need for physical strengthening and rehabilitation to establish optimal functioning capacity.

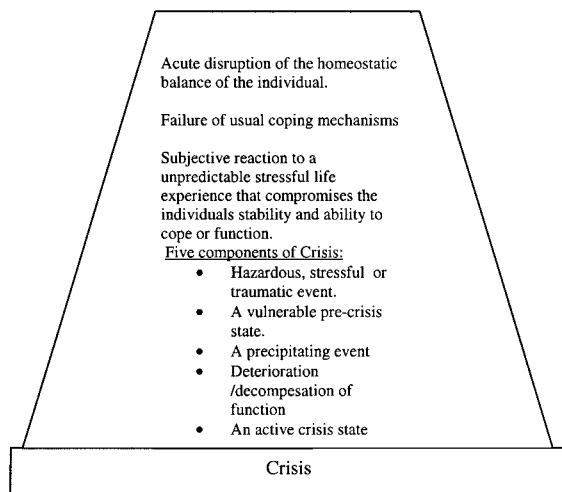
William and his family met with the team consisting of a physician, neurologist, physical therapist, and social worker. Of the team members William connected best with the social

worker. Building upon this strength the treatment team selected the social worker to review and develop treatment planning with William. Initially the treatment plan addressed strengthening and integration into a physical rehabilitation program. However, as time progressed all team members became involved in assessment and reassessment of functioning. For example, 2 weeks into rehabilitation William decided the process was too painful and he could not go on. Rather than engaging in arguments with William, the team took the approach of establishing a treatment plan based on William transitioning into an extended care facility rather than returning to his home as he intended. The physician, physical therapist, and social worker met with William to discuss the nature of his extended care placement and the need to refocus attention of transition planning rather than on rehabilitation (Stage 5 of Roberts' Seven-Stage Model).

This shift in planning evoked a remarkably emotional response. The team made time for William and listened to his complaints of their lack of caring, validated this feeling, and proceeded to rewrite his treatment plan to move

in a more aggressive manner toward strength training and rehabilitation (Stage 6 of Roberts' Seven-Stage Model). In application of solution-focused therapy, setting goals receives more emphasis than defining problems (DeShazer, 1985). In William's case goal setting was based on a desired future state, based on how the client perceives he or she will be acting, thinking, and feeling differently once the goal is accomplished. Without exception, William demonstrated willingness to work with the team and his family to successfully complete his rehabilitation (Yeager & Gregiore, 2000).

Resolving financial stressors was a remarkable issue in this case. Initially, William's wife assumed the responsibility for this process. However, the social worker arranged for a case conference with the company, William, his wife, and his attorney. Setting the process into motion led to a quick and fair settlement rather than a prolonged court hearing. Prior to establishing this conference William was asked with his family to establish concrete, precise indicators of changes for themselves. This process led to the ability to clearly articulate what their needs were and what concessions the family would be willing to make to facilitate the change process.



**FIGURE 8**

This figure demonstrates key diagnostic decision and treatment factors presented in Case #4.

*Case Autopsy.* William was able to return to his home. Today he is able to walk with the assistance of support devices. William and his family are living a modest life. William is receiving disability from his company. This disability was supplemented by the corporation, based on agreements made within the rehabilitation facility. In this case crisis intervention and solution-focused therapy integrated commonalities focusing on time-limited, intense interventions. In this case resistance was avoided through the presentation of alternative realities. William made his choice to continue in rehabilitation as this supported his perception of where he would like to be once discharged from the facility.

*Factors of Resilience.* These factors include utilization of multidisciplinary team approach, clear focus of ongoing living plans, supportive family, integrated treatment planning, utilization of problem-solving approach to address financial issues, and family cooperation.

In each of the case examples the critical components for completion of diagnosis and development of treatment planning are addressed. This is in addition to the previous diagram outlining characteristic symptoms associated with each disorder. This has been completed in an effort to provide an integrated overview of the critical factors associated with accurate classification of each disorder. More importantly this article provides a paradigm to clarify critical components, operational definitions and demonstrates a method to examine parameters and differences both within and between stress, crisis, acute stress disorder, and PTSD.

## Conclusion

Differentiating and operationally defining the related concepts and disorders known as stress or stressors, crisis or acute crisis episodes, psychological trauma, acute stress episodes, and PTSD are both challenging and complex. This article has carefully reviewed the professional literature and developed a theoretical paradigm, with case illustrations and treatment goals to help clinicians, administrators, and researchers to respond effectively to persons in stress, crisis, and trauma. Because of the significant increase in stressful life events, crisis episodes, psychological trauma, and PTSD experienced by millions of persons throughout the world each year, it is the authors' hope that clinicians and administrators will find the classificatory framework useful in early intervention, biopsychosocial assessments, and treatment planning. We urge researchers and program evaluators to gather systematic data on the effectiveness of

the paradigm (Figure 1) described in this article for reducing crisis episodes, acute stress disorders, and PTSD.

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